COMMITTED TO NUTRITION
A TOOLKIT FOR ACTION

Fulfilling UNICEF's Core Commitments for Children in Humanitarian Action

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The Toolkit for Action is a living document and will be updated as new guidance and tools emerge. Please send your comments, suggestions and new materials to nutrition@unicef.org

Acronyms

AM	Acute Malnutrition
BMS	Breast Milk Substitutes
CO	Country Office
CCC	Core Commitments for Children in Humanitarian Action
CCPM	Cluster Coordination Performance Monitoring
CCRM	Cluster Coordination Reference Model
CERF	Central Emergency Response Fund
CLA	Cluster Lead Agency
CMAM	Community Based Management of Acute Malnutrition
EPRP	Emergency Preparedness and Response Plan
ERP	Emergency Response Plan
GAM	Global Acute Malnutrition
GNC	Global Nutrition Cluster
OCHA	Office for the Coordination of Humanitarian Affairs
HIV	Human Immunodeficiency Virus
HTP	Harmonized Training Package
IASC	Interagency Standing Committee
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IFE	Infant Feeding in Emergencies
IMAM	Integrated Management of Acute Malnutrition
INGOs	International Non-Governmental Organisations
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
LNS	Lipid-Based Nutrient Supplement
MAM	Moderate Acute Malnutrition
MIRA	Multi-Cluster/Sector Initial Rapid Assessment
MNP	Multiple Micronutrient Preparation

MOH	Ministry of Health
MOU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
NIE	Nutrition in Emergencies
NIS	Nutrition Information System
NGOs	Non-Governmental Organisations
OTP	Out-Patient Therapeutic Programme
PCA	Project Cooperation Agreement
PLW	Pregnant and Lactating Women
POLR	Provider of Last Resort
RRT	Rapid Response Team
RUIF	Ready to Use Infant Formula
RUTF	Ready to Use Therapeutic Food
RCM	Refugee Coordination Model
SAG	Strategic Advisory Group
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SFP	Supplementary Feeding Programme
SMART	Standardized Monitoring and Assessment in Relief and Transition
SOP	Standardized Operating Procedure
SUN	Scaling up Nutrition
TFC	Therapeutic Feeding Centre
TOR	Terms of Reference
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commission for Refugees
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

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Introduction

1.1 Purpose

UNICEF's Toolkit for Action aims to provide UNICEF Country Offices, and to some extent counterparts and partners, with one source of information on recommended nutrition actions for preparedness, response and recovery from emergencies. This Toolkit for Action is not a guide for Nutrition in Emergencies programming. It is a tool with practical actions to take to support capacities to prepare or respond to nutrition issues in emergencies. This Toolkit for Action does not replace programming guidelines; it identifies key practical actions as defined by relevant global guidelines and policies in each of the specific nutrition areas as highlighted in the UNICEF Core Commitments to Children (CCC's) in Humanitarian Action. The Toolkit for Action contains an extensive compilation of resources, which complement and provide more depth to the actions outlined within this document.

1.2 Target Audience

The primary target audience for this Toolkit for Action is the UNICEF country office staff who have responsibility for nutrition programming, but might not have nutrition experience or experience with nutrition in emergencies. For example this could be a health officer with nutrition in his/her portfolio, the chief of young child survival, early child development officers with nutrition in their portfolio, or a nutrition officer with no experience in emergencies. The importance of resources for emergencies was highlighted in

a recent mapping of training needs of UNICEF Health staff which indicated a low completion rate of emergency training in the last two years, and high demand for specialized training for health emergencies in order to ensure better preparedness and response during an emergency.

The secondary target audience is government counterparts and partners such as NGOs, UN and Civil Society Organisations (CSOs) working in nutrition, preparedness and response to emergencies, for which the Toolkit for Action may also be a useful resource.

1.3 Structure of the Toolkit for Action

The Toolkit for Action is structured to mirror the UNICEF CCC's, which is organised according to preparedness, response, and early recovery actions in line with the nutrition actions noted in the CCCs, and affirms that all response activities should build off of good baseline programming. It is comprised of 6 technical chapters with an additional chapter on UNICEF specific administrative issues that are good for UNICEF staff to be aware of. Each of the chapters have specific actions outlined with an extensive listing of relevant resources for further information and use as well as a final selection of key 'Additional Resources'. Links to web-based resources are included throughout the document when possible. The Toolkit has been derived through a significant review and compilation of existing global, regional and national level guidance and tools from multiple sources. Acknowledgment is given to the UNICEF EAPRO Toolkit on Preparedness for Nutrition in Emergencies as crucial source for much of the preparedness sections in this toolkit. The Toolkit for Action is a living document and will be updated annually to reflect new guidance and examples as they become available.

The Toolkit for Action is divided into discreet chapters that can be used in conjunction or independently of each other. The Checklists at the beginning of each chapter summarise the essential actions to be taken for that area and indicate how these contribute to fulfilling the actions detailed in UNICEF's CCCs. The essential actions are listed to follow a logical sequence, although given the variety of operational contexts, the exact ordering may and can vary.

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Why Nutrition is Important in Emergencies and UNICEF's role

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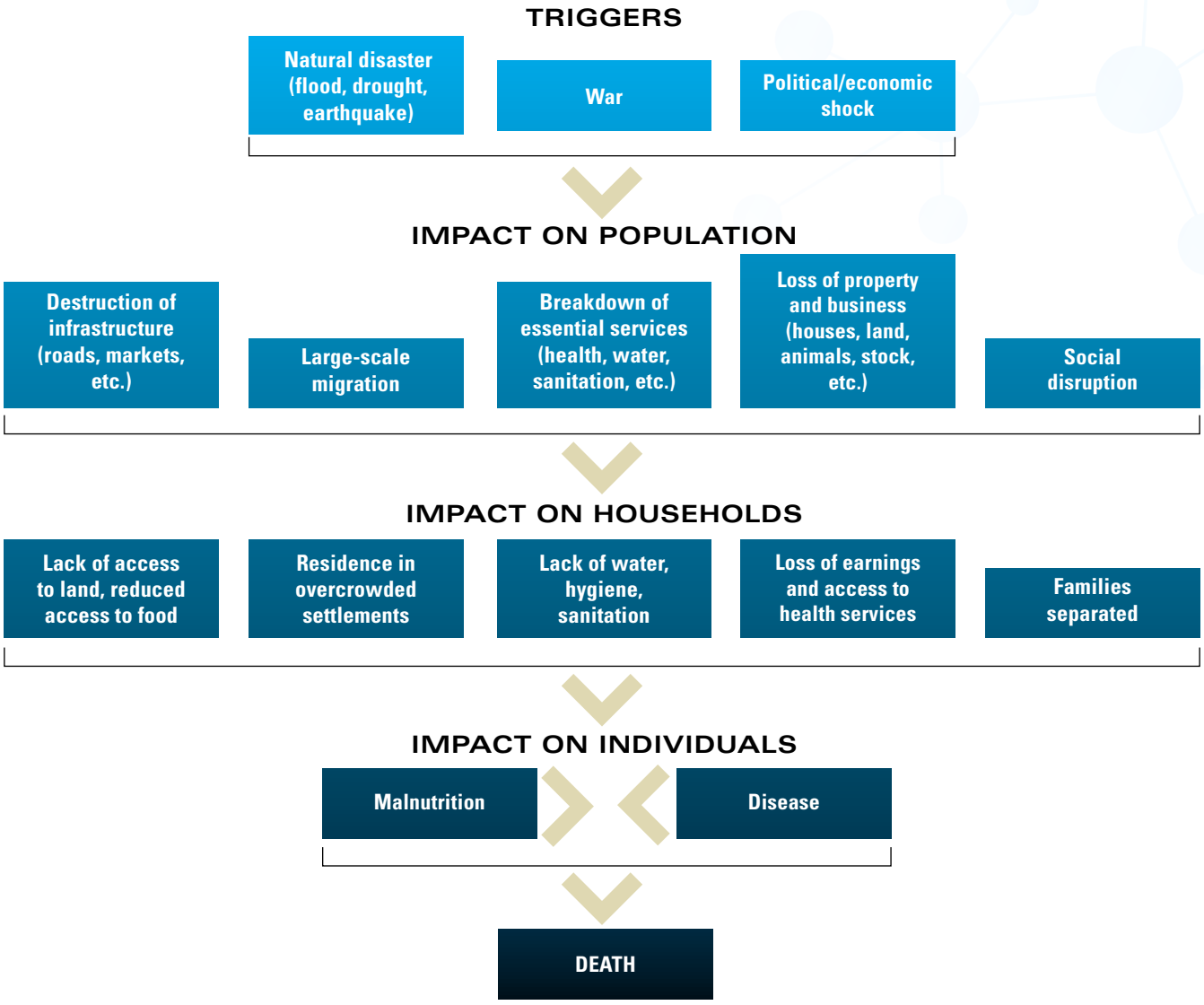
Despite increased attention to undernutrition in recent years, nutritional deficiencies remain a significant problem globally, irrespective of emergencies. Undernutrition represents a violation of children's right to survival and development and the highest attainable standard of health. Globally, 45% of all under-five deaths are attributable to undernutrition, either as a direct cause of death or through the weakening of the body's resistance to illness. The risk of mortality from acute malnutrition is directly related to the severity of malnutrition. A child with severe acute malnutrition is, on average, eleven times more likely to die than a well-nourished child. Chronic malnutrition (stunting) also increases mortality and more widely impacts children by causing irreversible physical and cognitive impairment.

The harmful consequences of micronutrient deficiencies for women and infants include a greater risk of maternal death during childbirth, giving birth to an underweight or mentally impaired baby, and poor health and development of breastfed infants. For young children, micronutrient deficiency increases the risk of death due to infectious disease and impaired physical and mental development. Individuals who suffer from malnutrition are much more likely to become sick and die. At the same time, sick individuals are more likely to become malnourished.

In emergencies, the problems of malnutrition are heightened, making nutrition response critical. Protecting the nutritional status of vulnerable groups affected by emergencies is enshrined

FIGURE 1 The Impact of an Emergency on Nutritional Status



in human rights law. Emergencies have an impact on a range of factors that can increase the risk of malnutrition, illness (morbidity) and death (mortality) (see Figure 1 below). Emergencies can often be the tipping point, revealing and exacerbating underlying pre-existing nutrition concerns. If a population has a relatively good nutritional status at the onset of an emergency, it is important to protect this through appropriate responses as it can deteriorate during the emergency. Populations that have a poor nutritional status at the onset of an emergency are, in general, even more vulnerable to widespread nutritional crises as a result of an emergency.

Particular population groups are more nutritionally vulnerable in emergencies. Their vulnerability can be categorised in the following way:

- Physiological vulnerability: due to i) increased nutrient requirements (e.g. young children, pregnant and lactating women) or ii) reduced appetite or ability to eat (e.g. older people, disabled) or both (e.g. people living with chronic illness such as HIV/AIDS). Gender also plays a role in physical vulnerability. For example, when food is in short supply, women and girls within a household may be more likely to reduce their food intake as a coping strategy.

- Geographical vulnerability: Examples include people living in drought- or flood-prone areas or in areas of conflict, who are more likely to be food - and nutritionally – insecure.

- Political vulnerability: Examples include oppressed populations.

- Socio-economic vulnerability: In general, the poorest are already the most at risk of undernutrition. In emergencies the poorest households are often some of the most vulnerable, often struggling the most to cope with shocks.

- Internal displacement and refugee status: Examples include those who have fled with few resources and are at risk of food insecurity.

Recognition and understanding of increased vulnerability is crucial in the design of nutrition interventions in emergencies. Within any population, young children and pregnant and lactating women are extremely vulnerable in emergencies. Nutrition interventions should be targeted to protect their nutritional status and guarantee their survival.

2.1 What are NiE Interventions?

The main nutrition concerns in emergencies are high and/or rising rates of acute malnutrition, micronutrient deficiencies, and in some contexts chronic malnutrition. The key objective of the response to any humanitarian emergency is to prevent excess mortality and morbidity. Therefore, the main focus of nutrition response in emergencies is on the provision of nutrition-specific interventions, that have proven effective in reducing mortality and morbidity associated with undernutrition. Depending on the specific context, these include: general food distribution, management of severe and moderate acute malnutrition, treatment and prevention of micronutrient deficiencies, the support, promotion and protection of appropriate infant and young child feeding and nutritional care for groups with special needs e.g. HIV/AIDS. These are to be delivered in combination with complementary nutrition-sensitive interventions including livelihood support, voucher schemes, emergency school feeding, food for work, public health and WASH interventions. The starting point of any emergency nutrition response is assessment and analysis of the situation, from which appropriate interventions can then be designed to meet the needs.

Nutrition response in emergencies is often thought of primarily in terms of treatment of acute malnutrition. As a consequence, other nutritional problems such micronutrient deficiencies and sub optimal IYCF may be present but poorly addressed. This in part reflects limitations in existing assessment and analysis frameworks, and also knowledge and policy gaps. For example, the recent crises in Syria has highlighted the need for a more comprehensive, inclusive approach to nutrition interventions in emergencies beyond the more traditional food based approaches. There is also increasing recognition and understanding that there needs to be a balanced continuum between short-term and long-term responses. Short-term responses intend to prevent and reduce immediate excess morbidity, undernutrition and mortality, while longer-term development solutions help build the resilience of communities by protecting and supporting people's long-term health, nutrition and overall livelihoods. This underpins the focus on preparedness and risk informed programming and early recovery, as well as response phases. Where possible, nutrition response should build on local structures and enhance local capacities.

2.1 UNICEF's Responsibilities in Nutrition in Emergencies

UNICEF's overall humanitarian mandate is to save lives, alleviate suffering and protect the rights of children in complex emergencies. Within this mandate, UNICEF's humanitarian response in nutrition encompasses a number of key actions:

- **Providing life-saving treatment** – Every year UNICEF works with partners to manage the urgent treatment of millions of children suffering from severe acute malnutrition by supporting the establishment and scale up of community based management of acute malnutrition, including technical support, training and capacity development and the supply of ready-to-use therapeutic foods.

- **Delivering key micronutrients to vulnerable populations** – UNICEF ensures that women and children have access to supplementation or fortified foods to address micronutrient deficiencies. Micronutrient deficiencies are often exacerbated in emergencies.

- **Supporting infant and young child feeding** – UNICEF supports programmes that provide counselling and establish safe spaces for infant feeding. UNICEF also monitors the distribution of, and in some cases, provides breast milk substitutes.

- **Conducting assessment and surveillance** – UNICEF supports timely nutritional assessment and surveillance systems in order to track malnutrition rates and improve programme performance.

- **Strengthening monitoring** – UNICEF provides support to strengthen food and nutrition security monitoring systems in many countries, including building capacities within Ministries of Health to manage health facility data.

- **Developing norms and standards** – UNICEF develops key guidelines to support emergency planning and response. For example, contributing to interagency guidance on nutritional care of children and adults in treatment centres with the Ebola virus disease.

- **Fostering resilience** – UNICEF works with communities to plan for, withstand and bounce back from crises, enabling local communities to be less dependent on outside interventions.

UNICEF has a key role in supporting government leadership and coordination of nutrition during emergencies by promoting the use of standardised guidelines and protocols, as well as integrated and harmonised approaches that strengthen existing systems. Emergencies can bring benefits in terms of additional resources: technical, financial and human, that can serve to strengthen national systems and capacities but these additional resources can also have negative effects. Emergency response may undermine government ownership, complicate coordination, create parallel programming, and put in place inappropriate resource intensive solutions to problems (e.g. monetary incentives for volunteers, complicated reporting). UNICEF plays an important role mediating on these issues.

Risk reduction and resilience building are paramount to all of UNICEF's work in humanitarian situations. Disaster and human-made risks must be anticipated, prevented and mitigated. In both development and emergency contexts, UNICEF supports countries to prepare for emergencies, promote rapid recovery and build resilience. This is reflected in the CCCs actions (see below) that cover preparedness, response and early recovery.

The Core Commitments for Children (CCCs) in Humanitarian Action are a global framework for humanitarian action for children undertaken by UNICEF and its partners. The CCCs for nutrition (see figure 2) aim to address major causes of nutritional deterioration and death by protecting the nutritional status of children and women, including their micronutrient status, and by identifying and treating those already suffering from undernutrition using evidence-based interventions and according to inter-agency agreements and existing inter-agency standards (e.g., Sphere Standards).

2.2 UNICEF's Role as Cluster Lead Agency

UNICEF is the Cluster Lead Agency (CLA) for nutrition as mandated by the Interagency Standing Committee (IASC). As such, at the global level, it is responsible for establishing broad partnership bases to engage in activities in four main areas: i) partnership, communication, advocacy and resource mobilization, ii) capacity developing in humanitarian coordination, iii) operational and surge support to country clusters and iv) information and knowledge management. The Global Nutrition Cluster guarantees global level partnership, guidance and resource mobilization to support coordinated rapid emergency response where the scale of emergency is so large that no single agency or national authority can address it alone.

At the country level, the CLA can be any IASC member agency, provided it has the resources and expertise to fulfill the terms of reference required. In practice, most times it is UNICEF. Through this role, and with partners, UNICEF works to promote coordinated, timely and effective nutrition emergency response both at national and sub-national levels.

FIGURE 2 The UNICEF Core Commitments to Children (CCCs) in Nutrition

NUTRITION STRATEGIC RESULT		
THE NUTRITIONAL STATUS OF GIRLS, BOYS AND WOMEN IS PROTECTED FROM THE EFFECTS OF HUMANITARIAN CRISIS.		
COMMITMENTS		**BENCHMARKS**
Commitment 1: Effective leadership is established for nutrition cluster interagency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.	>	Benchmark 1: Coordination mechanism provides guidance to all partners regarding common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified; also provides information on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication.
Commitment 2: Timely nutritional assessment and surveillance systems are established and/or reinforced.	>	Benchmark 2: Quality assessments are reported on in a timely fashion and provide sufficient information for decision-making, including the scope and severity of the nutritional situation, the underlying causes of malnutrition and contextual factors.
Commitment 3: Support for appropriate infant and young child feeding (IYCF) is accessed by affected women and children.	>	Benchmark 3: All emergency-affected areas have an adequate number of skilled IYCF counsellors and/or functioning support groups.
Commitment 4: Children and women with acute malnutrition access appropriate management services.	>	Benchmark 4: Effective management of acute malnutrition (recovery rate is >75%, and mortality rates are <10% in therapeutic care and <3% in supplementary care) reaches the majority of the target population (coverage is >50% in rural areas, >70% in urban areas, >90% in camps).
Commitment 5: Children and women access micronutrients from fortified foods, supplements or multiple-micronutrient preparations.	>	Benchmark 5: Micronutrient needs of affected populations are met: >90% coverage of supplementation activities, or >90% have access to additional sources of micronutrients for women and children.
Commitment 6: Children and women access relevant information about nutrition programme activities.	>	Benchmark 6: Communication activities providing information on nutrition services (including how and where to access them) and entitlements are conducted in all emergency-affected areas.

As CLA, UNICEF commits to being the 'provider of last resort' which means it will be held accountable to the Resident Coordinator/Humanitarian Coordinator for ensuring that critical gaps are identified and addressed to the best extent possible and that, where security and funding allow, the CLA will fill those gaps. Where access is not possible or security constraints limit access, the CLA is expected to continue advocacy efforts and explain constraints to stakeholders[1].

2.3 Cross-cutting issues in emergencies

There is a need to be aware of cross cutting issues related to gender, disability, HIV and protection during the preparedness, response and early recovery phases of an emergency. Below follows a brief outline of key actions to take to address these concerns in nutrition programming in emergencies with references for further information. Accountability to Affected Populations is another key cross-cutting issue to be aware of. A summary can be found in Good to Know Box on page 13.

Gender mainstreaming of a nutrition project means ensuring the distinct needs and realities of women, girls, men and boys are reflected throughout the project. Gender equality in programming aims to ensure the different nutrition needs of all are understood and to ensure that they all have equal access to and benefit from relevant interventions.

1 More information available in GNC Handbook page 317

Key activities to ensure gender equality in nutrition programming include[2]:

- Design nutrition interventions in accordance with food culture and nutritional needs of all community members.
- Ensure meaningful participation of women and men in decision making and programme design, implementation, monitoring and training.
- Monitor access to services by different population groups to ensure adequate access.

DISABILITY

Older people and people with disabilities are often overlooked in humanitarian relief and response and they may find it harder than others to access the assistance and protection they need, despite the humanitarian principle of impartiality. The Minimum Standards for Age and Disability Inclusion in Humanitarian Action are a step towards addressing this. The document defines Nutrition Standards and outline the actions needed to meet each standard. The four standards are defined as follows:

1. The nutritional status of people with disabilities and older people is systematically assessed and monitored. Nutritional assessments are used to trigger and inform emergency nutrition responses that include or target people with disabilities and older people.
2. People with disabilities and older people, and their carers, participate in the design, implementation, monitoring and evaluation of nutrition-related services and interventions, including nutrition assessments.
3. Information relating to food and nutrition services and interventions is fully accessible and available to people with disabilities and older people, and their carers.
4. Moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) among people with disabilities and older people are prevented and treated on the basis of impartiality of humanitarian assistance.

Further information on the key actions to meet each of the standards can be found in the document[3].

HIV

Humanitarian crises, which are often linked to displacement, food insecurity and poverty, increase vulnerability to HIV and negatively affect the lives of people living with HIV. Pre-emergency HIV services may be disrupted and people may no longer have access to services for care, support and prevention. HIV infection causes poor immunity and increased metabolic demands. A recent review showed that more than 30% of severely malnourished children in sub-Saharan Africa admitted to inpatient nutrition rehabilitation units were HIV-infected. HIV-infected children with severe acute malnutrition were three times more likely to die compared with uninfected children.[4] Eight critical HIV and nutrition-related activities in emergencies have been identified:

1. Integration of HIV into all aspects of emergency care – prevention, education, health, basic services, planning and management
2. Targeted food support
3. Maternal and infant health and feeding
4. Treatment and care of HIV (and TB) including testing of pregnant women and child
5. Treatment of severe malnutrition
6. Support networks, including livelihood support and home based care
7. Food hygiene, sanitation, water, shelter

2 Adapted from IASC Gender Handbook, 2006. http://www.humanitarianreform.org/Default.aspx?tabid=656

3 Minimum Standards for Age and Disability Inclusion in Humanitarian Action: http://nutritioncluster.net/?get=004064|2015/10/Minimum-Standards-for-Age-and-Disability-Inclusion_July-2015.pdf

4 Reginald A. Annan and Florence M. Turyashemererwa, University of Southampton, Southampton, United Kingdom of Great Britain and Northern Ireland April 2011

8. Protection

Protection is concerned with the safety; dignity and rights of people affected by disaster or armed conflict. Protection covers a wide range of activities that are aimed at ensuring respect for the rights of all individuals, regardless of their age, gender or social, ethnic, national, religious or other background. Standard 22 from the Minimum Standards for Child Protection in Humanitarian Action states that: *Child protection concerns are reflected in the assessment, design, monitoring and evaluation of nutrition programmes. Girls and boys of all ages and their caregivers, especially pregnant and breastfeeding women and girls, have access to safe, adequate and appropriate nutrition services and food.* The standard identifies key actions for nutrition actors regarding protection and vice versa to meet the standard.

Some examples of key actions of nutrition actors to incorporate protection into programming include[5]:

- Include the safety of the affected population as a sub-objective of each nutrition intervention;
- Monitor unaccompanied and separated children admitted into nutrition programmes and make sure there is coordination with child protection staff in terms of defaulters;
- Include child protection messages, including on prevention and response, as well as referral
- Mechanisms, in activities related to nutrition, community outreach and raising awareness;
- Include discussions related to protection, including psychosocial support and gender-based violence (GBV), in mother-to-mother nutrition activities

5 Taken from http://cpwg.net/wp-content/uploads/sites/2/2015/05/Cluster-Guidance-Eng-5-June.pdf

GOOD TO KNOW!

Accountability to Affected Populations (AAP) underpins all response areas and actions.

AAP is defined as an active commitment to use power responsibly by taking account of, giving account to, and being held to account by the people humanitarian organisations seek to assist. It proposes a people-centred and rights-based framework that links many of the core, people-centred issues and related response paradigms, including age, gender, diversity, disability, protection and communicating with communities. It is concerned with respecting the rights, dignity and safety of people affected by disaster and conflict, identifying their unique needs by gender, age, disability and diversity, and ensuring that all segments of an affected community can equally access and benefit from assistance. The women, men, girls and boys, including older people and persons with disability, receiving humanitarian assistance are the primary stakeholders of any humanitarian response and have a basic right to participate in the decisions that affect their lives, receive the information they need to make informed decisions and to complain if they feel the help they receive is not adequate or has unwelcomed consequences.

On April 2011, together with other members of the IASC, UNICEF endorsed five formal Commitments to Accountability to Affected Populations (CAAPs) in order to guide concrete action to achieving a system wide culture of accountability. Those commitments are captured under 1) Leadership/governance; 2) Transparency; 3) Feedback and complaints; 4) Participation; and 5) Design, monitoring and evaluation.

More information can be found in the The IASC Committements to on Accountability to Affected Populations and in the Nutrition Cluster Operational Framework on Accountability to Affected Populations

http://nutritioncluster.net/wp-content/uploads/sites/4/2016/01/Nutrition-Cluster-Framework_AAP_WEB.pdf`

3

Nutrition Coordination

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Nutrition Commitment 1:

Effective leaderships is established for nutrition cluster interagency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.

Benchmark 1:

Coordination mechanism provides guidance to all partners regarding common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified; also provides information on roles, responsibilities and accountability to ensure that gaps are addressed without duplication.

The cluster approach was adopted to increase the effectiveness of humanitarian responses. At country level, it establishes a system for leadership and accountability of the international humanitarian response under the leadership of the humanitarian coordinator. It makes clear the respective roles and responsibilities of the various agencies and provides a framework for effective partnership among international humanitarian actors, host governments, local authorities, local civil society agencies and affected populations. UNICEF is the global cluster lead agency (CLA) for nutrition coordination, and a major agency supporting humanitarian response programming.

While UNICEF is the global CLA for nutrition, at country level the CLA can be any IASC member agency, provided it has the resources and expertise to fulfil the terms of reference required. In practice, most times it is UNICEF. As the CLA, amongst other things UNICEF has the responsibility to provide staff and resources to coordinate cluster partners in partnership with the national government.[6] Not all emergencies require a formal activation of the cluster approach but UNICEF still has responsibilities to deliver effective humanitarian response with the support and engagement of nutrition coordination platforms such as nutrition working groups. Having established nutrition working groups that embeds discussions on preparedness and response within existing Gov't coordination platforms for nutrition programmes with emergency preparedness on the agenda is one of the most practical methods for bridging the divide between development and emergency.

