

Field Exchange

Emergency Nutrition Network



**Special focus on Nutrition
Cluster coordination**

Contents

1 Editorial

Field Articles

- 5 Accountability to affected populations: Somalia Nutrition Cluster experiences
- 11 Development and added value of the Nutrition Cluster in Turkey
- 16 Development of multi-cluster rapid and in-depth assessment methodologies in Afghanistan
- 20 Cluster coordination in a government-led emergency response in Ethiopia
- 25 Experiences of Nutrition Sector coordination in Syria
- 29 Partnership and accountability in the South Sudan Nutrition Cluster (2015-2017)
- 76 Global Nutrition Cluster Rapid Response Team
- 79 Experiences of the 'Whole of Syria' coordination for nutrition
- 84 From cluster to Nutrition Sector coordination: Government leadership in coordination for effective nutrition emergency response in Borno State, Nigeria
- 89 Nutrition in health response in emergencies: WHO perspectives and developments



© UNICEF/Motiba



WFP/Maria Klemm

47 Call for action

News

- 47 Promoting an integrated famine prevention package: Breaking bottlenecks. Global Food Security and Nutrition Cluster meeting, 26 April 2017 at World Food Programme HQ, Rome

Field Articles

- 50 Post-Rome integrated action: Experiences from North-eastern Nigeria
- 53 Somalia Nutrition Cluster: integrated famine prevention package
- 56 Yemen Nutrition Cluster: Integrated famine-prevention package
- 59 South Sudan Nutrition cluster 2017: famine lessons learnt

55 Nutrition Tech RRT

Field Articles

- 62 Nutrition Technical Rapid Response Team: Experiences and lessons learned
- 66 Tech RRT CMAM Adviser: Experiences from Nigeria and Yemen
- 68 Tech RRT IYCF-E/CMAM Adviser: Experiences from Niger, Haiti and Nigeria
- 71 Tech RRT Assessment Adviser: Experiences from South Sudan, Mozambique, Iraq and Yemen
- 73 IYCF-E Tech RRT support: Experiences from Iraq
- 74 Tech RRT IYCF-E support for Aleppo response, Northern Syria

News

- 35 Update of the Nutrition in Emergencies Coordination Handbook: A product of the Nutrition Cluster
- 36 Global Nutrition Cluster Strategy 2017-2020
- 37 Nutrition Cluster advocacy strategy/framework and toolkit
- 37 Guidance on accountability to affected populations
- 38 Global Nutrition Cluster HelpDesk
- 41 Inter Cluster Nutrition Working Group (ICNWG)

Views

- 42 Strengthening nutrition humanitarian action: Supporting humanitarian cluster/sector coordination transition



Dear readers

Since its inception over ten years ago, the Global Nutrition Cluster (GNC) has progressed from its early focus on the development of technical tools and materials and filling research gaps to a much greater emphasis on strengthening country coordination and providing surge support to secure appropriate and high-quality nutrition programming in emergency contexts.

As well as the changes evident at country level, the GNC has very strong strategic partnerships with its members. Referred to as the GNC Collective, members are guided by the GNC Standard Operating Procedures and a small elected group serve as representatives on the GNC Strategic Advisory Group (SAG), which helps guide priorities and positioning of the GNC within the wider architecture. Today the GNC has 44 partners (including ten observers) contributing their time and efforts, often freely. Without them, the Cluster would not be able to achieve the progress evident today.

The ambitious GNC Strategy (2016-2020), summarised in this issue of *Field Exchange*, and the related work plan guide the work of the Collective. Indeed, a review of the previous GNC strategy concluded that strong partnership was most evident where partners led aspects of the work plan in line with their respective strengths and skillsets. Maintaining and growing this commitment is always a challenge, however, as much of the work of the Collective relies on the continued goodwill of the individuals representing their agencies and organisations – with an uneven distribution of the workload that is perhaps inevitable.

When an emergency is declared, several immediate steps are taken by the GNC. First, there is the deployment of the stand-by surge capacity, either for coordination or for technical support or both, depending on context. Two valuable rapid response mechanisms have been developed to meet need: Rapid Response Teams (RRTs) that provide coordination and information management 'surge' support and an inter-agency Nutrition Technical Rapid Response Team (Tech RRT), funded by the Office of US Foreign Disaster Assistance (OFDA) (see article by Andi Kendle in this issue), that provides



rapid, flexible, nutrition technical expertise. Both are vital cogs in the Nutrition Cluster wheel as they provide immediate support for national coordination and the design of technical programmes and they help strengthen national capacities. Surge is a support, not a substitute, for longer-term Nutrition Cluster Coordinators (NCCs) and Information Management Officers (IMOs) – a vital partnership in coordinating the 4Ws (Who, What, When, Where) – and an incredible resource at the heart of the Nutrition Cluster. In addition to these key on-the-ground personnel, the GNC manages and staffs a 24-hour helpdesk, which provides country teams with immediate support; be it in soft skills (coordination, advocacy, etc) or in technical resources (survey design, access to global or normative guidance, etc).

The GNC also has key overarching documents which guide its focus and work. These include an Advocacy Framework and tool kit, a Framework for Accountability to Affected Populations (AAP), a Framework for fostering linkages with the Scaling Up Nutrition (SUN) Movement in fragile and conflict-affected states (FCAS) and an emerging inter-cluster collaboration with the Food Security Cluster (see news item in this issue of *Field Exchange*). Together, these are all steps in the right direction in terms of better linkages with global initiatives and other clusters.

The AAP has built on and more formally recognised the work done over the past ten years, which is to ensure that affected populations are consulted and that they participate throughout the response, so they are not passive recipients of aid but active stakeholders in the

shape and design of programmes. We see AAP in action in Somalia, where the Nutrition Cluster has led development and adoption of an AAP Framework and where pooled funding is now contingent on minimum AAP implementation, and in South Sudan, where partnership and accountability cut across all cluster activities and are crucial to programme quality.

GNC work is enabled by constant developments in information management, which has involved toolkits to help standardise the use of information across the Nutrition Cluster – although how information is managed between clusters is an ongoing challenge. Knowledge Management (KM) is another cross-cutting activity and crucial to the GNC in order to capture what is working well and identify where change is needed. The body of work reflected in this issue has involved considerable support by ENN to help NCCs unpack, dig into and document their wealth of insights and experience through 2016 and 2017. The engagement of NCCs in this process in the face of huge operational demands, and the quality and number of articles in this special issue of *Field Exchange*, are testament to the desire by NCCs, IMOs and RRTs to share their learning.

Despite all these achievements, the GNC faces a number of challenges and opportunities as it looks towards the next decade of emergency coordination and response in a rapidly changing global architecture.

It is apparent that there is a limited understanding among donors and other actors of the impact the Cluster is having, as evidenced by the gradual decline we are seeing in the

financing of the GNC work plan (see below). There is now an urgent need to better showcase the vital work going on in countries, particularly as we are facing an unprecedented number of emergencies that are often chronic in nature and span years. We share experiences from Somalia, South Sudan, Ethiopia and Syria in this issue; all have featured in our pages many times before.

Added to this, we are witnessing a profound deterioration in the nutrition status of populations in FCAS contexts which, if left unchecked, will prevent the realisation of important global targets for reductions in malnutrition. The application of cluster coordination performance monitoring (CCPM), rolled out in several countries, captures some of the impact story but this, too, needs to be better documented and more widely shared. There is also a need to develop and ensure more robust monitoring and evaluation.

While the GNC has an ambitious strategy, to realise it we need to ramp up strategic-level engagement with the other clusters (Water, sanitation and hygiene (WASH), Health, Food Security/Cash, etc), development actors, UNICEF as Cluster Lead Agency (CLA) and donors, as well as with local actors and governments. Central to this is a need to focus on preparedness, contingency planning, the humanitarian-development nexus and support for workable models of coordination, with greater support for strategic decision making in 'forgotten' and complex crises.

Many of these elements are touched on in the articles in this issue. In Ethiopia and Nigeria, NCCs describe alignment with and capacitating existing government sector coordination mechanisms; preparedness, contingency planning and longer-term 'development' goals are a pri-

ority in the Turkey cluster-led, cross-border response in Syria; while strategic planning has been taken to a whole new level through the Whole of Syria (WoS) coordination mechanism established in Jordan that constitutes one comprehensive framework, a common response plan and a supporting coordination structure across three operational hubs (Turkey, Syria and Jordan).

We also need the CLA to take a greater leadership role in technical support for the Nutrition Cluster and implementation of the structures for technical leadership, with broad-based engagement from GNC partners. By doing so, it will enable the GNC to focus on the wider strategic engagement needed to deliver on the recent global pledges and targets as set out in the Grand Bargain, the New Ways of Working, the Sustainable Development Goals, World Health Assembly targets and other initiatives which call for much greater linking of humanitarian and development efforts and for greater localisation.

In this special issue of *Field Exchange*, the 18 articles by NCCs, IMO and RRT staff aim to share the work of the Nutrition Cluster across widely varying and challenging contexts. These articles provide frank, open and honest accounts of their achievements as well as the critical barriers that need to be addressed and overcome through actions taken by the GNC, the CLA and all those concerned with protecting the nutrition status of populations living in emergency contexts. This is KM in action: it delves deep into country experiences, it examines context-specific experiences and it helps the GNC to see what we are doing well, what we need to do better and what we need to do differently. The following highlights some of the common themes from these articles.

Firstly, are we focused on the right nutrition problems? Looking at the history of the GNC, the default nutrition problem we have focused on is the treatment of acute malnutrition. This is highly appropriate in contexts where prevalence of global acute malnutrition (GAM) has increased or is in danger of increasing, such as in the famine-risk countries of Somalia, Yemen, South Sudan and Nigeria highlighted in this issue, but what about other high-impact interventions, and what do we do when faced with populations with low levels of acute malnutrition but high levels of anaemia, stunting, non-communicable disease, low prevalence of breastfeeding and sub-optimal infant and young child feeding (IYCF) practices in general? Over the many decades of emergency response, our default has been to treat acute malnutrition (we call this "the GAM ghetto"). The narrative hasn't changed, yet the contexts in which emergencies are taking place has and the nutrition problems that populations present with are as diverse as the contexts they live in. We have been unwittingly shooting ourselves in the foot by not having changed the narrative to ensure the coordination and delivery of a package of high-impact, nutrition-specific interventions.

The experiences shared in this issue show some progress. For example, stunting and IYCF feature strongly in the three-year strategy of the Turkey Nutrition Cluster, but what are considered 'life-saving' interventions dominate. In order to effect change in our story, we need different partnerships at global and local levels to have the capacity to deliver and, in turn, a reorientation of staff at various levels. Changing the narrative is one step, but how we advocate to donors to fund more comprehensive packages of nutrition interventions while ensuring the partner skillset needed to scale up these interventions is a work in progress.

A recent look at 20 humanitarian response plans over a two-year period showed that, in all contexts, treatment of acute malnutrition is systematically included – unlike the rest of the high-impact nutrition interventions. NCCs describe significant barriers with donors and with government, such as in Turkey and Syria, to accommodating a more holistic approach to nutrition in emergencies (NiE), with any progress eventually achieved being through determined cluster advocacy. Getting ourselves out of the GAM ghetto is going to be a significant challenge.

Next in line with treatment of acute malnutrition is the focus on infant and young child feeding in emergencies (IYCF-E). In many countries, our response is typically to issue a joint statement on IYCF-E, but we struggle to implement the full range of IYCF-E activities;



© UNICEF/Karel Prinsloo

i.e. from promotion, protection and support of recommended feeding practices to supporting the policy environment, including Code violations, and supporting mothers who do not breastfeed. Even in countries where one would expect a strong IYCF programme to be in place before a crisis hits, it has been necessary to deploy a Tech-RRT to produce a strategy and develop plans for a comprehensive IYCF package. In fact, across the range of experiences shared by the Tech-RRT advisors in this issue across many different contexts, IYCF was the dominant technical support 'ask' from the Collective. This raises questions about leadership and accountability to ensure a comprehensive IYCF-E response that should be grounded in preparedness planning; arguably, the only difference between IYCF-E and IYCF is the context. Several partners have developed tools and have been building capacity on IYCF-E, but there is still limited capacity among implementing partners and NCCs for the effective integration of IYCF-E programmes. Part of the problem may be poor appetite to invest in IYCF programmes in emergencies because they are viewed as preventative and not urgent, an issue raised in experiences in Iraq and Syria. This raises a further issue: without programmatic capacity to scale up (and down), cluster coordination loses its meaning. How can we be predictable in all technical areas and use the specific capacity of global partners effectively and strategically to strengthen capacity at country level in order to deliver a package of interventions at scale? How can we ensure that, when short-term technical surge is necessarily deployed to support the Collective, there is continuity with what has gone on before and follow-through on what happens afterwards, and what is the CLA responsibility in this regard?

Secondly, how do we enable multi-sector activities? In recent years, there has been much global and country-level emphasis on multi-sector approaches to prevent stunting and micronutrient malnutrition, and more recently attention has also been shifting to the double burden of undernutrition co-existing with overweight and obesity. Facilitating stronger linkages with other sectors is a challenge in stable contexts, so it is not surprising that the humanitarian community is also struggling with this way of working.

The four famine-risk countries are trying to do this (see experiences from South Sudan, Yemen, North-eastern Nigeria and Somalia in this issue, sharing their responses to the mid-2017 Rome Call for Action to prevent famine through inter-sector action), but the country-level efforts need agency-wide commitments and global-level direction and support to make

it a reality. Many agencies house the relevant sectors, such as Food Security, WASH and Health, and it is here where the discussion on integration is needed which is slowly happening. For example, an article by WHO describes internal reform around nutrition and health in emergencies within the agency and this sets the policy framework for a more operational approach, with nutrition integrated into health goals; we look forward to seeing how this unfolds in programming. The questions are, can it progress faster, who leads this vision and how can government and operational partners be brought on board to apply the approach quickly?

Thirdly, coordination needs a strong sector to embed emergency preparedness, response and transition. Over the past ten years, particularly across protracted emergencies, coordination, whether in countries with an activated cluster or in sector-led settings, the cluster has been filling a critical gap. This is because, with few exceptions, there are no strong sector coordination mechanisms that embed the coordination of NiE and support the coordination and scale-up of response to emergencies when needed, then scale down the response when the situation improves. This is reflected in the findings of a review commissioned by UNICEF in 2016 to examine what is needed to operationalise transition of cluster coordination structures into national coordination platforms – less than one third of clusters had transitioned to deactivation, despite guidance on how to transition out of cluster-led coordination. We see prime examples from South Sudan and Yemen in this issue, where cluster coordination is central to the coordination of response and with no prospects of deactivation or transition. The authors of the review propose working principles to link emergency and development coordination, based on government leadership and support, a systems approach and capacity-gaps analysis, whereby emergency coordination is embedded within sector nutrition coordination and phasing out of support is determined by changing context and competencies.

The challenge is to operationalise such thinking and there are promising working examples to draw on. In the absence of an existing sector coordination mechanism, the GNC often works in countries to build longer-lasting coordination capacity, as well as the mechanisms needed for emergency response. Kenya, Ethiopia and North-eastern Nigeria are three countries where emergency coordination is embedded in government and investment is made by both government and the CLA to maintain this capacity. Ensuring this happens across a much larger number of countries is a key focus. Indeed, in SUN Movement countries which may have multi-stakeholder platforms and plans, embedding

nutrition preparedness needs to be a key activity, particularly in FCAS and countries prone to large-scale natural disasters.

The article from North-eastern Nigeria is an example of a government decision to avoid the formal activation of the cluster mechanism (as it was seen as a sign of government failure) and instead adopt a sector coordination mechanism, with stronger government leadership with support from the CLA. If this is a growing trend, we need to better document these developments and influence the Inter-Agency Standing Committee discussion on how we classify the various contexts that are emerging and how the Nutrition Cluster can support and engage with them.

Fourthly, localising nutrition response and delivery: The new paradigm. The commitment to promote responses that are both "as local as possible" and "as international as necessary" underpins one of the new targets set out in the Grand Bargain. Localisation is the process by which the humanitarian response is reconfigured to meet this collective commitment. There are times when local actors may be overwhelmed by the scale or complexity of the humanitarian crisis and/or may be confronted with technical and/or institutional capacity, access or resource constraints. There may also be other reasons why local actors are unable or unwilling to adhere to humanitarian principles (particularly if they are party to a conflict, are perpetrating human rights violations or are compromised by their actual or perceived political or other affiliations). In these cases, the international community would respond – as much as necessary. However, at all times, local and international actors are expected to continuously review their involvement and contributions and ensure that they remain in line with the principle – as local as possible, as international as necessary.

One of the core cluster coordination functions is to strengthen local capacities to better prepare and respond to the humanitarian needs, while the cluster partners and the CLA, as well as the operational partners, have a role in ensuring technical capacity before, during and after an emergency. Although the GNC does not have a formal position on localisation, there are actions that we collectively need to take, while we also have examples that can support our actions.

In Ethiopia, for example, most nutrition interventions are delivered through government structures; therefore a different role is required to the one used in the past. On the other hand, in South Sudan there is weak government and minimal or no existing structure. Ideas about what is needed to scale up response in these

contexts and the countries that fall between the two extremes are evolving, as responses will differ according to each context. There is therefore a need to reorganise our support to local actors in a way that is well researched and planned. In South Sudan and Somalia, consolidated humanitarian funds (pooled funds) are being used to support/fund local non-governmental organisation (NGO) delivery services, although this is a funding arrangement and not systems building. We need a system that capacitates local NGOs to actually write proposals and implement quality programmes based on strong systems of financial and project management. We also need to explore systems of peer support (e.g. pairing of local NGOs with international NGOs) and to identify what is needed to develop capacity and build programme quality. Capacity development works both ways: local agencies are a rich resource of local knowledge and have good access to affected populations. They have been the cornerstone of humanitarian response in contexts like Somalia and Syria. The Nutrition Cluster may need to champion local agency participation in response as sometimes local partners are given less credence by government than international partners. Local NGO roles should not be limited to programme implementation – if organised in such a way, they could be capacitated and empowered to ensure they lead the response coordination, not just the grass-roots service delivery. A good example comes from Turkey, where 30 out of 36 cluster members are local agencies and a Syrian national NGO is cluster co-lead. At global level, we need to support countries to do the following: 1) Map existing coordination mechanisms and avoid creating parallel mechanisms; 2) Understand local

response capacities and gaps and continuously assess what is possible and what is necessary; 3) Model and broker an appropriate balance in local and government leadership and decision-making structures within the cluster setting at country level; 4) Identify capacity needs and document and share learning and initiatives that take the capacity needs of local actors into consideration.

Fifth and finally, after ten years of adding value, the GNC faces unparalleled resource constraints. The funding situation of the Nutrition Cluster has undergone gradual decline from 2010 onwards, with eight regular donors between 2006 and 2009 to a current three donors per year since (including the CLA). This drop in funding is due partially to the policy of a number of donors, who have asked the CLA to mainstream cluster positions (which has been done) so it is not all bad news. Indeed, out of the 21 countries supported by the GNC, about 18 positions have dedicated cluster coordinators, many of whom are on fixed-term contracts thanks to advocacy and the response of UNICEF in those countries. However, there is no funding to recruit for the other RRT/Tech-RRT positions, the helpdesk – or, indeed, to make real progress on the GNC work plan activities. The GNC is now facing its biggest funding shortfall since its establishment, threatening the very solid ground on which it stands – at a time when we have more emergencies and more complex contexts, and greater ambitions to link humanitarian and development systems, foster multi-sector actions for greater integration, and grow in-country capacities for localisation. Sometimes you only appreciate what you have when it is missing. Compromised information management, duplicated effort,

service gaps and lack of attention to nutrition are just some of the problems that characterised the cross-line, cross-border operations in Syria before the Nutrition Cluster was eventually activated there and in surrounding countries. These problems were captured in a special edition of *Field Exchange* in 2016¹; in this special issue of *Field Exchange*, we feature material that shows the added value of nutrition cluster coordination in these very same countries.

A key challenge for the CLA is how it can help articulate the funding deficit and advocate for it to be filled to protect these gains and help ensure a cluster fit for purpose in the changing global landscape. An ENN blog² following the GNC 2017 Annual Meeting stated: “We refer you to the 1996 Great Lakes Evaluation if you need reminding of how bad it was pre-humanitarian reform. We therefore have a very simple message ‘SAVE OUR NUTRITION CLUSTER.’

Josephine Ippe,
Global Nutrition Cluster Coordinator

Carmel Dolan,
Technical Director, ENN and Member of the
GNC Strategic Advisory Group



The findings, interpretations and conclusions in this editorial are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

¹ www.ennonline.net/fex/48/perspective

² www.ennonline.net/mediahub/gncannualmeeting



Dedication to Leo Matunga, 31.01.1977 - 21.05.2017

In recognition of the dedication of Leo Matunga, Nutrition Cluster Coordinator, who died in May 2017, we dedicate this special edition of *Field Exchange* to his memory. His huge loss, personally and professionally, are reflected in the words expressed by Josephine Ippe, in a condolence book compiled for his family and shared here.

*My Dear Brother Leo,
I saw the potential in you back in 2005 when we recruited you in UNICEF as part of my Nutrition Team based in El Fasher, in Darfur, Sudan. You have since then been more than a colleague to me. We have shared and celebrated each other's technical achievements and talked about our personal challenges over the years. I have been involved in your move from Sudan to Pakistan, Somalia and Afghanistan and I have seen you grow professionally and personally in all aspects of life. Your dedication, hard work and professionalism brought you this far. You were and you will continue to be the best humanitarian worker we have had. Since the day of your passing, the outpour of condolences received from the Global Nutrition Cluster partners, UNICEF staff and others, including donors all over the world, is a demonstration of your good work. I will personally ensure that your good name and work lives on. Goodbye my baby brother, until we meet again, when my own time comes.*

Josephine Iziku Ippe, GNC Coordinator, Geneva, Switzerland

Discussion with community elders on project implementation, Baidoa, Somalia, March 2017



Accountability to affected populations: Somalia Nutrition Cluster experiences

By Samson Desie and Meftuh Omer Ismail



Samson Desie is a nutrition specialist currently working as Nutrition Cluster Coordinator in Somalia with UNICEF. He has over 10 years' experience in managing large-scale and complex programmes in grassroots, national and international contexts, including in

the South Sudan crisis situation, Sudan protracted emergency and Somalia.



Meftuh Omer Ismail is a Senior Nutrition Technical Specialist for Save the Children Somalia, a position he has held since 2016. He has previously worked as a Nutrition Programme Manager for Save the Children South Sudan and Nutrition and Health

Coordinator for Merlin in South Sudan and Ethiopia.

The authors would like to thank the Federal Ministry of Health Somalia, UK Department for International Development (DFID), World Food Programme (WFP) and Save the Children International (SCI) in Somalia. A special acknowledgment goes to Paul O'Hagan, Humanitarian Advisor for DFID Somalia, for his review, guidance and support during the development of this paper.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

This field article is based on a presentation made by Samson Desie, supported by ENN, at the annual Global Nutrition Cluster (GNC) meeting in Amman in October 2016 and subsequently updated mid-2017 by Samson and key stakeholders.

Location: *Somalia*

What we know: Accountability to affected populations (AAP) is a key Nutrition Cluster function, reflected in five commitments (leadership/governance; transparency; feedback and complaints; participation; design, monitoring and evaluation).

What this article adds: "Weak" AAP, identified in a Nutrition Cluster evaluation in 2014, prompted revitalised coordination and a systematic approach to address weaknesses. Since 2015, the Somalia Nutrition Cluster has led development and promoted adoption of an AAP framework. Three levels of accountability around AAP in Somalia have evolved: large-scale (led by WFP), moderate-scale (led by Save the Children) and a minimum level (access to cluster-controlled pooled funding is contingent on this). There is increasing donor buy-in, including by DFID. Community conversations have been introduced in almost all emergency service delivery units/areas. A comprehensive online platform on monitoring and evaluation has integrated AAP for imminent launch; programme quality, coverage and performance will be tracked and transparent. Complaints are investigated by the cluster in a consultative verification and resolution process. Since May 2017 OCHA Somalia, alongside clusters and partners, has implemented Common Feedback Project (CFP) for AAP in prevention of famine. Looking ahead, AAP is mainstreamed in the Humanitarian Response Plan (HRP) cycle to facilitate uptake.

In 2014, the Somalia Nutrition Cluster (SNC) performance evaluation found that accountability to affected populations (AAP), a key cluster function, was "weak". A consultative workshop was organised in June 2015 to revitalise the coordination mechanism and identify a more systematic and integrated approach to address all weaknesses (Desie, 2016), acknowledging the traditional accountability mechanisms between and among communities in Somalia which are mainly through clan leaders/elders and sheiks. A new way of working was agreed, centred on ensuring AAP through coordinated and inclusive systems. The Somalia Nutrition Cluster Coordinator (SNCC) considers AAP a central element of its Humanitarian Response Plan (HRP) (as de-

scribed by the five commitments to AAP displayed in Box 1). Sparked by developments in 2015, the SNCC has been working to ensure that all cluster partners adopt an AAP framework. Experiences since then are shared in this article.

AAP in Somalia: levels of accountability

Until 2016 the World Food Programme (WFP) and Save the Children International (SCI) were the main agencies working in Somalia with a fully adapted AAP framework, although other cluster partners were beginning to follow suit. Three levels of accountability around AAP in Somalia have evolved: large-scale, moderate-scale and a minimum (mandatory) level. The distinctions between these levels are as follows:

BOX 1 Commitments to accountability to affected populations (CAAP)

Agreed by the Interagency Standing Committee (IASC) in December 2011, the five commitments to accountability to affected populations (CAAP) are:

1. **LEADERSHIP/GOVERNANCE:** Demonstrate their commitment to accountability to affected populations by ensuring feedback and accountability mechanisms are integrated into country strategies, programme proposals, monitoring and evaluations, recruitment, staff inductions, trainings and performance management and partnership agreements, and highlighted in reporting.
2. **TRANSPARENCY:** Provide accessible and timely information to affected populations on organisational procedures, structures and processes that affect them to ensure they can make informed decisions and choices and facilitate a dialogue between an organisation and its affected populations over information provision.
3. **FEEDBACK and COMPLAINTS:** Actively seek the views of affected populations to improve policy and practice in programming, ensuring that feedback and complaints mechanisms are streamlined, appropriate and robust enough to deal with (communicate, receive, process, respond to and learn from) complaints about breaches in policy and stakeholder dissatisfaction. Specific issues raised by affected individuals regarding violations and/or physical abuse that may have human rights and legal, psychological or other implications should have the same entry point as programme-type complaints, but procedures for handling these should be adapted accordingly.
4. **PARTICIPATION:** Enable affected populations to play an active role in the decision-making processes that affect them through the establishment of clear guidelines and practices to engage them appropriately and ensure that the most marginalised and affected are represented and have influence.
5. **DESIGN, MONITORING AND EVALUATION:** Design, monitor and evaluate the goals and objectives of programmes with the involvement of affected populations, feeding learning back into the organisation on an ongoing basis and reporting on the results of the process.

<https://interagencystandingcommittee.org/accountability-affected-people>

Large-scale

This has been achieved by WFP through the use of call centres (hotlines/phone lines) and interactive voice response/recording (IVR). This approach involves a substantial number of staff, a wide scope of activity and coverage and is decentralised through regional service delivery areas. The IVR has two main functions: surveys

and complaints. IVR (complaints) provides pre-recorded, interactive beneficiary support outside working hours through call centres to deliver information on WFP programmes, sensitisation on health and nutrition issues and the chance to record a question or complaint for WFP to call back and answer. IVR (surveys) involves pre-recorded, interactive, short surveys to ben-

BOX 2 SCI's approach in ensuring AAP

SCI believes that real accountability to children and communities affected by crises involves giving them not only a voice but also the opportunity to influence decisions affecting them and holding the organisation to account by influencing SCI's policies, priorities and actions at local, national and global levels. Accountability is part of SCI's core values and is a main component of the organisation's quality framework and management operating standards. SCI ensures APP with its beneficiaries through various approaches, including:

– **Complaints feedback response system (C/FMS):** Established by SCI, this comprises hotlines/toll-free numbers, focus group discussions, complaints desks and random proactive calls/SMS to programme/project beneficiaries and non-beneficiaries. Random proactive calls/SMS involves systematic listening and setting up formal mechanisms in intervention areas for people to express views and concerns on SCI's approach, activities and impact, as well as on safety issues and the behaviour of SCI staff. In addition, beneficiaries from the health and nutrition service have an exit interview once they finish the cycle of support to get feedback on the service.

– **Translation of project documents:** All SCI programme/project key information is translated into local languages, printed and posted in community gathering places. This communicates information on beneficiary targeting, beneficiary entitlements, complaint response mechanisms, project duration, donor and platforms for community participation in implementation of the project activities. There are also random checks and calls on beneficiaries to find out whether they have received their entitlements.

– **Developing and printing programme accountability standards:** These are printed in illustrated form (for illiterate people) and in narrative form to explain what behaviour people can expect of SCI staff and representatives (in line with SCI's child safeguarding policy and code of conduct), and how people can be involved and provide feedback and complaints.

– **Use of accountability system feedback:** SCI has developed an accountability database for all beneficiary and non-beneficiary complaints and feedback from its programmes. The information is analysed on a monthly basis and shared with the senior management team for discussion and decision-making to adjust programme activities in response to the local context, proposal development and knowledge generation.

eficiaries using outgoing calls. These can be used to collect information on awareness, food security, access to nutrition services and acceptability of the WFP feedback and complaints mechanisms for respondents who cannot read. Hotline call centres and IVR questions and complaints are managed by professionally trained operators, experienced in handling calls from beneficiaries and the general public. Systems in most areas are supported with dedicated, full-time staff. The system covers 'hot spots' and obtains information on geographic coverage of the programme and numbers of staff and exit interviews. Messages are sent using bulk short text messages (SMS).

WFP has incorporated a two-to-three-step verification process of complaints in its AAP system to identify whether issues raised are important or trivial. Some issues are discarded after two to three case investigations, while others, such as questions around cash/voucher/food distribution, require follow-up action. WFP takes the need to rectify problems and ensure that services are delivered as planned very seriously. The feedback mechanism is still being developed and does not yet provide a complete loop. However, AAP information is being acted on and WFP has modified programming as a result of beneficiary feedback found to be credible and/or valid.

Moderate-scale

SCI has adopted this approach. Its main component is an online facility and it operates in just a few sites. There are random checks on beneficiary experiences by programme staff in routine monitoring and evaluation (M&E), activities, but no dedicated, separate staff. This system is known as MEAL (monitoring, evaluation, accountability and learning) and operates within SCI both at the global and Somalia level. The MEAL framework resonates with the SCI quality framework¹, which puts M&E, accountability and learning at the heart of programme quality, together with technical excellence and evidence base. SCI's approach is detailed in Box 2.

Minimum (mandatory) level

All SNC partners are required to adopt this minimum level of AAP; pooled funding secured via the SNC, mainly via the Somalia Humanitarian Fund (SHF) (formerly the Common Humanitarian Fund (CHF)), is contingent on this. This approach involves exit surveys with those discharged from programmes and with defaulters.

Training on AAP – community conversations (CC)

The SNC implemented training in Somalia to help incorporate AAP into community management of nutrition. The concept of community conversations (CC) was introduced to all partners with the understanding that it was to be implemented in almost all emergency service delivery units/areas. This is mainly being achieved through the adoption of two key communication approaches in every personal/interpersonal

¹ <https://onenet.savethechildren.net/sci/QualityFramework/Pages/default.aspx>

communication with beneficiaries (i.e. negotiation with caretakers) and in group conversations/dialogues.

Negotiations with caretakers involve two key steps, **GALIDRAA** and **ORPA**. These are acronyms for the first letter of part of the intended communication. ‘**GALIDRAA**’ stands for **G**reet the mother/caretaker, **A**sk the mother, **L**isten to the mother, **I**dentify current nutrition or care practice and any problems and challenges to taking action on optimal practices, **D**iscuss different options to overcome any challenges, **R**ecommend and negotiate actions, **A**gree, and make an **A**ppointment for a follow-up visit. This approach is supported using visual aids, guided by the acronym ‘**ORPA**’: have the caretaker **O**BSERVE the illustration, **R**EFLLECT on what they see, **P**ERSONALISE/put themselves in the situation and see if they are willing to **A**CT on what they have seen and discussed.

CC is an ongoing process of facilitating and enabling community group to meet regularly to identify and reflect on its problems and their root causes; analyse and build consensus on possible solutions; develop community action plans; secure the necessary human, material, information and financial resources; and take collective actions at family, community and institutional levels that will lead to long-term, positive change. The main objective of CC is to generate an effective, community-based nutrition response to social/communal problems/issues that integrates individual and collective concerns, values and beliefs and that addresses attitudes, behaviors, practices and other underlying factors embedded in social systems and structures.

CC is a cyclical process that involves relationship building, problem identification, resource

exploration and planning, reflection of process, action, intervention and problem exploration. These should not to be confused with traditional behavioural change communication (BCC)/ information, education and communication (IEC) activities: the whole purpose of the CC/community dialogue in the AAP is to avoid the BCC expert approach and instead focus on helping the community to assess its own situations/problems, questioning the ‘why’ in an attempt to analyse the causes and choosing prioritised courses of action to address the situations/problems identified.

Training in the use of CC began in 2015 and has since been integrated with all capacity development efforts, including nutrition in emergencies (NiE) training. The SNC has also given training in AAP in Hargeisa, Mogadishu, Bosaso and Nairobi as part of a larger programme of NiE training. Every outpatient therapeutic programme (OTP) is now expected to involve a CC to nurture a basic understanding of malnutrition and what the community can contribute to help address the problem. The aim is to make malnutrition visible to the population and broaden ownership of its management. There is now a community group in every service delivery area.

Using funding as leverage for AAP

Funding provided through the CHF since 2016 has been contingent on agencies having an AAP framework in their proposals. There has been resistance to the AAP from some partners who felt that the mandatory requirement was “too controlling” and that the AAP is effectively an audit mechanism. However, the cluster has managed to clear some misconceptions and convince an increasing number of partners of its merits.

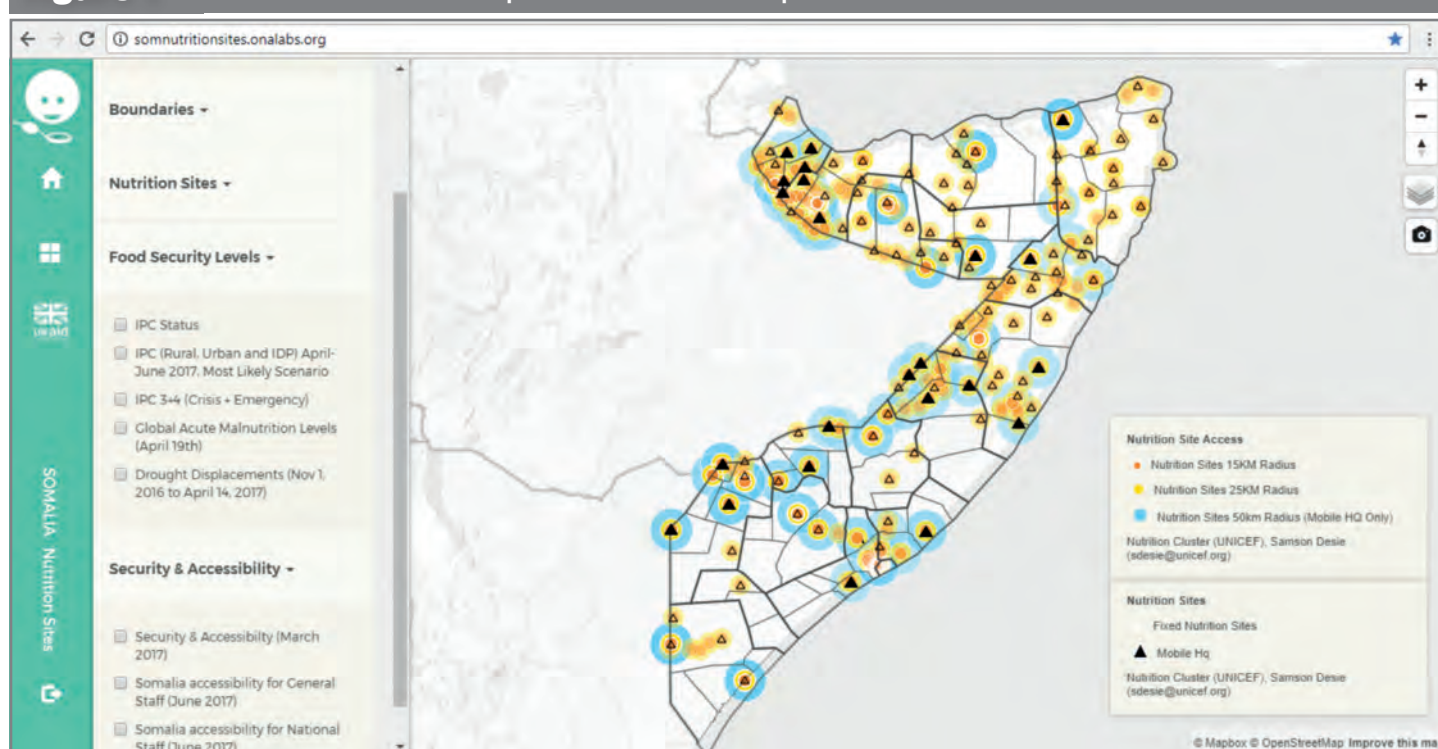
While cluster funding has provided leverage to make this happen, some partners have voluntarily bought into the AAP. Donors, such as the UK Department for International Development (DfID), have shown great interest in the AAP and have encouraged the cluster to move forward with its development. DfID has cited the AAP as a means of ensuring accountability and transparency and is now implementing a third-party monitoring (TPM) system whereby DfID-funded partners must adopt an AAP as part of their overall monitoring. The new DfID Humanitarian Reform Policy² has a strong emphasis on people’s right to participate in the decisions that affect them, for DfID to be more accountable to them and for them to make their own choices.

DfID continues to encourage and support the cluster, pushing for more innovative practice in the field, and appears to be learning from the Somalia experience and applying it to other country contexts.

The SHF has increasingly been used to invest in the scale-up of the AAP framework, especially the minimum package. In 2016 the SHF funded 11 partners, including five international, non-governmental organisations (NGOs) and six local partners. From January to July 2017, 14 partners (eight local and six international NGOs) incorporating the AAP were funded and around \$5.6 million dollars was invested by the fund in the pre-famine response. Through the SHF mechanism the SNC has played an important role in enabling national NGOs to access funding; approximately 60 per cent of SHF funding goes to local agencies.

² www.gov.uk/government/uploads/system/uploads/attachment_data/file/651530/UK-Humanitarian-Reform-Policy.pdf

Figure 1 Screenshot of the collaborative map function on the SNC online platform



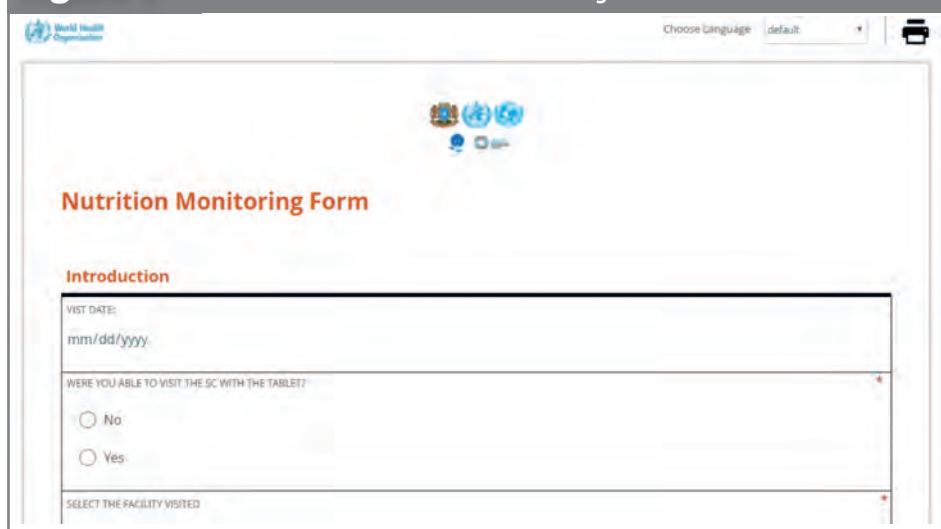
Online platform incorporating AAP

In 2016 the SNC began work on a comprehensive online platform (ONA – <https://ona.io/home/>) that has an integrated component on AAP as part of a wider M&E system. The platform is being finalised; almost all components (except AAP) became operational and were officially released in July 2017. The platform will be fully functional in early 2018. This online development is being supported by UNICEF, WFP and DFID. The platform allows for geotagging of service sites, infrastructure assessment, and capacity assessment of service delivery facilities in terms of service provision and human resources. An integrated AAP framework links with beneficiaries and facilities and a contact database for beneficiaries allows complaints and a feedback mechanism (with comments via SMS). The platform covers planning and monitoring and reporting (M&R) on top of AAP.

Planning: Service plans are developed and thresholds for scale-up are agreed. Based on assessment results, planning takes place according to which areas have been identified for scale-up or where to consolidate services. Planning tools include:

- Collaborative maps which can be overlaid with multiple sectors/clusters and refocus programming and responses based on objective analysis: <http://somnutritionsites.onalabs.org/> (using password 'ncs' if required) (Figure 1).
- Well-defined food security risk information that can be used to formulate comprehensive integrated management of acute malnutrition (IMAM) coverage/expansion plans.
- Validated information on service delivery sites and capacity that can be used to guide,

Figure 2 Screenshot of the online nutrition monitoring form



<https://enketo.aws.emro.info/x/#YYYY>

consolidate and strengthen the existing capacity of emergency nutrition units across Somalia, develop overall emergency preparedness/resilience and help in the scale-up of IMAM.

- Immediate actions/steps that can be taken by all partners/organisations to improve standards of specific nutrition sites.
- Opportunity for partners to self-report on progress of nutrition sites (such as whether they are new, opened or closed).

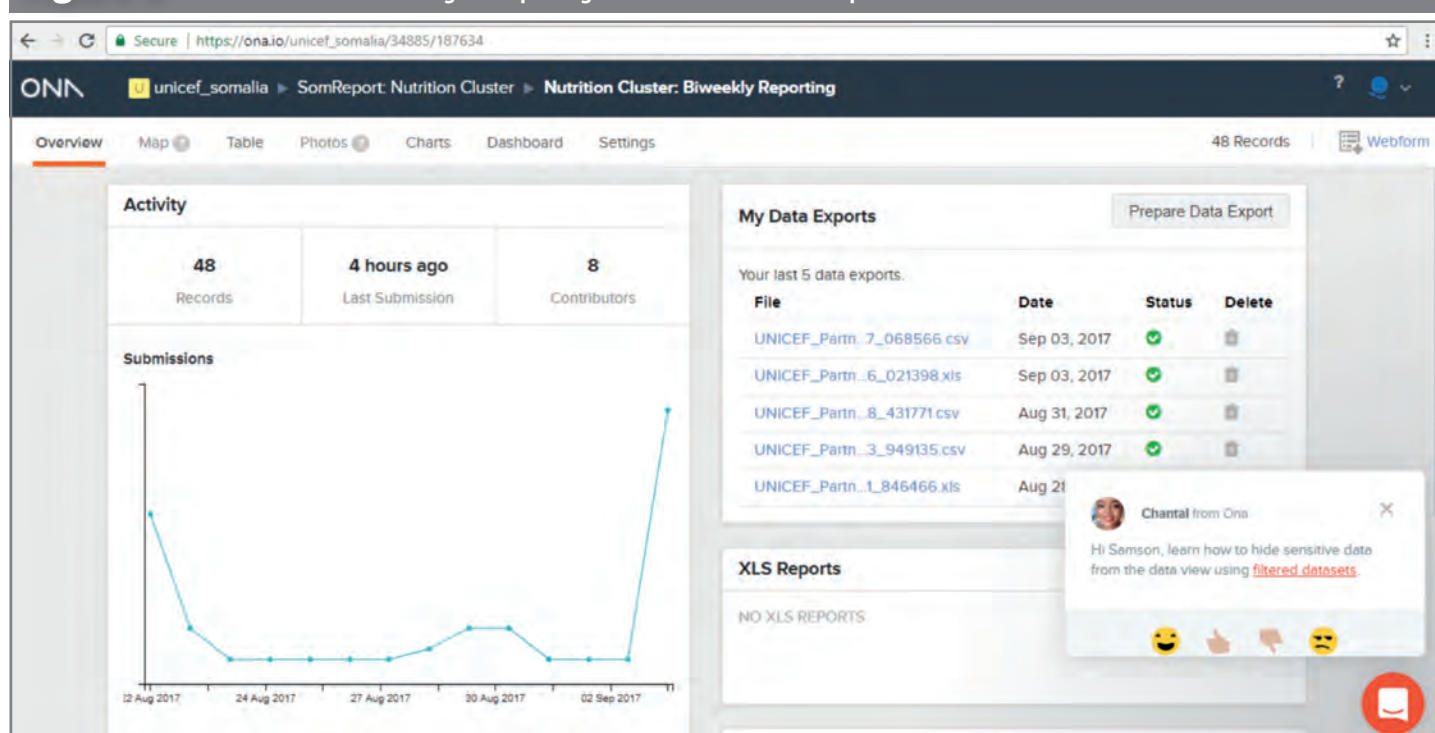
Monitoring and reporting: The online platform enables monitoring and reporting of partner activities and includes the following functions:

- The presentation of performance indicators in simple graphics, including a dashboard of performance indicators for each service

delivery unit. Information is currently updated fortnightly to help monitor the performance of pre-famine scale-up and response.

- Digital and automated upload of facility-level information using a standardised, user-friendly reporting form. This is available online via mobile/open data kit (ODK), SMS and off-line (Figure 2). All partners are assigned unique access to the system via the following links: https://ona.io/unicef_somalia/34885/187634 (for Somalia) and https://ona.io/unicef_somalia/34885/196108 (for Somaliland)
- A standard online monitoring framework that allows monitoring of the combined activity of all partners while maintaining confidentiality

Figure 3 Screenshot of the monitoring and reporting function of the SNC online platform





Abdullahi Nuriz/UNICEF

Regional consultation in Beletweyn, Somalia, May 2017

AAP: This adds an additional layer to the performance indicators which includes a confidential database of contacts managed by the SNC on all service delivery points. The database is used to generate bulk SMS/key messaging, IVR and to verify service delivery. Service users interact with the platform via SMS and IVR to communicate directly on the quality of services, geographic coverage and priorities and preferences on services. It is likely that international and local NGOs will adopt and rely on the AAP platform for their activities as the system is made fully functional and accessible to all.

Experiences using AAP online to date

So far over 15,000 community contacts/phone numbers have been collected and integrated into the online platform. There are 20 or more contacts for each fixed service delivery point, as well as the headquarters of mobile sites, who can be reached to provide quality assurance and monitoring and check functionality of the services. There are 1,000 facility contacts who can be linked up with regard to specific complaints.

Although not yet launched online, complaints are already being lodged with the SNCC, with notification of issues by elders who have engaged government counterparts in the Ministry of Health (MoH) at state level. The system is operating in all states and provides an overview of quality and coverage. To date (September 2017), nine specific complaints from MoH and clan elders have been received, largely in relation to partner neutrality, clan affiliation and misuse of resources. These have been filed and addressed accordingly through a consultative verification and resolution process. Complaints that come via the MoH must be documented in a letter, which is signed and stamped by the MoH. For complaints from elders, a simple email is sufficient. Following receipt of a complaint, a bilateral meeting with the complainant is set up by the organisation.

Out of six example cases, four complaints were resolved by the partner with the community. In two cases, the organisations withdrew from the location (due to an incident related to clan affiliation and recruitment processes); one of

these partners was identified as high-risk and has been denied access to resources until a detailed audit report is produced. A key guiding principle to resolving clan issues is that, as long as a partner has capacity and resources, it should be able to deliver a programme irrespective of clan.

As there is no direct communication with beneficiaries yet (this will be possible through SMS on launch of the complaints section of the online platform), no beneficiary complaints have yet been received except those organised by community elders. It is anticipated that most beneficiary complaints will concern ration size/quality, service access and service quality. Currently there is no structured template for feedback (this is in development with UNICEF). In the future, the plan is to set up a hotline which may involve a greeting, key messages and a simple structure for feedback and presenting a complaint.

The SNC is dependent to a large degree on agency self-reporting regarding the feedback received. Sub-national clusters are also informed of feedback. In addition, feedback is received

via mechanisms such as United Nations Office for the Coordination of Humanitarian Affairs (OCHA) regular field missions. Challenges around the AAP include getting organisations to sign up to the idea and, once they have, ensuring that they share all data (currently data sharing is voluntary). Most feedback is sourced from contact points, state MoH staff and facility managers and partners.

The online platform now maps and links technical performance indicators, such as admissions and performance, by site. This allows for greater transparency and will remedy the situation where aggregate data can mask poorer performance of individual sites. The SNC will also be able to initiate calls independently to beneficiaries around facilities/sites that are poorly performing to gain more insight and information.

On launching the platform in July 2017 a joint programme by the World Health Organization (WHO) and the Health Cluster was initiated to implement health facility mapping. After 2017 the plan is to overlay health systems onto existing nutrition service data. For now, however, attention is on consolidating the approach within the Nutrition Cluster and to fully overlay or integrate access, security and food security cluster data, as well as integrated phase classification (IPC) information.

Sustaining AAP in the face of programming priorities

Despite the large-scale humanitarian assistance delivered, the Food Security and Nutrition Assessment Unit Somalia-Famine Early Warning Systems Network (FSNAU-FEWSNET) post-Gu (April to June) cereal harvest assessment (FSNAU-FEWSNET alert, 31 August 2017) indicates a deteriorating situation with sustained high risk of famine until the end of the year due to a combination of severe food insecurity, high acute malnutrition and high burden of disease. The number of people in need is estimated to



Samson Desie/UNICEF

Regional consultation in Baidoa, Somalia, June 2017



Samson Desie/ UNICEF

Describing AAP for programme implementers at field level, Garowe, Somalia, February 2017

be 6.2 million, including 3.1 million people in crisis. The drought is also uprooting people, with 916,000 displaced since November 2016, adding to the 1.1 million existing IDPs (UNHCR PRMN Somalia Update, 31 July 2017). This includes 130,000 newly displaced in the month of July alone. The projected number of children who are or will be acutely malnourished has increased by 50 per cent since the beginning of the year to 1.2 million, including over 231,000 who have or will suffer life-threatening severe acute malnutrition (SAM). WHO surveillance data indicates that more than 77,000 cases of acute watery diarrhoea (AWD)/cholera have been reported so far this year; five times more than the 2016 caseload. Since the start of the year, 1,115 deaths have been recorded, with a case fatality rate (CFR) of 1.4 per cent. More than 15,000 measles cases have been reported since the start of the year and an estimated 4.5 million are in urgent need of water, sanitation and hygiene (WASH) assistance.

Assuming the worst-case scenario, the SNC cluster is prioritising an integrated comprehensive nutrition response in drought-affected areas of Somalia. Given the current humanitarian situation and needs, the AAP is progressing more slowly

due to competing demands but it remains operational and the SNC continues to document cases and lessons.

Moving forward

Since May 2017 OCHA Somalia, alongside clusters and partners, has implemented and managed a Common Feedback Project (CFP) for AAP and communication with communities in Somalia for the prevention of famine. The CFP, which is based in the Drought Operations Coordination Center (DOCC) in Mogadishu and structured as an inter-agency/inter-cluster common service, is built on existing feedback mechanisms/structures and partnerships with government, clusters (including the Nutrition Cluster), local/international organisations, mobile telecoms providers and media. The CFP supports joint response planning, includes harmonised messages and aims to avoid duplication by establishing a turnkey (ready-to-use) service that every organisation can adopt and/or feed into, while allowing individual organisations and/or clusters to continue the implementation of broader AAP frameworks.

The Nutrition Cluster also engages with media and communication entities to advance

AAP work. It has a framework of engagements with BBC Media Action and Radio Ergo to create an enabling environment that is independent and neutral with wider reach at grassroots level, interacting with affected populations on what matters to them (see Box 3).

Discussion and lessons learned

A key lesson learned so far is the need to ensure that AAP is mainstreamed and incorporated in the Humanitarian Response Plan (HRP) cycle at a higher level, mainly through OCHA, donors and lead agencies. This will greatly facilitate and ease uptake and successful implementation of the AAP among partner agencies. Currently uptake depends on the willingness and understanding of AAP among individual agencies.

A phone-based approach was chosen because the Somali community is an oral community and mobile phone penetration is one of the highest in the region. The Nutrition Cluster is aware, however, of the importance of interpersonal skills and listening and therefore balances the use of phone/online methods with CCs and direct feedback/interactive live communications from local leaders. This ensures brokering, discussion and understanding of the different perspectives. The AAP therefore consists of more than conventional complaints and feedback mechanisms: the various feedback mechanisms have different value/acceptance in different contexts and together provide richer and deeper information.

Ideally, the SNC would have initiated the process of establishing an AAP at grassroots and/or community level with the affected population. However, difficult access, the operational reality of this context, made this impossible, limiting involvement of the community in the co-design of the AAP mechanism. Recognising this limitation, the Nutrition Cluster will explore greater involvement and feedback by the community on the mechanism itself.

Conclusions

AAP is an integrated approach that facilitates the accountability of donors and partner organisations to the affected population. It also has great potential to improve efficiency and effectiveness of the humanitarian response by creating greater transparency and a platform to facilitate full engagement of the affected population. This will create a better understanding of problems on the ground and the formulation of humanitarian actions and plans that respond to real needs and build resilience of affected communities. This will be further demonstrated over time in the Somalia context through ongoing learning and practice.

For more information, contact: Samson Desie, email: sdesie@unicef.org

BOX 3 Nutrition Cluster collaboration with BBC Media Action and Radio Ergo in Somalia

BBC Media Action (www.bbc.co.uk/mediaaction) is the BBC's international development charity. It uses the power of media and communication to help reduce poverty and support people in understanding their rights. The collaboration with the Nutrition Cluster focuses on key messaging around malnutrition and possible community actions, including where and how nutrition services could be accessed and user feedback, with the aim of informing and connecting people with cluster service providers.

Radio Ergo (www.radioergo.org/en/) is run by international Copenhagen-based NGO International Media Support from its Kenya regional office. The station broadcasts original humanitarian news and information in Somali every day across Somalia and the Somali-speaking region. Its aims are to amplify the voices of ordinary Somalis, enabling better communication with the wider international humanitarian community, and to provide Somali audiences with the critical information they require to make better informed choices on issues affecting their lives. The partnership with the Nutrition Cluster is being built on concrete grounds in a systematic manner. It includes informing where and how nutrition services can be accessed, messaging and interactive dialogue on what malnutrition is and what the community can do about it, and longer-term programming to empower the community on nutrition vulnerability, needs and priorities. The Cluster is working with the Radio Ergo team on an operational framework and the development of effective messaging/programming content.

References

Desie S. *Changes to Nutrition Cluster governance and partnership to reflect learning and operational realities in Somalia*. Field Exchange 52, June 2016. p68. www.enonline.net/fex/52/nutritionclustergovernance



Qatar Red Crescent team, conducting screening for malnutrition in Joseph village, Idleb governorate, 2017

Living Farms, 2012

Development and added value of the Nutrition Cluster in Turkey

By Wigdan Babikir Makki Madani



Dr Wigdan Madani is the Nutrition Cluster Coordinator for Turkey, based in the UNICEF MENARO Outpost, Gaziantep. She has a PhD in Food Science and

Technology from McGill University and has mainly worked for UNICEF as a nutrition specialist for the last ten years.

The author would like to acknowledge the technical contribution of the co-lead from GOAL (Lindsay Pexton, Abyan Ahmed, Aileen Wynne and Tamanna Ferdous), the Nutrition Cluster from start up to January 2017, and the co-lead from Physicians Across Continents (Mona Maman) from February 2017 to date. The author would also like to thank the Nutrition Cluster members, Syrian NGOs and international NGOs for their commitment and the great work that they are doing in scaling up curative and preventative nutrition interventions to save lives and prevent short-term and long-term consequences of malnutrition.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: Turkey

What we know: Cross-border operations from Turkey have been and remain a critical part of the Syria humanitarian response. Coordination and information sharing is complex and challenging.

What this article adds: In 2015 the Nutrition Cluster in South Turkey transitioned from a sub-group of the health sector working group to a Nutrition Cluster. Pre-cluster activation, coordination and information sharing of cross-border/crossline activities were severely hampered. Key areas of cluster action included generating nutrition information and gap analysis to inform response plans; harmonising reporting tools; developing, implementing and monitoring an infant and young child feeding in emergencies (IYCF-E) strategy and action plan that encompasses acute malnutrition treatment, micronutrient supplementation and inter-sector working; preparedness; developing capacity of national staff/local NGOs; and catalysing inter-sector collaboration. A Syrian NGO is the cluster co-lead and most partners are now local NGOs. Coordinated convoys and service delivery have been a key success of the 'Whole of Syria' (WoS) coordination approach. Challenges remain regarding access to besieged and hard-to-reach areas; indiscriminate distribution of breastmilk substitutes (BMS); coverage of services; and securing donor commitment in a low global acute malnutrition (GAM) prevalence context for longer-term, flexible funding that accommodates preventative as well as curative interventions.

Nutrition Cluster activation in Turkey

Prior to Nutrition Cluster activation in Turkey, there were considerable shortfalls in coordination and information sharing in programming in Syria. Nutrition occupied a small space in the health sector working group in Turkey. Donors prioritised other sectors such as food security, water, sanitation and hygiene (WASH) and tertiary health needs in the context of low global acute malnutrition (GAM) prevalence. Less attention was given to infant and young child feeding (IYCF) problems by the donor community, who did not consider IYCF support an 'emergency' intervention. Inadequate information sharing between Damascus cross-line and Turkey cross-border operations led to gaps and duplication. With no official cross-border United Nations (UN) role, access to certain humanitarian funding streams (such as the Central Emergency Response Fund (CERF)) was limited. A coherent and harmonised response was also severely lacking, with different guidelines and tools used by non-governmental organisations (NGOs).

Beginning in 2014, a series of UN resolutions enabled official UN cross-border activity, which paved the way for Nutrition Cluster activation in Turkey¹. There was a strong push from NGOs for official recognition of cross-border operations and activation of the Nutrition Cluster. In February 2015, the Humanitarian Liaison Group (HLG) formally requested the emergency relief coordinator to activate the cluster, citing the need to coordinate partners, enable access and increase the response and cost-effectiveness of interventions in North Syria from Gaziantep, Turkey. The Nutrition Working Group (NWG) was eventually solidified in January 2015 and the Nutrition Cluster was activated one month later.

The Nutrition Cluster Coordinator (NCC) position was initially covered by short-term surge capacity from the Rapid Response Teams (RRTs), which resulted in high turnover and lack of continuity/follow-up. In the last quarter of 2015 the combined effort of the RRT NCC, UNICEF regional advisor and cluster co-lead from GOAL paved the way for the preparation of the humanitarian needs overview (HNO) and the humanitarian response plan (HRP) for 2016 and the identification of nutrition funds. A dedicated NCC was eventually appointed by UNICEF in early 2016. In January 2017, a co-lead from a national Syrian NGO was elected. The Nutrition Cluster now comprises six international NGOs (INGOs), 30 local NGOs and four UN organisations. Coordination meetings take place in Gaziantep every two weeks.

Nutrition Cluster priorities and nutrition activities

Nutrition Cluster priorities are to strengthen life-saving curative and preventative nutrition services for vulnerable population groups, focusing on appropriate IYCF practices, micronutrient interventions and optimal maternal nutrition, and systematic identification, referral and treatment of acutely malnourished cases under five years of age and pregnant and lactating women (PLWs). The Nutrition Cluster also seeks to support the development of a robust, evi-

¹ UN Security Council Resolution 2165/2191/2258 authorised UN the border crossings at Bab al-Salam, Bab al-Hawa, Al Yaru biyah and Al-Ramtha to deliver humanitarian assistance, including medical and surgical supplies, to people in need in Syria. The government of Syria is notified in advance of each shipment and a UN monitoring mechanism has been established to oversee loading in neighbouring countries and confirm the humanitarian nature of consignments. www.humanitarianresponse.info/en/system/files/documents/files/cnv_syr_xb_regional_may_160616_en.pdf

dence-based system through surveys and a surveillance system to inform programme implementation.

From January to June 2017 the South Turkey cross-border cluster partners reached 455,966 children under five years old and PLWs in 352 communities with both preventative and therapeutic nutrition interventions. A total of 224,729 children under five years old and 27,376 PLW were screened for malnutrition. Among them, 1,060 children were treated for severe acute malnutrition (SAM), including 48 complicated cases, and 4,170 for moderate acute malnutrition (MAM). Lipid-based nutrient supplements (LNS) were provided to 85,103 children aged 6-59 months, targeted based on food security vulnerability criteria, and counselling on appropriate IYCF was provided to 162,368 PLWs. A total of 586 health workers received training in the community-based management of acute malnutrition (CMAM), while 782 health workers received IYCF counselling training.

Key responsibilities of the Nutrition Cluster are to provide gap analysis of the overall response (to determine where partners are responding and identify critical gaps and areas requiring scale-up) and to accelerate/scale up the response into gap areas. Access to cross-border communities increased from 9 per cent in 2016 to 50 per cent in 2017 and access to health facilities increased from 60 per cent in the first quarter of 2017 to 70 per cent in the third quarter of 2017 (World Health Organization (WHO) health resources availability mapping system report, 2017).

The HNO and HRP were established in 2015 and include severity scores and population needs. Seventeen nutrition-specific indicators are measured, including prevalence of malnutrition (wasting, stunting, anaemia), vitamin A deficiency, nutrition programme coverage and recently added indicators from other sectors (including diarrhoea in the past two weeks, hand-washing at critical times (provided by WASH sector) and food consumption score (provided by food security sector). The HNO and HRP also identify districts that will be covered by cross-border operations and those that are covered by Damascus (cross-line) and via Amman (cross-border from Jordan). 'Whole of Syria' (WoS) joint planning is now a regular exercise between hubs to facilitate joint planning and avoid duplication. Nutrition surveillance was established in July 2017 (funding constraints and low GAM rates meant that surveillance was not prioritised before this) and is integrated within the Early Warning Alert and Response Network (EWARN) in 100 health facilities across seven governorates, (Aleppo, Ar-Raqqa, Dar'a, Hama, Homs, Idleb and Quneitra) to serve as an early-warning, early-action system for nutrition. Cluster partners collect data from the health facilities to contribute to the EWARN.

The Turkey Nutrition Cluster has harmonised reporting tools for the nutrition programme. In collaboration with the Health Cluster, nutrition indicators have been integrated into the health information system (using DHIS2²). The DHIS2 was established in opposition-held areas (there is a *de facto* government that is not officially

recognised by the UN), where the response is largely implemented by NGOs. The system was developed to strengthen the health system and have one reporting system instead of individual NGO systems. Nutrition Cluster interventions were also costed as part of the primary healthcare package of service developed by WHO.

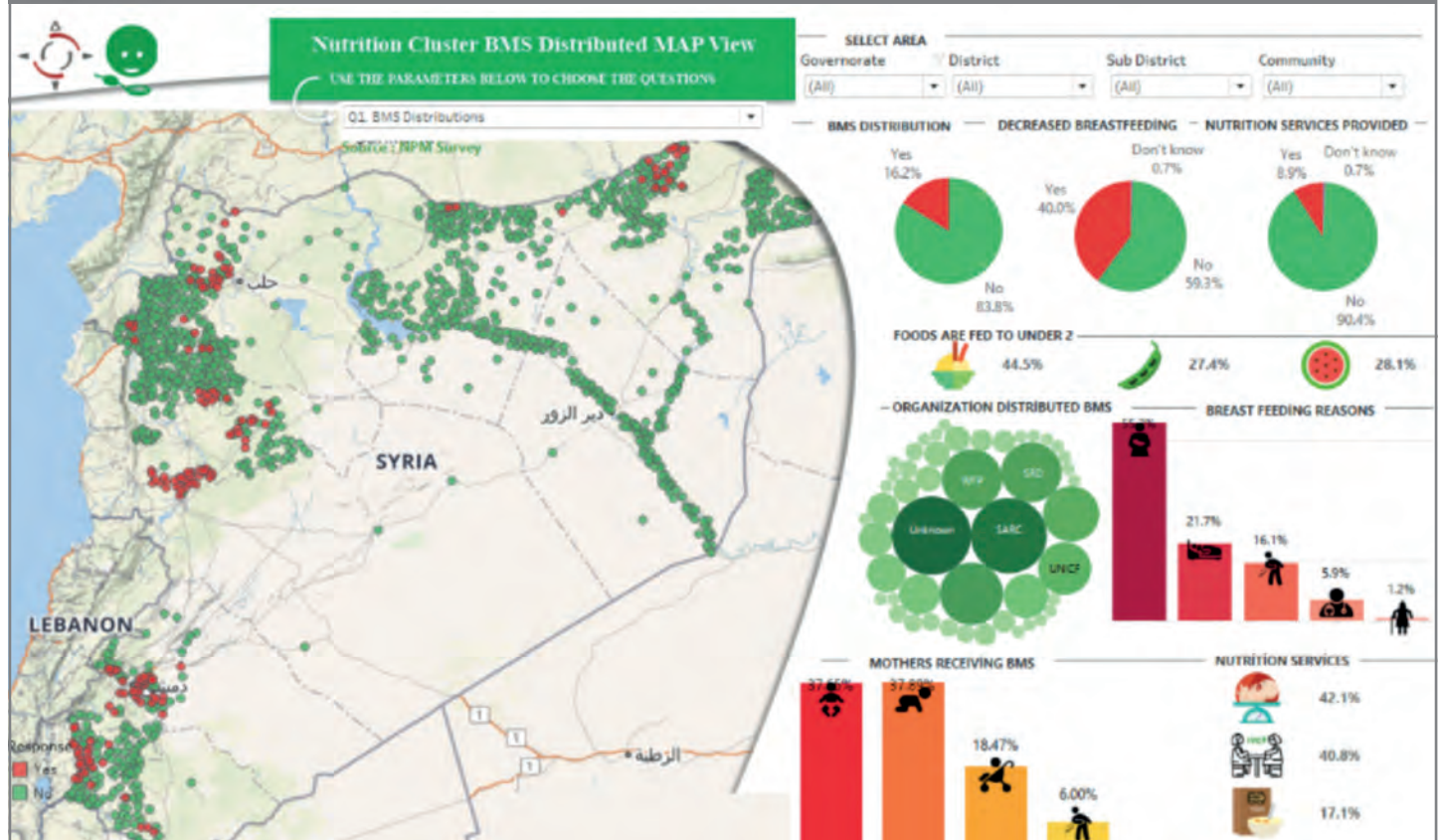
Nutrition programming

Various assessments have identified low GAM, prevalent stunting and anaemia in children as significant and deteriorating problems, coupled with poor IYCF practices. Most recently, in January 2017, a SMART survey was conducted and validated in Eastern Ghouta (rural Damascus) in nine of the besieged areas and in Idleb. Prevalence of GAM was low (2.1 per cent and 2.2 per cent respectively). Prevalence of stunting was low in Idleb (13 per cent) and high in East Al-Gouta (30.5 per cent) compared to a national average of 16 per cent (SMART surveys, 2016). Anaemia prevalence in Idleb governorate was moderate at 35.29 per cent (578 children were tested; 204 had HGB < 11 mg/dl).

Findings from a 2014-2015 SMART survey and community surveys identified deteriorating IYCF practices within Syria, with breastfed infants using infant formula. This was linked to indiscriminate distribution of breastmilk substitutes (BMS) (16 per cent of communities had random BMS distributions, usually by Syrian NGOs operating independently of the cluster

² DHIS2 is an open-source software platform enabling governments and organisations to collect, manage and analyse data in the health domain and beyond.

Figure 1 Indiscriminate BMS distribution (2016)





coordination mechanism; see Figure 1). Following this a scale-up of IYCF programmes by partners and large-scale advocacy and awareness-raising campaign (200 communities) by the Nutrition Cluster and partners on the standard operating procedures (SOPs) for the control of the distribution of BMS took place in 2016.

Subsequently in March 2017 the Nutrition Cluster, with technical support from the Global Nutrition Cluster RRT, conducted an IYCF knowledge, attitude and practice (KAP) assessment in Aleppo, Idleb and Hama in North Syria governorates (areas accessible from Turkey cross-border). Results found low exclusive breastfeeding rates (30.9 per cent compared to 43 per cent pre-conflict), low early initiation of breastfeeding (37.8 per cent vs 46 per cent pre-conflict) and 57.3 per cent minimum acceptable diet. However, prevalence of exclusive breastfeeding had improved in Hama and Idleb from earlier post-crisis rates of 21.2 per cent and 21.1 per cent respectively (SMART, 2014-15). These findings concur with a joint community-based food security and nutrition assessment conducted in 8,088 households in seven governorates in Syria.

Some improvement in feeding practices was noted in 2017 and a reduction in reports of random distribution of BMS reflect the positive impact of the scale-up of IYCF programmes (which now covers 89 per cent of the comprehensive primary health facilities and their catchment areas) and the success of the advocacy campaign, which improved awareness of IYCF-E and BMS SOPs among NGOs in Syria. A BMS management programme now operates in IDP camps, with individual assessment of each child and guidance on BMS management. There has been some success with relactation; some mothers reestablished breastfeeding while others continued to bottle feed. Currently individual NGOs are using donated BMS supplies in ac-

cordance with the SOPs and providing BMS kits (which include a cup, water boiler and thermos to keep the water hot). The cluster has tried to secure a common pipeline for BMS supplies but this is not yet in place due to funding issues. Partners are reporting monthly on their BMS stock and consumption.

The IYCF programme also includes blanket distribution of Plumpy'Doz (a lipid-based nutrient supplement) for children aged 6-23 months for prevention of malnutrition among the most vulnerable IDPs and host community, implemented by WFP and UNICEF, and counselling on complementary feeding. The programme covers 45,000 children under two years of age, targeting only the most vulnerable IDPs and host communities based on food security criteria. Home fortification using multiple micronutrient powder (MNP) has low coverage due to poor acceptance; this is being addressed through communication and awareness-raising activities.

Nutrition programming is integrated into 75 per cent of the primary healthcare centres (including hospitals, mobile clinics and health units) in North Syria and in the primary health care package developed with WHO in 2016. Community-based IYCF programming is integrated into primary healthcare and implemented through partnerships with NGOs due to the absence of a government primary healthcare system. Informed by a capacity-gap assessment of Nutrition cluster partners in 2016, several trainings were conducted, which included cluster coordination and cluster coordination performance evaluation, facilitated by the GNC. Nine NGO partners were trained as SMART survey managers by CDC. In addition, capacity building of health staff and community health workers on IYCF counselling has been undertaken and is ongoing to support the scale-up plan in 50 per cent of communities.

Given the context of chronic concerns and challenges in IYCF, an IYCF strategy (2017-

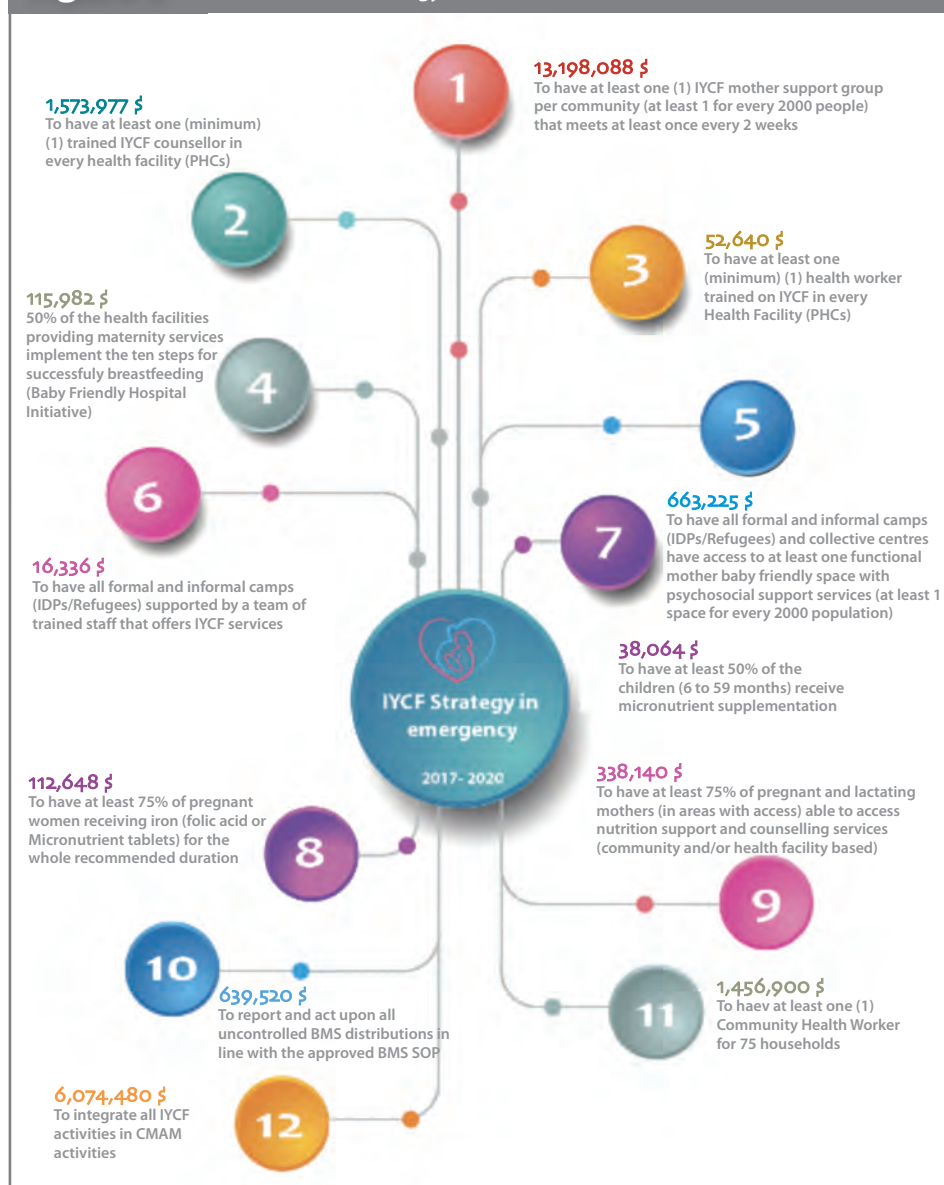
2020) and costed action plan were developed and launched in December 2017. The overall objective is to improve the health and nutrition status of mothers, newborns and children under five years old among affected populations, using a preventative approach that also encompasses stunting and anaemia prevention. The programme targets children under five years old and PLWs and includes micronutrient supplementation and a range of integrated health, food security and WASH interventions, based on a multi-sector approach. This is backed up by health, food security and WASH cluster collaboration in North Syria. In addition, sector cluster partners launched a one-year IYCF advocacy and awareness-raising campaign in 2017 covering over 200 communities in North Syria to strengthen IYCF programming and scale up screening and treatment of acute malnutrition. This marked the beginning of a concerted effort of integration with other sectors. A recent mid-year review of the strategy revealed progress towards targets. From January-June 2017 a total 352 communities (50 per cent of 2017 target) implemented IYCF activities in 68 sub-districts (68 per cent of target). Significant progress has been made in key IYCF indicators; 162,368 PLWs (69.4 per cent of target) were counselled on IYCF and 19,430 IYCF counselling sessions (39 per cent of target) were conducted.

Preparedness and IDP response

The Nutrition Cluster established five RRTs in IDP reception centres and camps and areas of expected displacements and return to support timely response to IDPs and returnees. Community health workers and mobile teams are usually deployed in immediate response. The teams supported IDPs displaced from East Aleppo, Barze, Qaboon, Alawaer, Madaya, Zabdan and Arsal. For preparedness, nutrition supplies (ready-to-use therapeutic food (RUTF), ready-to-use supplementary food (RUSF), Plumpy'Doz, high-energy biscuits (HEB) and multiple micronutrients for PLWs and children under five



Trucks loaded with food assistance cross the Turkey-Syria border, February 2016

Figure 2 Overview of IYCF-E strategy (2017-2020)

years old) are pre-positioned by partners through support from UNICEF in Azaz, Jarablus, Albab and in different locations in Idleb to cover the immediate needs of newly displaced people.

In 2016 the Nutrition Cluster partners reviewed the rapid response to IDPs from Aleppo and documented overall lessons learned to improve the response to IDPs. With IYCF-E Tech RRT support (see article in this edition of *Field Exchange*), lessons regarding IYCF-E were used to define a minimum IYCF-E package for rapid response which takes account of limited contact time/caregiver access/opportunities for meaningful counselling. A review involving IYCF-E technical working group (TWG) members established which existing tools could be applied, which required adapting to accommodate compromises in programming, and which new tools were needed. The Tech RRT adviser also provided feedback on the overall integrated health and nutrition rapid response mechanism.

The Nutrition Cluster has worked to build the capacity of Food Security Cluster partners

to integrate nutrition in the IDPs response. This has included distribution of HEB and Plumpy'Doz for children under five years of age as part of the emergency food basket and mid-upper arm circumference (MUAC) screening by food security partners. Lessons learned from this experience will be documented with a view to scale-up.

Impact of 'Whole of Syria' approach on cross-border programming

The WoS nutrition sector has played an important role in heralding the way to share information between cross-border and Damascus-led programming; there is much closer collaboration as a result. Cross-line convoy plans to reach besieged and hard-to-reach areas are shared via OCHA and the WoS coordinator on a monthly basis. The Turkey cluster informs partners on plans and when supplies (RUTF, RUSF, Plumpy'Doz and multiple micronutrients) will arrive. Some interruptions of pipeline remain due to funding constraints. For besieged and

hard-to-reach areas, cross-line convoys deliver supplies to the local relief committees and cross-border partners are informed of the delivery; supplies may be accessed directly or beneficiaries or health staff can approach relief committees as appropriate. Additionally, cross-border partners may inform the respective hubs/sectors/clusters about the availability of and/or gaps in supplies to support the planning of future cross-line convoys.

Integrated programming

A priority area of Nutrition Cluster advocacy is to advocate to donors on the need for integrated efforts between sectors and for more funding for the Nutrition Cluster. Advocacy to donors highlighting IYCF and related stunting issues has led to more funding through UNICEF and INGOs for capacity building of local Syrian NGOs to scale up preventative nutrition interventions and for procurement of nutrition supplies. Funding to nutrition is improving to the Nutrition Cluster and to national and international partners, but considerable shortfalls to achieve nutrition programming at scale remain. There were also delays in receiving funds in 2017 due to the diversion of funds to support famines and cholera outbreaks in other countries.

Information sharing has improved dramatically over the last two years, with stronger coordination between sectors and joint programming with both food security and child protection on nutrition. Three priority areas have been identified by the Nutrition Cluster for integration with other sectors:

- Raising awareness on IYCF;
- Blanket feeding of Plumpy'Doz (children aged 6-23 months for prevention of malnutrition) and multiple micronutrient supplementation; and
- Screening for malnutrition and referral for treatment.

The Nutrition Cluster has conducted a workshop with child protection, food security and WASH and identified areas of integration (see Box 1). It has also worked with the Food Security and Livelihoods Cluster in joint emergency response to new IDPs, integrated programming in 2017 and collaborated on nutrition-sensitive agriculture (kitchen gardening). UNICEF recently signed a project cooperation agreement with two food security partners to integrate nutrition interventions with the general food distribution and there are plans to do the same with livelihood partners. The Nutrition Cluster has undertaken capacity development on nutrition with food security, WASH and child protection partners and has developed an integrated (multi-sector) programming training manual and information, education and communication (IEC) material to support this effort.

Capacity development of national NGOs

The Nutrition Cluster is co-chaired by a local NGO and national NGOs now make up a high proportion of cluster partners. The cluster has heavily invested in capacity building of national



Development of multi-cluster rapid and in-depth assessment methodologies in Afghanistan

By Anna Ziolkovska, Hassan Ali and Baseer Qureshi



Anna Ziolkovska is currently the Nutrition Cluster Coordinator in Yemen. Anna has a PhD and over ten years' experience in nutrition, humanitarian assistance, cluster coordination, information management, capacity building and project management at HQ

and country levels, including in South Sudan, Somalia, Philippines, Ukraine, Afghanistan and Yemen.



Hassan Ali is a nutrition survey and surveillance expert with over three years' experience in SMART methodology in Kenya, Somalia, Afghanistan and Yemen, working with Ministries of Health and Nutrition Clusters.



Baseer Qureshi is a medical doctor (MD, MPH, MBA) working with the public nutrition directorate (PND) of the Ministry of Public Health (MoPH) in Afghanistan as a national nutrition surveillance consultant.

The authors would like to acknowledge the support of the Common Humanitarian Fund (CHF) in funding the workshop. The Nutrition, Health, Food Security and Agriculture (FSAC), and WASH (water, sanitation and hygiene) Clusters; their respective cluster coordinators and assessment working groups; and the relevant government ministries, including MoPH, and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) are also acknowledged for their role in the development of multi-sector assessments.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: Afghanistan

What we know: Joint (multi-sector) data collection and analysis is needed to inform nutrition-specific and nutrition-sensitive interventions.

What this article adds: Due to limitations in inter-sector assessment frameworks and experiences, the Nutrition Cluster took the lead in improving joint assessment tools and their implementation in Afghanistan. A nutrition data clinic (to define standards for assessment) was followed by a multi-sector workshop (Nutrition, Health, FSAC and WASH) to develop a multi-sector method for rapid and in-depth assessments for Afghanistan. Two SMART-based methodologies and questionnaires were developed, with a rollout plan. Nine SMART assessments have since been undertaken. The Nutrition Cluster and MoPH have overall responsibility for joint assessments. The Afghanistan National Disaster Management Authority (ANDMA) has a key role in assessment coordination. The Nutrition Cluster will undertake joint assessments and share information with working groups/authorities. Protection and Shelter Clusters will be brought into the process. This successful initiative is catalysing multi-sector analysis and programming through development of a Nutrition Integrated Phase Classification (IPC).

Context

The UNICEF conceptual framework, used by the nutrition community for several decades, identifies three levels of causes of malnutrition: *immediate* causes, which operate at the individual level (inadequate dietary intake and infection); *underlying* causes that influence households and communities (inadequate access to food and/or poor use of available food, inadequate child care practices and poor water and sanitation and inadequate health services); and *basic or root causes* around the structure and processes of societies (economic, cultural and religious systems). This framework is an important tool that helps understanding and causal analysis and reflects the importance of joint programming between sectors. This highlights the need for joint data collection and analysis to fully inform the range of nutrition-specific and nutrition-sensitive interventions required.

A coordinated approach to emergency assessment and prioritisation of the needs of affected people lays the foundation for a coherent and efficient humanitarian response. For protracted crises, the depth and volume of information needed for an effective response increases as the crisis evolves. This often translates into a requirement for in-depth cluster/sector, thematic or agency-specific assessments to inform planning and operations, which in turn necessitates a harmonised assessment approach with joint needs analysis.

According to the Inter-Agency Standing Committee (IASC) Operational Guidance for Coordinated Assessments in

Humanitarian Crises,¹ the Humanitarian Coordinator (HC), supported by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), is responsible for coordinating emergency assessments across clusters/sectors at the country level. In turn, clusters/sectors at the country level are responsible for engaging in all relevant aspects of multi-cluster/sector assessment coordination. OCHA is mandated to ensure that each cluster/sector is provided with the necessary common services and tools for effective inter-cluster/sector collaboration, including inter-agency needs assessments. Coordination mechanisms applied to needs assessments differ depending on the phase and nature of a crisis. A multi-cluster/sector initial rapid assessment (MIRA) is recommended during the first two weeks following a disaster, followed by joint or harmonised intra-cluster/sector in-depth assessments as the crisis continues.

There has been a 'silo-minded approach' to conducting assessments in Afghanistan for many years there. No inter-sector assessment framework existed at government level; all government agencies/ministries worked in isolation. The Humanitarian Coordinated Assessment Working Group (HCAWG) was established in January 2016 under the Afghanistan Humanitarian Country Team (HCT). However, membership was at a management rather than a technical level. Formerly the Household Emergency

¹ www.humanitarianresponse.info/system/files/documents/files/ops_guidance_finalversion2012_1.pdf

Assessment Tool (HEAT), developed in Afghanistan and updated in September 2016, was the primary multi-sector tool used in the country. While it was nominally developed in consultation with the clusters, in-country implementation was fraught with challenges in terms of methodology, data collection and analysis, and the tool faced ongoing criticism from WASH, Nutrition and Health clusters. For example, HEAT assessments were overly long, with too many questions, yet failed to capture important information necessary for individual and multi-cluster analysis. Furthermore, since there was no sampling method but an exhaustive assessment of households instead, data was too bulky and difficult to analyse.

In response to these limitations, and considering the UNICEF conceptual framework for malnutrition, the Nutrition Cluster made the logical choice to take the lead in improving joint assessment tools in Afghanistan. A workshop was proposed to develop a new, multi-sector framework as a collaboration between the different relevant ministries. This process is described in this article.

Process of the development of the multi-cluster assessments

In March 2016 the Nutrition Cluster and the Ministry of Public Health (MoPH)/Public Nutrition Department, with financial support from the Common Humanitarian Fund (CHF), organised a nutrition assessments data clinic to try to standardise how nutrition assessments are conducted by defining and adapting standard, globally accepted tools and methods for country-wide adoption. Following the success of the nutrition data clinic, the Nutrition Cluster and its Assessment and Information Management Working Group (AIM WG) organised a multi-sector workshop in November 2016 through Action Contre la Faim (ACF) Afghanistan with the purpose of developing a multi-sector method for rapid and in-depth assessments for Afghanistan. The project was first discussed in

the AIM WG before being taken forward for implementation. Guided by the UNICEF conceptual framework for malnutrition, information from Nutrition, Health, FSAC and WASH sectors was considered the most important for defining nutrition response; therefore representatives from these four sectors were invited to participate.

In the initial stages the Nutrition Cluster Coordinator and an ACF representative approached the Cluster Coordinators of the WASH, Food Security and Agriculture (FSAC) and Health Clusters to discuss the aim, objectives and modalities of the workshop. After general agreement and buy-in from all three coordinators, a workshop preparation task force was created that included one or two representatives from each cluster (usually the Cluster Coordinator and a chair of the relevant Cluster's Assessment Working Group (AWG)). The taskforce met twice to discuss the agenda and the remaining work was carried out through emails. The main functions of the task force were to develop an agenda for the workshop and agree facilitators for each section; nominate participants from each cluster with expertise and decision-making responsibility in assessments; and prepare workshop materials (including a presentation of the current rapid and in-depth assessments used by the clusters in Afghanistan).

Participants of the workshop came from all four Clusters (Nutrition, WASH, FSAC and Health) and a representative from OCHA was invited to observe. (Given that it was a technical activity, they were not in the position to directly participate.) Clusters were represented by Cluster Coordinators, local non-governmental organisations (NGOs), international NGOs and United Nations (UN) agencies. Where a cluster had an AWG, representatives were prioritised for participation. In addition each cluster invited a counterpart from the government (from each relevant ministry) to ensure government engagement and buy-in from the beginning of the process. In total, 30 participants attended the three-day workshop, including MoPH and Min-

istry of Rural Rehabilitation and Development.

In working towards its objectives, the workshop focused on:

- Clarifying what is meant by multi-cluster assessments: Why and when are they conducted?
- Understanding assessments after an emergency: What do we know, what should we know, and how do we make it happen?
- Analysis of existing coordinated and sector assessments to make structured observations about what worked and what did not; distillation and prioritisation of the most important lessons learned; and capture of recommendations on how these can be addressed.

This was done largely in group work, with each group focusing on key elements of multi-sector assessments as follows: preparation and planning; data collection and field work; and analysis, interpretation, preparing findings/reports and dissemination.

The first day was dedicated to rapid multi-sector assessments. Current methodologies in use at the inter-cluster level were presented (HEAT tool) and gaps and key challenges discussed. This was followed by a presentation by each cluster of their own rapid assessment methodologies. In general, the methodologies, frequency, indicators and tools used by each cluster varied significantly. For example, the WASH cluster used a one-page questionnaire to collect information from 210 households, regardless of the size and population as needed, while the FSAC cluster conducted a national food security assessment of food security twice per year. In order to ensure that the rapid multi-sector assessment method proposed at the workshop could meet the diverse requirements of each cluster and could be undertaken in different emergency scenarios as witnessed in Afghanistan, participants developed the methodology, indicators and questionnaire collaboratively. This included a joint timeline of assessments, potential tools, sampling methodologies, representativeness, quality assurance, limitations and type of indicators.

A similar process was undertaken for in-depth assessments on day two. At the time of the workshop no in-depth multi-sector assessments existed; each cluster worked in isolation to collect and analyse its data.

Day three focused on next steps, including how to ensure that the recommendations of the workshop were implemented; designing the multi-sector assessment framework; developing a workplan; defining main tasks for the inter-cluster AWG; developing agreement on how to move forward with joint programming following the assessments; and agreeing how to conduct multi-sector programme analysis.

Multi-cluster assessments methodologies

Two methodologies and questionnaires were developed at the workshop for integrated Nu-

Box 1 Choice of sampling methods in Rapid SMART methodology

In this methodology, the choice of sampling method depends on the geographical zone and population group to be assessed.

Where there is one **settlement to assess** (e.g. one camp, one block of houses in a city, one village) and:

- the population is less than 200 households, then an exhaustive assessment on all eligible children living in the area should be carried out. In this case, the team must exhaustively visit all households in the settlement.
- the population is above 200 households, then follow the decision tree (Figure 1) for a simple or systematic method of random sampling. In such cases, a minimum sample size of 150 households is enough to gather relatively meaningful prevalence. A design effect of one is assumed. The precision of the results varies in this case, as shown in Table 1 (third column).

Where there is *more than one settlement and if the population is dispersed*, cluster sampling should be used. For rapid multi-sector assessments, at least 25 clusters should be selected using probability proportional to size (PPS) in order to cover all the target population in the geographical zone. To select the clusters, an estimate of the number of the population living in each settlement is necessary. Random selection of clusters can be made using emergency nutrition assessment (ENA) software. For cluster random sampling, a minimum sample size of 250-300 households is enough to estimate GAM prevalence. A design effect of 1.5 is assumed. The precision of the results varies, as described in Table 2.

Figure 1 Decision tree for household selection at last stage of sampling

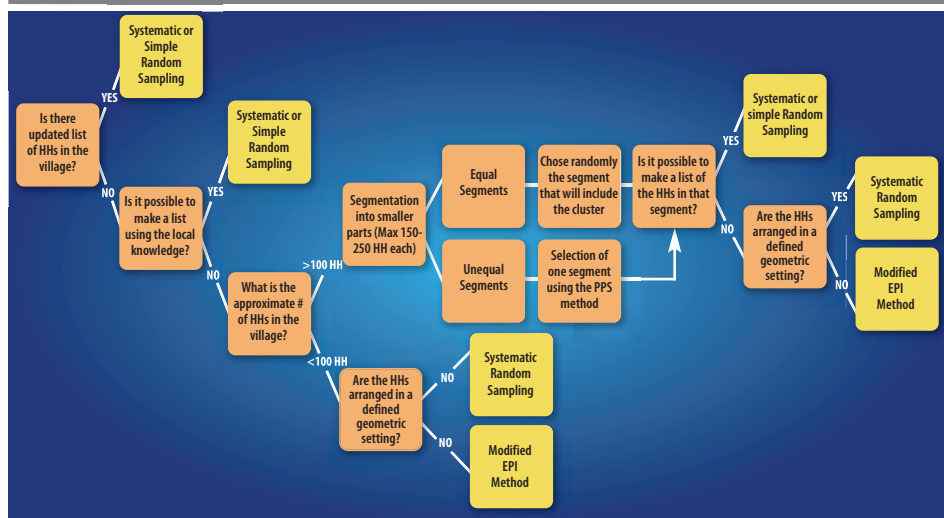


Table 1 Sample size and precision for one-settlement rapid multi-sector assessments

Expected prevalence	Minimum sample size	Precision
20%	150 HH	+/- 6.4%
15%	150 HH	+/- 5.7%
10%	150 HH	+/- 4.8%
5%	150 HH	+/- 3.5%

HH: households

Table 2 Sampling strategy and precision for more than one settlement/dispersed population rapid multi-sector assessments

Expected GAM prevalence	Minimum sample size	Precision with 250HH	Minimum sample size	Precision with 300 HH
20%	250 HH	+/- 6.3%	300 HH	+/- 5.8%
15%	250 HH	+/- 5.7%	300 HH	+/- 5.2%
10%	250 HH	+/- 4.8%	300 HH	+/- 4.3%
5%	250 HH	+/- 3.5%	300 HH	+/- 3.2%

HH: households

trition, WASH, FSAC and Health Cluster rapid and in-depth assessments, as well as a plan for rollout in Afghanistan.

Multi-sector rapid assessments

For multi-sector rapid assessments, the main challenges identified with the HEAT assessment tool in Afghanistan, as outlined earlier, were the absence of a sampling methodology and limited relevance of data collected for the four clusters (due to lack of consultation and limited use of cluster feedback by OCHA in its development). To address the first challenge, it was agreed to use an improved simplified methodology, similar to Rapid SMART. (A Rapid SMART survey is most often used in emergency contexts with high insecurity, which limits the team’s access to survey areas. Rapid SMART has limitations compared to the standard full SMART methodology: it cannot be used to assess global acute malnutrition/severe acute malnutrition (GAM/SAM) for larger geographical areas, cannot be extrapolated beyond the zone of assessment, and can only be used to inform emergency responses, not long-term programmes. <http://smartmethodology.org/survey-planning-tools/smart-methodology/rapid-smart-methodology/>)

Consultation on the adoption of the SMART methodology started at the nutrition data clinic, which was technically supported by the ACF Canada SMART team. Further consultations on the adoption of the Rapid SMART sampling approach were undertaken through the ACF HQ technical contacts to ensure a representative, random, rapid approach. Key considerations regarding Rapid SMART sampling methods are outlined in Box 1.

During the group sessions each cluster was asked to develop up to four indicators and questions to collect in rapid multi-cluster assessments. These were then discussed in plenary, but it was subsequently agreed post-workshop that only two indicators should be selected per cluster, as follows (see Table 3 for details):

- **Nutrition:** Wasting based on mid upper-arm circumference (MUAC) (children and women of reproductive age) and exclusive breastfeeding of infants aged 0-5 months (six completed months, equivalent to 0 - < 6 months).
- **WASH:** Proportion of people who have access to safe drinking water and proportion

of people who have access to sanitation facilities.

- **Fragile and conflict-affected states (FCAS):** Household Dietary Diversity Score (HDDS) and food stock availability.
- **Health:** Prevalence of acute respiratory infection (ARI), diarrhoea and measles and access to basic health services.

Multi-sector in-depth assessments

After evaluation of different methodologies used by clusters, it was agreed that the Modified SMART methodology was applicable for the development of the multi-sector in-depth assessment. (Modified SMART (also known as SMART++) is where additional indicators from other sectors are included. This does not affect the sampling approach, since only anthropometry and mortality (the most critical indicators) are considered when determining sample size.)

Modified SMART was adopted without substantial changes to the methodology; however the standard questionnaire was expanded to include additional indicators from other sectors. The nutrition SMART surveys being implemented in Afghanistan at the time were already taking into account additional indicators from each cluster. This was the result of a standardisation exercise conducted in March 2016, during which members of the Nutrition Cluster consulted with WASH, FSAC and Health Clusters to determine a broader range of indicators to include (albeit restricted to those with a direct impact on child nutritional status). As this process had already taken place, and in general the indicators being used were the same as those proposed in the workshop, little work was needed to come up with the list of indicators and questions to be included in the final questionnaire (Table 3).

Multi-sector assessments in practice

Since January 2017 nine SMART assessments have been conducted in the provinces of Kandahar, Farah, Saripul, Samangan, Jawzjan, Takhar, Bamyán, Kapisa and Dykundi. Joint inter-sector analysis was constrained by a capacity gap in the position of Nutrition Cluster Coordinator for several months. At a follow-up and lesson-learning workshop conducted by ACF, and to ensure government ownership of the process, it was decided that a main coordination body should take the responsibility of multi-cluster assessments that should involve the Afghanistan National Disaster Management Authority (ANDMA).

Key lessons learned

The previous multi-cluster assessment methodology had many limitations, which reflected the limited technical capacity of OCHA. The approach to improving the methodologies, led by the Nutrition Cluster, helped overcome this constraint and was regarded as an improvement by all involved, including OCHA, who agreed to continue using the approach and to engage additional clusters (such as Protection and Shelter) in this collective effort. Certain difficult-to-achieve aspects of coordinated multi-sector assessments – such as multi-stakeholder buy-in and participation

Table 3 Indicators and questions included in the multi-sector in-depth assessment questionnaire

Sector/Cluster	Indicator	Questions
Food security	Household Dietary Diversity Score (HDDS)	<p><i>Could you please tell me how many days in the last seven days your household has eaten the following food groups? What was the main source of them?</i></p> <p><i>Please make sure that we are asking about food groups eaten by the entire household members and also in a quantity that makes sense. If a household member has eaten a type of food outside the household it should not be considered. If two or more foods of the same food group are eaten in one day the number of days eaten will be one.</i></p> <ol style="list-style-type: none"> 1. Cereals and tubers 2. Beans and nuts 3. Vegetables 4. Fruits 5. Meat of any type, fish, eggs 6. Dairy products 7. Oil 8. Sugar
	Food stock	<p>How long will your current food stock last?</p> <ol style="list-style-type: none"> 1. No stock 2. Less than a week 3. 1-3 months 4. More than 3 months
Health	Daily Crude Mortality Rate	Did anyone die in your family within the past 24 hours? If yes, what was their age and sex?
	Daily Under 5 Morbidity rate	<p>Is there any child aged under five sick in your household? Yes/No</p> <p>If yes, what type of sickness (please circle)</p> <ol style="list-style-type: none"> 1. Diarrhoea 2. Acute respiratory infection (ARI) 3. Fever with rash 4. Other
	Access to basic health services	<p>Are you able to get basic health services within one hour walking time? Yes/No</p> <p>If yes, what type of facility: BHC/CHC/Mobile team/DH/PH.</p>
Nutrition	Wasting based on MUAC (children and women of reproductive age (WRA))	<ol style="list-style-type: none"> 1. Take measurement of all children aged 6-59 months using a MUAC tape. 2. Take measurement of all women aged 15-49 years of age using the adult MUAC tape (World Food Programme). <p><i>(Measurement is taken on the left upper arm)</i></p>
	Exclusive breastfeeding	Has your baby aged under 6 months received any liquid or food other than breastmilk (including water) during the past 24 hours? Yes/No
WASH	% of people having access to safe drinking water	<ol style="list-style-type: none"> 1. Do you have access to a safe source of drinking water (piped water, borehole, hand pump, protected spring and protected wells)? Yes/No 2. How long does it take you to fetch water and return home? (Time in minutes from to) 3. Do you think the quantity of water available from the source is sufficient to meet the drinking and personal hygiene needs? Yes/No
	% of people having access to sanitation facilities	<ol style="list-style-type: none"> 1. Do you have access to a toilet? Yes/No 2. Do you practice open defecation? Yes/No

and a degree of joint analysis – have been realised through the process. Furthermore a broad range of stakeholders contributed to the workshop, which created a positive environment for meaningful discussion and agreed actions going forward. Finally, the process benefited from a great willingness among stakeholders to tap into and strengthen existing structures (AWGs of the clusters under the leadership of technical experts from UN/NGOs and relevant ministries) in order to fast-track the process of multi-sector assessments. This approach also facilitated strengthening of government capacities, securing government buy-in and ensuring its ownership of the process and willingness to take it forward.

Agreed next steps

Involve Protection and Shelter Clusters: For rapid multi-sector assessments, the clusters agreed

that the two remaining clusters, Protection and Shelter, should be included going forward. This will ensure the development and use of a single joint tool. It is important to note that it was the consultative process and constant engagement with the four clusters that ensured their buy-in to the rapid multi-sector assessment tool. This same process must now be applied to the Shelter and Protection Clusters to ensure their buy-in, too. OCHA has agreed to support this process.

Operationalise the HCAWG: Following discussions at the 2016 workshop, the HCAWG was reconvened in January 2017 under the Inter-Cluster Coordination Team (ICCT) at a technical level. This will ensure a more operational focus for the group, with clear Terms of Reference (ToR) that focus on coordination of joint assessments and joint data analysis.

Nutrition Cluster to conduct future joint assessments: Given that the Nutrition Cluster has experience and capacity on SMART assessments, it was agreed that it will be responsible for undertaking joint assessments and sharing information with other clusters, the HCAWG and the ICCT. Data sharing and multi-sector analysis will also be facilitated through the inter-cluster HCAWG.

Nutrition Cluster and MoPH to have overall responsibility for joint assessments: Once all clusters agree on the 'multi-cluster' questionnaire, including Protection and Shelter, the Nutrition Cluster will officially update the current SMART guideline. MoPH will then approve this as the new standard methodology for assessments. Overall responsibility to undertake the assessments and prepare the final reports will lie with the Nutrition Cluster and MoPH, owing to the alignment of the new assessment methodology with the Nutrition Cluster's existing ways of working.

Action joint data analysis in future: The clusters have agreed on the need to collaborate not just on data collection, but also on data analysis and there is impetus to realise this: extracting individual, cluster-specific data for siloed analysis defeats the purpose of the exercise.

Explore multi-cluster programming: Clusters would like to use the momentum of this effort to explore how they can work together operationally. One proposed way of doing this is to conduct a Nutrition Integrated Phase Classification (IPC). This is planned for November 2017 and will be led at country-level by the Nutrition Cluster AWG, with input from experts in other clusters as necessary. Another proposed activity is a four-cluster workshop to explore ways to plan and work together. Both activities are currently included in the Nutrition Cluster work plan for 2017; however this has not been implemented yet due to a seven-month capacity gap in the position of Nutrition Cluster Coordinator.

Conclusions

The development of rapid and in-depth multi-sector assessment tools, led by the Nutrition Cluster, has been a success both in generating fit-for-purpose tools for the collective and in creating momentum and commitment for joint analysis and programming. The tools produced are largely relevant for other countries; however it is important that the full consultative process is implemented in each country, rather than merely adapting the tools. This will ensure buy-in from all relevant clusters and government ministries, which is fundamental to the success of joint assessments. Continued engagement and advocacy is needed across sectors. The Nutrition Cluster is an obvious choice for leading such processes, given the need to apply a nutrition lens to multi-sector analysis and response.

For more information, contact: Anna Ziolkovska, aziolkovska@unicef.org

A child is assessed at Abela Lida health post before receiving therapeutic food, SNNP region, Ethiopia

Cluster coordination in a government-led emergency response in Ethiopia

By Amal Tucker Brown, Orla Mary O'Neill and Ki Yeon Yoon



Amal Tucker Brown has worked for UNICEF since 2007. She joined UNICEF Ethiopia as head of the community-based nutrition and micronutrient unit in 2015;

in the same year she acted as interim team leader of the Emergency Nutrition Coordination Unit (ENCU) (nutrition cluster coordinator). Amal also has experience working for UNICEF in Madagascar, South Sudan, Somalia, Malawi and Uganda and for NGOs in Democratic Republic of Congo, Niger and Rwanda.



Orla Mary O'Neill is currently the team leader of the ENCU in Ethiopia. She has over 15 years' experience as a nutritionist with Concern and UNICEF in Bangladesh and Ethiopia

in nutrition development projects and emergency nutrition response.



Ki Yeon Yoon is a monitoring and evaluation (M&E) professional with an increasing focus on nutrition. She joined UNICEF Ethiopia as Nutrition M&E Officer in

2015. Since the El Niño-driven drought, Ki Yeon has been increasingly involved in the UNICEF emergency nutrition response, including cluster coordination and information management.

UNICEF would like to acknowledge the donors, including the governments of Sweden, the United Kingdom and the United States, who provided funds for the cluster coordination.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: *Ethiopia*

What we know: The Government of Ethiopia responded quickly to the El Niño drought in 2015/16 and, due to its strong leadership, established the coordination mechanism and the resilience of the health system.

What this article adds: Overall coordination is led by the Ethiopian Government's National Disaster Risk Management Coordination Commission (NDRMCC). The UNICEF-supported Emergency Nutrition Coordination Unit (ENCU), in existence since 2000 and aligned with the cluster approach, coordinates nutrition partners at federal and sub-national levels in emergency nutrition response via a range of coordination platforms. These govern assessment, information management, response planning and implementation. Tools developed to improve coordination include a woreda (district) capacity-mapping tool, cross-referenced with the 4-W matrix (who, what, where and when) to distinguish type and level of support needed by partners, and an accountability matrix to help define roles and responsibilities, resulting in more tailored, non-duplicative support to health services. Responding to the needs of the affected pastoral communities requires mobile and innovative approaches to secure access and capacity. High-level decision-makers in emergencies are non-nutritionists; orientation on nutrition in emergencies is critical. Government leadership ensures partner activities are aligned with government priorities; government-led assessment is critical with stakeholder involvement. The cluster provides key technical support and the platform to help bring different stakeholders together.

Context

Ethiopia has come a long way in reducing poverty and child undernutrition, with stunting prevalence falling from 58 per cent in 2000 to 38 per cent in 2016 (EDHS 2000, 2006, 2011, 2016). However, widespread poverty and malnutrition persist and the country remains disaster-prone and vulnerable to weather-related shocks. Vulnerability is predominantly rural and linked to land degradation, small land-holding, population pressure, outdated farming practices and highly variable rainfall, resulting in recurrent food insecurity and disease outbreaks.

In 2015 Ethiopia experienced one of the worst droughts in decades due to El Niño. The two rainy seasons, vital for supplying water for 80 per cent of Ethiopia's agricultural production, failed. The crop failure resulted in a massive spike in humanitarian needs, with 10.2 million out of 92.3 million people requiring food assistance, 0.4 million children with severe acute malnutrition (SAM) and 1.7 million with moderate acute malnutrition (MAM) (HRD, 2016). This was against the backdrop of eight million people already suffering from chronic food insecurity in the country.

The Government of Ethiopia (GoE) was able to cope with the humanitarian shock and respond quickly to the El Niño-driven drought owing to its strong leadership, established coordination mechanism and the resilience of the health system. The success of the 2015/2016 El Niño response compared to the 2011 Horn of Africa response and the strengthening of health system resilience are well documented (Babu et al, 2017; Tucker Brown and Ategbro, 2017). This article focuses on UNICEF support to government-led coordination in response to the nutrition emergency.

Cluster coordination structure

In Ethiopia the overall humanitarian coordination is led by the National Disaster Risk Management Coordination Commission (NDRMCC)¹ of the GoE with the support of the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). The NDRMCC leads federal and regional-level Disaster Risk Management Technical Working Groups (DRMTWGs) across Ethiopia and hosts specialised task forces that work in tandem with the clusters/sectors, including nutrition, health, water, sanitation and hygiene (WASH), food security, shelter/non-food items (NFI), protection, education and agriculture.

With technical support by UNICEF, the Emergency Nutrition Coordination Unit (ENCU) was formed by the GoE in 2000 within the Ministry of Agriculture to provide better coordination of NGO activity in the country. In 2007, following the introduction of the Inter-Agency Standing Committee (IASC) cluster approach, the Terms of Reference (TOR) for the ENCU were modified to be in line with the Global Nutrition Cluster (GNC). Nevertheless, the aim of the ENCU remained the same, which is to lead and coordinate nutrition partners at national and sub-national levels to provide coherent and effective emergency nutrition preparedness and response that can save lives and improve nutrition of people in Ethiopia during emergencies.

The ENCU is supported by UNICEF as the Nutrition Cluster lead agency and is embedded within the NDRMCC at federal level and the Disaster Prevention and Preparedness Bureau (DPPB) in the six main regions (Afar, Amhara, Oromia, Tigray, SNNP and Somali) – a feature

¹ Formerly Disaster Risk Management and Food Security Sector (DRMFSS) and before that the Disaster Presentation and Preparedness Agency (DPPA).

that is unique to Ethiopia. Both federal and regional ENCU employees were previously staffed by UNICEF; however, as part of its increased ownership of the cluster, the GoE has taken over regional staffing, while federal-level staff continue to be UNICEF employees. The federal ENCU is made up of a team leader (Nutrition Cluster Coordinator), deputy team leader, information manager and administrative assistant. The regional ENCU consists of a nutritionist and an information management officer (IMO) (see Figure 1).

Coordination platforms

The ENCU participates in and chairs meetings across the GoE partners and donors to ensure cohesion of nutrition emergency-related information, planning and response. The ENCU co-chairs with NDRMCC monthly Nutrition Cluster meetings, known as the Multi-Agency Nutrition Task Force (MANTF), to address bottlenecks in planning and implementation. In addition, the ENCU and NDRMCC co-chair the quarterly Strategic Advisory Group (SAG), with representation from the Federal Ministry of Health (FMoH) as well as elected partners from United Nations (UN) agencies, donors and NGOs. The SAG provides strategic guidance in formulating and reviewing the cluster strategy. Finally, extraordinary Technical Working Groups (TWGs) are established to discuss specific technical issues that may arise. At the regional level Nutrition

Clusters are chaired by the Regional Health Bureau (RHB), with the ENCU nutritionist and/or IMO providing secretariat support.

In 2015, due to the severity of the drought, the FMoH established a Health and Nutrition Incident Command Post (ICP) in addition to the above mechanisms supported by the ENCU/NDRMCC. Modelled on a health sector approach, the ICP aimed at supporting the FMoH component of the emergency response. During the El Niño drought, the ICP met twice per week and worked closely with the NDRMCC and respective clusters. In 2017 the ICP was reinstated in Somali region to respond to the acute watery diarrhoea (AWD) outbreak and nutrition emergency and has proven a strong platform to trigger cross-sector engagement and government leadership².

Coordinated assessment of the situation

Every year the NDRMCC leads two national multi-agency assessments: the meher assessment (around October/November) and the belg assessment (around June/July). These bring together some 200 government, UN, NGO and donor representatives who visit affected communities across Ethiopia. The information gathered from these visits, along with a review of current data on nutrition, health, population movement and meteorological predictions, is used to estimate

the number of people in need of humanitarian assistance. This government-led, multi-agency approach increases cost-effectiveness and ownership and acceptance of the results by the humanitarian community.

For the El Niño drought, the belg assessment in June-July 2015 concluded that 4.5 million people would be in need of emergency food assistance in August 2015. Following the erratic summer rains, the GoE decided to conduct a pre-harvest, rapid multi-agency assessment in early October 2015, which concluded that the number of people in need of assistance had increased to 8.2 million. This was followed by the meher assessment in late October, which revised the number further upwards to 10.2 million (Figure 2). This formed the basis of the 2016 HRD appeal for US\$1.4 billion, of which US\$115.4 million (US\$135 million including NGO support) was needed for the nutrition response.

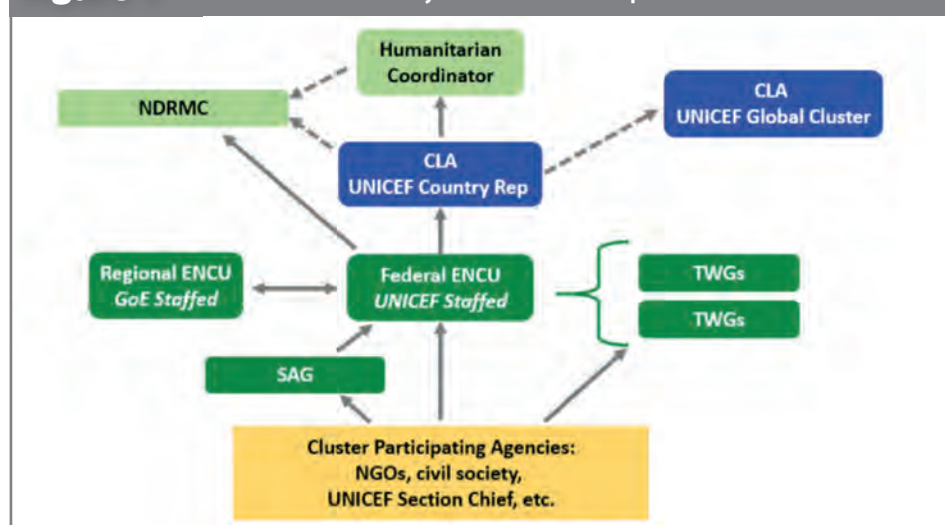
Hotspot classification

Based on the meher and belg assessments, the Household Economic Assessment (HEA) data, food security and early warning assessments, SMART surveys, disaster area assessments and routine programme data from multiple sectors, the regional and federal ENCUs lead a series of meetings at regional and then federal levels to classify woredas into different hotspot priorities to signal varying levels of vulnerabilities (Figure 3). During the El Niño drought, the number of priority one woredas – those in utmost need of humanitarian interventions – steadily increased from 49 in February 2015 to 186 in December 2015, reaching a peak of 219 in March 2016 (Figure 4).

At federal level the ENCU led a hotspot technical working group (HTWG) to review the suggested regional classification. The HTWG normally involves NDRMCC, FMoH, UNICEF and World Food Programme (WFP). In 2015/16, however, cluster leads from WASH, health, child protection, agriculture and food security were also invited to participate. This broad-based exercise contributed to building trust in the classification process and increased the use of quantitative data from different sectors. Nevertheless, the hotspot classification still heavily relies on subjective inputs and thus would benefit from inclusion of more objective criteria and cut-offs, given the increased availability of routine data from many sectors.

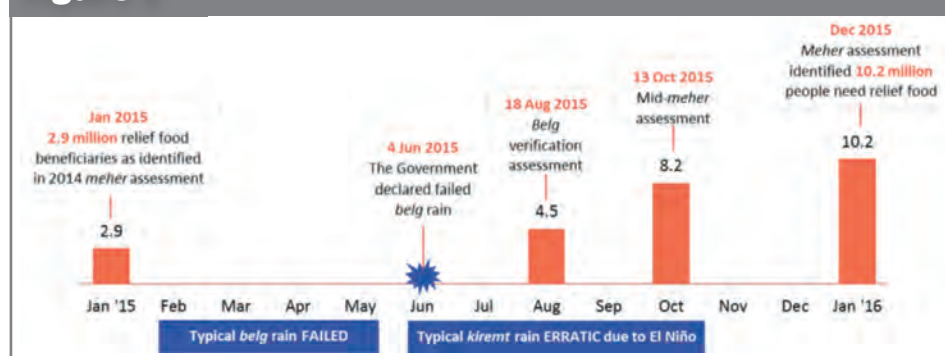
Based on the hotspot classification, humanitarian needs and current and past trends in acute malnutrition, the SAG collectively estimated the caseload for SAM and MAM. Prior to the El Niño emergency, caseload estimation was confined to a limited number of experts from UNICEF, WFP, FMoH and NDRMCC. Including the broader SAG members in this process led

Figure 1 Structure and accountability of the ENCU in Ethiopia



NDRMCC: National Disaster Risk Management Coordination Commission; CLA: Cluster Lead Agency; ENCU: Emergency Nutrition Coordination Unit; TWG: Technical Working Group; SAG: Strategic Advisory Group; NGO: Non-governmental organisation

Figure 2 Timeline of the crisis



² The ICP involved establishment of six pillars: case management, surveillance, logistics, WASH, coordination/information management, and social and behaviour change communication/communication for development (SBCC/C4D). Representatives from each cluster were appointed to chair, update and attend each of these pillars, thus ensuring that cluster inputs were well distributed across these aspects of operations, which are critical in the response.

Figure 3 Definition and classification of hotspot priority in Ethiopia

The ENCU leads the hotspot classification, which is updated every quarter and is based on multi-sector indicators from, health, nutrition, agriculture, food security, market information, water for human consumption, education and other pertinent indicators such as unusual migration patterns and increase in petty crime.

Code of Severity	Class description	General IPC equivalent
Priority 1 Very severe	Hazards of high damaging level have occurred and affected the lives and livelihoods of the population with very severe lack of adequate food security and may include excess mortality, very high and increasing malnutrition, and irreversible livelihood asset depletion.	Humanitarian Emergency
Priority 2 Severe	Hazards of high damaging level have occurred and affected the lives and livelihoods of the population with high stress and lack of adequate food security which resulted in high level of malnutrition and accelerated depletion of livelihood assets.	Acute Food and Livelihood Crisis
Priority 3 Moderate	Hazards have occurred and affected the lives and livelihoods of the population moderately so that most households are at risk to adequate food security in a stable manner.	Moderate Food Insecure or Chronically Food Insecure

to an enhanced understanding and subsequent acceptance of the SAM and MAM estimations by the humanitarian community.

Following this process the ENCU presented the suggested hotspot classifications and caseload estimates to the NDRMCC management, who then validated the results and began planning for the response.

Coordinated planning

The SAG was responsible for drafting the response plan under the leadership of the ENCU team leader and NDRMCC representative. The response plan contributed to the HRD 2016 and was anchored in three strategic areas:

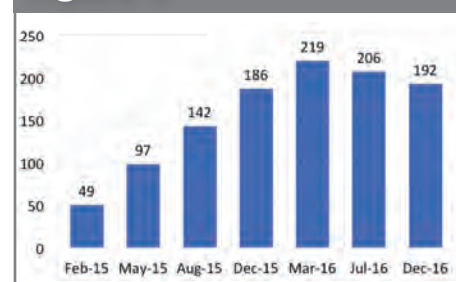
1. Management of acute malnutrition, with a focus on enhancing SAM-MAM continuum of care.

2. Prevention of acute malnutrition, including infant and young child feeding in emergencies (IYCF-E) and micronutrient deficiency control for children.
3. Strengthening the coordination of the nutrition response, notably the core functions of the ENCU.

Cross-cutting issues were taken into account, such as inter-cluster coordination, gender and protection mainstreaming and linkages with development programmes. Advances in gender and protection mainstreaming were seen; however cross-sector programming remained challenging due to the diversity of needs.

Information management

Nutrition trends are monitored across the country via data, surveys and inputs from members of the MANTF. The ENCU manages multiple data-

Figure 4 Trends in Priority 1 woredas 2015-2016

bases that consolidate data from government, UN and NGO sources, including: (1) The national therapeutic feeding programme (TFP) database for SAM management; (2) The national therapeutic supplementary feeding programme (TSFP) database for MAM management; and (3) The National database of surveys (including SMART and SQUEAC/Coverage Assessments) and rapid assessments. The flow of MAM and SAM management data is explained in Figure 5. The information system strengthening and challenges encountered during the emergency are detailed in an article by Tucker Brown and Ategbro (2017).

Coordination of implementation

The El Niño response was one of the biggest emergency nutrition responses the GoE and partners encountered in terms of funding, number of stakeholders involved and complexity of implementation arrangements. The overall roles, responsibilities and achievements of each major implementing partner during the nutrition response are summarised in Box 1.

Following each hotspot classification, the ENCU requested NGOs to state who was doing what, where and when (4-W) to populate the 4-W matrix for effective coordination and identification of gaps (see Box 2). In the past the ENCU used a 'one NGO to one priority one

Box 1 El Niño nutrition response implementing agencies

Federal Ministry of Health

The emergency nutrition response is delivered primarily through the Health Extension Programme (HEP), implemented by government-employed health extension workers (HEWs) with support from partners. Under the HEP, the FMOH has built at least one health post and assigned two HEWs per kebele (sub-district) to provide preventative and basic curative services. At the community level the Women Development Army (WDA), a network of volunteers, links the neighbourhood with HEWs and is responsible for behaviour change communication (BCC) and community mobilisation (Figure 6). Some five health posts are supported by one health centre, staffed by nurses and providing more advanced curative services. Hospitals in densely populated towns and cities provide tertiary treatment for cases with severe complications.

In 2008 the FMOH integrated SAM management into the HEP to increase access and coverage of SAM treatment. The number of treatment facilities has since risen steadily from around 400 in 2008 to over 16,000 in 2016. At the same time, cognisant of the importance of prevention, the FMOH also introduced the Community Based Nutrition (CBN) programme. The CBN was gradually taken up by the FMOH as a key preventative and promotional nutrition programme.

These integrated nutrition programmes and community structures enabled the healthcare system to respond quickly and efficiently to the drought, reaching 350,451 SAM cases in 2015 and 320,883 in 2016, a 40 per cent and 30 per cent increase from non-emergency years, respectively.

The resilience-building efforts of the health system are further detailed in Tucker Brown and Ategbro (2017).

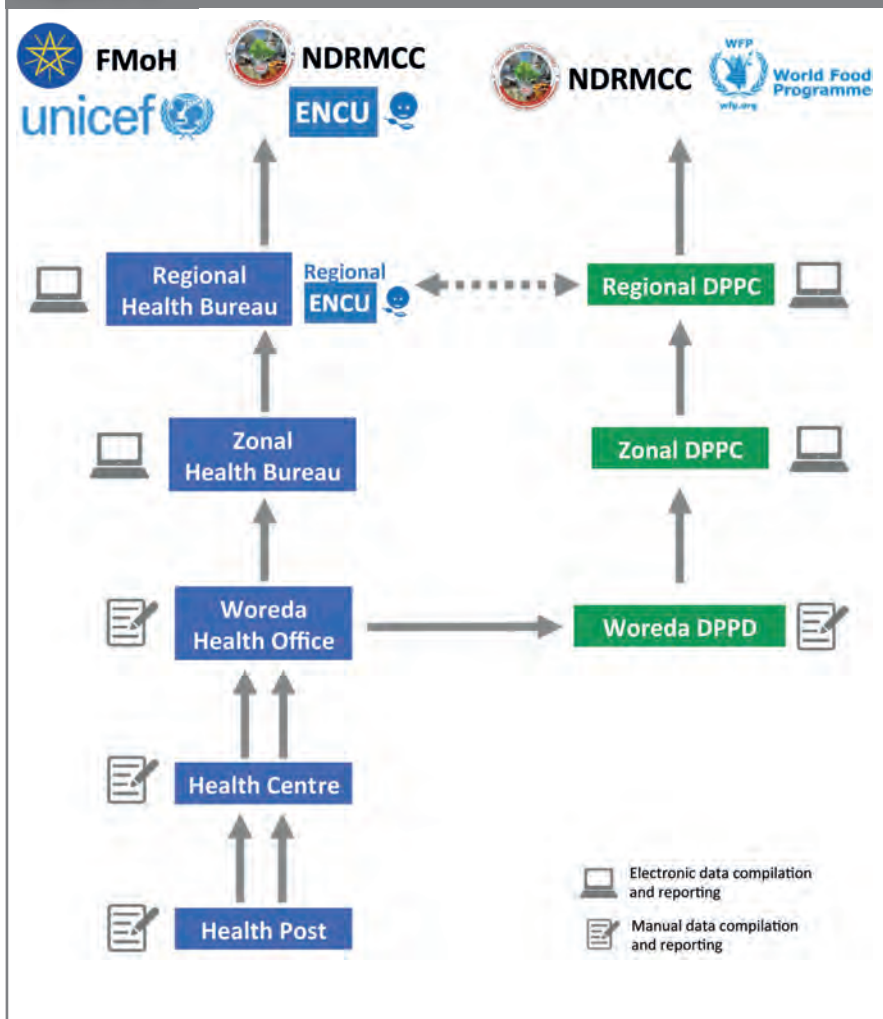
NDRMCC

Ethiopia adopted the community-based management of acute malnutrition (CMAM) approach to detect and treat acute malnutrition. However, the SAM management component of CMAM was integrated into the HEP, whereas MAM treatment was left under the Ministry of Agriculture and is now under the mandate of the NDRMCC. Screening for acute malnutrition is conducted by HEWs, with referral of SAM cases for treatment within the health system. MAM cases are referred to Food Distribution Centres (FDCs), where food distribution agents (FDAs) distribute MAM supplies. One FDC, equipped with two to three FDAs, caters for five health posts. WFP is supporting the GoE in the integration of MAM treatment into health posts in 44 woredas.

Partners

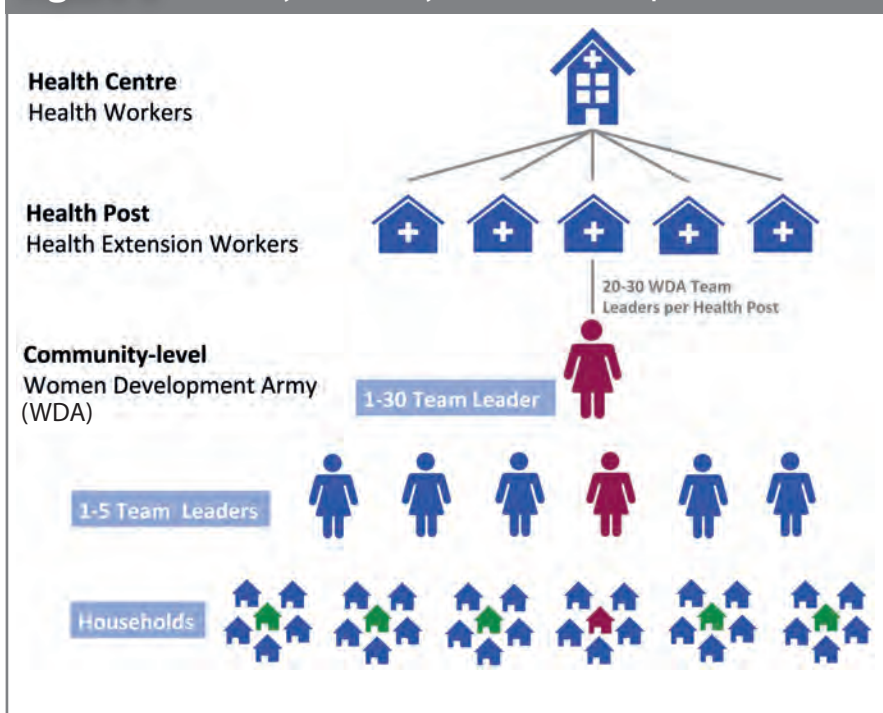
To avoid duplication and utilise the comparative advantage of each agency, WFP took the lead in supporting the NDRMCC with the treatment of MAM, whereas UNICEF, along with the World Health Organization (WHO), supports the FMOH in strengthening the overall health system to identify and provide quality and timely treatment for SAM and provide key preventative interventions. Considering the high caseload of acute malnutrition and the subsequent burden on the health system, NGO support to the woreda sector bureaus has been essential to ensure that quality services reach the most vulnerable and hard-to-reach. This is further illustrated in Andert et al (2016).

Figure 5 Flow for nutrition data reporting



FMoH: Federal Ministry of Health; NDRMCC: National Disaster Risk Management Coordination Commission; ENCU: Emergency Nutrition Coordination Unit; DPPC: Disaster Prevention and Preparedness Commission; DPPD: Disaster Prevention and Preparedness Department

Figure 6 Community-level health system structure in Ethiopia



woreda' approach for NGO support. However, with the quadrupling of priority one woredas over the course of the emergency and the serious shortage of trained nutritionists, this was not possible. (GOAL was one of the few NGOs able to expand quickly in response to the increased number of priority woredas, described in detail by Andert et al (2016)). However, as the response was mainly via the health system, many priority one woredas had the capacity to respond to the emergency with minimal support from NGOs.

To better identify the level of support needed for each priority woreda, the ENCU developed a woreda capacity-mapping tool, which was cross-referenced with the 4-W matrix to further refine the gaps and guide NGOs accordingly. The woreda capacity-mapping tool was based on routine data such as the hotspot classification history, CMAM programme performance (cure, default, death rate and reporting rate), average caseload per facility, coverage of SAM and MAM treatment sites, screening data and coverage, development programme presence, physical accessibility, and distance from regional health bureau. Data were collected by the regional ENCU and compiled into a single tool by the Federal ENCU. Using the above information and pre-defined cut-offs, it was possible to suggest the level of support that a woreda might need, ranging from high-intensity NGO support to partial support on system strengthening.

In addition, an accountability matrix was developed to clearly identify roles, responsibilities and accountabilities of each stakeholder in the response. The matrix was organised by the three strategic areas of the response plan. Under each area main activities and responsibilities/contributions were listed by each entity. The process was led by UNICEF for UN agencies, Plan International for NGOs, and the NDRMCC and FMoH for government. The ENCU consolidated the information into one coherent document (Figure 7).

Lessons learned

The strong and well established, government-led coordination system was key to an effective emergency response to the El Niño drought in 2015/16. However, main decision-makers at the peak of the emergency lacked technical understanding in nutrition, calling for frequent orientation on nutrition in emergencies (NiE). This likely delayed some critical decisions at the start of the emergency and highlights the need to examine how to orient high-level stakeholders on the basics of NiE. Despite this, involvement of government in cluster coordination ensured that partner activities were in line with government priorities. At the same time, decision-makers could utilise the UNICEF-supported Nutrition Cluster for technical guidance in the planning and execution of the response.

Government-led assessments are important to government ownership, including domestic resource mobilisation. In 2016 just under half of the US\$1.4 billion funding needs were funded by the GoE. However, inclusion of multiple partners and sectors during the assessment, classification of priority woredas and the acute malnutrition caseload estimation proved to be essential in increasing transparency and acceptance of the results by the humanitarian community. The cluster remains the main platform to bring these different stakeholders together.

Box 2 Tools for better response planning and coordination

- The 4-W matrix was refined to include:
- Number of kebeles covered by each NGO to advocate for complete coverage in all woredas. - Details of the type of support provided (OTP, SC and TSFP) to encourage NGOs with limited capacity to pair up with each other to fill gaps in services.
 - IYCF-E coverage to advocate for more donor and partner attention on this area.
 - Hygiene-promotion activities to promote better inter-cluster coordination (it was not possible to do the same with other sectors due to the differing needs of each region).

The large number of stakeholders and limited awareness with regard to supporting a government-led emergency response had the potential to lead to confusion and loss of accountability. The accountability matrix helped clarify roles and responsibilities and was developed in part in response to questions by the government on the added value of NGOs where the CMAM programme is relatively well established. The role of the NGO has, over the last ten years, been reduced to a 'light touch' approach, largely to gap-fill a parallel logistics system, provide refresher training and (where commodities are available) ensure monthly TSFP delivery, which remains outside the health system. There is a need to continue the dialogue on better defining the roles and responsibilities and subsequent accountability of partners in a government-led response.

With such decentralised services for the treatment of acute malnutrition, despite the peak in admission, average monthly admissions

in 2015/2016 remained well within the capacity of the Government to manage; this capacity needs to be taken into account when mounting a response. The woreda capacity-mapping tool helped to identify woredas that FMOH was capable of managing and those that required a higher-level of partner engagement. This enabled more refined support to the health system to respond to the emergency, without creating a parallel system, over-stretching existing government health resources, or undermining efforts to strengthen the health system. The woreda capacity-mapping tool should be further tailored and linked to a set of region-specific triggers and responses in order to accelerate the decision-making process in identifying woredas in need of additional support to manage surges in acute malnutrition.

These newly developed tools, along with the various regional and sub-national coordination platforms, helped coordinate the multiplicity of partners and make best use of available resources, although continuous commitment from partners is needed to keep the tools updated and ready for use in future emergencies.