Beyond sectoral coordination, networks such as Scaling up Nutrition (SUN) and the REACH Initiative are examples of such coordination forums that UNICEF has key role to play through strategic engagement with development actors to improve preparedness, response and transition in crisis prone and affected countries to ensure the humanitarian-development continuum. Started in 2010 the SUN movement sets out to increase national commitment for accelerating progress towards reducing undernutrition through increasing resources, both financial and technical, to align interventions aimed at the critical window of 1,000 days between pregnancy and age 2 years, where interventions to improve nutritional status have the largest potential impact.

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The following chapter provides guidance on the key actions for UNICEF staff that should be taken to ensure that UNICEF is able to fulfil its coordination commitments. The actions are meant to be relevant to a UNICEF staff member who has responsibility for the nutrition portfolio, and who sits in theff nutrition working group/cluster. This is not specific guidance for an appointed Cluster Coordinator – that guidance can be obtained from the Global Nutrition Cluster resources. Checklist 1 provides an overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. Following Checklist 1 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

6 Much more information on the roles and responsibilities of UNICEF in the cluster approach at the country level can be found in the UNICEF Cluster Coordination Guidance for Country Offices (2015).

CHECKLIST 1 Essential Actions for coordination in emergencies

PREPAREDNESS FOR COORDINATION		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR PREPAREDNESS FOR COORDINATION**	
	Clarify the responsibilities of UNICEF and its partners regarding nutrition in humanitarian situations	Strengthen existing coordination mechanisms or, if unavailable, create them in collaboration with national authorities to ensure that the humanitarian response is timely and coordinated, and that it conforms to humanitarian principles and agreed-upon standards and benchmarks
Facilitate awareness and knowledge within UNICEF country office, the sector partners and governmental counterparts on aspects for humanitarian action	✓	
Support a functioning nutrition sector working group	✓	
Support and strengthen national authorities capacities to coordination the nutrition sector		✓
Build the capacity of the national government and partners by investing in and agreeing on up-to-date and technical standards for core NiE programming		✓
Establish relationships with other sectors so that multi-sector assessment and response is facilitated in the event of an emergency	✓	✓
Within the nutrition working group, develop a common framework to guide actions in the nutrition sector in the event of an emergency		✓

RESPONSE FOR COORDINATION		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR RESPONSE FOR COORDINATION**	
	Strengthen and/or establish a nutrition cluster/inter-agency coordination mechanism to ensure rapid assessment of the nutrition sector	Prepare a nutrition cluster/inter-agency plan of action and coordinate the implementation of a harmonized and appropriate response to address all critical nutrition gaps and vulnerabilities identified in the rapid assessment, including women and children
With partners, establish a nutrition coordination group or strengthening an existing group	✓	
If a nutrition cluster lead is UNICEF get an understanding of the coordination needs, secure funding for cluster coordination functions and recruit coordination/ information management support	✓	✓

RESPONSE FOR COORDINATION

ESSENTIAL ACTIONS	UNICEF CCCS FOR RESPONSE FOR COORDINATION	
Support assessments of nutrition needs (either multisectoral or nutrition only) through contributing to joint assessments actions	✓	
Work with the nutrition cluster/ working group to put in place technical standards	✓	✓
Contribute to the development of an over-arching vision for a collective sector response		✓
Ensure that nutrition is appropriately represented in the overall humanitarian response		✓

EARLY RECOVERY FOR COORDINATION

ESSENTIAL ACTIONS	UNICEF CCCS FOR EARLY RECOVERY FOR COORDINATION			
	Ensure that nutrition coordination and action links to recovery and long-term development by applying sustainable technologies, strategies and approaches to strengthen the national nutrition sector capacity	Link to existing national strategies and the early recovery cluster/ network	Establish a reporting mechanism to inform decision making	Initiate a gap analysis of local and national capacities and ensure integration of capacity strengthening in early recovery and transition plans, with a focus on risk reduction
Plan nutrition services with consideration of routine services that should be maintained beyond the emergency period	✓			✓
Utilise monitoring information to adjust both nutrition coordination and programming strategies	✓		✓	
Reinforce mechanisms to ensure that information and actions from the sector/cluster are shared and assimilated within the UNICEF CO			✓	
Involve and build on national authority capacity	✓			✓
With the de-activation of the formal cluster, transfer the leadership and accountabilities from the CLA to the national authorities		✓		

GOOD TO KNOW!

How does coordination through SUN relate to Cluster coordination?

Both the Scaling up Nutrition (SUN) Movement and the Cluster Approach aim to bring people together to deliver programming relevant to the context. The cluster approach, activated in sudden onset disasters and protracted crises, builds off of existing coordination structures and mechanisms, such as the SUN network, to ensure effective transition into longer term nutrition sector coordination mechanisms. They both work together to:

1. Advocate for and support government leadership at national and sub-national level to coordinate the humanitarian response by building upon existing structures and mechanisms (wherever possible);
2. Promote dialogue among all stakeholders with responsibility to ensure that populations can better endure emergencies and conflicts;
3. Invite humanitarian agencies to engage within the SUN Movement at global and country level;
4. Foster the accountability of humanitarian and development agencies towards preparedness, resilience and disaster risk management;
5. Support and participate in technical forums that enable multiple stakeholders to share experience on nutrition in development and in emergency.

The difference is that membership to SUN reflects government commitment to the principles of the SUN framework and is an active and optional commitment and cluster coordination is specific to emergency response (including preparedness for response).

More information can be found in the Global Nutrition Cluster Advocacy Strategic Framework 2016-2019 http://nutritioncluster.net/resources/nutrition-cluster-advocacy-strategic-framework-2016-2019/

GOOD TO KNOW!

Tips for Creating a Neutral Coordination Environment within UNICEF

Since UNICEF often both coordinates clusters and participates in them as a partner, it's important to know that there are several options for creating a neutral coordination environment:

- Appointment of a dedicated coordinator with no UNICEF programmes responsibilities. This neutral position should be articulated in the coordinator's job description and performance appraisal.
- The cluster coordinator reporting to someone other than the chief of section;
- Regular clarification of a position of neutrality with partners, backed up by practice, i.e. cluster coordinators should not be expected to represent UNICEF or take on any UNICEF programme work;
- The UNICEF chief of section and senior staff participating actively in cluster meetings, representing UNICEF as a cluster partner (so the cluster coordinator doesn't have to represent UNICEF);
- In contexts where it is appropriate, location of cluster offices outside UNICEF premises (however, it is recognized that this is not always viable due to security and office/operational support requirements); and
- Clear differentiation by the double-hatting coordinator when speaking on behalf of UNICEF as opposed to when speaking on behalf of the cluster.

Source: Cluster Coordination Guide for Country Offices, UNICEF 2015

3.1 Preparedness Actions

Before an emergency is declared UNICEF operates as a partner within the nutrition community at the country level and often supports the government in sector coordination. In line with globally agreed cluster responsibilities, UNICEF as cluster lead agency for nutrition should work towards that a functioning coordination group is established and ensure that within this group: a) clear terms of reference are agreed by the members, including responsibilities for preparedness, response and recovery; b) an analysis of risks relevant to the sector/cluster is conducted and integrated into the work of the sector/cluster; and c) preparedness measures and plans per sector/cluster are agreed. Detailed preparedness actions for the nutrition sector/cluster can be found below.

FROM THE CCC'S

Preparedness Actions for Nutrition Coordination:

Clarify the responsibilities of UNICEF and its partners regarding nutrition in humanitarian situations; strengthen existing coordination mechanisms or, if unavailable, create them in collaboration with national authorities to ensure that the humanitarian response is timely and coordinated, and that it conforms to humanitarian principles and agreed-upon standards and benchmarks.

PREPAREDNESS ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
A. **Facilitate awareness and knowledge** within UNICEF country office, the sector partners and governmental counterparts on aspects for humanitarian action such as: ▪ humanitarian principles ▪ components of an effective nutrition response and international standards and guidelines ▪ accountability to affected populations ▪ the cluster approach and role and responsibilities of UNICEF within that framework	**HUMANITARIAN PRINCIPLES HANDOUT** https://docs.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf **GNC NUTRITION CLUSTER AWARENESS TRAINING** (in English and French) http://nutritioncluster.net/training-topics/cluster-approach-awareness-trainings/ **GUIDE ON HUMANITARIAN PRINCIPLES:** https://docs.unocha.org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf **IN THE CCCS-** https://www.unicef.org/publications/files/CCC_042010.pdf **TRANSFORMATIVE AGENDA PROTOCOLS:** **HPC -** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/06/HPC-Reference-Module-2015-final-.pdf **CCRM -** http://nutritioncluster.net/wp-content/uploads/sites/4/2015/08/Cluster-Coordination-Reference-Module-2015-final.pdf **ERP -** http://nutritioncluster.net/wp-content/uploads/sites/4/2015/08/Emergency-Response-Preparedness-2015-final.pdf **MIRA -** http://nutritioncluster.net/wp-content/uploads/sites/4/2015/08/MIRA-2015-final.pdf **PROTECTION FROM SEXUAL ABUSE AND EXPLOITATION:** http://goo.gl/43tZwD **GUIDANCE ON AAP:** http://nutritioncluster.net/resources/guidance-mainstreaming-aap-core-people-related-issues-hpc-cluster-system/ http://nutritioncluster.net/resources/nutrition-cluster-operational-framework-aap/ **IASC GUIDANCE ON PROTECTION:** http://goo.gl/aaohcB

PREPAREDNESS ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
B. **Support a functioning nutrition sector working group** as a basis for working collectively on nutrition preparedness and as a platform for launching a collective response. ▪ Establish or strengthen a nutrition sector working group with a terms of reference (TOR) for the working group documenting the roles and responsibilities of UNICEF, the Government and other partners, and the key functions. ▪ Ensure that nutrition in emergency is on the agenda of the working group to ensure that there is knowledge and a structure in place so that it can become the cluster/emergency nutrition working group in the event of an emergency. ▪ Within the working group acknowledge the importance of pre-crisis information and make sure that critical information is easily accessible in the event of an emergency. Especially in crisis prone or chronic emergencies invest in joint information management system that partners contribute to. ▪ Develop a contact list of nutrition sector partners and make an updated list easily available to nutrition partners and others (placement on UNICEF/partners websites, emailed quarterly, etc.). ▪ If there are a lot of active partners or if you are operating in a fragile context a more advance listing of who does what where (3W or 4W) is useful.	**NUTRITION CLUSTER HANDBOOK CHAPTER 1.4.3:** guidance for developing a TOR **GLOBAL NUTRITION CLUSTER COORDINATION HANDBOOK** Section 1.2 Roles and Responsibilities of the CLA at the country level **GNC IM TOOLKIT** http://nutritioncluster.net/topics/im-toolkit/ **NUTRITION CLUSTER CONTACT LIST TEMPLATE** http://nutritioncluster.net/resources/contact-list-template/ **4W TEMPLATE (WHO DOES WHAT WHERE WHEN)** http://nutritioncluster.net/resources/4w/
C. **Support and strengthen national authorities'** capacities to coordination the nutrition sector. ▪ Assess the capacities of the Government department responsible for nutrition coordination and response. ▪ Investment in strengthening this capacity.	**NUTRITION CLUSTER MAPPING TOOL** http://nutritioncluster.net/resources/capacity-mapping-tool/
D. Build the capacity of the national government and partners to adequately address nutrition emergency response by investing in **up-to-date and agreed upon technical standards** for core NiE programming ▪ Within the nutrition sector working group identify what relevant standards exist at national levels. Review available standards in terms of their coherence with international standards and identify where standards need to be revised and/created. ▪ Draft, review, pre-test and revise technical standards in relation to the wider nutrition sector. ▪ Support the government so that they can actively engage in the process and so standards are integrated/adopted into national guidelines. This may include advocacy at national level with policy-makers, but also with local-level stakeholders and authorities, in addition to service providers.	**HTP NUTRITION IN EMERGENCIES MODULES** http://nutritioncluster.net/training-topics/harmonized-training-package/ **THE SPHERE HANDBOOK** http://www.sphereproject.org/handbook/
E. Establish **relationships with other sectors so that multi-sector assessment and response is facilitated in the event of an emergency.** ▪ Have discussions with other sectors of what the potential key actions for response are and articulate the linkages in each sectors preparedness and response plans.	**INTERCLUSTER MATRICES OF ROLES AND ACCOUNTABILITIES** http://www.themimu.info/sites/themimu.info/files/documents/Checklist_Inter-Cluster_Matrices_of_Roles_Accountabilities.pdf **GOOD COORDINATION AND PROGRAMMING BETWEEN FOOD SECURITY AND NUTRITION CLUSTERS** http://nutritioncluster.net/wp-content/uploads/sites/4/2015/05/Guidance-Checklist-for-Good-Coordination-and-Programming-between-Food-Security-and-Nutrition-Clusters_final.pdf **EXAMPLE: PAKISTAN NATIONAL NUTRITION CLUSTER PREPAREDNESS AND RESPONSE PLAN** http://www.pakresponse.info/LinkClick.aspx?fileticket=AznBC-l80og%3D&tabid=78&mid=1084

PREPAREDNESS ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
F. **Within the nutrition working group, develop a common framework to guide actions** in the nutrition sector in the event of an emergency. This does not replace the need for planning by individual agencies in relation to their responsibilities and mandates but provides focus and coherence to the various levels of planning that are required to respond effectively. ▪ Assess the risks that all or part of the country's population face that might require a coordinated nutrition response. This is done within UNICEF as an agency or within other partner agencies and this information can be jointly assembled to do a joint analysis. ▪ Develop a sector specific preparedness plan. ▪ In situations in which the scale of the potential emergency requires the concerted action of a number of agencies/ organizations or in ongoing emergencies the Emergency Response Preparedness (ERP) Approach will be led by OCHA and the nutrition sector will need to feed into this process.	**EXAMPLE: INDONESIA FOOD AND NUTRITION CLUSTER PREPAREDNESS AND CONTINGENCY PLAN 2011** https://www.humanitarianresponse.info/system/files/documents/files/Contingency%20Plan.pdf

GOOD TO KNOW!

The Emergency Response Preparedness (ERP) Approach

The Emergency Response Plan (ERP) focuses on situations in which the scale of the potential emergency requires the concerted action of a number of agencies/organizations. The ERP outlines how the international humanitarian community can organize itself to support and complement national action. It is part of the Humanitarian Programme Cycle (HPC). In countries with ongoing emergencies, the ERP approach should be mainstreamed in the humanitarian response planning process. All actors likely to take part in a response are required in ERP planning. The approach is:

- Led by a Resident/Humanitarian Coordinator.
- Managed by a Humanitarian Country Team.
- Supported by an inter-cluster/sector coordination group and clusters/sectors.
- Inclusive of a broad range of actors, including at sub-national level.
- Supports of the national authorities, who have primary responsibility for affected people.

The first step of ERP is to assess the risks that all or part of the country's population face and which might require a coordinated humanitarian response.

The second step is to devise Minimum Preparedness Actions (MPAs) that represent a set of core preparedness activities that need to be undertaken to achieve positive outcomes in the initial emergency response phase.

The last phase has two components. The first is Advanced Preparedness Actions (APAs) designed to guide a HCT to an advanced level of readiness to respond to a specific risk. Unlike the MPAs, the APAs are risk-specific. They build on the MPAs already in place. The second component is Contingency Planning (CP). This process sets out the initial response strategy and operational plan to meet critical humanitarian needs during the first three to four weeks of an emergency. The CP reflects the decisions taken by all partners involved in the planning process. A CP should seamlessly transform into a Flash Appeal if the emergency occurs.

Source: ERP Guidance 2015

GOOD TO KNOW!

The Importance of Inter-sectoral Coordination

Effective intercluster/sectoral coordination is especially important for nutrition, as nutritional status and nutritional security in emergencies is closely linked to other sectoral outcomes; particularly WASH, health, food, protection, and shelter. This can be highlighted by the conceptual framework for malnutrition which highlights the many pathways to poor nutritional outcomes.[7]

Nutrition is usually one of the smaller sectors in terms of resources and partners and as such it is particularly important for nutrition to leverage opportunities with other sectors. Often intercluster coordination is limited to conversations in intercluster meetings during an emergency response and opportunities for meaningful coordination and planning ahead are missed. Malnutrition is partially an outcome of constraints in the other sectors such as health, WASH and food security and thus identifying nutrition sensitive intervention and what actions needs to be taken during preparedness phase is what should be highlighted

How the nutrition sector coordinates and programs with other sectors should be a key conversation in the preparedness phase, when response activities are mapped and ideas or opportunities for alignment are documented. Appropriate linkages will depend on the specific context of the emergency, however, discussion amongst clusters coordinators/sector leads in the preparedness phase and analysis of realistic opportunities based on key nutrition sensitive interventions by each sector will promote quick and coordination action in the immediate response phase. Where possible, the linkages should be articulated in each sectors preparedness and response plans.

Concrete collaboration falls into broad categories of:

- **needs assessment and overall information management,** in terms of jointly identifying key information, conducting assessments, sharing data collected and contributing to joint analyses;
- defining **indicators** that explicitly address the inter-cluster nature of activities (e.g. a livelihoods programme that aims to positively influence nutrition status);
- coordinated **physical site planning** for services in terms of location and available resources that contribute to improved access;
- development of **integrated or coordinated guidelines and standards** for clusters that take into account guidelines and standards from other clusters;
- capacity **building** and awareness of emergency response staff in relevant concepts and technical standards;
- screening **and referral linkages** between programmes in different clusters;
- activities **to inform, raise awareness and promote positive behaviours** that are within the capacity of the individual or household to address;
- communication **and monitoring** of field-level implementation;
- advocacy **and resource mobilisation.**

Source: Global Nutrition Cluster Handbook, UNICEF 2013

3.2 Response Actions

Not every emergency applies the cluster approach, however coordination or response remains key regardless. The activation of clusters should be strategic, considered, and time limited. The criteria for cluster activation are met when:

- Response and coordination gaps exist due to a sharp deterioration or significant change in the humanitarian situation.
- Existing national response or coordination capacity is unable to meet needs in a manner that respects humanitarian principles due to the scale of need, the number of actors involved, the need for a more complex multi-sectoral approach, or other constraints on the ability to respond or apply humanitarian principles).

FROM THE CCC'S

Response Actions for Nutrition Coordination:

Strengthen and/or establish a nutrition cluster/inter-agency coordination mechanism to ensure rapid assessment of the nutrition sector; prepare a nutrition cluster/inter-agency plan of action and coordinate the implementation of a harmonized and appropriate response to address all critical nutrition gaps and vulnerabilities identified in the rapid assessment, including women and children.

7 For more details on the Conceptual Framework for Malnutrition visit the UNICEF training http://www.unicef.org/nutrition/training/2.5/4.html

At the country level UNICEF is often both the designated coordinator of the cluster and a partner within it. It is recommended, particularly at the height of a humanitarian crisis, that the UNICEF appoint dedicated, full-time cluster coordinators and information management officers (IMO) who have no other programme responsibilities. This often takes time and in practice UNICEF staff often 'double-hat', taking on the responsibility of cluster coordination alongside their UNICEF programmatic responsibilities. It is crucial that UNICEF maintains the neutrality of the cluster and crucially that UNICEF's nutrition interests are represented at cluster meetings by an additional focal point from UNICEF who is not the nutrition cluster coordinator (see Good to Know Box on Tips for Creating a Neutral Coordination Environment within UNICEF on page 18).

Even when a cluster is not activated, through its Core Commitments to Children UNICEF has committed to strengthening and engaging in a coordinated humanitarian response. Therefore most of the response actions apply both to formally activated cluster groups and nutrition working groups. However, within the cluster approach UNICEF is the dedicated provider of last resort (PoLR). The 'provider of last resort' concept is critical to the cluster approach, and without it the element of predictability is lost. It represents a commitment of global cluster leads to do their utmost to ensure an adequate and appropriate response. Where there are critical gaps in humanitarian response, it is the responsibility of cluster leads to call on all relevant humanitarian partners to address these. If this fails, where a UNICEF-led cluster is activated, UNICEF must be ready to ensure provision of services to fill critical gaps identified by the cluster and reflected in the Humanitarian Response Plan and Flash Appeals, when access, security and funds are in place.[8]

8 IASC Cluster Coordination Reference Module (CCRM) Cluster characteristics and accountability matrix (Section 1.1, page 31)

GOOD TO KNOW!

Coordination in Refugee Settings

Since the mandate and accountability for refugees is non-transferable, **the cluster approach does not apply in refugee situations.** International law and practice addresses refugee and internal displacement emergencies differently. Refugees are not citizens of the country of asylum and therefore have specific protection needs. They often have no or very limited access to services, material assistance, adequate housing, health care, education and employment opportunities and are sometimes restricted in movement (for example, confined to a camp), hence the status of being a refugee is a vulnerability in itself. Seeking to address these concerns, the UN established a specialised agency for refugee protection (UNHCR) to focus on refugees and their plight. Therefore in coordinating response in refugee situations UNHCR will take the lead. The UNHCR Refugee Coordination Model (RCM) clarifies how UNHCR leads and coordinates a refugee response.

In mixed humanitarian response situations where internally displaced people and refugees may be located in the same area OCHA and UNHCR have an agreement that outlines respective roles and responsibilities of UNHCR and partners. This means that in some responses UNHCR may be coordinating nutrition response within a refugee population and UNICEF may be coordinating response through the cluster approach for the affected internally displaced. Use of sector or cluster capacities will be determined by operational context and location of responses (geographically together, or separate), Size of refugee and IDP populations and Capacity of UNHCR sectors / IDP clusters to deliver services according to the specific needs of both population groups.

UNHCR Refugee Coordination Model *and the* **Joint UNHCR-OCHA Note on Mixed Situations** *can be found on the UNHCR website*

http://www.unhcr.org/pages/538dd3da6.html

GOOD TO KNOW!

Operational and administrative support to the nutrition cluster: A UNICEF Responsibility

UNICEF has the responsibility to strengthen the nutrition cluster to ensure predictable response. Within in **this operational and administrative support for clusters includes the provision of:**

- Suitable office space and furnishing for cluster coordination teams to work effectively and to meet with partners.
- Adequate communication and information technology equipment and technical support.
- Technical support to establish and maintain a cluster/AOR website or web page where an information manager may not be in post or does not have the required technical assistance.
- Adequate logistics support, including transport, with an appreciation that cluster staff are often expected to work after normal office working hours and will require transport.
- Access to translation services.
- An adequate level of administrative support. Options include: i) the appointment of an administrative officer to provide administrative support to all clusters; and ii) an administrative officer from the programme section to perform a dual function – providing administrative support for both programme and cluster. In such a case, it will be important to ensure that cluster-related responsibilities and allocation of time for cluster functions be clearly articulated in the job description and performance appraisal of the post holder, and good collaborative working relationships be established between the cluster coordinator and the chief of section and senior technical staff.

More info at: Cluster Coordination Guide for Country Offices, UNICEF 2015

GOOD TO KNOW!

Human Resource Mobilization Options for UNICEF-Led Clusters

UNICEF is responsible for ensuring the timely recruitment of adequate numbers of staff with the appropriate level of seniority, facilitation skills and technical skills to ensure effective cluster coordination, including information management.

Human resource options vary:

- UNICEF recruitment of dedicated cluster coordination staff on fixed-term (protracted complex emergency), temporary assignment (short term up to 18months) or special service assignment contracts (short-term and immediate deployments)
- Secondment of staff from operational NGOs with the arrangement written into the NGO/UNICEF programme cooperation agreement, with an understanding that seconded staff members report to and are line-managed by UNICEF.
- Surge staff including the use of the GNC Rapid Response Team, the use of re-deployed UNICEF staff and short-term secondment from other agencies.

At the height of a large humanitarian crisis, it is recommended that UNICEF recruit fulltime, dedicated cluster and information managers who have no other (programme) responsibilities (single-hatted). However, in smaller-scale crises and in some protracted crises, it may not be operationally or financially viable or justifiable to have dedicated cluster staff. In such cases a single person may fulfil both cluster coordination and programming responsibilities (double-hatting).

Decisions as to how much capacity is required will depend on analysis of the context. A clear strategy for staffing of clusters should be put in place, posts should be reflected in the programme and budget review, as well as in the operational staffing matrix of the country office. In developing the strategy for staffing of the clusters, the grades of the various positions should be determined based on the scale and complexity of the emergency and level of responsibility of the post (national or sub-national). Transitioning back to sector coordination should also be considered at the outset. This will feed into the decision on fixed-term or temporary assignment.

See more info on requesting additional support in Chapter 9, UNICEF Administrative Concerns

Source: Cluster Coordination Guide for Country Offices, UNICEF 2015

RESPONSE ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
G. **With partners, establish a nutrition coordination group or strengthen** an existing group for a coordinated response. If a nutrition working group or cluster exists then: ▪ the preparedness Actions A-H should be reviewed and strengthened as necessary. If the country did not previously have a nutrition working group/cluster, then: ▪ preparedness actions A-H should be rapidly carried out. In larger clusters/sectoral working groups, **establish a smaller representative group** to enable decision-making on behalf of the larger group and make the coordination process much smoother. ▪ Establish a nutrition sector working group strategic advisory group (SAG) with a TOR for the SAG and chairs (usually co-chaired by the Government and UNICEF) Where there are technical tasks such as development of guidelines, operational standards, and tools, it may be necessary to establish a **smaller technical working group (TWG).** The TWGs generally meet independently, update the nutrition cluster on the status of the work, and present the final outputs for feedback and agreement by partners. This allows for technical work to be progressed and coordination meetings remain concise and focused. ▪ Identify the technical needs, if any, for the nutrition sector and establish a technical working group(s) TWG to concentrate that area. Have a TOR for the TWG with key objectives and outputs with clarity that when the task is completed, the TWG may be disbanded.	**NUTRITION CLUSTER HANDBOOK** http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf **CLUSTER COORDINATION REFERENCE MODULE** **NUTRITION CLUSTER HANDBOOK TABLE 2.3:** Overview of structures in the Nutrition Cluster **TWG TORS** http://nutritioncluster.net/training/sample-tor-twg/
H. If a nutrition cluster is activated with UNICEF as the lead it is critical to **get an understanding of the coordination needs, secure funding for cluster coordination functions and recruit coordination/information management support** through: ▪ analyse the coordination capacity and information management function of existing nutrition sector working group/cluster ▪ Identify cluster coordination staffing needs both for coordination and information management and develop a strategy for staffing for clusters[9] ▪ incorporate all cluster coordination posts into the programme and budget review and operational staff matrix. **Secure funding for cluster coordination functions** (salaries and core activities) by one or a combination of the below: ▪ Including funding request in UNICEF project submissions to the HRP or Flash Appeals ▪ Including funding request in the relevant project proposals submitted through the various pooled funding mechanisms (e.g. Central Emergency Response Fund, Common Humanitarian Fund) ▪ Include funding request in UNICEF programme proposals submitted to bilateral donors. ▪ Request funds from UNICEF emergency programme funds managed by EMOPS (although this must be reimbursed). **Begin recruiting support** immediately as soon as you identify the need for short or long term staffing support in coordination and/or information management: ▪ Develop ToRs ▪ Request temporary surge support ▪ Recruit cluster coordinators and information management specialists. ▪ Inform global cluster coordinators about recruitment and invite them to be involved in the process of recruitment and orientation.	**SEE BOX ON RECRUITMENT OF COORDINATORS** **SEE BOX ON NEUTRALITY OF THE CLUSTER** **CLUSTER COORDINATION GUIDANCE FOR COUNTRY OFFICES PART 2** http://nutritioncluster.net/?get=003509|2015/05/Cluster-Coordination-Guidance-for-Country-Offices-Final-Report-2015.pdf **UNICEF CLUSTER COORDINATION GUIDANCE FOR COUNTRY OFFICES PART 2** http://nutritioncluster.net/?get=003509|2015/05/Cluster-Coordination-Guidance-for-Country-Offices-Final-Report-2015.pdf **FINANCIAL TRACKING TOOL:** Adaptable Excel Template http://nutritioncluster.net/resources/financial-tracking-tool/ **UNICEF CLUSTER COORDINATION GUIDANCE TO COS PART 2,** Section 3.6 http://nutritioncluster.net/?get=003509|2015/05/Cluster-Coordination-Guidance-for-Country-Offices-Final-Report-2015.pdf

9 In some situations (e.g. in smaller-scale or some protracted emergencies), it is appropriate for a UNICEF programme staff member to function as cluster coordinator in addition to his/her UNICEF programme responsibilities. This is termed 'double-hatting' and should be identified through the staffing strategy.