Immediate challenges and opportunities

In pastoral communities where the rollout of static CMAM services has lagged behind the highlands, resilience building of the health system is essential to respond rapidly to increases in SAM cases. This will require links to other sectors, given the high operational costs in pastoral areas and elevated health risks associated with disease outbreaks in areas where routine health services are challenged.

Regional leadership can better guide and promote cross-sector programming, monitoring and response, with particular attention to addressing context-specific needs at site level. The ICP model used to treat AWD was a new and successful approach in mounting an effective, multi-sector response to reduce the AWD outbreak at the time. The DPPB/RHB requested that the same strategy and approach be used to manage the nutrition crisis in Somali region, which arose in 2017 and continues.

Finally, until MAM management is fully integrated into the health system, external support will continue to be needed as this integration remains a priority. WFP and UNICEF have developed a roadmap to accelerate this integration under the leadership of the Ministry of Health and it is now under discussion between NDRMCs currently managing MAM treatment and FMOH.

For more information, contact:
Amal Tucker Brown atuckerbrown@unicef.org

References

Babu G, Rutishauser-Perera A and Prudhon C (2017). Assessing the differences in the scale of nutrition response efforts to El Niño in Ethiopia. *Field Exchange* 54, February 2017. p98. www.ennonline.net/fex/54/elniñoineethiopia

Andert C, Muzeiny Z, Barthorp H and O'Mahony S (2017). CMAM scale-up: experience from Ethiopia's El Niño response 2016. *Field Exchange* 54, February 2017. p11. www.ennonline.net/fex/54/cmamelinethiopia

Tucker Brown A and Ategebo EA (2017). Interventions to build resilience of the health system to the El Niño drought in Ethiopia. *Field Exchange* 55, July 2017. p94. www.ennonline.net/interventionstobuildresilienceofthehealthsystemtotheelniodroughtineethiopia

EDHS 2000, 2006, 2011, 2016. Ethiopia Democratic and Health Surveys 2000, 2006, 2011, 2016.

HRD 2016. Human Requirements Document, Ethiopia (2016). https://reliefweb.int/sites/reliefweb.int/files/resources/ethiopia_hrd_2016.pdf

Figure 7 Example of the accountability matrix

	Activity	NDRMC	FMOH	UN	NGO	ENCU
Strategic Area 1	Facilitate the management of acute malnutrition					
Expected Result 1.1	Improved community outreach, service uptake and MAM/SAM continuum of care					
Activity 1.1.1	Equip HEW screening material and forms	No action	- Develop harmonised tools and screening material specification - Estimate the required number of screening materials and forms. - Disseminate screening materials and tools from the regional all levels up to the health post.	UNICEF: - Procure MUAC tapes for screening. - Provide financial and technical support to develop, procure and distribute materials and tools to the regional level	- Participate in the harmonization of tools and materials - Adapt and use new tools in their catchment area.	- Ensure all partners are aware of the latest tools and materials for screening.
Activity 1.1.2	Mobilise the community to participate in screening sessions (early case referral and default tracing)	No action	- Provides guidance to HEW to engage the HDAs in community mobilization and early case referral and default tracing - Diffuse messages and other IEC materials on importance of screening and SAM/MAM management.	UNICEF: - Develop and implement a communication strategy on the importance of screening and SAM/MAM management to RHBs	- Participate in the development of IEC materials - Adapt and use IEC material in their programme area.	- Support the development of BCC material for effective community mobilisation. - Ensure all partners have access to the communication strategy and BCC materials for community mobilisation.
Activity 1.1.3	Conduct regular screening	No action	<i>All modalities of screening:</i> - Decide on the most appropriate screening modality for the woreda. - HEW conduct regular screening based on the approached decided by the RHB <i>EOS:</i> - Develop the micro-plan and mobilise all health workers and health officers to participate in EOS. <i>Monthly:</i> - Develop and disseminate SOP for enhanced Mass Targeted Monthly screening in priority areas	UNICEF: <i>All modalities of screening:</i> - Provide technical and financial support to MOH staff for training of HEW on screening. <i>EOS:</i> - Provide operational cost for EOS in developing regional states. <i>Monthly:</i> - Supported MOH to develop SOP for enhanced Mass Targeted Monthly screening in priority areas	- Support the HEW in managing their screening sessions. - Assist with transportation of HEW/HDAs in hard to reach areas whenever required	- Provides quality checks on screening data at regional and national level and triggers follow up actions. - Support the development of SOP for enhanced Mass Targeted Monthly screening in priority areas

HEW: Health extension worker; HDA: Health Development Army; EOS: Enhanced outreach strategy; SOP: Standardised Operating Procedures; BCC: Behaviour change communication; IEC: Information, educational and communication; RHB: Regional Health Bureau; NDRMCC: National Disaster Risk Management Coordination Commission; FMOH: Federal Ministry of Health; UN: United Nations; NGO: non-governmental organisation; ENCU: Emergency Nutrition Coordination Unit

Experiences of Nutrition Sector coordination in Syria

By Muhiadin Abdulahi



Muhiadin Abdulahi has worked with UNICEF Syria as a Nutrition Sector/Cluster Coordinator since July 2015, before which he worked as a nutrition specialist for UNICEF Syria from March to June 2015. He has over 13 years' experience working in nutrition in emergencies, household economy approach, nutrition assessments and food security in Ethiopia, Sudan, Kenya, South Sudan, Somalia and Syria.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: Syria

What we know: A coordination mechanism for emergency nutrition did not exist in Syria pre-crisis as the country was among low-middle income countries with less need for emergency response. Nutrition programming comprised prevention and surveillance, with no capacity to treat acute malnutrition.

What this article adds: A Nutrition Sector coordination mechanism was initiated in 2013 in Syria. Scope and participation was initially limited but has evolved into a strong government-UNICEF co-led initiative, with high national partner participation. There has been considerable investment in capacity building of national partners, international partners, United Nations (UN) agencies and Ministry of Health. Access to funding by national agencies has increased. Needs assessments have informed nutrition response plans across the country. Cross-line and cross-border programme coordination has been greatly facilitated by the development of the 'Whole of Syria' (WoS) approach that includes a common Humanitarian Response Plan (HRP). Access to those affected has improved through negotiated, inter-agency, cross-line convoys that are cooperatively planned with cross-border operations, reducing duplication and maximising synergies. Challenges remain in meeting needs in UN declared besieged and hard-to-reach areas, supporting internally displaced persons (IDPs) and regarding national non-governmental organisation (NGO) operational and technical capacity to deliver at scale.

Background

Syria, once a lower-middle income country, had little experience of emergency nutrition prior to the current crisis as there was no need for emergency response. The focus of the Ministry of Health (MoH) primary healthcare services with regard to nutrition was the promotion of preventative behaviours and nutrition surveillance; no treatment of acute malnutrition through community-based management of acute malnutrition (CMAM) existed due to the low acute malnutrition caseload in the country. Furthermore, as health services delivery was well covered by the MoH, there was no need for non-governmental organisation (NGO) partners and therefore no nutrition coordination mechanism was required.

Due to the Syrian conflict the delivery of basic health services was severely disrupted and a need emerged for support from the humanitarian community. In view of this, after major advocacy by UNICEF and other United Nations (UN) partners, the Nutrition Sector was established in March 2013. Initially, scope and participation were limited as few partners existed and nutrition was not yet seen as a priority by the government with the perception that no

malnutrition related problems existed. Many challenges were faced from the outset as the concept of coordination was not well understood and engagement and participation of national NGO partners in coordination fora was not welcomed by government. However, over time, there has been considerable progress. This article describes the process of establishing Nutrition Sector coordination in Syria and challenges and lessons learned.

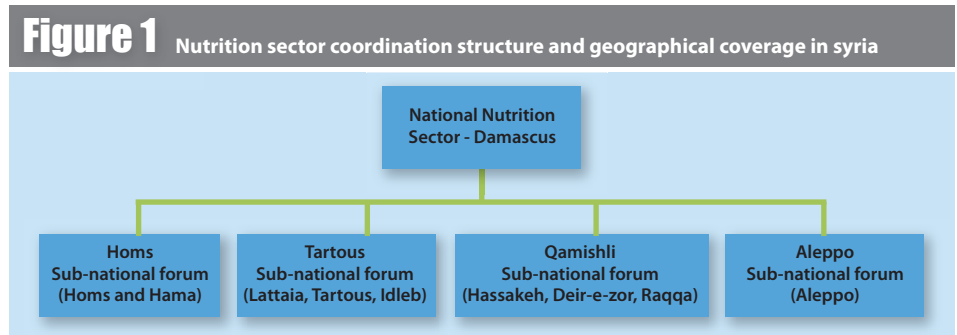
Emergence of Nutrition Sector coordination in Syria

The Nutrition Sector began with few partners, mainly UN agencies (UNICEF, the World Food

Programme (WFP) and the World Health Organization (WHO), MoH and the Syrian Arab Red Crescent (SARC). Government authorities were initially sceptical of the valid role of national NGO partners in the emergency response and were therefore reluctant to include them in co-ordination activities. During this difficult period, the cluster lead agency (UNICEF), through the Nutrition Sector, supported national partners to continue their response while at the same time advocating to the authorities for their inclusion in coordination fora at all levels. Because of this continued advocacy, and with the recruitment of a designated sector coordinator, the participation of national NGOs increased gradually from five in 2013 to 60 in 2017.

The Nutrition Sector is co-led by the MoH and UNICEF. There are also four sub-national coordination fora, in Aleppo, Homs, Tartous and Qamishli. As indicated in Figure 1, each sub-national forum covers several governorates which are supported by the UN hub. In addition, the sector has a technical working group (TWG) which provides support on matters pertaining to the response strategy, protocols and guidelines. Due to the evolution of the role of national partners, they are now part and parcel of the system and their key role in the emergency nutrition response is acknowledged. National partners form part of the sector TWG, along with MoH, UN agencies and international NGOs, and are involved in technical thematic areas such as development of infant and young child feeding (IYCF) strategy, community-based management of acute malnutrition (CMAM) protocols, and training packages, surveillances system and reporting tools.

The sector prioritised development of technical and coordination capacity of sub-national



focal points from Directorates of Health (DoH) and UNICEF, the central nutrition team at MoH, as well as sector partners. This involved trainings in-country and outside the country facilitated by the sector supported by the WoS nutrition sector and the Global Nutrition Cluster (GNC). Adequate nutrition coordination capacity was created among the sub-national focal points from UNICEF and Ministry to lead the response.

Initially, the Nutrition Sector focused on capacity development of partners, particularly MoH, including the introduction of the concept of nutrition in emergencies (NiE) and the implementation of small-scale, preventative nutrition activities, such as the provision of high-energy biscuits (HEBs), fortified spread, micronutrients; limited promotion and counselling sessions through MoH health facilities; and partner-run programmes and curative nutrition services. The sector has since expanded efforts to engage the food security and agriculture sectors in the development of common tools for assessments and key messaging around optimal feeding and proper use of nutrition products, as well as delivering nutrition interventions through food security mechanisms. With support from the Food and Agriculture Organization (FAO), the Nutrition Sector has initiated small-scale, nutrition-sensitive activities through schools and at household level. The initiative provides nutrition information and agricultural inputs to school children and their teachers and families to establish backyard gardens at school and home to improve access to nutritious foods.

Achievements

The Syria Nutrition Sector has made significant progress since it was established in 2013. Achievements include the integration of nutrition services such as mid-upper arm circumference (MUAC) screening into polio and measles campaigns; nutrition surveillance in MoH health centres; provision of lipid-based nutrition supplements (LNS) through food security platforms; development of curative services in MoH health centres; and cross-line convoys as part of the

Efforts have also been made to develop standards and protocols for the delivery of both preventative nutrition services (IYCF provision of fortified foods, micronutrients and HEBs) and curative nutrition services (identification and treatment of acute malnutrition). The TWG has developed a CMAM protocol in the form of field cards translated into Arabic for easy use by services providers, CMAM and IYCF training packages and tools, and standardised reporting templates, such as the 4W matrix to collect information on who is doing what, where and when to monitor the response and identify gaps. These tools were further harmonised and shared across hubs.

In addition, in 2015-2016 the Nutrition Sector, through the MoH and with the financial and technical support of UNICEF and technical support of Medair and WFP, conducted SMART nutrition surveys in accessible areas, including 11 of the 14 governorates in Syria (the exceptions

were Deir-e-zor, Ar Raqqa and Idleb). The SMART surveys identified an acceptable level of global acute malnutrition (GAM) of three per cent and 0.6 per cent severe acute malnutrition (SAM) in children, moderate levels of acute malnutrition among women (7.8 per cent), moderate public health problem levels of anaemia among both women and children, and poor IYCF practices. These findings were used to inform the 2017 Humanitarian Needs Overview (HNO)/HRP and guided nutrition responses in 2017 and subsequent plans. Subsequently, the sector prioritised promotion and support for optimal IYCF practices, provision of micronutrients and other fortified supplements, and strengthening of the identification and treatment of acute malnutrition in pocket areas, as well as integration with other sectors.

The Nutrition Sector supported 550,000 and 260,000 women and children in UN declared besieged and hard-to-reach areas in 2016 and 2017 respectively through the provision of essential, life-saving nutrition supplies delivered in inter-agency, cross-line convoys. The convoys included nutrition supplies such as LNS (Plumpy'Doz), multiple micronutrient powders

(MNPs) for children; micronutrient tablets for mothers; HEBs for prevention of undernutrition and micronutrient deficiencies; and therapeutic and supplementary supplies such as Plumpy'Nut, therapeutic milks and supplementary foods for the treatment of SAM and moderate acute malnutrition (MAM). These supplies were accompanied with a simplified CMAM protocol and flyers to raise awareness on the use of preventative nutrition supplies. In addition, the Nutrition Sector made efforts to create capacity through remote technical support in close collaboration with other hubs, although this was very challenging as carried out through skype calls.

Table 1 summarises the Nutrition Sector's reach in 2016 and the first half of 2017. As indicated in the table, the sector delivered life-saving nutrition services in accessible areas in 11 out of 14 governorates throughout the country, as well as UN declared besieged and hard-to-reach areas. Several indicators were constrained, including provision of multi-micronutrients and treatment of acute malnutrition among pregnant and lactating women (PLWs) and children, largely due to lack of access, capacity, funding and operational challenges, including the fact

Table 1 Nutrition Sector reach (number of women and children provided services) in 2016 and 2017

Year	Agency	Reach	Target	Percentage of target
2017	# of health workers trained on CMAM guidelines	1,296	1,000	130%
	# of health workers trained on IYCF	603	2,150	28%
	# of children 6-59 months reached with multiple micronutrients	379,862	774,691	49%
	# of children 6-59 months reached with LNS/HEB	724,436	774,691	94%
	# of children 6-59 months reached with VA supplementation	1,313,827	1,162,036	113%
	# of children 6-59 screened for acute malnutrition	736,931	968,364	76%
	# of children 6-59 months reached with SAM treatment	2,527	5,100	50%
	# of children 6-59 months reached with in-patient SAM treatment	659	1,680	39%
	# of children 6-59 months reached with MAM treatment	7,478	20,000	37%
	# of PLW counselled on IYCF	555,223	589,365	94%
	# of PLW reached with micronutrient supplementation	122,710	589,365	21%
	# of PLW screened for malnutrition	191,506	589,365	32%
	# of PLW with MAM reached with treatment	4,092	10,000	41%
Total reach	2,996,606			
2016	# of health staff trained on CMAM guidelines	1,848	1,000	185%
	# of health workers trained on IYCF	1,008	1,000	101%
	# of children 6-59 months screened for acute malnutrition	955,890	732,200	131%
	# of children 6-59 months reached with out-patient SAM treatment	4,298	7,827	55%
	# of children 6-59 months reached with in-patient SAM treatment	516	783	66%
	# of children 6-59 months reached with MAM treatment	17,785	18,180	98%
	# of children 6-59 months reached with LNS/HEB	1,579,541	915,249	173%
	# of children 6-59 months reached with MNPs	445,798	915,249	49%
	# of children 6-59 months reached with vitamin A supplementation	441,217	1,647,449	27%
	# of estimated beneficiaries of nutrition supplies distribution	554,062	500,000	111%
	# of PLWs screened for acute malnutrition	206,118	133,184	155%
	# of PLW reached with MAM treatment	2,107	7,991	26%
	# of PLWs counselled on IYCF	358,825	266,368	135%
# of PLWs reached with MMNs	126,281	133,184	95%	
Total reach	3,086,073			

that PLWs are served by the reproductive health department rather than the nutrition department in the MoH. However, most other indicators performed well. The total reach of the Nutrition Sector in 2016-2017 was mainly in accessible areas of the 11 governorates (78 per cent of total reach) rather than in UN declared besieged and hard-to-reach areas (22 per cent). Figures 2 and 3 show the geographic spread of reach.

Added value of the 'Whole of Syria' (WoS) approach

UN Security Council Resolutions 2165 and 2191 in 2014 paved the way for the provision of humanitarian assistance to people in UN declared besieged and hard-to-reach areas through inter-agency, cross-line convoys (from Syria) and cross-border convoys (from Turkey). In line with these resolutions, the humanitarian community in Syria, under the lead of the UN Office for the Coordination of Humanitarian Affairs (OCHA) and with the close coordination of SARC, initiated the inter-agency delivery of supplies to people under the WoS approach. This process is described elsewhere (see article on the WoS approach in this edition of *Field Exchange*).

Prior to the establishment of the WoS architecture, the Nutrition Sector faced challenges in planning and delivering nutrition interventions in UN declared besieged and hard-to-reach areas. The main challenges faced included a lack of information sharing between hubs in Syria, Turkey

and Jordan, which led to programme gaps and duplication in certain areas; varied and limited access by different hubs to the affected population; inadequate nutrition capacity in the UN declared besieged and hard-to-reach areas affected by the lack of access; lack of trust between hubs (making cooperation difficult); and the application of different standards in different areas/hubs due to difficulties in sharing programme information, guidelines and protocols.

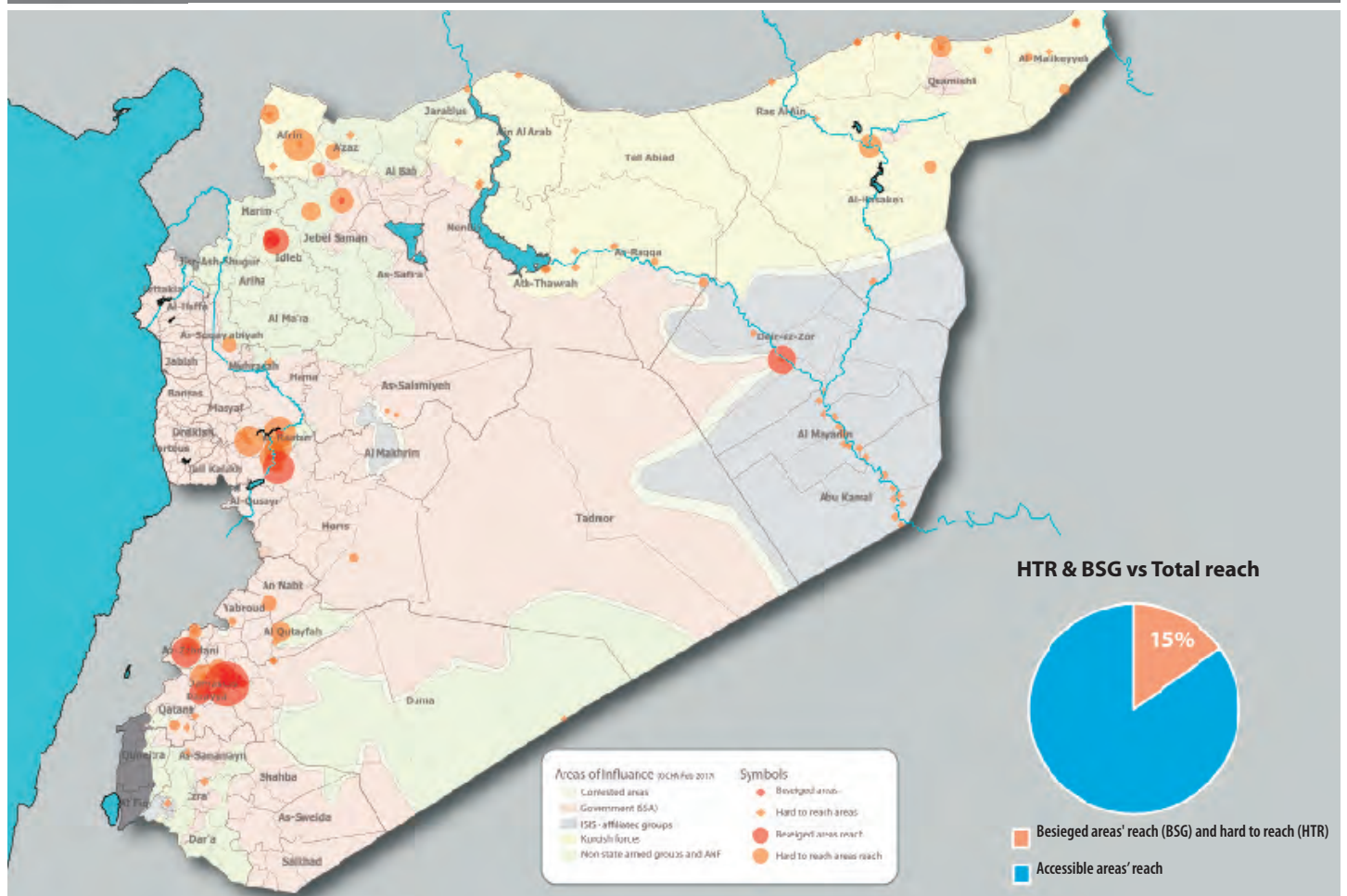
However, with the inception of the WoS structure, these challenges were gradually overcome as trust between hubs was built and cooperation improved. For example, the sub-national focal points with their counterparts in the DoH in Aleppo and Hassakeh responded to internally displaced persons (IDPs) from Ar Raqqa and Aleppo during the escalation of the conflict at the end of 2016. The response was made more effective by improved levels of engagement with the WoS team, which played a key role in improving information sharing, creating a conducive environment for hubs to work together, and by providing a platform for experience sharing and mobilisation of cross-border partners.

To facilitate access to UN declared besieged and hard-to-reach areas, OCHA set up an Access Working Group (AWG) attended by sector/cluster coordinators, cluster lead agencies, key UN agency members, OCHA and SARC. The AWG meets in the middle of every month to prepare

the inter-agency convoy plan for the following month with inputs from sector members based on their mandate. The plan is then reviewed and endorsed by the Resident/Humanitarian Coordinator and submitted to the Ministry of Foreign Affairs (MoFA) for endorsement and approval.

The inter-agency convoy process was initially ad hoc as developing the plan and consolidating supplies was time-consuming. Endorsement and approvals were unpredictable and delivery of the convoys involved a very cumbersome process requiring authorisation at multiple levels. Because the plan targets UN declared besieged areas where initially no or few partners from cross-border operated, communicating the list of required supplies was often not smooth, as sharing information was not systematic and at times sensitive. There were also challenges in obtaining reliable information on the nutrition situation of women and children as there was no nutrition capacity inside UN declared besieged areas, with very limited or no trained health workers. This made substantial planning of an effective nutrition response very difficult. Despite these difficulties, the convoy process has gradually matured and become more predictable, with the development of monthly plans. Rapid nutrition assessments (using MUAC screening), observations and discussions with health workers are also now carried out by technical experts from Nutrition Sector partners and findings are used to inform convoy plans.

Figure 2 Syria Nutrition Sector reach in besieged and hard-to-reach areas through convoys in 2016



The proposed lists of locations and supplies are also now shared with other country hubs (Amman in Jordan and Gaziantep in Turkey) through the WoS structure for feedback and the resulting approved plan is shared by the Nutrition Sector with UN agencies (UNICEF, WFP and WHO) for their inputs (nutrition supplies). The final plan is then compiled and submitted to OCHA for further consolidation. This process is intensive, with a lot of communications back-and-forth, and many changes in locations and supplies; however, the result is a co-ordinated plan that avoids duplication and responds to real needs.

Cooperation has been greatly facilitated by the fact that a single HRP was introduced in the WoS approach that combined the separate response plans of all three hubs into a single document. Consequently, the Nutrition Sector had a well-coordinated response plan that covered the entire country from within Syria and encompassed cross-border operations. Information sharing, better synchronisation and regular exchange of experiences and ideas has since developed further, making coordination much more systematic.

The speed with which inter-agency convoys are delivered is not as rapid as intended in 2017 compared to 2016 due to the evolving security situation on the ground and the changing dynamics of the conflict in addition to cumbersome administrative procedures. However, efforts

from the humanitarian community continue to address this.

Conclusions

Sector coordination in Syria has gone through various iterations since its establishment in 2013. Given the country context, coordination was not considered a priority in the early days of the conflict. However, with consistent advocacy from the cluster lead agency and other key UN sector partners, this view started to change and gradually the nutritional needs of the population were acknowledged. This led to the engagement of the relevant line ministry (MoH), SARC and UN agencies in establishing coordination mechanisms, identifying gaps in the response and mobilising potential partners to respond, with heavy investment in national capacity building on NiE. Over time, national NGOs also became fully engaged in the Nutrition Sector and are now a vital part of the coordinated response. Increased access of national partners to funding from UN agencies (UNICEF, WFP and WHO) in the sector has helped to scale up their response, although limitations in their operational and technical capacity in implementing large-scale interventions remain. In addition, national NGO partners are yet to access financial resources from the Syrian Humanitarian Fund (SHF) through OCHA.

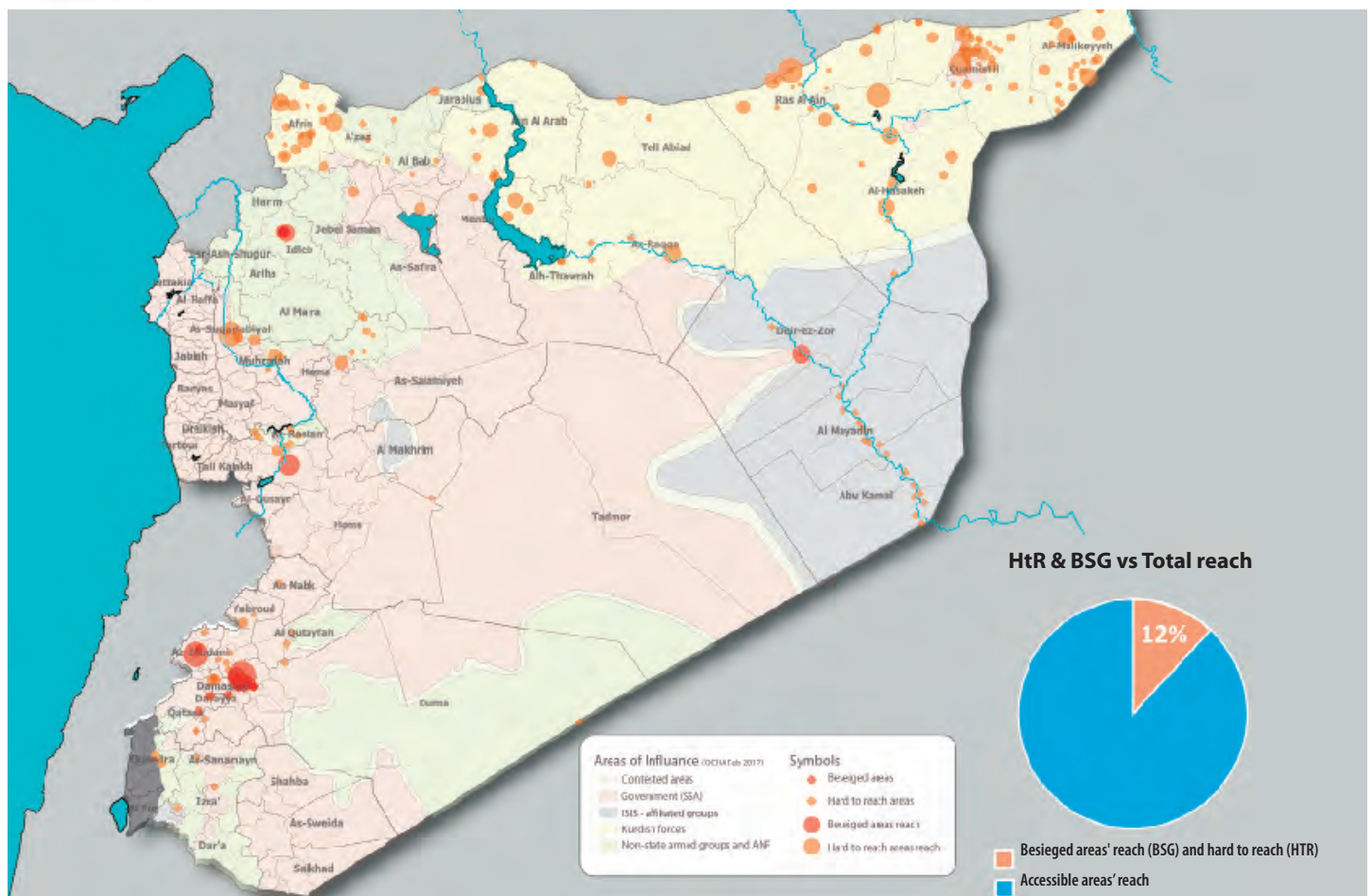
In the absence of the WoS structure, cooperation between hubs was not taking place, which compromised operations in UN declared besieged

and hard-to-reach areas. From the inception of the WoS approach, the Nutrition Sector made significant progress on various aspects, including harmonisation of tools, coordination of nutrition activities and representation of the sector at WoS strategic forums, including donor meetings. The WoS added value in terms of information sharing for decision making, avoiding duplication of efforts and capitalising on existing opportunities, while delivering cross-line and cross-border response. The presence of the WoS forum made the development of a single HNO/HRP response plan more systematic and easier.

The maturation of the Nutrition Sector and the development of the WoS approach has allowed a more systematic and coordinated response to the needs of women and children throughout the country, particularly in areas affected by the conflict such as East Aleppo, Ar Raqqa and, to some extent, Deir-e-zor. However, the sector still faces challenges that are affecting the response, including limited funding, inaccessibility to certain locations (including UN declared besieged and hard-to-reach areas) and difficulties in providing comprehensive nutrition support to IDPs in Raqqa and Hassakeh. Engagement and support of the WoS and improved collaboration of the three hubs in Syria, Jordan and Turkey are key to delivering a comprehensive and coordinated nutrition response in Syria.

For more information, contact: Muhiadin Abdulahi email: mabdulahi@unicef.org

Figure 3 Syria Nutrition Sector reach in besieged and hard-to-reach areas through convoys, Jan to August 2017



Women with young children attend a health education session on feeding and hygiene practices in Baidoa, Bay Region, Somalia, 2017

By **Isaack Biseko Manyama**



Isaack Manyama is the Nutrition Cluster Coordinator for South Sudan. He has 24 years' experience in the nutrition sector. Previous roles have included Team

Leader of the Emergency Coordination Unit (ENCU) in the Early Warning and Response Directorate of the Ministry of Agriculture in Ethiopia, Primary Health Care Officer for UNICEF Tanzania and Senior Nutritionist at the Tanzania Food and Nutrition Centre.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Partnership and accountability in the South Sudan Nutrition Cluster (2015-2017)

Location: *South Sudan*

What we know: Acute malnutrition remains a major public health emergency in several parts of South Sudan, driven by ongoing conflict and displacement, poor access to health services, inadequate water, sanitation and hygiene, and chronic food insecurity.

What this article adds: The Nutrition Cluster is well established in South Sudan and involves a Strategic Advisory Group, thematic technical working groups, including on quality and accountability to the affected population, and a rapid response mechanism task force. Partnership and accountability is a cross-cutting theme in assessment, response gap analysis, response planning, costing, implementation and monitoring. Experiences reflect the key role the Nutrition Cluster plays in brokering partnerships, resolving differences and holding responders to account. Transparency across all aspects of the humanitarian project cycle, together with trust and open dialogue among all stakeholders, is critical. High staff turnover and competition for operational opportunities stifle good partnership and accountability. Sustained capacity building, monitoring, awareness raising and lesson learning are key.

Background Nutrition context

Acute malnutrition remains a major public health emergency in several parts of South Sudan. Over 1.1 million children are estimated to be acutely malnourished in 2017, of which 706,427 (63.7%) are expected to be reached with curative nutrition services (75% of those children with severe acute malnutrition (SAM) and 60% of children with moderate acute malnutrition (MAM)). The May 2017 integrated phase classification (IPC) estimated that 6.1 million people (50 per cent of the population) would be severely food insecure in June/July 2017, compared to 5.5 million (45 per cent) people in May 2017. This is the greatest number of people ever to experience severe food insecurity (IPC phases 3, 4 and 5) in South Sudan.

As expected, the 2017 food security situation, which builds on food insecurity and deterioration of livelihood assets from previous years, has been manifesting in increased levels of acute malnutrition. The proportion of SMART surveys reporting critical levels of global acute malnutrition (GAM \geq 15 per cent) increased from 77 per cent (of 40 surveys conducted from January to September 2016) to 82 per cent (of 33 surveys

conducted in the same period in 2017). A peak of 36.1 per cent GAM was found in Twich County, classifying it as 'extremely critical'. Admissions in selective feeding programmes increased from January to July 2017, with an overall combined 19 per cent increase in both SAM and MAM compared to the same period in 2016. Key drivers of the high levels of acute malnutrition across South Sudan include: ongoing conflict and displacements; poor access to basic services; economic crisis, with increased staple food prices associated with the devaluation of the South Sudanese Pound; disease outbreaks; inadequate dietary intake in terms of both quality and quantity; low coverage of sanitation facilities; and poor hygiene practices.

Nutrition Cluster partners and other stakeholders continuously support the Ministry of Health (MoH) in responding to the ongoing nutrition emergency. While the nutrition situation remains highly insecure, famine is no longer occurring in Leer and Mayendit Counties, and further deterioration was prevented in Koch and Panyijiar Counties of former Southern Unity State due to immediate and sustained multi-sector humanitarian assistance delivered to the affected population from March to May 2017.

The MoH with UNICEF, the World Food Programme (WFP), the World Health Organization (WHO) and Save the Children International (SCI) have continued to lead Nutrition Cluster partners in developing and finalising three important national guidelines, including their respective implementation tools and training packages: community-based management of acute malnutrition (CMAM); maternal, infant and young child nutrition (MIYCN); and inpatient management of SAM.

The South Sudan Nutrition Cluster

The Nutrition Cluster in South Sudan was established in 2010 and currently comprises 64 active partners, including 43 national and international non-governmental organisations (NGOs) implementing nutrition responses on the ground. The cluster is coordinated through a fortnightly meeting, chaired by the Nutrition Cluster Coordinator (NCC). Several regular bilateral and tripartite meetings are also held with partners and other stakeholders, including donors, to provide updates and address or respond on assessments, monitoring and funding issues. In addition, meetings between the Nutrition Cluster coordination team -and donors are held once every two months with an agenda

which is agreed with the donors. The strategic direction of the Nutrition Cluster is decided by the Strategic Advisory Group (SAG), composed of MoH, United Nations (UN) agencies, national and international NGOs as well as representation from the Health Pool Fund (HPF), a donor that applied to be a member of the reformed SAG (August 2017).

Several thematic working groups (TWGs) have been formed to coordinate specific technical areas on behalf of Nutrition Cluster partners. These include: *CMAM TWG*, which is responsible for CMAM technical issues, scale-up and revision/development of CMAM guidelines, support in the review of the stabilisation centre guidelines, and CMAM training rollout to the states; and the *Nutrition Information Working Group (NIWG)*, responsible for coordinating emergency nutrition data collection (based on SMART/Rapid SMART surveys), and analysis, validation and dissemination to the cluster members through the fortnightly cluster meetings and other cluster-approved channels. The NIWG also represents the Nutrition Cluster in IPC preparation/revision and other inter-cluster information-related activities. The *MIYCN TWG*, which was established in 2015, is responsible for all MIYCN issues, including supporting the MoH in the development of national MIYCN guidelines, strategy documents and training packages.

The *Rapid Response Mechanisms (RRM) Task Force* was also established in 2015 to coordinate outreach services through the RRM, implemented by UNICEF and WFP, as well as short-term response approaches implemented by Medair and Action Against Hunger (AAH). Lastly, the *Quality and Accountability to Affected Population (QAAP) TWG* is responsible for ensuring improved assessment of quality services and integration of the Nutrition Cluster Accountability to Affected Populations (AAP) framework into partners' projects.

Needs assessment and analysis

Needs assessment

Nutrition Cluster needs assessments are conducted through a number of assessment and information-gathering methodologies. First, **periodic SMART surveys** are conducted during the pre-harvest period (March-September) and the post-harvest period (October-February) in priority counties. Ad hoc surveys are also conducted based on IPC analysis or where there is a need to confirm or clarify the status of a reported deteriorating nutrition situation based on mid upper arm circumference screening. By the end of September, a total of 33 SMART surveys had been conducted, of which 27 reported critical levels of acute malnutrition (GAM \geq 15 per cent).

Food Security and Nutrition Monitoring Systems (FSNMS) are conducted twice per year, in June/July and November/December. These surveys highlight the nutrition situation at state level. Recently, the FSNMS team agreed to increase the sample sizes to integrate at least four SMART surveys at county level with the FSNMS

surveys. The June/July 2017 survey also indicates deterioration of the nutrition situation, with consistently higher levels of GAM than those reported in 2016 in the same period. Specifically, eight out of the nine states assessed reported GAM levels above the 15 per cent emergency threshold, compared to seven out of ten states during the same period in 2016.

IPC classification is one of the methods that provide guidance on the specific county-level and overall food security and nutrition situation in the country and identifies areas with information gaps. As mentioned above, such areas are prioritised for ad hoc SMART surveys, especially when food security indicators signal deterioration. Based on the available IPC analysis, the food security and nutrition situation deteriorated consistently in the last three years (2015-17).

Good quality **monthly new admissions programme data (therapeutic feeding programme (TFP) and targeted supplementary feeding programme (TSFP))** is very useful in tracking how the nutrition situation is evolving at site, county, state and national levels. It increases understanding of whether the observed situation is usual or unusual. For the last three years (2015-2017), monthly admissions trends have informed the Nutrition Cluster partners and stakeholders on whether the situation is stable or improving or a crisis is imminent and whether timely actions are needed. The data guides the need for supply/procurement top-up and delivery to areas of need and deployment of surge staff to balance quality and workload, among other necessary activities.

Response gap analysis

At the beginning of 2016, the Nutrition Cluster initiated nutrition response gap analysis, focusing on outpatient therapeutic programme (OTP)/TSFP geographic coverage in health facilities, expected optimal coverage (distance from one site to another) and population size. This approach and tool was criticised by partners as the process of identifying gaps was subjective. In view of this, the Nutrition Cluster, through the QAAP TWG, coordinated revision of the tool in 2017. The response gap analysis tool was revised and expanded to include assessment of gaps in service quality based on several weighted indicators; structural status of nutrition sites; and geographic coverage of nutrition sites, with clear scoring and decision-making rules for characterising a site as under-performing. The tool was presented and reviewed by partners and approved. It was piloted at the end of August 2017 and was due to be rolled out in December 2017 at the time of writing.

Gaps in response are also identified by cluster field monitoring visits jointly carried out with UNICEF, WFP or the MoH. Identified gaps are discussed with the partners concerned and an action plan is drawn up to address them, with regular updates provided to the cluster coordination team.

Cluster targets in all programme areas

The Nutrition Cluster targets for both SAM and

MAM are estimated based on the existing burden coupled with actual and planned partners' capacity to expand, as well as previous year performance coverage and absolute number of children enrolled in OTP and TSFP. For example, if 90-100 per cent of the target was attained and the situation is expected to be similar or worse, subsequent annual targets are set at the same level or increased as necessary. The cluster targets are estimated initially by the cluster coordination team and presented to the SAG members for further guidance before discussion and approval by the all Nutrition Cluster partners.

Challenges related to needs analysis

It is difficult to link emergency and long-term development information systems, partly because development nutrition information is scant and not readily available, with a lack of national survey data for comparison of levels of acute malnutrition. Insecurity limits coordination and assessments in conflict-affected states. It is also difficult to conduct assessments in all counties due to limited capacity and the prohibitive cost of SMART surveys (US\$20,000 to US\$30,000 depending on the location, security and logistics needed and whether implemented by a consultant). There is limited funding to sustain the number of annual surveys conducted over the coming years. The quality of some nutrition survey results is sub-optimal. In such situations, the NIWG may reject the SMART survey; one survey was rejected in May/June 2017 due to poor quality of results. There is high staff turnover among partners and therefore there is a need for regular training on SMART surveys. The latest training was done in June 2017.

To try and overcome these challenges, state-level results are extrapolated to county level, where the information gap is plausible and accepted by stakeholders. However, in some situations this can overestimate the levels of acute malnutrition in low-prevalence counties. NIWG collective review and discussion of survey results fosters transparency and credibility and instils a sense of responsibility and accountability among both partner and NIWG members. Follow-up, capacity building and feedback to partners improve information/data quality (accuracy, timeliness, comprehensiveness/reporting rate and records). Improved information management is a continuous process requiring time, dedicated staff and sufficient funding.

Response planning

For the last four years (2014-2017), Nutrition Cluster response planning has focused on the following three priorities: providing life-saving services on management of acute malnutrition (TFP/TSFP); increased access to prevention programmes (blanket supplementary feeding programme (BSFP) and targeting pregnant and lactating women (PLW) and maternal infant and young child nutrition (MIYCN); and enhanced nutrition situation analysis, monitoring and coordination. A fourth priority – integration of nutrition responses with other nutrition-sensitive interventions from other sectors (including health, water, sanitation and hygiene (WASH)

and food security and livelihoods (FSL)) – was introduced in 2017.

Response planning process

First, the timelines for development of the national and cluster Humanitarian Response Plan (HRP) is drafted by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), discussed in the Inter-Cluster Working Group (ICWG) and approved by the Humanitarian Country Team (HCT). Once approved, the Nutrition Cluster coordination team drafts the cluster response plan based on available assessment and response information from different sources (SMART, programme data, FSNMS, IPC, the Humanitarian Needs Overview (HNO) and priority response needs. The response (actions) are presented to SAG members for review before being presented to Nutrition Cluster partners for further discussion, review and approval. The cluster response plan is then submitted to OCHA for ICWG-level peer review/defence and comments. Based on the comments/inputs from OCHA/ICWG, the response plan is finalised and submitted to OCHA.

Contribution and participation of partners and government is critical. During the SAG/partners discussion phase, the cluster coordination team must engage respective government ministries to ensure buy-in and support. For example, ad hoc meetings were organised by the cluster coordination team, during which partners reviewed the 2015, 2016 and 2017 drafts and enriched it accordingly before it was submitted to OCHA for defence. While there was limited involvement of government in the initial stages of the 2015 plan, government reviewed the final cluster caseloads/targets and situation analysis in the 2017 response plan.

Costing

The total funding requirements published by OCHA, coordinated by the Nutrition Cluster, reflects frontline and pipeline needs. Nutrition Cluster coordination costs are not part of the HRP budget; these are covered by UNICEF. The cost for HRP was determined using two different approaches in 2016 and 2017. The first approach, used in 2016, was based on OCHA's guidance. The cluster's funding requirement was determined based on how much funds the cluster could raise in 2015 (including carry over from 2014). A 10 per cent contingency of the total cluster-secured funding for 2015 was added to determine the funding requirement for 2016. This approach was used for all clusters. Partners recommended estimating the funding requirements based on need, but the approach for 2016 had already been decided by OCHA/HCT. The total budget (funding requirements) was communicated to all cluster partners. In 2017, clusters were allowed to estimate funding requirements based on need. With respect to the Nutrition Cluster, the funding requirement was determined by multiplying the number of beneficiaries with the estimated costs of managing one case of PLW and children enrolled in TFPs, TSFPs and BSFPs. The sum of these individual costs was taken as the total requirement for the programming identified by the Nutrition Cluster in 2017. In practice, the total HRP budget does not mean that all the nutrition requirements are reflected/covered – a funding ceiling is applied by OCHA for all clusters, beyond which clusters cannot increase funding even if needed. Notwithstanding, mid-reviews provide an opportunity for clusters to review their respective humanitarian needs, targets and funding requirements. In situations

where there is an unforeseen major crisis/emergency, as in the case of the Declaration of famine in February 2017, the Nutrition Cluster may revise its funding requirements for counties affected and additional funding may be provided by donors to meet heightened needs.

Since different costing approaches were used, it is difficult to compare funding requirements across the years. The 2016 costing/budget was not based on need and was instead very much driven by donor's willingness to fund; 2016 cluster budgets had to be cut considerably to fit within the budget ceiling. Determining funding requirements based on funding status misleads donors/stakeholders that the project requires less resources, while the unmet funding needs in reality are huge. It is difficult to separate projects that are emergency per se and those that focus on development. As a result, partners continue to advocate for projects whose resources are not reflected in the HRP/online project system (OPS). Donors can still fund projects outside of the HRP/OPS, which arguably undermines the importance of the HRP (among the donors and partners themselves). A separate funding tracking system (FTS) is needed to capture projects outside the HRP-FTS in the OPS in future.

Response implementation

Several emergency nutrition response modalities are coordinated by the Nutrition Cluster in South Sudan. These include: static/mobile, RRM, inter-cluster response mission (ICRM), emergency response team (ERT)/multi-sector emergency team (MET) and survival kit (see Box 1). In terms of supplies, partners agreed in 2013/2014 that UNICEF and WFP would be responsible



Women with young children attend a health education session on feeding and hygiene practices in Baidoa, Bay Region, Somalia, 2017

for procurement and delivery of the core pipeline (ready-to-use therapeutic food (RUTF) and ready-to-use supplementary food (RUSF)) and other supplies to project implementation counties/sites. While WFP delivers the supplies to partners using its own logistics unit assets, UNICEF relies on private transporters and the Logistics Cluster in transporting SAM supplies from designated state-level warehouses to partners' operational counties/sites. Few partners procure their own buffer stock to be used in case of constraints in the core pipeline status. Médecins Sans Frontières (MSF) procures its own supplies most of the time and occasionally accesses the core pipeline supplies.

MoH, UNICEF, WFP and national and international NGOs engage in capacity building on management of acute malnutrition (CMAM and MIYCN) activities across the country. This is particularly important given the high staff turnover among partners in South Sudan, necessitating the need for continuous training of partners on CMAM and MIYCN annually or sometimes twice per year.

For the last two years, there has been limited involvement of state ministries and county health departments (CHDs) in the direct implementation of emergency nutrition activities in the context of South Sudan. Contributing factors include insecurity in some of the locations, limited number of staff trained on nutrition and limited logistics capacity. However, following the development of the new CMAM guideline in 2017, a total of 251 participants in nine former states, including government staff, were trained on SAM and MAM management.

Challenges

Transparency and AAP are still a challenge in all five elements/commitments (leadership/governance; transparency; feedback and complaints; participation; and design, monitoring and evaluation). The cluster, through the QAAP TWG, has requested all partners to include the minimum six indicators agreed to be monitored by the cluster on AAP. Some partners are only active in the cluster during HRP preparation and the South Sudan humanitarian fund (SSHF) funding process, which limits engagement and accountability. Late funding from some donors has delayed implementation of some of the nutrition projects. In practice, there are PCA/FLA challenges from partners as well as from UNICEF and WFP. Failure to acknowledge gaps during project implementation and a territorial attitude among some of the partners has hampered programming, with incidences of some partners trying to forcefully initiate response in other partners' operational areas. These are sorted out by the cluster coordination team through tripartite coordination meetings. Linking provision of funding to an emergency threshold undermines the preventative aspects of nutrition responses and encourages late responses, at which point more children will have been affected by acute malnutrition. Some partners raise funding first for areas without consulting the cluster coordination team as to whether there is

need/space to engage a new partner. This leads to potential duplication of services and sometimes misunderstanding among the partners involved before the overlap is sorted out by the cluster or local authorities.

Cluster implementation experiences have identified that field visits are a must; independent monitoring of nutrition projects is important to avoid biased reports and complaints of unfairness in some situations. Government involvement at county and community levels in planning, implementation, monitoring and supervision of projects instils ownership. Transparency and openness in engagement with partners on response issues builds trust and confidence – the cluster is the place where issues of overlap or differences can be objectively resolved. Devising an inclusive and transparent strategy for national NGO engagement in humanitarian response, coupled with regular updates on strategy implementation status, might clear misunderstanding and help prevent encroachment into other partner's operational areas.

Resource monitoring

Funding

The Nutrition Cluster uses two ways of monitoring funding secured for emergency nutrition response: the OCHA FTS and the cluster funding tracking tool. While the OCHA FTS tracks funding for projects in the HRP, the cluster tool tracks financial status from projects both in the HRP and those outside it. Projects outside the HRP include projects funded bilaterally either with funds from partners' HQs, or development partners who transit to emergency response as the situation evolves, in consultation with their respective donors. This is very important information to the cluster. For example, recent analysis by OCHA SSHF (August 2017) indicated there were no projects outside the FTS, whereas in reality there were 14 projects (including five MSF agencies)¹ not reflected in the HRP. The cluster financial tracking tool is usually updated once per quarter or twice per year.

Supplies

Core supplies are procured and delivered to partners by UNICEF and WFP. Regular update of core supplies pipeline is provided by WFP and UNICEF on a monthly basis to all Nutrition Cluster partners during cluster meetings. The Nutrition Cluster also tracks supplies status at site level on a monthly basis for key core pipeline items, including RUSF for TSFP and RUTF for OTP. If any site has stock out, the number of days and reasons for stock out are reported. The cluster coordination team consolidates all the information and presents the summary to Nutrition Cluster partners, WFP and UNICEF. Since this information started being collected in March 2017, the proportion of sites with adequate supplies through the month has ranged from 70 to 83 per cent for TSFP sites and 77 to 92 per cent for OTP sites. Where necessary, the cluster seeks clarification from WFP, UNICEF or the partner concerned. Information on status of partners' own supplies is not regularly received.

The cluster requested partners to provide this information in 2015 and in 2016; none did so, despite having procured buffer stock in case of shortfall/delayed delivery. The cluster is pursuing partners' own supply reporting in 2017.

Human resource capacity

The Nutrition Cluster drafted a tool in 2015 for partners' capacity mapping. This tracks the number of existing staff in each organisation and how many have been trained or need to be trained on SMART surveys, CMAM, IYCF and coordination twice per year. About 57 per cent of 1,51 target staff had been trained by end of September 2017. The Nutrition Cluster coordination team also follows up on recommendations by different TWGs (CMAM, MIYCN, NIWG and QAAP) on their capacity-building action plans. For example, the CMAM TWG released its capacity-building plan for 2017 for the new CMAM guideline that was implemented by MoH/UNICEF/WFP/SCI in collaboration with the Nutrition Cluster coordination team. The Nutrition Cluster requests partners' profiles when joining the cluster for the first time. This provides an understanding of partners' capacity and guides them on which forthcoming training they should attend/participate in to sharpen and broaden their understanding so that they are on the same level as other organisations.

Challenges

Not all partners provide funding information to the cluster (approximately 75 per cent provide this information sometimes), which hampers timely understanding of cluster funding status and coordination in general. Some partners are also hesitant to provide their own supply information to the cluster, making it difficult to calculate/understand overall supplies and coordinate in a timely way regarding shortfalls/excesses. This is coupled with interruption of supply pipelines due to insecurity and transportation challenges, plus limited supply storage and safety among partners at site level. Some partners request supplies based on FLA/PCA instead of the real needs of beneficiaries on the ground, leading to excess supplies in some instances. High staff turnover leads to inadequate implementation capacity among some of the partners.

Open and honest discussions with cluster partners and donors increases trust and credibility of the cluster coordination team. Continuous capacity building is inevitable in an emergency context that is characterised by high staff turnover, as is the case in South Sudan. Monitoring supplies status at site level has helped in understanding the challenges and systematically devising actions to address them.

Response monitoring and accountability mechanisms

As part of the Nutrition Cluster response plan development process, the cluster coordination

¹ This is based on the Nutrition Cluster's understanding of MSF sister agencies nutrition responses. The Nutrition Cluster does not track funding status of MSF sister agencies.

team recommends minimum key indicators that should be monitored and reported/updated monthly as per OCHA guidance. The indicators are then reviewed by the SAG, then discussed and approved by partners. Monthly programme reports (TFP (stabilisation centre (SC) and OTP), TSFP, IYCF, BSFP) are submitted by partners either through the nutrition information system (NIS) or 5Ws tools. The reports/updates are consolidated by the cluster coordination team on a monthly basis and an update is provided to all Nutrition Cluster partners during the fortnightly cluster meetings.

Field monitoring and supervision visits are conducted regularly by UNICEF, WFP and MoH or jointly with either the cluster or donor field visits. Partners also conduct their own monitoring and supervisions; however, the Nutrition Cluster is not updated on these.

The Nutrition Cluster, through the QAAP TWG, in collaboration with the Global Tech Rapid Response Team (Tech RRT), with funding from the United States Agency for International Development/Office of the United States Foreign Disaster Assistance (USAID/OFDA), is now engaging Tech RRT technical support in areas on IYCF and monitoring of nutrition projects implemented by partners. With respect to the monitoring, a random selection of projects will be monitored, technical support provided in the field and an action plan for improving quality of services prepared and monitored by the cluster. This is a new initiative which was expected to commence in January 2018.

Accountability

PCAs/FLAs keep partners accountable for delivering on agreed interventions and monitoring and supervision activities, including capacity building of staff and improvement of infrastructures where appropriate. The Nutrition Cluster is generally updated and involved in discussions regarding performance and accountability issues emanating from either WFP or UNICEF monitoring and supervision visits. In a number of instances, the Nutrition Cluster has organised meetings to find solutions on accountability-related issues identified during the field visits conducted either by UNICEF or WFP.

To ensure that AAP is uniformly implemented/adopted by all Nutrition Cluster partners, partners were oriented on the Nutrition Cluster framework on accountability, which was distributed to all Nutrition Cluster partners during the first half of 2016. However, it was not implemented or reflected in partners' projects until the QAAP TWG was formed in early 2017. Among other things, the QAAP TWG recommends a minimum of six indicators that should be monitored by the Nutrition Cluster coordination team in four elements of AAP (transparency and communication, monitoring and evaluation, complaints and feedback mechanisms, planning and implementation). The six indicators are currently reflected in most of the partners' projects, especially those reviewed by the cluster peer review team. The six indicators have also been shared with donors, who are

encouraged to reflect them in their respective bilateral projects.

Challenges

Reliability of some monthly reports in terms of performance indicators and beneficiaries in the programme is a challenge. In some situations, there are questions regarding ethical and transparency issues among some of the partners in terms of adhering to agreed guidelines and standards on management of acute malnutrition. Some stakeholders only include SAM/GAM prevalence, crude and under-five mortality rate as the nutrition indicators to describe the nutrition situation of an area/county, which greatly limits interpretation and analysis.

Lessons learned

Joint verification of randomly selected reports/nutrition sites enhances transparency, acknowledgement of gaps and invites joint solutions. Open and honest discussions with cluster partners and donors increases trust and credibility of the cluster coordination team.

Mentoring new partners, especially national NGOs, needs patience, understanding of context and appropriate guidance on how they can be part of the humanitarian community. Increased monitoring and supervision significantly improves quality and performance of emergency nutrition projects. Establishment of quality and AAP with independent monitors/agencies is the best way of monitoring partners' projects and documenting and sharing best practices within and outside the country.

Reflections on developments over the last 12 months

By the end of the third quarter of 2017, Nutrition Cluster partners implemented nutrition activities in ten former states, in 69 out of 79 counties. The coverage of OTP services increased by 8.5 per cent, from 678 in 2016 to 736 in 2017, while TSFP coverage increased by 40.3 per cent, from 504 to 707, during the same period.

In terms of transparency and accountability, there has been an increase in the number of partners acknowledging their technical gaps and requesting technical support, including paving the way for other partners to take over operational areas.

The funding environment is also changing. Most funding support provided to Nutrition Cluster partners is short-term, ranging from three months (for example, the Rapid Response Fund managed by the International Organization for Migration (IOM)) to 12 months (for example, the SSHF). However, there is now bilateral funding to partners that extends beyond one year, such as the HPF, which has a nutrition component supported by the UK Department for International Development. There are also in-kind donations, especially of core pipeline supplies, most of which are short-term extending to one year.

The way in which WFP, UNICEF and the Nutrition Cluster work together has improved significantly in 2017. For example, review of

the WFP and UNICEF 2016/17 joint response plan and development of the 2017/18 plan involved the Nutrition Cluster. A joint monitoring and supervision plan was prepared by the cluster and agreed by both UNICEF and WFP. A high-level quarterly meeting was established between WFP and UNICEF management (representative level) and the Nutrition Cluster to review the implementation of the work plan and support the cluster in areas of need, such as development of contingency and preparedness plans where the cluster was still lagging behind.

There have also been significant improvements in inter-cluster (sector) collaboration. During the famine response in Unity State, for instance, the four clusters (FSL, Health, WASH and Nutrition) developed an integrated response plan. The Nutrition and FSL clusters developed an action plan for implementation of an integrated response plan for prevention of famine. The action plan was discussed and approved by the Nutrition and FSL cluster partners. A number of collaboration activities were also carried out with the Health Cluster. For example, the Health Cluster trained Nutrition Cluster partners on rapid testing and treatment of malaria in OTP sites; the first time such a collaboration was implemented at scale. Nutrition Cluster (UNICEF) agreed with Health Cluster (WHO) to procure SC kits and necessary funds were allocated to the Health Cluster rather than the Nutrition Cluster. The WASH and Health Clusters agreed to implement the guidance provided by the Nutrition Cluster on treatment of children with SAM and cholera.

Conclusions

The experiences detailed in this article reflect what partnership and accountability look like on the ground during implementation of core cluster functions. Considerable strides have been made, despite continuing conflicts since 2013 and many ongoing challenges. One of the key lessons learned is that partnership and accountability are products of transparency in all aspects of the implementation of the humanitarian project cycle, including trust; as is open feedback/dialogue among all the stakeholders.

High staff turnover, questionable ethical behaviour and competition for operational opportunities/space by some of the implementing partners stifle efforts to improve partnership and accountability. More work and efforts are still needed for sustained improvement in partnership and accountability through continuous capacity building, monitoring and awareness raising and ensuring that lessons learned are used to improve ongoing and future emergency nutrition programming. One task could be to devise a mechanism to document good partnership and accountability elements and factors contributing to their successes or hindrance in all projects implemented by partners, so that the positive elements can be emulated by other stakeholders.

For more information, contact: Isaack Manyama, email: imanyama@unicef.org or ssnutritioncluster.coordinator@gmail.com



Update of the *Nutrition in Emergencies Coordination Handbook*: A product of the Nutrition Cluster

By Vivienne Forsythe, Jacqueline Frize and Nicki Connell

Vivienne Forsythe and Jacqueline Frize are independent public health and nutrition consultants, each with over 20 years of humanitarian experience, hired by Save the Children (SC) to carry out the handbook update consultation process and revision. Nicki Connell is Save the Children's Emergency Nutrition Advisor who was the Project Manager for the revision of the Handbook.

The project was managed by Save the Children and the first phase was conducted by independent consultants Jacqueline Frize and Vivienne Forsythe from March 2016 to May 2017. The final review was led by independent consultant Leah Richardson from July to October 2017 and the Global Nutrition Cluster Coordination Team (GNC-CT).

Update process

Version 1 of the *Nutrition Cluster Handbook – A Practical Guide for Field Coordination* (2013) has been revised to reflect the significant changes and developments in Inter-Agency Standing Committee (IASC) guidance and tools, in line with the Transformative Agenda (TA), the outcome of the World Humanitarian Summit in 2016 (<http://agendaforhumanity.org/summit>) and to incorporate the learning and operational experience of the Nutrition Cluster over the last five years.

A comprehensive, consultative process was undertaken to update the handbook. Generic humanitarian response materials and Nutrition Cluster-specific reference materials were comprehensively reviewed. A consultative process was carried out based on 20 key informant interviews (KIIs) with Nutrition Cluster Coordinators (NCCs), Nutrition Cluster Information Management Officers (IMOs), Nutrition Cluster Partners (NCPs), members of the Global Nutrition Cluster Coordination Team (GNC-CT) and UNICEF's Office of Emergency Programmes (EMOPS) Global Cluster Coordination Unit (GCCU). The KIIs aimed to garner a breadth of views and opinions on required changes in terms of both structure and content. This was followed by a document review. A consultative group made up of NCCs and NCPs was established to provide support and technical oversight to the consultants. Structure and content of the revised and renamed *Nutrition in Emergencies (NiE) Coordination Handbook* was agreed by the GNC-CT and SC. Chapters were drafted,

peer reviewed by the GNC-CT, SC members, other NCCs and NCPs and revised accordingly. Each chapter was reviewed by the GNC-CT and SC with a minimum of two (and most often four) other individuals.

Structure, scope and content

The aim was to meet the diverse needs of users and contexts. Demand ranged from succinct guidance on coordination during a humanitarian crisis to content accessible to national actors on preparedness and transition, and guidance on coordination in slow-onset crises where there is no formal cluster activation.

The handbook is structured around the Cluster Coordination Reference Module 2015 (CCRM)¹ and the Humanitarian Project Cycle 2015 (HPC)², which did not exist when the last version of the handbook was developed in 2013. These provided a helpful framework to structure content to address each of these situations (see Box 1). The new structure emphasises establishing and maintaining the coordination platform in support of the response (Section One) before moving on to coordination and implementation (Section Two). There is greater focus on the role of national authorities and sharing leadership with government, sub-national level coordination, the role of UNICEF as Cluster Lead Agency (CLA), the role and responsibility of partners, bridging the divide between emergency and longer-term development, transition-related issues and a multi-cluster integrated approach. Following feedback, sections on nutrition tech-

nical/programming were reduced since they are not the primary focus of the handbook.

Additional new materials have been incorporated. These include generic humanitarian assistance materials, such as the CCRM, HPC guidance, Cluster Coordination Performance Monitoring, the various Accountability to Affected Populations (AAP) protocols and commitments, as well as other Nutrition Cluster guidance and tools. Best-practice tips and operational examples are incorporated throughout the handbook, such as examples of different models of leadership of Technical Working Groups (TWGs) and sub-national clusters and models of working with government.

Considerations in the update process

Several crucial humanitarian assistance initiatives were underway during the revision period. Content from these was included where possible and schedules were extended to allow for this. Ongoing initiatives include:

- The 2016 World Humanitarian Summit (WHS) and Grand Bargain and subsequent New Ways of Working (NWOW 2017) as outlined by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) in 2017. (These have significant impact on Nutrition Cluster operations; NWOW 2017 promotes collective action,

¹ https://interagencystandingcommittee.org/system/files/cluster_coordination_reference_module_2015_final.pdf

² www.humanitarianresponse.info/en/programme-cycle/space

Box 1 Structure and content

Section One of the Handbook covers NiE and humanitarian principles, protocols, coordination mechanisms and standards, as follows:

Chapter 1: Humanitarian principles, protocols and coordination mechanisms.

Chapter 2: Establishing and maintaining nutrition in emergency coordination functions in support of response (structured around the CCRM).

Chapter 3: Core Cluster functions (structured around the CCRM).

Chapter 4: Key coordination skills.

Chapter 5: Information management to support emergency nutrition response.

Chapter 6: Nutrition Cluster transition and deactivation.

Section Two of the Handbook focuses on developing and supporting the implementation of emergency nutrition strategic response through the various phases of the Humanitarian Programme Cycle (HPC) as outlined in the HPC Guidance (developed in 2015).

Chapter 7: The Nutrition Cluster response / a multi-cluster approach.

Chapter 8: Coordinating nutrition in emergency preparedness.

Chapter 9: Coordinating nutrition assessment and analysis.

Chapter 10: Developing the Nutrition Cluster Strategic Response Plan.

Chapter 11: Mobilising resources for the Nutrition Cluster response.

Chapter 12: Supporting and monitoring the implementation of the Nutrition Cluster Strategic Response Plan.

which involves enhancing a multi-sector approach and linkages with development programming and advocates building the capacity and role of local agencies, including increased funding opportunities, and promotes multi-year funding mechanisms where appropriate.

- The Sphere handbook is under revision in 2017 and due out in 2018. Relevant components will need to be reflected in a future update.
- Ongoing development of UNICEF Nutrition Cluster Transition and Deactivation Guidance, due out in 2018. The handbook has incorporated current guidance on best practice from this initiative.
- The Global Nutrition Cluster (GNC) and Global Food Security Cluster (GFSC) are in the early stages of developing a training package on integration to achieve better nutrition outcomes. Relevant elements of this package may need to be incorporated into the new Handbook

In many humanitarian situations, humanitarian coordination and emergency nutrition coordination may be carried out in a context where Clusters are not

formally activated. It was therefore critical to ensure that content was both relevant and accessible, including language and terminology, to both cluster and non-cluster scenarios.

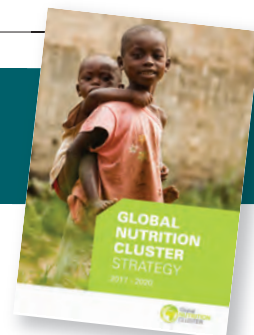
Striking a balance between appropriate level of detail to include and organising the information to accommodate different levels of user experience was a challenge. Inexperienced emergency NCCs/NCPs need very basic information and detailed explanations; experienced coordinators and partners are looking for a quick reference document. To address this, clear headings and sub-headings are used to signpost readers.

There was a tension between incorporating new material and reducing the size of the handbook; consultation helped to identify sections and chapters to reduce. Different users prefer a print edition versus an electronic one, so both will be produced. The process highlighted the limited tools available in French and the need for handbook translation.

Schedule for release

The new handbook will be available in English (with forthcoming French version) at: <http://nutritioncluster.net/>

Global Nutrition Cluster Strategy 2017-2020



The 2017-2020 Global Nutrition Cluster (GNC) Strategy was developed by the GNC-Coordination Team and the GNC Strategic Advisory Group with support from consulting firm Avenir Analytics. The process involved an extensive review and consultation with a wide range of stakeholders using an online survey, key informant interviews and a focus group discussion, undertaken during the last quarter of 2016. The new GNC strategy also drew on lessons learnt from the previous strategy, changes in the humanitarian operating and policy environment, and GNC stakeholder expectations. The draft strategy was extensively reviewed and endorsed by GNC partners. Based on this analysis and review, the core of the GNC Strategy for 2017-2020 is focused on the following three areas:

- 1) **Supporting operational delivery** of national emergency nutrition coordination platforms. This is focused on supporting national platforms to deliver the core cluster functions to ensure a more timely, effective and people-centred response. Based on the emergency continuum,⁷ this involves supporting national platforms to:
 - a. **Prepare** for crises and be well positioned to meet their responsibilities during the response phase of an emergency.
 - b. **Respond** to crises when they arise, primarily by delivering the core cluster functions.
 - c. Lead the timely **transition** to national coordination mechanisms (where not already leading) to maximise efficiency, effectiveness and local ownership of responses.
- 2) **Strengthening capacity** through national/regional and global platforms to support national coordination platforms to deliver more effective and people-centred responses. The GNC intends to develop the capacity of nutrition practitioners globally and locally on nutrition in emergency response coordination. These outcomes are highly correlated with objective one as supporting national platforms helps build coordination capacity in practice.
- 3) **Advocating and influencing** for more effective coordination. The GNC will provide leadership (along with the cluster lead agency and cluster partners) in advocating for greater nutrition coordination in crises and for inter-cluster and multi-sector approaches to meet the needs of affected populations.

Other areas highlighted in the strategy include:

Scope of activities which fully clarify the GNC's role in terms of its mandate and technical responsibilities, with an attempt to delineate the areas that are within the GNC's scope of activities and those that are not.

Ways of working which briefly outline the roles and responsibilities of GNC constituents and other key stakeholders who would help deliver the strategy and related work plan.

Outcomes, indicators and baseline targets have been linked to the strategic priorities and supporting objectives to help with delivery.

The GNC strategy, and specifically the strategic priorities, have guided the development of a rolling work plan and prioritisation of activities to be implemented in the first two years (2017-2018).

A mid-term review will be undertaken at the end of 2018 to determine progress made against strategic priorities and inform any adjustments required.

The strategy is available at: <http://nutritioncluster.net/download/6805/>

Nutrition Cluster advocacy strategy/framework and toolkit



The development of an advocacy strategy/framework for the Global Nutrition Cluster (GNC) and an advocacy toolkit for country level was identified by GNC partners as a priority in 2012 and reaffirmed in the 20014-2016 strategic objective. A high-level overall strategic direction and focus for GNC advocacy efforts, to ensure linkages with relevant initiatives and provide guidance to cluster partners in developing common messages to leverage impact for nutrition in emergencies (NiE) work, was first outlined at a GNC partner meeting in 2014. An advocacy framework was subsequently drafted by the Strategic Advisory Group (SAG) of the GNC in a three-day workshop organised by the GNC Core Team (CT), led by ACF-UK, in July 2015. This workshop brought together the GNC SAG members, the Scaling Up Nutrition Movement Secretariat (SMS) and the GNC-CT to develop the advocacy framework. The final Global Nutrition Advocacy Strategic Framework 2016-2019 has three overall goals:

Goal 1: The effectiveness of the humanitarian response;

Goal 2: Resource mobilisation for NiE;

Goal 3: Foster the accountability of humanitarian and development agencies with respect to preparedness, response and transition to safeguard the nutritional needs of emergency-affected populations by ensuring that the existing expertise and technical capacity on NiE contributes to informing and shaping nutrition policies.

Each advocacy goal is supported by objectives and results, specifying the changes required to contribute to achievement of the overall goal. For each result, the advocacy framework assesses the state of play and key challenges, opportunities and Nutrition Cluster role to date. Sample advocacy activities are proposed for GNC partners to undertake; however the framework also recommends that context-specific activities should be developed further.

The development of the framework was followed by the development of the Nutrition Cluster Advocacy Tool Kit. Its aim is to assist the Nutrition Cluster Lead Agency, UNICEF, Nutrition Cluster Coordinators, Information

Management Officers and Nutrition Cluster partners at country and global levels in the development, implementation and monitoring of the Strategic Framework and country-level advocacy activities.

The Advocacy Toolkit is a practical guide that helps the GNC and country clusters to develop, implement and monitor advocacy work in NiE. It provides key questions for reflection, basic advocacy pointers and advocacy tools to support Nutrition Cluster partners through the different stages of the advocacy cycle, with a specific focus on advocacy for nutrition in humanitarian contexts. Country-level Nutrition Cluster and cluster partner advocacy experiences have been used to illustrate the different areas in which advocacy can work.

The Nutrition Cluster Advocacy Strategic Framework is available at: <http://nutrition-cluster.net/wp-content/uploads/sites/4/2016/02/Nutrition-Cluster-Final-Advocacy-Framework-v2.pdf>

The Nutrition Cluster Advocacy Toolkit is available at: <http://nutritioncluster.net/wp-content/uploads/sites/4/2016/03/Nutrition-Cluster-toolkit-low-res.pdf>

Guidance on accountability to affected populations



The Global Nutrition Cluster (GNC) is committed to integrating its commitments on accountability to affected populations (AAP) in the Nutrition in Emergency (NiE) response. As a part of the GNC 2014-2016 strategy, an initiative was taken to operationalise the Inter-Agency Standing Committee (IASC) five Commitments on Accountability to Affected People (CAAP)¹ (leadership/governance; transparency; feedback and complaints; participation; design, monitoring and evaluation) endorsed in December 2011.

The IASC Principals (heads of all IASC member agencies or their representatives) agreed “to incorporate the CAAP into policies and operational guidelines of their organisations and to promote these with operational partners, within the Humanitarian Country Team (HCT) and amongst cluster members” with a draft Operational Framework on AAP and associated tools

that were designed and piloted in 2012. Despite global efforts in the ensuing years, it has been found that, even though there are “increasing numbers of non-governmental organisations (NGOs) demonstrating considerable success in building an organisational ‘culture of accountability’ and the commitments endorsed by the IASC Principals in 2011, AAP is still not sufficiently prioritised at the senior, inter-agency, or cluster levels”. The IASC’s key objective for 2014-2016 was to “create a system-wide culture of accountability”; thus the development of the AAP framework and associated tools constitute concrete action on behalf of the GNC and its partners to contribute to the achievement of this aim.

The GNC AAP framework and tools are founded on the IASC CAAP and the Core Humanitarian Standard (CHS), currently the two key sets of guiding commitments on quality

programming and accountability in the humanitarian sector. The CHS was launched in December 2014, superseding the Humanitarian Accountability Project (HAP) 2010 Standard in Quality and Accountability and the People In Aid Code. Depending on their governing bodies, global nutrition actors may be accountable for reporting against the IASC CAAP, the CHS, and/or against their agency’s accountability framework, which may for some time still follow the structure of the HAP 2010 Standard. The GNC operational framework on accountability explores how it may be possible to work with these core commitments simultaneously to create common ground among actors, regardless of their agencies’ obligations. It does not generate new commitments but attempts to provide a shared platform that highlights the nutrition context and the priorities identified by nutrition actors, allowing all agencies to meet their particular commitments while working together.

The GNC guidance on AAP is available at: <http://nutritioncluster.net/resources/guidance-mainstreaming-aap-core-people-related-issues-hpc-cluster-system/> and <http://nutritioncluster.net/resources/nutrition-cluster-operational-framework-aap/>

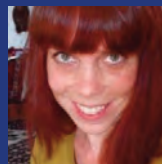
¹ IASC website: www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-common-default&sb=90



Children are treated for acute watery diarrhoea at Alsonainah Health Centre in Sana'a, Yemen, 2017

Global Nutrition Cluster HelpDesk

By Geraldine Bellocq



Geraldine Bellocq provides the service at the Global Nutrition Cluster (GNC) HelpDesk. She has 17 years of experience mainly in humanitarian contexts and has served in support of nutrition in emergency responses throughout Asia, South America and Africa.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: *Global*

What we know: Nutrition cluster/sector coordinators (NCCs) need access to immediate and reliable information and tools to support their work at country level.

What this article adds: The GNC HelpDesk was established in June 2015 to provide remote support to country coordinators regarding nutrition cluster/sector coordination. One officer operates the service on a part-time basis. A list of 36 countries are prioritised into three categories to facilitate time allocation/engagement needed. Support is provided in two domains – technical assistance and communication. The top five countries with highest interaction are Mali, Chad, Turkey for the Whole of Syria (WoS) response, Central African Republic (CAR) and Nigeria. On average nine countries are supported per month. There is good buy-in from country teams, with consistent rapid support. Challenges include how to measure impact, demand exceeding capacity and delivering rapid response while maintaining quality. A more comprehensive system to respond to technical questions that cannot be answered directly by the GNC HelpDesk is in development. Future development could include emergency preparedness, greater support on information management and systematic analysis of coordination and information capacity to tailor country specific support needs.

Context and origin of the GNC HelpDesk

Nutrition cluster/sector coordinators (NCCs) often need access to immediate and reliable information to support their work, drawing on existing/interim guidance or tools; orientation on new services/concepts; and support during development of key work areas, such as Humanitarian Response Plans (HRP), or cluster strategies. Until 2015, support to NCCs was informally provided by GNC Rapid Response Team (RRT) members and the GNC-CT (Global Nutrition Cluster Coordination Team) but consistency and responsiveness was often compromised due to RRT deployments. The need for a dedicated Global Nutrition Cluster (GNC) Help Desk to support NCCs was recommended in a 2014 evaluation (UNICEF, 2015); raised by several country cluster/sector coordinators who sought a permanent, rapid response 'hot-line'; and discussed during a GNC meeting in late 2014. To meet demands, the GNC HelpDesk was established in June 2015 and sustained since, directly supporting the GNCs strategic commitments to provide operational support to country clusters.

How the GNC HelpDesk works

The GNC HelpDesk is a service hosted by the GNC to provide remote support to country coordinators regarding nutrition cluster/sector coordination matters to benefit the cluster coordinator and the collective response. The objectives of the GNC HelpDesk are:

1. To provide new and existing nutrition cluster/sector coordinators at country level with technical assistance during different cluster/sector milestones (Humanitarian Needs Overview (HNOs), Humanitarian Response Plans (HRPs), Flash Appeals, transition plans, etc.), mentoring and remote training/orientation sessions on specific cluster related topics.
2. To establish a sustainable and systematic platform for regular communication, experience exchange and feedback with country nutrition clusters/sectors, including monthly and bilateral teleconferences with coordination teams.

One officer operates this service, on a part time consultancy basis (10 days per month). Working hours of the HelpDesk are allocated based on country requests and spread through the year to absorb regular requests and peak

time demands, e.g. during the development of HNOs and HRPs. HelpDesk support is available in English, French or Spanish.

At inception of the HelpDesk, the GNC-CT established a list of countries that benefit from the service to facilitate allocation of HelpDesk officer time and evaluate the level of engagement needed. To establish the list, the countries were split into two main categories: countries with an existing coordination mechanism that is a cluster or a sector. Then within those two categories, sub-categories were considered to facilitate the prioritisation process such as activated cluster following an official declaration of Level 3 emergency, sector responding to Level 3 or acute emergencies, activated cluster in Level 2 or Level 1 emergencies, deactivated cluster that has shifted to sector, 'cluster like' long term coordination structure, sector prone to crisis, etc. The countries considered for HelpDesk support were then classified into three priorities:

Priority I countries are all Level 3 declared emergencies countries with an activated cluster and countries with sectoral coordination re-

Table 1 Categories of countries receiving support from the HelpDesk

# Cluster activated	Priority I	12	15	English speaking countries	Priority I	11	22		
	Priority II	1				Priority II		6	
	Priority III	2				Priority III		5	
# Sector activated	I	4	13	Spanish/ Portuguese speaking countries	I	0	2		
	II	4				II		1	
	III	5				III		1	
# Sector activated (deactivated cluster)	I	0	8	French speaking countries	I	5	12		
					II	4			
					III	3			
	II	6		Total per priority	I	16			
	III	2			II	11			
					III	9			
Total countries		36		Total countries		36			

sponding to acute emergencies (16 countries: 12 have an activated cluster and four have a sector).

Priority II are countries who had an acute emergency in the past and who still need close follow up (11 countries: one cluster, four sectors and six deactivated clusters that have shifted to sectoral coordination).

Priority III are countries that have kept the cluster as a longterm coordination platform looking at both emergency and development, countries with a deactivated cluster that has shifted to sectoral coordination and countries with sectoral coordination who are prone to crisis (nine countries: two “cluster like” coordination platforms, six deactivated clusters that have shifted to sectoral coordination and five sectors prone to crisis).

Priority I countries are closely followed up with frequent interaction with coordination teams. Countries in Priority II receive regular attention and support. Countries in Priority III receive information from the HelpDesk and remain on the radar of the GNC but the level of engagement is lower than for the two other categories. See Table 1 for an overview of country categorisation.

Type of support provided by the GNC HelpDesk

The GNC Help Desk Service is divided into two domains - technical assistance and communication. From the inception of the HelpDesk in June 2015, real-time support has been provided to 32 different countries out of the 36 prioritised in the GNC HelpDesk support list (see Table 2 for details on support and deliverables by domain). The remaining four countries have received regular information from the HelpDesk but no direct contact was established as needs did not arise. The top five countries with highest interaction are Mali, Chad, Turkey for the Whole of Syria (WoS) response,



Table 2 Type of support provided by the GNC HelpDesk and results

Technical assistance for new and existing nutrition cluster/sectors coordinators	Selection of results (June 2015 – December 2017)
Induction and mentoring of newly appointed nutrition cluster/sector coordinators using the induction/orientation pack which is regularly updated and presented in line with IASC coordination tools.	Nine NCCs, co-lead or deputy inducted/mentored since June 2015 (Afghanistan, Turkey, WoS, Chad, South Sudan, Haiti).
Provision of remote orientation sessions for cluster/sectors partners on cluster approach based on requests from the national nutrition coordination team.	Seven remote sessions provided and 129 participants briefed (Guinea Conakry, Chad Yemen, Mali, Nigeria x 2, Turkey for Northern Syria).
Review of HNOs and HRP/Flash Appeals developed by country clusters prior to their finalisation.	Sixteen countries supported (see Table 3).
In collaboration with the NCCs, systematic identification of the needs and timelines for various milestones of nutrition clusters that requires GNC-CT support (e.g. Cluster Coordination Performance Monitoring (CCPM) exercise run every year in both clusters and sectors). Development and implementation of appropriate support plan.	On average, six countries and one RRT member supported per month with ad hoc requests. Examples include: feedback on drought and nutrition situation update – Somalia; provision of samples and feedback of Technical Working Group Terms of Reference – Nigeria; samples and feedback on Nutrition Cluster Strategy and action plan – Yemen; samples and feedback of nutrition cluster bulletin – Chad; interim guidance on acute watery diarrhoea and nutrition – Sudan; caseload calculation - WoS; documentation sharing on nutrition sensitive interventions, social protection and resilience - Iraq. On average four countries/month supported on CCPM exercise. Since June 2015, 14 countries have undertaken at least one CCPM and have received a range of HelpDesk support during the process. A full package of CCPM remote support includes remote orientation and follow up with the coordination team and with partners, support on validation workshop organisation and delivery, and workshop report finalisation.

Table 2 *Continued* Type of support provided by the GNC HelpDesk and results

Sustainable and regular communication, experience exchange and feedback with country clusters/sectors	Selection of results (June 2015 – December 2017)
Establishment of regular NCC calls (monthly and on “needs” basis) for all nutrition cluster/sector coordination teams in country and the GNC-CT to enable systematic information flow, experience exchange and timely identification/resolution of challenges, such as during the development of HRPs, transition plans, etc. Provision of regular inputs reflecting the issues raised during the NCC calls in the GNC Bulletin.	Twelve calls organised with NCCs/IMOs, with an average attendance of 13 participants. Topics, identified by votes case by coordination teams, presented by external contributors to date are: older people, nutrition causal analysis, rapid SMART surveys, bottleneck analysis, infant and young child feeding in emergencies (IYCF-E), coverage assessments, accountability to affected populations.
Provision of regular inputs reflecting the issues raised during the NCC calls in the GNC Bulletin.	<p>On average, there are eight supports to GNC work per month, where the HelpDesk can strategically contribute in light of the service set up and the overall perspective of country situations. Examples include: revision of GNC Handbook chapters; active participation in the elaboration of the GNC strategy and workplan; collaboration with cluster/sector coordinators to prepare country updates for GNC partners calls; input in relevant global level databases; and participation in discussions on humanitarian architecture.</p> <p>There have been 10 trips undertaken by the HelpDesk Advisor; two deployments to support nutrition cluster and sector emergency responses in Chad and Bangladesh and eight trips to attend global events such as the GNC annual and working meetings, Global Food Security Cluster annual meeting, Rome prevention of famine meeting.</p> <p>The GNC HelpDesk participates in an average of two global calls per month (42 in total to date). Contributions include: update on HelpDesk activities during monthly RRT calls; participation at all GNC partner calls on emergency countries; participation at OCHA Geneva calls on Humanitarian Programme Cycle and HRP process.</p>

Central African Republic (CAR) and Nigeria. On average nine countries are supported per month.

Lessons learned

Buy-in to the HelpDesk service by coordinators was quite fast; by June 2015, six countries were using the assistance/accessing remote support. There are two annual peaks of activity when support intensifies – the first between September and October, during the HNO/HRP process, and the second in January/February when

several countries conduct their CCPM exercise with the cluster/sector partners.

A key challenge is how to measure impact of the service provided; follow up of country requests is currently on a case by case basis only. A satisfaction survey of the 36 countries that are part of the GNC priority list could be conducted as a starting point – this would help ascertain if coordination teams are satisfied with the service provided to date and identify improvements. However, assessing impact first

requires examination of what is measurable and what is feasible for the HelpDesk to undertake, and must remain ‘light’ to avoid burdening coordination teams with additional work.

Another challenge is the limited time allocated to the HelpDesk. At the inception of the service, time allocation (10 days/month) was logical but in reality, the demand is much greater. As a result, activities such as organisation of NCCs/IMOs calls or remote orientation sessions on the cluster approach, despite their importance, have been reduced.

Partners’ perception and understanding of the cluster approach has improved through the years. Nevertheless, efforts in this sense need to continue. The organisation of remote orientation sessions on the cluster approach is part of a permanent effort to raise awareness of in-country partners. Such remote orientations are needed and the fact that they are being delivered by a GNC-CT member from HQ adds weight to the overall message. Where and when possible, these remote orientation sessions should be reinforced by a cluster partners training in country, conducted by the GNC-CT.

The HelpDesk is a functional service today because support and responses are consistent and rapid. When NCCs or IMOs contact the HelpDesk, they expect a response with no delay. On certain occasions, when questions were referred to external bodies, the delay in obtaining a first answer as a “good enough to go” was a challenge. For the HelpDesk to continue to be efficient, quality and consistency of the support needs to be ensured as well as rapidity. Coordination teams in the field can approach the HelpDesk in confidence, which is appreciated; this way of working should be encouraged and preserved.

Table 3 Support to HNOs/HRPs/Flash Appeals

Country	Support for HNO 2016	Support for HRP 2016
WoS	X	X
Kenya		X
Chad		X
Mali	X	X
Mauritania	X	
Burkina Faso		X
DRC	X	X
	Support for HNO 2017	Support for HRP 2017
Mali	X	X
Niger	X	X
CAR	X	X
Chad	X	X
Nigeria	X	
Yemen	X	X
Somalia	X	X
Ukraine	X	X
Syria	X	X
South Sudan	X	X
Afghanistan	X	X
DRC	X	
Haiti	Support to Flash Appeal and CERF	



Women and children wait at a health and malnutrition clinic in Old Maiduguri, Borno State, Nigeria, 2017

To date, any nutrition technical question coming from a country cluster/sector will be immediately answered by the HelpDesk if the response is known or referred to the Tech RRT (Technical Rapid Response Team) manager and the appropriate Tech RRT advisor (see article on this service in this edition of *Field Exchange*). As reflected in the introduction, this set up has limitations when Tech RRT advisors are deployed in-country to support a nutrition emergency response. Discussions are well underway at global level to develop a more comprehensive system to respond to specific Nutrition in Emergencies (NiE) technical questions that cannot be answered directly by the GNC HelpDesk. The anticipated 'Nutrition In Emergency Technical Advisory Group (NiE TAG)' will be accessible to all coordination

teams in the field and their partners. The NiE TAG will have three different technical roles: to provide technical advice, to produce consensus driven guidance, and to propose specialized technical expertise. This service is expected to be launched during 2018.

Way forward of the GNC HelpDesk

The service has been active for more than two years with rapid buy-in and should be continued; it represents a cost-effective means to engage regularly and closely with country coordination teams. The range of topics covered by the HelpDesk remote support could be enlarged to embed a preparedness lens to systematically structure, in crisis-prone countries, a coordination mechanism that strongly engages gov-

ernments and national actors that can shift to a full-strength cluster during emergency and shift back to a strong sectoral coordination when the emergency is over. Moreover, the support to date is mainly around coordination issues; a similar service for information management would be an asset. Expansion of HelpDesk support should also consider analysis of the capacity mapping reports from countries and identification of survey support needs; CMAM (community based management of acute malnutrition) and IYCF-E (Infant and Young Child Feeding in Emergency) training needs; and linking technical needs to global resources, the NiE Technical Advisory Group, as well as the SMART Global Team and Centers for Disease Control and Prevention (CDC). Production of a quarterly overview report of country performance (based on country bulletins) would offer valuable, efficient insights. Systematic analysis of coordination and information capacity to tailor country specific support needs would be particularly valuable to shape and target support.

For more information, contact: GNC HelpDesk, email: gnchelp@gmail.com

UNICEF, 2015. Evaluation of the support provided by the Global Nutrition Cluster to National Coordination Platforms. http://nutritioncluster.net/wp-content/uploads/sites/4/2015/06/UNICEF_report_homeprint.pdf

Inter Cluster Nutrition Working Group (ICNWG)

The Inter Cluster Nutrition Working Group (ICNWG) is a sub-working group of the Global Nutrition Cluster (GNC) and global Food Security Cluster (gFSC) that was established as a collaboration between both clusters in 2012. It is co-chaired by both clusters. Current members are World Vision International (WVI), the World Food Programme (WFP), the Food and Agricultural Organisation (FAO), Plan International, USAID/OFDA, WASH (Water, Sanitation and Health) Cluster, Health Cluster, GNC-Coordination Team (CT) and gFSC support team. Initially hosted by the gFSC, it is now hosted by the GNC. The overall goal of the ICNWG is to contribute to safeguarding and improving the nutritional status of crisis affected populations, preventing a deterioration of the nutrition situation in at-risk population groups and enhancing the overall nutritional situation of the affected population. It aims to provide technical direction, guidance and coordination solutions and promote a coherent multi-sectoral integrated approach to ensure good nutrition in humani-

tarian crises with the needs of the affected population at the centre.

So far, the ICNWG has successfully supported inter-cluster coordination at the country level, manifesting in the Whole of Syria training workshop in Amman, March 2017 and the four-country famine prevention meeting held in Rome in April 2017; this was organized by the GNC and gFSC with participation of Nutrition and Food Security country cluster coordinators. However, bottlenecks in scaling up effective joint inter-cluster activities are still present; missions are scheduled to Yemen and South Sudan to further investigate and support countries in practically facilitating analysis and development of a multisectoral integrated response to achieve a better nutrition outcome.

The integrated food security and nutrition guidance on accountability to affected populations (AAP) is one of the earlier collaborative initiative taken by the GNC and the gFSC cluster under the ICNWG. The ICNWG has developed the technical capacity of country stakeholders on

nutrition-sensitive programming through a multi-cluster workshop held in Geneva in June 2017. This workshop produced an outline of a multi-sectoral approach for better nutrition outcomes that includes clear sectoral responsibilities, key messages, dissemination plan, and a glossary of key terms. The group has also begun to develop a training package on integration or multisectoral work for cluster coordinators and cluster partners. This package will define the 'how to' of the multi-sectoral approach, and elaborate on the package of nutrition sensitive interventions that need to be delivered to achieve a better nutrition outcome. The ICNWG will continue to advocate for a nutrition-sensitive agenda in humanitarian contexts within various global and country level settings, such as multi-cluster workshops, and inter-cluster missions.

ICNWG Terms of Reference: www.nutrition-cluster.net/intercluster-topics/5-inter-cluster-nutrition-working-group/

ICNWG Terms of Reference: www.nutrition-cluster.net/intercluster-topics/5-inter-cluster-nutrition-working-group/

Joint guidance on AAP : www.nutritioncluster.net/wp-content/uploads/sites/4/2016/01/Revised-15153_V04_MainstreamingGuidance_WEB.pdf



Strengthening nutrition humanitarian action: Supporting humanitarian cluster/sector coordination transition

By Peter Hailey and Brenda Akwanyi



Peter Hailey is founding Director of the Centre for Humanitarian Change (CHC), a humanitarian think tank based in East Africa. He has over 25 years' experience in the nutrition and humanitarian sector in Africa, Central Asia and the Balkans.



Brenda Akwanyi is a public health nutritionist with over 15 years' experience working with nutrition clusters and sectors in over ten countries and is currently living in Mozambique. Until December 2014, Brenda served as the Nutrition Sector Coordinator in Kenya through UNICEF embedded technical assistance in the Ministry of Health, nutrition department.

The authors extend thanks to Josephine Ippe, Global Nutrition Cluster Coordinator, and Diane Holland and Ruth Situma, UNICEF Programme Division – Nutrition, for reviewing this article. The authors also acknowledge the contributions of Tamsin Walters and Rebecca Brown of Nutrition Works as part of the team that facilitated the review report commissioned by UNICEF on which this article is based.

This article summarises the findings of a 2016 synthesis review (UNICEF and GNC, 2016) on strategic issues that UNICEF, within its Core Commitments for Children and as the Nutrition Cluster Lead Agency, should consider addressing to strengthen transition of cluster coordination structures into national coordination platforms. The article suggests approaches and a set of actions to better link nutrition coordination across the humanitarian-development nexus.

Location: *Global*

What we know: Through joint efforts, both nutrition emergency coordination (nutrition in emergencies) and nutrition development coordination (Scaling Up Nutrition Movement coordination) has significantly improved in the last ten years. The re-energised discussion on bridging the humanitarian and development divide should include developing approaches to link coordination of nutrition across the nexus.

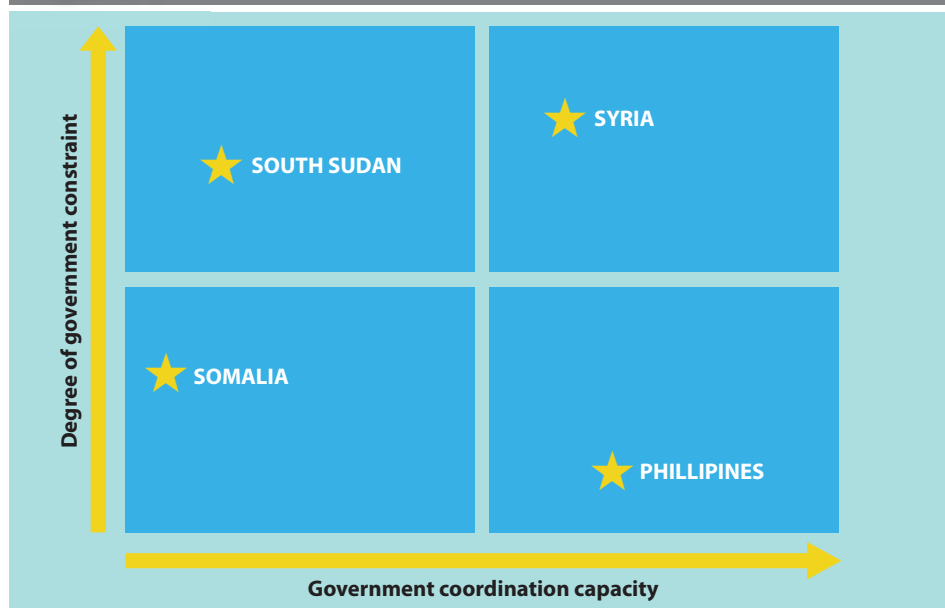
What this article adds: The UNICEF and Global Nutrition Cluster Strengthening Nutrition Humanitarian Action Phase 2 synthesis review examined what is needed to operationalise transition of cluster coordination structures into national coordination platforms. As of July 2016, only 11 out of 36 (30 per cent) of activated Nutrition Clusters had transitioned¹ to deactivation. Building on the Phase 1 report, the review identifies working principles to link emergency and development coordination, principles related to government leadership, a systems (rather than technical) approach, capacity development of government to lead and coordinate, capacity gaps analysis, embedding emergency coordination within sector nutrition coordination, preparedness, and phasing of support determined by changing context and competencies. An adaptive model is proposed, describing the process from cluster activation to deactivation, where government has primary responsibility to coordinate and is supported to do so wherever possible in both 'normal' and emergency situations. Several areas of action are identified to operationalise the proposed model, including developing and piloting a method to appraise government coordination capacity, adaptation of training approaches and tools to support government coordination competencies, and investment in emergency nutrition coordination and capacity development during nutrition emergencies. The proposed approach advocates for joint, government, humanitarian and development actors' understanding of roles and responsibilities for nutrition coordination and is not limited to the cluster system alone.

The first World Humanitarian Summit in 2016 discussed commitments to bridge the divide between development and humanitarian partners. A call to change working modalities to respond to the rapidly changing operational landscape in which humanitarian, development and peace-building actors find themselves featured heavily. There is understanding and appreciation of the potential synergies and advantages of linking emergency and development approaches. It is recognised that emergencies put development gains at risk; consequently emergencies/disasters can no longer remain a concern for humanitarian actors only. Equally, humanitarian actors recognise that

ever-increasing demands on the humanitarian system cannot be dealt with by humanitarian actors alone. In the last ten years, the three types of nutrition coordination – Interagency Standing Committee (IASC) clusters, government-led emergency or crisis sector coordination and the Scaling up Nutrition (SUN) Movement coordination mechanisms – have significantly improved. Evaluations of major emergencies had identified substantial weaknesses in coordination of responses and nutrition was very often a low priority in national development priorities. However, there is now far greater recognition of the importance of coordination for the advancement of nutrition priorities and conse-

quently for development objectives, led by the SUN Movement. Under the SUN Movement, policy and guidance for nutrition sector coordination are being driven by the national and global SUN networks, with a focus on multi-sector coordination for nutrition-specific and nutrition-sensitive programming. Equally, the need for nutrition sector coordination and capacity development of government and key in-country stakeholders is recognised throughout the IASC Global Nutrition Cluster (GNC) normative policy and guidance. The SUN Movement has recognised

¹ Transitioning is the step between having an active Cluster and deactivating a Cluster.

Figure 1 Relationships between government coordination constraints and capacity

that fragile and emergency contexts are a priority, so the suggested approaches in this article aim to guide nutrition stakeholders across the nexus to take up these opportunities for better and more linked nutrition coordination mechanisms.

Review method

The review was conducted between January and June 2016 by Nutrition Works, an international public nutrition resource group (www.nutritionworks.co.uk) on behalf of UNICEF and the GNC. It employed a combined approach of a literature review and key informant interviews (KIIs). Secondary data analysis was conducted first on the 2014 to 2015 Nutrition Cluster Transition Phase 1 study (<http://nutritioncluster.net/?s=transition>) to highlight the learning and good practice from country-specific analyses and review the proposed generic framework of best practice, working principles and guidance on cluster transition benchmarks produced. Secondly, relevant recent reviews covering the period 2014 to 2016 relating to humanitarian and development coordination, case studies, nutrition in emergency (NiE) toolkits and country-level resources, plus relevant UNICEF internal policy and planning documents from HQs, regional and country offices, the IASC and the GNC, were collated and analysed. To gather the views of participants on the key investments needed by UNICEF and their experiences of what has worked in relation to emergency nutrition coordination, a wide range of key informants from UNICEF management and staff (cluster and programmes), cluster partners and donors were interviewed using an in-depth, semi-structured questionnaire.

Findings

Systems approach – multi-sector, nutrition sector, nutrition emergency, nutrition cluster coordination confusion!

The review found that, in the ten years since the

cluster approach began and despite very clear guidance on activating, transitioning and deactivating clusters, only 11 out of 36 (30 per cent) of activated Nutrition Clusters have transitioned to deactivation. This reflects a lack of clarity in many contexts about what coordination mechanism the Nutrition Cluster is transitioning to and how emergency nutrition coordination and cluster-led emergency nutrition coordination (NiE coordination) is positioned within nutrition sector coordination as a whole.

Consequently, the NiE coordination mechanisms are wrestling with transitioning and deactivation. The review found that policy and guidance is clear about the specific steps and issues to take into account in transitioning. The review found that in countries such as Malawi, Philippines, Kenya and Ethiopia, the nutrition sector coordination platforms and preparedness for emergency coordination mechanisms are evident and are a result of emergency coordination mechanisms providing an entry point to establish a more systemic approach to nutrition coordination. In these and several other countries the NiE coordination mechanism has often acted as the impetus or foundation on which to build longer-term sector coordination. Many countries use the cluster approach to coordinate NiE without referring to it as “cluster” (Kenya, Ethiopia, Nigeria) and the GNC provides significant support to the NiE coordination mechanisms of these countries. In these cases, a clear vision of how the whole nutrition coordination structure (emergency and development) will look significantly improved the process of transitioning from emergency to sector coordination. However, overall strategic and operational ambiguity remains in how cluster coordination capacities fit into non-cluster-led emergency nutrition coordination, as well as wider sector coordination.

The SUN Movement is focusing on government-led nutrition sector and multi-sector nutrition coordination. At present, 60 countries

have signed up to the SUN Movement. The review found that while the SUN Movement has undoubtedly increased the degree of attention given to government leadership and governance of nutrition, there is still a significant challenge related to embedding NiE coordination within the wider picture of SUN government-led coordination for nutrition.

This review therefore:

- Advocates for using a nutrition coordination systems approach that bridges the emergency and development nexus, embedding NiE coordination approaches into a wider systems view of nutrition coordination as a whole.
- Suggests that a nutrition cluster envisages transitioning to deactivation and transitioning of emergency coordination to sector coordination to be the same process.

Government lead on coordination of NiE

Figure 1 shows how interviewees discussed the relationships between government constraints² and coordination capacity to lead a response in four different country examples, from South Sudan (low government coordination capacity, high coordination constraints), to Syria (high capacity, high constraints), Somalia (low capacity, low constraints) and Philippines (high capacity, low constraints). In these examples and in all countries considered during the review, these complexities have resulted in the development of hybrid models to manage the relationship between the cluster and the government in leading and coordinating the response. The emergence of a hybrid model for emergency coordination, response and leadership, even in places where the government's role in leadership of the emergency response is contested, points to the need for the structure of emergency coordination and leadership in the delivery of the response to be context-specific and adaptive.

The documents reviewed from nutrition cluster and sector coordinators' minutes and nutrition cluster/sector reports revealed different interpretations of the government's leadership role and responsibilities, resulting in the use of different approaches to structure the emergency nutrition stakeholder's engagement with the government. For example, in many cases government authorities act as chairs or co-chairs of cluster meetings at the national level but there is still ambivalence about how the government is put in the lead of coordination of the response. At sub-national level, there is often far less government involvement. The system-based approach to development and emergency nutrition coordination suggested by this review requires the clear understanding that the government is leading on the whole nutrition coordination system. Therefore, the proposed approach suggests that:

² Government is classified as 'constrained' when it is unable or unwilling to act (for example, because it is itself party to a conflict (Cluster Coordination Reference Module 2015). A government is classified as 'severely constrained' when it is unable or unwilling to coordinate (for example, because it is itself a party to a conflict).

- On activation of a cluster or emergency coordination mechanism, it is a principle that emergency responses are **government-led**, except in exceptional circumstances when a government is severely constrained. In most cases, the exact nature of the relationship between the Nutrition Cluster and the government will be based on local circumstances.

We often confuse a state's capacity to lead with its responsibility to lead.

The review found examples where a government is party to a conflict or has a significant hand in causing an emergency (commission) or did not take up its responsibility to its people in case of an emergency (omission). Consequently the review acknowledges that recommendations to reinforce the role of government in leading emergency responses need to be taken in the context of a decision on the way the wider humanitarian response makes a balance between humanitarian principles and the rights and responsibilities of a sovereign state.

Capacity to coordinate and activation

The decision to activate clusters is taken by the Humanitarian Coordinator (HC)/Humanitarian Country Team (HCT) or Resident Coordinator (RC) engaging in a consultative process with government. In theory, the decision to activate a cluster is partially based on an analysis of the capacity of the government to lead (and coordinate); however, the review found very little evidence of pre-emergency coordination capacity analysis or review of nutrition coordination structures, roles and responsibilities being used to inform decision making on activation of clusters. In several cases, strong government-led nutrition emergency coordination mechanisms (e.g. Nigeria and Philippines) did insist on cluster or emergency coordination mechanisms building on existing structures, but there appears to have been no structured analysis of what capacity gaps were to be filled or supported by the cluster or emergency coordination mechanism.

In other cases, somewhat subjective assessments of the government's capacity to lead are judged against the magnitude of the need and the expected response. The lack of coordination capacity analysis means that the decision to activate a cluster is not clearly linked to building on existing government coordination capacity and its responsibility to lead. In these cases, ultimately cluster activation based on a subjective assessment of capacity to lead often results in the cluster **substituting for** as opposed to **building on** existing capacity. The review found that this lack of clarity about the difference between poor capacity to lead and the responsibility to lead makes it difficult for governments and humanitarian actors to decide when to transition and what to transition coordination to. As discussed above, a clear systems view of government-led emergency and development nutrition coordination will allow both emergency and development partners to identify what structures

and capacities they will contribute to strengthening. In countries such as Pakistan, Nepal, Philippines, Ukraine, Kenya and Zimbabwe, a strong focus on the government's responsibility to lead has resulted in a consensual process of transition and scalability of emergency coordination, as well as increasing capacity of the government to lead emergency nutrition coordination. In these and other cases, the GNC has taken a leading role in facilitating these transitions in countries with activated cluster or non-cluster emergency nutrition coordination mechanisms. The proposed approach therefore suggests that:

- Coordination capacity analysis is conducted before taking the decision to activate a nutrition cluster. If this is not possible a capacity analysis should be conducted as rapidly as possible after activation.
- The decision on when and how to transition and deactivate a cluster should be based on a capacity assessment of the government's capacity to manage the lead and coordination of nutrition as a whole.
- Building on government capacity to coordinate and lead a nutrition response should be one of the roles of an activated cluster.

Capacity as the key metric for transitioning and deactivation

Coordination competencies (and often technical competencies for NiE) for sector, multi-sector and emergencies are not necessarily present within governments and there appears to be a low prioritisation from international nutrition organisations, including donors, to support coordination capacity development. This seems to be especially the case prior to an emergency or when the government is seen to be compromised by its role in the emergency. When capacity development of government staff does happen, the review found that international organisations, including donors, do not appear to give coordination skills of government staff the same weighting as programme core competencies (technical expertise).

Context analysis of preparedness and readiness for NiE pre-crisis in countries with the largest humanitarian needs in 2017, such as in the Middle East and countries in southern Africa, shows that these countries have very weak NiE agendas and poor awareness of the IASC cluster approach in their development nutrition programmes. In some cases, NiE preparedness actions were not explicitly featured in strategic plans due to low levels of acute malnutrition in the country. In these contexts, government, local and international nutrition partners were found to have limited competencies, skills and supporting institutional architecture to lead an emergency response. Therefore, the review found that, particularly in lower-risk/middle-income countries, preparedness for NiE and nutrition emergency coordination is not prioritised to match the rhetoric of the strategic visions of governments and international organisations concerning disaster risk reduction (DRR), government leading in emergencies, and increased

resilience to emergencies of country systems. In the 36 clusters activated since 2006, most investment in strengthening nutrition coordination (emergency or sectoral) by governments, UNICEF, GNC and partners was initiated after the onset of an emergency, while many of the currently operating sector coordination mechanisms can trace their roots to an emergency nutrition coordination mechanism. In several countries, international organisation and government staff have received coordination capacity development support, mostly with a lead from the GNC and UNICEF. The review found that this training has at times taken the form of capacity development during an ongoing emergency (e.g. Syria), or in some cases in high-risk countries, preparedness for NiE (e.g. the Sahel region). Yet without a systems view of how emergency nutrition coordination fits into the wider context of nutrition coordination, this somewhat ad hoc coordination capacity-strengthening process may result in less than efficient and effective impact on the overall coordination of nutrition in a country and confusion in transitioning and deactivation of clusters. The review therefore advocates for the following:

- Preparedness for emergencies, including strengthening capacity to coordinate and lead an emergency nutrition response, is a priority for regular nutrition support and for emergency and cluster (including GNC) support to governments. During an emergency, especially a protracted emergency, this support takes the form of strengthening the entire nutrition coordination system, rather than just the NiE coordination structure or cluster structure.

Funding for coordination

In recent years, significant advances have been made in adapting funding modalities to reflect and accommodate the lessons learnt in emergency programming. For example, the recent report of the High-Level Panel on Humanitarian Financing (High-Level Panel on Humanitarian Financing, 2016) and the report on the World Humanitarian Summit (United Nations, 2015), recommend use of multi-year funding and the use of the resilience approach to better link emergency-funded activities to development-funded activities. Both reports include significant commitments that require all stakeholders (implementing organisations, donors, member states and others) to change the way they work, such as making better use of different financing instruments; breaking down silos in donor budgets; increasing the localisation of responses; and increasing resilience.

A significant challenge is that emergency/humanitarian funding for coordination and for capacity development is still in siloes, as shown by the different donors' funding arms, policies and procedures for funding coordination activities and mechanisms. Donors signalled to the review that articulation of a clear holistic model for nu-

³ This review was about coordination but clarity on a model for coordination to bridge the nexus will also need to include issues of capacity strengthening for the technical aspects of NiE.

trition coordination would be welcome and would help in decision making on funding coordination, particularly capacity development and preparedness for coordination³. The GNC advocacy framework has elaborated opportunities for influence between the SUN Movement and REACH (<http://www.reachpartnership.org>) coordination mechanisms. For instance, the GNC has articulated commitment to support SUN national multi-stakeholder platforms to analyse their nutrition plans for inclusion of emergency preparedness, response and recovery and DRR strategies and activities (Gonzalez and Mutuma, 2016).

This review therefore:

- Suggests a holistic capacity-based model for nutrition coordination and the transition between modes of coordination across cluster, emergency and sector nutrition coordination mechanisms.

Adaptive model as a way forward!

Based on the desk review (the findings from the Phase 1 report and KIIs from Phase 2), the model outlined in Figure 2 proposes a model of emergency coordination and leadership whereby government holds the primary responsibility for leading emergency response and places the foundation of nutrition sector and nutrition emergency coordination as an embedded mechanism in nutrition sector-led coordination structures. The model emphasises the need to assess governments' capacity to coordinate, plan, activate, implement, transition and deactivate emergency nutrition coordination mechanisms, including cluster-led coordination or IASC activated coordination, and the need to optimise the government's capacity to assume its responsibility to lead nutrition coordination in both 'normal'

times and emergencies. Given that the vast majority of countries who might apply this model regularly experience upsurges and quiet periods in emergency nutrition needs, the model incorporates a phasing up or down aspect as part of its adaptive approach.

Key elements of the model involve:

Nutrition sector coordination. The cycle starts and ends with nutrition sector coordination. This type of coordination is led by the government with technical assistance from UNICEF and other nutrition stakeholders.

Nutrition sector emergency coordination preparedness. The review highlights the strategic importance of preparedness as well as the emphasis that UNICEF, as cluster lead agency, the IASC and others place on promoting quality and regular preparedness planning. An essential part of this component is an emergency nutrition capacity-gaps analysis for the nutrition sector, including a focus on the government's capacity to lead and coordinate emergency nutrition response. The gaps analysis should form the basis for the emergency nutrition capacity development plan. The analysis can also be used to set threshold-based triggers for activation of the emergency coordination response. The triggers will allow technical assistance to the government to be tailored to complement government capacity and to plan capacity development activities throughout the emergency using techniques such as mentoring and shadowing. Finally, regular monitoring of government coordination capacity, triggers and thresholds will allow the cluster and/or emergency nutrition coordination transition plans to be pre-agreed in general and amended to fit the emergency context.

Activation. Using the capacity-gaps analysis and the pre-agreed triggers described above, the nutrition sector coordination mechanism would agree to activate government-led emergency nutrition coordination. Technical assistance to the government coordination mechanism would be planned and implemented based on an analysis of the scale and severity of the emergency and how this characterisation of the emergency will affect the identified capacity gaps (See Box 1).

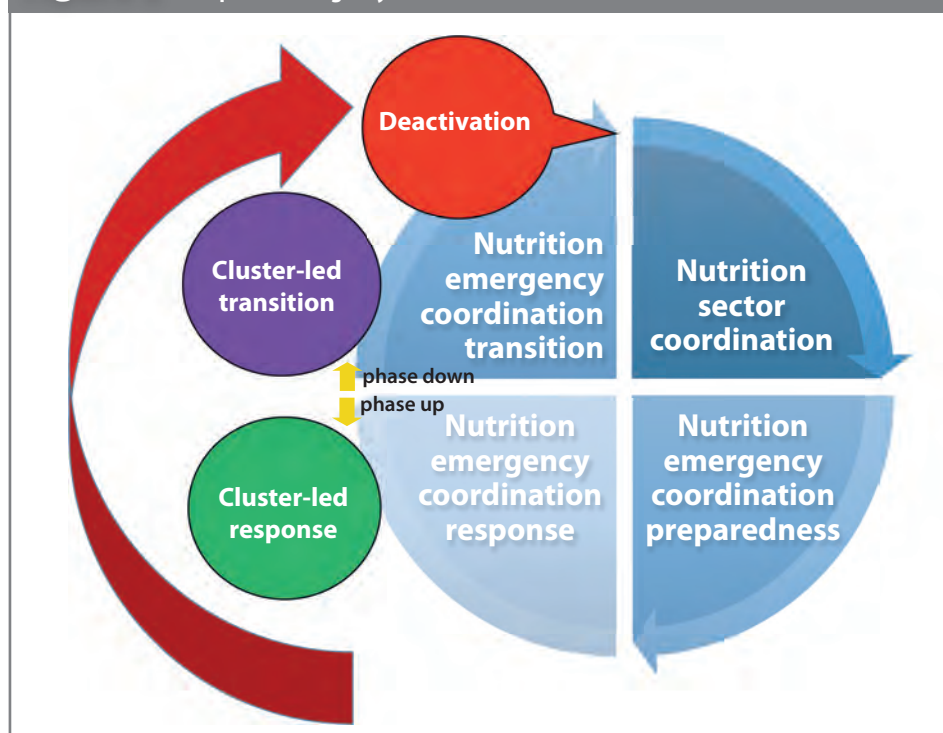
Emergency nutrition coordination response. The nutrition sector coordination mechanism activates the emergency nutrition coordination response based on pre-agreed triggers. This may be in the form of a technical working group for nutrition emergencies being authorised to manage and coordinate the emergency response and to regularly report to the nutrition sector coordination mechanism.

IASC cluster-led emergency response. Based on pre-agreed, capacity-based triggers and thresholds, the HC/RC and HCT, GNC and IASC, in consultation with the nutrition sector coordination mechanism led by the government, would activate the national Nutrition Cluster. The cluster would work in collaboration with the emergency nutrition coordination mechanism. The degree of collaboration would depend on the HC/RC and HCT analysis of the government

Box 1 Suggested working principles for emergency coordination

1. Emergency responses are **government-led**, except in exceptional circumstances when a government is constrained.
2. The value of investing in nutrition sector and emergency coordination is seen and measured using a **systems-based approach** to nutrition, as opposed to a technical perspective.
3. **Capacity development** of a government to lead and coordinate a nutrition emergency response is a nutrition sector strategic priority.
4. Decisions on activating, transitioning and deactivating a cluster is capacity-based using a regular capacity-gaps analysis to decide on the nature of the additional technical support required from nutrition partners.
5. Emergency nutrition coordination, including cluster-led coordination, is **embedded** within sector coordination systems, mechanisms and processes.
6. **Preparedness** for a nutrition emergency and nutrition emergency coordination is a strategic priority for the nutrition sector.
7. External support to the government to lead and for coordination and emergency nutrition response is **phased up or down** based on government competencies and capacities to lead and coordinate and should not be managed as a linear process from emergency response activation through response and transition to deactivation. This is especially important in countries with recurrent or chronic emergencies.

Figure 2 Proposed emergency coordination model



constraints to lead the response using humanitarian principles. Collaboration could range from co-lead (government and UNICEF) for emergency nutrition coordination (e.g. Somalia) through to complete separation of the two mechanisms. A government would be classified as 'constrained' when it is unable or unwilling to coordinate (for example, because it is itself a party to conflict). It is important to note that the decision to activate the Nutrition Cluster would be based on the same pre-agreed triggers and thresholds based on an analysis of the capacity of the government to lead the coordination. Starting with this analysis will allow the cluster transition plan to be drafted at the preparedness phase and adapted to the context during the activation and response phases.

Using this model, cluster activation can happen at the same time or instead of the activation of the government-led emergency coordination. This may be the case in a very large, rapid-onset emergency where government capacity is immediately overwhelmed by the scale and severity of the emergency. Alternatively, a cluster can be activated sometime after the activation of the government emergency coordination phase. This may be the case in a slow-onset emergency where early coordination actions can be fully accomplished by the existing capacity, but thresholds are reached as the severity and/or scale of the emergency increases, dictating the need to activate the Nutrition Cluster.

IASC cluster-led emergency response + emergency nutrition coordination transition phase. As discussed above, the setting of triggers and thresholds based on a government capacity-gaps analysis allows an informed decision on activation and coordination capacity development plans before and during the emergency response. These same thresholds and capacity development plans are also used to plan and manage the transition phases of the cluster and/or the government-led emergency nutrition coordination mechanisms. The cluster can transition back to the government-led emergency coordination mechanism where an emergency resolves slowly or can transition immediately back to the nutrition

sector coordination mechanism should the emergency resolve quickly.

Phase up, phase down. One common characteristic of emergency coordination and clustered emergency coordination, especially in chronic emergencies, is that the emergency coordination mechanisms remain activated for a long period. Yet the need for external support fluctuates significantly over the period of the crisis. This approach allows stakeholders supporting the government to tailor their technical assistance support to coordination based on emergency circumstances as they change. Regular monitoring of capacity gaps also allows thresholds for scaling up or scaling down of external coordination support to be modified to reflect changes in the government's capacity due to on-going coordination capacity development processes. An example of a coordination competency that might be phased up or down is the support to nutrition information systems, with greater need for more and specialised capacity and resources during the peak of a shock and less during quiet periods.

Deactivation. As for activation, using a pre-agreed set of coordination, capacity-based triggers and thresholds, an informed decision to deactivate can be made by the HC/RC, HCT, IASC, GNC and nutrition sector coordination mechanism.

What it will take to adapt the proposed model

The review identifies several areas for action considered necessary to operationalise this adapted model:

- A methodology to rapidly assess a country's (and government's) capacity to manage and lead an emergency nutrition response should be developed and piloted in two contexts: a) as part of a process to prepare for a nutrition emergency embedded in a larger emergency preparedness process and b) in a context with ongoing Nutrition Cluster support, moving into the transition phase.
- Capacity development tools and approaches, particularly those aimed at mainstreaming

emergency coordination competencies (such as training tools and learning and knowledge management strategies), should be adapted to ensure that coordination for nutrition, including emergency nutrition coordination, is appropriately included as a nutrition systems priority.

- Design a range of approaches to develop government capacity to lead and coordinate nutrition emergencies during an emergency. This should consider the likely demand on resources (including funds and human resources) for the primary life-saving objective of an emergency response.
- The Cluster Lead Agency and significant players in nutrition sector coordination should act as conveners to pilot and further develop the suggested model, thus supporting SUN and IASC structures to adapt the model and principles and agree to incorporate the model in their policies, strategies and guidance as a shared nutrition coordination model across development and emergency contexts.
- Using the agreed holistic and adaptive model for nutrition coordination, review UNICEF, SUN and IASC programme cycle and budgeting instruments to ensure adequate attention to emergency nutrition coordination and capacity development during the nutrition emergency.
- Develop and implement an advocacy strategy for senior leadership in government, local and international nutrition partners' agencies and donors to promote the value of a nutrition systems-based approach including coordination, which incorporates nutrition coordination in emergencies, capacity building for coordination in emergencies and preparedness for emergency nutrition coordination.

For more information, contact: Peter Hailey, email: peter.hailey@whatworks.co.ke

References

Gonzalez and Mutuma 2016. Gonzalez E and Mutuma S. Nutrition Cluster advocacy strategy framework 2016-2019: Responding to the nutritional needs of emergency affected populations. <http://nutritioncluster.net/wp-content/uploads/sites/4/2016/02/Nutrition-Cluster-Final-A-dvocracy-Framework-v2.pdf>

High Level Panel on Humanitarian Financing 2016. High-level Panel on Humanitarian Financing Report to the Secretary-General: Too important to fail – addressing the humanitarian financing gap (January 2016). https://interagencystandingcommittee.org/system/files/hlp_report_too_important_to_failgoaddressing_the_humanitarian_financing_gap.pdf

UNICEF and GNC 2016. Strengthening Nutrition Humanitarian Action Phase 2: Supporting Humanitarian Cluster/Sector Coordination Transition. A synthesis review of findings on strategic issues that UNICEF, within its Core Commitments for Children and as the Nutrition Cluster Lead Agency, needs to address in order to operationalise transition of cluster coordination structures into national coordination platforms. July 2016. <http://nutritioncluster.net/just-published-gnc-review-supporting-humanitarian-clustersector-coordination-transition/>

United Nations 2015. One humanity, shared responsibility: Report of the United Nations Secretary-General for the World Humanitarian Summit. <http://sgreport.worldhumanitariansummit.org/>



Cash and voucher distribution centre in Democratic Republic of the Congo

People waiting at a WFP distribution point, Hodeidah, Yemen, 2017



WFP/Reem Nada

Promoting an integrated famine prevention package: Breaking bottlenecks

Summary of the report of the global Food Security and Nutrition Cluster meeting, 26 April 2017 at World Food Programme HQ, Rome

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

The global Food Security Cluster (FSC) and Global Nutrition Cluster (GNC) co-organised a meeting focused on four countries currently at risk of famine: North-east Nigeria, Yemen, South Sudan and Somalia. The objectives of the meeting were to review current collective nutrition and food security responses and identify gaps; establish the parameters for an integrated food security and nutrition response; agree on an appropriate integrated famine prevention response package; and complete plans for scaling up responses across the four countries through the Food Security; Nutrition; Health; and Water, sanitation and hygiene (WASH) Clusters. The meeting involved 70 participants from 24 international and national non-governmental organisations (NGOs), United Nations (UN) agencies and the International Committee of the Red Cross (ICRC).

The meeting was opened by Daniel Gustafson, Deputy Director General of the Food and Agriculture Organization (FAO), who discussed the severity of current food crises in North-eastern Nigeria, Somalia, South Sudan and Yemen, where over ten million people are on the brink of famine and a further 30 million are severely food-insecure. He emphasised the need for new forms of engagement at all levels to address the multi-dimensional drivers of food insecurity and hunger, stressing the importance of working together across sectors to find concrete operational solutions to famine.

Manuel Fontaine, UNICEF Director, Office of Emergency Programmes, described the “perfect

storm” in which humanitarian agencies find themselves when operating in the four countries. The situation, he said, is driven by conflict, restricted access to affected populations, breakdown of capacity and infrastructure, and protection risks. He emphasised the need to find practical solutions to overcome access problems and to integrate strategies to protect vulnerable beneficiaries in all programmes to ensure that no harm is done. He also emphasised the need to find practical programmesolutions, identify accountabilities among humanitarian partners and explore all possible options to prevent famine in the four focus countries.

A contextual overview of the food insecurity situation in each country was jointly provided by Arif Husain, Head of the Food Security Analysis and Trends Service of the World Food Programme (WFP), and Luca Russo, FAO Senior Food Crisis Analyst. Overall around 180 million people are affected by food insecurity in 38 countries, out of which nearly 30 million people are located in North-east Nigeria, Yemen, South Sudan and Somalia. These countries are all affected by adverse weather conditions (drought), conflict or a combination of both. A famine is declared when there is evidence in a single location of: a) at least 20% of the population facing extreme food shortages; b) at least 30% of children under five years suffering from global acute malnutrition (GAM); and c) daily deaths occur at double the normal rate.

Josephine Ippe, Global Nutrition Cluster Co-ordinator, provided an overview of the nutrition

situation in each country, including information on WASH and health. She identified emerging social and political issues, including drought; conflict/insecurity; access restriction; unemployment; dwindling oil production; internal displacement/population movement; influx of refugees into neighbouring countries; breakdown of social services; and non-payment of salaries. A deleterious nutrition situation common to all countries includes high levels of stunting, GAM, vitamin A deficiency, anaemia, sub-optimal infant and young child feeding practices and low coverage of nutrition programmes. The situation in each country was briefly described.

In terms of WASH, millions of people affected by the crisis currently have no access to safe drinking water, basic sanitation and hygiene services. Cases of cholera, acute watery diarrhoea and malaria are rising. Low water tables are causing competition between host communities and internally displaced persons (IDPs) and between people and animals, and water access is a driver of the crisis in arid lands, especially in Somalia.

In terms of health, conflict has damaged or destroyed much health service infrastructure and remaining facilities are under strain from the influx of displaced families. There is a chronic shortage of medicines and health worker salaries are not being paid. Millions of children are at risk of diarrhoeal disease, measles and meningitis. Conflict continues to disrupt health services and attacks on health workers are common. For the Nutrition Cluster, breakdown in national

health systems has a huge implication on the delivery of nutrition-specific programmes.

There is a funding shortfall in all sectors in all four countries and urgent fundraising is required. There is also no integrated information system to inform and monitor the response. All four sectors were urged to innovate to overcome these challenges and scale up coverage to deliver a quality and timely response.

Nutrition and food security famine prevention responses

Country Cluster Coordinators for Nutrition and Food Security made presentations on the current food security and nutrition situation in their respective countries, existing joint programmes,

opportunities for scale-up, challenges and recommendations. The challenges identified across all four countries were grouped under three thematic areas: systems, capacity and implementation.

Bottlenecks identified with regards to *systems* include: a) the lack of a platform for integration at strategic level (since the Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP) are sector-specific); b) lack of an accountability framework for cluster lead agencies and partners; c) funding shortfalls and unequal funding of the related sectors, which affects multi-sector integration; and d) lack of comprehensive joint targeting for response.

In terms of *capacity*, challenges include: a)

limited capacity of implementing partners to implement both food security and nutrition interventions (most are sector-specific); b) high staff turnover and insufficient human resource capacities; c) poor infrastructure and weak governance; d) lack of global guidance on joint planning and integrated or multi-sector response; and e) no clear sector transition strategy from emergency to development interventions.

In terms of *implementation*, bottlenecks include: a) different delivery platforms for food security and nutrition interventions (households versus health facilities); b) lack of physical access; c) needs assessment and analysis hindered by access and security concerns and lack of sectoral integration; and d) frequent pipeline breaks due

Table 1 Priority bottlenecks to an integrated response and proposed actions to address them		
Bottleneck to be addressed	Proposed action	Responsibility
SYSTEMS		
Data collection and targeting	Increase capacity of local actors to collect data, including when and where access is limited	Multidisciplinary team with support from global level for tools and methodologies
Multi-dimensional analysis	Create conditions for in-country joint analysis (including through neutral and outsourced expertise)	Global Cluster Coordinators Group or NGO initiatives
In-country leadership for timely integrated analysis and response	Guidance on how to integrate responses	Humanitarian Country Team (HTC) or Inter Cluster Coordination Group (ICCG) with support from global level (buy-in from donors needed)
Optimising the ways we do integrated response	Develop integrated response package (Food Security Nutrition, Health, WASH Clusters), including preparedness elements	All humanitarian actors and donors
	Ensure proper registration of beneficiaries so they can be traced even if moving	Experts in new technologies
Accountability frameworks	Advocacy in relation to donors – build the cost of accountability in budget design	All humanitarian actors
CAPACITY		
Funding	Advocacy – call for more funding flexibility	All humanitarian actors
	Advocacy – access to pool fund by NGOs	Cluster Coordinators
	Advocacy – collective resource mobilisation	Cluster Coordinators
	Joint proposal for integrated programmes	All institutions
	Better understanding of donors’ strategy (requirements and attraction to integrated projects)	Cluster Coordinators
Partnership and Human Resources/Technical Capacity	Advocacy for duration of partnerships/operational agreements between agencies and implementing agencies	All humanitarian actors
	Advocacy – longer-term funding for implementation (short-term can be an issue to guarantee sustainability of staff and programmes)	All humanitarian actors
	Increase integrated Food Security/Nutrition capacity building for implementing partners	All humanitarian actors
Accountability to mainstream integration (staff, institution, across sectors)	To create enabling environment	Cluster lead agencies, OCHA (UN Office for the Coordination of Humanitarian Affairs), HCs (Humanitarian Coordinators), HCTs
IMPLEMENTATION		
Conflict and humanitarian access	Common analytical capacity	All partners
	Building relationships	All partners
	Mapping of access capacities among organisations/clusters	All partners
	Sensitisation of local communities and taking information from them	All partners
	Risk sharing with donors	All partners
	Update guidelines on dealing with armed groups	HCs/HCTs
Localisation	Increase capacity building of local actors	All partners
	Conduct rationalisation plans (which partner has which strength in which sector) to maximise capacities and complementarity	Cluster Coordinators
	Due diligence to building trust, sharing analysis	All partners

People queue to fill jerry cans and other containers with water from a tank provided by UNICEF in Sana'a, Yemen, 2017

© UNICEF/Moath Alqabail



Box 1 Inter-cluster operational response in South Sudan, Somalia, Yemen and Nigeria: Call for action¹

First category of actions: Commitment to address structural operational bottlenecks

1. We commit to coordinate data collection between sectors and share all data available in order to conduct systematic multi-sector analyses, under the umbrella of the existing UN Office for the Coordination of Humanitarian Affairs (OCHA)-facilitated inter-cluster working groups at country level.
2. We commit to participate and support the development and operationalisation of joint action plans in all of the four countries that are promoting integrated response between Nutrition, Food Security, Water, sanitation and hygiene (WASH) and Health.
3. Under the umbrella of existing inter-cluster working groups, we commit to working towards joint programming and integrated responses that are based on vulnerability and composite indicators so that all the factors contributing to increased malnutrition, diseases and mortality within the current famine context are addressed.
4. Recognising that resources are limited and might not allow for a full coverage of all needs, we commit to working at cluster and inter-cluster levels in order to ensure prioritisation based on geographic convergences.
5. Acknowledging the importance of information sharing, we commit to share beneficiary lists, with respect for confidentiality, through the set-up, to the extent possible, of a single beneficiary database for the four sectors in each country.
6. Recognising the need to demonstrate our collective outcome, we commit to conducting regularly, through clusters and inter-cluster, joint monitoring of our integrated interventions through the set-up of joint indicators as well as to document lessons learned.
7. We commit to support the local governments and national partners, based on their operational capacities and comparative advantage, in delivering an integrated famine response. We also commit to the provision of minimum technical capacity to improve programme quality for national partners who are front-line implementers.
8. We commit to ensuring that, across four countries, integrated approach is defined and understood by all partners. For the purpose of the call for action, integration is defined as "an intentional combining of sectoral interventions in order to improve humanitarian outcomes". Based on this definition, an integrated package of interventions will be outlined for each country based on context, situation and vulnerabilities in the respective countries.

We will ensure that affected communities are reached with an integrated package of interventions that reduces the risk of famine, malnutrition, diseases and mortality, by effectively utilising the respective cluster partner's comparative advantages.

Second category of actions: Commitment to influence enablers to humanitarian actions

9. Recognising that conflict and insecurity have affected access to affected populations in the four countries, we commit to support one another in facilitating access, through the development of country-level task teams with membership from all relevant actors. In so doing, we commit to uphold and fully adhere to humanitarian principles.
10. Given insecurity and access-related challenges, maximising the effective use of common services such as logistics and access/corridors of tranquillity will be key in four countries' contexts. We therefore commit to effectively sharing logistics and access information and the delivery of integrated response where access has been granted. Linked to this, we pledge to share and coordinate communication on access problems that hampers delivery of services and systematically report to Humanitarian Coordinators (HCs)/ Humanitarian Country Teams (HCTs) and relevant authorities to take action in addressing the access problems.
11. We also commit to engage donors in strategic discussions related to risk sharing in hard-to-reach areas.
12. Recognising that the current format of the Humanitarian Response Plan (HRP) is not agile enough to support multi-sector programming, we commit to initiating discussions on complementary or alternative options to the sector-by-sector approach.

Third category of actions: Commitment to advocate for solutions to external operational bottlenecks

13. The Food and Agriculture Organization (FAO) and World Food Programme (WFP), as the Cluster Lead Agencies for the Food Security Cluster, commit to report periodically to the United Nations Security Council on the food security situation in the four countries as well as on other conflict-affected countries and to call on the parties to conflicts to grant urgent and unrestricted access to deliver humanitarian assistance to affected populations.

to lack of funds, restrictions on imports and dysfunctional markets.