RESPONSE ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
I. **Support assessments of nutrition needs (either multisectoral or nutrition only) through contributing to joint assessments actions:** ▪ If not already done in preparedness, do an analysis of pre-crisis nutrition data including sex-age-geo disaggregation. If there is a MIRA, it will contribute to it as a secondary data review (SDR) and if there is no MIRA, it will feed into a situation analysis. ▪ If a technical working group (TWG) on assessment is established, ensure that UNICEF has representation. Engage in identifying what the nutrition information needs are and propose methods for obtaining that information (nutrition rapid assessments, nutrition survey, inter-sectoral needs assessments, etc.). ▪ Contribute and participate in multi-sectoral assessments, most often an initial joint rapid assessment (such as the MIRA in L3 emergencies) (See Box on MIRA). ▪ Contribute and participate in a nutrition specific rapid assessment that focuses on answering questions on specific aspects of nutritional status/needs (such as IYCF or acute malnutrition) or assessments can have a more comprehensive view of nutrition.	**NUTRITION CLUSTER HANDBOOK TABLE 2.3:** Overview of structures in the Nutrition Cluster http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf **MIRA GUIDANCE** https://www.humanitarianresponse.info/en/programme-cycle/space/document/multi-sector-initial-rapid-assessment-guidance-revision-july-2015 **NUTRITION CLUSTER HANDBOOK: CHAPTER 4-ASSESSMENT** http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf **OPERATIONAL GUIDANCE FOR COORDINATED HUMANITARIAN ASSESSMENT IN HUMANTIARIAN CRISES 2012** https://www.humanitarianresponse.info/programme-cycle/space/document/operational-guidance-coordinated-assessments-humanitarian-crises-0 **SEE CHAPTER 4 ON ASSESSMENTS FOR MORE DETAILED INFORMATION**
J. **Work with the nutrition cluster/working group to put in place technical standards** to promote quality nutrition responses and to ensure that the nutrition response objectives are met through activities that are appropriately planned, implemented and monitored. ▪ Identify what relevant standards exist at national levels ▪ Review available standards in terms of their coherence with international standards and identify where standards need to be revised and/created. ▪ Developing standards within a short timeframe is generally best done with a group of technical experts in a Technical Working Group (TWG). Ensure UNICEF participation in the TWG or in discussions on standards. This can include drafting, review, pre-testing and revising technical standards in relation to the wider Nutrition Cluster. ▪ Support the national authority to ensure they are engaged in the process as the ultimate aim is to support national-level standards. ▪ Ensure that standards are integrated/adopted into national guidelines. This may include advocacy at national level with policy-makers, but also with local-level stakeholders and authorities, in addition to service providers.	**GNC CLUSTER COORDINATION HANDBOOK CHAPTER 6.1** Standards within Nutrition Cluster Response. http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf **SPHERE HANDBOOK:** Minimum Standards in Food Security and Nutrition http://www.sphereproject.org/handbook/

RESPONSE ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
K. **Contribute to the development of an over-arching vision for a collective sector response** to ensure that all nutrition actors are working within the same framework and working towards the same goal. ▪ Participate in the development of a Humanitarian Response Plan that lays out the plan of action with common objectives and comprehensive plan of action, with clearly allocated roles and responsibilities. ▪ Build on preparedness actions that have been taken to speed up this step. For example, an existing up-to-date Emergency Response Plan (ERP) can be used to flesh out the response plan. ▪ Provide guidance and engage in determining target caseloads for the response.	**DEVELOPING A CLUSTER RESPONSE PLAN (GNC)** https://www.dropbox.com/s/rrhwp1mlzbnxqda/Overview%20HPC%20process_2015_Final.pdf?dl=0 **HUMANITARIAN RESPONSE PLAN TEMPLATE 2016** https://www.humanitarianresponse.info/en/programme-cycle/space/strategic-response-planning-guidance-templates **STRATEGIC RESPONSE PLANNING GUIDANCE 2015 (OCHA)** https://www.humanitarianresponse.info/programme-cycle/space/strategic-response-planning-guidance-templates **GNC HPC/SRP TIPS** http://nutritioncluster.net/wp-content/uploads/sites/4/2015/11/16062_HRtips_layout_v06_RC_www.pdf **CALCULATING CASELOAD TOOL** http://nutritioncluster.net/resources/caseload-targets-supplies-calculator/ **INDICATORS REGISTRY** http://nutritioncluster.net/resources/indicators-registry/ **CLUSTER LEVEL M&E TEMPLATE** http://nutritioncluster.net/resources/m-and-e-framework/
L. **Ensure that nutrition is appropriately represented** in the overall humanitarian response. This can be achieved through: ▪ Contribute to Humanitarian Needs Overview (HNO) or situational analysis to ensure that the nutrition needs are adequately captured and represented. ▪ Advocate for the importance of a nutritional response that adequately meets the needs of the affected populations.	**HNO GUIDANCE** https://www.humanitarianresponse.info/programme-cycle/space/page/assessments-overview **THE HNO GUIDANCE IS ISSUED EVERY YEAR BY THE OCHA OFFICE. LATEST**: https://www.humanitarianresponse.info/en/programme-cycle/space/document/humanitarian-needs-overview-guidance-and-templates-updated-august-0 **NUTRITION CLUSTER ADVOCACY STRATEGIC FRAMEWORK 2016-2019** http://nutritioncluster.net/resources/nutrition-cluster-advocacy-strategic-framework-2016-2019/ **THE NUTRITION CLUSTER ADVOCACY TOOLKIT** http://nutritioncluster.net/advocacy-toolkit/

Common Challenges in Nutrition Cluster Coordination

The role of the nutrition cluster coordinator in representing needs and leading the Nutrition Cluster is challenging for a number of reasons. The coordinator has responsibility for the process, but has no direct line management over partners (i.e. "responsibility without authority"). The cluster coordinator has to identify, guide and reflect the inputs and point of view of the Nutrition Cluster collectively, rather than those of the agency that hired him/ her. At times the cluster coordinator may be filling two different roles ("double-hatting") of UNICEF staff member and cluster coordinator.

In order to address these limitations, the cluster coordinator should:

- ✔ ensure that his/her relationship in relation to CLA nutrition staff, and to other CLA staff, is clear to the CLA and to Nutrition Cluster partners, and ideally is set out in the coordinator's TOR (sections 1.2.1 and 1.3.2);
- ✔ ensure that CLA staff understand the Cluster Approach, beginning with the head of the CLA and senior management. If this orientation of staff has not happened, think about doing it with other CLA cluster staff if they are on the ground. Follow up with additional information as needed to ensure comprehension, since a single orientation may not be sufficient;
- ✔ attend CLA management team meetings and staff meetings to build working relations with CLA staff;
- ✔ work with the head of the CLA and the CLA nutrition staff as allies, and engage their support to navigate the appropriate administrative procedures within the CLA e.g. security clearance, procurement of supplies, travel arrangements, human resource issues;
- ✔ clearly communicate his/her neutrality, e.g. hosted by the CLA but acting on behalf of the Nutrition Cluster (section 1.3.4).

Refer to the Nutrition Cluster Handbook for more details.

3.3 Early Recovery

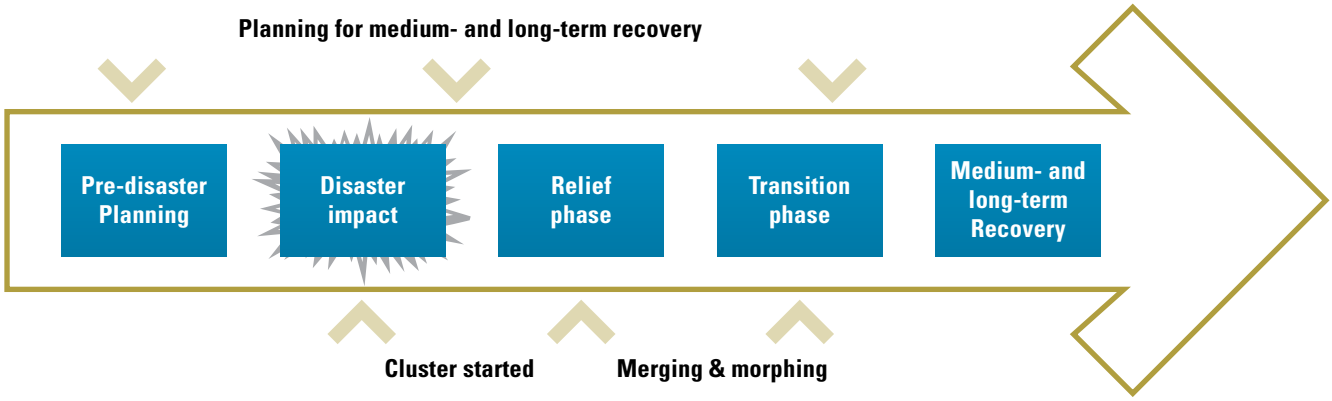
Early recovery needs to be considered by the nutrition coordination group from the outset of an emergency (see Figure 3). Planning around early recovery should involve and build on national authority capacity based on a thorough understanding of the local context. Existing local networks and local coordination mechanisms for nutrition should be at the core of nutritional emergency strategies. To ensure that clusters continue to operate only while they are strictly needed plans to deactivate and transition clusters should be prepared as soon as possible after activation. Building the capacity of local partners and Government should be an objective from the outset.

FROM THE CCC'S

Early Recovery Actions for Nutrition Coordination:

Ensure that nutrition coordination and action links to recovery and long-term development by applying sustainable technologies, strategies and approaches to strengthen the national nutrition sector capacity; link to existing national strategies and the early recovery cluster/network; and establish a reporting mechanism to inform decision making.

FIGURE 3 Lifespan of Clusters



Source: Nutrition Cluster Handbook, UNICEF 2013

EARLY RECOVERY ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
M. Plan nutrition services with **consideration of routine services** that should be maintained beyond the emergency period through ▪ Identify existing in-country competencies and engage them as much as possible. Capacity mapping and strengthening is a critical component. ▪ Give attention to the quality, coverage, access and safety of services to ensure that they are responsive and efficient and produce improved health and nutrition for all (e.g. equity). ▪ Initiate discussion on national policy, strategy and guidelines for sustainable management of SAM and MAM, if not already in place. ▪ Advocate that agencies engaged in the response focus on building upon existing systems and that existing facilities are used, reactivated and repaired wherever possible;	**GNC CLUSTER COORDINATION HANDBOOK** Section 5.5 Linking Emergency Response and Early Recovery http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf
N. **Utilise monitoring information** to adjust both nutrition coordination and programming strategies with the view of moving from emergency to development programming. ▪ Contribute to interagency monitoring of the results achieved in the response, preferably with reference to predefined objectives and plans. The Humanitarian Response Monitoring Framework is an operational tool that supports the clusters to implement monitoring of the activities as detailed in the nutrition cluster SRP. ▪ If applicable, participate in cluster coordination performance monitoring and the processes as a self-assessment of cluster performance against the six core cluster functions and accountability to affected populations. The results of this self-assessment can be used to ensure that coordination mechanisms remain effective and actively meeting the changing needs of the affected populations. The CCPM cannot be used for "activation or de-activation" of the cluster or for "merging" clusters but is a self-assessment tool which can help refine the work and direction of the cluster. The CCPM is not only used in Early recovery but can be used at any time during the life of a cluster.	**HUMANITARIAN RESPONSE MONITORING GUIDANCE** https://www.humanitarianresponse.info/en/system/files/documents/files/humanitarian_response_monitoring_guidance_2016_en_1.pdf **THE HUMANITARIAN RESPONSE MONITORING FRAMEWORK TEMPLATE** https://www.humanitarianresponse.info/programme-cycle/space/document/humanitarian-response-monitoring-framework-template **CLUSTER COORDINATION PERFORMANCE MONITORING (CCPM) GUIDANCE NOTE** http://nutritioncluster.net/topics/cluster-coordination-performance-monitoring **PRESENTATION TO CLUSTER PARTNERS ON THE CCPM** http://nutritioncluster.net/topics/cluster-coordination-performance-monitoring/page/2/?mrc_confirmation=add **EXAMPLES OF COUNTRY LEVEL CCPM REPORTS** http://nutritioncluster.net/topics/cluster-coordination-performance-monitoring/?mrc_confirmation=add
O. As the response progresses, **reinforce mechanisms to ensure that information and actions from the sector/cluster are shared and assimilated within the UNICEF CO.** ▪ Establish mechanisms to ensure that there is a reliable flow of information between the cluster/sector and the country office in order to inform decision making around response. ▪ Make sure that information from the cluster is available to senior management to inform decision making. In activated clusters it is crucial that the UNICEF Representative is well briefed and versed in the decisions and actions taken within the cluster because it is their responsibility to represent the cluster in the Humanitarian Coordination Team (HCT)	**UNICEF CLUSTER COORDINATION GUIDANCE TO COS** http://nutritioncluster.net/?get=003509|2015/05/Cluster-Coordination-Guidance-for-Country-Offices-Final-Report-2015.pdf

EARLY RECOVERY ACTIONS FOR NIE COORDINATION	EXAMPLES/RESOURCES
P. **Involve and build on national authority capacity** based on a thorough understanding of the local context, building as much as possible on long-term development policies and on national/local initiatives. ▪ Support the government and/or partners to establish or reinforce a national information system that captures nutrition. The nutrition coordination group should agree upon and advocate for a defined set of nutrition indicators to be included in the national Health Management Information System and/or in other national surveillance modalities. The GNC indicators registry is a good place to start with a set of a defined and agreed upon indicators. ▪ Use the monitoring results of both cluster performance and cluster activities to identify capacity gaps and develop capacity building plans to address those gaps. ▪ With the government and cluster/sector partners, initiate a gap analysis of local and national capacities and ensure integration of capacity strengthening in early recovery/transition plans.	**NUTRITION CLUSTER MAPPING TOOL** http://nutritioncluster.net/resources/capacity-mapping-tool/ **NUTRITION CLUSTER INDICATORS REGISTRY** http://nutritioncluster.net/resources/indicators-registry/
Q. **With the de-activation of the formal cluster, transfer the leadership and accountabilities from the CLA to the national authorities.** A nutrition sector working group, retaining many of the same functions will remain under the guidance of national authorities. ▪ Use the five principles outlined in the CCRM to guide and inform the decision to deactivate Nutrition Cluster. Time needs to be allowed for required partner consultation which should be facilitated by UNICEF employed cluster coordinator. Realistically, in countries where the nutrition sector has not been strong pre–emergency, transition of nutrition clusters to effective nationally led coordination platforms will take an extensive period of time, years rather than months. ▪ Support the government to clarify the various government institutions to take responsibility for the various functions and activities of the cluster/sector. ▪ Clarify and agree on required support from UNICEF through transition and following deactivation. UNICEF retains a responsibility to support coordination functions after deactivation[10], and these support activities following deactivation should be clearly incorporated into the AWP of the nutrition programme (in line with CCC responsibilities). ▪ Secured funding and support should be identified and then the coordinator and UNICEF as CLA need to work towards securing required funding to enable deactivation and sustaining the emergency preparedness and response and coordination capacities	**IASC REFERENCE MODULE FOR CLUSTER COORDINATION AT COUNTRY LEVEL 2015 (CCRM)** **CONSOLIDATED LEARNING AND BEST PRACTICE ON NUTRITION CLUSTER TRANSITIONING (2014)** http://nutritioncluster.net/consolidated-learning-best-practice-nutrition-cluster-transitioning/

10 IASC Reference Module for Cluster Coordination at Country level 2015

Lessons learned for cluster deactivation

- ✔ Transition and deactivation strategies should be considered from the very early stages of Nutrition Cluster activation.
- ✔ Transition strategies should be incorporated into Nutrition Cluster response planning documents.
- ✔ A preliminary transition/deactivation plan or position paper should be developed within the first quarter of Nutrition Cluster activation and should be updated regularly (suggest at least quarterly)
- ✔ Set a realistic timeframe for transition/deactivation process to allow for required partner consultation. Realistically, in countries where the nutrition sector has not been strong pre–emergency, transition of nutrition clusters to effective nationally led coordination platforms will take an extensive period of time, years rather than months.
- ✔ Not all clusters must be de-activated at the same time. The timing of de-activation is related to ongoing need and the presence or absence of national structures competent to manage the functions in question.
- ✔ Transition should be based on assessment of national capacity and leadership should be transferred only when sufficient capacity is in place.

Source: Consolidated Learning and Best Practice on Nutrition Cluster Transitioning. GNC 2015

KEY GENERAL RESOURCES ON NUTRITION COORDINATION

CLUSTER COORDINATION GUIDE FOR COUNTRY OFFICES, UNICEF 2015: provides clear guidance for UNICEF Representatives and Country Offices on what UNICEF's responsibilities are to support clusters and coordination

IASC REFERENCE MODULE FOR CLUSTER COORDINATION AT COUNTRY LEVEL (CCRM) 2015: Outlines the basic elements of cluster coordination and serves as a reference guide for field practioners, taking in to account the Transformative Agenda.
https://www.humanitarianresponse.info/en/system/files/documents/files/cluster_coordination_reference_module_2015_final.pdf

NUTRITION CLUSTER HANDBOOK: provides those involved with coordination practical tools, guidance and information to support their roles.
http://nutritioncluster.net/nutrition/wp-content/uploads/sites/4/2013/09/GNC_Handbook_v1_FINAL_no_links.pdf

GLOBAL NUTRITION CLUSTER: This website provides information on who the GNC is, what it does, and provides resources such as the Nutrition Cluster Coordination handbook.
http://nutritioncluster.net/

IASC EMERGENCY RESPONSE PREPAREDNESS (ERP) 2015: Guidance on risk profiling, minimum preparedness actions (MPAs) and advanced preparedness actions (APAs).
https://www.humanitarianresponse.info/en/programme-cycle/space/emergency-response-preparedness-guidance-and-templates

IASC REFERENCE MODEL FOR THE HUMANITARIAN PROGRAMME CYCLE 2015: Provides an overview of the HPC elements such as preparedness, needs assessment, and strategic response planning.
https://www.humanitarianresponse.info/en/programme-cycle/space/programme-cycle-policies

NUTRITION CLUSTER OPERATIONAL FRAMEWORK ON ACCOUNTABILITY TO AFFECTED POPULATIONS: The framework and associated tools should be used in conjunction with each agency's own accountability framework, and serve as a bridge between actors and agencies, through the cluster, to negotiate common or collective approaches.
http://nutritioncluster.net/resources/nutrition-cluster-operational-framework-aap/

REACH: assist governments of countries with a high burden of child and maternal undernutrition to accelerate the scale-up of food and nutrition actions. It seeks to facilitate the creation/enhancement of country-led national coordination mechanisms.
http://www.reachpartnership.org

SUN MOVEMENT: brings different stakeholders together in a collective action to eliminate all forms of malnutrition.
http://scalingupnutrition.org/

4

Nutrition Assessments

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Nutrition Commitment 2:
Timely nutritional assessment and surveillance systems are established and/or reinforced.

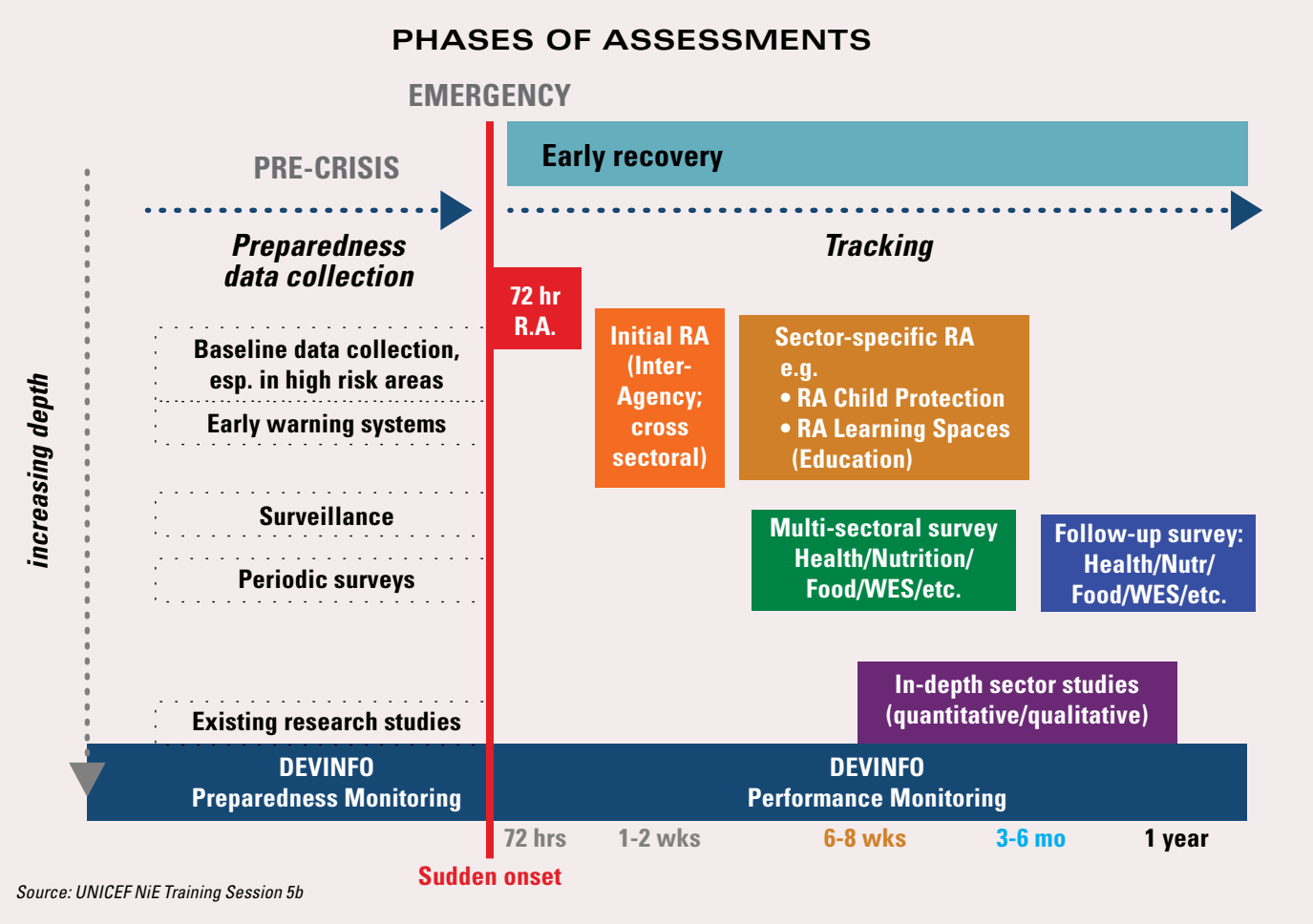
Benchmark 2:
Quality assessments are reported on in a timely fashion and provide sufficient information for decision-making, including the scope and severity of the nutrition situation, the underlying causes of malnutrition and contextual factors.

Nutrition assessments are essential to guide response during an emergency. In acute crises, assessment, monitoring and evaluation must provide a high frequency and broad coverage of information. Often, national information systems deteriorate and previous baselines are invalidated. The number of actors increases, making coordination and standardization of data collection more difficult. Varied information sources and data collection methods must be pulled together, compared and analysed to build a complete and relevant picture.

There are three distinct but closely related phases to assessment and monitoring activities in emergencies: the initial rapid assessment, the expanded rapid assessment and ongoing monitoring and evaluation (Figure 4). Standard methods and tools exist for each of the assessments that may need to be taken and all efforts should be made to ensure that methods and techniques used are in line with international standards and guidance.

The purpose of the initial rapid assessment, which should be completed within the first 72 hours, is to establish a reliable statement on the situation of children in the crisis area, help early decision-making and guide advocacy and media work. This assessment is the basis for the immediate response for the first 6–8 weeks. The expanded assessment, done as soon as possible and ideally within 8 weeks, builds upon the initial rapid assessment and draws on the analysis

FIGURE 4 Timeline for Nutrition Assessments in Emergencies



Source: UNICEF NiE Training Session 5b

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of more comprehensive information collected from the field, as well as information from secondary sources. It is designed to guide response for the medium term depending on how much the situation stabilizes. Monitoring and evaluation provide information on the results and continued relevance of the humanitarian response. This feedback is vital for the country office senior management, programme managers, partners and donors to further improve the focus, size and quality of humanitarian programmes. This should be a continuous feedback, and the earlier it comes, the more valuable it is.