Actions to address bottlenecks for an integrated response

Participants worked in groups to identify and prioritise specific actions to respond to these challenges. Integration of the food security and nutrition sectors was underlined as key, although health and WASH interventions must also be included for effective nutrition outcomes. It was also recognised that some system-level bottlenecks are beyond the control of individual Cluster Coordinators and require significant support from lead agencies and cluster partners. For these, advocacy is key. Table 1 outlines priority bottlenecks and practical actions identified by the group.

Cluster Coordinators also met to develop concrete integrated workplans for their respective countries in response to the proposed actions. Progress on these workplans is described in a series of articles in this issue, developed with ENN support and presented at the annual GNC meeting in Geneva 10-12 October 2017.

Conclusions and way forward

The Emergency Directors of WFP, FAO and UNICEF facilitated a discussion around the proposed solutions and committed to working closely together to support them at global level. They also agreed to advocate for increased funding for adequate staffing for clusters and cluster lead agencies and to influence the humanitarian architecture to support effective multi-sector integration at country level. It was highlighted that, in order to effect scale-up, partners should actively participate in country-level clusters; donors should provide adequate, flexible funding that supports multi-sector programming; and the quality of the response should be measured, including accountability to the affected population.

Ramiro Lopes da Silva, Associate Executive Director of WFP, closed the meeting by emphasising the fundamental role that clusters and cluster lead agencies play in ensuring that there is adequate leadership for an effective humanitarian response in the clusters they lead. He also emphasised the positive work going on in the affected countries, but urged agencies to break down silos and truly integrate and invest limited resources in critical interventions, fast, in order to avoid famine. Speaking on behalf of the cluster lead agencies (UNICEF, FAO and WFP), he said they will fully commit to engage and pursue this work through country-level clusters with the support of global teams, specifically the Emergency Directors, to address the strategic global issues raised.

Global stakeholders, including over 30 international NGOs and UN agencies, committed to supporting this process through a series of actions described in Box 1.

¹ http://fscluster.org/sites/default/files/call_for_action_final.pdf

Aerial view of Monguno town, hosting around 122,888 IDPs, North East Nigeria, 2017

Kirathi Mungai

Post-Rome integrated action: Experiences from North-eastern Nigeria

By Kirathi Reuel Mungai and Adeola Goriola Makanjuola



Kirathi Reuel Mungai is a nutrition specialist currently working with UNICEF as a Nutrition Sector Coordinator in Nigeria, based in Borno. He has worked

as a public health nutritionist for the last 11 years in Kenya, South Sudan and Nigeria for UNICEF, Action Against Hunger, Concern Worldwide, World Food Programme (WFP) and the Government of Kenya. He has also worked as the Nutrition Cluster Coordinator in South Sudan.



Adeola Goriola Makanjuola is an information management and technology expert with ten years' experience in

telecommunications in humanitarian emergencies. He is currently seconded from iMMAP to UNICEF as an information management officer for the Nutrition Sector in North-eastern Nigeria. He previously worked as a geographic information system officer for the International Organization for Migration Displacement Tracking Matrix (DTM) in Nigeria.

The authors would like to acknowledge the input of the UNICEF Cluster Lead Agency, World Food Programme (WFP), Nutrition Sector partners and donors and the Food Security Cluster in Nigeria to the work described in this article.

The findings, interpretations, and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: *Nigeria*

What we know: Conflict in North-eastern Nigeria has led to mass population displacement and an unstable nutrition situation.

What this article adds: Nutrition sector coordination is led by government with UNICEF support. Prior to the Rome 'call for action on integrated famine prevention', the Nutrition Sector was engaged with the Food Security and other sectors on joint programming and preventative activities. Post-Rome country action plan priorities included development of multi-sector assessments and associated guidance to include nutrition, food security, WASH and health; joint fundraising; and development of a joint response package. Achievements to date include joint contingency planning and geographical targeting; increased availability of data and partner participation in the Cadre Harmonisé; and multi-sector programming funds secured. Significant challenges include poor and militarised access to those affected; inconsistent naming of administrative boundaries; and tools that are designed for sector-specific rather than integrated planning. Joint programming has presented opportunities to link emergency and development programming.

North-eastern Nigeria nutrition context

The conflict in North-eastern (NE) Nigeria has significantly affected physical infrastructure, disrupted social services and displaced approximately 1.7 million people, with the bulk of the internally displaced persons (IDPs) in Borno state, at the epicentre of the crisis (DTM, 2017). Over half of the IDPs, mostly women and children under 18 years of age (56 per cent of whom are girls under 17 years old), are living outside IDP camps in local communities in overcrowded conditions under makeshift shelters. Weak protection and safety measures are in place for this population, who experience increased risk of gender-based violence, harassment, disease outbreak, food insecurity and malnutrition.

The nutrition situation in NE Nigeria has been unstable following the crisis. An estimated 450,000 children are at risk from severe acute malnutrition (SAM) in the region, many of whom require urgent access to treatment. A nutrition surveillance system conducts surveys in February to March, July to August and October to November each year. Data from these surveys for 2017 so far suggest that the prevalence of global acute malnutrition (GAM) declined between the first two rounds: from 11.4 per cent (9.7-13.3; 95 per cent CI) to 8.0 per cent (6.7-9.4; 95 per cent CI) in Yobe, and from 11.3 per cent (9.7-13.0; 95 per cent CI) to 6.7 (5.4-8.3; 95 per cent CI) in Borno. However, pockets of high malnutrition remain, mostly observed in areas with access challenges and areas that lack the necessary intensity of humanitarian action; GAM rates above 15 per cent emergency thresholds are reported in Jakusko and Northern Yobe, Karasuwa, Machina, Nguru, Yunusari and Yusufari.

Coordination arrangements in Nigeria

Humanitarian coordination arrangements have been modified to incorporate federal and state

government efforts to strengthen linkages with humanitarian actors. The Presidential Committee on the North East Initiative (PCNI) was established by President Muhammadu Buhari to serve as the primary national strategy, coordination and advisory body for all humanitarian interventions, transformational and developmental efforts in the North-east region. The PCNI works closely with other state agencies such as the National Emergency Management Authority (NEMA). At federal level, nutrition sector (cluster) coordination is chaired by the Head of Nutrition under the Director of Family Health. At the state level, nutrition sector coordination is chaired by the Director of Primary Health and co-led by UNICEF. For more in depth details on nutrition coordination in Nigeria, see article in this issue of *Field Exchange*.

Nutrition Sector priorities, capacity and preparedness

The Nutrition Sector developed a humanitarian response strategy for 2017 which aims to save lives by scaling up nutrition services to manage and prevent acute malnutrition in Adamawa, Borno and Yobe States. It has the following objectives:

Nutrition Sector Objective #1: Improve equitable access to quality life-saving services for management of acute malnutrition for children aged 6-59 months and pregnant and lactating women (PLW) through systematic identification, referral and treatment of acutely malnourished cases.

Nutrition Sector Objective #2: Promote access to services preventing undernutrition for the vulnerable groups (children under the age of five and PLW), focusing on infant and young child feeding in emergencies (IYCF-E), micronutrient supplementation and blanket supplementary feeding.

¹ The current regional framework that aims to prevent food crisis by quickly identifying affected populations and appropriate measures to improve their food and nutrition security, similar to the Integrated Food Security Phase Classification (IPC).

The nutrition partners further elaborated the strategy in a response plan, which outlines the key priorities and strategies to be undertaken by all sector partners in responding to the nutrition crisis. The response plan identifies the following priorities:

- Provision of quality care for treatment and management of acute malnutrition;
- Strengthen community capacity and linkages to enhance early identification of malnutrition and referral to facilities;
- Promotion and support of optimal infant and young child feeding (IYCF) practices;
- Protection of vulnerable groups against deterioration in nutrition status (prevention) and mainstream gender and protection in programme delivery;
- Strengthen nutrition surveillance systems to monitor the nutrition situation; and
- Strengthen Nutrition Sector coordination and partners’

engagement with and across sectors such as Food Security; Health; Water, sanitation and hygiene (WASH); and Education, where possible.

Realising the complexity and unpredictability of the operational space in NE Nigeria, Nutrition Sector partners identified preparedness actions to deal with events such as flooding and increased hostility resulting in further displacements. These are captured in the Nutrition Sector response plan. Nutrition actions are also included in other preparedness and contingency plans, including the inter-sector disaster response plan, led by the state emergency management authority, and joint food and nutrition emergency contingency plans for both flood and lean seasons.

The number of partners responding to nutrition in NE Nigeria has continued to increase since the beginning of 2017 (see Figure 1). Currently the Nutrition Sector has 25 partners, including 14 international non-governmental organisations (INGOs), three United Nations (UN) organisations, three donors and three observers. The ca-

capacity to respond has been strengthened by the human resources deployed by the partners and the increased ability to scale up in the newly accessible areas, where the need for nutrition services is immense.

In collaboration with the state government, the federal government has also strengthened the emergency response by deploying 25 health and nutrition teams, made up of 12 additional health workers (who work in two groups for alternate periods of two weeks) to 25 local government areas to boost the current human resource.

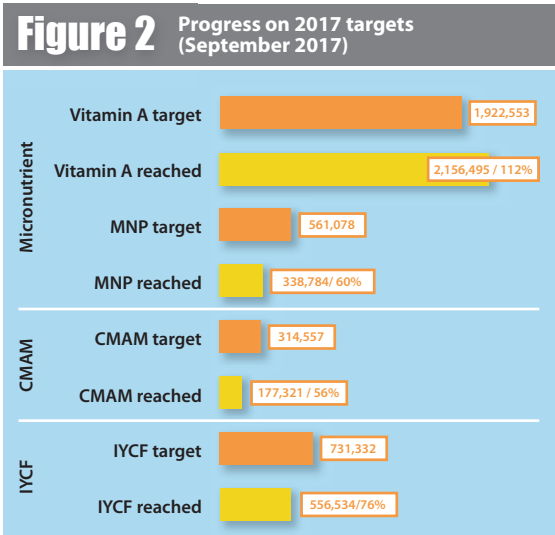
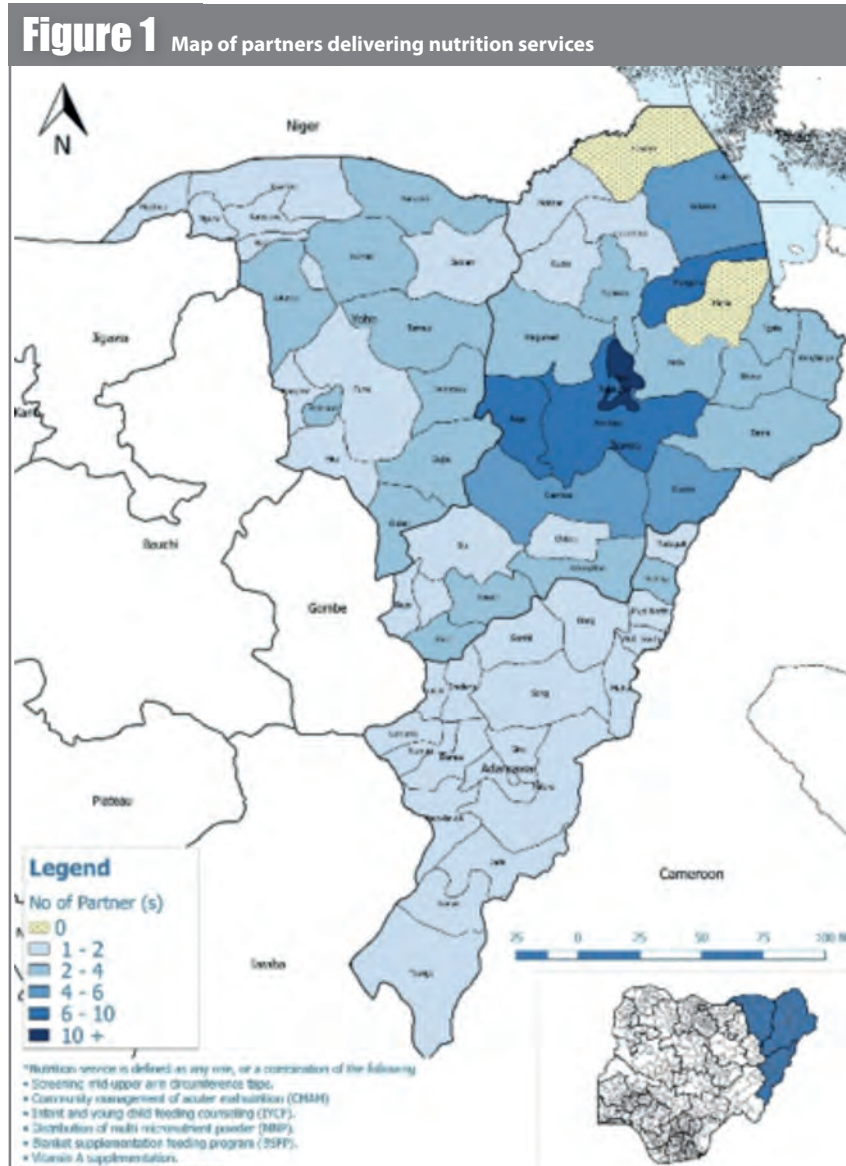
Nutrition Sector pre-Rome famine response preparedness

Prior to the Rome call for action on integrated famine prevention, the Nutrition Sector was engaged with Food Security and other sectors on joint programming and preventative activities involving:

- Joint targeting: Households with SAM children were targeted for general food distributions;
- Conditional cash transfers to the poor linked to uptake of nutrition services;
- Evidence-based, multi-sector assessment using Cadre Harmonisé;
- Prepositioning commodities in access-challenged areas;
- Strengthening human resource capacity through state government by supporting its work in remote areas; and
- WFP-UNICEF joint scale-up plan.

Country buy-in to the Rome commitments

Following the Rome meeting and the call for action on famine prevention, both the Nutrition Sector and the Food Security Sector coordinators in Nigeria undertook consultation to secure buy-in from the different stakeholders in-country. The country action plan, drafted in Rome by Nutrition and Food Security country cluster coordinators, was presented to government counterparts and partners in both sectors, accompanied by a briefing on the Rome call for action. The validated action plan was then presented to the heads of cluster lead agencies (food security and nutrition). An update of the action plan was undertaken in the Humanitarian Coordination Working Group comprised of all the humanitarian actors in the North-east and other government agencies. Implementation was overseen by a task force made up of three partners each from the Nutrition and Food Security Sectors. The final plan was shared with the Global Food Security Cluster (GFSC) and the Global Nutrition Cluster (GNC).



Country plan: Highlights and progress

The need to conduct joint multi-sector assessments (involving all four clusters: Nutrition, Food Security, WASH and Health) was identified; a guideline on joint assessment existed but needed to be contextualised to facilitate multi-sector assessment in the region. The funding situation (gap) of both sectors required attention; advocacy on the need to fund both food and nutrition interventions to avert a famine prompted joint fundraising based on an integrated approach to famine prevention. Presence on the ground of both sectors was necessary to maximise the impact of each sector's intervention; hence a joint response package involving both food security and nutrition partners was called for, especially in areas with limited access. To strengthen mutual commitment and collaboration, both sectors also felt the need to develop a joint accountability framework. By the end of October 2017, the following initiatives had been achieved:

- Joint food and nutrition lean season and floods contingency planning;
- Joint funding advocacy, with a larger allocation of Central Emergency Response Fund (CERF) funds for multi-sector programming secured as a result;
- Two meetings of the joint task force to oversee implementation of the country plan;
- Joint geographical targeting through analysis of both food and nutrition vulnerability;
- Alignment of the timing of assessments conducted by the Nutrition and the Food Security sectors (discussions to undertake joint assessments are ongoing);
- Implementation of the WFP-UNICEF joint scale-up plan, which has contributed to multi-sector funding; and
- Increased availability of nutrition data and partner participation in the Cadre Harmonisé.

Progress of the Nutrition Sector to date

The Nutrition Sector estimated a financial requirement of US\$110 million to respond to the crisis in 2017. By the end of September 2017 the sector had received US\$87 million (78 per cent of required funds). With the ongoing advocacy and donor interest, it is highly likely that the sector will realise 100 per cent funding. As a result, the Nutrition Sector is on track and projected to reach 90 per cent of its targets by the end of 2017 (see Figure 2).

Key challenges in the implementation of the integrated country action plan

Despite significant scale-up efforts during the last six to nine months and increased global attention, humanitarian needs have continued to rise, and dwarf, the response capacity. As more areas become accessible following the insurgency, demand on existing partners is ever-increasing, but they have limited logistical capacity and

operational presence to respond in these places. Most partners have been in the country for less than one year and face the challenge of mobilising the experienced human resources necessary to support the fast-evolving crisis. Agencies must operate in a highly insecure environment, dominated by the military, with an extremely limited capability of civilian authorities in local government areas (LGAs) to assist humanitarian delivery and provide basic and essential services. Large areas of Borno in particular are inaccessible or only partly accessible to the humanitarian community, which is forced to rely on – and to a degree be directed by – the Nigerian military in delivering aid. Progress has been made in establishing a civil-military interface with the Nigerian army; however, there is still more work to be done. Parameters must be agreed internally among the humanitarian community and then externally with the government and military; for example, with regard to armed escorts and military presence during humanitarian activities.

Another challenge is that the names of administrative boundaries of LGAs, wards and settlements are not consistent. This hampers harmonisation of the 5Ws (who does what, where, when and for whom) common operations database and makes it difficult to identify activity overlap between sectors. The multi-sector humanitarian needs overview (HNO)/humanitarian response plan (HRP) has been the most difficult to advocate for, as the tools are limited to 'silo' planning (the online project sheets are sector-specific and do not provide an option for multi-sector planning). Emergency humanitarian coordination is relatively new and commitment of partners to coordination is still not optimal – most do not have adequate human resources and capacity to respond and engage on coordination.

Next steps to strengthen implementation of the action plan

Immediate plans are to continue to implement pending actions, especially the development of joint dashboards and presence maps. The Cadre Harmonisé analysis of the food and nutrition situation in October 2017 will inform the HRP 2018-2019 process and planning, and joint vulnerability mapping for food security and nutrition will inform prioritisation. Emphasis will be placed on partners responding to out-of-camp populations and people who are displaced in urban settings. Discussions on harmonisation of joint assessment methodology and timing of a joint nutrition and food security assessment will also be finalised.

Reflections and lessons learned

The critical role of the government in the humanitarian response as sector lead and its support to decentralise coordination to state level has facilitated increased engagement with partners and strengthened accountability as all response activities are now aligned to government priorities.

Joint programming has presented an opportunity for the Nutrition and Food Security sectors to link emergency to early recovery and

development through some innovative approaches, such as cash-based transfers that have enabled the revitalisation of markets and the stocking of nutritious foods.

Deep field presence has been strengthened for all partners through the operationalisation of 'humanitarian hubs' in locations where humanitarian partners previously had no physical presence. The hubs have enabled partners to work more closely with beneficiaries and have enhanced monitoring and supervision of the quality of response activities.

Deconstructing the silo mentality of sectors has been important, enabling increased engagement with other sectors (WASH and Health) and increased use of cash in the emergency response, which has led to plans to strengthen multi-purpose cash grants in the 2018 HRP.

The action planning and commitments described in this article have increased the frequency of engagement between country and global clusters and have facilitated learning from the other countries facing near-famine situations.

Support required from the GNC and its partners is necessary to continue to progress, including:

- Advocacy by the GNC with agency HQs for increased capacity of partners in-country;
- Guide the taskforce in Nigeria with the development of an accountability framework;
- Clearly illustrate the protracted nature of the crisis in North-east Nigeria and the need for sustained funding;
- Partners in-country to increase their human-resource capacity with adequate experience to respond to the complex situation; and
- Address the system challenges inherent in the multi-sector HRP, which hamper putting the vision of multi-sectorality into practice.

Progress to date has been the result of the work of many stakeholders. State actors have been very supportive of coordination activities at federal and state levels. The Nigerian government's investment in health and nutrition emergency response in the North-east to support humanitarian assistance and recovery needs has been and remains crucial. The commitments of the cluster co-lead agencies to support coordination staff is also greatly appreciated. The GNC has provided invaluable support through monthly phone calls to support, guide and receive updates of the response to the four famine countries. Finally, donor support has enabled us to keep the nutrition response on track.

For more information, contact: Kirathi Reuel Mungai rkmungai@unicef.org

References

DTM, 2017. Displacement Tracking Matrix (DTM) Nigeria Round XVIII Report – August 2017. www.globaldtm.info/dtm-round-xviii-report-and-dashboards-august-2017

A woman and her niece sit outside their makeshift home after being forced to leave their village due to drought, near Burao, Somalia, 2017

By Samson Desie



Samson Desie is a nutrition specialist currently working as Nutrition Cluster Coordinator in Somalia with UNICEF. He has over ten years' experience in managing large-scale and complex programmes in grassroots, national and international contexts, including in the South Sudan crisis situation, Sudan protracted emergency and Somalia.

The author gratefully acknowledges the contributions of the Global Food Security and Nutrition clusters; the Somalia Ministry of Health and Humanitarian Affairs; Somalia ICCG and OCHA; Somalia UNICEF, WFP, WHO, FAO, IOM and international/local partners implementing IERT, the affected population, and ENN.

The findings, interpretations, and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Somalia Nutrition Cluster: integrated famine prevention package

© UNICEF/Kate Holt

Location: *Somalia*

What we know: Somalia was one of the focal countries identified in the Rome call for action on integrated programming to prevent famine.

What this article adds: Pre-Rome, an integrated approach – the Integrated Emergency Response Team (IERT) – was underway involving nutrition, health and WASH life-saving activities delivered by mobile teams to poor access areas. Post-Rome, significant funding was secured for the IERT and a package of food security support was integrated into the IERT. Challenges to implementing country actions have included lack of cross-sector guidance, protocols, and accountability frameworks; limited multi-sector capacity among partners; and resource gaps which hamper sector commitment to collective operations. Next steps include development of the IERT to broaden its remit (livelihoods and education); joint nutrition and food security assessment/analysis/planning; and development of common registries for internally displaced populations. Government is a key actor at state and federal level and a champion of the integrated multi-sector approach. To sustain momentum, the integrated approach should be a standing agenda in famine-prone countries.

Context

Somalia humanitarian needs continue to deteriorate and the risk of famine persists. Malnutrition levels have followed a deteriorating trend in recent years, with a steady increase in the number of malnourished children and number of internally displaced person (IDP) sites with malnutrition rates >15 per cent global acute malnutrition (GAM). At national level, median prevalence of acute malnutrition has steadily deteriorated from 12 per cent GAM in 2014 to 17.4 per cent in late 2017. Further data analysis conducted during the period 2007–2016 indicates that acute malnutrition trends in Somalia persist at GAM/severe acute malnutrition (SAM) emergency thresholds, with further deterioration.

Currently we are witnessing a significant deterioration in the malnutrition situation among IDPs and host communities, driven by high morbidity (disease incidence; e.g. acute watery diarrhoea, measles), low humanitarian support, poor child feeding and caring practices, food insecurity, limited health service availability (poor expanded programme on immunisation

(EPI) coverage), increased morbidity, poor health-seeking behaviour, and difficulty in accessing clean water supplies. Overall, Somalia has endured a persistent complex emergency resulting from continued conflicts, displacements, drought and disease.

Against this backdrop and elevated risk of famine, in early 2017 the Rome plan of action was initiated at the global level through global nutrition and food security clusters alongside the lead agencies. Somalia was one of the focal countries.

Pre-Rome country actions/ initiatives

The country Inter-Cluster Coordination Group (ICCG) had already initiated an integrated approach – the Integrated Emergency Response Team (IERT) – with a focus on three key life-saving clusters – Water, sanitation and hygiene (WASH), Health and Nutrition – to deliver services in a mobile team approach to some of the inaccessible remote areas. The approach with clear operational guidance was endorsed by the Humanitarian Country Team (HCT) in

March 2017. The key objective of the IERT is to ensure access to integrated life-saving health/WASH/nutrition services of vulnerable and most affected communities in rural areas and villages of Somalia. For WASH it involves delivery of key WASH activities, services and a hygiene kit; for health, provision of primary services (mainly to children under five years of age and mothers); and for nutrition, acute malnutrition identification and treatment on the spot (see Box 1). The teams comprise health professionals and paramedics identified from main urban cities who were provided with refresher training on key functions and deployed to affected sites, including the rural villages of Bay, Bakol, Gedo, Lower Shebelle, Lower and Middle Jubba. Accordingly about 50 IERTs were deployed to four of the most affected regions¹ in Somalia selected based on the need, accessibility, existence of basic services and

¹ These are SWS(AII), JL (Gedo and Middle Jubba), PL/SL (Sool, Sanaag), Galmudug (South Mudug and North Galgadud) and Benadir region (IDP camps).

² Services include AWD/cholera, ARI, pneumonia, UTI/others, AFI/malaria, child screening, SAM/malnutrition with complications, referrals and ANC.



A woman and her child walk towards a mobile medical unit in their settlement near Ainabo, Somalia, 2017

© UNICEF/Kate Holt

Box 1 Package of services provided by the Integrated Emergency Response Team (IERT)

Case management

- Provide basic life-saving medical services, including acute watery diarrhoea (AWD)/cholera patients.
- Ensure accurate, documented patient history.
- Follow strict case management of AWD/cholera.
- Practice strict infection control.
- Treat uncomplicated malnourished cases (both moderate and severe acute malnutrition (MAM/SAM)).

Referral

- Identify, provide first aid service and refer patients with medical complications requiring admission to health facilities.
- Referral of complicated cases of malnourished children to appropriate services.

Health education, sanitation and hygiene promotion

- Support community hygiene promotion for AWD/cholera prevention.
- Promote good hygiene and sanitation practices to affected communities.
- Breastfeeding promotion and infant and young child feeding support.

Community-based work in remote areas

- Identify and train community volunteers on health education.
- Mid upper arm circumference (MUAC) screening and identification of malnourished children.
- Danger sign identification of malnourished children with medical complications and use of appetite test.

WASH

- Organise community sensitisation and mobilisation sessions at facility and outreach levels of the affected areas.
- Distribute standard information, education and communication (IEC) materials for social mobilisation.
- Closely coordinate with those involved in activities in the community, regional and district levels, including NGOs, social mobilisers, elders and sheikhs.
- Strengthen the Case Tracing Model and support implementation at facility treatment centres.
- Strengthen capacity of partners for hygiene promotion. Continuous follow-up and refresher trainings and/or mentoring in the field to build partner capacity.

Nutrition

- MUAC screening for all children aged 6-59 months and pregnant and lactating women (PLW).
- Treatment of MAM and SAM without medical complications.
- Referral of MAM and SAM cases with medical complication and failed appetite test.
- Breastfeeding promotion.

Box 2 Country-level buy-in to action plan

- **Global meeting** lead by executive directors in Rome – 25/26 April 2017/Global call for action – May 2017.
- Somalia lead agencies, partners and ICCG **consultation** with development of **plan of action (POA)** – May 2017.
- **Somalia IERT and FSN Initiative** – May 2017.
 - Briefing partners, lead agencies (UNICEF, FAO and WFP) and ICCG on the initiative.
 - Success in securing Somalia Humanitarian Funds (SHF) funding to implement the IERT – WASH, Health and Nutrition.
- Somalia **Nutrition Cluster and Food Security Cluster (FSC)** finalised **plan of action** and shared with three lead agencies.
- Somalia **Nutrition Cluster and FSC** work on **joint priority areas** with help of FSNAU.
- The **FSC** consolidates the protocol and package of **the IERT** in Somalia to complement the ongoing initiative of the IERT of Nutrition, WASH and Health clusters.
- Current allocation of SHF (**12 million**) predominantly for support of the IERT where FSC component is integrated into the three-cluster initiative.

presence of IDP camps. The team reached about 45,000 beneficiaries with life-saving nutrition, health and WASH² services during the initial short period of deployment time (April–Mid May 2017).

Post-Rome actions and progress to date

The Rome call for action has significantly catalysed change around integrated programming in Somalia. It is now the primary driver of the integrated agenda and has been crucial to securing donor acceptance and buy-in; many donors are now using it to push partners to implement the approach. Significant cluster actions on integrated programming have taken place since Rome, besides continued/maintained IERT responses. A series of events took place at country level to secure buy-in (Box 2) and act on the country action plan (Box 3), the release of which coincided with the Rome call for action in May 2017; this in turn strengthened the case for implementation. Buy-in involved consultations at various levels and across sectors to secure high level and cross-agency (UNICEF, WFP, FAO) endorsement of the country plan of action.

A key development was integration of food security into the IERT. The Somalia nutrition and FSC worked on joint priority areas, consolidating the protocol and package of food security components for inclusion. In the country plan of action, two key initiatives were prioritised to prevent famine:

- 1) Secure support for the IERT. Post-Rome, the IERT has received huge support from the HCT and has received two rounds of funding (US\$6.5 million and US\$11 million). The IERT reached over 135,000 beneficiaries during May to July 2017 (see Figure 1).
- 2) Food security and nutrition integration has involved two key actions:
 - a. All families identified with a malnourished child receive a one-month food security package.
 - b. Outpatient therapeutic programme (OTP) discharge package. The discharge package now provides a food security package for a minimum of three months after discharge and food security programmers provide food for all caretakers for inpatient units while a child is admitted.

Government is a key actor at state and federal level, from planning to implementation and monitoring, and a champion of the integrated multi-sector approach. The creation of the new Ministry of Humanitarian Affairs has brought added benefits in creating streamlined contacts/processes (dispensing with the need to engage with multiple ministries), a permanent cluster member and a full-time presence in the drought operations coordination centre. Monitoring and IERT team supervision are implemented by the Ministry of Health. Planning (where and by who) is undertaken by government at state and federal levels.

Box 3 Country action plan

- Joint response analysis and identification of priority areas for integrated responses.
- Map ongoing and planned responses and gap identification in priority areas, including revision of existing response plan as necessary.
- Identify mutual partners for implementation of revised/integrated response plan in gap areas while building on any existing consortia and/or supporting establishment of a new consortium where there is limited capacity around multi-sector programming.
- Define joint targeting criteria and ensure use of a common platform for data capture, including use of SCOPE and Common Registration. It was agreed to target families of malnourished children with food security/livelihood intervention if they are not already enlisted.
- Support and integrate nutrition-sensitive programming, mainly involving WASH, Health, Food Security and Livelihood interventions in joint areas.
- Engage WASH Cluster and Health Cluster on the integration plan.
- Expand the scope of the current IERT to include FSC-related responses.
- Strengthen linkages between WASH, FS, Nutrition and Education response.
- Introduce multiple use of water at household level to cater for livestock water needs, which is as important as water for human consumption given dependence of pastoralist livelihoods on livestock.
- Develop priority interventions aligned with seasonal calendar across the Nutrition, WASH, Health and FS clusters in an integrated manner.
- Advocate for multi-sector HRP at HCT level based on lessons learnt.
- Capacity development of partners regarding multi-sector programming.
- Ensure centrality of accountability to affected populations (AAP), protection and gender-based violence (GBV) mainstreaming.
- Secure financing for joint programming.

Key challenges, context and lessons learned

The major key challenge faced involves the protocols, standards and quality assurance of an integrated multi-sector response plan and its implementation in the absence of clear guidance, common accountability and results framework at all levels. Field manuals are sector-specific and heavily detailed; simplification is needed to make integration feasible at ground level. Moreover, there was limited capacity for a multi-sector integrated approach, compounded by resources mobilisation challenges. There have been issues around sensitivity to organisational mandate versus collective approach on integration; agencies have sector-specific mandates and agendas that may conflict with an integrated approach. There have been some challenges relating to exclusion, clan affiliation and government promotion of partners to access pooled funding who have not been risk assessed/cleared for funding; UNICEF negotiates and refers such issues to the Humanitarian Coordinator or to OCHA as necessary. These issues have not been major obstacles to services being implemented. There have also been capacity limitations: funding is channelled through local partners who have sector-specific specialities that limit planning and implementation of multi-sector approaches. Most of the challenges are being addressed as follows:

- Working through consortia that bring together different expertise to overcome capacity constraints;
- Development of a simplified field manual on bringing together key sectors;
- An online monitoring tool is being supported by WHO to assure and monitor

- quality (this is in the early stages of development); and
- Discussion underway on how to develop accountability and a results framework across sectors. Currently, results are monitored using sector-specific frameworks.

This intensive collective effort galvanised by the Rome call for action has proved it is possible to implement a multi-cluster integrated response in the context of famine prevention. Donor and lead agency support is crucial to achieving this, while government buy-in and partner commitment are also critical.

Next steps

The IERT terms of reference will be broadened and renamed to reflect learning to date and to ensure inclusion of other clusters. The focus for immediate development of this approach is inclusion of FSC and livelihood packages and presentation of the revised, integrated re-

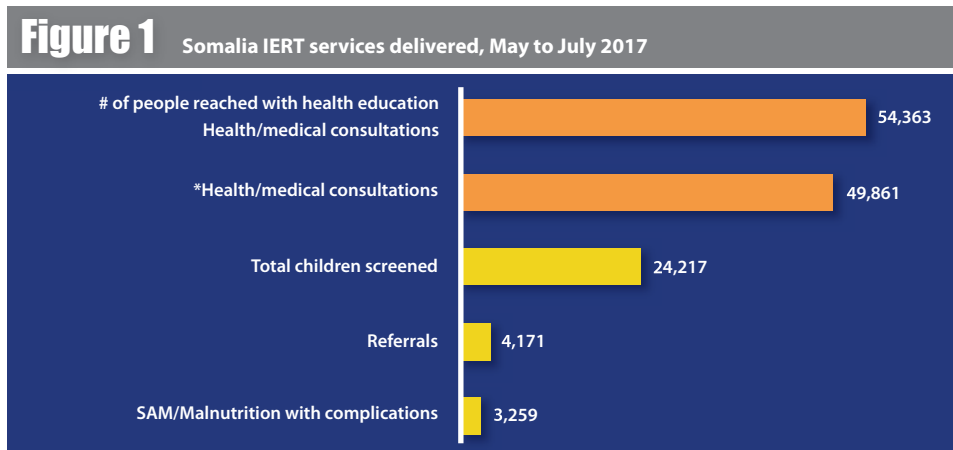
sponse package; plan, map, identify affected population and ways forward to a joint-cluster strategic advisory group (SAG) meeting and the ICCG for review and endorsement. An oversight committee from the three lead agencies (UNICEF, WHO, WFP) will then be established to guide and support implementation.

Joint response/gap analysis will be conducted for priority areas to use in advocacy and planning. Maps will be developed to show where key sectors overlap, who is doing what and where, and gaps. Potential partners will be identified that can fill the gaps; this may involve existing or new consortia and securing joint financing for implementation. To that end, a merger between the food security technical working group (WG) and the nutrition cluster assessment management information WG is underway, so that only one team is appraising information; this will be the highest authority looking at nutrition information to guide interventions.

A new initiative under development is a registration task force for developing a common registry. While there are lots of IDPs, there is no systematic database/tracking system in place. The aim is to have a common database across clusters and actors to generate quality data and make more efficient use of resources. The newly activated Camp Management Cluster (CCM) is leading on this.

In terms of global requirements to support integrated programming in Somalia, there is a need to broaden the narrow focus of agencies and partners to a wider perspective of integrated programming through continuous follow-up, monitoring and support. Efforts should not stop at the call for action: to sustain momentum, the integrated approach should be a standing agenda in famine-prone countries. Documentation of lessons learnt and development context-specific guidance for scale-up efforts is also needed. The support of the global Nutrition Cluster team to monitor progress and guide country challenges is crucial. Brief updates/bulletin reports should be provided to the global humanitarian committee/action.

For more information, contact: Samson Desie, email: sdesie@unicef.org



A woman carries bread made using WFP rations, Hodeidah, Yemen, 2017

Yemen Nutrition Cluster: Integrated famine-prevention package

By Anna Ziolkovska



Anna Ziolkovska is currently the Nutrition Cluster Coordinator in Yemen. Anna has a PhD and more than ten years' experience in nutrition, humanitarian assistance, cluster coordination, information management, capacity building and project management, both at HQ and country-levels, including in South Sudan, Somalia, Philippines, Ukraine, Afghanistan and Yemen.

The author would like to acknowledge the input of the Food Security and Agriculture Cluster (FSAC) Coordinator (Gordon Dudi), who co-led the prioritisation process with the Nutrition Cluster Coordinator. The author would also like to acknowledge the contributions of the nutrition, health, WASH and FSAC partners, their respective Cluster Coordinators and Strategic Advisory Groups (SAGs), the Nutrition Cluster Assessment Working Group, relevant ministries and the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), as well as support from the Humanitarian Country Team (HCT) in the development and implementation of the integrated famine-prevention package.

The findings, interpretations, and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: *Yemen*

What we know: There has been escalation in conflict in Yemen since 2015, with 20.7 million people in need of assistance, and risk of famine.

What this article adds: Before the Rome meeting call for action to prevent famine, the Nutrition and Food Security and Agriculture Cluster (FSAC) collaborated to prioritise locations at high risk of famine and in need of a joint minimum response package. Post-Rome, country-level actions were collaboratively identified by Nutrition, FSAC, Water, Sanitation and Hygiene and Health Clusters. The process since has been led by the Nutrition Cluster. Ongoing activities include adaptation of SMART to integrate indicators from other sectors and a joint chapter on famine prevention in the humanitarian needs overview and in the humanitarian response plan. Imminent plans are to agree on joint analysis and integrated package of interventions for priority districts. Commitment for joint funding has been secured. Challenges to integrated programming include lack of recent district-level mortality and sector data; collapsing health systems (coupled with large cholera outbreak); and lack of partner capacity on integrated programming, among others. Country-led process is key. High-level advocacy by the Global Nutrition is critical to ensure country-level management commitment.

Context

There has been an escalation in conflict in Yemen since March 2015; there are now over two million internally displaced persons (IDPs) and an estimated 20.7 million people in need of humanitarian assistance out of a total population of 27.4 million. An estimated 17 million people (60 per cent of the overall population) are food insecure, 10.2 million of whom are classified under the Integrated Phase Classification (IPC) as in 'crisis' (phase 3) and 6.8 million in 'emergency' (phase 4). Figure 1 shows the classification of governorates in Yemen according to prevalence of global acute malnutrition (GAM). Prevalence of acute malnutrition is high, with an estimated 400,000 children under five years of age with severe acute malnutrition (SAM) and 1.8 million children under five years with moderate acute malnutrition (MAM). An estimated 14.5 million people need support to meet basic water, sanitation and hygiene (WASH) needs and 14.8 million require assistance to ensure adequate access to healthcare. According to the health resources availability

mapping system (HERAMS) only 50 per cent of health facilities are currently fully functional. Cholera is also a problem, with more than 750,000 suspected cases as of October 2017.

Nutrition Cluster in Yemen

The Nutrition Cluster approach was adopted in Yemen in August 2009 immediately following the outbreak of the sixth war between government forces and the Houthis in Sa'ada governorate in northern Yemen. Since then, Yemen has continued to face complex emergencies that are largely conflict-generated and in part, aggravated by civil unrest and political instability. The Nutrition Cluster has been constantly active during this time. Following the escalation of the conflict in March 2015, a Level three system-wide emergency was declared in Yemen, which is still in place today.

The Nutrition Cluster is currently established at national level, with five sub-national clusters at the zonal level in Hodeidah, Ibb, Aden, Saada and Sanaa. The Cluster is co-led by the Ministry

of Public Health and Population (MoPHP) and UNICEF and consists of 32 partners, including United Nations (UN) agencies, MoPHP, and national and international non-governmental organisations (NGOs). A Strategic Advisory Group (SAG) provides strategic directions to the Cluster, while three technical working groups (TWGs), on infant and young child feeding (IYCF), community-based management of acute malnutrition (CMAM) and assessments, support partners in these specific areas.

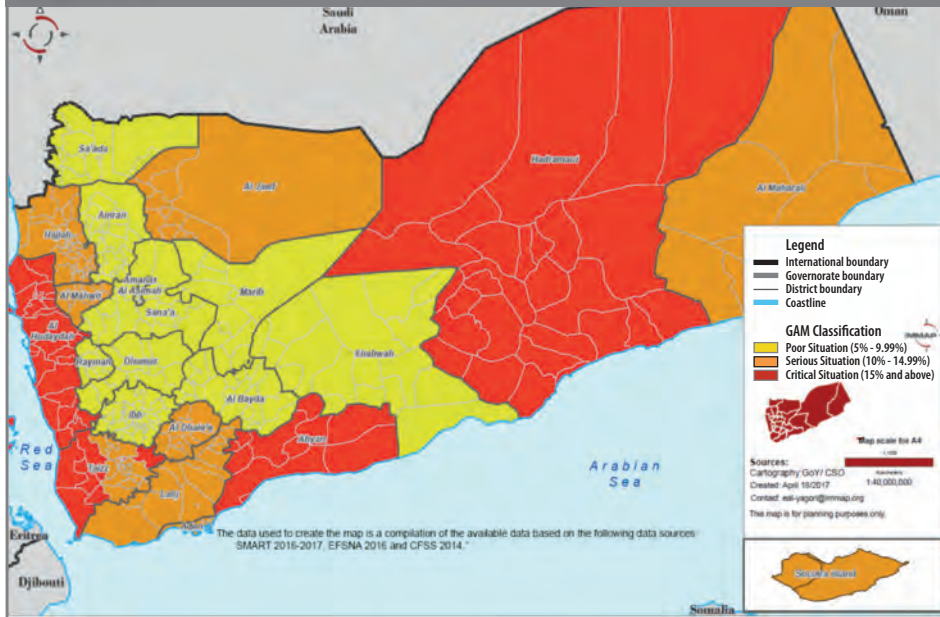
Nutrition priorities

According to the 2017 humanitarian response plan (HRP) developed at the end of 2016, the nutrition objectives in Yemen are as follows:

1. Deliver quality, life-saving interventions for acutely malnourished children and pregnant and lactating women (PLW);
2. Contribute to prevention of malnutrition by enhancing the blanket supplementary feeding programme, micronutrient support, deworming, and infant and young child feeding (IYCF) support;
3. Strengthen the capacity of relevant authorities and local partners to ensure an effective, decentralised nutrition response; and
4. Ensure a predictable, timely and effective nutrition response through needs analysis, monitoring and coordination.

There has been a clear shift towards integrated (multi-sector) nutrition programming in 2017 following the IPC classification of acute food insecurity in Yemen in February 2017. As the risk of famine rose, there was widespread realisation of the complexity of the situation that is not only related to malnutrition, but also to underlying causal factors. The immediate link to food security was clear, given that the indicators of famine used by the IPC technical committee are in large part related to food security (mortality + prevalence of GAM + food consumption or livelihood change or documented inference analysis based on at least four pieces of somewhat

Figure 1 Nutrition Cluster GAM classification, Yemen (April 2017)



reliable evidence (direct or indirect) on food security contributing factors or outcomes).

Country buy-in to integrated workplan

The integrated response began in Yemen prior to the joint Global Food Security Cluster (GFSC) and Global Nutrition Cluster (GNC) meeting on 26 April 2017 in Rome. Initially the process in Yemen was led by the Nutrition Cluster and Food Security and Agriculture Cluster (FSAC), which resulted in the prioritisation of locations at high risk of famine (see Box 1) and development of a joint minimum response package (Figure 2). Seventy-seven districts have been identified as high-priority districts based on the selected cut-off points. Additionally, 18 districts were upgraded to high-priority districts following discussions with partners of both clusters at field and national levels. If only one threshold was reached (more than 15 per cent GAM or more than 20 per cent of population severely

food insecure), the districts were assigned as priorities for the relevant sector only (Nutrition Cluster or FSAC).

Following the Rome meeting, the Nutrition Cluster and FSAC also brought the WASH and Health Clusters on board. The group chose not to use the Rome-generated country action plan as this was perceived as being developed by two Cluster Coordinators (Nutrition Cluster and FSAC) without consultations with any partners and without engagement of the other two clusters (WASH and Health). Instead, the group agreed a way forward with all four Cluster Coordinators and four Strategic Advisory Groups (SAGs). The country action plan developed in Rome has been largely followed and is described in Table 1. Advocacy from the Rome meeting, including the ‘call for action’ and letter from the Emergency Relief Coordinator (ERC), supported the process to ensure management and humanitarian country team (HCT) buy-in.

Progress to date (September 2017)

The process has been led by the Nutrition Cluster, which was identified by the collective to take this forward. To date, the way forward has been agreed by all involved. Adaptation of the SMART guidelines to the Yemen context is ongoing, including a review of the standard SMART questionnaire used in the country to ensure that information from/for Health, WASH and FSAC is incorporated. A joint chapter on integrated programming for famine prevention to incorporate the humanitarian needs overview and the HRP is in progress. At the time of writing (October 2017), a joint meeting of the four cluster SAGs, relevant technical ministries, sub-national coordinators and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) was scheduled to agree on the four-clusters integrated minimum package of interventions for the priority districts. The meeting was due to reach agreement on the joint needs analysis and the development of a joint minimum package of interventions and its implementation modalities. Commitment for joint funding has been secured, with a dedicated envelope allocated from the Yemen Humanitarian Pooled Funds in 2017 to address the underlying and immediate causes of food insecurity and malnutrition by ensuring adequate access to food, nutrition, health and WASH by the most vulnerable through an integrated approach. Similarly, many donors are showing interest in funding integrated programmes in the priority districts.

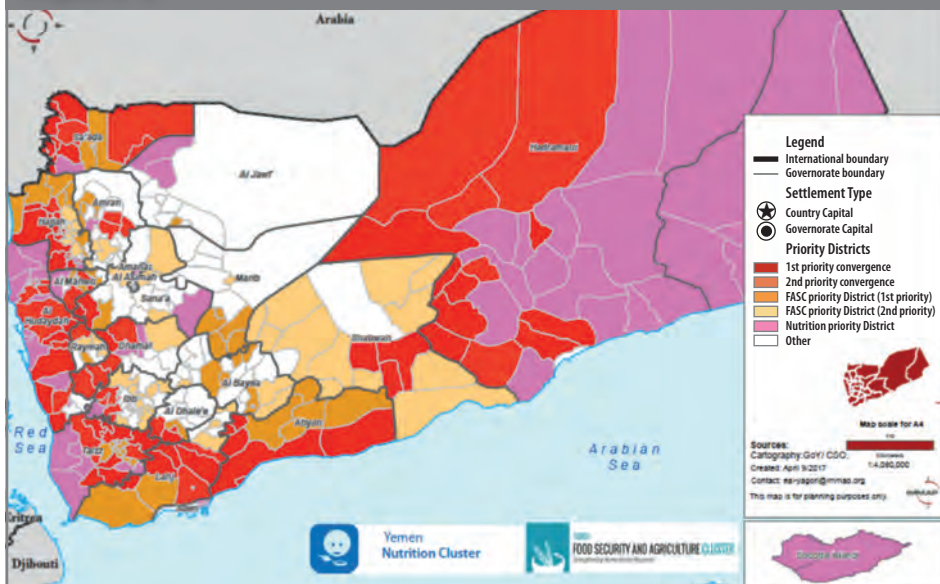
Challenges

There have been challenges in the process of planning and implementing integrated programming in the context of famine prevention. For example, there is a lack of recent mortality data – one of the main indicators for declaring famine and for geographical prioritisation – for

Box 1 Prioritisation of locations at high risk of famine

The following indicators were used for prioritisation: GAM prevalence (based on SMART surveys 2016-2017, emergency food security and nutrition assessment (EFSNA) 2016 and a comprehensive food security survey in 2014), and percentage of food-insecure population (based on the IPC March 2017 and EFSNA 2016). There was a need to prioritise districts for nutrition and food security interventions within governorates; however there was a lack of representative district level data to base this on. As a result districts were clustered by livelihood zone, agro-ecological zone and elevation, and the proportion of GAM cases in the new clusters was recalculated. The resulting percentages used for prioritisation do not provide GAM prevalence rates for the clustered districts, but represent the proportion of children with GAM from the total number of children measured. This provides an indication of the severity of the situation in that area. Cut-off points for each category were assigned based on the international thresholds where possible, taking into account the local context.

Figure 2 Joint prioritisation of famine-prevention locations



Yemen. There is also a lack of district-level nutrition, WASH and health data, making it difficult to monitor changes in the priority geographical locations efficiently. The collection of nutrition information even at governorate level is challenging: necessary permissions from appropriate authorities are required and there are access constraints. Baseline population is not standardised, as clusters use different approaches to calculate population. For example, some use adjusted population for population movements while others use non-adjusted projections issued by the Central Statistics Organisation.

Health facilities are on the verge of collapse; according to the health resources availability mapping system (HERAMS) in 2016, only 50 per cent of health facilities are fully operational. This is exacerbated by the non-payment of salaries to health workers for over one year, with many leaving to look for alternative income sources.

Yemen is currently site of the biggest cholera outbreak in the world, which has diverted attention of the HCT away from the nutrition needs of the population, as well as the attention of the WASH and Health Cluster Coordinators, who are fully engaged in the cholera response.

The fact that many of the partner agencies are cluster/sector-specific, with little capacity

for joint programming, is another impediment to integrated programming. One of the suggested ways to overcome this is for partners to connect with agencies from other clusters working in the same geographical locations and submit joint projects; however this is still in early/pilot phase. The heavy focus on integrated programming has had a negative impact in terms of disregard of nutrition-only priority locations, where the malnutrition situation is also critical but for reasons unrelated to food security.

Lessons learned

The process should be country-led in order to ensure buy-in to integrated programming, with the clear willingness of clusters (and cluster coordinators) to contribute time to the discussions with a desire to move the agenda forward. While each cluster is finding its own way to prioritise and plan its response based on the limited information it has, it remains difficult to ensure joint planning, given the limited availability of information on which to base decisions. Global Cluster engagement in high-level advocacy is needed to ensure management commitment. For example, post-Rome advocacy with management and the HCT has been instrumental in lending profile to the initiatives and helping catalyse multi-cluster engagement and commitment. Constant sensitisation of partners on joint

response is needed in order to ensure understanding and buy-in of cluster partners to integrated programming. There is a need to explore how to develop the capacity of partners to expand programmes to other technical areas to ensure that programmes are integrated at ground level and to discover ways for several NGOs with different expertise to work together.

Next steps

SMART assessments must now be scaled up in Yemen and joint IPC and nutrition analysis carried out. The joint response package must be operationalised at sub-national level. The Yemen HRP is currently in development and continued advocacy is required for joint planning, resource mobilisation and response. At the global level support is needed to facilitate the inter-cluster workshop in Yemen on joint programming with all four clusters. GNC partners should reflect on their capacity for joint four-clusters programming and on the changes to be implemented at organisational level to allow this. Support (both technical and in terms of human resources) in Yemen is needed for international NGOs and UN agencies and to ensure constant monitoring of their performance.

For more information, contact: Anna Ziolkovska, email: aziolkovska@unicef.org

HPC stage	Action	Responsible	Timeline	External support needed
Needs assessment and analysis	Organise a multi-cluster data clinic (four clusters) to agree on the joint assessment methodology and indicators and a platform for the joint analysis (include key Food Security, WASH and Health indicators in SMART Surveys)	Led by FSAC and Nutrition Cluster Coordinators and SAGs of the four clusters	May-June 2017	Tech RRT for assessments
	Joint IPC and FS nutrition analysis	FSAC and Nutrition Cluster SAGs	Aug-17	IPC nutrition HQ support
	Joint meeting with four Cluster Coordinators (FSAC, nutrition, WASH, Health) on the way forward with joint prioritisation and package of interventions	Four cluster coordinators (FSAC, NUT, WASH, Health)	Jun-17	None
Strategic Planning	Defining and operationalisation of nutrition and FSAC minimum package of joint interventions	SAG of FSAC and NC, plus key partners if needed	May-17	Global nutrition and FS Working Group (WG)
	Engagement with Health and WASH Clusters to expand minimum joint package of interventions	SAGs of four clusters, led by Cluster Coordinators, plus key partners if needed	May-June 2017	Global Health Cluster Coordinator support to bring Yemen Health Cluster Coordinator on board
	Yemen humanitarian response plan (HRP) revision, including four clusters' joint strategic objectives and response plans	Led by four Cluster Coordinators (FSAC, NUT, WASH, Health)	May-17	Advocacy from Cluster Lead Agencies (CLAs) and Global Cluster to donors
Resource mobilisation	Advocacy for facilitation of unimpeded humanitarian supplies delivery	Emergency Directors (EDs) for FAO, UNICEF, WFP and Humanitarian Coordinator (HC)/Humanitarian Country Team (HCT)	Continuously	EDs for FAO, UNICEF, WFP and HC/HCT
	Ensure the donor pledges are honoured ASAP	EDs for FAO, UNICEF, WFP and HC/HCT	May-June 2017	EDs for FAO, UNICEF, WFP and HC/HCT
	Prepare a two-page advocacy brief on Yemen joint programming	Four cluster coordinators (FSAC, NUT, WASH, Health)	July-Aug 2017	Four Global Cluster Coordinators (GCCs)
	Advocacy with donors for funding of joint programmes in the 95 priority districts	Four cluster Coordinators, four GCCs, CLAs in-country, EEDs for FAO, UNICEF, WFP and HC/HCT	Continuously	Four GCCs, CLAs in-country, EDs for FAO, UNICEF, WFP and HC/HCT
Implementation and monitoring	Call for action to be finalised and shared with the CLAs and global partners	GCCs, EDs for FAO, UNICEF, WFP	May-17	GCCs, EDs for FAO, UNICEF, WFP
	Orientation of sub-cluster coordinators in four clusters on the joint programming	Four Cluster Coordinators	June-July 2017	None
	Orientation of partners at sub-national level on the joint programming	Sub-national coordinators with support from national Cluster Coordinators	July-September 2017	None
	Develop monitoring framework of current famine risk situation (for 95 districts)	Four Clusters	Jun-17	Global Nutrition and Food Security Working Group, WASH and Health GCCs

A vitamin A supplement is given to a child during a Rapid Response Mechanism (RRM) mission in Thonyor, Leer county, South Sudan, 2017

© UNICEF/Mogda



South Sudan Nutrition cluster 2017: famine lessons learnt

By Isaack Biseko Manyama



Isaack Manyama is the Nutrition Cluster Coordinator for South Sudan. He has 24 years' experience in the nutrition sector.

Previous roles have included Team Leader of the Emergency Coordination Unit (ENCU) in the Early Warning and Response Directorate of the Ministry of Agriculture in Ethiopia, Primary Health Care Officer for UNICEF Tanzania and Senior Nutritionist at the Tanzania Food and Nutrition Centre.

This article was prepared by the Nutrition Cluster Coordinator with input from the Food Security and Livelihoods Cluster Coordinator on the Impact of Rome call for Action, and UNICEF and WFP nutrition sections that reviewed and enriched the article.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: South Sudan

What we know: South Sudan is affected by a chronic complex emergency characterised by ongoing conflict, widespread acute malnutrition and food insecurity, disease outbreak and limited access to those affected.

What this article adds: Famine was declared in February 2017 in two counties in South Sudan, which sparked a strong humanitarian response, including nutrition. A minimum life-saving nutrition response package was agreed with nutrition cluster partners, linked with health; food security; and water, sanitation and hygiene (WASH), and using existing and new strategies including mobile response, inter-cluster and integrated rapid response mechanisms, and blanket supplementary feeding programmes (BSFP) in the targeted SFP sites. Famine was averted within four months in two counties and prevented in two others. Critical success factors included strong inter-cluster coordination at national and sub-national level, active information management and gap analysis/filling, good triangulation of food security and nutrition information and two-way communication with partners on the ground. The April 2017 Rome call for action on integration reinforced and heightened pre-existing inter-sector collaboration and partnership, catalysed development of an early warning tool to prompt preventive action, and increased funding availability. Challenges to achieving ambitious country actions on integration included sector-specific shortfalls in funding, short time frames to implement, and workload. To prevent famine, separate thresholds to guide decision makers, donors and technical humanitarian community to initiate early actions/responses are needed.

Since 2013 until now, the Republic of South Sudan has experienced a complex emergency characterised by ongoing and spreading conflict; widespread acute malnutrition at county-level (most of which is at critical levels); increased food insecurity reaching up to 50% of the population by May 2017; prevalence of morbidities and disease outbreaks; and limited access and insecurity for humanitarian services. This has resulted in increased humanitarian needs in all sectors. The food and nutrition situation deteriorated further in 2017 in some parts of the country leading to a declaration of famine in February 2017 in two counties (Leer and Mayendit) with two other counties (Kouch and Panyijar) at famine tipping point (Integrated Phase Classification (IPC) 4).

Following the declaration, humanitarian responses including nutrition activities were initiated with concerted efforts by all partners, including generous funding from donors, which resulted in famine being averted within four months. In April 2017, the Rome call for integrated action to prevent famine in South Sudan reinforced pre-existing collaboration and partnership. Lessons learned from the overall famine prevention/response regarding coordination, information analysis and triangulation, and response are shared in this article.

Coordination

Following the declaration of famine in February 2017, a dedicated coordination forum chaired by the Nutrition Cluster Coordinator (NCC) was formed. The forum was based in Juba as it was not possible to bring all the partners together in Bentiu town due to security and access concerns. Any partner intending to contribute to or participate in the nutrition response had to

go through the cluster coordination team, which was observed by partners in all but a few cases. This prevented duplication and ensured a coordinated nutrition response. Overall, UNICEF, as cluster lead agency (CLA) ensured the presence of a strong coordination team at Juba level and at sub-state level in Bentiu (comprised of operational partners located nearby) that rallied all partners to work together guided by the principles of partnership - equality, mutual accountability, transparency, responsibility and results-orientation, with each partner successfully fulfilling their respective roles.

Nutrition response

A minimum life-saving nutrition response package was agreed with Nutrition Cluster partners that included community-based management of acute malnutrition (CMAM); maternal, infant and young child nutrition (MIYCN); deworming; and vitamin supplementation in areas that had not been reached, through campaigns or during Integrated Rapid Response Mechanisms (IRRM) (see article in this issue of *Field Exchange* that elaborates on this and other response mechanisms in South Sudan). This was complemented by malaria treatment in outpatient therapeutic programmes (OTPs) and health facilities for children with severe acute malnutrition (SAM). Multiple response strategies included static services; mobile/outreach services; IRRMs implemented by UNICEF and the World Food Programme (WFP); inter-cluster response mechanism (ICRM) coordinated by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA); and the Multi-sectoral Emergency Team (MET) and Emergency Response Team (ERT) implemented by Action Against Hunger (AAH) and Medair respectively. In addition,

integrated community case management (ICCM) was implemented by Medair in Leer and the International Rescue Committee (IRC) in Panyijar. Mass screening and treatment of SAM and moderate acute malnutrition (MAM) in selective feeding programmes (Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding Programme (TSFP)) of children under five years with acute malnutrition and pregnant and lactating women (PLW) prevented further deterioration. The use of a combination of response strategies enabled reach to affected populations both in accessible and difficult to reach/inaccessible/under-served areas. For example, IRRM/ICRM missions were implemented in 17 locations (14 by IRRM and three by ICRM) that were not easily accessible reaching a total of 28,984¹ with lifesaving interventions (Vitamin A supplementation, deworming, infant and young child feeding in emergencies (IYCF-E) key messages) of which 2,907² were treated for SAM and MAM.

Situation monitoring, analysis and triangulation

A combination of nutrition situation monitoring mechanisms were used, ranging from weekly admission trends analyses in OTP and TSFP sites, and SMART surveys implemented by partners under the coordination of the cluster coordination team through the Nutrition Information Working Group (NIWG). The weekly monitoring and analysis of OTP and TSFP new admission trends during the famine period provided timely understanding of how the nutrition situation was evolving and enabled effective decision making. Sharing and publication of weekly admission trends in a dedicated famine bulletin in April 2017 by the Nutrition Cluster enhanced trust, transparency and confidence on the information provided to stakeholders.

In addition, the Nutrition Cluster, through the NIWG, coordinated implementation of SMART nutrition surveys in Leer, Panyijar and Kouch. The survey results in Panyijar and Southern Leer counties in March and April 2017 respectively, indicated lower prevalence of acute malnutrition that was consistent with decreasing admission trends in OTP and TSFP selective feeding programmes.

Lessons learned

Information sharing and communication

One limitation of the coordination process was the lack of field/ground-level information and experience sharing between partners due to insecurity and lack of access. Coordination between partners would be greatly improved by the recruitment of a focal point person who could visit partners in their operational sites. The experience also revealed the importance of consultation with all stakeholders before major decision-making takes place, with respect to introducing or starting a new response strategy or initiative. This should be a two-way process, so that strategic decisions made at lower levels are brought to the attention of senior management of respective cluster lead agencies to achieve

common understanding and buy-in. Two-way information sharing and communication should also be strengthened between national and state or sub-state levels and should be cross-checked using different communication channels.

Improvements in situation monitoring, analysis and triangulation

The use of mechanisms to facilitate situation monitoring was effective. It is important to ensure that the description of the nutrition situation is consistent across different sources of nutrition information. For example, admission trends were consistent with SMART survey findings in Leer and Panyijar. This avoids confusion, enhances trust and confidence in the information and the coordination team. In the future, where it is not possible to conduct regular monitoring and supervision, joint monitoring would be very useful. In this scenario, a group of partners would together visit another implementing partner's site once per month to identify issues, agree on corrective action together, and put things right following the recommended protocols. While this was not implemented during the recent response, the cluster is encouraging all state level focal points to initiate this approach in collaboration with respective cluster partners.

Rapid integrated response to avert famine

A key lesson learned from the response is that famine can be averted within a short time period. In this case, within four months an integrated response (involving food security; nutrition; health; WASH) was implemented at scale with good coverage of beneficiaries using multiple responses strategies. For example, the number of OTP and TSFP sites increased by 62% from 37 in February 2017 to 60 in May 2017 while TSFP sites increased by about 54% from 41 to 63 during the famine period. The increase in nutrition sites enabled selective feeding programme enrolment of 8,859 children with SAM and MAM in the four counties, while blanket supplementary feeding programming (BSFP) reached 362,921 under-fives and 33,896 PLW in Unity State during the same period. Meanwhile, a total of 4373 PLW were also enrolled in TSFP.

“Thinking outside the box” by introducing new response strategies also worked. For example, WFP in collaboration with partners implemented a blanket supplementary feeding programme in the targeted supplementary feeding programme (TSFP) sites in three counties (Leer, Mayendit and Panyijar). This strategy ensured that under-five children and PLWs accessed BSFP supplies (CSB++) in-between general food distribution rounds. The Nutrition Cluster partners believe this key intervention prevented children from becoming moderately acutely malnourished and accelerated improvement in the nutrition situation in the famine affected counties.

Another important lesson learned is that the declaration of famine should not wait for coordination meetings to occur and higher level decisions to be made, but should be guided by early warning information before famine tipping points or thresholds are reached.

Another important lesson learnt is that famine can be prevented if multi-sectoral, multi-year, flexible and timely funding is provided to humanitarian and respective authorities that can build and restore resilience of the affected communities. This calls for unrestricted access, ensuring security and protection for humanitarian actors, especially in famine linked with conflict dynamics.

Effective use of coordination mechanisms

Gap analysis and filling was a regular point on the agenda during weekly cluster famine coordination meetings. In this way, the NCC tracked gaps and commitment of partners to fill them, holding them accountable to agreed time frames. This made partners more accountable to themselves, to the cluster coordination team and to the affected population.

The ICRM provided an opportunity to partners that were not operational in the famine affected counties to participate in the famine response. This alleviated pressure on the cluster coordination team and avoided competition between partners for implementation of response in the affected counties. Collaboration between new and existing partners was also encouraged through the cluster coordination team, one such example being the collaboration that was established in Leer county between Save the Children International (SCI) and Nile Hope. Since Nile Hope was already implementing OTP in the county, SCI through the cluster, agreed to establish a Stabilisation Centre (SC) in Nile Hope operational areas, trained Nile Hope staff and provided infrastructure construction materials and other SC supplies.

Pre-existing capacity and coordination

The presence of partners and on-going nutrition response programmes prior to the famine enabled a timely response. The existing response was accelerated/scaled up through amendment of project cooperation agreements (PCAs)/field-level agreements (FLAs), rather than starting from scratch (e.g. recruitment of staff, establishing an office base, communication arrangements). There was also pre-existing collaboration and partnership between cluster coordinators for WASH, health and nutrition, which had initiated an integrated response plan even before the famine was declared.

Availability of adequate supplies

UNICEF and WFP, the core pipeline partners, ensured that adequate supplies were made available to support the response. In some situations, supplies were relocated from non-famine areas to optimise availability of supplies in the famine affected counties. Prioritised transportation of surge staff by the United Nations Humanitarian Air Service (UNHAS) and delivery of supplies by the Logistics Cluster also ensured timely

¹ UNICEF/WFP Integrated mission reached 25,714 children and the remaining 3,270 were reached by ICRM

² UNICEF/WFP treated 2,474 SAM and MAM cases and the remaining 433 were treated by ICRM



Women wait with their children to be examined and possibly give supplementary food in a mobile clinic in the village of Rubkuai, Unity State, South Sudan, 2017

availability of supplies at site level. This enabled most malnourished children to complete their treatment regimen without or with minimal supply interruption. Use of expanded criteria³ enabled the Cooperating Partners (CP) to manage the cases of acute malnutrition when one of the nutrition commodities was not available. The expanded criteria have been applied both for regular nutrition responses and during IRRM missions. For example, they have been used in Leer county (Padeah, Thonyor), in Mayendit (Mayendit centre, Dablual, Rubkuay, Thaker) and in Koch (Ding ding) where Ready to Use Supplementary Food (RUSF) from WFP was used to treat both SAM and MAM for at least one month.