As a corporate UNCIEF nutrition strategy, an operational approach strengthens systems to ensure effective monitoring, evaluation and knowledge management to improve nutrition policy and programming. This step is critical to strengthen national, sub-national and community-based monitoring and evaluation processes and ensuring that knowledge acquired feeds back to promote institutional learning to improve programme performance. Within this framework the UNICEF CCC's core principles

CHECKLIST 2 Essential Actions for nutrition assessment in emergencies

PREPAREDNESS FOR ASSESSMENTS				
ESSENTIAL ACTIONS	**UNICEF CCCS FOR PREPAREDNESS FOR ASSESSMENTS**			
	Support a multi-sectoral rapid assessment mechanism and format that includes priority nutrition information	Ensure the availability of guidelines and capacity for conducting and reporting on rapid nutrition surveys and assessments	Advocate for the inclusion of nutritional assessment and programme monitoring data in national early warning systems	Ensure availability of key nutrition baseline data (including data on pre-existing malnutrition and disease prevalence and feeding practices) to inform response
Identify tools and methods that will be used in rapid assessments to ensure that nutrition information will be captured	✓	✓		
Advocate and contribute to the harmonization of nutrition assessment methods across the nutrition sector partners	✓	✓		
Initiate capacity development on implementing, understanding and using nutrition assessments		✓		
Support the government in the development or refinement of national information systems to ensure that appropriate nutrition information is being collected for action			✓	✓
Organize nutrition baseline data to enable a basic understanding of the nutritional vulnerability				✓

CHECKLIST 2 Essential Actions for nutrition assessment in emergencies

RESPONSE FOR ASSESSMENTS		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR RESPONSE FOR ASSESSMENTS**	
	Undertake a multi-sectoral rapid assessment, including key priority information for nutrition, within the first week of an emergency	Undertake a rapid household-level nutrition assessment within six weeks of an emergency
Work closely with other sections within UNICEF and partners to ensure adequate nutrition participation in multi-sector assessment	✓	
Take stock of what pre-crisis and crisis nutrition information is available	✓	✓
Facilitate an appropriate response to the crisis by identifying the nutrition needs		✓

EARLY RECOVERY FOR ASSESSMENTS	
ESSENTIAL ACTIONS	**UNICEF CCCS FOR EARLY RECOVERY FOR ASSESSMENTS**
	Introduce, reinforce and/or adapt the nutrition information system (including routine monitoring of data from malnutrition management programmes, results of nutrition surveys and surveillance data) to facilitate national or regional situation analysis and decision-making for enhanced disaster risk reduction and prevention
Work with Governments and partners to ensure that information needs are defined and systems are put in place	✓
Contribute to the development of a NIS that is multi-level	✓

is that ' UNICEF is committed to supporting humanitarian action through systematic monitoring, analysis and assessment'. The sector specific commitments are supported by specific cross-cutting actions in rapid assessment, monitoring and evaluation. Therefore UNICEF's role in assessments in emergencies is two-fold: there is an internal responsibility to ensure that UNICEF programs and actions are underpinned by evidence gathered through this information systems while additionally UNICEF has a role to play in supporting governments and working with nutrition partners to ensure that the situation for children and women is monitored and sufficiently analysed. In consultation and collaboration with partners, UNICEF will carry out an assessments of the situation of children and women. Drawing upon data compiled in the preparedness phase, this situation analysis will determine the exact nature of the crisis, including potential developments, implications for the rights of children and women, and the required programmatic response.

The following chapter provides guidance on the key actions that should be taken to ensure that UNICEF is able to fulfil its assessment commitments in preparedness and response to emergencies and in the early recovery phase. Checklist 2 provides and overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. Box 1 presents the globally accepted Sphere standards on assessments in emergencies with associated key actions and indicators. Following Checklist 2 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

BOX 1 Sphere standard for Nutrition Assessment

Food security and nutrition, Assessment Standard 2: nutrition

Where people are at increased risk of undernutrition, assessments are conducted using internationally accepted methods to understand the type, degree and extent of undernutrition and identify those most affected, those most at risk, and the appropriate response.

KEY ACTIONS

- Compile existing information from pre–disaster and initial assessments to highlight the nature and severity of the nutrition situation
- Identify groups with the greatest nutritional support needs and the underlying factors that potentially affect nutritional status
- Determine if population level qualitative or quantitative assessments are needed to better measure and understand anthropometric status, micronutrient status, infant and young child feeding, maternal care practices, and associated potential determinants of undernutrition
- Consider the opinions of the community and other local stakeholders on the potential determinants of undernutrition
- Include an assessment of national and local capacity to lead and/or support response
- Use nutrition assessment information to determine if the situation is stable or declining

KEY INDICATORS

- Assessment and analysis methodologies including standardised indicators adhering to widely accepted principles are adopted for both anthropometric and non anthropometric assessments
- Assessment findings are presented in an analytical report including clear recommendations of actions targeting the most vulnerable individuals and groups

Source: Sphere Handbook, 'Chapter 3: Minimum Standards in Food Security and Nutrition', The Sphere Project, Geneva, 2011.

GOOD TO KNOW!

Monitoring and Evaluation Runs Through Everything

The monitoring of programs and actions should start from the very beginning and be continuously looped back into programming. Both the situation of children and the implementation of UNICEF assisted programmes need to be monitored. Collecting information is a key part of humanitarian response but we don't collect information just to fill databases and write reports – information should be used for action.

One of the six pillars of the UNICEF Nutrition Policy[11] focuses on information management: 'Strengthen systems to ensure effective monitoring, evaluation and knowledge management to improve nutrition policy and programming.' This requires UNICEF to support the development of robust result frameworks, aligned with the nutrition programme's theory of change; to strengthen monitoring systems for nutrition; to strengthen UNICEF and partner capacities to support results-based management to improve programme performance; to support evaluations and incorporate lessons in programming; and to develop knowledge management systems for nutrition that also include learning from innovations. These principles apply also in humanitarian settings. For example, the actions detailed in the nutrition policy as also key actions for humanitarian response:

- Support the development and functioning of national-level information and monitoring systems to generate, analyse and use nutrition information (including both situation analysis and programmatic data).
- Ensure regular monitoring of key nutrition inputs, outputs and outcomes as well as bottlenecks to achieving effective coverage of interventions across the policy and programming environment. (This monitoring can both make use of existing data collection systems and explore new ways to collect information on bottlenecks).
- Support evaluation and formative research on nutrition programmes.
- Communicate and disseminate programme results and experiences, including operational and implementation research.

11 UNICEF's Approach to Scaling up Nutrition for Mothers and their Children. June 2015

GOOD TO KNOW!

The agreed commitments of UNICEF and WFP in nutrition assessments relevant in emergencies as per the WFP-UNICEF MOU

PROGRAMME AREA	UNICEF COMMITMENTS	WFP COMMITMENTS	JOINT PRINCIPLES AND ACTION
Nutrition Assessment In consultation and collaboration with WFP, UNICEF will generally take the lead in undertaking nutrition surveys. However, in geographic regions or in certain beneficiary groups where WFP intervenes, WFP can request UNICEF to collect data or will organize the collection itself.	To provide the lead role in surveys on nutrition. To provide technical support for survey design and training.	To participate in the technical discussion, planning and design of nutrition surveys. To provide staff who will actively participate in surveys.	To share all data on nutrition, mortality and morbidity supporting national governments' activities, which are developed by either agency. To developed joint methodologies, indicators and reporting methods for different purposes. Joint review of analysis and interpretation of the findings.
Emergency Food Security and Nutrition Assessments WFP and UNICEF will enhance the role of nutrition, including attention to special needs in areas of high mortality or HIV prevalence and conflict zones, within emergency assessments.	To participate in Emergency Food Security Assessment (EFSA) on a more regular basis, if appropriate, by providing technical support on nutrition assessments.	Take the lead in organizing the EFSA missions and Vulnerability analysis and mapping (VAM).	To define the roles of nutrition within EFSA, VAM and other food assistance tools

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GOOD TO KNOW!

Engaging with UNHCR nutrition assessments and information management systems in emergencies

Undertaking a nutrition survey in refugee settings is the primary responsibility of UNHCR. UNHCR encourages the use of SMART (Standardised Monitoring and Assessment of Relief and Transitions) methods for survey design and anthropometric assessments. In addition UNHCR conducts Standardised Expanded Nutrition Survey (SENS)[12] on an annual basis in order to monitor the situation and to react in a timely manner to nutritional problems.

The UNHCR Health Information Systems (HIS[13]) is a system to collect primary public health data from the populations of concern to rapidly detect and respond to health problems, monitor trends and coverage, and evaluate the quality of programs. The HIS captures 10 primary components of primary health care, of which nutrition is one. Each response/refugee setting has a health information system that should be able to provide information to UNICEF and partners.

In addition UNHCR uses an online platform called TWINE[14] to manage and analyse public health data collected in refugee operations. This allows information from the individual HIS systems to be collated and more widely shared.

The Letter of Understanding[15] between UNHCR and UNICEF sets out how the two agencies will collaborate in countries to maximize synergies between technical and management capacities, availability of resources and response capacity before, during, and after refugee emergency operations. With reference to situation analysis and assessment key areas of cooperation are:

- In acute refugee emergencies public health and nutrition needs will be assessed as early as possible in the crisis, with UNHCR leading the initial rapid assessment, drawing on strong participation and collaboration and expertise of UNICEF and other key actors.
- UNICEF and UNHCR will agree to work with common methodologies concerning anthropometric nutrition surveys (SENS), health and nutrition coverage surveys and other integrated assessment with health and HIV.
- UNHCR takes the lead in routine health and nutrition information systems for refugee programing, which can help guide situation analysis and programme action.

4.1 Preparedness

FROM THE CCC'S

Preparedness Actions for Emergency Nutrition Assessments:

Support a multi-sectoral rapid assessment mechanism and format that includes priority nutrition information; Ensure the availability of guidelines and capacity for conducting and reporting on rapid nutrition surveys and assessments; advocate for the inclusion of nutritional assessment and programme monitoring data in national early warning systems; and ensure availability of key nutrition baseline data (including data on pre-existing malnutrition and disease prevalence and feeding practices) to inform response.

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12 More information on SENS can be found: http://sens.unhcr.org/

13 More information on UNHCR HIS can be found: http://www.unhcr.org/4a3374408.html

14 More information on TWINE can be found: http://www.unhcr.org/pages/49c3646ce0.html

15 More information on UNHCR-UNICEF LOU technical guidance: http://educationcluster.net/wp-content/uploads/2015/02/UNICEF_UNHCR_LoU_Technical-Notes_UNICEF-UNHCR-28-Jan-2015.pdf

PREPAREDNESS ACTIONS FOR EMERGENCY NUTRITION ASSESSMENTS	EXAMPLES/RESOURCES
A. Identify tools and methods that will be used in rapid assessments to ensure that nutrition information will be captured. ▪ Ensuring that priority nutrition questions for a joint/common rapid assessment questions are identified and agreed to by sector partners ▪ Familiarize UNICEF staff and partners with the Multi-Indicator Rapid Assessment (MIRA) methodology (if a country does not already have their own existing methodology). ▪ Adapt generic tools such as the UNICEF 'Rapid assessment matrix', the MIRA questionnaire or comparable tools from partner organizations to the specific emergency context and agree on tools and methods with likely partner organizations. Depending on the context and the secondary information available, it will be possible to narrow down what data need to be collected at the field level. ▪ With partners (and preferably in the coordination forum) discuss and agree on roles and responsibilities for rapid assessments before emergency including responsibilities for analysing, interpreting and reporting the data from the joint/common assessment. Document this in sector/cluster preparedness plans (see Pakistan example).	**UNICEF EMERGENCY FIELD HANDBOOK RAPID ASSESSMENT MATRIX** **MIRA GUIDANCE** https://interagencystandingcommittee.org/node/4048 **PAKISTAN EPRP SECTION 6.2 EXAMPLE** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment
B. **Advocate and contribute to the harmonization of nutrition assessment methods across the nutrition sector partners,** with agreement in place for when different assessments should be conducted. ▪ Disseminate best practice guidance/tools within UNICEF and to partners such as MUAC screening, the SMART nutrition survey methodology, key methods for collecting IYCF-E information and essential micronutrient assessments. ▪ Identify and engage the relevant government body for data (statistics bureau) to facilitate vetting methods and sharing final results.	**RAPID SMART SURVEYS FOR EMERGENCIES GUIDELINES** http://smartmethodology.org/survey-planning-tools/smart-methodology/rapid-smart-methodology/ **SMART SURVEY** http://smartmethodology.org/ **METHODS & INDICATORS FOR ASSESSMENT OF IYCF IN EMERGENCIES:** http://www2.unicef.org/nutrition/training/5.5/4.html **FIGURE 5 UNDERSTANDING THE SITUATION THROUGH THE IYCF LENS IN THE ASSESSMENT CHAPTER**
C. **Initiate capacity development on implementing, understanding and using nutrition assessments** within the nutrition community and directly in the UNICEF office. ▪ Engage the government from the very beginning in defining capacity needs and in development plans. ▪ Discuss within the nutrition coordination group and with governmental partners on the nutrition assessment gaps in order to refine capacity development efforts. ▪ Identify experts within UNICEF and partners and encourage them to hold seminars and mini-trainings to further build the capacity of agencies/individuals to use and apply the guidance/tools. ▪ Plan ahead for external support if needed through identifying and training staff or consultants to do nutrition assessments. ▪ Draft a contractual Terms of Reference for assessment teams to be hired or seconded to speed up hiring in the event of an emergency.	**UNICEF NIE TRAINING SESSION 5B NUTRITION ASSESSMENTS** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **HTP MODULE 7 NUTRITION ASSESSMENTS** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment

PREPAREDNESS ACTIONS FOR EMERGENCY NUTRITION ASSESSMENTS	EXAMPLES/RESOURCES
D. **Support the government in the development or refinement of national information systems to ensure that appropriate nutrition information is being collected for action.** ▪ If there is a functioning surveillance/monitoring system in the country work with the national government and partners to define/refine a minimum set of core indicators that relate to nutritional status and provide an understanding of the underlying causes of malnutrition. ▪ If a system has yet to be established, support the national government to design the surveillance system on the basis of context being clear on the objectives and what the information will be used for. Primary objectives can be: ○ **ADVOCACY.** *This is used as a means of highlighting an evolving crisis* ○ **IDENTIFICATION OF APPROPRIATE RESPONSE/INTERVENTION STRATEGIES.** *In emergencies these may include non-food as well as food assistance to address the underlying causes of malnutrition. In development scenarios, this may include nutrition education and activities directed to increasing diversity of food production food access. Both emergencies and development settings may also require micronutrient supplementation programmes.* ○ **TRIGGERING A RESPONSE.** *Nutrition surveillance systems provide a trend analysis focusing on the magnitude of change. This may trigger a more in depth assessment that in turn may lead to response.* ○ **TARGETING.** *Nutrition information can help target areas that are more at risk or in greater need of assistance,* ○ **IDENTIFICATION OF MALNOURISHED CHILDREN.** *Most forms of surveillance will identify acutely malnourished children.*	**UNICEF NUTRITION INFORMATION STRATEGY AND RELATED GUIDANCE** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **HTP MODULE 10 ON NUTRITION INFORMATION AND SURVEILLANCE SYSTEMS** http://nutritioncluster.net/training-topics/module-10-nutrition-information-and-surveillance-systems/
E. **Organize nutrition baseline data[16] to enable a basic understanding of the nutritional vulnerability.** ▪ Identify baseline data sets and refined/organize for key information and disaggregated geographically and by sex and age to inform a response. Sources of information could be: ○ **REPEATED NATIONAL SURVEYS:** *MICS, DHS, National Nutrition Surveys* ○ **AREA LEVEL SURVEYS:** *SMART Surveys, SQUEAC, KAP, LQAS, Micronutrient Survey, Iodine Survey* ○ **ROUTINE DATA SYSTEMS:** *national nutrition information systems (NIS)* ○ **DEVINFO GEOGRAPHIC INFORMATION SYSTEM:** *which can produce user-friendly maps, graphs and tables* ▪ Layer and analyze with other sources of data such as hazard mapping and relevant country determined indicators of vulnerability. ▪ Work with governmental bodies to ensure that key minimum indicators are being collected through national monitoring systems.	**UNICEF MINIMUM INDICATORS IN HMIS OR CBHIS** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **TABLE 1 NUTRITION ASSESSMENTS AND SOURCES OF INFORMATION** **DPRK EXAMPLE OF BASELINE DATA** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment

16 Baseline data for nutrition will include wasting, stunting, underweight, anemia and exclusive breastfeeding rates, disaggregated geographically and by sex and age. Other indicators may be relevant depending on the country context.

GOOD TO KNOW!

Recommendations for Assessment Preparedness from the MIRA Guidelines

- Raise awareness, increasing awareness of the importance of the process helps ensure timely, quality and relevant information.
- Agree on assessment coordination structures. Identify key stakeholders; maximize the use of existing coordination mechanisms; include links to national disaster management bodies and other appropriate government entities and international/national NGOs.
- Review assessment planning already undertaken; particularly government contingency planning, assessment formats and approaches. Review technical guidelines produced and used in the past, based on lessons learned.
- Set out collaborative arrangements. Agree on standard operating procedures, draft terms of reference for an assessment and information management working group, and/or assessment- related tasks. Develop partnerships with national research institutions and other national bodies that have a data collection capacity.
- Develop assessment tools and data collection methodology. Adapt standard operating procedures, reporting formats, information requirements and questionnaires (existing ones, when possible). Share with stakeholders, carry out field- testing, and revise based on feedback.
- Strengthen capacities and skills of partners and stakeholders through training. Maintain a list of trained staff, their location and contact details in case of emergency.
- Compile and store baseline data and risk analyses. Work with partners to collect baseline data, populate key indicator sets, and compile common datasets. based on vulnerability and risk mapping, adapt fact sheets and lessons learned to the affected area context.
- Gather and disaggregate qualitative and quantitative data. Integrate a gender perspective in the MiRA process by collecting and analysing gender-disaggregated data and gender-sensitive information related to the specific context in order to facilitate a robust understanding of the situation of female and male populations of various age and diversity groups.
- Ensure the organization of logistics and human resources. This includes agreements for the funding and transportation of equipment (tools, computers, tablets, smartphones). Identify members of the assessment team, ensuring a suitable gender balance and, where needed, train in-country capacity.
- Develop protocols for data sharing and a dissemination plan for communicating the findings.

MIRA Guidance Annex 1 MIRA Preparedness

4.2 Response

FROM THE CCC'S

Response Actions for Emergency Nutrition Assessments:

Undertake a multi-sectoral rapid assessment, including key priority information for nutrition, within the first week of an emergency, and a rapid household-level nutrition assessment within six weeks

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RESPONSE ACTIONS FOR EMERGENCY NUTRITION ASSESSMENTS	EXAMPLES/RESOURCES
F. **Work closely with other sections within UNICEF and partners to ensure adequate nutrition participation in multi-sector assessment** so that recommendations can be made to ensure that the nutrition needs of an emergency-affected population are met. ▪ Use nutrition baseline data if action preparedness actions have been undertaken, or do that step now, in order to understand the underlying vulnerabilities (see Preparedness E). ▪ Engage with nutrition coordination group or stakeholders with agency participation in relevant rapid assessments being conducted. ▪ Identify if additional support is needed and engage in securing that support (see preparedness step C). Additionally there is surge support available through the Technical RRT for the GNC which aims to improve overall emergency nutrition response by deploying technical surge advisors in major and complex humanitarian crisis building the capacity of stakeholders involved in humanitarian responses. They are deployable within 72 hours for a duration of 4 weeks and there is one for assessments. ▪ Ensuring that priority nutrition questions[17] for a joint/common rapid assessment questions are agreed to by sector partners and communicated to OCHA or lead actor for joint assessments. ▪ Identify gaps in information that need to be filled to enable the emergency to be effectively addressed, as well as the human and physical resources that will be required to carry out additional data collection. The initial rapid assessment forms the basis for the expanded rapid nutrition assessment within 6 weeks after the onset of the emergency.	**MIRA GUIDANCE** **HNO GUIDANCE** https://www.humanitarianresponse.info/en/programme-cycle/space/document/humanitarian-needs-overview-guidance-and-templates-updated-august-0 **TECHNICAL RAPID RESPONSE TEAM FOR THE GNC FOR ASSESSMENT** http://nutritioncluster.net/establishment-gnc-technical-rapid-response-team/
G. **Take stock of what pre-crisis and crisis nutrition information is available.** ▪ Review what information you have available first, consider whether it is adequate and identify information gaps. Engage with the nutrition sector/cluster and partners to share information. ▪ With reference to the crisis context, identify the key indicators that will provide the information needed for response and identify how you will collect the information so that you can understand the severity of the situation as well as have a baseline for monitoring against.	**SEE TABLE 1 FOR SOURCES OF INFORMATION**
H. **Facilitate an appropriate response to the crisis by identifying the nutrition needs.** ▪ In contexts where there has been a drastic alteration of context or where information is lacking, do or participate in a nutrition assessment. This can either be a UNICEF specific assessment or in partnership depending on the objectives, the nature of the anticipated, and the national partnership context. WFP and UNHCR are common partners in emergency assessments ▪ As it is an often neglected area and one of UNICEFs CCC, advocate and ensure that information is collected on infant and young child feeding practices and needs. ▪ Identify if additional support is needed and engage in securing that support.	**RAPID SMART SURVEYS FOR EMERGENCIES GUIDELINES** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **GNC INDICATORS REGISTRY** https://www.humanitarianresponse.info/applications/ir **SAVE THE CHILDREN IYCF-E TOOLKIT –INITIAL RAPID ASSESSMENTS AND SECTOR SPECIFIC ASSESSMENT** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **TECHNICAL RAPID RESPONSE TEAM FOR GNC FOR ASSESSMENTS** http://nutritioncluster.net/establishment-gnc-technical-rapid-response-team/

17 Joint rapid assessments rarely include MUAC and other anthropometric measurements due to time and capacity restrictions. Where anthropometric information is needed, a nutrition sector specific assessment is warranted.

TABLE 1 Assessment Tools and Sources of Information

NAME	ACRONYM	AGENCY	OBJECTIVES	TOOLS
Emergency Food Security Assessment	EFSA	WFP	Analyses the impact of a crisis on the food security of households and communities including changes in levels of malnutrition and coping strategies.	
Standardized Expanded Nutrition Surveys	SENS	UNHCR	The SENS collects, analyses and presents data on nutrition, but also health, food security and water, sanitation and hygiene at the household level.	http://sens.unhcr.org/
Joint Assessment Mission	JAM	UNHCR & WFP	To assess the food and non-food needs of refugees and other communities of concern	http://www.unhcr.org/521612d09.html
Standardized Monitoring and Assessment of Relief and Transitions	SMART	NGOs	SMART is a standardised, simplified household-level survey methodology that provides representative and accurate nutrition and mortality data.	http://smartmethodology.org/
Nutrition Casual Analysis	LINK NCA	ACF	NCA is a mixed method to identify the most relevant factors leading to under-nutrition in a local context for improving Nutrition Security programming.	http://linknca.org/
GNC Information Management Toolkit	IM Toolkit	GNC/ UNICEF	Consists of 20+ tools that support the different phases of Humanitarian Programme Cycle (HPC) including assessment, implementation and administrative.	http://nutritioncluster.net/launch-gnc-toolkit/
Semi-Quantitative Evaluation of Access and Coverage	SQUEAC	Varied	A tool to analyse the barriers and boosters to coverage and give an estimate of coverage. It is also provides succinct actions for improving access and coverage	http://www.fantaproject.org/monitoring-and-evaluation/squeac-sleac
Knowledge Attitude Practice Survey	KAP	Varied	KAP surveys are focused evaluations that measure changes in human knowledge, attitudes and practices in response to a specific intervention	http://www.fao.org/docrep/019/i3545e/i3545e00.htm
Demographic Health Survey	DHS	USAID	DHS are nationally representative household surveys that provide data for a wide range of indicators in the areas of population, health, and nutrition including IYCF practices, nutritional status and micronutrient deficiencies.	https://dhsprogram.com/Topics/Nutrition.cfm
Multiple Indicator Cluster Survey	MICS	UNICEF	Country wide information on topics ranging from maternal and child health, education and child mortality to child protection, HIV/AIDS and water and sanitation	http://mics.unicef.org/

GOOD TO KNOW!

Is the MIRA right for this response?

The MIRA is an inter-agency process enabling actors to reach, from the outset, a common understanding of the situation and its likely evolution. Based on its findings, humanitarian actors can develop a joint plan, mobilize resources and monitor the situation. The MIRA is underpinned by an analytical framework that guides the systematic collection, organization and analysis of secondary and primary data. The MIRA informs and supports the design of subsequent needs assessments and analysis which are often more detailed and operational in focus.

A MIRA is most appropriate in a natural disaster setting, where a specific event triggers an emergency that is new or sudden in nature and generates a confirmed or potential humanitarian impact that is followed by a period of relative stability, allowing humanitarian actors to carry out response activities and more detailed assessments. The MIRA is also best applied to inform strategic-level decisions under tight deadlines.

Preconditions for a successful MIRA are:

NEW AND SUDDEN?

- New sudden-onset emergency
- Significant deterioration in an ongoing emergency or new and sustained access to a previously inaccessible area
- New or additional risks to lives and livelihoods

STABILITY?

- Environment supports sustained access to majority of affected population
- No significant additional population movements anticipated
- Safe and sustainable access to the majority of the affected population

URGENCY?

- Urgent need for new information to support joint planning
- No or limited detailed cluster/sector or agency assessments available

JOINT?

- HCT supports a joint analysis and planning process
- Agencies and clusters willing to share information for joint secondary data analysis
- Agencies and clusters willing to contribute resources for joint primary data collection

Source: MIRA Guidance July 2015

4.3 Early Recovery

FROM THE CCC'S

Early Recovery Actions for Emergency Nutrition Assessments:

Introduce, reinforce and/or adapt the nutrition information system (including routine monitoring of data from malnutrition management programmes, results of nutrition surveys and surveillance data) to facilitate national or regional situation analysis and decision-making for enhanced disaster risk reduction and prevention

EARLY RECOVERY ACTIONS FOR EMERGENCY NUTRITION ASSESSMENTS	EXAMPLES/RESOURCES
I. **Work with Governments and partners to ensure that information needs are defined and systems are put in place** to ensure these needs are met. ▪ If not already existing, support the government to create a nationally recognized body in order to ensure data of adequate quality and frequency. ▪ Integrate with, or build on, health management information systems (HMIS). ▪ Contribute to the development of capacity to introduce, reinforce or adapt the Nutrition Information System. The needs differ by administrative level, from community through district to national. . different training programs will apply to different levels. For example, NGOs may focus on community levels, universities on national and district levels. ▪ Support a 'skills audit' to determine requirements and best approaches at different levels. This may be done through a regional or national coordination group, familiar with the relevant organizations and their capacities.	**UNICEF NUTRITION INFORMATION SYSTEM STRATEGY** **HTP MODULE 10 ON NUTRITION INFORMATION AND SURVEILLANCE SYSTEMS** http://nutritioncluster.net/training-topics/module-10-nutrition-information-and-surveillance-systems/ **UNICEF NIS ADVOCACY** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment
J. **Contribute to the development of a NIS that is multi-level,** with certain indicators meaningful at the community level, together with district and national indicators. ▪ Conduct a bottleneck analysis of NIS to prioritize key actions for strengthening the system. ▪ Determine what role the country office will have in building up capacity of national partners to coordinate data collection and in contributing to standardize data-collection systems among agencies. Identify any corresponding capacity-building activities and the best timing for them.	**UNICEF NIS ASSESSMENT TOOL** **UNICEF MINIMUM NUTRITION RELATED INDICATORS HF AND CHW LEVELS** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment **UNICEF MORES SAM MANAGEMENT MODULES** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/2.%20Assessment

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Monitoring Results for Equity Systems (MoRES)

In line with its equity approach, UNICEF is increasingly promoting the use of the Monitoring Results for Equity Systems (MoRES) approach, using existing nutrition information systems to plan, implement and monitor effectively at national and decentralized levels. The four levels of MoRES reinforce good programming practice and management for results.