Thresholds for declaring famine and initiating response

Robust analysis and triangulation of food security and nutrition information is key in declaring famine. For confidence, trust and transparency, the thresholds for declaring famine should be reached. However, it can be challenging in a conflict context, characterised by insecurity and access constraints, to have reliable and accurate information to conclude beyond doubt that famine thresholds for the three indicators (food security, acute malnutrition and mortality) have been met. In such situations, use of plausible proxies should be recommended after vetting by respective experts.

There is a need for a composite index to guide early response based on early warning information. Prevention of famine implies early analysis of warning information and implementation of preventive actions. Relying on current famine thresholds may imply that the humanitarian community is waiting for thresholds to be reached before scaling up responses. New famine prevention thresholds are needed that use a composite index of famine-like conditions that will trigger early actions, such as increased funding from donors and advocacy with the media. Any stakeholder that does not fulfill its responsibility in this regard should be made to account for failing/ignoring the need to prevent famine.

Impact of the Rome call for action

The Rome call for action on promoting an integrated famine prevention package had a no-

ticeable added value to the coordination and implementation of integrated responses in South Sudan. First, the need for working together was reinforced and was part of regular agenda in the ICWG meetings and through IRRM and ICRM responses mechanisms. Second, it increased the understanding of the importance of partnership, building relationships among the clusters and organisations, bringing synergies and complementarity among all the humanitarian responses and actors to a level that had not been previously achieved. Third, the call highlighting the need for timely response, initiated the discussions for developing a composite indicator to guide early response based on early warning information. Fourth, while donors immediately provided increased funding to respond to the famine before the Rome call for action, some partners received additional funding and surge capacity following the Rome call.

Many actions were discussed and initiated following the Rome call for action. An important activity was initiation of the buy-in process at country level that involved holding meetings with cluster lead agencies (FAO/WFP and UNICEF), cluster partners (FSL and Nutrition), and circulation of the 16 points of the call for action to all cluster partners. One key action outcome was the development of integrated action plan and commitment from stakeholders and clusters (Health, Nutrition, FSL and WASH) on prevention of famine that did not previously exist.

FSL and Food Security and Nutrition Monitoring Report (FSNMS) methodology was revised to collect information at county level rather than just at state level as was previously the case. Nutrition SMART surveys were also conducted at county level in selected counties as part of the FSNMS assessments. Capacity building was conducted with both partners and government on FSNMS assessments across the country. The Rome call also reinforced the implementation of targeted General Food Distribution (GFD) as opposed to a blanket approach. For example, enrolment of families of children discharged from selective feeding programme into targeted GFD.

Other important actions included development of an early warning tool by REACH that provides an analysis framework for preparing a localised severity index that in turn guides the IPC and ICWG in prioritising response actions.

A couple of challenges were noted in the process of implementing the Rome call for action. It was viewed by country stakeholders as a 'top down' initiative driven by headquarters, as there was limited involvement of humanitarian partners in South Sudan in the development of the call for action. The implementation of the developed action plan included meetings that increased workload, adding to already planned activities in the HRP and other initiatives. The implementation plan was overly ambitious; in practice, many actions were planned for implementation within a short period that proved unrealistic. Limited funding for some of the clusters was one of the major challenges and impaired the call for integrated responses. For example, as of October 2017, the Nutrition and FSL clusters were funded at 62% and 73% respectively; WASH and Health clusters were still trailing at below 30 percent.

Thus while the call for action implied increased need for resources, existing funding requirements were not even being met. It is even more challenging funding long term development activities with short term/emergency funding resources designed for reactive responses.

Conclusions

Key lessons learnt from the 2017 famine response in South Sudan can be emulated in similar or different famine contexts. The need for a strong cluster coordination team and early initiation of coordination mechanisms that engages all stakeholders in major decisions and that has two-way communication cannot be overstated. Timely multiple nutrition response and strategies integrated with other sectors that are implemented at scale can avert famine in a relatively short period. However, this calls for all sectors/clusters to be adequately and timely funded; one sector alone will achieve very little. Perfection should not be the enemy of the good. Good analysis and triangulation is critical in declaring famine to win confidence of all stakeholders and key decision makers, and to ensure transparency. Separate thresholds to guide decision makers, donors and technical humanitarian community to initiate early actions/responses for preventing famine are needed.

The Rome call for action re-revigorated the need for strengthened partnership resulting in development of an integrated action plan focusing on food security and nutrition with input from WASH and Health clusters. The need for engaging all key stakeholders in the development of such initiatives is key for buy-in at county level, ownership and continuity of the proposed actions.

For more information, contact:

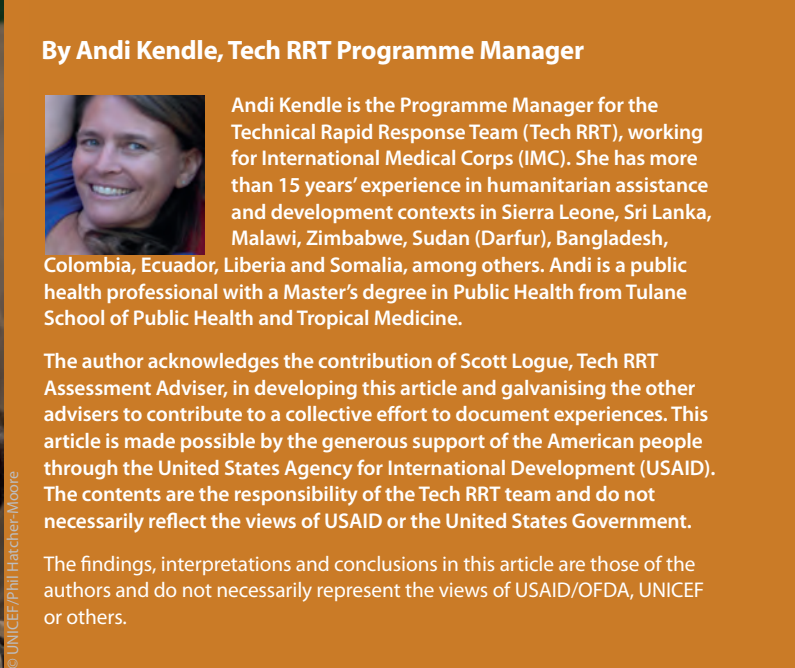
Isaack Manyama, email:

ssnutritioncluster.coordinator@gmail.com

³ Expanded criteria are used when one of the nutrition supplies, either Ready to use Therapeutic Food (RUTF) or RUSF, is used to treat both children with either SAM or MAM for a short period jointly agreed by UNICEF/WFP/operational partner and the cluster coordination team. This decision is reached only when either RUTF or RUSF is unavailable/or there is shortage for a short period, e.g. for one month.

A woman feeds her nine-month old son therapeutic food in a malnutrition ward in the Al-Sabbah children's hospital in Juba, South Sudan, 2017

Nutrition Technical Rapid Response Team: Experiences and lessons learned



By Andi Kendle, Tech RRT Programme Manager



Andi Kendle is the Programme Manager for the Technical Rapid Response Team (Tech RRT), working for International Medical Corps (IMC). She has more than 15 years' experience in humanitarian assistance and development contexts in Sierra Leone, Sri Lanka, Malawi, Zimbabwe, Sudan (Darfur), Bangladesh, Colombia, Ecuador, Liberia and Somalia, among others. Andi is a public health professional with a Master's degree in Public Health from Tulane School of Public Health and Tropical Medicine.

The author acknowledges the contribution of Scott Logue, Tech RRT Assessment Adviser, in developing this article and galvanising the other advisers to contribute to a collective effort to document experiences. This article is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Tech RRT team and do not necessarily reflect the views of USAID or the United States Government.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

Location: *Global*

What we know: In emergencies responders often struggle to find immediate, adequate human resources to meet urgent technical needs.

What this article adds: In August 2015 International Medical Corps, Save the Children and Action Against Hunger established the Nutrition Technical Rapid Response Team – a rapid response mechanism to provide immediate, flexible, nutrition technical expertise on community-based management of acute malnutrition, infant and young child feeding in emergencies (IYCF-E), nutrition assessments during emergencies and social behavior change. Deployment or remote support must benefit the collective. Deployments are short (around six weeks) and within 72 hours if necessary. To date, there have been 30 deployments, with the majority on IYCF-E, and mostly in countries with cluster/sector coordination mechanisms. Challenges include deployment in early emergency response and negotiating clear, feasible terms of reference. New developments include expanding support to individual agencies and learning webinars. Future priorities are to expand the funding base, provide specialist support to inter-sector nutrition programming as well as to national actors and engage in emergency preparedness.

Context

In August 2015, International Medical Corps (IMC), Save the Children and Action Against Hunger joined forces to establish the Nutrition Technical Rapid Response Team (Tech RRT) – a rapid response mechanism to provide immediate nutrition technical expertise during emergencies. This need was identified, discussed and debated for several years among Global Nutrition Cluster (GNC) members as they repeatedly observed technical gaps when national capacities were overstretched and unable to tackle and/or scale up nutrition services. Response capacity of governments, United Nations (UN) agencies and international and local non-governmental organisations (NGOs) is often compromised as they struggle to find adequate human resources to meet urgent technical needs. With the GNC's primary focus on coordination and information

management, including support for people in these roles, it was agreed that GNC partners have the responsibility to ensure they have capacity to deliver nutrition in emergencies (NiE) response and that UNICEF, as the Cluster Lead Agency (CLA) and 'Provider of Last Resort', would then cover the capacity gaps. While UNICEF explored ways to provide this support, the Tech RRT came on board so that countries could rapidly access support for technical nutrition programming in emergencies in the meantime. Demands in the areas of community-based management of acute malnutrition (CMAM), infant and young child feeding in emergencies (IYCF-E) and nutrition assessments were identified (as recognised in a 2015 evaluation of the GNC (Richardson and Ververs, 2015). The technical complexity of new emergencies has only exacerbated this need.

How the Tech RRT works

The Tech RRT consortium agencies work in close collaboration with the GNC and UNICEF, funded by Office of the United States Foreign Disaster Assistance (OFDA) of USAID until the end of 2017. The purpose of the Nutrition Tech RRT is to improve the quality of nutrition humanitarian response by deploying technical surge, providing remote support and building the capacity of nutrition partners when national capacity is overstretched or inexperienced in nutrition in emergencies.

The Tech RRT operates almost as an independent body, housed within IMC, with technical advisers employed according to each consortium partner's area of technical expertise. The team consists of either four or five experienced nutrition professionals with expertise in assessment, IYCF-E, CMAM and social behavior change (SBC). Action Against Hunger provides the assessment adviser, Save the Children the IYCF-E adviser, and IMC employs the programme manager as well as two advisers with flexible specialties (IYCF-E/CMAM and SBC/CMAM/assessments). The programme manager receives and handles all requests, follows all stages of each deployment, communicates with the steering committee and donor and manages the team to ensure that as many requests as possible are responded to. The consortium partners meet on a monthly basis and there is a deployment steering committee with representatives from each consortium member as well as from the GNC Coordination Team and UNICEF.

There is a set of agreed criteria and priorities for deployment and remote support, based on and adapted from those of the GNC RRT mechanism, ensuring harmony of approach between the two mechanisms (see Box 1). To date, a key criterion is that identified work should improve

Box 1 Criteria and priority for Tech RRT deployment and remote support**Criteria for deployment (adapted from the GNC RRT mechanism)**

1. Level 2/Level 3 categorisation where cluster or sector coordination mechanisms are in place.
2. Humanitarian crisis, including rapid-onset emergency such as natural disaster or slow-onset emergency as defined by OCHA, such as drought, political/economic crisis and global challenges (climate change, etc.).
3. Countries with limited technical capacity in nutrition in emergencies.
4. Does not duplicate other support on the ground or planned.

Priority

1. Declaration of a Level 3 emergency.
2. Rapid-onset emergency OR rapid deterioration of pre-existing situation.
3. Threat or forecast of Level 2/Level 3 emergency.

General conditions for Tech RRT remote support

1. The work will advance or promote the global, regional or country-level agenda in one of the Tech RRT technical areas.
2. The work is in follow-up to country-level work that an adviser has been involved in, with the underlying aim for the country to take on these responsibilities, and using techniques to build their capacity to do so.
3. Technical support that goes beyond the role of the GNC helpdesk, usually requiring some dedicated time and attention but not requiring presence in a country.
4. The work is either short enough to ensure that it will be completed prior to any potential deployment or can be put aside should the adviser need to deploy.

the technical quality or scale and reach of the emergency response and should benefit the collective rather than the individual interests/needs of an agency. Tech RRT personnel are deployable within 72 hours (depending on visa procedures) and deployments are normally for up to six weeks, with a 50-50 split between field and remote time.

Any in-country agency (Nutrition Cluster/Sector group/government/ministry of health (MoH)/provincial lead/district lead/NGO) can make a request on behalf of the collective following appropriate consultation on the needs with partners in-country, specifically ensuring that both UNICEF, country and regional offices and other UN agencies and NGOs are aware of and involved in the request. The request is sent to the Tech RRT programme manager, after which a detailed terms of reference (TOR) document should be finalised within three weeks. The deployment steering committee reviews requests and decides within 48 hours. In general, the TOR for a deployment is agreed by the Tech RRT and the requester before arrival in-country, but is only considered final following discussion in person between the adviser and their in-country supervisor. This brings the technical lens of the adviser together with the contextual knowledge of the supervisor to establish priorities for the short duration of the deployment.

All assignment-related costs, such as travel, staff costs, per diem and accommodation, are covered by the Tech RRT grant. Normally costs for in-country activities, such as to

conduct an assessment or a training, are covered by the requesting agency or as a collaboration with other partners; however the Tech RRT can support or share some of these costs as they should not be an obstacle to the activities taking place. When this is the case, a budget is prepared and discussed with the programme manager

The Tech RRT adviser may be hosted by the requesting agency, another agency on the ground, one of which could be one of the Tech RRT consortium partners. The host agency provides the adviser with administrative and logistical support, the most important aspect of which is security arrangements. When the hosting agency is not the contracting agency, a letter of understanding is signed with the host agency in-country (with the exception of UNICEF, where the Standby Partnership Agreement covers this). The most common scenario is that the Nutrition Cluster makes the request, via UNICEF, and therefore either UNICEF or a consortium partner hosts the Tech RRT Adviser and they sit with the Cluster Coordination Team or one of the Cluster's Technical Working Groups, if it exists.

Occasionally, when there is more demand for Tech RRT support than capacity, or when a request goes beyond the current skill-set of the team, agencies within the partnership (such as Save the Children Humanitarian Surge Team or IMC) may second staff with the right skills, experience and language to the Tech RRT to support a deployment. This adds a great deal of flexibility to the system.

Box 2 Typical activities of Tech RRT advisers

Tech RRT advisers usually work in close collaboration with Technical Working Groups or a Strategic Advisory Group (SAG) when present as part of the Nutrition Cluster, either under their direction or building their capacity.

Assessment: Expertise to assess the situation rapidly may be lacking at the outset of emergency response programmes. Tech RRT advisers can lead, plan and conduct nutrition assessments in close collaboration with nutrition partners and potentially with other sectors; identify and design assessment activities according to needs (this may include initial planning, selection of tools and methods, sampling and writing guidelines); collect information on background/context relevant to the assessment/survey; identify learning needs and build the capacity of different stakeholders in conducting nutrition assessments and methodologies; plan and facilitate technical capacity building/training for government ministries and partner agencies.

See Scott Logue's article in this issue of *Field Exchange* on experiences providing Tech RRT assessment support in South Sudan, Mozambique, Iraq and Yemen.

CMAM: Where acute malnutrition is an urgent priority, technical expertise within individual agencies as well as for the collective response is required to set up or scale up CMAM quickly. Tech RRT advisers can provide technical training, strategic advice and operational support on CMAM rollout (or on a specific component, such as inpatient care, where expertise is needed); assess CMAM capacity building needs across partners; conduct training of trainers (TOT) and orientations for stakeholders; provide support to the MoH and cluster/sector in the development of a CMAM strategy, guidelines or mapping; lead assessments for CMAM set-up or scale-up and advocate for inclusion of CMAM in multi-sector rapid assessments; monitor and provide recommendations/ corrective actions to improve the quality of CMAM programming.

See Simon Koranja's article in this issue on his experiences as Tech RRT CMAM adviser in Nigeria and Yemen and Michele Goergen's article on her experiences in Nigeria.

IYCF-E: In-country-expertise on IYCF-E is often insufficient and there is a need for technically sound and realistic programming support. Tech RRT IYCF-E advisers can lead IYCF-E assessments and advocate for the inclusion of IYCF-E in multi-sector rapid assessments; support the development of an IYCF-E strategy or response plan; lead mapping exercises; guide the establishment of systems for monitoring of the International Code of Marketing of Breastmilk Substitutes; assess capacity-building needs across partners and develop a plan to meet them; conduct TOTs and orientations for stakeholders; advise on integration with other sectors; and provide recommendations or corrective actions to improve the quality of IYCF-E programming.

See articles in this issue by Tech RRT IYCF-E advisers detailing their deployment experiences, including Michele Goergen (Niger and Haiti), Sebsibie Teshome (Iraq) and Isabelle Modigell (Gaziantep, Turkey, supporting cross-border operations into Northern Syria).

SBC: Effective SBC is a critical but often unrecognised tool to reduce deaths, disease and deterioration of nutrition status in an emergency; it can also contribute to improved programme uptake by helping communities to understand the value of these programmes. Tech RRT SBC advisers can provide SBC training, strategic advice and operational support relating to nutrition (as well as sanitation and hygiene); lead SBC assessments (such as barrier analysis); design appropriate and evidence-based SBC national guidelines, response plan and strategy; advise on integration of SBC nutrition and hygiene behaviours with other sectors; adapt and design monitoring and evaluation tools and indicators; assess SBC capacity building needs across partners and develop a plan for meeting them; conduct TOTs and orientation for stakeholders and monitoring; and provide recommendations/corrective actions to improve the quality of SBC programming.

See the article in this issue co-authored by Daniel Takea, who was deployed as Tech RRT SBC adviser to support IYCF-E programming in Iraq.

Tech RRT country deployments

Typical activities of Tech RRT advisers in each of the four areas of expertise (assessment, CMAM, IYCF-E and SBC) are listed in Box 2; these are adapted to each country's needs and are not exhaustive. Since August 2015 there have been 30 Tech RRT deployments, summarised in Table 1. Most have been to chronic emergencies as there have been few large-scale, rapid-onset emergencies in the last two years compared to previous years. Almost all deployments have been to countries with an active Nutrition Cluster/sector coordination mechanism (except Mozambique which in fact took on the same NiE coordination structure for the sector and Iraq which had a Nutrition Working Group under the Health Cluster), likely reflecting the roots of the Tech RRT. Since the mechanism is still young and awareness of the Tech RRT is lower in countries without an established cluster or sector coordination mechanism, most deployment requests come out of proactive engagement with in-country actors. Each deployment is unique in terms of who makes the request, who hosts the adviser and who supervises their work – this depends on the context and is designed for maximum efficiency and ownership by in-country stakeholders. Deployment within 72 hours has rarely been needed as countries need time to make requests, develop TORs and ensure the necessary in-country consultations and buy-in.

Figure 1 gives a breakdown of deployments by technical area, which likely reflects the relative maturity of each within the nutrition sector. IYCF-E is now understood to be important but technical expertise is lacking and therefore requests for technical support are the most common. CMAM is an established intervention and has a greater pool of technical expertise; support is only required when the scale of the problem is vast. SBC in emergencies remains poorly understood and likely explains why requests for Tech RRT SBC are the least common. Many types of assessment require support, but for the most typical (SMART and SQUEAC), longstanding support has been available through the ACF-Canada SMART team and the Coverage Monitoring Network. Therefore, requests for assessment support are also rare.

The Tech RRT also provides remote support during non-deployment time. This is currently guided by the consortium partners and their knowledge of gaps and involvement with global level forum within each technical area. These have included input into global initiatives, such as the revision of the Operational Guidance on IYCF-E (artificial feeding section) and the revision of the CMAM Toolkit (led by Save the Children). Remote support is also provided to countries linked to previous deployments, such as in Yemen to support the Assessment Working Group in the review and validation of survey protocols and assessment results; in Nigeria to review the 2017/2018 response plan; and in Turkey/Syria to draft IYCF components of the Food Security Assessment Report. The team can also respond to stand-alone requests for remote support from countries although not that common, such as in Afghanistan to support the standardisation of nutrition indicators in multi-sector assessments and in Puerto

Rico to support the prioritisation of IYCF-E activities during the first phase of the hurricane response (2017). These have come either directly to the Tech RRT or through the GNC Help Desk and, with priority given to country level needs, the Tech RRT makes every effort to respond and support these

Lessons learned

In the past two years, significant efforts have been made to observe the strengths of the Tech RRT mechanism as well as to learn from the challenges. Table 2 summarises some of the strengths and challenges observed to date. Several important lessons have been learned across the Tech RRT deployments, some of which are highlighted in the Tech RRT case studies in this issue.

Firstly, TORs must be well defined, ideally prior to the adviser's arrival in-country to avoid delays at the start of deployment and to allow the organisation of activities, such as training, to be put in place in advance. Where activities are likely to take longer than the deployment period, such as the development of strategies and guidelines that require buy-in from stakeholders, the role of the Tech RRT should be carefully considered, clearly defined, and embedded within bigger process, led by the cluster, a partner, or a Technical Working Group.

There have been very few requests for deployments in rapid-onset emergencies (other than

Haiti in 2016 and the Caribbean in 2017); in these situations there is often limited capacity to understand the need for nutrition support. The request, TOR development and approval process must be reconsidered for these situations so that the Tech RRT can provide support at the critical onset.

So far the Tech RRT has had a substantial focus on policy-level work, particularly on the development of strategy and guidelines, tasks that largely support UNICEF's role in working with governments. These tasks are critical to ensure an enabling environment for appropriate humanitarian response – i.e. if a guideline isn't in place and endorsed by the MoH, it is unlikely that health workers will be allowed to implement it. However, the Tech RRT wants to be more available and accessible to NGOs for support to their programming and has therefore now opened the scope of potential deployments to individual agencies as well as the collective. This will enable the Tech RRT to make a greater and more immediate difference to the quality and scale of technical programming at ground level as well.

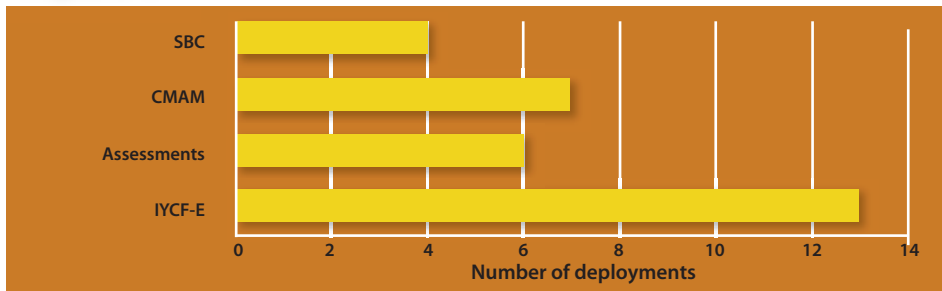
While working for the collective has been the aim of Tech RRT deployments, managing expectations of host agencies and their individual needs has been an important part of negotiating deployments. In principle, if all agencies have a chance to input into the TOR development, the support needs of individual agencies (be it the

Country	Number of deployments	Thematic area	When	Length of deployment (weeks)
Ethiopia	3	CMAM/CMAM	2016 – Jan/Feb	5.6
		IYCF-E	2016 – Jan/Feb	5.6
		CMAM	2017 – Oct-Dec*	6.3
South Sudan	4	Assessments	2016 – Jan 2016 – Jan	3.9
		SBC Assessments	2016 – Mar/Apr	5.6
		IYCF-E	2016 – Mar-May	6.7
			2017 – Oct/Nov*	6.7
Serbia/Greece**	1	SBC	2016 – Jan/Feb	5.1
Syria/Turkey	3	IYCF-E	2016 – Feb/Mar	5.9
		IYCF-E	2017 – Feb/Mar	9.7
		SBC	2017 – Jul/Aug	4.3
Yemen	4	CMAM	2016 – Mar/Apr (remote)	5.7
		CMAM	2017 – Feb/Mar	5.6
		IYCF-E	2017 – Feb-Apr	8.0
		Assessments	2017 – May	4.6
Mozambique	2	Assessments	2016 – Jun-Aug	7.9
		CMAM	2016 – Jul-Sep	6.7
Niger	2	IYCF-E/IYCF-E Assessments	2016 – Jul-Oct	10.1
Nigeria	4	CMAM	2016 – Aug-Sep	5.3
		IYCF-E	2016 – Aug-Sep	4.6
		IYCF-E	2016 – Oct/Nov	5.6
		CMAM – SC	2017 – Jun/Jul	4.9
Haiti	1	IYCF-E	2016 – Oct/Nov	4
Iraq	3	Assessments	2016/17 – Nov-Feb	10.6
		IYCF-E	2016/17 – Dec/Jan	8.6
		SBC	2016/17 – Dec/Jan	8.6
East Africa	1	IYCF-E	2017 – Jan/Feb	2
Somalia	1	IYCF-E	2017 – Apr/May	5.3
Bangladesh**	1	IYCF-E	2017 – Oct/Nov*	2
Total	30			Average: 5.8

* Deployment currently underway

** Deployment covered by private consortium member funds

Figure 1 Breakdown of deployments by technical area



host agency or others) will likely be mirrored by others and should be captured in the TORs. However in practice this has not always happened, creating pressure on the Tech RRT adviser when the host agency asks the adviser to support additional activity not factored into the deployment work plan.

The Tech RRT, configured as a ‘project’ with bilateral funding, has experienced some challenges around the ability to respond to any type of emergency request, as well as the reliability and sustainability of the mechanism. Currently, for example, if a request comes in towards the end of the funding cycle or for a refugee situation, the Tech RRT is unable to respond (refugee situations are not covered by OFDA funding but by another branch of USAID). To overcome these funding-related challenges, alternative funding modalities are being explored, such as models for cost recovery and/or cost sharing to pay deployment costs, providing periodic trainings to generate adviser salaries, as well as looking into pooled funding possibilities.

Much of the work that the Tech RRT advisers have undertaken would, in fact, be carried out more opportunely as nutrition preparedness for emergencies. Eleven out of 14 deployments over the past year had such key activities, i.e. updating guidelines, developing strategies or carrying out certain assessments. With a large proportion of emergencies being of a chronic nature, the line

blurs on when these types of activity should take place, but without them it becomes difficult to programme appropriately. The recent hurricane season has also demonstrated that rapid-onset emergencies are critically in need of nutrition-preparedness initiatives – protecting, promoting and supporting infant feeding was barely on the horizon in the Caribbean, likely resulting in increased morbidity and mortality for these most vulnerable infants. Similarly, new initiatives such as the CMAM surge approach (www.concern.net/resources/cmam-surge-toolkit) are also about preparedness, but to date there are few human resources with the necessary skills to support its implementation. These are key areas that Tech RRT advisers could provide support to during ‘quiet’ times. While it could be argued that this is a role for development actors, it is a job that must be done together, bringing the knowledge and understanding of the specificities of emergencies.

New developments

The Tech RRT has been learning and evolving since its inception. It has recently expanded its scope to provide support to individual agencies, not just the collective, to improve the technical quality and/or scale and reach of agency response. Importantly, the Tech RRT is not a consulting service and in this new venture it will be critical for the Deployment Steering Committee to have clarity on the line between an individual agency’s

responsibility for a programme and how a particular deployment really improves the emergency response. Another new development has been systematic user-satisfaction surveys at the end of deployments to gather information from a wide range of people involved. The team now conducts post-deployment webinars to foster discussion on the situation on the ground, share information about the deployment and improve follow-up and uptake of recommendations. The team is also exploring possibilities to support and strengthen technical capacity of national and local actors. For example, a deployment request has now been submitted by the South Sudan MoH for IYCF-E support; ways to technically support the International Federation of the Red Cross (IFRC) and their national societies is being explored; and a webinar series has been initiated on detailed topics within each specific technical area aimed at strengthening the capacity of national actors.

Way forward

It is imperative that the Tech RRT can work with disaster and emergency-prone countries on emergency-preparedness initiatives, particularly in ‘quiet’ times. These efforts, combined with an increased focus on support and capacity strengthening of local actors, whether governments or local/national NGOs, will go further to build resilience of countries and help them to respond quickly in emergency situations to mitigate their effects.

All Tech RRT advisers already work with countries to integrate nutrition within the programming of other sectors, but to date this has not been the full focus of a deployment. This critical area needs to be taken to a higher level by providing specific support to countries and/or organisations on nutrition-sensitive programming, to integrate nutrition at a minimum with the health, water, sanitation and hygiene and food security sectors.

Finally, there is a need to broaden the funding base for the Tech RRT. Thanks to funding from OFDA/USAID, the Tech RRT has been able to support a range of emergencies since 2015. Pooled funding would allow the Tech RRT to go further in responding to a broader range of situations, including refugee situations and contexts that are not considered humanitarian, and would enable more flexible scope and timeframes (that are not limited to one donor’s remit or funding cycle). Reliable, multi-year, multi-donor funding will provide the greatest flexibility to be able to offer predictable, consistent support from a team of experts in the situations and technical areas where it is most needed.

For more information, contact: Andi Kendle, email: akendle@InternationalMedical-Corps.org or andikendle@yahoo.co.uk

References

Richardson and Ververs, 2015. Evaluation of the support provided by the Global Nutrition Cluster to national coordination platforms, Leah Richardson and Mija-tesse Ververs, February 2015, Recommendation #12, page 49. http://nutritioncluster.net/wpcontent/uploads/sites/4/2015/06/UNICEF_report_homeprint.pdf

Table 2 Strengths and challenges of the Tech RRT mechanism

Strengths	Challenges
<ul style="list-style-type: none"> Ability to rapidly deploy technical experts where needed Flexibility in deployment modalities (i.e. requesting agencies, host agencies, etc.) Consortium partners bring high level of technical expertise and wide reach in countries experiencing emergencies Capacity to mobilise additional human resources in times of high demand from the consortium partners Independence, which aids acceptance of work on deployments in complex environments Possibility of additional funding as a direct result of Tech RRT deployments (according to feedback received by various countries) Overall positive feedback from internal evaluation, deployment performance evaluations and user satisfaction surveys 	<ul style="list-style-type: none"> Getting the TORs right is a time-consuming process (although necessary to gain country-level buy-in and technical input from Tech RRT and the deployment steering committee) Rapid-onset emergencies: coordination systems not in place, little knowledge of what is needed, nobody to request Balance of policy vs programme support Follow-up after deployments, and completion of longer-term initiatives and continuity of functions started by Tech RRT Effective use of non-deployment time Lack of awareness, especially by national/local actors (MoH and NGOs) on availability of the mechanism and who can request/how Balance between cost to manage the mechanism while ensuring appropriate staffing for workloads Restrictions linked to donor mandates on where deployments can take place Short duration of funding and sustainability



Tech RRT CMAM Adviser: Experiences from Nigeria and Yemen

CMAM guidelines review, Yemen, 2017

By Simon Kiarie Karanja



Simon Karanja is a nutritionist with over ten years' experience in nutrition in emergencies, holding various positions in NGOs, UNICEF and the

Global Nutrition Cluster in Kenya, Somalia, Uganda, Sudan, Ethiopia, Sierra Leone and DRC, specialising in CMAM programming, cluster coordination and information management.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

Nigeria

What we know: Technical area: CMAM

Location: Maiduguri, Borno State, Nigeria

Period: 3 August to 9 September 2016

Requesting agency: International Medical Corps (IMC)

Host agency (in-country): IMC

The purpose of the Technical Rapid Response Team (Tech RRT) deployment to Maiduguri, Nigeria, was to support the Ministry of Health (MoH), non-governmental organisations (NGOs), and United Nations (UN) partners to strengthen and scale up the emergency nutrition response through community-based management of acute malnutrition (CMAM) technical capacity building, response coordination, and monitoring and evaluation. The mission was requested, organised and hosted by the International Medical Corps (IMC) Nigeria country office and involved a 50-50 split between direct support to the IMC nutrition team and support to the collective, including the Nutrition Sector.

Key deployment deliverables included:

- A CMAM/infant and young child feeding (IYCF) six-day training for 25 MoH, seven IMC, four Norwegian Refugee Council (NRC) and three Mercy Corp staff. IYCF was included in the context of CMAM to mainstream IYCF support in treatment;
- Support for the UNICEF nutrition programme section to develop a micro-plan for the integration of mid-upper arm circumference (MUAC) screening and mobile outpatient therapeutic programme (OTP) sites to treat severe acute malnutrition (SAM) cases 'on the spot' within a planned mass polio vaccination campaign;
- Support for the State Nutrition Officer (SNO) (Nutrition Sector Coordinator) to map and produce the first 4W (who, what,

where, when) of CMAM programmes and to carry out a gap analysis;

- Technical capacity building of the SNO and two assistant SNOs to effectively plan and conduct programme monitoring, supportive supervision and mentoring. This included a review of CMAM supervision checklists and the planning of a joint sector supervision and mentoring mission (including UNICEF, NGO partners and government nutrition staff); and
- Technical support to the SNO to establish and coordinate the activities of a CMAM technical working group (TWG), including drafting of the TWG Terms of Reference (TOR) and meeting management.

The deployment also involved technical capacity building for the IMC nutrition team on OTPs, blanket supplementary feeding programmes, IYCF and care group programming through on-the-job coaching and technical briefs, as well as technical capacity support on mass MUAC screening (including micro-planning, data analysis and reporting).

Several challenges were faced during the deployment, likely linked to it being among the first undertaken by the Tech RRT. The TOR would have benefited from more input from the Nutrition Sector or MoH; while it included objectives focused on all stakeholders, effort was duplicated in practice with some overlap in roles between the SNO and Tech RRT. In addition, UNICEF brought in three staff through

its surge mechanism to assist the sector on CMAM, which caused some initial confusion. - partners were not clear on whom to submit reports/4W to or whose directions to follow and the SNO was overwhelmed by the different sources of 'support'. Eventually the National Nutrition Sector Coordinator, based in Abuja, was moved to Borno state level to assist and harmonise coordination. These challenges highlight the importance of good coordination and consultation in the development of TORs

There were also challenges in this deployment in balancing host agency demands with those of the collective. Due to unforeseen human resource developments in IMC at field level, additional support to national IMC staff was necessary to help manage the IMC nutrition programme. IYCF and care group programming – both IMC priorities – were also added to the TOR on arrival in the field, likely crossing the line into support to agency specific responsibilities. This impacted on time available for the collective and reinforced the general perception within the Nutrition Sector that the support was largely for the host agency; there was reduced demand from the collective as a result.

The training proved an excellent opportunity to introduce current CMAM technical knowledge and best practice to MoH health staff and to allow them to benchmark their CMAM skills and practices with those of other countries with more established CMAM programmes, such as Ethiopia.

Given the dynamics and the many stakeholders involved in sector coordination in Borno, it was necessary to use networking and persuasion skills to demonstrate the Tech RRT's capabilities and show added value within the Nutrition Sector. This included initiating or suggesting activities valuable to the collective, such as compiling the 4W and gap analysis; encouraging cooperation from the SNO; and providing SNO support behind the scenes.

Yemen

Technical area: CMAM

Location: Sanaa, Yemen

Period: 29 January to 9 March 2017

Requesting agency: Nutrition Cluster

Host agency (in-country): IMC

The main objective of this deployment was to provide technical support and capacity building to Nutrition Cluster members. This focused on the review and update of the national CMAM guidelines and protocols. The mission was requested by the Nutrition Cluster Coordinator (NCC).

Key deliverables included:

- A redrafted interim guideline on CMAM, steered by the Nutrition Cluster Strategic Advisory Group (SAG). This included updating the guideline with current technical knowledge and best practice, a review of monitoring and evaluation (M&E) tools and simplifying the guidelines to make them user-friendly and action-oriented. Support was also provided to the Ministry of Public Health and Population (MoPHP) to organise and conduct a workshop to review the redrafted guidelines. The workshop's output was collated into the new draft guidelines/protocols;
- Organising and leading of a joint monitoring mission of stabilisation centres (SCs), OTPs and targeted supplementary feeding programmes (TSFPs) in three hospitals in Sanaa urban. Observations and recommendations were shared and discussed with cluster members;
- A review of and recommendations for the UNICEF/World Health Organization (WHO)/World Food Programme (WFP) scale-up plan on CMAM. The suggestions included innovations to increase CMAM coverage, such as expanded admission criteria; a combined SAM/moderate acute malnutrition treatment protocol; and MUAC measurement by mothers. Particular consideration was given to implementation through local NGOs with limited capacities. The reviewed document was shared with the NCC as these agency specific plans aim to align with the cluster plan; and
- Working with the Tech RRT IYCF adviser on IYCF integration into the CMAM guidelines. This included mainstreaming IYCF in all chapters and inclusion of a specific IYCF section to ensure referral to IYCF services.

The deployment also provided OTP/SC training, focused on monitoring and supervision training and on-the-job coaching for IMC (host agency) staff (16 in total; 12 in Sanaa and four in Ebb).

The Tech RRT role to facilitate the review of the Yemen CMAM guidelines was well received and appreciated by partners and the MoPHP. The Tech RRT adviser acted as a neutral arbitrator between stakeholders, some of whom were keen to influence the review process to bring the result closer to their existing Standard Operating



Training of health workers in Maiduguri, North-eastern Nigeria, 2017

Procedures (SOPs) rather than find collective ways of working in response to the needs of the whole sector.

There were also challenges in adopting the suggestions for innovation during the final stages of the guideline review. Barriers cited by participants included low technical capacity to adapt/implement innovations; lack of evidence of impact of innovations in the Yemeni context (and lack of related guidelines available in Arabic); and lack of resources to support new initiatives such as expanded admission criteria.

Tech RRT arrival in Yemen coincided with a transition in the leadership of the Nutrition Cluster and the overlapping of an incoming and outgoing NCC; this required careful balancing of the different working styles of the two cluster leaders. Working closely with the national-level Nutrition Cluster SAG and the MoPHP and maintaining a neutral position were both critical to a successful deployment.

In Yemen there was some friction between the host agency (IMC), the Nutrition Cluster and MoPHP regarding how the Tech RRT adviser's time was used for sector-wide versus agency-specific demands. Due to the physical proximity of the Tech RRT adviser to the host agency staff, it is understandable how this dynamic developed.

Reflections from both deployments

In both countries (and in many other instances) support for CMAM programming is closely linked with or integrated into the overall Nutrition Cluster/Sector coordination activities. While this is positive, it does create a potential for overlap or duplication with the cluster's role in existing acute malnutrition treatment programming; this overlap can be avoided with good coordination between the adviser and the cluster as well as with well-defined TORs.

In Nigeria, as outlined earlier, the TOR would have benefited from greater input from the Nutrition Sector or MoH, which resulted in duplicated activities and coordination as well as confusion among stakeholders as to who had ultimate responsibility. There was also limited awareness within the Nutrition Sector of the role and responsibilities of the Tech RRT adviser. These issues also led to initial challenges in creating space within the cluster mechanism to support CMAM rollout effectively.

In Yemen the initial TOR included activities that could not be completed within the short deployment duration and would have been better implemented over a longer period as part of the overall cluster coordination process. For example, the original TOR included bottleneck analysis of cluster partner capacity and development of a cluster preparedness and contingency strategy and plan. From experience, these activities would likely take more than the six-week duration of the mission. The decision to remove them from the TOR was supported by the Nutrition Cluster members.

The overall challenge of identifying CMAM technical capacity and activity (gaps) is not easily addressed within the overall cluster coordination process. In Yemen this was a challenge due to restricted movement, making it impossible to visit CMAM sites or even the NGOs/MoPHP/health facilities to assess their capacities. In addition, NGOs operating in some locations (particularly those in Al Qaeda-held areas) do not participate in the cluster coordination mechanism and there is minimal participation from those operating outside the major towns. It is also very difficult in Yemen to collect information remotely as email is limited. The political and administrative fragmentation makes it difficult to coordinate or bring together all the actors on nutrition/health issues.

In both deployments, the nutrition partners indicated that the Tech RRT resource was ideal to deliver CMAM training, either as a training of trainers or directly to health facility/NGO staff. Staff training is expensive for NGOs and collaborating with health facility staff and joint training significantly reduces the cost. The Tech RRT is arguably in a better position, with greater flexibility, to conduct on-the-job training/mentoring and to provide remote support, compared to consultants frequently used.

The Tech RRT CMAM adviser role may vary by situation. For example, in the initial phase of a sudden-onset emergency, the role may be focused on coordination (scale-up) with less time spent on technical issues. In chronic emergencies, Tech RRT technical skills may be better utilised to improve programme quality and coverage, mentoring and monitoring support.

For more information, contact: Simon Karanja, email: kiariekaranja@gmail.com or skaranja@unicef.org

Tech RRT IYCF-E/CMAM Adviser: Experiences from Niger, Haiti and Nigeria

By Michele Goergen



Michele Goergen has been an IYCF-E/CMAM adviser with the Tech RRT for one and a half years. She is a registered dietitian who has worked on designing and implementing nutrition programmes worldwide for the past seven years, including CMAM and IYCF programs in DRC, Sierra Leone and Niger; working to reopen CMAM programs after Ebola in Liberia; and training IYCF counsellors to work in refugee camps in Greece.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.



Niger

What we know: IYCF-E and assessment

Location: Diffa, Niger

Period: 28 July to 7 October 2016

Requesting agency: Nutrition Cluster/Save the Children

Host agency (in-country): UNICEF

A security crisis in 2016 in Diffa, Niger, led to massive population movements and significant deterioration in an already precarious humanitarian situation. This area had previously been weakened by recurrent food crises, malnutrition in all its forms, floods, epidemics and limited access to basic social services. Both the local population and refugees from Nigeria and Chad were affected, with women and children particularly at risk. The Nutrition Cluster in Niger and Save the Children requested the Technical Rapid Response Team (Tech RRT) to conduct a Rapid SMART assessment and an infant and young child feeding (IYCF) assessment and to use the results to develop an IYCF in emergencies (IYCF-E) strategy and action plan for host communities, refugees and people living in sites for internally displaced persons (IDPs).

A Tech RRT adviser was deployed to conduct a Rapid SMART assessment in the IDP sites on the border with Nigeria to evaluate the nutrition status of children under 59 months of age (anthropometric data was collected for children aged 6-59 months and health data for children aged 0-59 months). A national SMART survey was in progress but did not include the IDP sites, hence the need for the Tech RRT-led assessment. The Rapid SMART survey was conducted jointly with the National Institute of Statistics (INS Niger) and UNICEF and the results were validated by the district health team and nutrition partners in Diffa and nationally in Niamey by the country cluster coordination team (involving public health ministry staff, INS and nutrition partners). The Rapid SMART assessment found the prevalence of acute and chronic malnutrition 'serious' based on World Health Organization (WHO) evaluation thresholds, as follows: global acute malnutrition (GAM): 13.6 per cent (9.1 to 20.0 95 per cent CI); severe acute

malnutrition (SAM): 2.4 per cent (1.1 to 5.2 95 per cent CI); stunting: 36.2 per cent (30.3 to 42.5, 95 per cent C.I.); underweight: 30.4 per cent; severe underweight: 10.2 per cent.) Results of the Rapid SMART survey were validated alongside those of the national SMART survey; there was consistency between the results of both.

Several recommendations were issued as a result:

- Increase the frequency and regularity of active screening at all displaced sites in Diffa;
- Activate enhanced surveillance of the food security situation in the region;
- Ensure that the most vulnerable people receive food distributions, including appropriate complementary foods for children;
- Promote IYCF-E best practices to ensure health workers and community members understand how to counsel pregnant and lactating women (PLW) and children under 24 months of age;
- Strengthen vitamin A supplementation and deworming in children aged 6 to 59 months; and
- Improve linkages with water, sanitation and hygiene (WASH) programmes.

The same Tech RRT adviser conducted an IYCF assessment in the IDP sites to understand priority programme needs and develop a response strategy and action plan. This was conducted jointly with the District Health Team in Diffa and implementing partners from other international non-governmental organisations (INGOs). Both also participated in the strategy planning workshop. The assessment revealed many concerns caregivers had in feeding their children. Challenges varied from perceived reduced breastmilk supply resulting from maternal malnutrition and stress, to lack of access to ap-

propriate complementary foods. With this information, the Tech RRT adviser worked with the district nutritionist and implementing partners to determine IYCF programme bottlenecks and develop an effective IYCF action plan to address the issues illuminated by the assessment. IYCF assessment results were validated and presented by the Tech RRT adviser at both district and national levels. Identified areas for action were: interventions to increase exclusive breastfeeding rates, especially after two months of age; support to mothers reporting stress, breastmilk insufficiency and inadequate food intake (as their main difficulties when breastfeeding); inclusion of PLW and families with children aged 6-24 months to receive emergency food rations and complementary food rations to help improve dietary diversity scores; and improved awareness among mothers of available health services and IYCF activities (support groups, counselling) in the IDP sites (many mothers were not aware of existing services).

Following the assessments, a two-day workshop led by the Tech RRT adviser was held for district health workers and implementing partners (totalling 30 participants) to develop an action plan to address priority needs and strengthen existing IYCF programming. Interventions included in the plan were mother-to-mother support groups and inclusion of PLW and children under two years of age as target groups in multi-sector interventions. Once this was completed, IYCF-E training was delivered to over 30 participants, including field workers currently implementing IYCF and nutrition programmes. This focused on the key IYCF-E elements of the action plan and aimed to increase technical capacity of field workers on IYCF practices and counselling. An abridged training curriculum, using standard resources and case studies adapted to the Diffa context, was used. Participants largely comprised Save the Children staff and district nutrition team members. The training was well received by field workers, who reported improved understanding of the key elements of IYCF-E and improved skills to respond to problems faced by mothers and caregivers. On departure of the Tech RRT adviser, the district nutritionist and Save the Children assumed leadership of the programme.

Haiti

What we know: IYCF-E

Location: Haiti

Period: 14 October to 11 November 2016

Requesting agency: International Medical Corps (IMC)

Host agency (in-country): IMC.

Tech RRT support was initiated by the Tech RRT Steering Committee after Hurricane Matthew devastated homes, harvests and infrastructure in five departments in Southern Haiti in 2016. The mission was to help design an IYCF-E response package by assessing priority needs and strengthening the capacity of nutrition stakeholders to include IYCF-E indicators in assessments and programme monitoring. IMC hosted the Tech RRT and UNICEF provided technical supervision. The Nutrition Cluster was not activated; in the south of the country, only a health cluster was activated and in Port au Prince nutrition coordination was just gaining momentum.

As an immediate action, a joint IYCF statement was drafted by the Tech RRT (this was an updated version of a statement issued in the 2010 earthquake response) and, led by UNICEF in coordination with the Ministry of Public Health and Population (MSPP), was disseminated to key partners.

A rapid IYCF assessment was conducted in eight of the worst hit sites in Southern Haiti to better understand the impact of the hurricane on IYCF practices. Sixteen focus group discussions were held with caregivers of children under 24 months of age (n=89) and 42 health workers. Results helped pinpoint priority needs for IYCF emergency interventions and identify the most effective measures to improve IYCF practices

for children under two years of age. Key findings included: low to zero dietary diversity due to limited availability of food; mothers believing that their breastmilk was finished or no good because they were hungry; and high rates of infant formula and bottle use (using infant formula purchased from markets). Other difficulties noted were fatigue and poor sleep of mothers; diarrhoea, cough and fever in infants; lack of potable water; unequal distribution of food items; and collapse of health systems, including existing IYCF and nutrition programming. There was a lack of interest in the community to continue IYCF/nutrition programmes as people were prioritising the reconstruction of homes, dealing with the lack of food and money and avoiding illness. Results of the assessment were presented to health officials and NGO partners for validation and discussion. An IYCF-E response plan was developed by the Tech RRT adviser, supported by a workshop attended by nutrition partners from the south of the country. In addition, a key IYCF message sheet was developed and shared with all partners to encourage inclusion of IYCF in multi-sector responses, such as including trained IYCF counsellors (who already existed in Haiti) in emergency mobile clinics and cholera clinics.

A number of challenges associated with the rapid-onset nature of the emergency hindered the completion of all objectives in the terms of reference (TOR) for the deployment. On the Tech RRT adviser's arrival, the nutrition emergency response received minimal support from the MSPP at central and departmental level; health issues, specifically the cholera response, mobile medical clinics and food distributions were priorities at that point rather than nutrition. In addition there was no IYCF technical working group or platform to discuss technical issues at departmental level. IYCF needs were identified in the assessments and a response plan developed, but responsibility to take this forward and the



View from outside of a health facility following Hurricane Matthew, Grande Anse, Haiti, 2016

Michèle Georgan

best modalities to deliver on activities could not be identified in the absence of engagement by the MSPP. At the time of Tech RRT deployment, national nutrition coordination was just evolving; a nutrition working group was set up at Port au Prince and UNICEF was recruiting to increase nutrition programme capacity. Finally, the TOR included IYCF-E and response plan trainings, however participants were not available for training within the deployment's short timeframe. After the Tech RRT deployment ended the nutrition working group followed up on outstanding TOR objectives.



Community mapping for rapid SMART assessment in Diffa, Niger, 2016

Michèle Georgan

North-eastern Nigeria

What we know: CMAM

Location: North-eastern Nigeria

Period: 23 June 2017-27 July 2017

Requesting agency: Nutrition Sector

Host agency (in-country): UNICEF

In Northern Nigeria the Tech RRT was deployed to help improve the quality of care in stabilisation centres (SCs) across Borno and Yobe states. Northern Nigeria has been in a state of violent conflict for the last few years, causing unprecedented movement of populations. The conflict has left a significant number of people with limited access to food. The onset of the lean season in June 2017 impacted the situation negatively, leading to increased rates of SAM. This created a need to improve reach and quality of community-based management

of acute malnutrition (CMAM) services, particularly services offering inpatient management of SAM with medical complications.

The Nutrition Cluster requested a Tech RRT adviser to undertake the following:

- Assess the capacity of health staff in the management of SAM with complications;
- Train a team of coaches to follow up on SC trainings conducted by WHO and the NGO ALIMA; and
- Development of a 'Stabilisation Centre Capacity Building Plan and Scale-up Strategy', including quality improvement, standardisation of service delivery and scale-up of inpatient services in Borno and Yobe States.

The capacity assessment was conducted in seven SCs in Borno and Yobe States and involved interviews with 43 SC staff. Estimating that 10 per cent of outpatient therapeutic programme (OTP) cases require inpatient treatment, an analysis of admissions revealed that only 22 per

Coaching and scale-up strategy planning in Yobe State, Nigeria, 2017



cent of estimated complicated SAM cases were admitted to an SC at the time of analysis. Fifty technical questions were asked during the assessment. These were based on admissions; nutrition and medical protocols; follow-up; discharge; reporting; stock management; nutrition education and play; and hygiene and overall SC set-up. The results revealed an overall SC capacity score of 75 per cent and noted individual scores for each SC included in the assessment. Some were supported by NGO partners and operating at very high levels, while others were struggling to operate and meet standards. The areas that scored the lowest were execution of national nutrition and medical protocols, overall hygiene and SC set-up. Borno state ranked higher on following nutrition and medical protocols and lower on reporting; Yobe state showed the converse, with higher marks in reporting and lower marks on the nutrition and medical protocols. Other challenges revealed were weak referral systems with limited linkages between OTPs and SCs, limited training and post-training follow-up, and challenges regarding accessibility of services due to insecurity.

As a result, a capacity development plan was developed with the overall goal of contributing to a reduction of under-five mortality by increasing access to high-quality treatment of SAM with complications; WHO is taking the responsibility to carry this plan forward. Part of the capacity development plan was to train teams of coaches to conduct on-the-job coaching in all SCs to improve quality of treatment. Two three-day coaching workshops were held with a total of 23 (nine from Borno; 14 from Yobe) state health/NGO staff participants. A four-step coaching process was presented that involved observing the work in the SCs, noting strengths and areas for improvement then working with the SC team to improve capacity.

Following this a scale-up plan was developed jointly with the State Nutrition Officer and the Health Management Board. This analysed the areas that lacked SC coverage and presented a three-phase plan to open an SC in each local government area in every state. The Nutrition Cluster and WHO took the lead in executing these plans on departure of the Tech RRT adviser.

A challenge in the initial stages was the time taken to develop the TOR. The deployment was

clearly needed but it took a long time (five months) to get buy-in and sign-off from UNICEF as it was necessary to ensure that the TOR was in line with the long-term work already underway with the government in supporting SCs. A positive effect of this long lead in time was that all involved were well prepared and 'on board' when the deployment finally happened.

Reflections from all deployments

Typical deliverables across deployments are IYCF assessments in the wake of insecurity and natural disasters; development of IYCF-E response/implementation/action plans; facilitation of workshops to analyse and validate assessment results; and IYCF-E orientation and trainings. CMAM deployments for this adviser followed the same type of deliverables, such as assessing capacity and developing response plans and trainings.

Across all the deployments, key partners had challenges distinguishing between IYCF and IYCF-E programming, likely reflecting the weak capacity for IYCF programming pre-crisis, which in turn means limited knowledge and programmes to build upon when the crisis hits. The focus of IYCF-E programmes is on immediately saving lives by protecting, promoting and supporting the needs of lactating women and infants under 24 months of age in the context of an emergency. Different levels of intervention will be necessary, depending on the context. IYCF programmes take more time to establish and provide more

intricate IYCF technical support with (usually) a large behaviour-change component. This involves strengthening the policy environment for the International Code of Marketing of Breastmilk Substitutes, strengthening capacity of health workers at both facility and community levels, and improving the quality of the diet of young children. When these activities are taking place pre-crisis, the building blocks are there for an effective emergency response. Other common findings are: lack of inclusion of planning on IYCF-E in national nutrition plans and emergency response plans; limited awareness of IYCF indicators to use in multi-sector assessments; difficulty in monitoring violations of the International Code of Marketing of Breastmilk Substitutes; and limited knowledge of IYCF-E programme monitoring and evaluation. Follow-up requests post-deployment have been for more IYCF-E monitoring tools.

In the wake of the hurricane response in Haiti the rapid IYCF assessment, development of a joint statement and an IYCF response plan were crucial; however low prioritisation of IYCF by government and partners and lack of programming platforms to integrate IYCF limited putting plans into practice in the immediate term. In the context of an acute emergency, including training is more challenging within the Tech RRT deployment timeframe as staff are much less available due to acute project priorities.

The Nigeria deployment provides an ideal example of how the Tech RRT can contribute and improve emergency nutrition responses. In this case, partner organisations were available to contribute to assessments and trainings and provide inputs into national strategies. The need for the request was clear. Since the completion of the deployment, Nigeria has received additional funding for SC scale-up activities. This shows the dedication of the team on the ground and how Tech RRT support can feed into longer-term response plans.

For more information, contact: Michele Goergen, email: mgoergen@InternationalMedicalCorps.org



The group on completion of training on the IYCF-E response plan in Mogadishu, Somalia, 2017

Qayyarah camp before opening, Nineveh Governorate, Northern Iraq, 2016

Tech RRT Assessment Adviser: Experiences from South Sudan, Mozambique, Iraq and Yemen

By Scott Logue



Scott Logue has been the Assessment Adviser with the Technical Rapid Response Team (Tech RRT) since the project started in the autumn of 2015. He has a Masters degree in Applied Human Nutrition and has acquired extensive assessment experience over the past five years working in various emergency and development contexts.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

South Sudan

What we know: Assessment

Location: Juba, South Sudan

Period: 3 to 29 Jan 2016; 27 March to 13 May 2016

Requesting agency: Nutrition Cluster

Host agency (in-country): Action Against Hunger

To date there have been two Tech RRT assessment-related deployments in South Sudan, in the first half of 2016, both requested by Action Against Hunger with Nutrition Information Working Group (NIWG) endorsement. These were among the Tech RRT's first deployments. The main objective of the first deployment was to provide technical and coordination oversight to the NIWG, a sub-group of the Nutrition Cluster. The primary objective of the second deployment was to oversee the implementation of two nutrition surveys and to continue to provide support to the NIWG.

The key deliverables for both deployments included:

- Support to the NIWG in validating surveys submitted to it and strengthening their capacity to undertake this process. This included feedback on several surveys; identification of areas requiring increased capacity within the NIWG; creation of preliminary and final report templates based on SMART methodology templates, tailored to the South Sudan context; and a presentation on the validation of data collection process using Emergency Nutrition Assessment (ENA) for SMART software with sample data sets.
- Assistance to the survey manager in planning the Leer nutrition survey. This included meeting with partners to learn about the context in Leer; support to establish partnerships to implement data collection (to arrange accommodation, transport, government approval, recruitment and security); and support to the survey manager to develop and present the survey protocol and reports.
- Attendance to Integrated Phase Classification (IPC) meetings held in Juba in April 2016 and support to nutrition colleagues to

identify priority counties and complete IPC-specific worksheets.

- Presentation of a session to the NIWG on the importance of translating survey questionnaires, using the Bentiu Protection of Civilian (POC) site survey in the Nuer language.
- Provision of support to both Surveillance and Evaluation Team (SET) survey managers for the Guit County and Bentiu POC surveys. Support was provided remotely from Juba and one field visit was carried out for each survey. Support included writing and presenting survey protocols and support for data analysis and report writing.

South Sudan is the only country that the Tech RRT assessment adviser has been deployed to twice. One benefit of a follow-up deployment was to see whether capacity-building activities introduced in the first deployment were being implemented; this visit confirmed that the validation tools and procedures introduced to the NIWG were being used.

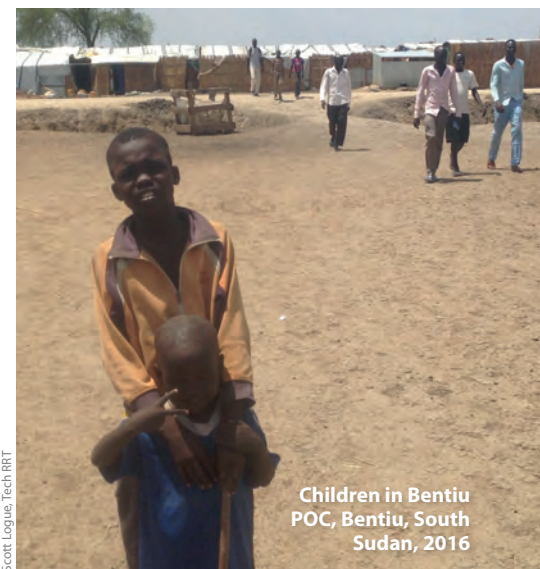
Several challenges were encountered during the South Sudan deployments, which were at the beginning of the Tech RRT project. As a result, partners were unfamiliar with the project and on several occasions assumed that the Tech RRT assessment adviser was a staff member of the host agency, Action Against Hunger. On deployment, it was not initially known if Tech RRT advisers would have the capacity to support additional requests such as those coming through the Global Nutrition Cluster (GNC) Helpdesk requests while in-country. In this case, during the second week of the first deployment, the GNC forwarded a request for support to multiple surveys being conducted in besieged areas of Syria. This additional request was initially supported but was then found to be too much on top of deployment activities, so Centre for

Disease Control (CDC) was able to provide this additional support that Syria needed.

Logistical challenges were frequent in both deployments. A few days before the start of the training for the Leer survey, it was determined that staff could no longer stay at the previously agreed accommodation and limited vehicles were available. Both issues were resolved. Vehicles were also a concern at the Bentiu POC survey due to limited availability and those that were available were prone to breaking down during data collection.

Obtaining up-to-date population figures for the assessment was difficult due to recent population displacement. This was compounded by the fact that some areas were under the control of the Sudan People's Liberation Movement-in-Opposition (SPLM-IO) while others were under government control. The survey managers met with the appropriate individuals to obtain demographic figures, but once in the field it was determined that the population figures provided were overestimated in many clusters.

There were also several unforeseen delays throughout the training and data collection phases of the assessments. These delays included staff strikes, adverse weather conditions, security problems and vehicle breakdown. In future, additional days must be included into the planning when conducting assessments in South Sudan.



Children in Bentiu POC, Bentiu, South Sudan, 2016

Mozambique

What we know: Assessment

Location: Maputo, Mozambique

Period: 12 June to 6 August 2016

Requesting agency: Nutrition Cluster

Host agency (in-country): UNICEF

The objective of the deployment to Maputo was to build the capacity of response stakeholders in the design, implementation, analysis and reporting of nutrition assessments (including the Technical Secretariat for Food Security and Nutrition (SETSAN) assessment) and advise on the overall strengthening of routine data management in line with the needs and requirements of the emergency nutrition response. This was to be done in coordination with the Ministry of Health (MoH) and the Nutrition Cluster.

The key deployment deliverables included:

- Leading anthropometric demonstration sessions at national level (for use of mid-upper-arm circumference (MUAC), weight and height) and leading and performing an analysis for an 11-province, MUAC-only, standardisation test.
- Creation of a template that was used during partner data quality checks, which were used throughout the data collection process for the SETSAN assessment.
- Facilitation of provincial training sessions for six provinces on the collection of data from SETSAN colleagues so that ENA plausibility checks could be performed.
- Provision of preliminary data analysis for all six drought-affected provinces and final results reports for Tete, Manica, Gaza and Inhambane provinces.
- Creation of a document titled Road Map for Strengthening Future SETSAN Assessments with urgent recommendations for all nutrition partners and government colleagues based on observations and best practice.

One of the original deliverables of the deployment was to lead all phases of an assessment in one of the provinces. However, this was changed in order to provide additional support for the SETSAN assessment.

There were some challenges during the deployment. Quality issues had been found with previous SETSAN assessments and it took a significant amount of time and various proposals before an agreed plan was reached with the Nutrition Cluster to improve the quality of data collected. This delay can partly be attributed to the Tech RRT adviser not being able to meet with the cluster as a group until a couple of weeks after arrival, despite significant effort by the Nutrition Cluster Coordinator to do so; the Nutrition Cluster had just recently met and was not practical to reconvene so quickly, further complicated by a changeover in the Nutrition Sector Coordinator. Language barriers also presented a challenge at times as the Tech RRT adviser could not speak Portuguese and several background documents were not available in English.

Iraq

What we know: Assessment

Location: Erbil, Iraq

Period: 23 November 2016 to 4 February 2017

Requesting agency: UNICEF

Host agency (in-country): UNICEF

The main objective of the deployment to Erbil was to provide technical support on assessments and build the capacity of stakeholders involved in the humanitarian response to the Mosul crisis. Support involved planning and leading a nutrition survey in internally displaced persons (IDP) camps, established as a result of the crisis. The

requesting agency was UNICEF, in their role to support the emergency response, particularly as the Nutrition Cluster was not activated and coordination was instead located in a technical working group within the Health Cluster.

The key deployment deliverables included:

- Creation of the survey protocol and support to UNICEF and MoH for questionnaire development.
- Provision of enumerator survey training for MoH and UNICEF staff and leading the data collection, data entry, nutrition analysis and reporting/presenting of the nutrition-related results from the IDP camps surveyed.

The rapidly changing population of all six IDP camps in the period leading up to data collection

(most increasing in population; two decreasing) presented a key challenge during deployment. The selection of clusters was therefore necessarily delayed until only a few days before data collection to ensure a representative sample. This made it difficult to submit a plan for security and checkpoints that left sufficient time in advance of data collection. In addition, camps were located up to two hours travel away from Erbil and security protocol required that teams returned to the Erbil checkpoint by 4pm each day.

See also the article in this issue of *Field Exchange* that describes experiences from the perspectives of the IYCF-E and social behavior change communication (SBC) Tech RRT advisers during their deployment during the same period to Iraq.

Yemen

What we know: Assessment

Location: Sana'a, Yemen

Period: 30 April to 31 May 2017

Requesting agency: Nutrition Cluster

Host agency (in-country):

Action Against Hunger

The objective of the deployment was to strengthen the overall emergency nutrition response by building the capacity of response stakeholders in the design, implementation, analysis and reporting of nutrition assessments at national and sub-national level. This was accomplished by providing technical support and capacity building to the Assessment Working Group (AWG), a subgroup of the Nutrition Cluster.

The key deployment deliverables included:

- Creation of a database of Yemen nutrition assessments based on the GNC Nutrition

assessment template.

- Facilitation of a workshop by the Tech RRT assessment adviser with AWG partners to determine priority indicators and accompanying questions to include in all governorate-level nutrition assessments as part of the development of a Yemen standard SMART survey questionnaire.
- Facilitation of a two-day Yemen Nutrition and Mortality Guideline workshop and creation of the *Yemen National Guidelines for Conducting Integrated Anthropometric and Mortality Surveys*, which is currently in the process of being validated.

There were a few challenges with this deployment. Due to the delay in receiving a visa (this took four months) and circumstances beyond the control of the Tech RRT, the deployment could only be for approximately one month. As a result the terms-of-reference (TOR) deliverables had to be modified and a great deal of remote support was required post-deployment. It took a lot of time to gather the required information to de-

termine what demographic data to use for cluster and household sampling for nutrition and mortality surveys in Yemen. It became evident early in this process that there would likely be slightly different sources for urban and rural settings. The information-gathering process included several meetings with AWG colleagues and the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), as well as colleagues who attended the two-day Yemen Nutrition Survey Guideline workshop. All this information was consolidated and is now included in the Yemen National Guidelines for Conducting Integrated Anthropometric and Mortality Surveys. While this deployment increased capacity of the AWG and created momentum for appropriate processes around surveys, the Tech RRT assessment adviser will continue to provide remote support for several more months using a capacity strengthening approach to solidify their new skills and knowledge.

For more information, contact: Scott Logue, email: slogue@actionagainsthunger.org

IYCF-E Tech RRT support: Experiences from Iraq

Infants in an IDP Camp in Erbil, Iraq, 2016

© UNICEF/Daniel Hadgu Takea 2016

By Sebsibie Teshome, Tech RRT IYCF-E adviser seconded from Save the Children, and Daniel Hadgu Takea, Tech RRT SBC adviser



Sebsibie Teshome is a humanitarian nutritionist with over 15 years' experience in national and international emergency and development contexts, including in Ethiopia, South Sudan, Yemen, Mozambique, Iraq

and Nigeria. He is currently Nutrition Adviser in the Humanitarian Surge Team at Save the Children UK.



Daniel Hadgu Takea has worked as a public health nutritionist for over 15 years in Ethiopia, Pakistan, Yemen, Nigeria, South Sudan, Kenya, Mozambique and Iraq on emergency humanitarian response and

capacity building. He is currently continuing his education in the UK.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

Iraq

What we know: IYCF-E and SBC

Location: Erbil, Iraq

Period: December 6 2016 to February 4 2017

Requesting agency: UNICEF

Host agency (in-country): UNICEF

The conflict between armed groups in Iraq has had profound humanitarian consequences; by 2016 nearly ten million people were in need of humanitarian assistance and around 188,000 people were displaced. The Nutrition Cluster was not formally activated in the Mosul emergency response; instead, a Nutrition Technical Working Group (NWG) was established within the Health Cluster. The NWG was suspended in April 2016 (due to the departure of the UNICEF-engaged nutrition specialist leading it) and reactivated on December 14 2016 following the deployment of a Nutrition Cluster Coordinator from the Global Rapid Response Team (RRT)¹. Clearly, this lack of continuity has implications on the quality and speed of emergency response, with preparedness diminishing if the structure that was established is not maintained.

A nutrition assessment adviser, a social behavioural change (SBC) adviser and an infant and young child feeding in emergencies (IYCF-E) adviser were deployed by the Tech RRT mechanism at the request of UNICEF Iraq to provide surge support for UNICEF, the Ministry of Health (MoH) and nutrition partners. The Tech RRT assessment adviser was deployed in the third week of November 2016 for 11 weeks. The Tech RRT SBC and IYCF-E advisers were deployed in the first week of December 2016 for nine weeks. Details of the assessment deployment are included in this issue of *Field Exchange*. The experiences of the IYCF-E and the related SBC deployment are shared below.

The Tech RRT SBC adviser supported the MoH and UNICEF by conducting barrier analysis surveys on infant and young child feeding (IYCF) in eight internally displaced persons (IDP) camps to feed into an SBC strategy. Training was also provided on barrier analysis for health workers from MoH and nutrition partners (Samaritans Purse and the World Food Programme (WFP)). The survey revealed that the main barriers to optimal IYCF practices were birth complications, perceptions of insufficient breast milk, maternal stress and sickness (as barriers to breastfeeding) and mother's workload, infant sickness and concerns about infant overweight (leading to sub-optimal complementary feeding practices). Recommendations included skilled breastfeeding support by birth attendants and, in the community, a referral system for women with breastfeeding difficulties, dissemination of key IYCF messages to support optimal practices and community cooking demonstrations. An SBC strategy for IYCF was developed based on these findings. (To access these documents, go to <http://techrtr.org/past-deployments/>).

Informed by the work of the Tech RRT SBC adviser, the Tech RRT IYCF-E adviser provided technical support on advocacy, capacity building, development of IYCF action plans (to provide support for breastfed and non-breastfed infants), and development of guidelines for the management of breastmilk substitutes (BMS), particularly in the camp setting. Health workers from MoH and nutrition partners were trained on IYCF-E to provide support for breastfed and non-breastfed infants in the IDP camps. A workshop was also held to create awareness among different sectors of the importance and integration of IYCF-E into sectors such as water, sanitation and hygiene (WASH), health and food security.

A key challenge to this deployment was the many long-existing barriers to optimal IYCF practices in this context, including low prevalence of exclusive breastfeeding in Iraq pre-crisis (19 per

cent, MICS 2011), low early initiation of breastfeeding (42.8 per cent) and high bottle-feeding prevalence (37 per cent). Infant formula had been included in public food distributions for more than 20 years; untargeted distribution only ceased in February 2017 after successful advocacy from United Nations (UN) agencies and international non-governmental organisations (NGOs). The International Code of Marketing of Breast-milk Substitutes legislation (incorporated in 2015) is poorly enforced. Emergency response within this bleak IYCF panorama is nearly an impossible feat, emphasising the role of development programmes that lay the foundation that can be built upon when the crisis hits.

The deployment of Tech RRT advisers was timely to provide technical surge support. However, despite a dedicated NWG within the Health Cluster, nutrition was not prioritised and nutrition/IYCF activities, indicators and budget lines were not included in the 2016 or the 2017 Humanitarian Response Plan (HRP). This was quite shocking given the poor IYCF landscape and compared to contexts with a formally activated nutrition clusters. Furthermore, few partners were implementing nutrition programmes, likely due to its absence in the HRP and the consequent lack of funding for them. Thus the benefit of anticipated collective deliverables and objectives was mostly limited to UNICEF and the Directorate of Health (DoH). While breastfeeding support programmes were established in IDP camps (DOH/UNICEF/Samaritans Purse), there was a gap in programmes for the management of BMS for non-breastfed infants

An SBC strategy was critical to respond to IYCF barriers identified in the survey; however this was hampered by the fact that the SBC IYCF approach designed prior to deployment was not context-specific, so adapting it to suit the context took more time than anticipated. There was also a lack of capacity among stakeholder staff to implement SBC.

Other practical challenges faced in this deployment were the unavailability of nutrition coordination staff (staff were at times unable to participate actively due to the nature of the crisis) and the time it took to build consensus on priority technical support; with three technical experts requested at once, more coordination was required, which was further constrained by limited coordination by the NWG and overwhelming emergency needs. UNICEF has since hired a full-time nutrition specialist that is now based in Erbil, Iraq, who is working on IYCF issues.

For more information, contact: Sebsibie Teshome, email: s.teshome@savethechildren.org.uk or Daniel Hadgu Takea, email: danielhadgu@hotmail.com or SLNDTAKE@ljmu.ac.uk

References

MICS (2011) Iraq multiple indicator cluster survey, 2011. Volume 1: Final Report. Available from: <http://mics.unicef.org/surveys>

¹ The RRT is the result of a partnership between the Global Nutrition Cluster (GNC) and five GNC partners that aims to support cluster coordination and information management through rapidly deployable Nutrition Cluster Coordinators (NCCs) and Information Management Officers (IMOs).

Destruction in
East Aleppo City,
Syria, 2017

Tech RRT IYCF-E support for Aleppo response, Northern Syria

By Isabelle Modigell



Isabelle was a Tech RRT IYCF-E Adviser from 2016 to 2017, prior to which she was part of Save the Children's humanitarian surge team, rapidly deploying to emergencies to support assessments, programme design and set-up. Isabelle is currently working as an IYCF-E consultant, based out of Yangon, Myanmar.

The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.

Turkey-Syria cross-border 2016

What we know: Infant and Young Child Feeding in Emergencies (IYCF-E)

Location: Gaziantep, Turkey (Response: Aleppo, Northern Syria)

Period: 18 February – 30 March 2016

Requesting agency: Turkey-Syria cross-border Nutrition Cluster

Host agency (in-country): Save the Children Turkey

By 2016 an estimated 13.5 million people needed humanitarian assistance in Syria; 4.5 million of whom were in hard-to-reach and besieged areas. At the start of February 2016 intensified conflict caused a new wave of internally displaced persons (IDPs) to flood into the governorates of Aleppo (63,000) and Idlib (over 12,000), in addition to the more than two million IDPs already there. By February 2016 some camps were at triple capacity, with two or three families occupying tents intended for one or living in communal tents, informal settlements or under trees.

Prior to the Syrian crisis infant and young child feeding (IYCF) practices were already sub-optimal (46 per cent early initiation of breastfeeding, 43 per cent exclusive breastfeeding at two years of age, 37 per cent timely introduction of complementary foods, and wide acceptance of the use of breastmilk substitutes (BMS) (UNICEF, 2012). Rapid needs assessments of IDP areas in Northern Aleppo in 2016 revealed a high-risk situation for infants and young children, with widespread distribution of infant formula, poor availability of complementary foods, lack of safe water supply, mothers reporting breastfeeding difficulties, low awareness of recommended IYCF practices and a lack of adequate skilled support for breastfeeding mothers. In addition there was a lack of protection and support for non-breastfed infants and regular one-off BMS distributions without any support or measures to minimise risks.

In early 2016 the Nutrition Cluster requested a Tech RRT IYCF-E adviser to work with cluster members for six weeks to lead and support an IYCF-E response to the recent wave of displacement.

Key deliverables of the deployment were:

- Mapping of IYCF-E priority needs and partner capacities;

- Provision of technical support to the Nutrition Cluster co-ordinator and IYCF-E technical working group (TWG) co-chair on IYCF-E;
- Provision of technical support on the procurement, management, distribution and use of BMS, milk products, commercial baby food and infant feeding equipment, and guidance on uncontrolled donations of these products;
- Support to establish links with other sectors, including the integration of IYCF into community-based management of acute malnutrition (CMAM) programming and the integration of IYCF into health and other clusters;
- Capacity building of Nutrition Cluster partners to set up/scale up IYCF-E activities through orientation, training and on-the-job remote support; and
- Facilitation of consensus on common messaging relating to IYCF-E and provision of technical support on a communication/advocacy campaign.

There were several operational challenges in this deployment. Firstly, the working language for most Nutrition Cluster partners is Arabic, which the Tech RRT IYCF adviser did not speak. This made it difficult to gain rapid insight into partner programming, identify pre-existing tools and produce outputs at speed. A translator was available, but only part-time. In post-deployment feedback, it was recommended that in future deployments potential language barriers should be anticipated in advance and a skilled translator, familiar with technical terminology, should be engaged early for the duration of the deployment.

There were also challenges associated with remote programming. It was not possible to enter Syria directly to observe operations, so the Tech RRT adviser was reliant on information provided by partners whose capacity to imple-

ment IYCF-E programmes still required strengthening. In such circumstances, a broader range of technology (such as web-based technology) could be used to facilitate remote ways of working, including remote supervision.

Due to low quality of data shared by partners it was difficult to gain an accurate picture of partner capacity, as well as current and future plans. The use of simpler formats for data collection (such as KOBO questionnaires – a suite of tools for field data collection for use in humanitarian/development contexts), all accurately translated into Arabic, was proposed to help improve this.

Another challenge emerged regarding BMS distribution. IYCF-E programming was relatively new to most implementers, many of whom had previously worked in a medical sector in which BMS prescriptions were the norm. Some actors distributing BMS did not respect minimum standards but, since they operated outside of the Nutrition Cluster, were difficult to hold to account. More comprehensive BMS distribution monitoring was needed; for example, within the planned monthly Whole of Syria (WoS) needs assessment and through wide rollout of a BMS distribution alert system (a smartphone-based online form that field staff can use to log BMS distributions and alert the Nutrition Cluster). These activities require strong advocacy and support from the Nutrition Cluster, particularly geared towards local NGOs, who often have the power to negotiate and act at local level when given the necessary information. In addition, it was recommended that Nutrition Cluster partners should align themselves with BMS standard operating procedures (SOPs) developed by the Tech RRT adviser and that community mobilisation and sensitisation efforts, including the use of social media, should be intensified.

An additional lesson learned was the great importance of integrating IYCF into the delivery of health services, particularly in a context where most of the nutrition actors originated from the health sector and so were frequently also implementing humanitarian health programmes. Sometimes practices within these very health programmes were negatively impacting IYCF practices. Existing programmes, such as integrated management of childhood illness (IMCI), provided an important opportunity for IYCF-E

programming and needed to be strengthened to ensure that IYCF components were adequately implemented.

Despite the challenges, the deployment went well and achieved most of its deliverables. The value of the Tech RRT deployment was the provision of a dedicated resource to drive the establishment of the Aleppo IYCF-E response. The Tech RRT adviser could allocate all her time to building partner capacities, harmonising and coordinating IYCF-E activities, creating common

consensus and goals, and ensuring that the response was technically sound, without having to deal with multiple competing priorities inevitable in programme management. There was a clear need and demand for such support given the magnitude of the emergency and the limited IYCF-E experience of those mandated to respond. Catalysed by the Tech RRT deployment, the IYCF-E response transitioned from a piecemeal approach implemented by partners working in silos to a collaborative effort with partners aligned

to agreed standards, with shared resources and a common response plan. Over the course of the deployment there was a palpable change in the momentum of the IYCF TWG and partners visibly became more enthusiastic about implementing IYCF-E as their awareness and understanding grew. While significant work remained to be done in strengthening IYCF-E programming, the groundwork was laid by the end of this deployment for a more coherent IYCF-E response that could feed into the wider effort.

Turkey-Syria cross-border 2017

What we know: IYCF-E

Location: Gaziantep, Gaziantep, Turkey (Response: Northern Syria)

Period: 26 January to 13 February 2017 in-country and 14-24 February remote

Requesting agency: Turkey-Syria cross-border Nutrition Cluster

Host agency (in-country): Save the Children Turkey

During 2016 the Nutrition Cluster partners continued to advance the IYCF-E response, using the tools and mechanisms established during the 2016 Tech RRT IYCF-E deployment and guided by the development of a three-year IYCF-E strategy (2017-2020) accompanied by a detailed costed plan of activities, launched in 2017 (see article on Turkey cluster experiences in this issue of *Field Exchange*).

In 2017, the Nutrition Cluster requested a further deployment from the Tech RRT IYCF-E adviser (hosted by Save the Children Turkey), as well as a Tech RRT social behaviour change (SBC) adviser (hosted by International Medical Corps (IMC)). The purpose of the deployment was to help plan baseline knowledge, attitudes and practices (KAP) assessments and barrier analyses inside Syria (for implementation by an incoming IYCF-E adviser) and to provide technical support to establish a rapid response system for the frequent population displacements.

The IYCF-E adviser met with those involved in the Aleppo evacuation at the end of 2016 (see article on Turkey cluster experiences in this issue) to understand experiences and lessons learned. This provided several useful insights but came too late, with many lessons already forgotten. Partners were urged to strengthen systematic knowledge management to share learning which could feed into the ongoing response and other responses in the region. Following a review of existing tools and approaches, a context-specific minimum rapid IYCF-E response package was defined which addressed situations in which the provisions of the BMS SOP (developed in 2016) could not be met. In consultation with the IYCF-E TWG, acceptable compromises were defined and guidance was developed for interventions such as bottle sterilisation and on-site wet feeding for populations in transit.

In addition the Tech RRT IYCF-E adviser provided support for the ongoing IYCF-E ad-

vocacy campaign and supported engagement with other sectors.

By the time of this second deployment, IYCF-E programming had matured. IYCF-E coordinating mechanisms (the IYCF-E TWG) were working well with good attendance, enabling the Tech RRT IYCF-E adviser easy access to the appropriate audience for discussions and information sharing. Familiarity of the adviser with the context, operating environment and Nutrition Cluster partners and low local (Syrian) staff turnover meant work could be started quickly. Several tools developed in the 2016 deployment were being used routinely by Nutrition Cluster partners. It was noted that it is important to push for the finalisation of tools while still in-country as there is a risk of them becoming lost among partners' multiple priorities later. BMS-related programming had evolved from basic advocacy to stop BMS distributions in 2016 to discussion with partners about necessary 'compromised' BMS programming.

There were several administrative/practical challenges with this deployment. Advisers were not able to arrive in-country simultaneously due to different regulations by hosting agencies, which made working together more difficult, particularly across different time zones. There were challenges for the SBC Tech RRT to balance remote support to the KAP survey against other normal (non-deployment) work. Some difficulties around the administrative planning for the KAP survey training and implementation ahead of the deployment (sampling and sample size calculations needed to identify and quantify training participants and funding needs were not done in advance) caused significant delays. This was further complicated by key staff changes in the Nutrition Cluster during this period. It was recommended that advisers should be allocated a few non-administrative preparatory days for non-urgent deployments to establish contact with those on the ground and understand the



A woman with her young child at a food distribution site in East Aleppo City, Syria, 2017

needs and level of readiness to receive the advisers and maximise the adviser's time in-country. A checklist covering all aspects of trainings, workshops and assessments could support this type of discussion – perhaps a worthwhile non-deployment task. The six weeks budgeted for the KAP survey proved an unrealistic timeframe that did not allow for the provision of support during analysis and interpretation of data, a critical phase during which technical support is vital. Both the KAP and barrier analysis assessments were carried out, in March and August respectively, and reports are being finalised by the Nutrition Cluster. Once complete, these reports will be available through the Nutrition Cluster as well as on the Tech RRT website (<http://techrrt.org/past-deployments/>).

Despite these challenges the 2017 deployment was successful in moving the IYCF-E response forward, helped by the obvious growth in Nutrition Cluster partners' commitment and technical abilities, initiated during the 2016 deployment.

For more information, contact: Isabelle Modigell, email: i.modigell@gmail.com

References

UNICEF 2012. The State of the World's Children 2012: Children in an Urban World. United Nations Children's Fund (UNICEF), February 2012. www.unicef.org/sowc2012/pdfs/SOWC%202012-Main%20Report_EN_13Mar2012.pdf



Global Nutrition Cluster Rapid Response Team

By Ayadil Saparbekov



Ayadil Saparbekov has been in a position of the Deputy Global Nutrition Cluster Coordinator with UNICEF Office of Emergency Programmes in Geneva since 2013.

He is a medical doctor and has a Master's Degree in Humanitarian Assistance with focus on Nutrition in Emergencies. He has been working on management of UNICEF health and nutrition programmes since 1995, including in humanitarian contexts, in Kazakhstan, UN-administered province of Kosovo, West Darfur State of Sudan, Turkmenistan and Tajikistan.

The author acknowledges the work of Action Against Hunger – UK and US, International Medical Corps – UK, Save the Children UK, World Vision Canada and UNICEF reflected in this article and the funding support of ECHO, DFID, Swiss Development Cooperation and UNICEF. Thanks to Josephine Ippe, GNC Coordinator, for her support in writing this article.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors, or the countries that they represent and should not be attributed to them.

Location: *Global*

What we know: UNICEF as the Cluster Lead Agency for the Global Nutrition Cluster is committed to supporting the timely, effective and predictable coordination of nutrition in emergencies (NiE) responses.

What this article adds: In 2012, UNICEF established the GNC Rapid Response Team (RRT). to support timely coordination and information management functions through rapid deployment of nutrition cluster coordinators (NCCs) and information management officers (IMOs). The RRT is a partnership between UNICEF and AAH, IMC, Save the Children UK and World Vision Canada, managed by the GNC-Coordination Team and overseen by a steering committee. Deployment is within 72 hours (visa allowing) for up to 12 weeks. From 2012 to date, the GNC RRT has had 57 deployments to 22 high priority countries, 43% to L3 emergencies and 23% to L2. One quarter of non-deployment time was spent implementing the GNC Work Plan (including tool development) and 22% on capacity building of host agencies on the cluster approach across 20 countries. A formal evaluation in 2015 found the mechanism contributed to better coordination of the emergency response. Having established it meets a very crucial need, challenges include; lack of in-country capacity on NiE with gaps in transition contexts, retaining RRT staff and significant funding shortfalls.

Context

As part of a process of humanitarian reform, the cluster approach was introduced in 2006 by the Inter-Agency Standing Committee (IASC) “to strengthen system-wide preparedness and technical capacity to respond to humanitarian emergencies by ensuring that there is predictable leadership and accountability in all the main sectors or areas of humanitarian response” (IASC, 2006). Global clusters were established, including the Global Nutrition Cluster (GNC), for which UNICEF was designated by the IASC as cluster lead agency (CLA). Despite progress following reform, the response of the humanitarian community to the Haiti earthquake and Pakistan floods in 2010 exposed ongoing weaknesses and inefficiencies in the humanitarian system. A subsequent review commissioned by the IASC Principals in 2010-2011 (IASC, 2017) exposed weakness such as lateness of the responses, inadequate leadership, lack of effective coordination structures and limited accountability for performance. In December 2011, based on these lessons learned, the IASC Principals agreed a set of actions known collectively as the Transformative Agenda, to substantively improve the humanitarian response model by working on three key areas: leadership, coordination and accountability, with focus on improved and strategic coordination (IASC, 2017).

Establishment of the GNC Rapid Response Team

In 2012, to support the Transformative Agenda and following the good example of the Global Water, Sanitation and Hygiene (WASH) Cluster, UNICEF established the GNC Rapid Response Team (RRT). The purpose of the GNC RRT is to support timely coordination and information management functions in nutrition in emergencies (NiE) responses by rapidly deploying nutrition cluster coordinators (NCCs) and information management officers (IMOs). The GNC's RRT mechanism is a partnership between

the GNC and four of its partners: Action Against Hunger – UK, International Medical Corps (IMC) UK, Save the Children – UK and World Vision Canada. UNICEF, as CLA, raises funds for RRT positions that are channelled via grants to partner agencies through Programme Cooperation Agreements (PCAs). Funds cover all associated costs, including remuneration of the GNC RRT members and assignment-related costs, such as travel, per diem and accommodation. The partner agencies are responsible for the recruitment, hosting and management of RRT personnel, including facilitation of deployment related administrative issues. During their deployment RRT members are seconded to UNICEF under the terms and conditions of the Standby Agreements that UNICEF concluded with all GNC RRT partner agencies.

The GNC's RRT mechanism started with one NCC recruited and seconded by IMC UK in 2011, initially funded by ECHO (European Civil Protection and Humanitarian Aid Operations). From 2013 to date, funding for the GNC RRT has been received from ECHO, Swiss Development Cooperation and the UK Department for International Development (DFID). From 2012 to 2015, funding was provided for six GNC RRT members including three NCCs and three IMOs. Following recommendations of an evaluation of the support provided by the GNC to national coordination platforms (UNICEF, 2015), as well as funding constraints, in 2016 the number of GNC RRT members was decreased to four: two NCCs and two IMOs.

Conditions for deploying the GNC RRT

GNC RRT members are available for deployment within 72 hours of the surge request from the UNICEF Country Office for up to eight weeks with a possibility of an extension for four more weeks (total deployment up to 12 weeks). RRT members can be deployed for:

Figure 1 Breakdown of GNC RRT support by type 2012-2017

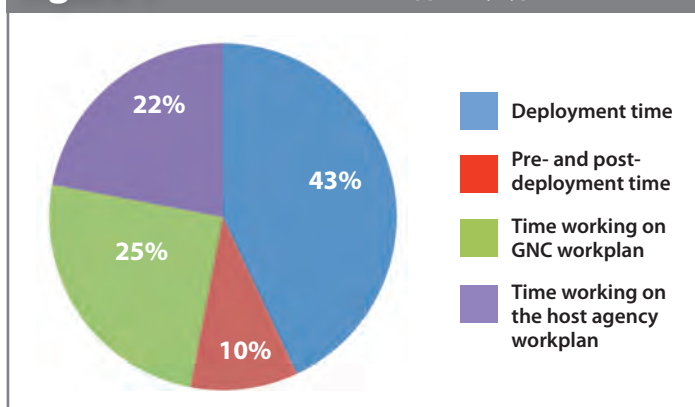
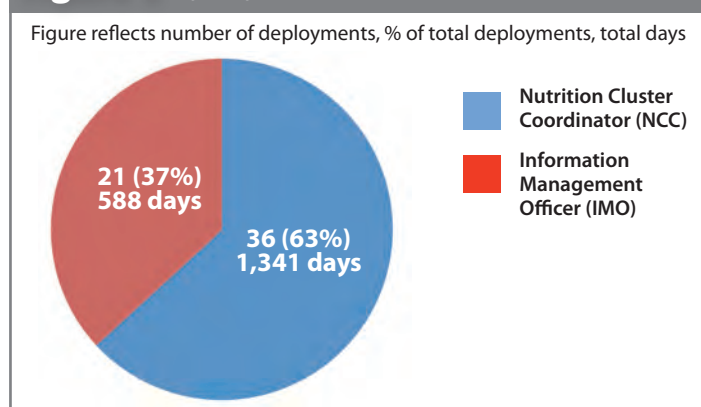


Figure 2 Breakdown of GNC RRT deployments by function, 2012-2017



1. A declared level three (L3) emergency;
2. A rapid onset emergency or rapid deterioration of pre-existing situation;
3. The threat or forecast of L2 or L3 emergency;
4. An unpredictable and sudden loss of NCC/IMO capacity in an established cluster/sector;
5. To strengthen underperforming NCC/IMO platforms in an established cluster/sector.

Contractual agreements are set up so that up to 50 per cent of an RRT member's working time is spent on deployment and their non-deployment time is split equally between host agency tasks (focussing on promotion of the cluster approach within the partner agency and advancing the host agency's NiE agenda) and supporting activities outlined in the GNC workplan. At the start of the contract or year, each RRT member develops a work plan that outlines deliverables for the non-deployment period, which is then agreed by the host agency and consolidated at global level by the GNC Coordination Team (GNC-CT). Figure 1 represents an average proportion of time that GNC RRT members spent on different tasks from 2012-2017.

When deployed, GNC RRT members facilitate and support nutrition cluster coordination

processes at national and sub-national levels as per the IASC six core cluster functions (supporting service delivery; inform humanitarian coordinator (HC)/ humanitarian country team (HCT) strategic decision-making; plan and implement cluster strategies; monitor and evaluate performance; build national capacity in preparedness and contingency planning and support robust advocacy).

Management of the GNC Rapid Response Team

GNC RRT members are directly managed at the global level by the GNC-CT and the respective host agencies. At national level, RRT members are supported remotely by the GNC-CT and host agencies while reporting directly to a line supervisor identified by UNICEF in country. The GNC RRT Steering Committee, which consists of GNC-CT and RRT partner agencies, decides on the appropriate use of RRT members, following a request for deployment from a UNICEF country office and receipt of Terms of Reference (TOR) pre-reviewed and agreed by the GNC-CT, within 48 hours of the request being submitted. Following the Committee's endorsement, the date for deployment is agreed with the requesting UNICEF Office, normally

within 72 hours, although lengthy visa procedures can delay the departure of the RRT member in certain countries.

A monthly call takes place between RRT host agencies, the GNC-CT and all RRT members (whether on deployment or not) to manage team progress. For evaluation purposes, each RRT member submits an end of mission report after every deployment to the related country office, GNC-CT and the seconding RRT partner agency. This report details achieved results, constraints and lessons learned during the mission, as well as recommendations and follow-up actions required following their departure. Since June 2014, each RRT member has been evaluated by the UNICEF country office; results are used to tailor mentoring support for the RRT member to improve their performance. Following deployments, each RRT member is entitled to a number of days off to prevent stress accumulation and 'burnout' in line with the human resources (HR) regulations of their host agency.

GNC RRT deployments and activities

From 2012 to date, the GNC RRT members have conducted a total of 57 deployments to 22 high priority countries totalling 1,923 days with an average deployment duration of 7.3 weeks per deployment. Out of this, 24 deployments (42%) were to countries where a system-wide L-3 emergency was activated and 13 deployments (23%) were to L2 emergency countries. Figure 2 presents the breakdown of GNC RRT deployments by function from 2012-2017. Countries supported to date include Afghanistan, Bangladesh (national level and Rohingya response), Central African Republic, Chad, Ethiopia (national level and Somali region response), Haiti, Iraq, Malawi, Mali, Mauritania, Mozambique, Nepal, North-eastern Nigeria, Pakistan, Philippines, Somalia, South Sudan, Sudan, Yemen, Ukraine, the Whole of Syria (WoS) response and Syria cross-border responses. Box 1 describes four examples of support provided by the GNC RRT in four of these countries; Box 2 provides more details of the Yemen deployment.

From 2012-2017, 25% of the non-deployment time of the GNC RRT members was spent implementing the GNC Work Plan, which included the development of the Information Management

Box 1 Achieving successful partner coordination in Monguno

In **South Sudan (2014)**, two RRT members were deployed. One of them supported the development of the Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP). This involved the analysis of existing data, review of cluster achievements and constraints to date and close working with cluster partners and the Strategic Advisory Committee (SAG) to develop the final HNO, HRP and an implementation and monitoring plan for the collective GNC partnership.

In **Somalia (2013)**, following the sudden loss of the IMO, an RRT was deployed to support the maintenance of the Somalia information management system for eight weeks after which the Somalia country office hired a dedicated IMO.

In **Sudan (2015)**, one RRT member and a deputy GNC Coordinator were deployed to facilitate the training of 31 cluster partners on the cluster approach. As this trip was done immediately after a cluster coordination performance monitoring (CCPM) exercise, the team helped the cluster partners and the coordinators to review the results and develop action plans to address the shortfalls in coordination.

Two RRTs were deployed to **Yemen (2015)**, to support coordination following the declaration of an L3 emergency. This deployment took place after the HNO and HRP were already developed, so the RRTs supported implementation and programme scale-up and maintenance of coordination and information management. Given the need to restructure ways of working within the cluster, the RRT facilitated the establishment of a SAG and technical working groups (TWGs) on assessments/surveys, community-based management of acute malnutrition (CMAM) and infant and young child feeding in emergencies (IYCF-E).

toolkit (www.nutritioncluster.net/topics/im-toolkit), consolidation of best practices on contingency planning in nutrition clusters, updating the HRP tips for nutrition clusters (www.nutritioncluster.net/resources/hrp-tips), provision of remote coordination and information management support to nutrition clusters and assistance in drafting of GNC bulletins and the updating the GNC website. Additionally, 22% of non-deployment time was used to build the capacity of host agency staff on the cluster approach and NiE, covering over 20 countries where host agencies have operational presence.

The results achieved by GNC RRT members during deployment and non-deployment times have provided clear benefits to the country cluster coordination mechanism as well as the global level host agency and GNC. Overall, countries that received surge support from the GNC RRT mechanism had coordination and information management systems up and running within a very short period of time, with collective response plans based on a clear articulation of nutrition needs, costed to provide donors and stakeholders with clear information on funding requirements to implement plans. This has greatly enabled clusters/sectors to raise funds and advocate for country-based pooled funding. The RRT mechanism also greatly contributed to the establishment of strong information systems to support effective monitoring of performance and advocacy.

The GNC-CT continues to address long term capacity gaps in coordination and information management, alongside short-term provision of surge support by the GNC RRT. The GNC-CT and UNICEF office of emergency programmes (EMOPS) senior management advocate for cluster countries to provide a dedicated cluster coordinator (or coordination person) for GNC RRT members to hand over to while still on the ground. This is now one of the conditions for deployment.

Challenges and lessons learned

A formal evaluation of the support provided by the Global Nutrition Cluster to national coordination platforms from March 2012 to September 2014 was conducted in 2015 (UNICEF). The evaluation captured both deployment and non-deployment periods of the GNC RRT members and assessed the quality of support to countries in L3 emergencies and chronic crises and the relationships with host agencies. Overall, the evaluation found that the GNC RRT mechanism contributed to better coordination of the emergency response.

The management of the RRT system by partners was found to have a positive effect on the GNC's global credibility as the mechanism is perceived to be driven by partners with RRT members being viewed as neutral brokers. It was also noted that there was good collaboration between the GNC-CT and host agencies.

The report highlighted challenges faced by GNC partners at country level, such as the lack of capacity for NiE response, reflected in the long-term capacity gap for nutrition cluster coordination. It was recognised that this must be dealt with in a sustainable way. The report emphasised the need for handover from GNC RRT members to a dedicated coordinator in-country during the deployment period. Recruitment processes can currently be very lengthy, which must be addressed.

Another challenge highlighted by both the evaluation and through discussions with RRT members and host agencies is the difficulty in retaining RRT staff. Only one third of GNC RRT members have continued their contracts beyond the initial one-year commitment; a more sustainable funding model is needed to ensure that RRT members commit for longer. Host agencies also pointed out the difficulties of finding and hiring competent RRT members.

Funding of the GNC Rapid Response Team remains a major concern. Despite the considerable work that the GNC RRT has done over the last six years to support national coordination platforms, the mechanism is facing severe funding shortages to the extent that its existence is at risk. This is extremely unfortunate given the level of investment donors, the GNC-CT, UNICEF as the CLA, and the host agencies have made into building this essential mechanism, and given the continued capacity gap at country level which would otherwise not be filled.

Ways forward

UNICEF as the CLA for the GNC remains committed to support the timely, effective and predictable coordination of NiE responses. It is clear that the GNC RRT mechanism is relevant and effective and meets a very crucial need in countries where the cluster/sector approach has been activated, as well as in well-established nutrition cluster countries. For the next five-year programme cycle, UNICEF is integrating the positions of one NCC and one IMO into the structure of the GNC-CT. However, funding of these positions, as well as additional positions seconded by the GNC RRT host agencies, has not yet been secured. Reliable, multi-year funding provides the greatest opportunity to be able to sustain such support in order to respond to the situations where it is most needed.

For more information, contact: Ayadil Saparbekov, email: asaparbekov@unicef.org

References

Inter-agency Standing Committee (IASC) (2006). Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response, November 2006. Available from: https://interagencystandingcommittee.org/system/files/legacy_files/Cluster%20implementation%2C%20Guidance%20Note%2C%20WG66%2C%2020061115-.pdf

Inter-agency Standing Committee (IASC) (2007). IASC transformative agenda. Available from: <https://www.interagencystandingcommittee.org/iasc-transformative-agenda>

UNICEF (2015). Evaluation findings of the GNC support to country Cluster Coordination platforms, UNICEF, 2015. Available from: http://nutritioncluster.net/wp-content/uploads/sites/4/2015/06/UNICEF_report_homeprint.pdf

Box 2 Activities of the GNC RRT deployment to Yemen, June-August ,2015	
Core functions	Achievements
1. Support service delivery	Coordinated sub-national discussions on gaps/duplications and plans to scale-up; Organised a Strategic Advisory Group (SAG) to provide guidance to the cluster on strategic issues and scaling up response; Chaired weekly cluster meetings with clear agenda and action points to follow up; Initiated organisation of the Infant and Young Child Feeding (IYCF) working group to support delivery of IYCF programmes.
2. Inform HC/HCT decision making	Organised an Assessment Working Group (AWG) to support cluster partners in nutrition surveys; Organised webinar on Rapid SMART and secured engagement of ACF-Canada in providing SMART technical support to Yemen; Led process to develop a survey plan, securing engagement of key partners; Introduced process of validation of survey protocols and reports via AWG to ensure that Nutrition Cluster had reliable data.
3. Plan and develop strategy	Operationalised the humanitarian response plan (HRP) by leading the prioritisation of districts for cluster response; Coordinated development of situation analysis and action plans for scaling up response in 14 priority governorates; Led development of the nutrition part of the inter-cluster humanitarian response plan as well as operational plan for Aden.
4. Monitor and evaluate performance	Conducted full review of information management system and developed an action plan for its improvement; Led modification of reporting tools to align with the Yemen HRP; Produced three-monthly bulletin on Nutrition Cluster response; As a part of inter-cluster efforts, contributed to production of four months response. report and weekly situation reports.
5. Capacity building of partners	Provided orientation to partners on cluster approach and their commitments to the cluster; Initiated the organising of a two-day SMART survey methodology orientation workshop to non-governmental organisations (NGOs) and identified responsible partners.
6. Advocacy	Led identification of key advocacy concerns and advocated on behalf of the cluster to partners, the Inter Cluster Coordination Group (ICCG), the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and GNC, that contributed to change in several practices, including alignment of NGOs and United Nations (UN) agencies priorities with cluster priorities; streamlining information requests to clusters and optimising inter-cluster monitoring, enhanced support of international NGO HQs to their country offices, and organising an inter-cluster supplies task force.

A UNICEF-supported health worker measures the upper-arm circumference of 18 months-old Khatoun to detect malnutrition. Khatoun was diagnosed with moderate acute malnutrition.



©UNICEF/Syria/2017/AH/ISS

Experiences of the 'Whole of Syria' coordination for nutrition

By Saja Farooq Abdullah and Lindsay Spainhour Baker



Dr Saja Abdullah is currently working as the 'Whole of Syria' (WoS) coordinator with UNICEF MENARO office. Saja is a medical doctor

and holds a Master's degree in Community Health. She has over 23 years' experience in health and nutrition in emergency and development contexts in Yemen, Syria and Iraq with the United Nations, international NGOs and government. Previous roles include Chief of Nutrition for UNICEF and Nutrition Cluster Coordinator, both in Yemen.



Lindsay Baker is the WoS Nutrition Sector Co-Coordinator seconded to the Nutrition Sector by Action Against

Hunger in Jordan. Lindsay holds a Master of Science degree in International Health. She has spent the last 13 years in South Asia and East Africa working in technical, management and coordination capacities for health and nutrition organisations.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors or the countries they represent and should not be attributed to them.

Location: *Whole of Syria*

What we know: Coordinating delivery of humanitarian assistance in Syria is complex and challenging.

What this article adds: A Whole of Syria (WoS) coordination approach was established in 2015 to bring humanitarian actors working in Syria and in neighbouring countries (cross-border operation) together to increase the overall effectiveness of the response. It constitutes one comprehensive framework, a common response plan and a supporting coordination structure. The WoS Nutrition Sector is coordinated by the WoS Coordinator (UNICEF) based in Amman, with ACF as co-coordinator. Nutrition coordination mechanisms operate at 'hub' level (Turkey, Syria and Jordan). The WoS Nutrition Sector ensures suitable and single-sector input for humanitarian needs overview, periodic monitoring reports, the humanitarian response plan and related exercises (such as joint operational plans). Added value to date includes coordination between hubs with joint geographic presence to avoid duplication; ensure complementarity, enhanced collaboration between nutrition and food security; greater information sharing between hubs; flexible, responsive coordination; and joint planning. There has been considerable investment in national capacity development. The WoS approach has been instrumental in increasing the profile of nutrition, with a significant increase in the number of nutrition partners delivering nutrition activities and funding requests. Remaining challenges include limited funding; inadequate information about the nutrition situation in hard-to-reach and besieged locations; inadequate capacity of partners around nutrition; ongoing population displacements; and ever-changing frontlines.

The challenges humanitarian organisations face in their efforts to alleviate the suffering of people in Syria and to deliver assistance to meet their most basic needs are profound. Humanitarian partners provide assistance in Syria across three operational hubs (Syria, Turkey and Jordan) which are committed to working together under a 'Whole of Syria' (WoS) approach. This article describes the development, characteristics and added value of this approach with regard to coordination for nutrition.

Background

Nutrition was not a priority in Syria at the onset of the emergency due to the low prevalence of global acute malnutrition (GAM), lack of sufficient information on the nutrition situation and inadequate country capacity to understand and implement nutrition programming. The Nutrition Sector was only set up in Damascus in March 2013 after intense advocacy. Before the sector was established, there were limited partners carrying out uncoordinated nutrition activities for children under five years of age and women coming into Syria from neighbouring countries. In 2014 a series of United Nations (UN) resolutions enabled official cross-border humanitarian assistance in opposition-held areas. UN Security Council Resolution 2165, unanimously adopted on 14 July 2014, authorised UN humanitarian agencies and their partners to "use routes across conflict lines and the border crossings of Bab al-Salam, Bab al-Hawa, Al Yarubiyah and Al-Ramtha, in addition to those already in use," to deliver humanitarian assistance to people in need in Syria. As part of this arrangement, the Government of Syria is notified in advance of each shipment of humanitarian assistance. A UN monitoring mechanism was established to oversee and confirm

the humanitarian nature of consignments. The cross-border cluster system was subsequently activated and the WoS approach developed.

Country-specific challenges pre-cluster/sector activation and WOS approach

Coordination was difficult in the early days of establishing a Nutrition Sector in Syria (Damascus). Partners on the ground and donors did not perceive nutrition issues as priorities and donors prioritised other sectors because GAM prevalence among children under five years of age was low and infant and young child feeding (IYCF) activities were not classed as emergency interventions. In addition, the concept of nutrition sector coordination – its role and added value – was not fully understood by partners inside Syria. Consequently, the sector started with few partners; these were mainly UN agencies (UNICEF, World Food Programme (WFP) and WHO), the Ministry of Health (MoH) and the Syrian Arab Red Crescent (SARC). However after intensive advocacy it grew significantly, engaging local NGOs in the response, with technical and operational support from the three UN agencies. In the early days the sector focused on capacity development of local NGOs, SARC and MoH staff while providing preventative services, followed by establishment of curative interventions.

The nutrition response faced key challenges in timely reporting and situation analysis, aggravated by the lack of clear validation processes and inadequate in-country nutrition capacity. There were also challenges for the cross-border hubs from Turkey and Jordan before and during activation of the Nutrition Cluster/working groups and prior to the WoS approach. In Jordan, nutrition activities targeting children under five years of age and women occupied a small space in the health sector

working group. In Turkey pre-cluster activation, the lack of an official UN role prevented access to certain humanitarian funding, such as the Central Emergency Relief Fund (CERF). There was also little consideration of nutrition supplies in inter-agency cross-border convoys.

Challenges common to all hubs included inadequate information sharing between the operational hubs, which led to programming gaps and duplication; limited access to the affected people in the hard-to-reach and besieged areas; limited capacity of organisations carrying out nutrition activities, particularly on community based management of acute malnutrition (CMAM), IYCF and assessments; lack of communication between hubs, making cooperation and information exchange between humanitarian actors difficult; and varied application of different standards and tools by organisations carrying out nutrition activities.

WoS approach Coordination mechanism

The WoS approach constitutes one comprehensive framework, a common response plan and a sup-

porting coordination structure. Bringing together over 270 international and national actors, it seeks to ensure strategic and operational coherence in the delivery of humanitarian assistance in Syria. The approach supports the use of a variety of response modalities to ensure that humanitarian assistance, including therapeutic and preventative supplies, reaches people in need throughout the country via the most direct routes. These include regular programming, inter-agency convoys, air drops, cross-border activities and remote programming. When needed, modalities are delivered to complement each other to maximise value and opportunity.

The WoS Nutrition Sector¹ is part of the overall WoS structure that comprises sector-specific leads (UN agencies) and co-leads (NGOs) and the Inter-Sector Coordination Group (ISG), chaired jointly by the UN Office for the Coordination of Humanitarian Affairs (UNOCHA) and international NGOs, with participation of the sector lead/co-lead at the WoS level (see Figure 1 for coordination structure). A Strategic Steering Group (SSG) sits above the ISG, with

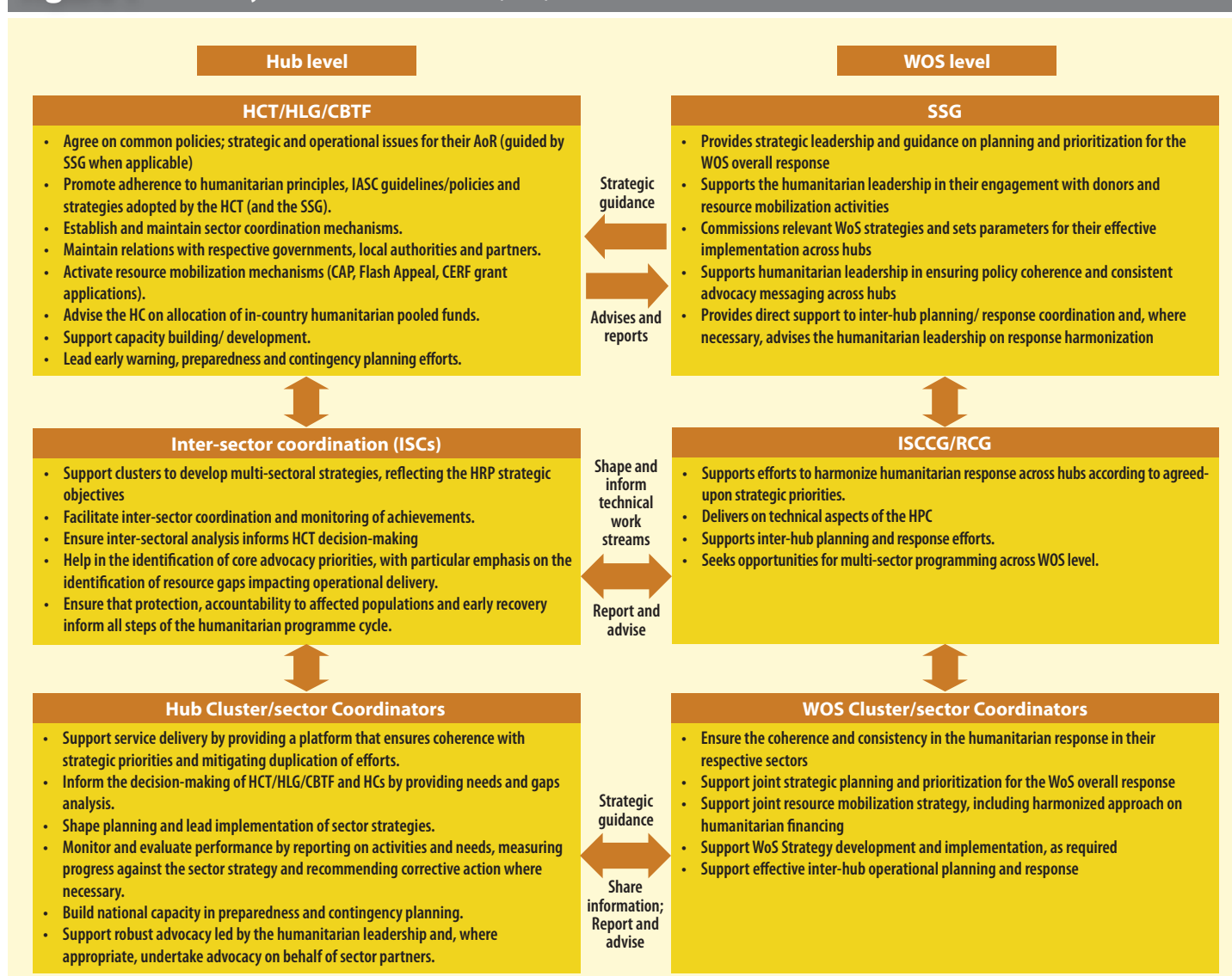
representatives from key UN agencies and the NGO regional forum. The Nutrition Sector for the WoS provides technical and policy advice through the ISG to the WoS SSG to support decision-making throughout the humanitarian planning cycle. Final and strategic decisions regarding WoS coordination are made by the SSG.

Evolution of approach

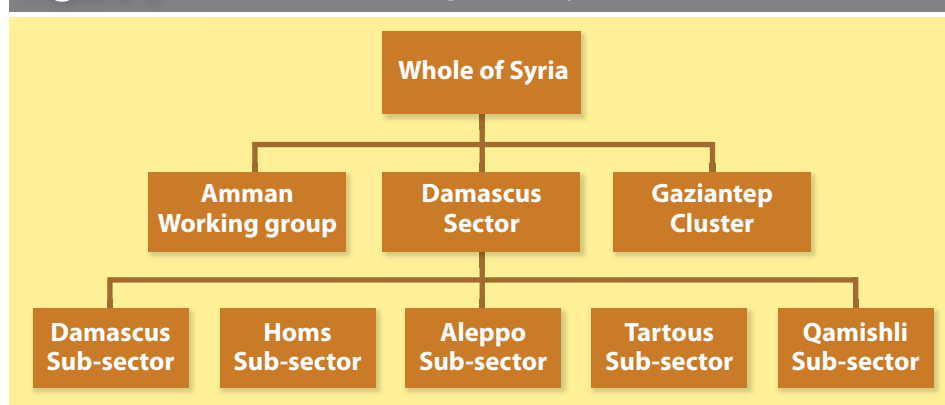
Following the adoption of the WoS approach, the Nutrition Sector at WoS level was coordinated by UNICEF's regional nutrition specialist based in Amman, while ACF was elected co-chairagency and assigned a nutrition specialist for the coordination support. In 2016 UNICEF recruited a

¹ The term 'sector' is used to describe the existing nutrition coordination forums/mechanisms at the WoS level and Damascus/Syria hub, while the term 'cluster' is used by Gaziantep/Turkey and the term 'working group' is used by Amman/ Jordan hubs to describe the same concept. The three terms are equally relevant and the coordination forums share the same function at the three operating hubs, but slightly different functions at WoS level, as described in this article. The decision on which term to be used is taken by the humanitarian leaderships in the respective hubs based on consensus among the actors.

Figure 1 Whole of Syria coordination architecture (draft)



AoR: Areas of Responsibility; HCT: Humanitarian Country Team; HLG: Humanitarian Liaison Group; CBTF: Cross Border Task Force; SSG: Strategic Steering Group; ISCCG: Inter Sector Group; RCG: Response Coordination Group

Figure 2 Nutrition coordination arrangement for Syria

fixed-term WoS nutrition coordinator and an information management officer, both based in Amman, Jordan. Action Against Hunger Spain seconded an international staff member as the co-coordinator for the WoS sector, based in Amman.

Alongside WoS coordination on nutrition there are also national-level nutrition coordination mechanisms within each hub (see Figure 2). In Syria, the Nutrition Sector is based in Damascus and is led by a dedicated UNICEF Nutrition Sector coordinator together with the MoH, under which there are five sub-national Nutrition Sectors at field level. In Turkey, the unofficial cross-border sector working group transitioned to a cluster approach in 2015, with rapid response teams providing surge capacity in coordination. A UNICEF Nutrition Cluster coordinator was appointed early in 2016 on a long-term basis in Gaziantep and a co-coordinator was staffed by GOAL. The co-coordinator role rotates among agencies and is currently staffed by Physicians Across Continents (PAC). In Jordan initially there was no standalone nutrition coordination forum: nutrition was part of the health and nutrition working group led by WHO and there were no nutrition partners responding from Jordan. With the appointment of the WoS nutrition coordinator by UNICEF in Feb 2016, the staff

took on extra responsibility to coordinate the nutrition working group in the Jordan hub and began to mobilise nutrition partners based in Amman for the South Syria cross-border response from Jordan. By the end of 2016 a standalone coordination group for nutrition under the leadership of UNICEF had been established, with at least five NGO partners implementing cross-border nutrition activities in southern Syria. In 2017 a co-coordinator for the South Syria cross-border response from Jordan was elected and is now staffed by Syria Relief and Development.

Responsibilities of the WoS Nutrition Sector

The WoS Nutrition Sector is responsible for ensuring suitable and single-sector input for humanitarian needs overview (HNO), periodic monitoring reports (PMR), the humanitarian response plan (HRP) and all related exercises, such as joint operational plans. The WoS Nutrition Sector identified four strategic objectives in the HRP 2017, all of which have strongly linked humanitarian and resilience programming (see Box 1). Strategic objective one (SO1), for instance, addresses the main nutrition problems with short-term consequences but that also contribute to long-term problems, such as stunting. Hence the focus of SO1 is to prevent micronutrient deficiencies; promote, protect and support rec-

ommended IYCF practices in emergencies (IYCF-E); and optimise maternal nutrition. Likewise, for (SO2), while the emphasis is the treatment of acute malnutrition treatment in children and women to save lives, interventions to prevent long-term consequences (stunting) are also important. SO2 also considers in-country capacity development in preparedness and contingency planning in the event of pockets of acute malnutrition. Both SO3 and SO4 are vital to ensure updated information on nutrition for early warning and early action, as well as for long-term programming through the development of in-country capacity on robust, evidence-based information systems. This is also applicable to coordination because capacity development and intelligent joint programming are necessary to maximise impact and make efficient use of available resources.

The WoS Nutrition Sector is responsible for coordinating sector assessments and needs identification. It has an operational coordination role which involves the coordination of interventions to ensure complementarity and prevent overlap and duplication, as well as to assess and prioritise countrywide gaps. Furthermore, the WoS facilitates agreement on joint advocacy messages at sector level across hubs when required and provides strategic backing to hub-level sector/cluster leads, including sharing of best practices and knowledge, capacity building and policy advice. In this way the WoS helps to standardise response approaches across hubs and ensure preparedness and complementarity between different programmes, while consistently working towards the goal of 'do no harm'.

Added value of the WoS coordination

The WoS Nutrition Sector coordination team provides added value in this particularly challenging context in several ways:

Coordination of nutrition responses between hubs when more than one hub is responding in a geographic area: For example, the Nutrition Sector at WoS level is conducting coverage and gap

Box 1 HRP 2017 WoS nutrition strategic objectives

1. Strengthen life-saving preventative nutrition services for vulnerable population groups focusing on appropriate IYCF practices in emergency, micronutrient interventions and optimal maternal nutrition.
2. Improve equitable access to quality life-saving curative nutrition services through systematic identification, referral and treatment of acutely malnourished cases for children under five years of age and pregnant and lactating women (PLWs).
3. Strengthen robust, evidence-based system for nutrition with capacity in decision-making to inform needs-based programming.
4. Establish coordinated and integrated nutrition programmes between and across relevant sectors through enhanced coordination and joint programming.



Participants of the Nutrition Cluster Coordination Training held in Istanbul, Turkey organized by the Global Nutrition Cluster

Box 2 Nutrition and Food Security joint package of services**Platform one: Ready-to eat-foods for five days to a maximum of two weeks for new internally displaced persons (IDPs)**

Nutrition interventions: High-energy biscuit (HEB) distribution for children under five years of age (6-59 months) and PLWs.

Platform two: Regular food parcels given on a monthly basis under GFD for a period of one year, with quarterly assessment of vulnerability status. Nutrition interventions include: Supply of HEB, Plumpy'Doz and micronutrient powder; nutrition messaging; MUAC assessment of mothers and children; revision of the food basket to ensure nutrition value; and adherence to Sphere Standards

Platform three: Cash and voucher-based transfer programme (CBT) targeting the most vulnerable groups and based on specific assessment according to mode of distribution. Nutrition interventions: Include PLWs and children under five years of age as eligibility

criteria; provide recommendations to partners and beneficiaries on the nutritional value of different local foods as per their availability in the market; and advise on a healthy balanced meal.

Platform Four: Schools
Nutrition interventions: Provision of HEBs, nutrition messages and micronutrient supplements.

Platform five: Livelihoods programmes targeting people based on joint food security and nutrition vulnerability criteria with livelihood interventions.

Platform six: Agricultural programmes
Nutrition interventions: Development of nutrition-sensitive agricultural programming based on the capacity-building workshops currently underway across all hubs.

Target group and eligibility criteria
Food Security: Vulnerability criteria
Nutrition: Children under five years of age and PLWs

analysis every month. Following the analysis monthly alerts are shared with the hubs, where joint geographic presence is identified to ensure no duplication and enhance complementarity.

Capacity development: This has targeted staff from key nutrition partners to establish a roster of trained personal on important nutrition topics across the hubs, such as SMART surveys, IYCF-E and cluster coordination. This initiative will ensure a good level of preparedness, so that the trained resources can run cascade trainings at their respective hubs should the response warrant scale-up.

Enhance inter-sector collaboration: Through joint collaborative efforts between Nutrition and Food Security Sectors at WoS level, harmonised joint information, education and communication (IEC) tools have been finalised between both sectors and shared with partners across the hubs; joint assessment tools have been agreed; and standard operating procedures to use common delivery platforms are under development. In addition, the Nutrition Sector across the hubs committed to and actively participated in the Integrated Food Security Phase Classification (IPC) exercise launched during 2017.

Facilitating information sharing between hubs: Regular communication between nutrition coordinators and co-coordinators at hub level involves quarterly face-to-face meetings and dial-in meetings once every two weeks at a minimum (more often when necessary) to discuss common issues and agree standards. An information-sharing protocol for the Nutrition Sector has been developed and used by the coordinators, information management officers and partners across the hubs; this facilitates information sharing between the hubs and the WoS, especially information related to capturing and monitoring the ongoing response, such as the sector 4 Ws (who, what, where, when) tool. The WoS Nutrition Sector website is accessible to all nutrition partners working in Syria; this is a one-stop location for obtaining all reports, trainings

and tools: www.humanitarianresponse.info/en/operations/whole-of-syria/nutrition

Flexible and adaptable coordination: In the north-east of Syria, WoS coordinators across all sectors took on extra responsibility to coordinate the response between actors in the northeast who are operating across the border, mainly from Iraq and Qamishli (sub-national sector of Damascus hub), by facilitating information sharing on the response gaps for the Raqqa crisis and assigning roles to partners based on their access and operational capacity.

Harmonised assessments and monitoring: The WoS Nutrition Sector has led harmonised initiatives between cross-border programmes in the north and south of Syria, such as the nutrition surveillance system reaching hard-to-reach areas in Ar Raqqa and Eastern Ghouta to bridge the information gap and the joint barrier analysis for IYCF in the north and south of the country.

Joint planning: The WoS Nutrition Sector facilitates joint planning and has led the HNO and HRP development processes to generate a holistic and consolidated single plan. The latest HRP for Syria can be downloaded from: www.humanitarianresponse.info/en/operations/whole-of-syria/document/2017-syrian-arab-republic-humanitarian-response-plan.

Actions to support appropriate IYCF practices: Widespread random distribution of breastmilk substitutes (BMS) by different actors, including those providing health, nutrition and food services, is an ongoing problem. The WoS Nutrition Sector has worked hard over the past two years to address these obstacles to enable a coherent, coordinated and effective nutrition response to the people of Syria. Actions taken on IYCF include the development of an IYCF-E operational strategy for cross border-programming; a joint statement issued by cross-border partners to protect promote and support recommended IYCF practices; and development of standard

Participants of the Nutrition Cluster Coordination Training held in Istanbul, Turkey organized by the Global Nutrition Cluster



operating procedures (SOPs) for the targeted distribution of BMS.

Initiatives to mainstream nutrition services in existing systems and programmes: Due to ongoing advocacy, awareness raising and capacity development, the Nutrition Sector has succeeded in raising the profile of nutrition in the context of Syria. For example, in close coordination with the MoH, the Syria hub integrated mid upper arm circumference (MUAC) screening into a measles vaccination campaign in May/June 2017. As a result approximately half a million children were screened for acute malnutrition through over 600 health facilities by MoH with UNICEF support. The screening is part of efforts to identify acutely malnourished children and link them to treatment centres that provide CMAM services. In the Turkey and Jordan hubs, an intensive IYCF awareness campaign has had a positive influence on partners. Nutrition activities have been mainstreamed in the essential health service package at all three levels (primary, secondary and tertiary) and the nutrition surveillance system has been integrated into the Early Warning Early Action (EWARN) system that monitors the communicable diseases, water, sanitation and hygiene (WASH) and the Expanded Programme on Immunisation (EPI) programmes.

Advocacy for greater funding and supplies: Internal advocacy efforts by the WoS Nutrition Sector team have played a big role in identifying and securing funding from UNOCHA for nutrition interventions that, in turn, have led to increased Syrian (local) NGO funding. External advocacy efforts by the WoS coordination team have highlighted the nutrition needs beyond acute malnutrition, bringing attention to the pockets of malnutrition, poor IYCF practices, micronutrient deficiencies and the consequences of underfunding; this has increased the visibility of nutrition needs in Syria. The WoS coordinators have also fed into inter-agency convoy planning by informing on needs and gaps to ensure that necessary nutrition supplies are included.

Inter-sector collaboration at WoS level

In 2016 both the Food Security and Nutrition Sectors at WoS level took the initiative to explore common themes and opportunities on which to work jointly in order to maximise the efficiency of the response and achieve shared results. Both coordinators reached out to their global counterparts, who provided support for the first nutrition, food security and livelihoods (FSL) workshop, held at WoS level in October 2016 in Jordan and attended by the global Nutrition and Food Security cluster coordinators and country-level coordinators and partners. At the workshop a set of opportunities was identified and recommendations were made to promote enhanced inter-cluster operational collaboration around four areas: assessment and analysis; general food distribution (GFD) as a delivery platform for nutrition-specific interventions; delivery of nutrition messages in FSL programmes; and capacity development.

This strategic workshop was followed by an operational workshop in March 2017, where an action plan was consolidated with participation from all hubs and key partners, including WoS coordinators and co-coordinators from FSL and nutrition, and nutrition country-level coordinators and co-coordinators. Concrete and actionable outputs were identified in each of the four areas, as well as opportunities for the two sectors to work closely together.

An SOP/Memorandum of Understanding (MOU) for the Nutrition and Food Security inter-sector coordination on the use of the general food distribution as a delivery platform for nutrition interventions was drafted and endorsed in March 2017 at WoS level. This was an output of the second joint inter-sector workshop. It outlines a recommended package of services to be jointly delivered through various delivery platforms (See Box 2), eligibility criteria, nutrition and food security respective responsibilities, and an action plan. Services are shaped and de-

vised according to context, partner capacity and available resources. It was agreed to include nutrition vulnerability (children under five and PLW) as a criterion for food security vulnerability. According to the action plan in the SOP/MOU, an inter-sector strategic advisory group will be formed (both at WoS and at hub level) to act as a strategic guidance body; for ongoing planning, implementing and monitoring of the joint approach; and to update SOPs. Terms of References (TORs) for the group are under development.

A set of harmonised IEC materials for nutrition was made available to partners for operational day-to-day use. These covered topics such as advice to workers on food distribution; job aids on micronutrient powder distribution; flyers/brochures on general messages for good nutrition, breastfeeding (poster, flyer, storybook), complementary feeding, food safety, IYCF counselling cards, Plumpy'Doz, and HEBS. The tools are available in Arabic at: www.enonline.net/iec-toolsnutritionarabic

Following the finalisation of joint assessment tools (questionnaire), Turkey and Jordan cross-border partners conducted a joint food security and nutrition assessment in 80 sub-districts, reaching 8,808 households. The assessment captured information on key IYCF practices. The quality of the data collected was challenged and several limitations were detected, hence it could not be used for the HNO 2018 but will be used to generate lessons for future learning. Feedback to Food Security partners was given following the analysis to improve data collection quality in the future.

Conclusions

The WoS coordination on nutrition has been instrumental in achieving well organised and systematic information sharing to enhance efficient and effective nutrition response coverage. Having standalone coordination forums for nutrition has allowed for better recognition of nutrition priorities, which were initially diluted under the health working group; facilitated

more effective collaboration between partners and across sectors; and enabled joint planning and action to address nutrition priorities in both the short and long term. From just three appealing organisations in the HRP 2014 (WHO, WFP and UNICEF) with a total ask of US\$29.9 million, this has grown to 20 in 2018, requesting US\$70.7 million.

Many challenges for the Nutrition Sector remain in Syria. These include limited funding; lack of nutrition information from some hard-to-reach and besieged locations such as Dier ez Zor and Raqqa; inadequate capacity of partners around nutrition; ongoing population displacements; and ever-changing frontlines. Integration of nutrition activities in the health and food sectors is under continual negotiation and development. The WoS Nutrition Sector has worked hard with the Food Security Sector to develop joint assessment tools, conduct joint assessments and analysis and agree on common educational messages for nutrition and food security actors. However, there are opportunities to go further, such as integration of nutrition into the design and implementation of cash programming in Syria, particularly in areas with limited access for delivery of supplies and in conjunction with other sectors.

Through its unique operation and the 3RP², the WoS structure has reinforced the importance of establishing regional and sub-regional coordination mechanisms for nutrition that can enhance and coordinate a connected response between countries; exchange experiences between similar contexts and with those affected by similar crisis; and serve as a rapid response mechanism for technical support in coordination and technical areas.

For more information, contact: Saja Abdullah, email: sabdullah@unicef.org or Lindsay Baker, email: lbaker@me.acfspain.org

² 3RP is the Regional Refugee and Resilience Plan 2017-2018 in response to the Syria crisis. www.3rpsyriacrisis.org/the-3rp/



WOS nutrition team
in face to face
meeting Beirut
Lebanon, Aug 2017

From cluster to Nutrition Sector coordination: Government leadership in coordination for effective nutrition emergency response in Borno State, Nigeria

By Maureen L Gallagher, Kirathi Reuel Mungai, Ladi Linda Ezike and Dr Helni Mshelia



Maureen L. Gallagher is a nutrition specialist with UNICEF's Emergency Response Team based in UNICEF HQ, New York. She is a public health specialist with over 15 years' experience in nutrition programming. She has been deployed to support the emergency response in Nigeria, Yemen and Democratic Republic of Congo.



Kirathi Reuel Mungai is a nutrition specialist currently working with UNICEF as a Nutrition Sector coordinator in Nigeria, based in Borno. He has worked as a public health nutritionist for the last 11 years in Kenya, South Sudan and Nigeria for UNICEF, Action Against Hunger, Concern Worldwide, World Food Programme and the Government of Kenya. He has also worked as the Nutrition Cluster Coordinator in South Sudan.



Ladi Linda Ezike is the State Nutrition Officer for the Government of Borno State Nigeria, where she is the focal point for coordination and collaboration with all nutrition partners and oversees nutrition activities. She has worked with the Borno State Ministry of Health for over 30 years, including the last five years of the Boko Haram emergencies.



Dr Helni Mshelia is a public health specialist and medical doctor. She is presently the Director of Primary Health Care for the Borno State Primary Health Care Development Agency (SPHCDA), where nutrition is one of the key areas of her responsibility. She has coordinated all nutrition interventions in the state since the start of the Boko Haram emergency and is pioneer chair of the Borno State Nutrition Sector coordination group.

The authors would like to thank the Government of Nigeria at federal, state and local government levels as well as partners for their collaboration in fighting undernutrition in Nigeria. The authors would also like to thank Dominic Stolarow and Simeon Nanama for their valuable contributions to this article and Sultan Ahmed for the infographics used here.

The findings, interpretations and conclusions in this article are those of the authors. They do not necessarily represent the views of UNICEF, its executive directors or the countries that they represent and should not be attributed to them.

Location: *North-eastern Nigeria (NE Nigeria)*

What we know: NE Nigeria is currently experiencing mass population displacements due to internal conflict, aggravating a chronic serious problem of child undernutrition.