1. **SITUATION ANALYSIS, STRATEGIC PLANNING AND PROGRAMME DEVELOPMENT (LEVEL 1):** Identifying key deprivations of children's rights and groups; identifying priority bottlenecks and solutions.
2. **MONITORING ORGANIZATION-SPECIFIC PROGRAMME IMPLEMENTATION (LEVEL 2):** Tracking UNICEF budgets, inputs and outputs.
3. **PERIODIC SUB-NATIONAL/DISAGGREGATED MONITORING OF BOTTLENECKS TO EFFECTIVE COVERAGE OF HIGH IMPACT INTERVENTIONS (LEVEL 3):** Engaging partners and community stakeholders in monitoring bottleneck reduction at the sub-national level or among key populations: analyzing monitoring data and using data to identify and implement corrective actions, adjust plans and strategies as needed and influence policy dialogue.
4. **MONITORING OUTCOMES AND IMPACT (LEVEL 4):** Monitoring outcomes in target areas and groups every 3-5 years to see impact.

Efforts to strengthen nutrition information systems should align to this model and to the largest extent possible, support equity bottleneck analysis to be implemented. At the same time, a robust NIS can greatly strengthen nutrition policy and programming and ensure better results. In a time of normal programming, supporting the development of a national NIS system and related capacities will be a strong platform to build an effect and informed emergency response upon.

For more see the UNICEF Nutrition Information Strategy Document and related guidance https://unicef.sharepoint.com/teams/PD/MoRES/SitePages/MoRESCollab.aspx (INTERNAL)

KEY RESOURCES FOR NUTRITION ASSESSMENTS

UNICEF EMERGENCY FIELD HANDBOOK CHAPTER 3.1 ASSESSMENT AND MONITORING

UNICEF EAPRO NUTRITION EMERGENCY PREPAREDNESS TOOLKIT

MIRA http://www.humanitarianresponse.info/programme-cycle/space/document/mira-manual

RAPID SMART SURVEYS FOR EMERGENCIES GUIDELINES http://smartmethodology.org/survey-planning-tools/smart-methodology/rapid-smart-methodology/

SMART NUTRITION AND MORTALITY SURVEY GUIDANCE http://smartmethodology.org/

HARMONIZED TRAINING PACKAGE MODULE 7 NUTRITION ASSESSMENTS http://nutritioncluster.net/training-topics/module-7-measuring-malnutrition-population-assessment/

5

Support for Appropriate Infant and Young Child Feeding

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Nutrition Commitment 3:

Support for appropriate infant and young child feeding (IYCF) is accessed by affected women and children.

Benchmark 3:

All emergency-affected areas have an adequate number of skilled IYCF counsellors and/or functioning support groups.

IYCF-E concerns the protection and support of optimal feeding for infants and young children in all emergencies. Approximately a fifth of all deaths among children under-5 years in the developing world could be prevented through appropriate IYCF practices. Infants less than six months old who are not breastfed in non-emergency situations are already more than 14 times more likely to die from all causes than exclusively breastfed children.

Breastfeeding is critical for optimal brain development, maternal health and the prevention of non-communicable diseases. This practice, combined with appropriate feeding for young children, is crucial for the optimal development of young children and provides a foundation from which to protect infant and young children's nutrition and health within an emergency setting. Sub-optimal infant and young child feeding (IYCF) practices increase vulnerability to undernutrition, disease and death.

The risks are heightened in emergencies and the youngest are most vulnerable. Population displacement, overcrowding, food insecurity, poor water and sanitation, decreased availability of caregivers and an overburdened health care system all negatively impact on a mother's and family's capacity to feed and care for their young children. It is critical to keep in mind that infant and young child feeding is a preparedness and response measure that should be a key component in all emergencies even when malnutrition rates are low. In situations where malnutrition rates are low, optimal IYCF programming is an effective measure to prevent the most vulnerable from becoming malnourished. In situations where malnutrition rates are high, IYCF is a life-saving component. Regardless of the level of wasting, stunting or micronutrient defeciences IYCF-E interventions have a huge life-saving potential.

Infant and young child feeding is a core component of UNICEF's nutrition strategy and forms a cornerstone of scaling up nutrition gains in non-emergency settings. UNICEF has a particular role to play in providing technical advice and assistance to national governments and partners so that there are established nutrition policies and programmes concerning. Breastfeeding and complementary feeding are critical factors in child survival, growth and development in a development situation and forms the platform for UNICEF's commitment to enabling that affected women and children can assess appropriate infant and young child feeding support in humanitarian settings.

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The following chapter provides guidance on the key actions that should be taken to ensure that UNICEF is able to fulfil its commitments in IYCF in preparedness and response to emergencies and in the early recovery phase. Checklist 3 provides and overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. Box 2 presents the globally accepted Sphere standards on IYCF in emergencies with associated key actions and indicators. Following Checklist 3 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

CHECKLIST 3 Essential Actions for IYCF in emergencies

PREPAREDNESS FOR IYCF-E					
ESSENTIAL ACTIONS	**UNICEF CCC'S FOR PREPAREDNESS FOR IYCF-E**				
	Advocate for and provide guidance on appropriate quantities of quality complementary foods to add to the food basket	Define essential infant and young child feeding (IYCF) interventions in emergency scenarios	Develop, translate and pre-position appropriate materials for IYCF	Include emergency IYCF in ongoing training of health workers and lay counsellors	With Supply and Logistics, prepare supply plans, distribution strategies and long term agreements where this is possible locally
Understand the reality facing infants and young children prior to a crisis		✓			
Put IYCF-E on the agenda of nutrition sector coordination group	✓	✓			✓
Provide support to develop/strengthen policies for optimal IYCF practices and services in emergencies	✓	✓	✓		
Make IYCF and IYCF-E guidance and materials available			✓		✓
Provide different levels of orientation and training on IYCF-E		✓		✓	
Engage with partners to ensure that young children appropriately receive appropriate and safe complementary foods in emergencies	✓	✓	✓	✓	✓
Integrate IYCF components into other programming approaches		✓	✓		

RESPONSE FOR IYCF-E					
ESSENTIAL ACTIONS	**UNICEF CCC'S FOR RESPONSE FOR IYCF-E**				
	Protect, support and promote early initiation and exclusive breastfeeding of infants, including establishment of 'safe spaces' with counselling for pregnant and lactating women	Support safe and adequate feeding for non-breastfed infants less than 6 months old, while minimizing the risks of artificial feeding	Ensure appropriate counselling regarding infant feeding options and follow-up and support for HIV-positive mothers	With the World Food Programme and partners, ensure availability of safe, adequate and acceptable complementary foods for children	Identify and transmit supply inputs to Supply and Logistics
Make IYCF-E an integral component of the nutrition coordination group/ cluster response strategy	✓	✓	✓	✓	
Identify and understand the Infant and Young Child Feeding needs in the emergency context	✓		✓		
Develop and share consistent and appropriate communication on IYCF in emergencies	✓	✓	✓	✓	
Establish safe spaces that protect, support & promote optimal IYCF practices	✓	✓	✓		
Meet the nutritional needs of non-breastfeeding infants less than 6 months old	✓	✓			✓
Where relevant and needed, ensure that Breast Milk Substitutes (BMS) for the non-breastfeed infant are appropriately managed		✓	✓		✓
Maximise HIV-free child survival through assisting mothers living with HIV to find the best feeding option for their infants	✓	✓	✓		
Pay special attention to the nutritional value of the food available to infants and young children				✓	✓

EARLY RECOVERY FOR IYCF-E	
ESSENTIAL ACTIONS	**UNICEF CCC'S FOR EARLY RECOVERY FOR IYCF-E**
	Ensure that IYCF activities build on and support existing national networks for infant feeding counselling and support
Refine the IYCF-E programming and use the key components to build a good foundation for an IYCF programme	✓

BOX 2 Sphere Standards

Infant and young child feeding standard 1 Policy guidance and coordination

Safe and appropriate infant and young child feeding for the population is protected through implementation of key policy guidance.

Key actions

- Uphold the provisions of the Operational Guidance on infant feeding in emergencies (IYCF-E) and the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (collectively known as the Code).
- Avoid soliciting or accepting donations of BMS, other milk products, bottles, and teats.

Key indicators

- A national and/or agency policy is in place that addresses IYCF and reflects the Operational Guidance on IYCF-E
- A lead coordinating body on IYCF is designated in every emergency.
- A body to deal with any donations of breastmilk substitutes, milk products, bottles and teats is designated
- Code violations are monitored and reported

Infant and young child feeding standard 2: Basic and skilled support

Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks and optimises nutrition, health and survival outcomes.

Key actions

- Undertake integrated multi-sector interventions to protect and support safe and appropriate IYCF.
- Give priority to pregnant and breastfeeding women to access food/cash/voucher transfers and other supportive interventions.
- Integrate skilled breastfeeding counselling in interventions that target pregnant and breastfeeding women and children 0-24 months.
- Target mothers of all newborns with support for early initiation of exclusive breastfeeding.
- Support timely, safe, adequate and appropriate complementary feeding
- Enable access for mothers and caregivers whose infants require artificial feeding to an adequate amount of an appropriate BMS and associated support.
- Give special consideration to feeding support of infants and young children in exceptionally difficult circumstances (orphans, acutely malnourished, LBW infants and those affected by HIV). tivated in sudden onset

Key indicators

- Measurement of standard WHO indicators for early initiation of breastfeeding, exclusive breastfeeding rate in children <6 months, and continued breastfeeding rate at 1 and 2 years
- Caregivers have access to timely and appropriate, nutritionally adequate and safe complementary foods for children 6 to <24 months
- Breastfeeding mothers have access to skilled breastfeeding support
- There is access to Code-compliant supplies of appropriate BMS and associated support for infants that require artificial feeding

Source: UNICEF and WFP Memorandum of Understanding (2011) excerpt from Technical Annex for Nutritionv

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The agreed commitments of UNICEF and WFP in IYCF-E as per the WFP-UNICEF MOU

Programme area: supplementary feeding for young children

WFP will coordinate and manage the organisation of supplementary feeding programmes for children 6 months and older and pregnant and lactating women

(SUN) Movement and the Cluster A

UNICEF Commitments

To take the lead in organizing nutrition coordination meetings, as the global nutrition cluster lead, with partners to review the nutrition aspects of SFPs

To take the lead in ensuring access to public health care, safe water, sanitation and hygiene for children with MAM.

In case WFP is unable to provide SFP, UNICEF may do so after discussion with WFP at country level. If no arrangement can be made, agreements will be made at the regional or headquarters level.

WFP Commitments

To take the lead, in consultation with governments, UNICEF and the appropriate food security and nutrition emergency clusters, in designing and implementing SFPs for children and PLW.

To provide supplementary foods (improved fortified blended foods and ready-to-use supplementary foods) for the management of moderate acute malnutrition in children and PLW.

To support the training of health staff on the treatment of MAM.

Joint principles & action

To assist governments in adopting MAM treatment protocols including the appropriate food products in collaboration with the WHO.

Together with partners, seek program synergies for mobilising, screening and assigning children to the appropriate treatment programme.

It is recognized the exclusive breastfeeding and continued breastfeeding should be promoted and protected.

To carry out joint resource mobilisation for the management of acute malnutrition.

To strive toward joint training of staff on the management of acute malnutrition.(SUN) Movement and the Cluster A

Source: UNICEF and WFP Memorandum of Understanding (2011) excerpt from Technical Annex for Nutrition

GOOD TO KNOW!

Online Orientation and Training Options on IYCF-E

Infant Feeding in Emergencies e-learning (IFE) http://www2.unicef.org/nutrition/training/5.1/1.html

Introduction to Nutrition in Emergencies- Basic Concepts; UNICEF E-learning course, Module 5 IFE: http://www.ennonline.net/iycfeorientationpackage

Infant Feeding in Emergencies Orientation Package ENN 2010: This is a package of resources to help in orientation on infant and young child feeding in emergencies (IFE). These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies, at national and international level. http://www.ennonline.net/htpv2module17

Harmonized Training Package (HTP) Module 17 Infant and Young Child Feeding in Emergencies: is a primarily a resource for trainers in the Nutrition in Emergencies (NiE) sector and it can be used by individuals to increase their technitcal knowledge of the sector. It is designed to provide trainers from any implementing agency or academic institution with information from which to design and implement a training course according to the specific needs of the context. http://www.ennonline.net/iycfeorientationpackage

Save the Children IYCF Toolkit: is a rapid start up resources for emergency nutrition personnel.https://www.humanitarianresponse.info/en/operations/ukraine/document/save-children-iycf-toolkit

Online Orientation and Training Options on IYCF-E

Cornell University Programming for IYCF: offers an online training course that aims to enhance the competencies and build capacity of UNICEF staff and counterparts who are involved in Infant and Young Child Feeding (IYCF) programmes in developing countries. This includes programme development, programme implementation, programme evaluation, and other related activities for improving nutrition and health outcomes of infants and young children. https://www.nutritionworks.cornell.edu/UNICEF/about/

The IYCF-E Global Technical Support Cell (Tech Support Cell): is a small group of nutrition specialists who will respond to questions and requests for support in infant and young child feeding issues and concerns during emergencies. The coordination group is composed of representatives from Save the Children, UNICEF and ENN. You can access this support by sending an email the specific question or request for support: iycfe.tech.cell@gmail.com

5.1 Preparedness Actions

Emergency preparedness is essential. The presence of a comprehensive, at-scale IYCF programme with adequate national policies on the International Code of Use of Breast milk substitutes and IYCF-E, alongside available cohorts of trained and skilled health providers and community cadres, positions a country better to address IYCF in emergencies. IYCF-E should always be well reflected in a country's emergency preparedness and response plan as well as within UNICEF specific preparedness planning.

Improving poor feeding practices and sustaining breastfeeding in 'normal' times represents an important emergency preparedness activity. When families have optimal knowledge about IYCF they are more resilient in the face of emergencies. The more well fed and appropriately nourished infants and young children are, the better their chances in an emergency. Therefore, although not mentioned in the CCCs focusing efforts on strengthening the existing national IYCF programme to improve IYCF practices is a crucial preparedness action.

FROM THE CCC'S

Preparedness Actions for Appropriate IYCF-E:

Advocate for and provide guidance on appropriate quantities of quality complementary foods to add to the food basket; define essential infant and young child feeding (IYCF) interventions in emergency scenarios; develop, translate and pre-position appropriate materials for IYCF; and include emergency IYCF in ongoing training of health workers and lay counsellors.

GOOD TO KNOW!

Warning signs that infants and young children are at increased risk of malnutrition

IYCF considerations are a core commitment for UNICEF in both its regular and emergency programming. It is important to be away of some of the warning signs which could indicate that the nutritional security or status of infants or young children are at risk such as:

- General distribution of infant formula and milk products
- Mothers reporting difficulties in breastfeeding or stopping breastfeeding due to the crisis situation
- Reports of infants under 6 months who are not breastfed
- Reports of increased diarrhea in infants under 12 months
- Poor availability of food for complementary feeding
- Mothers reporting difficulties feeding their children
- Early or late introduction of complementary foods

Source: ECHO IYCF-E Guidance for Programming 2012

PREPAREDNESS ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
A. **Understand the reality facing infants and young children prior to a crisis.** ▪ Use secondary background information found in existing studies to understand IYCF practices, understand eating patterns such dietary diversity and meal frequency, in order to have a realistic understanding of the context. Use sources such as Demographic and Health Surveys (DHS); Multi-Indicator Cluster Surveys (MICS), Ministry of Health (MoH) reporting system or other relevant sector surveys. Information can also be located in government owned databases such as Health Information Systems (HIS) and existing community networks.components of an effective nutrition response and international standards and guidelines ▪ Map the services provided and the coverage of those services in order to understand where the most vulnerable are and to have an understanding of what systems and capacities are in place to form the foundation for a strong IYCF programme and potential response in a humanitarian setting. ▪ Consider what national and stakeholder policies are in place and the existing level of knowledge and skills on IYCF and IYCF in emergencies	**DEMOGRAPHIC AND HEALTH SURVEYS DATA (DHS)** http://dhsprogram.com/data/ **MULTIPLE INDICATOR CLUSTER SURVEYS (MICS)** http://mics.unicef.org/ **UNICEF PROGRAMMING GUIDE ON INFANT AND YOUNG CHILD FEEDING CHAPTER 2.2** Situation Assessment 2011 http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf
B. **Put IYCF-E on the agenda of nutrition sector coordination group's agenda.** ▪ the cluster approach and role and responsibilities of UNICEF within that framework Advocate and build capacity within nutrition partners on the importance of IYCF in an emergency response accountability to affected populations humanitarian principles ▪ Within the cluster approach, UNICEF is likely the UN agency responsible for coordination of IYCF in an emergency response. Therefore it is crucial that IYCF preparedness actions are collectively identified and acted upon by nutrition stakeholders. ▪ Build relationships with partners including through long-term agreements or preparedness PCAs to have in place distribution strategies for IYCF-E supplies	**IYCF-E ORIENTATION PACKAGE MODULE 1 VERSION 2.** http://www.ennonline.net/ourwork/capacitydevelopment/iycfeorientation
C. **Verify the availability of existing policies and regulations and provide support to government and key partners to develop and/or strengthen policies for optimal IYCF practices and services in emergencies.** It is crucial to make sure that there is good existing policy for IYCF programming that will serve the platform for response when an emergency happens. Do this through: ▪ Verifying the availability of existing policies and regulations pertaining to infant and young child feeding. Identify whether they exist, whether they are implemented/enforced. Assess if they are in line with international standards and recommendations and provide support in the refinement/development of a well functioning IYCF operational environment. ▪ Support the national government in developing and/or strengthening policies for the inclusion of IYCF specific responses that sets out what they aim to do and who is responsible for doing it in the context of an emergency. This should clearly state roles and responsibilities. Specific considerations should include breastfeeding, complementary feeding, artificial feeding management, and compliance with the Code. ▪ If there is no existing national policy on IYCF in emergencies, use Generic IFE Policy as guide in the development. ▪ Integrating key elements of IYCF-E into existing policies, such as emergency preparedness plans or national IYCF policies, and into operational procedures and guidelines for emergencies, should increase the chances of implementation. the cluster approach and role and responsibilities of UNICEF within that framework ▪ Sensitize Governments on the issue of donations as part of emergency preparedness, so that swift and decisive action can be taken at the onset of an emergency to ensure donations of BMS are not requested by the Government and that any donations are prevented and stopped effectively from the outset. ▪ Use the defined IYCF-E interventions to identify priority actions for optimal preparedness for response. (See IYCF- Interventions from page 56)	**BREAST FEEDING ADVOCACY BRIEF** http://www.unicef.org/nutrition/files/Breastfeeding_Avocacy_Initiative_Two_Pager-2015.pdf **BREAST FEEDING ADVOCACY STRATEGY UNICEF/WHO** https://www.unicef.org/nutrition/files/Breastfeeding_Advocacy_Strategy-2015.pdf **UNICEF PROGRAMMING GUIDE ON INFANT AND YOUNG CHILD FEEDING CHAPTER 2.3 DEVELOPING NATIONAL POLICY 2011** http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf **IYCF-E OPERATIONAL GUIDANCE FOR EMERGENCY RELIEF STAFF AND PROGRAMME MANAGERS, MODULE 1. IFE CORE GROUP (2007)** http://www.ennonline.net/operationalguidanceiycfv2.1 **GENERIC IFE POLICY** http://www.ennonline.net/ifegenericpolicy

PREPAREDNESS ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
D. **Make IYCF and IYCF-E guidance and materials available.** There is a wealth of materials on IYCF and IYCF-E so the most critical actions are to: ▪ Assess what IYCF materials exist within the national context, identify the gaps or the need for updating, and develop/translate materials as needed. ▪ Identify and share within the UNICEF office and with partners the key IYCF-E guidance that would enable UNICEF to proceed with a timely and appropriate emergency response. ▪ Understand what the key IYCF supplies are in the regular programming, consider if there might be any additions or increased demand, and work with supply to prepare for this eventuality. ▪ Use this toolkit as a resource and a source of information. Additional key on-line repositories are: ○ *Emergency Nutrition Network www.ennonline.net* ○ *The international Baby Food Network (IBFAN) http://ibfan.org/*	**IYCF-E OPERATIONAL GUIDANCE FOR EMERGENCY RELIEF STAFF AND PROGRAMME MANAGERS, MODULE 1. IFE CORE GROUP (2007)** http://www.ennonline.net/operationalguidanceiycfv2.1
E. **Provide different levels of orientation and training on IYCF-E to protect and support infant and young children in the event of an emergency.** This can be through: ▪ Orientate non-technical staff in IYCF-E, using available materials, to support appropriate IYCF response in emergencies. This includes recognizing that the cultural expectations and personal experiences of staff may present barriers to understanding and implementing suggested practice and therefore need to be addressed. ▪ Train health and nutrition programme staff, using available training materials, so that they are oriented and prepared to respond with IYCF-E consisderations in an emergency. . ▪ Work with national institutions and academic centres to include training on IYCF-E in pre-service training for key medical and health staff and community workers. The goal should be on developing adequate cohorts of skilled IYCF counsellors (health providers and community workers) across the country. ▪ Advocate for and support in-service (on the job) training of health and nutrition workers. ▪ Communicate where IYCF-E guidance and materials are available for use by partners/national government.	**INFANT FEEDING IN EMERGENCIES ORIENTATION PACKAGE MODULE I, IFE CORE GROUP, 2010** http://www.ennonline.net/iycfeorientationpackage **INFANT FEEDING IN EMERGENCIES TRAINING PACKAGE MODULE 2 FOR HEALTH AND NUTRITION WORKERS, IFE CORE GROUP, 2007** http://www.ennonline.net/ifemodule2 **MODULE 2 FOR HEALTH AND NUTRITION WORKERS IN EMERGENCY SITUATIONS. IFE CORE GROUP 2007.** http://www.ennonline.net/ifemodule2 **INFANT AND YOUNG CHILD FEEDING COUNSELLING INTEGRATED COURSE FOR HEALTH WORKERS UNICEF/WHO 2006** http://www.ennonline.net/bfcounsellingtraining **COMPLEMENTARY FEEDING COUNSELLING TRAINING COURSE, WHO 2004** http://www.who.int/nutrition/publications/infantfeeding/9241546522/en/ **VARIOUS INSTRUCTIONAL VIDEOS ON BREASTFEEDING** http://globalhealthmedia.org/videos/

PREPAREDNESS ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
F. **Engage in discussions and work with partners to ensure that young children have access to appropriate and safe complementary foods. Children from age of six months require appropriate, adequate and safe complementary feeding.** ▪ Advocate to the national government, WFP and other partners for the inclusion of culturally appropriate nutrient-dense complementary foods in the general food aid basket, where quality local foods are not available and the provision of resources e.g. fuel and cooking equipment, to support preparation of complementary foods . ▪ Work with national government and partners to develop guidance tailored to the specific local context, including: type of emergency, nutrition situation, pre-existing micronutrient deficiencies, target age groups, quality of and access to locally available foods. In recurrent drought-prone contexts, it is useful to prepare by documenting foods that can eaten during drought or lean season. Include guidance on appropriate use of specialized commodities such as supercereal and other specific products. ▪ If you are relying on ready-to-use foods in regular programming evaluate the need to stockpile and take action if necessary. Appropriate quantities of complementary foods can be calculated based on population data, average household size, number of children 6 to 24 months and RNIs of this age group. For calculation and planning of food assistance the NutVal software is useful however it requires a certain level of nutrition understanding in order to utilize it.	**HTP MODULE 17 ANNEX 8 KEY INFORMATION ON COMPLEMENTARY FOODS** http://www.ennonline.net/htpv2module17 **DESCRIPTION OF AVAILABLE COMPLEMENTARY FOODS AVAILABLE HERE:** https://intranet.unicef.org/PD/YCSD.nsf/0/
G. Integrate IYCF components into other programming approaches so that a timely and appropriate IYCF response in emergency can be implemented and scaled up. ▪ For inter-sectoral collaboration to be successful all stakeholders need to have a basic understanding of IYCF, even if they are not nutritionists or public health experts. Basic orientation and information distribution is a critical component of getting their by-in.. ▪ Identify opportunities to collaborate with key sectors such as WASH, health and protection. For example this could be through building the linkages between sectors, such as providing orientation/training on key IYCF messages within the hygiene component of WASH programming.	**ECHO IYCF-E GUIDANCE FOR PROGRAMMING EXAMPLES OF INTEGRATING IYCF-E INTO PROGRAMMING BY SECTOR** http://ec.europa.eu/echo/en/what/humanitarian-aid/nutrition **INTEGRATED MULTI-SECTORAL INFANT AND YOUNG CHILD FRIENDLY FRAMEWORK. SAVE THE CHILDREN AND UNHCR 2015** **(IN DROPBOX)** **INTEGRATION OF IYCF-E INTO CMAM, IFE CORE GROUP 2009** http://www.ennonline.net/integrationiycfintocmam **BABY FRIENDLY HOSPITAL INITIATIVE, WHO/ UNICEF 2009 BACKGROUND AND TRAINING MATERIALS** http://www.who.int/nutrition/topics/bfhi/en/ **INTEGRATING WASH AND NUTRITION TOOLKIT, UNICEF EAPRO** https://www.unicef.org/eapro/WASH_Nutrition_Toolkit_EAPRO_Final_w_ISBN_web_version_7Nov2016.pdf

GOOD TO KNOW!

The Key IYCF interventions in Emergencies

The Infant and Young Child Feeding in Emergencies (IFE) Operational Guidance proposes 8 areas of basic intervention to ensure the needs of mothers, infants and young children are addressed in the early stages of an emergency. Many of these intervention can be greatly facilitated by preparedness actions such as ensuring that there are national guidelines on Infant and young child feeding in place, that basic capacities to response exist, and that stakeholders are briefed on the importance of including IYCF assessments and interventions immediately and continuously in the response.

1. Prioritise support to meet the immediate essential needs
2. Register households to identify needs and help plan support
3. Establish secure and supportive places
4. Care for the nutritional needs of pregnant and lactating women
5. Enable safe and appropriate complementary feeding
6. Support early initiation of exclusive breastfeeding
7. Ensure consistent and appropriate communication on IFE
8. Ensure access to basic frontline feeding support
9. Care for the nutritional needs of the non-breastfed infant*

IFE Core Group (2007) Infant and young child feeding in emergencies operational guidance for emergency relief staff and programme managers

**The Operational Guidance is currently under-revision to reflect incorporating the non-breastfed infant.:*

5.2 Response Actions

A timely, appropriate response on IYCF relies on policy development and implementation, coordination, strong communication and advocacy, assessment and monitoring, technical capacity and resources.

FROM THE CCC'S

Response Actions for Appropriate IYCF-E:

Protect, support and promote early initiation and exclusive breastfeeding of infants, including establishment of 'safe spaces' with counselling for pregnant and lactating women; support safe and adequate feeding for non-breastfed infants less than 6 months old, while minimizing the risks of artificial feeding; ensure appropriate counselling regarding infant feeding options and follow-up and support for HIV-positive mothers; and, with the World Food Programme and partners, ensure availability of safe, adequate and acceptable complementary foods for children.

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Lessons learned in adapting iycf-e guidance to new challenges

Humanitarian response has to constantly adapt to new challenges and circumstances. Adapting appropriate response for the needs of vulnerable groups such as infants and young children is critical. In recent years large scale humanitarian crises of a virus origin have affected large numbers of people. In both the Ebola response in Western Africa and the Zika response in south and central Americas, guidance on infant and young child feeding has had to be rapidly adapted in order to account for transmission routes. In both cases the guidance was compiled by evidence based on the best knowledge of the virus, the operational context and the cost-benefit ratios involved.

Likewise the mass migration to European in 2015-2016 created an unprecedented operational environment where large numbers of people, including infants and young children, lived in transit. When a population in crisis is in movement both the immediate and underlying causes of under-nutrition increase and may result in negative nutrition outcomes. Childcare practices are interrupted and strained. Access to food can be limited in terms of availability or economic ability to purchase, and for children less than 2 years of age access to appropriate foods can be compromised.

Specific context specific guidance has been created through extensive interagency consultations and collaborations, in which UNICEF played a specific role in convening agencies to contribute to the existing global normative guidance. In case of new disease outbreaks or new challenges stay tuned for new guidance from WHO and partners.

Infant Feeding in the Context of Ebola, *ENN 2014*

http://www.ennonline.net/infantfeedinginthecontextofebola2014

Breastfeeding in the Context of the Zika Virus, Interim Guidance, *WHO February 2016*

http://www.who.int/csr/resources/publications/zika/breastfeeding/en/

Interim Operational Considerations for the feeding support of Infants and Young Children under 2 years of age in refugee and migrant transit settings in Europe, *EN-NET Working Document 2015*

Nutrition in Transit Policy Brief, WHO

http://www.ennonline.net/interimconsiderationsiycftransit

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RESPONSE ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
H. **Make IYCF-E an integral component of the nutrition sector/cluster response strategy.** This can be through: ▪ Establish a technical working group on IYCF in emergencies within the cluster and nutrition working group to focus exclusively on strengthening the IYCF aspect of the response. This working group can focus explicitly on advocacy/orientation, policy development, monitoring of BMS donations, identification and sharing of guidance, organizing assessments, etc. ▪ See Preparedness step C on providing support to government and key partners to develop and/or strengthen policies for optimal IYCF practices and services in emergencies ▪ See Preparedness step E on delivering orientation sessions on IYCF-E in order to highlight to stakeholders the importance of this issue.	**UNICEF IYCF PROGRAMMING GUIDE 2011** https://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf **TWG GUIDANCE** http://nutritioncluster.net/training/sample-tor-twg/
I. **Identify and understand the infant and young child feeding needs in this particular emergency context.** Do this by: ▪ Use the context analysis done in preparedness step A or if that has not been done, do a rapid analysis. It is essential to know the practices before an emergency situation in order to assess what has changed and to develop appropriate responses. For example, there are different needs and responses in contexts where HIV is prevalent, conflicts resulting in high numbers of unaccompanied orphans, or displaced populations with high numbers of artificially fed infants. ▪ Integrate key information needs on infant and young child feeding needs into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted. Assessment teams should include at least one person who has received basic orientation on infant feeding in emergencies. ▪ If necessary, conduct a more in-depth needs assessment to determine the IYCF priorities for action and response. This can be conducted in a variety of ways such as integrating key questions into a nutrition survey, conducting focus group discussions with caregivers or service providers, meeting with key informants, etc.	**METHODS & INDICATORS FOR ASSESSMENT OF IYCF IN EMERGENCIES:** http://www2.unicef.org/nutrition/training/5.5/4.html **INDICATORS FOR ASSESSING IYCF PRACTICES -PART 1 DEFINITIONS (USAID, UC DAVIES, WHO, UNICEF, IFPRI 2008** http://files.ennonline.net/attachments/950/indicators-for-assessing-iycf-practices-definitions-2008.pdf **ECHO IYCF-E GUIDANCE FOR PROGRAMMING: IYCF-E IN NEEDS ASSESSMENTS CHAPTER 4.1,** https://ec.europa.eu/echo/files/media/publications/2014/toolkit_nutrition_en.pdf **SEE FIGURE 4 UNDERSTANDING THE SITUATION THROUGH THE IYCF LENS** **SEE TABLE 1 FOR SOURCES OF INFORMATION**
J. **Develop and share consistent and appropriate communication on IYCF in emergencies to different target groups addressing the concerns of the affected population and those responding to their needs.** ▪ Work with those involved in the response within the government and other humanitarian agencies to produce coherent messages around IYCF needs and identified priority actions for the response. Issuing a joint statement of support of IYCF in the response and the appropriate handling and use of breastmilk substitutes is a useful method if no policies or regulations exist for getting actors to commit to the principles and to communicate those with donors, press and the national societies. In case adequate policies and regulations are already in place, a joint press release or statement might be useful to remind key actors of these documents. ▪ Standardized and appropriate messages for mothers, caregivers, and communities should be shared through multiple programming channels.(see Preparedness Step G) ▪ Share information on the Code for use of BMS ▪ It is important for UNICEF with its IYCF expertise to directly engage with communications staff and the external media and monitor press releases to ensure appropriate media coverage on IYCF-E.	**MODEL JOINT STATEMENT FOR IYCF IN EMERGENCY** http://www.ennonline.net/modelifejointstatement **BREASTFEEDING ADVOCACY INITIATIVE STRATEGY, UNICEF/WHO 2015** **KEY MESSAGES ON IFE FOR MOTHERS AND CAREGIVERS:** http://www.ennonline.net/ifekeymessagesmothers **UNICEF KEY MESSAGES BOOKLET FOR COMMUNITY IYCF COUNSELLING 2012:** http://www.unicef.org/nutrition/files/Key_Message_Booklet_2012_small.pdf

RESPONSE ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
K. **Establish safe spaces with that protect, support and promote optimal infant and young child feeding practices** with prioritized interventions such as: ▪ Skilled Breastfeeding Assistance ▪ Complementary Feeding Support ▪ Infant Feeding in the Context of HIV ▪ Support for the non-breast fed infant	**UNICEF PROGRAMMING GUIDE ON INFANT AND YOUNG CHILD FEEDING CHAPTER 2.4.4 PRIORITIZING INTERVENTIONS 2011** http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf **BABY FRIENDLY SPACES MANUAL, ACF INTERNATIONAL 2014** http://www.actionagainsthunger.org/publication/2014/12/baby-friendly-spaces-technical-manual **INFANT AND YOUNG CHILD FEEDING COUNSELLING: AN INTEGRATED COURSE. WHO/UNICEF** http://www.who.int/nutrition/publications/
L. **Meet the nutritional needs of non-breastfeeding infants less than 6 months old.** These could be for example orphaned children, children living in the context of HIV, cultural context with low breastfeeding prevalence, or in instances where breastfeeding has been interrupted due to the crisis. The decision to support artificially fed infants should be based on needs assessment. Interventions around artificial feeding should not be based on assumptions of feeding practices, on individual cases, emotive calls in the media for milk powder or in response to offers/receipt of donations of infant formula. A detailed analysis of the situation needs to be made in coordination with the national authorities and with other partners (preferably the Nutrition Cluster) to determine the numbers of non-breastfed children who need support. ▪ Adhere to the principle of 'do no harm' related to IYCF practices. Wherever possible, breastfeeding by the mother will be supported, including re-lactation if possible. The second best option is breastmilk from another mother where safe and culturally acceptable (wet-nursing or donor milk from a human milk bank if adequate milk banking facilities are available). The option of last resort is the provision of breastmilk substitutes (BMS) for the individual infant. ▪ Individual assessments need to be done before distributing BMS to specific children. When resources are limited, infants under six months of age should receive priority for support. ▪ BMS need to be made available in a regulated and safe manner for the non-breastfeed infant. ▪ If the need for the provision of breastmilk substitutes has been identified by UNICEF and/or the Nutrition Cluster, it is preferred that another partner, or the host country Government, takes the lead in procuring breastmilk substitutes. If UNICEF is requested to provide BMS in a humanitarian situation, UNICEF will support the management of the appropriate use of BMS with partners in accordance with the provisions of the UNICEF SOP on the use of BMS. UNICEF is the provider of last resort for the procurement and distribution of breastmilk substitutes and will only do so at the specific request of the host country government.	**UNHCR SOPS FOR THE HANDLING OF BREAST MILK SUBSTITUTES (BMS)** http://www.unhcr.org/55c474859.pdf **UNICEF STANDARD OPERATING PROCEDURE ON THE PROCUREMENT AND USE OF BREASTMILK SUBSTITUTES IN HUMANITARIAN SETTINGS AND ANNEXES (IN DRAFT)** **ACCEPTABLE MEDICAL REASONS FOR USE OF BREAST-MILK SUBSTITUTES, WHO 2009.** http://www.who.int/nutrition/publications/infantfeeding/WHO_NMH_NHD_09.01/en/

RESPONSE ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
M. **Appropriately manage Breast Milk Substitutes (BMS) and artificial feeding for the non-breastfeed infant (if needed).** It is crucial that: ▪ The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the coordinating agency, lead technical agencies and governed by strict criteria. ▪ BMS should only be targeted to infants requiring it. Interventions to support non-breastfed infants should always include a component to protect breastfed infants. ▪ Soliciting or accepting unsolicited donations of BMS should be avoided. Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel. ▪ Prevent inappropriate distribution of BMS, Bottles and Teats in order to protect the breastfed child and to ensure that the non-breastfed children are receiving appropriate care. ▪ Use the media to send appropriate messages. The general press relies heavily on the press releases of UN agencies and NGOs for the content of their own communication. Agency communication/media/press departments can have a key influence on messages in the general media. ▪ Identify and address violations of the Code. The Code does not ban the use of infant formula or bottles but controls how they are produced, packaged, promoted and provided. Report violations within coordination groups, to the national government, and register the violation online.	**TECHNICAL GUIDANCE NOTE ON THE PROCUREMENT AND USE OF READY-TO-USE INFANT FORMULA IN HUMANITARIAN SITUATIONS, UNICEF INTERNAL 2015** https://www.dropbox.com/scl/fi/rp9ksdmow0gypnnaynu0h/Technical%20guidance%20note%20on%20RUIF%20231115.docx?dl=0&oref=e&r=AAZa1tcAAgqksD1W-tGpaunc01p9G5JCYcSo9ngDnWJO4Pm06Fmcqd7gQD5A4DLriWJUIm4aPjH2FAG0VpCvLOcrh5hckPRcZDsSvGssqRe3Qw6m5_DqyFIktTSDg8gOgGeJ0wO3nWi7XkmiUoTJaDvbw9PMtt6Lucaf-3lYn4-msg&sm=1 **UNICEF STANDARD OPERATING PROCEDURE ON THE PROCUREMENT AND USE OF BREASTMILK SUBSTITUTES IN HUMANITARIAN SETTINGS AND ANNEXES (IN DRAFT)** **UNICEF EMERGENCY FIELD HANDBOOK BREASTMILK SUBSTITUTES P.122-125** https://www.unicef.org/lac/emergency_handbook.pdf **INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES OPERATIONAL GUIDE, SECTION 6 MINIMISE THE RISK OF ARTIFICIAL FEEDING. IFE CORE GROUP 2007.** http://www.ennonline.net/operationalguidanceiycfv2.1 **UNHCR SOPS FOR THE HANDLING OF BREAST MILK SUBSTITUTES (BMS)** http://www.unhcr.org/55c474859.pdf **HTP MODULE 17 ANNEX 12 INFORMATION FOR THE MEDIA** http://nutritioncluster.net/training-topics/module-17-infant-and-young-child-feeding/ **VIOLATIONS TO THE CODE ONLINE MONITORING FORM** http://ibfan.org/code-monitoringvf

RESPONSE ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
N. **Maximise HIV-free child survival through assisting mothers living with HIV to find the best feeding option for their infants.** The balancing of risks to maximise HIV-free child survival is especially critical in emergencies: ▪ Women should know their HIV status and receive appropriate counselling and support to ensure that they are able to make safe and appropriate infant feeding decisions and carry them out effectively: ○ *Where national/sub-national policy recommends breastfeeding pre-emergency, this becomes all the more critical in the emergency context.* ○ *In a pre-emergency context where national policy was to avoid breastfeeding, the shift in the balance of risks means this is likely to no longer be the safest option in the immediate term. Breastfeeding may be the safest option for HIV-exposed infants. National authorities and/or the authority managing the emergency should establish whether the recommendation for formula feeding is still appropriate given the circumstances. Urgent artificial feeding assistance will be needed for infants already established on replacement feeding.* ▪ Ensure that UNICEF response operates in accordance with the UN Policies on infant feeding and HIV. ▪ Include in the assessment of the local existing beliefs and capacities of the community to support the informed decision on infant feeding and HIV practices and to identify the necessary assistance.	**BABY FRIENDLY SPACES MANUAL, CHAPTER 6 IYCF AND HIV IN EMERGENCIES. ACF 2014** http://www.actionagainsthunger.org/publication/2014/12/baby-friendly-spaces-technical-manual **GUIDELINES ON HIV AND INFANT FEEDING, WHO 2016** http://www.who.int/maternal_child_adolescent/documents/hiv-infant-feeding-2016/en/
O. **In collaboration with partners pay special attention to the nutritional value of the food available to infants and young children whose particular nutritional requirements are often not covered by the general food commodities.** Nutrient dense foods for children should be chosen taking into account when possible micronutrient needs. ▪ Gather information on the food access, availability and utilization for children 6-23 months and use that information to advocate for appropriate commodities/response as needed. ▪ Ensure that the nutritional needs of children 6-23 months are included in national nutrition/IYCF policies and guidance. ▪ Advocate with the WFP and/or other partners distributing food commodities to include complementary food rations for children 6-23 months.	**HTP MODULE 17 ANNEX 8 KEY INFORMATION ON COMPLEMENTARY FOODS**

FIGURE 5 Understanding the situation through the IYCF lens

INFORMATION TO COLLECT	WHAT IT TELLS YOU
Demographic profile of the population, specifically noting infants and young children, pregnant women, unaccompanied children	• The caseload for response • The size of particular vulnerable groups
Conspicuous availability of BMS, milk products, bottles and teats, in emergency-affected population and commodity pipeline	May highlight need for Code enforcement, urgent attention to hygienic preparation practices and support to artificially fed infants, or alert for infant diarrhoea or acute malnutrition
Pre-crisis feeding/care practices and any recent changes	• Whether the normal care environment has been disrupted (e.g. through displacement or change in livelihood activities), affecting access to carers, foods for children or water • Normal maternal and infant feeding practices and current challenges; e.g. whether mothers are using BMS or manufactured complementary foods and what urgent support they need
Reported problems feeding infants and young children	• Whether any factors are disrupting breastfeeding • Challenges in accessing appropriate complementary foods and preparing them in a hygienic or timely manner • Adequacy of WASH facilities/shelter

INFORMATION TO COLLECT	WHAT IT TELLS YOU
Nutritional adequacy of the food ration: is the general ration sufficient for the needs of all household members?	• Women may be disproportionately affected by inadequate ration supplies • Accessibility of appropriate, nutritionally adequate and safe complementary foods for children 6 to 23 months
Cultural sensitivity around pregnant women, new mothers and child care	How can a decision be made about breastfeeding at household level, are there taboos that can have negative impact on the mothers or the children well being and that must be tackled
Existence of cultural barriers and boosters to use of relactation, expressing breast milk or wet nursing *9*	Whether the nutritional status of non-breastfed infants is at risk and what alternatives are available to support them
Identification of key decisionmakers at household, community and health facility level who influence IYCF practices	Who to target with awareness-raising activities and who to include in interventions to support IYCF-E
Identification of community members or medical personnel involved in pregnancy/ birth/ post natal care	Who can help relaying information on IYCF practices toward PLW, what is the local capacity and what are the messages/ beliefs/understanding of the communities and medical services on the field

Source: ECHO IYCF-E Guidance for Programming

GOOD TO KNOW!

Care for the Non-Breastfed Infant

Breast milk substitutes in emergencies have the potential to present even more risks than in normal situations due to lack of hygiene in storage, preparation & administering, lack of utensils and lack of longer term availability of age & language appropriate products. But most importantly it is the loss of immunological protection, optimal nutritional value and emotional well-being at a time where there is a higher risk of infection, reduced availability of quality complementary food and a higher risk of emotional problems. There is proof that unsolicited and unmonitored distributions of BMS leads to an increase in morbidity and mortality.

However, there are children who cannot be breastfed. There are several situations in which children cannot be, or are not, breastfed. These situations are:

1. Infants and young children who were orphaned or whose mother has been absent for a long period of time before the humanitarian situation and there is no option to wet-nurse,
2. Infants and young children who have become orphaned or whose mother is absent for a long period of time in the course of the humanitarian situation and there is no option to wet-nurse,
3. Extremely rare situations where the mother and/or infant has a medical condition during which breastfeeding is not possible and there is no option to wet-nurse.
4. Infants and young children who were not breastfed at the time the humanitarian situation developed regardless of the reason and for whom there is no option to be breastfed (including through relactation or wet-nursing).

While the first two groups are usually relatively small in number, the third and fourth group can be relatively large in specific situations, such as the Ebola crisis in Western Africa and the refugee and migrant situation in Europe. These children need to be fed an appropriate BMS to meet their needs in a safe and sustainable way that does not jeopardise breastfeeding in the remainder of the population. See response sections L and M above for more detailed information on UNICEF's actions in this regard.

Technical guidance note on the procurement and use of Ready to use infant formula (RUIF) in humanitarian situations, *For internal use by UNICEF. November 2015*

https://www.dropbox.com/home/NiE%20Toolkit%20Resources/3.%20IYCF

UNICEF Standard Operating Procedure on the procurement and use of breastmilk substitutes in humanitarian settings and Annexes Forthcoming

Infant and Young Child feeding Practices: Standard Operating Procedures for the Handling of Breast Milk Substitutes in Refugee Children 0-23months and the Annex. *UNHCR 2015*

http://www.unhcr.org/cgi-bin/texis/vtx/search/?page=&comid=4baa35c19&keywords=nutrition_guidelines

Infant and Young Child Feeding in Emergencies Operational Guide, Section 6 Minimise the Risk of Artificial Feeding. *IFE Core Group 2007*

Baby Friendly Spaces Manual, Chapter 4 Feeding of the Non-Breastfeed Infant. *ACF International 2014*

https://mhpss.net/?get=211/ACF_BFSManuel.2014.gb_.pdf

GOOD TO KNOW!

What is 'THE CODE'?

The International Code of Marketing of Breastmilk Substitutes is an international health policy framework for breastfeeding promotion, adopted by the World Health Assembly (WHA) of the World Health Organization (WHO) in 1981.
The Code provides recommendations on the restrictions on marketing of breastmilk substitutes, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed. The Code also covers ethical considerations and regulations for the marketing of feeding bottles and teats. Some of the provisions in the Code include:

- No advertising to the public of any product within the scope of the Code;
- No free samples to mothers;
- No promotion of products through healthcare systems;
- No gifts to healthcare providers
- No words or pictures idealizing artificial feeding or pictures of infants on labels of formula cans, feeding bottles, etc.

Since 1981, 84 countries have enacted legislation implementing all or many of the provisions of the Code and subsequent relevant WHA resolutions7.

Harmonized Training Package Module 17 Annex 3 Summary of the Code and WHA Resolutions

The Code of Marketing of Breastmilk Substitutes; Frequently Asked Questions. *WHO 2008*

http://www.who.int/nutrition/publications/infantfeeding/breastmilk-substitutes-FAQ2017/en/

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5.3 Early Recovery Actions

FROM THE CCC'S

Early Recovery Actions for Appropriate IYCF-E:

Ensure that IYCF activities build on and support existing national networks for infant feeding counselling and support.

RESPONSE ACTIONS FOR IYCF-E	EXAMPLES/RESOURCES
P. **Refine the IYCF-E programming and use the key components to build a good foundation for an IYCF programme.** ▪ Build existing health statistics systems to routinely capture age stratified numbers of children, morbidity and mortality of infants and feeding practices. ▪ Maintain records for future analysis and share experiences and practice with other agencies and networks to help inform and improve programming and policies. ▪ Integrate breastfeeding and infant and young child feeding training and support at all levels of health care: reproductive and maternity health services, growth monitoring and promotion, curative services, etc. ▪ Involve national bodies/networks from the beginning	**UNICEF PROGRAMMING GUIDE ON INFANT AND YOUNG CHILD FEEDING 2011** http://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf **BABY FRIENDLY HOSPITAL INITIATIVE TRAINING MATERIALS UNICEF 2009** http://www.unicef.org/nutrition/index_24850.html **BABY FRIENDLY 10 STEPS TO SUCCESSFUL BREASTFEEDING** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/3.%20IYCF

KEY GENERAL RESOURCES ON IYCF-E

IFE OPERATIONAL GUIDANCE 2007[18]: is a key policy guidance document fundamental to supporting safe and appropriate IFE. It has been developed by the IFE Core Group and was endorsed in WHA resolution in 2010. It aims to help those concerned with emergency response meet their responsibilities to infants and young children and their carers in emergencies, providing concise, practical and non-technical guidance.
http://www.ennonline.net/operationalguidanceiycfv2.1

THE SPHERE PROJECT 2011: Presents a set of minimum standards, key action and key indicators to guide the overall IYCF response.
http://www.sphereproject.org/handbook/

UNICEF PROGRAMMING GUIDE ON INFANT AND YOUNG CHILD FEEDING 2011: contains detailed programming information on IYCF, including breastfeeding, complementary feeding and infant feeding in general and in especially difficult circumstances including in the context of HIV and in emergencies.
https://www.unicef.org/nutrition/files/Final_IYCF_programming_guide_2011.pdf

ECHO IYCF-E GUIDANCE 2012: offers concise guidance to general practitioners on how to ensure that the specific needs of the infants and Young children are assessed and addressed adequately into programming.
https://ec.europa.eu/echo/files/media/publications/2014/toolkit_nutrition_en.pdf

GLOBAL NUTRITION TARGETS 2025, BREASTFEEDING POLICY BRIEF. WHO/UNICEF 2014: The purpose of this policy brief is to increase attention to, investment in, and action for a set of cost-effective interventions and policies to help achieve the 2025 Targets.
http://www.who.int/nutrition/publications/globaltargets2025_policybrief_breastfeeding/en/

BREASTFEEDING ADVOCACY STRATEGY, UNICEF 2015: sets out a strategic framework to galvanize global, regional and national stakeholder advocacy for breastfeeding.
http://www.unicef.org/nutrition/files/Breastfeeding_Advocacy_Strategy-2015.pdf

18 The IFE guidance is currently being revised for 2017

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6

Management of Acute Malnutrition

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Nutrition Commitment 4:

Children and women with acute malnutrition access appropriate management services.

Benchmark 4:

Effective management of acute malnutrition (recovery rate is >75% and mortality rates are <10% in therapeutic care and <3% in supplementary care) reaches the majority of the target population (coverage is >50% in rural areas, >70% in urban areas and >90% in camps).

The management of acute malnutrition (also known as 'wasting') is a key lifesaving nutrition programme. Without treatment, children with severe acute malnutrition (SAM) are nine times more likely to die than normal counterparts. Globally it is estimated 1 million children under five a year die from severe acute malnutrition. The objectives to support management of acute malnutrition in emergencies are two-fold: 1) to reduce the excess mortality resulting from increased caseloads of SAM and 2) to strengthen and build capacity of national systems to provide the needed services to do so.

Community-based Management of Acute Malnutrition (CMAM) is the generic term used to describe the approach and package of services used to manage acute malnutrition. However, other expressions are used by different agencies or in certain countries. It is also referred to as Integrated Management of Acute Malnutrition (IMAM) and Community-based Therapeutic Care (CTC), amongst others. The approach encompasses key interventions: community mobilisation for early identification and referral of cases, in-patient management of SAM with complications, outpatient therapeutic care of SAM, and the management of moderate acute malnutrition.

An underlying principle is that the approach provides a continuum of care across these different interventions based on the severity of acute malnutrition and the context. Not all elements are required or resourced in all contexts. To achieve the principle of continuum of care in the management of acute malnutrition and to maximise efficiencies and effectiveness, good coordination between different UN agencies and partners responsible is paramount on all preparedness, response and early recovery actions for management of acute malnutrition.

Countries may already have an existing programme for the management of acute malnutrition. This may have evolved from a previous emergency or as a response to recognition of the extent of the problem in the population as it is. Either way, all preparedness, response and early recovery actions for the management of acute malnutrition should build off the system that is in place already and address gaps where appropriate serving to support and strengthen it where possible.

Ideally services for the management of acute malnutrition are integrated into the routine health system and should aim to strengthen local capacity and seek sustainability for the management of acute malnutrition.

UNICEF plays a leading role in the management of acute malnutrition globally and leads on supporting the following:

- **Capacity building** – UNICEF works to strengthen the capacities of national governments and local actors to scale-up treatment for severe acute malnutrition in over 75 different countries. This includes supporting governments to institutionalize treatment programmes through national planning mechanisms and policy changes.