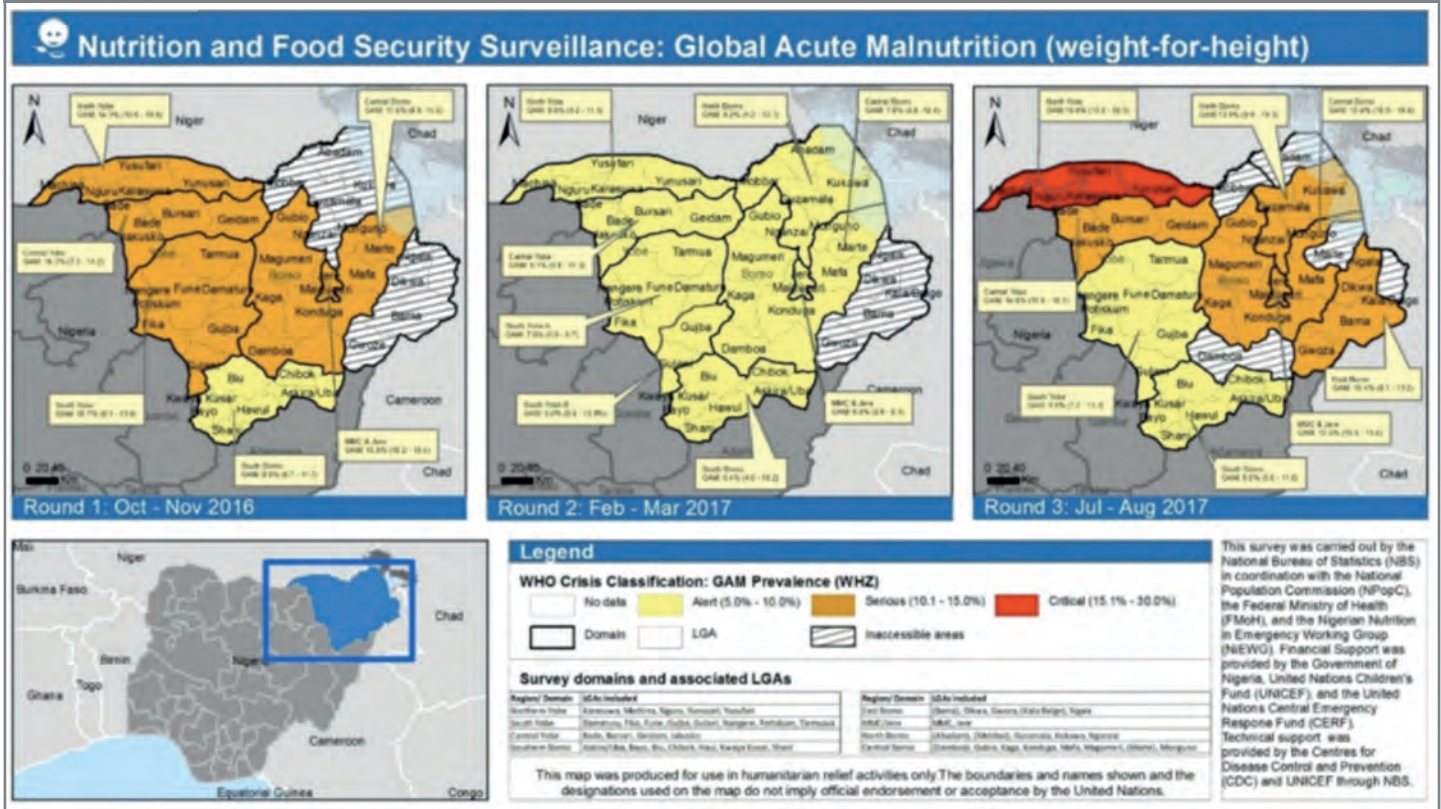
What this article adds: Borno State has been most affected by the current crisis (1.4 million people displaced), requiring a coordinated, multi-sector emergency nutrition response. Emergency nutrition coordination has built on existing development coordination mechanisms, located within the health sector with UNICEF support to government. The cluster system was not activated. The health system is devolved and leadership is strong at state level, with necessary links to federal arrangements. Coordination has been established at sub-state level to meet heightened coordination needs. Government leadership has facilitated considerable collaboration, including geographic mapping at ward level to identify gaps; development of a response plan aligned with national nutrition plans and policies; an integrated nutrition services minimum package and sector information database; a harmonised approach to human resources; and establishment of a nutrition surveillance system. Tripartite partnerships between government, non-government organisations and UNICEF aim for service quality. Government-led coordination has been enabled by strong high-level leadership, political will for an effective response and adequately resourced coordination capacity.

Prior to the Boko Haram conflict, Adamawa, Borno and Yobe states in North-eastern Nigeria (NE Nigeria) ranked below southern states on key socioeconomic indicators, with a poverty rate among the highest in the country at 69 per cent (World Bank Group, 2016). The prevalence of stunting among children under five years old of 47 per cent in Adamawa and Borno and 65 per cent in Yobe was above the national average of 36 per cent (NBS/UNICEF, 2010). Prevalence of wasting varied between the three states and was highest in Yobe. Poor feeding practices also prevailed, with only 12 per cent and 2.7 per cent of mothers in Borno and Yobe States respectively practicing exclusive breastfeeding (NBS/UNICEF, 2012). This already

serious undernutrition situation in NE Nigeria was further aggravated with the escalation of insecurity caused by Boko Haram in 2013.

Mass displacement continues to sustain chronic underdevelopment in Adamawa, Borno and Yobe States. According to the IOM (2017), the majority of internally displaced persons (IDPs) remain in Borno (1,439,940), followed by Adamawa (140,875), and Yobe (107,201), with 96 per cent of IDPs reporting displacement due to the ongoing Boko Haram conflict. The majority of the 1.7 million IDPs across the north-east states are among the most vulnerable groups: a quarter of the IDPs are children under five years old and over half (54 per cent) of the overall population are female.

Figure 1 Nutrition survey results round 3, August 2017

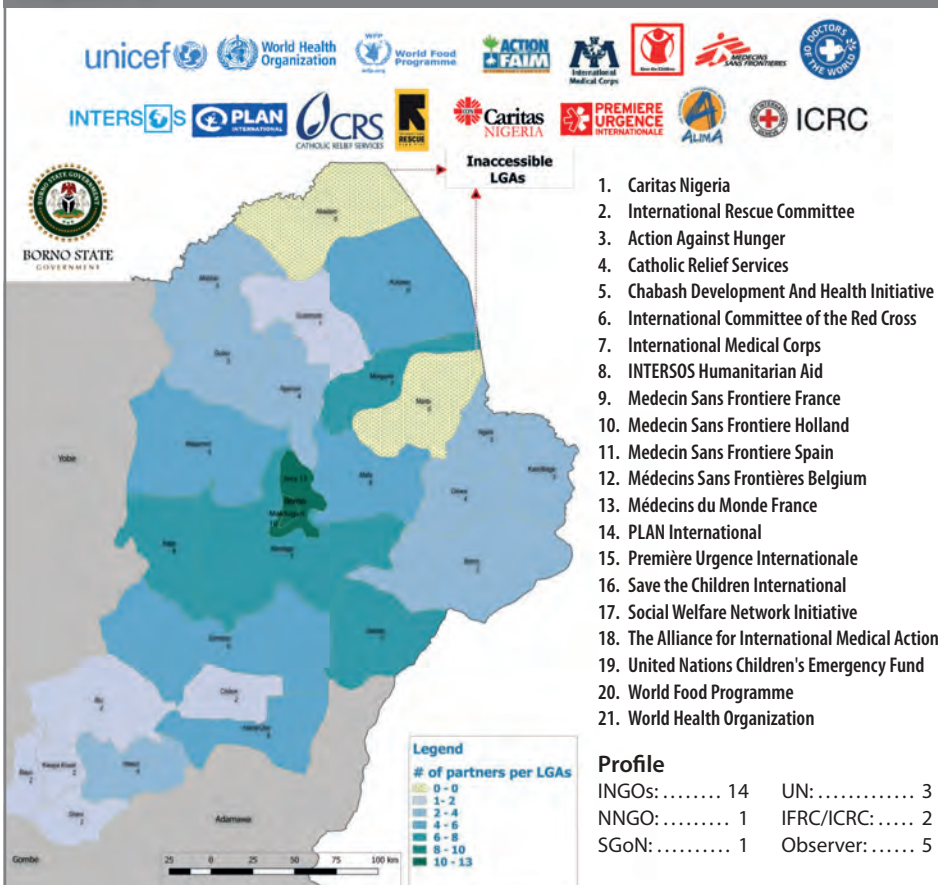


SMART nutrition assessments conducted in August 2017 indicated pockets of high malnutrition among children aged 6-59 months, with levels above the global acute malnutrition (GAM) emergency threshold rate of 15 per cent in the

local government areas (LGAs) Jakusko and Northern Yobe (Karasuwa, Machina, Nguru, Yunusari, Yusufari LGAs). Serious nutrition situations (GAM between 10 and 14 per cent) were reported in Northern Borno (Abadam,

Mobbar, Guzamala, Kukawa, Nganzai LGAs) and central Borno (Damboa, Gubio, Kaga, Konduga, Mafa, Magumeri, Marte, Monguno LGAs). Results are presented in Figure 1 for the three rounds of data collection completed.

Figure 2 Nutrition partner presence, Borno State, 2017



Borno has been the State most affected by the insurgency to date in terms of number of displaced people hosted and security incidents. To flee risks and violence, many households moved to new locations, resulting in over 1.4 million displaced people arriving in the main towns of LGAs and especially in the capital, Maiduguri Municipal Council (MMC), and neighbouring Jere LGAs, which host 80 per cent of all IDPs. MMC and Jere were the site of the first displacements, followed by the main towns of other LGAs when it became safe for people to move there. There has been a continued need for well coordinated, multi-sector (nutrition, health, water and sanitation and food security) scale-up of the humanitarian response across the State. Starting in 2013, as the insecurity escalated and needs increased, the number of partners supporting nutrition interventions increased from two to 18 (see figure 2 for nutrition partner presence in Borno State in 2017). The increased need for partner coordination in Borno set the stage for exploration of an improved and more sustainable mechanism for nutrition emergency response coordination.

History and evolution of the Nutrition Sector coordination structure

Nigeria is a federal country, with devolved autonomy at state level. The administrative units are as follows: *Federal Capital Territory* – Abuja; *State* – autonomous government; *LGA* – equiv-

alent of a district: *Ward level* – equivalent of a sub-district; and *Village/Settlement*. The Nigerian Nutrition Sector is led by the Federal Ministry of Health (FMOH) through the Department of Family Health under the Division of Nutrition. Sector coordination has always been and remains led at Abuja level for the three states of the north-east (Adamawa, Borno and Yobe State). Currently, national/federal coordination is chaired by the Director of Nutrition and meetings are held every month. Coordination at state level takes place through meetings chaired by the Director of the Primary Health Care Development Agency (PHCDA) in each of the three states – monthly in Yobe and Adamawa and every two weeks in Borno. The additional sector coordination support provided capacity for the existing coordination forum to engage in context analysis, partner response planning, technical development and information management.

A need to reinforce the coordination of the response in the north-east while ensuring linkages with the federal coordination arrangement was identified. Sector partnerships were growing, with most partners having presence in the north-east but with no representation in Abuja; hence they were absent from national-level coordination. This led UNICEF as cluster lead agency to request surge support from the Global Nutrition Cluster standby partner to add a sector coordination support position in Maiduguri in August 2016 for three months. After the three-month

deployment it became clear that the centre of coordination had shifted from Abuja to the State; this led the position to support coordination primarily in the north-east, with monthly support to national coordination. The sector coordinator spends most of their time in Maiduguri, the capital of Borno State (with some travel to Yobe and Adamawa), and one week a month in Abuja to support national coordination meetings and other FMOH-led initiatives.

The coordination architecture in NE Nigeria (described in figure 3) is unique in terms of the classic cluster approach, which is often put in place specifically for the emergency response. The cluster approach usually involves a parallel mechanism, led by one specific member of staff hosted by UNICEF and co-led by government and/or a non-government organisation (NGO). The decision was made not to activate the cluster system but instead build on on-going development coordination mechanisms and guide them on humanitarian response coordination. The Nutrition in Emergencies Working Group (NiEWG) was established through dialogue with the Government, who recommended the use of sector rather than cluster. As a result, sector coordination of the emergency response was strengthened with UNICEF as co-sector lead, with support from partners.

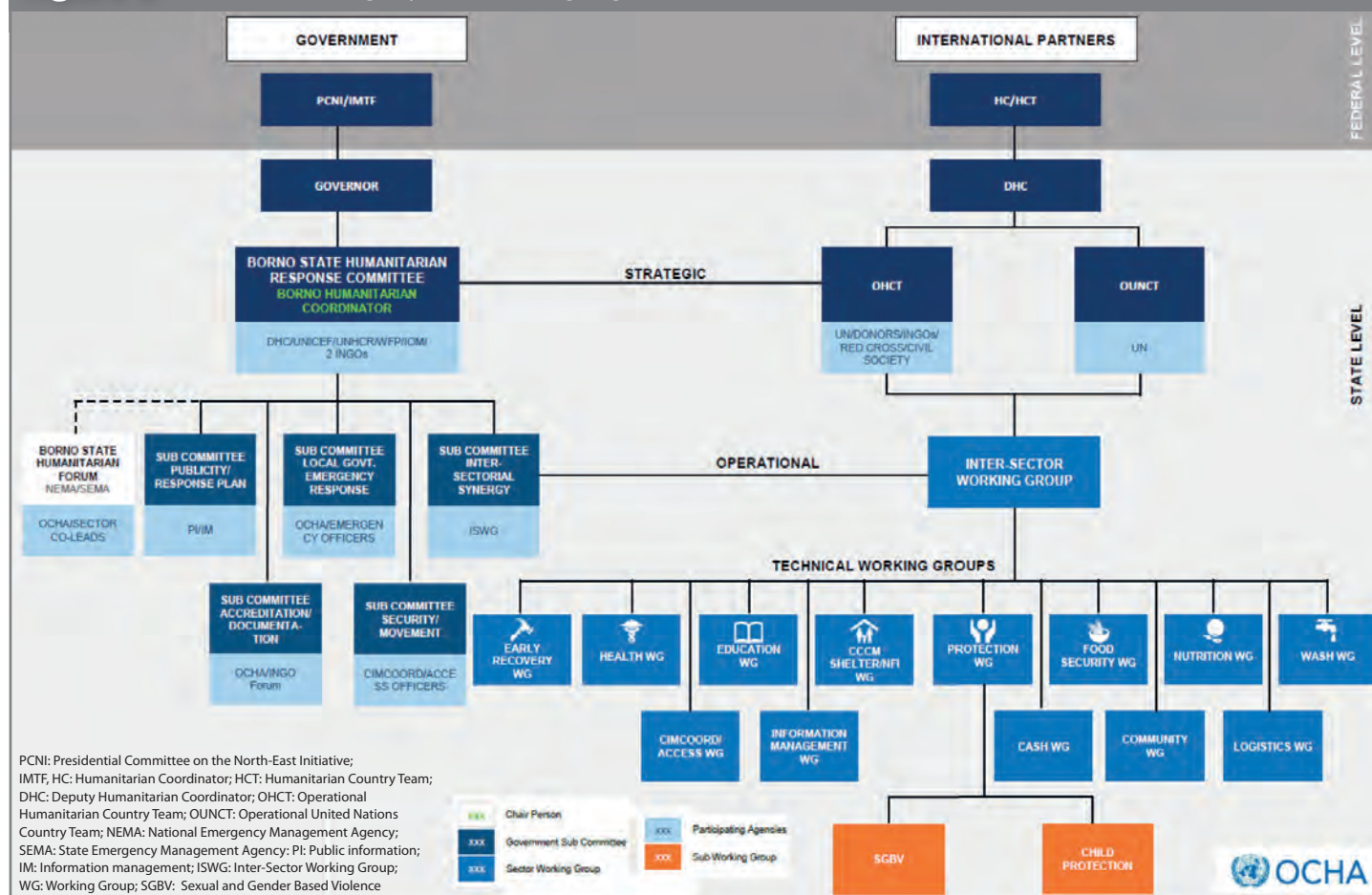
The devolved nature of the health system in Nigeria, given the strong leadership in health by the State Primary Health Care Development

Agency in Borno State, offered a key opportunity to explore new ways of working to maintain government leadership in coordinating the emergency response. Nutrition was also a key priority under the primary healthcare umbrella. As a result, the approach implemented became a sector coordination-strengthening approach. Initially health and nutrition coordination were merged and chaired by the permanent secretary in Borno Ministry of Health (MoH). As the response requirements grew, the need to establish nutrition-specific coordination was endorsed by the MoH and the State Primary Health Care Development Agency (SPHCDA), the body responsible for provision of primary healthcare, which was mandated to lead the coordination of nutrition activities with support from UNICEF.

The Director of Primary Health Care for Borno SPHCDA, who oversees primary healthcare services (which encompass nutrition services), has been committed to ensuring and directing service delivery in the geographic and technical areas she oversees in order to maintain coherence and strengthen the existing operational and human resource structure of the SPHCDA. In addition, the existing government structure has a dedicated nutrition team led by the State Nutrition Officer with support of four people, including one person dedicated to information and supply management.

State-level meetings are held every two weeks in Maiduguri. As the number of partners in-

Figure 3 Nutrition Sector emergency coordination organogram





Screening of a six year old child with severe acute malnutrition (SAM) at health centre in Muna garage IDP camp, Maiduguri, Borno state, NE Nigeria, 2016

WFP/Hussain Al-Sleih

creased, with many per each LGA, coordination forums at LGA level were created to improve engagements. These are currently active in five LGAs (Monguno, MMC and Jere, Askira Uba, Dikwa and Banki) and have the specific objective of ensuring that activities are well coordinated, with the ultimate aim of maximising coverage where security permits. These LGA-level coordination units are put in place where there are more than two partners, local or international, and engage the nutrition focal persons from the LGA, with support from one identified partner. The Nutrition Sector-specific LGA coordination mechanisms also link with the United Nations Office for the Coordination of Humanitarian Affairs multi-sector humanitarian coordination hub by attending meetings, which are decentralised at hub level. The state coordination also works with three technical working groups (TWG) on nutrition information and assessments, community based management of acute malnutrition (CMAM), infant and young child feeding in emergencies (IYCF-E), as well as with task forces to accomplish specific deliverables that have been formed as part of the technical and operational coordination architecture. The TWGs are forums for technical discussions related to the improvement of the response and are led by different partners. These state-level TWGs are linked to the federal-level TWG on some of the issues that need to be managed at federal level.

Achievements of the Borno State Nutrition NiEWG

The role of government in delivering the emergency response and its leadership in facilitating meetings has resulted in several collaborative

initiatives for services to be delivered in an increasingly harmonised way. These include:

Geographic mapping at ward level: Ward-level partner mapping of nutrition-related activities has allowed for a better understanding of gaps and identification of duplication, and extension of services in the scale-up process, with corrective actions as indicated (see Box 1).

Nutrition in Emergency Sector Response plan 2017-2018: The response plan is a strategic document on the approach, principles, overall strategies and activities to be implemented, as well as a specific plan with timeframe and deliverables. The response plan links the emergency activities with existing policy and national action plan on nutrition.

Integrated nutrition services – minimum package and modalities of operation: The package was developed by the CMAM TWG and outlines the minimum services in terms of assessments, treatment, prevention and coordination, including an agreed set of indicators for monitoring performance of CMAM programmes. It serves as a guideline and reference to all nutrition programme personnel and partners supporting nutrition services in Borno State. Interventions are mapped and described by service delivery platform, including health facility, community IDP camps, outreach and campaigns. The minimum package was a collaborative effort developed by partners and government, then consolidated by the sector coordinator.

Community nutrition monitor approach: A task force for community mobilisation was formed to review existing approaches and propose a harmonised way forward. A community nutrition

monitor approach was developed and agreed by a sub-committee to overcome challenges of coverage and reach of services. The task force agrees on incentives and a minimum set of activities to be performed by monitors, as well as the desired profile for the role.

Scale-up stabilisation care strategy: In view of very low coverage of inpatient services, the CMAM TWG developed a strategy for training hospital personnel and supporting set-up of inpatient nutrition care for cases with medical complications.

IYCF-E statement and strategy: The IYCF-E statement aimed at bringing the need to scale-up IYCF activities and control the use of breast-milk substitutes in the humanitarian response to the attention of the wider humanitarian community. Key successes have been achieved, such as the commitment to withdraw the use of powdered milk as an incentive for children during polio vaccinations. Finalisation of a reporting template and rollout of training of health workers has increased the reporting rate of IYCF activities. The statement and strategy are at final stages of endorsement.

Harmonised approach to human resources (HR): With many partners in Borno employing various incentive schemes and occasionally hiring paid health workers already employed by government, there was a clear need to harmonise the HR approach. The Director of PHC requested that all partners submit their staff incentive system approach and a list of employees to cross-check that they were not already receiving a salary. Partners were also required to request a letter of discharge from health employees applying for positions if they were selected. The objectives were to prevent double pay and the diverting of government workers from their station duties. The link between nutrition and health is made through the Director of PHC, who oversees both nutrition and health as part of routine services. The HR taskforce also managed to harmonise the monetary incentives given to the community nutrition volunteers. Challenges remain in having all partners function through one standardised system/approach and efforts are ongoing.

Sector information database: This includes mapping of partners and interventions at ward level; CMAM and IYCF databases for compilation of sector results; and harmonised reporting systems.

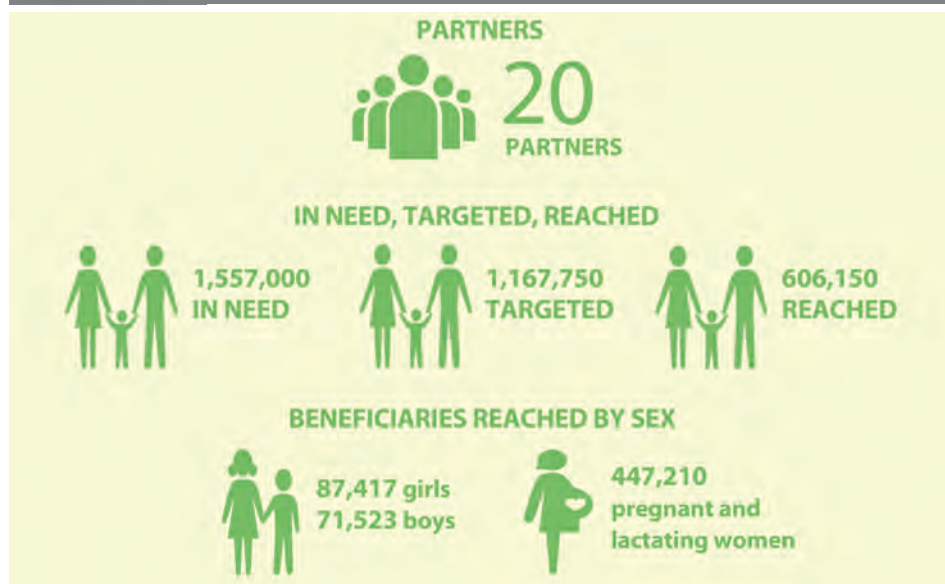
Joint monitoring approach: Government and partners form joint teams for monitoring visits and use a monitoring form that has been validated by sector partners for visits. Several joint monitoring visits have been conducted, with corrective action taken to strengthen the response. The outcome of the joint monitoring has been appreciated as the tools are harmonised and the corrective action agreed by all stakeholders.

Task force for monitoring misuse of nutrition commodities: The task force was established to support sector partners in enhancing monitoring and reporting misuse of ready-to-use therapeutic food (RUTF). Reporting templates were devel-

Box 1 Achieving successful partner coordination in Monguno

In October 2016, a geographic mapping was undertaken of nutritional services being delivered by MoH staff with support of partners in Monguno. Interventions had started in July 2016 with primary healthcare and nutritional centres being established with support from UNICEF; there were no existing health services, since the population was displaced into camps, thus services were set up with MoH. Following additional assessments, MSF-France, ALIMA, Action against Hunger and the International Rescue Committee also established CMAM and IYCF services. As a result it was found that some supported facilities were closely located and covered the same population. The Director of PHC, with support of the sector coordination, requested that the situation be resolved to stop the duplication of services. The sector coordinator had a number of meetings with partners to see how to best merge or handover facilities in close proximity. As a result all partners agreed on a strategy. In view of the arrival of partners in the area, UNICEF handed over all its supported facilities, while partners merged or exchanged locations for geographic coherence. The task was challenging yet successful and there is now a forum through which partners exchange and coordinate activities.

Figure 4 Nutrition Sector achievement in numbers, Borno State



oped and sensitisation carried out with local leaders and health workers. Stock management was also strengthened, with supplies delivered directly bi-weekly to the health facilities based on numbers of children in the programme.

Establishment of the nutrition surveillance system and increasing nutrition assessments: Nutrition assessments were conducted annually and figures for prevalence at state level calculated; the lack of disaggregated data limited informed programme decision making and response planning. Through discussion with the Food and Agriculture Organization, the Center for Disease Control, World Food Programme and UNICEF, the sector developed the nutrition and food security surveillance system (NFSS). Initiated in October 2016 and covering the three north-eastern states affected by the conflict, assessments are conducted three times a year. To date, three rounds of data collection have been completed and have informed the humanitarian needs overview.

CMAM guideline review workshop: The CMAM TWG in Borno convened a workshop to identify key gaps in current CMAM guidelines and to incorporate the management of moderate acute malnutrition. The TWG has the support of the state and the federal government, with assurances

of ministerial commitment to review the guideline and incorporate the missing elements.

The sector coordination group (Nutrition in Emergencies working group) is dynamic and will continue to address the need for guidance as these emerge and are agreed as a priority by partners. The government leadership has resulted in tripartite partnerships between government, international NGOs (INGOs) and UNICEF to ensure quality of services delivered. In this partnership, the state government provides the health infrastructure and the health workforce; UNICEF provides technical support to the state, fundraises and manages the supply of RUTF and therapeutic commodities for the sector; and INGOs focus on supporting the state with operational capacity and technical mentoring. Figures 4 and 5 illustrate the achievements of the response in numbers in Borno State.

Challenges and lessons learned

Despite many successes of the coordination approach, there have been challenges and lessons learned.

Competition for space between partners led to limited sharing of information and sometimes launching of activities without informing the coordination forum. Proposals were developed

for specific locations already covered by a partner. This led to temporary duplication of activities until it was resolved with support of the state. The key lesson here is twofold: first, the need for partners to ‘play the game’ and inform government and sector coordination of their planning; secondly, the importance of donors coordinating their support, being flexible and requiring that projects that are being funded are coordinated through the sector. All activities fall under the Humanitarian Response Plan and are externally funded. There is some consultation by donors with the coordination forum which can be further refined.

Competing priorities within government are important to consider as the Director of PHC also oversees several other primary healthcare-related units. While this oversight is conducive to integration, programmes are delivered vertically, which poses a challenge to integration. The state nutrition team and UNICEF-supported structure have both been vital components in maintaining regular activity of the group.

Low partner commitment on coordination activities has been a constraint. With new partners arriving to set up a response, humanitarian coordination was not always prioritised and was a new phenomenon for some, which limited their participation in coordination activities and contributions to TWGs.

Several factors enabled the government-led coordination mechanism to take shape in Borno State, including strong high-level leadership, political will for an effective response and HR structures to support the work involved in coordination. The focus of the coordination has been mainly on emergency partners, despite the availability of a wider range of development funding throughout other areas of the country. When enabling factors are in place, it is best to empower government and co-lead in strengthening sector coordination in the emergency response, rather than engage in parallel structures.

Conclusion

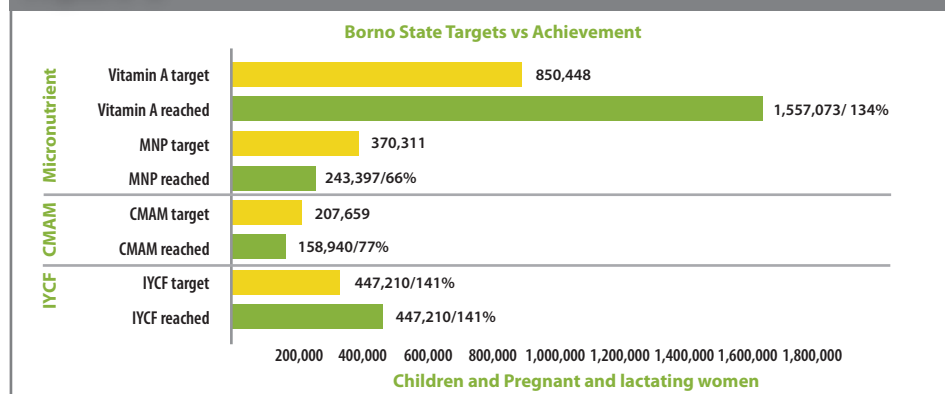
The experience of the Nutrition Sector coordination in emergencies in Borno State demonstrates that it is possible to work effectively through existing systems. In view of the linkages between development and humanitarian interventions, there is increased need to adapt approaches to specific contexts and local systems. Such experiences demonstrate further prospects for sustainability during and after a humanitarian response.

For more information, contact: Maureen Gallagher, mgallagher@unicef.org, or Kirathi Reuel, rkmungai@unicef.org

References

IOM, 2017. International Office for Migration (IOM) Data Tracking Matrix Round XVIII (2017) .
National Bureau of Statistics (NBS)/ UNICEF (2010)
National Bureau of Statistics (NBS)/ UNICEF (2012)
World Bank Group. 2015. North-East Nigeria Recovery and Peace Building Assessment: Synthesis Report. World Bank, Abuja, Nigeria. © World Bank. <https://openknowledge.worldbank.org/handle/10986/25791> License: CC BY 3.0 IGO.

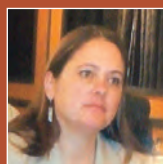
Figure 5 Nutrition Sector achievements by intervention in numbers, Borno State





Nutrition in health response in emergencies: WHO perspectives and developments

By Zita Weise Prinzo, Adelheid Onyango, Dr Ferima-Coulibaly Zerbo, Hana Bekele, Dr Ngoy Nsenga and Adelheid Marschang



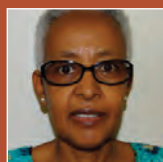
Zita Weise Prinzo is the focal point for Nutrition in Emergencies and Undernutrition at the World Health Organization (WHO) HQ. She has worked with WHO on public health nutrition for the past 25 years.



Adelheid Onyango is Regional Adviser for Nutrition, WHO Regional Office for Africa. She has 20 years' experience in public health nutrition research and policy issues, growth assessment and nutrition surveillance.



Dr Ferima-Coulibaly Zerbo is a paediatrician-nutritionist with extensive experience in nutrition in emergencies with WHO in the African Region.



Hana Bekele is Nutrition Advisor for the WHO/AFRO/Inter-country Support Team for East and Southern Africa countries.



Dr Ngoy Nsenga is Regional Advisor, Country Preparedness and Risk Assessment for WHO Regional Office for Africa. He has more than 20 years' experience in management of public health and humanitarian emergencies and a particular interest in vulnerability and risk analysis.



Adelheid Marschang is Senior Emergency Officer in Emergency Management and Operations at WHO HQ, working to support protracted crises in fragile and vulnerable settings. She holds a doctoral degree in medicine and specialisations in internal medicine, tropical medicine and

infectious diseases, and public health. She has more than 20 years' experience in public health in emergencies and disaster management.

Location: *Global*

What we know: The World Health Organization (WHO) has an essential role in supporting Member States to prepare for, respond to and recover from emergencies with public health consequences.

What this article adds: Informed by recent experiences, WHO has reshaped its emergency programme to include creation of WHO's Health Emergencies Programme, an updated Emergency Response Framework and adoption of the Incident Management System (IMS) to manage response. A key aim is to add a nutrition lens to WHO's work that is beyond outbreak management. Nutrition priorities identified include development of an operations model for nutrition in emergencies for WHO and improving the availability of nutrition actions in health systems. Better contextual understanding of emergencies helps determine where WHO should be operationally involved or where indirect technical support is most appropriate. Discussions are underway within WHO on such decision making. Efforts to achieve universal health coverage include the scaling up of essential nutrition actions in line with the strategy of the Nutrition Cluster. WHO's role as Health Cluster Lead Agency includes integration of nutrition into the health sector and close collaboration with the Nutrition Cluster/sector; development of a joint operational framework is underway. Recent WHO training in Tanzania centred on an operational model integrating nutrition and health emergency response within WHO at country level; 33 WHO staff from 14 countries participated. A training package for WHO staff will be developed for adaptation and use in other regions.

Context

Worldwide, 130 million people need humanitarian assistance and disease outbreaks are a constant global threat. Health is a top priority in all kinds of emergency, whether due to natural disasters, conflicts, disease outbreaks, food contamination, chemical or radio-nuclear spills, among other hazards. Undernutrition, in combination with a lack of access to health facilities and water supplies, leads to disease outbreaks and epidemics, including acute watery diarrhoea and cholera. During humanitarian crises, such as conflict and drought, the increased spread of communicable diseases heavily burdens the already weakened health system. In countries such as South Sudan, Somalia and Nigeria, a weak health system and low vaccination coverage can quickly trigger a vicious cycle, eventually leading to higher mortality. Studies consistently show that infectious diseases have been a major determinant of famine mortality. Malnutrition is an underlying cause in over 60 per cent of deaths, especially among children, resulting from diarrhoea, pneumonia and (in 40 per cent of cases) measles. Malnutrition among pregnant and lactating women (PLW) leads to higher-than-normal rates of mortality around childbirth.

Emergencies can undermine decades of social development and hard-earned

health gains, weaken health systems and slow progress towards the Sustainable Development Goals (SDGs). Chronic undernourishment and repeated infections contribute to high rates of stunting, while acute malnutrition (or wasting) increases the immediate risk of death two- to nine-fold among children under five years of age. Repeated episodes of acute malnutrition in childhood undermine human capital development and thus stifle the economic growth of nations. Renewed efforts to address malnutrition in emergencies are therefore imperative for saving lives, as well as ensuring long-term development.

WHO's framework for operational emergency response

WHO has an essential role in supporting Member States to prepare for, respond to and recover from emergencies. WHO also has obligations to the Inter-Agency Standing Committee (IASC) as Health Cluster Lead Agency, to the International Health Regulations (IHR) (2005) and to other international bodies and agreements. WHO takes a comprehensive approach to all aspects of emergency management, embracing prevention/mitigation, preparedness/readiness, response and recovery. WHO supports Member States to build their capacities to manage the risks of outbreaks and

Box 1 WHO areas of focus on nutrition in emergencies (NIE)**Life-saving programmes on nutrition and health**

- 1) Improve capacity of health staff on the inpatient management of SAM with medical complications, including in the context of outbreaks such as cholera.
- 2) Improve capacity of health staff on appropriate infant and young child feeding (IYCF) (i.e. breastfeeding and complementary feeding), including risk management and support of health needs of non-breastfed infants in the inpatient management of SAM to prevent relapse.
- 3) Ensure necessary supplies for the inpatient treatment of SAM.

Identification of those in need of nutrition interventions and appropriate referrals

- 4) Integrate nutrition screening at all levels of the health system (community, primary healthcare, tertiary healthcare) including mobile clinics; ensure key nutrition interventions are conducted in the health facilities where appropriate (e.g. iron-folic acid supplementation/micronutrient supplementation in antenatal care, inpatient management of SAM) and that referral is conducted for nutrition interventions (e.g. outpatient SAM and, where needed, supplementary feeding programmes for moderate acute malnutrition and PLW).

Nutrition surveillance mechanisms and monitoring and evaluation

- 5) Monitor and evaluate inpatient management of SAM in health facilities, ideally integrated within existing systems. Health resources availability monitoring system (HeRAMS) to monitor availability of services and resources at different points of service delivery to identify gaps for appropriate actions, including nutrition.
- 6) Integrate nutrition and health surveillance. Technical support to strengthen the existing routine health information system and to integrate key programme performance indicators to monitor the outcome of nutrition services implemented at health facilities.

Box 2 WHO Health Emergencies (WHE) Programme

The WHE has a common structure across WHO, in-country offices, regional offices and headquarters when it comes to workforce, budget, lines of accountability, processes/systems and benchmarks. It reflects WHO's major functions and responsibilities in health emergency risk assessment and management. The Programme is made up of five technical and operational departments. Their titles and specific outcomes are:

1. *Infectious hazards management*: Ensure strategies and capacities are established for priority high-threat infectious hazards.
2. *Country health emergency preparedness and the IHR (2005)*: Ensure country capacities are established for all hazards emergency risk management.
3. *Health emergency information and risk assessments*: Provide timely and authoritative situation analysis, risk assessment and response monitoring for all major health threats and events, including malnutrition.
4. *Emergency operations*: Ensure emergency-affected populations have access to an essential package of life-saving health services, including the treatment of SAM.
5. *Emergency core services*: Ensure WHO emergency operations are rapidly and sustainably financed and staffed.

Box 3 Incident Management System (IMS)

The IMS is the standardised structure and approach WHO has adopted to manage its response to public health events and emergencies and to ensure that WHO follows best practice in emergency management. WHO has adapted the IMS to consist of six critical functions: Leadership, Partner Coordination, Information and Planning, Health Operations and Technical Expertise, Operations Support and Logistics, and Finance and Administration.

On activation of the IMS within 24 hours of grading of acute emergencies, WHO will:

- Ensure the safety and security of all staff.
- Appoint an Incident Manager in-country for a minimum initial period of three months.
- Activate the emergency standard operating procedures (SOPs).
- Establish an initial Incident Management Team (IMT) in-country to cover the six critical IMS functions. This will be done initially through repurposing of country office staff.
- Establish contact with government officials, partners and other relevant stakeholders.
- Determine the need for surge support to the country to cover the critical IMS functions. This determination is made following an analysis of country office capacity to manage the emergency.
- Begin the deployment of surge support on a 'no regrets'* basis, as needed.
- Elaborate the initial response objectives and action plan, until a more detailed plan is developed.
- Appoint an Emergency Coordinator and Incident Management Support Team (IMST) at regional or headquarters level to coordinate organisation-wide support for the response to Grade 2 and Grade 3 emergencies. A focal point will be appointed at both regional and headquarters levels for Grade 1 emergencies to coordinate any required support.

* At the onset of all emergencies, WHO ensures that predictable levels of staff and funds are made available to the country office, even if it is later realised that less is required, with full support from WHO and without blame or regret. Immediate access to funds is provided from either CFE or the Regional Office's rapid response accounts and is replenished as funds are raised for the emergency. This 'no-regrets' policy applies to any expenditure incurred during the first three months of an acute emergency.

emergencies with health consequences. When national capacities are exceeded, WHO assists in leading and coordinating the international health response to contain outbreaks and provide effective relief and recovery to affected populations. WHO is also a member of the Nutrition Cluster and supports the nutrition response, especially in the areas of management of severe acute malnutrition (SAM) and nutrition surveillance (see Box 1).

Fundamental rethinking and redefinition of WHO's work in emergencies has recently reshaped its emergency programme. The second edition of WHO's Emergency Response Framework (ERF), issued in 2017, has incorporated lessons learned from WHO's response to recent outbreaks and emergencies, such as the Ebola response in 2016, and the reform of WHO's emergency work. This includes the creation of WHO's Health Emergencies Programme (WHE) in 2016 (See Box 2) and the adoption of the Incident Management System (IMS) (see Box 3 and Figure 1) as the main organisational approach to managing the response to emergencies. While the ERF focuses primarily on acute events and emergencies, it also introduces WHO's new grading process for protracted emergencies (see Box 4). The revised ERF focuses on building the operational capacities and capabilities that enable WHO to respond more effectively to outbreaks and emergencies and on improving underlying vulnerabilities through prevention and control strategies for high-threat infectious hazards and other hazards. These strategies must be integrated with health systems strengthening, since the health system as a whole provides the foundation required to raise readiness and resilience across the board. The reform articulates better contextual understanding of emergencies, including where WHO should be operationally involved, e.g. as currently in Yemen, Central African Republic (CAR), Ethiopia (Somali Region) and South Sudan; and where to provide technical support rather than become operational. Discussions on this dichotomy are ongoing within WHO.

WHO's responsibilities begin with early detection and risk assessment or situation analysis of a public health event or emergency. WHO supports countries to build their capacities to mitigate risks and manage outbreaks and emergencies, including nutritional emergencies with health consequences. When national capacities are exceeded, WHO assists in leading and coordinating the international health response to contain outbreaks and provide effective relief and recovery to affected populations, even if a Health Cluster has not been activated. Significant progress has been made in areas such as risk assessment and grading, and coordination of WHO's response at headquarters, regional offices and country offices through the IMS, which provides a standardised yet flexible approach to managing WHO's response to an emergency and the rapid release of funds from the WHO Contingency Fund for Emergencies (CFE). This rapidly disburses funds to enable the early stages of a response to

Box 4 WHO levels for graded emergencies

Grading is an internal activation procedure that triggers WHO emergency procedures and activities for the management of the response. The grading assigned to an acute emergency indicates the level of operational response required by WHO for that emergency.

Protracted emergencies (i.e. emergencies that persist for longer than six months) are assigned protracted grades to indicate the level of operational response to be sustained by WHO over a prolonged, often indefinite period.

- Ungraded* – Monitored by WHO but does not require an operational response.
- Grade 1* – A single-country emergency requiring a limited response by WHO but which still exceeds the usual country-level cooperation that the WHO country office has with the Member State.
- Grade 2* – A single country or multiple country emergency requiring moderate WHO response. Always exceeds WCO capacity and requires organisational/external support.
- Grade 3* – A single country or multiple country emergency requiring major/maximum WHO response.

humanitarian crises, disease outbreaks and natural disasters and/or to respond to rapid deterioration of crises. The fund requires constant replenishment. Since its creation in May 2015, CFE funds have supported WHO activities in more than 30 health emergency responses, including outbreaks of Ebola virus, yellow fever, cholera, Rift Valley fever and Zika virus, as well as natural disasters such as Cyclone Winston in Fiji and Cyclone Donna in Vanuatu and the climatic effects of El Niño in Papua New Guinea, and in response to complex emergencies.

WHO works with the local ministry of health (MoH) and partners to identify where health needs are greatest and regularly collaborates with partner networks to leverage and coordinate the expertise of partner agencies:

- *Global Health Cluster*: More than 700 partners are responding in 24 crisis-affected countries.
- *Emergency Medical Teams*: More than 60 teams from 25 countries classified by WHO to provide clinical care in the wake of emergencies, with the number expected to

rise to 200 soon.

- *Global Outbreak Alert and Response Network (GOARN)*: Since 2000, approximately 2,500 health personnel have been deployed in response to more than 130 public health emergencies in 80 countries.
- *Standby Partners*¹: In 2015, WHO's Standby Partners¹ deployed 207 months of personnel support to 18 countries.
- *Inter-Agency Standing Committee (IASC)*: WHO is an active member of IASC (the primary mechanism for inter-agency coordination relating to humanitarian assistance in response to complex and major emergencies under the leadership of the Emergency Relief Coordinator) and is a member of the Global Nutrition Cluster.

Examples of countries where WHO is operationally engaged in NiE response (SAM treatment) are Yemen, CAR, Ethiopia (Somali Region) and South Sudan.

WHO also plays a lead role in global policy guidance to inform country-level guidance de-

velopment. WHO's role includes:

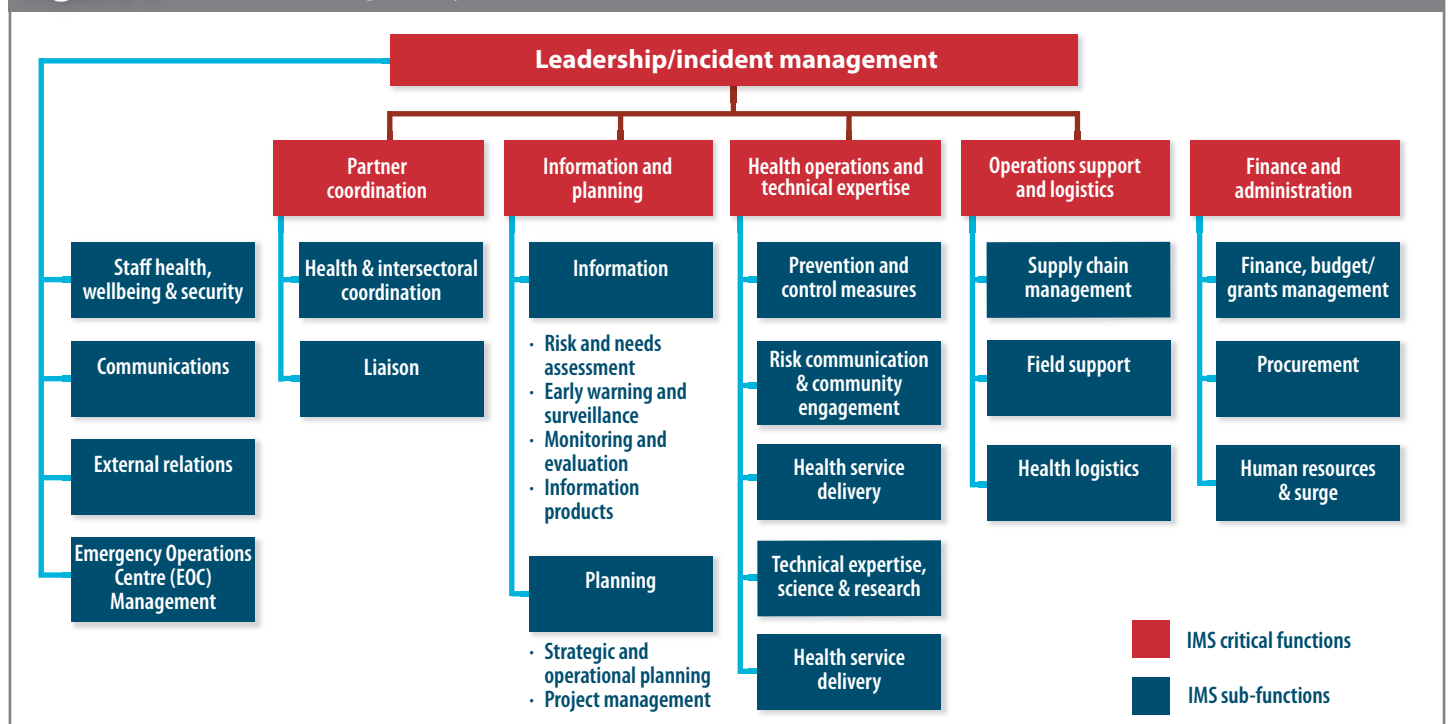
- Provide effective technical support through the production and dissemination of scientifically validated and up-to-date guidelines, including interim guidelines where there are gaps in recommendations (e.g. nutritional care in Ebola response and breastfeeding in the context of Zika), norms, criteria and methodologies on:
 - assessment of malnutrition, including specific micronutrient deficiencies;
 - improved management of malnutrition in all its forms; and
 - nutrition and health surveillance for both prevention/early warning and response.
- Strengthen, through information dissemination and training, national and sub-national capacities of the health workforce.
- Work with the government on developing and updating policies that have an impact on improving response and rehabilitation.

WHO's role in linking nutrition and health

WHO's Ambition and Action in Nutrition 2016-2025 is anchored on the six global targets for improving maternal, infant and young child nutrition and the global diet-related non-communicable disease (NCD) targets. In support of the 2030 Agenda for Sustainable Development, particularly SDG2 and SDG3, and with the 2016-2025 UN Decade of Action on Nutrition, WHO's nutrition strategy aims for: "A world

¹ Standby Partners are organisations with strong networks of deployable technical professionals. WHO's Standby Partnerships are managed by WHO HQ. WHO signs a global Standby Partnership agreement directly with the Standby Partner organisation which has a contractual relationship with the individuals who serve as Standby Personnel, e.g. CANADEM, DEMA, Norwegian Refugee Council.

Figure 1 WHO Incident Management System (IMS) structure and core functions



free from all forms of malnutrition where all people achieve health and well-being”.

One of the six WHO priorities in nutrition is to leverage the implementation of effective nutrition policies and programmes in all settings, including situations of emergency and crisis, by developing an operations model for NiE and preparedness plans to support the WHO Health Emergencies Programme. Another priority is to improve the availability of nutrition actions in health systems. Many effective nutrition actions and diagnostic procedures are delivered through health services such as provision of nutrient supplements where needed, treatment of SAM, dietary counselling, breastfeeding counselling and assessment of nutritional status. Most of these actions impact on morbidity and mortality, especially when combined with other health and poverty-reduction efforts. However, the coverage of these actions remains very low. Achieving Universal Health Coverage (UHC) has been established as one of the targets of the SDGs. WHO aims to ensure that efforts to achieve UHC include the scaling-up of essential nutrition actions, as reflected in WHO's recent nutrition strategy (www.who.int/nutrition/publications/nutrition-strategy-2016to2025/en/).

The underlying causes of child malnutrition and death are not only the lack of access to food and inadequate food intake but also inadequate reproductive, maternal and child care practices and poor public health services. Necessary immediate medical interventions include the medical management of SAM and the detection and

control of deadly diseases such as measles, acute respiratory infections (ARI), malaria, diarrhoea and waterborne diseases. In the mid to long-term, countries prone to undernutrition need to ensure that preventative measures are taken and that their health systems are strengthened to increase the population's health resilience at times of famine or in settings where there is a risk of famine. In countries with high levels of food insecurity, WHO has identified several key activities to reduce the risks of missed opportunities for screening, prevention and treatment of uncomplicated illness and malnutrition and to ensure appropriate referral and synergies between nutrition and health services (see Box 5).

The integration of humanitarian response with a vision of recovery and long-term development is among the guiding principles of the new WHO Emergency Response Framework (WHO, 2017). This calls for comprehensive emergency response planning which seeks not only to save lives but also to address the systemic contributors to the crisis. As an example, the humanitarian crisis in the Horn of Africa has fundamental health implications for local communities. The United Nations Office for the Co-ordination of Humanitarian Affairs (OCHA) declared health one of four key sectors for a famine response and prevention, along with food security, nutrition and WASH.

Coordination in emergencies: Health Cluster and nutrition

WHO plays an essential role in supporting

Member States to prepare for, respond to and recover from emergencies. As Health Cluster Lead Agency within the IASC, its primary responsibility is to coordinate the health response in emergencies. And since malnutrition is intimately associated with disease, WHO must strengthen the nutrition component of its emergency response strategy to achieve lasting impact. Data on food insecurity, famine and population malnutrition trends are a critical component of the information needed for early warning as well as situation analysis, risk assessment and response monitoring in major health threats and events. Similarly, nutrition interventions to prevent and treat acute malnutrition in emergency-affected populations are part of the essential package of life-saving health services expected of WHO's emergency operations; therefore it is particularly important to integrate nutrition action in the units responsible for health emergency information and risk assessments and for emergency operations.

As Health Cluster Lead Agency, in practice WHO works to ensure a functioning coordination of the health sector, targeting vulnerable people for improved healthcare, with a focus on life-saving services including timely and adequate response to disease outbreaks and epidemics. WHO is responsible for linking the work of the Health Cluster with other clusters, including the Nutrition Cluster and the WASH Cluster. All clusters are responsible for ensuring they work effectively together, supported by OCHA.

Continued and improved information sharing and collaboration between Health and Nutrition Clusters is critical. Areas of collaboration between both clusters include joint analysis of response capacities in health facilities/centres, building capacity of health workers and partners on in-patient management, referral systems, and management of supplies for in-patient management. Both clusters must continue to examine how to better utilise the capacities of MoH staff and structures. There are instances where nutrition is a sub-cluster within the Health Cluster (e.g. Fiji, Somali Region, Ethiopia). The Health and Nutrition Clusters have initiated discussions to develop joint operational frameworks to enable better integration of health and nutrition interventions. The Global Health Cluster (GHC) Strategy outlines its commitment to strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes, which involves deepening engagement with the Nutrition Cluster (see www.who.int/health-cluster/about/work/strategic-framework/GHC-strategy-2017-2019.pdf).

In close collaboration with the Nutrition Cluster and depending on the context and capacity, WHO focuses on life-saving programmes on nutrition and health, measures to improve identification of those in need of nutrition interventions and appropriate referrals, and nutrition surveillance mechanisms that generate regular information together with health (see Box 4). WHO also aims to ensure integration of nutrition into the health sector based on principles

Box 5 Key activities to maximise service delivery in countries affected by high levels of food insecurity

Early treatment of malnutrition and illness saves lives

1. In integrated community case management (iCCM), including the 'backpack model' for health delivery in mobile populations, all community health workers (CHWs) should be trained to screen, treat and refer as appropriate both acute malnutrition and illness. At least malaria, diarrhoea, and ARIs should be recognised and treated by the CHWs.
2. Frequent screening for acute malnutrition and illness at community level should be used to offer a standard package of preventative care.
 - All children screened should receive measles vaccination, long-lasting insecticide-treated nets (LLITNs), deworming and vitamin A (as per national protocol).
 - All PLWs should be referred for preventative care (including tetanus vaccination, ferrous and folic acid, LLITN and malaria prophylaxis) and safe delivery as indicated.
 - All outreach personnel should support coordinated social mobilisation and messaging campaigns regarding recognition of disease and malnutrition, as well as where and how to seek treatment.

Each contact with health is an opportunity to detect, refer and/or treat malnutrition

3. All people, but at least all children and PLW, presenting at inpatient and outpatient health facilities should be screened for acute malnutrition and referred to the appropriate nutrition programme or, when admitted, treated for malnutrition.

Each contact with nutrition is an opportunity to detect, refer and/or treat illness

4. All people, but at least all children and PLW, who are in nutrition programmes (including general food distribution, blanket and targeted supplementary, and outpatient therapeutic feeding programmes) should be screened for both illness and malnutrition each time there is a contact.
5. Treatment and preventative health interventions should be ensured, either integrated within the food/nutrition programme or by referral to a health facility, provided this can be ensured on the same day.
6. When referring people with either illness or malnutrition ensure
 - that they actually reach the facility or programme (e.g. by supporting transport); and
 - that the facility or programme has the capacity to treat all those referred on that same day.
7. All health and nutrition treatment sites should ensure the availability of the required quantities of safe drinking water and a correct water, sanitation and hygiene (WASH) environment.
8. Health information and surveillance data should be shared with other sectors to ensure their inclusion in food security and nutrition analysis.

of UHC to ensure:

- Equitable access to quality life-saving services for management of acute malnutrition through systematic identification, referral and treatment of acutely malnourished cases (as reflected in Box 1).
- Access to services preventing undernutrition for vulnerable groups (children under the age of five and PLW), focusing on infant and young child feeding (IYCF) and other preventative services by:
 - Scaling up IYCF interventions to protect and promote optimal IYCF practices;
 - Providing essential health and nutrition services to PLW;
 - Implementing a multi-programme approach where the focus is to strengthen the primary healthcare system and urgently attend to SAM children with severe complications.

WHO aims to use every contact, for example during immunisation and health checks, to incorporate nutrition activities, such as nutrition screening and appropriate referrals.

Building WHO country-level capacity to integrate nutrition into health response in emergencies

WHO needs a solid base of internal capacity close to where emergencies happen to deliver on commitments. A flagship effort in this regard involved a recent pilot training in Dar es Salaam, Tanzania (29-31 August 2017) on an operational model integrating nutrition and health emergency response. Thirty-three WHO emergency and nutrition officers participated from 14 countries in crisis or at risk thereof; namely Eritrea, Ethiopia, Kenya, South Sudan, Uganda, Tanzania, Nigeria, Niger, Chad, Cameroun, CAR, Burundi, Mali and the Democratic Republic of Congo. This was the first time WHO has conducted a training of this kind and was welcomed by participants, who acknowledged the strong link between the two areas of WHO's work.

The aim of the training was to enable WHO country staff to work effectively and safely in emergencies as part of surge teams to implement WHO activities as outlined in the ERF. This capacity building is part of the transformation to strengthen WHO's management of health crises and to enhance knowledge and practice on NiE settings. The nutrition and emergency focal points are based in WHO country offices. The nutrition focal points often 'double hat' for child health and non-communicable diseases (NCDs), which can be challenging when it comes to their involvement in responding to emergencies. However, this also offers opportunities to support government in preparedness, programme continuity and developing linkages between humanitarian and development efforts.

The overall objective of the workshop was to orient WHO staff on WHO emergency operations and malnutrition management in emergencies, with the goal of integrating nutrition



UNICEF/EAPRO/Sylvie Morel/Soyou

actions in the response to health emergencies. The training was conducted by facilitators from WHO with support from external training experts. A range of topics included an overview of WHO ERF and its role in the humanitarian architecture and coordination; collaboration with other humanitarian agencies in situation analysis for needs assessment and defining nutrition priorities; strategic response planning and implementation; evaluation and results tracking; and resource mobilisation. To assess learning, a case study of a country in emergency served as a framework running through the different stages of emergency response planning. Country-specific plans were developed by each of the participants on how to apply what they learned to their own contexts.

With specific reference to nutrition, the training went into greater depth on its relevance in the preparedness, response and rehabilitation phases of emergencies; overview of malnutrition and its immediate and underlying causes and indicators; nutrition assessments and classifications; surveillance and surveys; classification of the nutrition situation; population-level indicators and cut-offs; and the utility of the integrated phase classification (IPC) for food security and nutrition as a tool to identify the degree of public health importance of the nutrition situation in the emergency, given aggravating circumstances and underlying vulnerabilities.

The session on nutrition interventions included how to manage SAM in isolation and in the context of infectious diseases such as cholera, other diarrhoeal diseases, measles and malaria, which commonly occur in emergencies. The session on planning highlighted the necessity of assessing the scale of the disaster, risks and response needs considering underlying vulnerabilities and antecedents to the event. Nutrition was integrated into relevant actions in line with the WHO health system building blocks for planning, long-term

recovery and rehabilitation. Channels for resource mobilisation were considered. This workshop was a first step in integrating nutrition and health in emergencies at country level; a WHO consultant will follow up with participants on what needs to improve and how.

Next steps will involve consolidating and refining the training content that was drawn from various training packages, including the IASC Nutrition Cluster Harmonised Training Package (HTP) and developing a training package for WHO staff for adaptation and use in other regions.

Conclusions

The WHO reform has strengthened WHO's capacities for all hazards emergency response by drawing on required technical expertise from different health areas and support services, and offers opportunities to strengthen nutrition in health response. WHO is traditionally well placed to combine immediate emergency health response approaches with longer-term actions to address underlying issues and causes and sustainable interventions in emergency risk management. The main challenge is how to sensitise and get WHO staff of non-nutrition programmes fully on board with nutrition concerns, so that any opportunity to capitalise on WHO's comparative advantages in the health sector is not missed. Attention is centred on SAM management and surveillance in countries; there is a need to further integrate other emergency nutrition activities, such as nutrition-sensitive interventions.

For more information, contact: Zita Weise Prinzo, email: weiseprinzo@who.int

References

- WHO (2017) WHO Emergency response framework – 2nd ed. Geneva: World Health Organization, 2017. <http://apps.who.int/iris/bitstream/10665/258604/1/9789241512299-eng.pdf>

People in aid

Share pictures of you reading wherever you are in the world - we will tweet them and a selection will be published in the print edition. Send to chloe@enonline.net



Nutrition Cluster Coordination Performance Monitoring workshop in Sanaa, Yemen, April 2017



Integrated programming workshop with WASH, Health, Food Security and Nutrition Clusters, Sanaa, Yemen, October 2017



Participants in the GNC annual meeting, Geneva, October, 2017



WoS coordination meeting in progress, December 2017

© UNICEF/Anna Ziolkovska

© UNICEF/Anna Ziolkovska

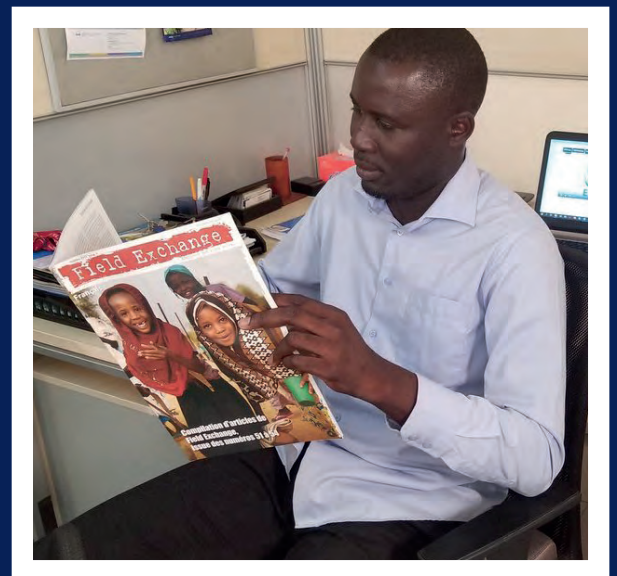
© UNICEF/Shabib Saleh Al Qobati



Leo Matunga with the UNICEF North Dafur team, where he worked for almost 5 years as the Head of the Nutrition section



Leo Matunga with the UNICEF North Dafur team, where he worked for almost 5 years as the Head of the Nutrition section



Ambarka Youssoufane, ENN Regional Knowledge Management Specialist (West Africa) reads the first compilation issue of in French



Editorial team Office Support

Jeremy Shoham Clara Ramsay
 Marie McGrath Judith Fitzgerald
 Chloe Angood Mary Murray
 Nick Mickshick Peter Tevret
 Josephine Ippe
 Carmel Dolan

Design

Orna O'Reilly/Big Cheese Design.com

Website

Phil Wilks

Contributors for this issue:

Samson Desie
 Meftuh Omer Ismail
 Wigdan Babikir Makki Madani
 Anna Ziolkovska
 Hassan Ali
 Baseer Qureshi
 Amal Tucker Brown
 Orla Mary O'Neill
 Ki Yeon Yoon
 Issack Manyama
 Muhiadin Abdulahi
 Saja Farooq Abdullah
 Lindsay Spainhour Baker
 Andi Kendle
 Kirathi Reuel Mungai
 Adeola Goriola Makanjuola
 Peter Hailey
 Brenda Akwany
 Josephine Ippe
 Simon Kiarie Karanja
 Michele Goergen
 Scott Logue
 Sepsibie Teshome
 Daniel Hadgu Takea
 Zita Weise Prinzo
 Adelheid Onyango
 Ferima Coulibaly Zerbo
 Hana Bekele
 Ngoy Nsenga
 Adelheid Marschang
 Isabelle Modigell
 Carmel Dolan
 Maureen L. Gallagher
 Ladi Linda Ezeike
 Helni Mshelia
 Ayadil Saparbekov
 Géraldine Bellocq
 Anteneh Dobamo

Thanks to all who contributed or helped source pictures for this issue.

Front cover

Bentiu, South Sudan, 2017. © UNICEF/UN053462/Modola



@theennonline



@ENNonline



ENN (Emergency Nutrition Network)



ENN Online



ENN Online

About ENN

ENN is a UK registered charity, international in reach, focused on supporting populations at high risk of malnutrition. ENN aims to enhance the effectiveness of nutrition policy and programming by improving knowledge, stimulating learning, building evidence, and providing support and encouragement to practitioners and decision-makers involved in nutrition and related interventions.

ENN is both a core team of experienced and academically able nutritionists and a wider network of nutrition practitioners, academics and decision-makers who share their knowledge and experience and use ENN's products to inform policies, guidance and programmes in the contexts where they work.

ENN implements activities according to three major workstreams:

Workstream 1: Experience sharing, knowledge management and learning. This includes ENN's core products: , Nutrition Exchange and en-net, as well as embedded knowledge management within two key global nutrition fora (the Scaling Up Nutrition Movement (SUN) and the Global Nutrition Cluster (GNC)).

Workstream 2: Information and evidence on under-researched nutrition issues. This comprises ENN's research and review work on filling gaps in the evidence base for improved nutrition policy and programming.

Workstream 3: Discussion, cooperation and agreement. This includes a range of activities for discussing and building agreement and consensus on key nutrition issues. It includes ENN's participation in and hosting of meetings, its activities as facilitator of the IFE Core Group and its participation in the development of training materials and guidance, including normative guidance.

ENNs activities are governed by a five year strategy (2016-2020), visit www.ennonline.net

The Team



Jeremy Shoham and Marie McGrath are *Field Exchange* Co-Editors and Technical Directors.



Carmel Dolan and Emily Mates are Technical Directors.



Chloe Angood is *Field Exchange* sub-editor.



Tui Swinnen is ENN's Global Knowledge Management Coordinator (SUN Movement).



Charulatha Banerjee is ENNs Regional Knowledge Management Specialist for Asia, based in India.



Ambarka Youssoufane is ENNs Regional Knowledge Management Specialist for West Africa, based in Senegal.



Lillian Karanja-Odhiambo is ENN's Regional Knowledge Management Specialist for East and Southern Africa, based in Kenya.



Judith Fitzgerald, is the ENN Office Manager based in Oxford.



Peter Tevret is ENN's Senior Finance Manager, based in Oxford.



Clara Ramsay is the ENN's Finance Assistant, based in Oxford.



Mary Murray is Administrative Assistant at ENN, based in Oxford.



Azaria Morgan is SUN Project Assistant, based in London.



Orna O'Reilly designs and produces all of ENN's publications.

supported by:



The Emergency Nutrition Network (ENN) is a registered charity in the UK (charity registration no: 1115156) and a company limited by guarantee and not having a share capital in the UK (company registration no: 4889844). Registered address: 32, Leopold Street, Oxford, OX4 1TW, UK. ENN Directors/ Trustees: Marie McGrath, Jeremy Shoham, Bruce Laurence, Nigel Milway, Victoria Lack and Anna Taylor.





ENN

32, Leopold Street, Oxford, OX4 1TW, UK

Tel: +44 (0)1 865 324996

Fax: +44 (0)1 865 597669

Email: office@enonline.net

www.enonline.net