- **Leadership and technical guidance** – UNICEF works with governments to develop national policies, strategies, protocols, and training packages for health workers, and provides technical support to national actors in their implementation.

- **Norms and standards setting** – UNICEF gathers global data and captures lessons learned to update treatment approaches and protocols, providing guidance to improve the coverage and quality of programmes.

- **Supply and delivery** – UNICEF is the world's largest provider of therapeutic supplies, including RUTF, and is continually identifying new ways to strengthen supply chain management particularly in difficult conditions and emergencies. UNICEF also supports local production of RUTF.

- **Advocacy** – At a global and national level UNICEF works to position acute malnutrition as a public health priority and improve understanding of the scope and scale of the problem.

As defined in the WFP UNICEF MOU 2011, the agreed commitments of UNICEF and WFP are summarised as follows; UNICEF has the specific mandate for programming for community mobilisation around in and outpatient therapeutic care in relation to SAM. while The management of moderate acute malnutrition falls under the mandate of WFP.

The following chapter provides guidance on the key actions that should be taken to ensure that UNICEF can fulfil its commitments on management of acute malnutrition in preparedness and response to emergencies and in the early recovery phase. Checklist 4 provides and overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. Box 3 presents the globally accepted Sphere standards on micronutrients in emergencies with associated key actions and indicators. Following Checklist 4 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

CHECKLIST 4 Essential Actions for management of acute malnutrition

PREPAREDNESS FOR MANAGEMENT OF ACUTE MALNUTRITION				
ESSENTIAL ACTIONS	**UNICEF CCCS FOR EARLY RECOVERY FOR COORDINATION**			
	Establish integrated guidelines for the management of acute malnutrition	Assess coverage of existing services for management of severe acute malnutrition (SAM)	Establish a contingency supply and distribution plan	With Supplies and Logistics, prepare supply plans and distribution strategies with long-term agreements where this is possible locally
Work with all relevant stakeholders to ensure national guidelines for the IMAM are established and up to date with latest evidence and international standards	✓			
Develop accompanying tools and job aids for implementing services for IMAM, in line with new/updated national guidelines	✓			
Ensure relevant staff at all levels are trained and familiar with new/updated guidelines and tools so protocols are followed	✓			
Map existing capacities for the management of acute malnutrition in consultation with all partners (government, NGOs, donors) and support activities to address identified gaps/weaknesses		✓		
Map geographical coverage of existing services for SAM and identify gaps & duplications in relation to current & potential needs depending on vulnerability, risks and hazards		✓		
Before caseloads become too large and if resources allow, establish new sites/services or mechanisms for surge support in high risk locations with support of community and existing health services		✓	✓	
Strengthen the existing monitoring and reporting system to ensure complete & timely programme data for more accurate early warning, supply forecasting and programme performance review	✓	✓	✓	✓
Work with supply and logistic colleagues to develop contingency supply and distribution plans based on risk analysis scenarios and forecasted caseloads			✓	
Provide necessary support to supply and logistics colleagues to enable them to prepare supply plans, distribution strategies, and LTAs, that build on existing systems				✓

RESPONSE FOR MANAGEMENT OF ACUTE MALNUTRITION				
ESSENTIAL ACTIONS	**UNICEF CCCS FOR RESPONSE FOR MANAGEMENT OF ACUTE MALNUTRITION**			
	Support existing capacity for the management of SAM for children at the community and facility levels	Initiate and support additional therapeutic feeding as required to reach the estimated population in need	In collaboration with WFP, ensure appropriate management of moderate acute malnutrition for children and supplementary feeding for vulnerable groups, including pregnant and lactating women, according to identified needs	Support and establish systems for community mobilisation, identification, and referral of acute malnutrition
Assess how the emergency has impacted the pre-existing situation, systems and services, and identify priority response actions accordingly	✓	✓	✓	✓
Support and strengthen national and community systems and capacities to maintain existing services and scale up as required	✓	✓	✓	✓
Establish new sites and/or delivery platforms as required to meet additional needs	✓	✓	✓	✓
Ensure the involvement of communities at the centre of efforts to maintain and scale up the services for SAM	✓	✓	✓	✓
Where necessary revise supply and distribution plans to meet additional requirements		✓	✓	
Work closely with WFP to establish a coordinated approach to providing continuum of care for AM according to needs		✓	✓	✓

EARLY RECOVERY FOR MANAGEMENT OF ACUTE MALNUTRITION	
ESSENTIAL ACTIONS	**UNICEF CCC FOR EARLY RECOVERY FOR MANAGEMENT OF ACUTE MALNUTRITION**
	Initiate discussion on national policy, strategy and guidelines for sustainable management of SAM, if not already in place
Continue to monitor the situation closely and scale down additional services relative to reductions in caseloads	
If not established already, support national adoption of IMAM and inclusion at national policy level	✓
Initiate discussions on the integration of nutrition product supply chain into regular national supply chain	✓
Undertake cost analysis of IMAM services to support planning and tracking and resource mobilisation for sustainable programming	✓
Initiate or strengthen efforts for multi-sectoral approaches for the prevention of SAM	✓

BOX 3 Sphere standards for management of acute malnutrition

Management of Acute Malnutrition Standard 2: Severe Acute malnutrition

Severe acute malnutrition is addressed.

Key Actions

- Establish from the outset clearly defined and agreed criteria for set-up or increased support for existing services, and scale down or closure
- Include inpatient care, outpatient care, referral and community mobilisation components and interventions for the management of severe acute malnutrition
- Maximise access and coverage by involving the community from the outset
- Provide nutritional and medical care according to nationally and internationally recognised guidelines for the management of severe acute malnutrition
- Discharge criteria include both anthropometric and non-anthropometric indices
- Investigate and act on causes of default and non-response or an increase in deaths
- Address Infant and Young Child Feeding (IYCF) with a particular emphasis on protecting, supporting and promoting breastfeeding

Key Indicators

These indicators are primarily applicable to the 6-59 month age group, although others may be part of the programme.

- More than 90% of the target population is within <1 day's return walk (including time for treatment) of the programme site
- Coverage is >50% in rural areas, >70% in urban areas and >90% in camp situations
- The proportion of discharges from therapeutic care who have died is <10%, recovered is >75% and defaulted is <15%

Source: Sphere Handbook, 'Chapter 3: Minimum Standards in Food Security and Nutrition', The Sphere Project, Geneva, 2011.

GOOD TO KNOW!

The agreed commitments of UNICEF and WFP in the management of acute malnutrition at global and country level.

PROGRAMME AREA	UNICEF COMMITMENTS	WFP COMMITMENTS	JOINT PRINCIPLES AND ACTION
Micronutrients and Fortification UNICEF will coordinate and support treatment programmes that follow established and agreed upon UN protocols, such as CMAM.	To take the lead in supporting and coordinating the organisation of therapeutic feeding programmes and interventions in communities and health facilities. To mobilise resources and ensure the availability of RUTF and other supplies and products required for the treatment of children suffering from SAM. To support the training of health staff on SAM. In case WFP is unable to provide SFP, UNICEF may do so after discussion with WFP at country level. If no arrangement can be made, agreements will be made at regional or headquarters office level.	To seek food for the recovery phase (SFP) of therapeutic feeding and for family members of children suffering from SAM. In cases where UNICEF unable to support therapeutic feeding, WFP may provide support after discussion at country level. If no arrangement can be made, agreements will be made at regional or headquarters office level.	To assist governments in adopting SAM treatment protocols incollaboration with the WHO. To explore and promote local production of therapeutic food To seek programme synergies for mobilising and screening children and assigning them to the appropriate treatment together with partners. To aim for the joint training of staff on management of SAM and MAM

Source: Sphere Handbook, 'Chapter 3: Minimum Standards in Food Security and Nutrition', The Sphere Project, Geneva, 2011.

6.1 Preparedness Actions

The key to being able to respond effectively in an emergency is investing to develop a strong programme beforehand that provides the basis from which to scale up activities in the event of an emergency. Thus, preparedness actions for the management of acute malnutrition focus on mapping existing capacities and services, then strengthening them and addressing gaps where appropriate whilst ensuring the technical guidance and protocols are in line with latest recommendations. Preparedness also involves understanding the potential risks and hazards facing individuals, communities, programmes and systems relative to their gaps and vulnerability. Preparedness actions can sup-

FROM THE CCC'S

Preparedness Actions for Management of Acute Malnutrition

Establish integrated guidelines for the management of acute malnutrition; assess coverage of existing services for the management of severe acute malnutrition (SAM) and establish a contingency supply and distribution plan.

With Supply and Logistics, prepare supply plans, distribution strategies and long-term agreements where this is possible locally.

port the development a strong programme with built-in mechanisms and flexibility to respond in the event of an emergency and mitigate the effects of those risks.

Furthermore, a stronger existing programme providing effective coverage of acute malnutrition reduces community **vulnerabilities** when an emergency happens. Children who are already malnourished before the emergency are more vulnerable to the shocks of the emergency.

In countries where there is no existing programme for the management of acute malnutrition, preparedness actions should focus on initiating discussions on its introduction. Outside of emergencies, severe acute malnutrition often remains an unrecognised yet significant problem affecting the survival and well-being of under-fives. Introducing integrated community based programmes for the routine management of acute malnutrition is an important approach for a country to achieve targets on the reduction of undernutrition and under-five mortality, as well as providing the basis from which to scale-up in the event of an emergency. More detailed guidance on the introduction and scaling up of programmes for the management of acute malnutrition can be found in UNICEF Programme Guidance Document 2015: Management of SAM in Children: working towards results at scale, page 5 onwards.

PREPAREDNESS ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
A. **Work with all relevant stakeholders, to ensure national guidelines for CMAM/IMAM are established and up to date with latest evidence and international standards.** ▪ Establish if national guidelines exist through consultation with MoH and partners. ▪ If guidelines do exist, review guidelines to establish if they are up to date with latest evidence/international standards and local context. ▪ If guidelines do not exist or require updating, ensure the overall process of developing/updating guidelines is as inclusive and participatory as possible, to build consensus and buy-in, achieve ownership and adherence. ▪ Include all relevant national stakeholders: government ministries, UN agencies, civil society organisations, donors. ▪ Use review/development process as an opportunity to build on and strengthen national capacity on technical issues and guidelines development. ▪ Consider establishing a technical working group to review/develop guidelines with regular feedback to a wider stakeholder group. Consider there may already be existing bodies/coordination mechanisms. ▪ Consult with regional or HQ nutrition advisers or international experts for additional support in addressing gaps or ensuring guidelines meet international standards whilst being adapted to the particular context. ▪ Ensure guidelines consider local context, existing capacity and coverage of services for management of acute malnutrition. ▪ Consider how national guidelines for routine programming need adaptation or inclusion of a specific chapter on emergency response e.g. surge support, rapid MUAC screening ▪ If limited time to develop and agree on national guidelines, reach agreement with relevant stakeholders on interim treatment protocols based on international standards, using generic guidelines.	**EXAMPLES OF GUIDELINES FROM DIFFERENT COUNTRIES OF DIFFERENT REGIONS -** **EXAMPLES CAN BE FOUND ON CMAM FORUM WEBSITE:** http://www.severemalnutrition.org/en/resource-library/Ge **UPDATES ON THE MANAGEMENT OF SEVERE ACUTE MALNUTRITION IN INFANTS AND YOUNG CHILDREN WHO 2013** http://apps.who.int/iris/bitstream/10665/95584/1/9789241506328_eng.pdf **CTC MANUAL 2005 VALID INTERNATIONAL** https://www.fantaproject.org/focus-areas/nutrition-emergencies-mam/ctc-field-manual-and-supplement **FANTA GENERIC GUIDELINES AND JOB AIDS:** http://www.fantaproject.org/focus-areas/nutrition-emergencies-mam/generic-cmam-materials

PREPAREDNESS ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
B. **Develop accompanying tools and job aids for implementing services for IMAM, in line with new/updated national guidelines.** ▪ Develop accompanying tools and job aids related to implementation of guidelines and programme management, including agreed monitoring and reporting formats, supervision checklists and job aids. ▪ Ensure tools are widely disseminated.	**EXAMPLES CAN BE FOUND IN: HTP MODULE 13 TECHNICAL NOTES. ANNEXES** **FANTA GENERIC GUIDELINES AND JOB AIDS:** http://www.fantaproject.org/focus-areas/nutrition-emergencies-mam/generic-cmam-materials **UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE: ANNEX E GIVES EXAMPLE** https://www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf
C. **Ensure relevant staff at all levels are trained and familiar with new/updated national guidelines and tools and protocols are followed.** ▪ Undertake orientation and sensitisation of all nutrition partners with integrated guidelines and associated materials. ▪ Conduct in-service trainings on updated guidelines and tools so relevant MoH staff at all levels are prepared and familiar, as part of wider capacity development strategy. ▪ Establish system of regular supportive supervision, including on the job training to reinforce learning, with regular feedback meetings.	**HTP MODULE 13 TRAINERS GUIDE:** http://files.ennonline.net/attachments/2050/HTP-v2-module-13-trainers-guide.pdf
D. **Undertake a mapping of existing capacities for the management of acute malnutrition in consultation with partners (government, NGOs, donors)** to provide the basis for preparedness actions to strengthen capacity prior to any emergency. ▪ When assessing existing capacity, available staff, supplies and resources should be measured in relation to the expected caseloads of SAM, risks, potential hazards & vulnerabilities. ▪ Based on identified gaps, undertake capacity development to strengthen national systems to provide existing services the ability to scale up to meet the additional needs in an emergency. Efforts should support national systems rather than parallel programmes. ▪ Provide in-service training and follow-up mentoring of MoH staff and community agents as required. ▪ Use results of capacity mapping to identify potential partners that could be involved in capacity development, provide surge support, rapid scale up or change of intervention area if required. Draft Humanitarian response plan based on the capacity mapping.	**UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE: PAGE 7 - 8** https://www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf **GNC IM TOOLKIT CAPACITY MAPPING TOOL:** http://nutritioncluster.net/topics/im-toolkit/page/2/ **EXAMPLES OF SUPERVISION CHECKLISTS: HTP MODULE 13 TECHNICAL NOTES ANNEX 15:** http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf

PREPAREDNESS ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
E. **Map geographical coverage of existing services for SAM and determine gaps or duplications in relation to current and potential needs, depending on analysis of vulnerabilities, risks and hazards** ▪ Establish locations of high risk and vulnerability. ▪ Undertake a geographical mapping of existing services for the management of acute malnutrition in consultation with partners (government, NGOs, donors) and develop a 3W/4W with sector working group. ▪ Present information on geographic coverage on an excel template, or a map overlaid with established needs to determine gaps and duplications in services in relation to current and potential emergency scenarios (e.g. there may be no routine SAM management program in district 'y' that is high risk location).	**WHO, WHAT, WHERE (WHEN) (3W/4W) INFORMATION (SECTION 3.5.3 OF GNC** Handbook); **UNICEF GRIP GUIDANCE** https://unicef.sharepoint.com/teams/Communities/RiskResilienceFragilityPeacebuilding/_layouts/15/WopiFrame.aspx?sourcedoc=%7BD8ABC738-3172-4BF2-A397-809E7B089490%7D&file=M1_GRIP%20May%208.docx&action=default https://intranet.unicef.org/pd/pdc.nsf/0/6B37B29109DD1E578525809100768BD7/$FILE/UNICEF%20Preparedness%20Procedure%2029%20Dec%202016.pdf https://intranet.unicef.org/pd/pdc.nsf/0/6B37B29109DD1E578525809100768BD7/$FILE/UNICEF%20Preparedness%20Guidance%20Note_29_Dec_%202016_.pdf
F. **If resources allow, establish new sites/services and/or mechanisms for surge support in high risk locations** with the support of community and existing health services, before the caseload become too large. ▪ Develop a strategy for community sensitization/ensuring community leaders are aware of the purpose of the interventions in areas where it doesn't currently exist and potentially plan to scale up (see Good to Know Box on community mobilisation). ▪ Encourage active participation of community in planning for new sites to increase ownership, foster demand for services and maximise appropriate use both before and during emergency. ▪ Support training of community agents and health workers on rapid screening of all children under five using MUAC measurement and assessment of the presence of bilateral pitting oedema. ▪ Identify partners and establish mechanisms for providing surge support to existing services in high risk locations.	**HTP MODULE 13: SECTION 3 COMMUNITY MOBILISATION** http://nutritioncluster.net/training/module-3-understanding-malnutrition-additional-resources-30-mb/ http://www.ennonline.net/htpv2module3 **TECHNICAL BRIEF: COMMUNITY ENGAGEMENT FOR CMAM:** http://www.severemalnutrition.org/en/resource-library/Ge **TECHNICAL BRIEF: COMMUNITY ENGAGEMENT: THE 'C' AT THE HEART OF CMAM:** http://www.severemalnutrition.org/en/resource-library/Ge
G. **Strengthen the existing Monitoring and reporting system** to ensure complete and timely programme data for more accurate forecasting and programme performance review. ▪ Identify and address gaps/bottlenecks in existing monitoring and reporting system, from the facility to central level. ▪ Encourage use of simple nationally agreed reporting formats respected by all partners to ensure consistency and comparability of reporting of results to the sector/cluster and government. ▪ Include stock reporting on supplies (e.g. stock balances, utilisation) within admission/discharge reporting forms with feedback loop to link with supply chain management. ▪ Introduce measures to encourage timely and complete reporting, including sensitisation on the importance of quality monitoring and reporting for effective programming. ▪ Strength MoH capacity to monitor monthly reports and assess programme performance indicators - recovery, death, default and coverage - according to international standards. ▪ Where international standards for SAM management are not being met, support the investigation of causes and respond with expanded supportive supervision as required - (appropriate performance indicators are outlined in CCC Handbook and are in line with SPHERE standards).	**UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE: PAGE 41** http://www.severemalnutrition.org/en/resource-library/Ge **HTP MODULE 13. SECTION 10 MONITORING AND REPORTING** http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf

PREPAREDNESS ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
H. **Work with supply and logistic colleagues to develop contingency supply and distribution plans based on risk analysis scenarios and forecasted caseloads.** ▪ Use risk analysis tools to develop different scenarios for contingency planning - most likely, worst case, best case - and for each scenario, estimate expected caseload of SAM. ▪ To estimate expected SAM caseloads, follow detailed guidance in Annex A of UNICEF Programme Guidance document for the management of SAM in Children, be sure to work in consultation with key stakeholders, including government. ▪ Use the UNICEF Emergency supplies calculator to estimate contingency requirements of relevant supplies (therapeutic milks, RUTF, medicines, equipment). ▪ In countries with existing programme for acute malnutrition, work with the national partners and NGOs to establish supplies already available in country to feed into contingency planning (to replenish stock). ▪ Work with logistics staff to ensure contingency supply and distribution plan includes the following: ○ *Specific products required* ○ *Scenario development* ○ *Forecast requirements based on scenarios* ○ *Procurement plan* ○ *Quality assurance* ○ *Inventory management* ○ *Distribution plan* ▪ Contingency plans for supplies need to be reviewed on an annual basis. ▪ Non-nutrition staff should familiarise themselves with different nutrition commodities and the UNICEF supply list as part of preparedness actions.	**UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE: ANNEX A** https://www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf **UNICEF TECHNICAL NOTE: EMERGENCY RISK INFORMED SITUATIONAL ANALYSIS 2012:** http://www.unicefinemergencies.com/downloads/eresource/docs/KRR/Guidance%20Risk%20Informed%20SitAn%20FINAL.pdf **UNICEF EMERGENCY SUPPLY CALCULATOR:** http://www.severemalnutrition.org/en/resource-library/Ge **UNICEF SUPPLY CATALOGUE:** https://supply.unicef.org/unicef_b2c/app/displayApp/(layout=7.0-12_1_66_67_115&carea=%24ROOT)/.do?rf=y **UNICEF EMERGENCY SUPPLY LIST:** http://www.severemalnutrition.org/en/resource-library/Ge **UNICEF SUPPLY MANUAL CHAPTER 10 (EMERGENCY SECTION) (INTERNAL)** https://intranet.unicef.org/Policies/DHR.nsf/6203f70108ece1f685256720005e2bfe/64788e14462ec487c1257f08004b3bed?OpenDocument
I. **Provide necessary support to supply and logistics colleagues to enable them to prepare supply plans, distribution strategies and LTAs, building on & strengthening existing systems.** ▪ Based on sound caseload calculation, ensure projections of supply requirements are estimated using the supply forecasting tool (see Preparedness Action H). ▪ Ensure existing information systems capture reporting on supplies e.g. include stock reporting (utilization, stock balances etc.) in CMAM admissions reports. ▪ Strengthen capacity of partners to monitor and report on programme data on admissions and supply use. Forecasting for supplies is more accurate when using programme data, compared to indirect calculation through estimation of caseload. ▪ Put in place measures for addressing stock-outs at the facility level e.g. borrowing from other partners or areas where there is surplus. ▪ Ensure that PCAs include a clause indicating flexibility on the use of supplies for emergency response. Include also 'Last mile' distribution - district to health facility level, where necessary. ▪ Support identification and availability of adequate warehousing and storage facilities for possibly large volumes of RUTF, especially if pre-positioning is required. ▪ Ensure quality assurance mechanisms are in place. ▪ Provide necessary support to Logistics for the preparation of Long-term agreements (LTAs) with providers where appropriate for the following: ○ *transport to and storage of supplies at end destination, covering all relevant different parts of the country, and including a clause for potential for scale up in emergency.* ○ *with partners for prepositioning emergency supplies in strategic locations.* ○ *for customs clearance of nutrition commodities.*	

GOOD TO KNOW!

The Importance of Community Mobilisation in effective services for management of SAM

Community mobilisation is an essential but often neglected component of CMAM. Community mobilisation aims to raise awareness about the availability of services for management of SAM to the affected population. It promotes understanding, access, use and can lay the foundations for community ownership. These are essential to achieving good coverage of the programme, increasing effectiveness and efficiency. An important step in community mobilisation is the first - community enquiry. Failure to complete this step has been identified as a major bottleneck in achieving coverage and therefore impact.

Poor community engagement can result in:

- large number of ineligible people attending the programme due to lack of understanding of admission criteria.
- poor coverage means programme doesn't reach the children most in need and reduces cost effectiveness and efficiency.

For more information see: Community Engagement: the 'C' at the heart of CMAM. CMAM Forum Technical Brief.
http://www.severemalnutrition.org/en/resource-library/Ge

6.2 Response Actions

During the emergency phase, UNICEF has a key role in supporting national capacities and systems to respond to the need for increased services for the management of acute malnutrition. This support may be technical and material (supplies, equipment, financial). It may be direct or indirect through partnerships with international and local organisations.

If urgent surge technical support is required, it is possible to refer to technical rapid response team which can provide a technical surge advisor with expertise in management of acute malnutrition. Deployable within 72 days for a maximum of 4 weeks, not as a gap filler but to improve collective humanitarian response. More information at: http://nutritioncluster.net/establishment-gnc-technical-rapid-response-team/

Over the years, UNICEF has developed internal and external categories for surge mechanisms.

Surge mechanisms using internal UNICEF staff and re-deployments include:

a. Emergency Response Team (ERT)
b. Humanitarian Support Personnel (HSP)
c. Immediate Response Team (IRT)
d. Regional rosters – Rapid Response Mechanism (RRM) or Rapid Response Roster (RRR)

FROM THE CCC'S

Response Actions for Management of Acute Malnutrition:

Support existing capacity for the management of SAM for children at the community and facility levels, and initiate and support additional therapeutic feeding as required to reach the estimated population in need.

In collaboration with the World Food Programme, ensure appropriate management of moderate acute malnutrition for children and supplementary feeding for vulnerable groups, including pregnant and lactating women, according to identified needs.

Support and establish systems for community mobilisation as well as for the identification and referral of acute malnutrition.

Surge mechanisms using externals:

1. Stand-by Partnerships (SBP)
2. Rapid Response Team (RRT
3. United Nations Volunteers (UNV)

https://intranet.unicef.org/emops/emopssite.nsf/0/9A18D408EC7C6AAD852579E60053286B/$FILE/Summary%20Surge%20Guideline%20-%20revised%20version%2030%20June%202016%20-%20FINAL.pdf (INTERNAL)

RESPONSE ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
J. **Assess and understand how the emergency has impacted the pre-existing situation, systems and services then identify priority response actions accordingly.** Consider if/how the emergency has affected the following: ▪ Caseloads of acute malnutrition. Are these changing and how are caseloads likely to change as an emergency progresses? ▪ What services and systems are still functioning and able to maintain provision of services and scale up if needed? ▪ Has availability of trained staff been affected? Is there a need to bring in surge support? ▪ Is access to services limited? How does this affect coverage? Are more mobile sites needed? ▪ Do delivery platforms need to be modified and what are the options for this? (e.g. increased outreach, new inpatient facilities). ▪ Is the supply chain interrupted and if so, what options are there to overcome this? ▪ Is the information system working? Are there additional information needs and how can these be attained?	
K. **Support and strengthen national systems and capacities to maintain existing services and scale up as required.** ▪ Support surge mechanisms established under preparedness actions H. ▪ Support recruitment and training of additional staff as required while considering how an emergency may affect availability and turnover of staff. ▪ Consider the option of technical surge support from GNC Technical Rapid Response team. ▪ Expand regular supportive supervision in conjunction with partners, including on the job supervision. ▪ Support national capacities to meet Cluster information needs. ▪ Maximise the availability of extra resources and partners to support strengthening of national systems and capacities.	**TECHNICAL RAPID RESPONSE TEAM:** http://nutritioncluster.net/establishment-gnc-technical-rapid-response-team/ **EXAMPLES OF SUPERVISION CHECKLISTS: HTP MODULE 13 TECHNICAL NOTES ANNEX 15:** http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf
L. **Ensure the involvement of communities at the centre of efforts to maintain and scale up provision of services for management of acute malnutrition.** ▪ Undertake preparedness actions H to ensure community engagement. Link with Nutrition Communication response actions. ▪ Use Community enquiry to identify appropriate and important community agents and communication channels for community mobilisation. ▪ Develop and implement a community mobilisation strategy. Remember that community mobilisation is a continuous process to be maintained over the course of the emergency ▪ Develop context appropriate messages and approaches for the affected community, based on the community enquiry. ▪ Agree on responsibility for community mobilisation system - may be MoH or shared with another ministry or administrative body e.g. social affairs.	**UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE: ANNEX B2** **COMMUNITY ENGAGEMENT FOR CMAM:** https://www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf

RESPONSE ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
M. **Establish new sites or delivery platforms to meet additional needs, include mechanisms for the timely identification, referral and follow up of cases to appropriate services.** ▪ According to preparedness action F, establish new sites and/or delivery platforms (inpatient care, facility based, outreach, community based) using existing structures where possible to maximise integration. ▪ Support NGOs identified in preparedness F & H to cover surge in demand for services that cannot be covered by the government. ▪ According to context, determine whether specific groups of the population (e.g. infants, elderly, people living with HIV) are particularly affected and require additional programme approaches. See Good to Know Box on HIV and SAM. ▪ Ensure a robust referral system is established between community, inpatient and outpatient services for continuity of care. Use the appropriate communication channels identified in Preparedness Action C. ▪ Support training of community agents and health workers identified in Preparedness Action C on screening of all children under five using MUAC measurement, assessment of the presence of bilateral pitting oedema, referral systems, on appropriate actions for home visits, and follow up of defaulters or non-responders. ▪ If there is already a network, use paid community health workers (CHWs) from other initiatives for the identification and referral of SAM/MAM cases. ▪ Aim to standardise across partners and programmes the use of community agents and the payment/rate of any incentives.	**UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE.** https://www.unicef.org/eapro/UNICEF_program_guidance_on_manangement_of_SAM_2015.pdf **ANNEX F: MANAGEMENT OF SAM IN OTHER GROUPS** **EXAMPLES OF REFERRAL SLIPS AND FORMS HTP MODULE 13 SAM TECHNICAL NOTES PAGE 45 & 46:** http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf **SEE SECTION 4 P.13 ON CASE FINDING IN HTP MODULE 13** http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf **SEE 'HOME VISITS' PAGE 29 HTP MODULE 13**
N. **As necessary, work with logistics colleagues to revise supply and distribution plans to meet additional needs.** ▪ Follow preparedness steps I and J using latest assessment data on numbers affected. ▪ Calculate additional supplies required. ▪ If necessary facilitate the 'borrowing' of supplies from unaffected areas of the country where there is a surplus, to meet additional needs in the interim.	
O. **Work closely with WFP to establish coordinated programming approaches to providing a continuum of care for acute malnutrition** that increases effectiveness and efficiency and minimises children being 'lost' between different services. ▪ Establish good communications, partnership and coordination mechanisms between agencies at the national and field level. ▪ Where possible, use common partners to support services for both SAM and MAM to ensure they are closely linked. ▪ Wherever appropriate, operate in the same locations to provide complementary comprehensive programmes to the same communities. ▪ Harmonise outreach activities and platforms to reach both SAM and MAM. ▪ Reach agreement at technical level on best programming approaches given the context. Support WFP in use the MAM Decision Tool to guide decision making (e.g. SFP may not be appropriate or needed in all emergencies. Under exceptional conditions, where there is no SFP, maybe appropriate to use RUTF for SAM and MAM under expanded admission criteria). ▪ As emergency progresses, continue to work closely with WFP to review and re-evaluate approaches according to evolving context.:	**WFP UNICEF MOU 2011** http://documents.wfp.org/stellent/groups/public/documents/reports/wfp262575.pdf **MAM DECISION TOOL:** http://nutritioncluster.net/resources/ma/ **GUIDANCE ON EXPANDED ADMISSION CRITERIA:** http://nutritioncluster.net/resources/ma/

GOOD TO KNOW!

Management of Acute Malnutrition and HIV positive children

In areas where there is high prevalence of HIV, special considerations are required when planning preparedness, response and early recovery actions for management of MAM. HIV positive children are more at risk of acute malnutrition and take longer to recover when they become acutely malnourished. They may therefore benefit from being included in therapeutic programmes at an earlier stage. More information at: https://www.wfp.org/hiv-aids/hiv-and-nutrition

WHO recommendations for SAM management 2013 recommend that children with SAM in countries where HIV is common be routinely tested for the virus, and those who are positive should start antiretroviral drugs as well as special foods and antibiotics to treat SAM. The full set of recommendations can be found here: http://www.who.int/elena/titles/full_recommendations/sam_management/en/index6.html

The integration of specific interventions for HIV testing and treatment into SAM care is essential.

A checklist for determining HIV status for children with SAM can be found in UNICEF Programme Guidance for SAM 2015, Annex F page 102.

Further information can be found in HTP Module 13 on SAM Technical notes page 37: http://files.ennonline.net/attachments/2048/HTP-v2-module-13-technical-notes.pdf

Lessons learned - Integration of Early Child Development (ECD) activities in programmes for the management of SAM improves outcomes

Specific guidance for this available at: UNICEF and WHO, 2012, 'Integrating Early Childhood Development (ECD) activities into Nutrition Programmes in Emergencies: Why, What and How,' www.who.int/mental_health/emergencies/ecd_note.pdf.

This approach is based on evidence that in emergency programmes, improving mother-to-child interaction through mother-to-mother support groups and home visits had other benefits including improvements in maternal mood and improved child nutritional and growth outcomes. Integrating ECD activities with management of SAM may therefore offer benefits in maximising recovery as well as physical, social, emotional and intellectual development of the child being treated.

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6.3 Early Recovery Actions

Early recovery actions should focus on building on what has been achieved in strengthening capacities and systems during the emergency to continue to provide services for the management of acute malnutrition in a sustainable way proportionate to 'non-emergency' caseloads of acute malnutrition.

Early recovery actions can be informed by country experiences of scaling up CMAM, often following an emergency response, as documented in reference ENN, 2011, 'Conference on government experiences of scaling up the Community-based Management of Acute Malnutrition (CMAM) and lessons for the Scaling Up (SUN) movement'. http://www.severemalnutrition.org/

Beyond the emergency phase, UNICEF's commitments to the sustainable management of SAM in countries are reflected in Strategic Plan 2014 -17, in its Disaster Risk Reduction approach. UNICEF has been involved in the introduction and scale up of CMAM in multiple countries.

FROM THE CCC'S

Early Recovery Actions for Management of Acute Malnutrition:

Initiate discussion on national policy, strategy and guidelines for sustainable management of SAM, if not already in place.

EARLY RECOVERY ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
P. **Continue to monitor the situation and scale down additional services - staffing, number of sites and delivery platforms - relative to reductions in caseloads.** ▪ As partners scale down, capitalise on their continued presence to support additional capacity strengthening efforts for a stronger national programme. ▪ Use establishment of new sites at facility level as entry point for sustaining integrated services beyond the emergency, proportional to caseloads. ▪ Scale back outreach services/mobile clinics to more sustainable facility based services. ▪ Maintain community engagement/involvement for community awareness, active case finding and referrals.	
Q. If not already established**, support national adoption of integrated management of acute malnutrition and inclusion at national policy level.** ▪ Finalise development of national integrated guidelines, if not already done. The development of national guidelines is a pre-requisite for inclusion in national policies. ▪ If not already done, establish a technical committee to advocate for sustainable management of SAM and oversee the process. ▪ Consider bringing in international experts to discuss with government and drive agreement on national adoption of integrated management of acute malnutrition. ▪ Aim for support from executive level - Office of President or Prime Minister - can play a strategic role in enhancing the momentum on sustainable management of SAM in country. ▪ Consider within which national policy integrated management of acute malnutrition best fits, depending on country context. If not included in the national multi sectoral plan, it may be overlooked for funding. ▪ Aim for inclusion within health sector policy and plans as health staff are largely responsible for implementation, therefore it needs to be reflected in health staff training, responsibilities and performance review. ▪ Consider inclusion in other sector policies e.g. community mobilisation may fall under social affairs; the link with preventive programmes may fall under food security.	**ENN, 2011, 'CONFERENCE ON GOVERNMENT EXPERIENCES OF SCALING UP THE COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION (CMAM) AND LESSONS FOR THE SCALING UP (SUN) MOVEMENT'** http://www.severemalnutrition.org/
R. Together with logistics colleagues**, initiate discussions on integrating the nutrition products supply chain into the regular supply chain, as a step in the normalisation of management of SAM and its sustainability.**[19] **Work towards:** ▪ Inclusion of nutrition products on the National Essential Medicines List. ▪ Inclusion of nutrition products on national supply chain catalogue. ▪ Obtaining official status from the regulatory authorities.	**UNICEF NUTRITIONAL SUPPLY CHAIN INTEGRATION STUDY VOLUME 2 GUIDELINES OCT 2015** http://supplychainsforchildren.org/Supply-Chain-Stories/Assessment-of-RUTF-Supply-Chain-Studies-to-inform-Nutrition-Supply-Chain-Strategies

19 In protracted emergencies, UNICEF may work with local producers towards national production of RUTF. See CMAM Forum Technical brief production for more details. http://www.severemalnutrition.org/

EARLY RECOVERY ACTIONS FOR MANAGEMENT OF ACUTE MALNUTRITION	EXAMPLES/RESOURCES
S. **Undertake cost analysis of integrated management of acute malnutrition services to support planning, tracking and mobilisation of resources for sustainable programming.** ▪ Use available, established costing tools. ▪ Estimate cost based on all service delivery requirements. ▪ Use cost estimates to secure financing mechanisms for supplies and programme inputs. Use the analysis of funding gaps to advocate for increased, longer term financing of management of acute malnutrition by MoH, traditional and non-traditional donors.	**CMAM COSTING TOOL. VERSION 1.1.** http://www.fantaproject.org/tools/cmam-costing-tool
T. **Initiate and strengthen efforts for multi-sectoral approaches to the prevention of SAM.** ▪ Work with UNICEF colleagues and national and NGO partners from other sectors to strengthen linkages with other sector programmes and promote the integration of nutrition. ▪ Work with national government to support the adoption of multi-sectoral approaches to nutrition.	**UNICEF BRIEF ON MULTISECTORAL APPROACHES TO NUTRITION:** http://www.unicef.org/eapro/Brief_Nutrition_Overview.pdf **IMPROVING NUTRITION THROUGH MULTISECTORAL APPROACHES:** http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2016/03/17/090224b08420b100/2_0/Rendered/PDF/Improving0nutr0isectoral0approaches.pdf

KEY RESOURCES FOR THE MANAGEMENT OF ACUTE MALNUTRITION

UNICEF PROGRAMME GUIDANCE DOCUMENT 2015: MANAGEMENT OF SAM IN CHILDREN: WORKING TOWARDS RESULTS AT SCALE.
http://www.severemalnutrition.org/en/resource-library/Ge

WHO. GUIDELINE: UPDATES ON THE MANAGEMENT OF SEVERE ACUTE MALNUTRITION IN INFANTS AND CHILDREN. GENEVA: WORLD HEALTH ORGANIZATION; 2013.
http://www.who.int/nutrition/publications/guidelines/updates_management_SAM_infantandchildren/en/

HARMONISED TRAINING PACKAGE (HTP) MODULE 13; MANAGEMENT OF SEVERE ACUTE MALNUTRITION TECHNICAL NOTES:
http://www.ennonline.net/htpv2module13

CMAM FORUM: KEY RESOURCES FOR THE MANAGEMENT OF ACUTE MALNUTRITION DECEMBER 2014:
http://www.severemalnutrition.org/en/resource-library/Ge

CMAM FORUM RESOURCES LIBRARY:
http://www.severemalnutrition.org/en/resource-library/Ge

7

Micronutrients in Emergencies

Nutrition Commitment 5:

Children and women access micronutrient fortified foods, supplements or multiple-micronutrient preparations.

Benchmark 5:

Micronutrient needs of affected population are met: >90% coverage of supplementation activities, or >90% have access to additional sources of micronutrients for women and children.

UNICEF's CCC on micronutrients in emergencies aims to protect the micronutrient status of women and children affected by emergencies through prevention and treatment of clinical cases in line with global standards and guidance and interagency agreements.

Micronutrient deficiencies are a significant global health problem. Women suffering micronutrient deficiencies have greater risk of dying during childbirth, giving birth to an underweight or mentally impaired baby; poor health and development of breast-fed infant. Young children suffering from micronutrient deficiencies have an increased risk of dying from an infection and impaired mental and physical development.

Micronutrient deficiencies can develop during an emergency or be exacerbated if already present in a population. Many factors/characteristics of emergencies contribute to increased risk of micronutrient deficiencies. Food supplies may be disrupted, livelihoods or food crops can be lost limiting access to micronutrient-rich food; dependency on food rations can lead monotonous and restricted diets. Inadequate housing, overcrowding, a lack of clean drinking and an unhygienic environment and interruptions to delivery of health care all increase the risk of outbreaks of diarrhoeal or other infectious diseases.

The micronutrient deficiencies of greatest public health significance globally are: iron deficiency anaemia, vitamin A deficiency and iodine deficiency. In addition, in protracted emergencies where populations may only access very limited diets, vitamin C, niacin, thiamine, riboflavin and vitamin D deficiencies have arisen. Detailed information on specific micronutrient deficiencies can be found at: http://www.unicef.org/nutrition/training/4.1/1.html

UNICEF supports the following strategies to prevent and treat micronutrient deficiencies in women and children:

1. **Improve dietary diversity** using community-based approaches to promote breastfeeding, improve complementary feeding, and encourage consumption of a diverse range of locally available foods.
2. **Supplementation** programmes to provide specific micronutrients that are not available as part of the regular diet. E.g. high dose vitamin A supplementation for children 6 to 59 months, iron folate supplementation during pregnancy.
3. **Mass fortification.** UNICEF advocates for and supports national governments to develop universal salt iodization and national food fortification programmes for vitamin A, iron and folic acid, and other micronutrients as required.
4. **Home fortification** programmes which provide caregivers with micronutrient powders to sprinkle on the foods they prepare for children at home. This can significantly improve the dietary quality of complementary food for children from 6 months to the age of 2 or older.

Beyond the strategies supported by UNICEF, there are other important approaches to improve micronutrient intakes. These include: provision of fortified foods within the general ration, diet diversification through promotion of home gardening or agricultural development, income generation and improving access to markets (see Good to Know Box on Effective Control of micronutrient malnutrition). None of these approaches are adequate in themselves and must be delivered in combination with appropriate IYCF and basic public health and WASH interventions to protect micronutrient status in emergencies.

GOOD TO KNOW!

Effective control of micronutrient malnutrition involves both preventive and curative measures.

Prevention of micronutrient malnutrition in emergencies Options for the prevention can be classified into 12, often complementary, approaches listed below. An effective prevention strategy with long-term impact is likely to use a combination of these different approaches. Not all approaches can be used in all situations. For example, there may be no general food aid ration in some situations or there may be no spare land or water available for home gardening in others.

i. Inclusion of nutrient-rich commodities in food assistance rations
ii. Provision of fresh food items that are complementary to a general ration
iii. Provision of fortified foods
iv. Increasing the size of the general food ration to facilitate diet diversification by exchange or trade
v. Distribution of food supplementation products for home fortification
vi. Distribution of micronutrient supplements
vii. Distribution of deworming tablets
viii. Promotion of home gardening and agricultural development
ix. Increasing income generation and improving access to markets
x. Promotion of recommended infant feeding practices
xi. Ensuring adequate health care and a healthy environment - prevention requires control of infectious diseases, e.g. ARI, malaria, diarrhoea which deplete micronutrient stores
xii. Ensuring access to adequate non-food items

Treatment of micronutrient malnutrition in emergencies Iron, zinc, vitamin A, iodine, and folate are among the most widespread global micronutrient deficiencies. Deficiencies in these and additional micronutrients may be further exacerbated in emergencies, especially if fortified foods are not available. The increasing introduction of micronutrient fortified foods has helped prevent outbreaks but micronutrient deficiencies remain a significant public health problem in emergencies.

Actions for the treatment of micronutrient deficiencies include:

- Appropriate diagnosis by medically qualified staff through recognition of clinical signs and symptoms and backed up by biochemical testing of blood or urine sample where appropriate/available.
- Treatment is usually supplementation using a single or small range of micronutrients, accompanied by a good general diet and appropriate health care.
- Appropriate diagnosis and treatment of cases should always be accompanied by the development of a prevention strategy using a combination of the different prevention approaches described above.

More detailed information on specific micronutrient deficiencies and their treatment can be found: UNICEF basic concepts nutrition in emergencies e-learning course, Section 4 on Micronutrients

http://www.unicef.org/nutrition/training/4.1/contents.html

HTP Module 4 on Micronutrient Malnutrition:

http://files.ennonline.net/attachments/1951/HTP-module-4-technical-notes.pdf

Source HTP Module 14 Technical Notes

The following chapter provides guidance on the key actions that should be taken to ensure that UNICEF is able to fulfil its commitments on micronutrients in preparedness and response to emergencies and in the early recovery phase. Checklist 5 provides an overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. As highlighted above, the activities defined within the CCCs should be considered within the wider context and a combination of measures. Box 4 presents the globally accepted Sphere standards on micronutrients in emergencies with associated key actions and indicators. The Good to Know Box outlines the agreed commitments of UNICEF and WFP in relation to micronutrient interventions. Following Checklist 5 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

CHECKLIST 5 Essential Actions for Micronutrients in Emergencies

PREPAREDNESS FOR COORDINATION			
ESSENTIAL ACTIONS	**UNICEF CCCS FOR PREPAREDNESS FOR MICRONUTRIENTS**		
	Establish guidance on micronutrient supplementation	Set up partnerships to implement emergency micronutrient activities	Form contingency plan and mechanism for procurement and distribution of all necessary supplies for emergency micronutrient interventions (vitamin A, iodised salt, multiple micronutrient supplements) including stockpiles or standby arrangements with providers of micronutrient supplements
Understand/map the existing micronutrient situation in country	✓	✓	✓
Work with all relevant stakeholders, to ensure national guidelines for the micronutrient interventions, including in emergencies, are established and up to date with latest evidence and international standards	✓		
Develop IEC materials, accompanying tools and job aids for implementing micronutrient interventions, in line with new/ updated national guidelines	✓		
Initiate training and sensitisation on new/updated guidelines and tools, within an overall approach to strengthening national capacity on micronutrients	✓	✓	
Support the development of good partnerships for the implementation of micronutrient interventions within an overall approach to build a stronger existing programme more able to scale up in emergency		✓	✓
Support the integration/addition of micronutrient indicators into the existing health system reporting	✓	✓	✓
Provide necessary support to supply & logistic colleagues (UNICEF & Government) to develop contingency plans and procurement & distribution mechanisms		✓	✓

RESPONSE FOR MICRONUTRIENTS			
ESSENTIAL ACTIONS	**UNICEF CCCS FOR RESPONSE FOR MICRONUTRIENTS**		
	According to the context, ensure provision of high dose vitamin A supplementation with vaccination to all children 6 to 59 months old and de-worm all children (12 to 59 months old) in collaboration with health sector workers	Ensure that iodised salt is included in the emergency food basket. If this is not possible and household consumption is less than 20%, consider iodised oil supplement distribution for all children 6-24 months old and women of child bearing age	Ensure provision of multiple micronutrient preparations for all children 6 to 59 months old - unless fortified complementary foods are provided - and multiple micronutrient supplements for pregnant or lactating women
Assess how the emergency has affected systems and communities and work in partnership with WFP so nutrient gap information is available and helps guide the design or modification of micronutrient interventions	✓	✓	✓
Work closely with health colleagues to ensure integration of micronutrient interventions within health response actions and the provision of associated public health measures	✓		✓
Establish if the context meets the criteria for high dose vitamin A supplementation & de-worming and if so, support implementation, in collaboration with health workers	✓		
Where a measles campaign is being implemented, work with health colleagues to ensure Vitamin A distribution accompanies measles vaccination in children 6 to 59 months	✓		
Support WFP to provide iodised salt in the emergency food ration. If not possible, and household consumption is less than 20%, consider iodised oil supplement distribution to defined target groups		✓	
In line with WHO/WFP/UNICEF Joint Statement 2007, ensure provision of multiple micronutrient preparations/supplements to children 6 to 59 months and PLW, according to context			✓
Ensure reporting and surveillance systems include indicators for essential micronutrients services during the response	✓	✓	✓

EARLY RECOVERY FOR MICRONUTRIENTS		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR EARLY RECOVERY FOR MICRONUTRIENTS**	
	Ensure that micronutrient activities build on and support existing national capacities	Initiate discussion on long-term strategies to provide micronutrients and potentially incorporate new approaches introduced during the emergency
Ensure early recovery actions focus on development and strengthening of national capacities to implement relevant micronutrient programmes	✓	
Initiate discussions on establishing/ strengthening national food fortification and salt iodisation programmes	✓	✓
Where MNPs have been introduced during the emergency, initiate dialogue with relevant national partners on adoption/scale up as a routine programme	✓	✓
Where MMNs have been introduced during the emergency, and multiple micronutrient deficiencies are known to be a persistent problem, initiate dialogue on possible replacement of IFA supplementation for PLWs	✓	✓

BOX 4 Sphere standards for micronutrients in emergencies

Food Security, Food Transfers Standard 1: General nutrition requirements

Ensure the nutritional needs of the disaster-affected population including those most at risk are met.

Key indicators

- There is adequate access to a range of foods, including a staple (cereal or tuber), pulses (or animal products) and fat sources, that together meet nutritional requirements
- There is adequate access to iodised salt for the majority (>90%) of households
- There is adequate access to additional sources of niacin (e.g. pulses, nuts, dried fish) if the staple is maize or sorghum
- There is adequate access to additional sources of thiamine (e.g. pulses, nuts, eggs) if the staple is polished rice
- There is adequate access to adequate sources of riboflavin where people are dependent on a very limited diet
- There are no cases of scurvy, pellagra, beriberi or riboflavin deficiency
- The prevalence of vitamin A deficiency, iron deficiency anaemia and iodine deficiency disorders are not of public health significance

Management of malnutrition standard 3: micronutrient deficiencies

Micronutrient interventions accompany public health and other nutrition interventions to reduce common diseases associated with emergencies and address micronutrient deficiencies

Key actions

- Train health staff in how to identify and treat micronutrient deficiencies
- Establish procedures to respond effectively to the types of micronutrient deficiencies from which the population may be at risk

Key indicators

- Cases of micronutrient deficiencies are treated according to current best clinical practice
- Micronutrient interventions accompany public health interventions to reduce common diseases associated with emergencies such as measles (Vitamin A) and diarrhoea (zinc)

Source: Sphere Handbook, 'Chapter 3: Minimum Standards in Food Security and Nutrition', The Sphere Project, Geneva, 2011.

GOOD TO KNOW!

The agreed commitments of UNICEF and WFP in the management of micronutrients at global and country level

PROGRAMME AREA	UNICEF COMMITMENTS	WFP COMMITMENTS	JOINT PRINCIPLES AND ACTION
Micronutrients and Fortification	To provide Vitamin A and iron and other micronutrient supplements to pregnant and lactating women as required.	To ensure all processed food commodities provided are fortified (e.g. salt, oil, blended foods, flours)	To assess and optimise complementary operational roles in addressing micronutrient deficiency
UNICEF will take a lead role in assessment of micronutrient deficiency and in collaboration with WFP, in the design of programmes, treatment and quality control. WFP will ensure that food commodities are adequately fortified.	To design and support implementation of universal salt iodisation strategies and legislation and provide support for salt iodisation to WFP if appropriate.	To take the lead where necessary in the design and implementation of milling/ fortification, including quality control and local and national levels.	With WHO to develop national supplementation and treatment guidelines
WFP will take responsibility for defining micronutrient concerns within food needs assessment and will document progress in resolving micronutrient deficiency in WFP operations.	To provide micronutrient supplements for distribution with WFP or alone, if appropriate.	To continue efforts to meet recommendations for (micro)nutrient intake of target population among others through provision of micronutrient fortified foods.	To advocate for greater national awareness and action on micronutrient deficiency
Food commodities will be appropriately fortified. WFP and UNICEF will work together on advocacy with donor nations in favour of appropriately fortified foods. They will also work together to increase capacity for local milling and fortification of local products and local production of fortified blended foods	To take the lead and responsibility for implementing public health interventions such as water, sanitation, health services (immunisations, vitamin A, ORS)	To take all efforts to ensure the distribution of iodised salt.	To examine appropriateness of the levels of micronutrients to be delivered by various methods
Targeting nutritionally vulnerable people	UNICEF will take the lead on ensuring supplies of safe water while WFP will support such activities	To facilitate the provision of deworming tablets in collaboration with UNICEF and WHO in the context of pre and primary schools and MCNH services where intestinal worms are a nutrition and health concern.	To support the mandatory use of iodised salt for human and animal consumption at national level
UNICEF strives to ensure basic health and nutrient needs of children are met.			To support implementation of treatment protocols to reduce iodine deficiency in high prevalence areas
WFP strives to ensure the basic health and nutrient needs of vulnerable people are met			To work with premix producers, technical/ scientific bodies and governments and private sector to support micronutrient fortification
			To mobilise resources to reduce micronutrient deficiencies

Source: UNICEF and WFP Memorandum of Understanding (2011) excerpts from Technical Annex for Nutrition

GOOD TO KNOW!

Excessive intake of micronutrients can also be harmful

Most micronutrients have a defined safe upper level of intake, or upper limit (UL), whereby regular consumption above this can have harmful effects. Examples where high intakes have negative impacts are high intakes of iron, which can be lethal, and in the case of iodine, both high and low intakes may result in goitre. Excess intakes are most likely in situations where there are multiple concurrent efforts to minimise the risk of micronutrient deficiencies. It is therefore essential to make sure any strategies for prevention of micronutrient deficiencies ensure intakes of specific micronutrients remain within recommended levels.

Actions to take:

i. In the design of any programme to address micronutrient deficiencies, always consider the possibility of excessive intakes.

ii. Before introducing any new micronutrient supplementation e.g. MNP, assess intake of specific micronutrients e.g. through food consumption surveys, where context allows. Where possible estimate average daily intake of specific micronutrients and compare against recommended nutrient intake values.

iii. This is particularly important for populations receiving and reliant on fortified food rations for their daily food intake.

iv. Estimating specific micronutrient intakes is not always feasible and proxy indicators can be used.

v. For most micronutrients, the levels of nutrients contained in a single sachet of MNPs are unlikely to lead to excessive intakes even in the presence of high-dose vitamin A supplementation, salt iodization, and other types of food fortification.

vi. Where MNP are introduced, ensure an effective system to monitor actual use at household level and estimate specific micronutrient intakes. It is important to continue to monitor the situation, especially if there is a change in ration or situation such that populations become more reliant on fortified foods or there is a change in the type of food being provided within the ration.

vii. Where symptoms of excessive intakes are suspected, investigate possible sources of excess intake and take necessary steps to ensure intakes are reduced below upper tolerable limits.

More information can be found at:

http://www.hftag.org/assets/images/site/hftag/HF-TAG_Program-Brief-Dec-2011.pdf

http://www.sightandlife.org/fileadmin/data/Publications/SAL_Risk_benefit.pdf

GOOD TO KNOW!

Zinc Supplementation for Diarrhoea

The provision of zinc supplementation alongside ORS for treatment of diarrhoea in emergencies is not identified within the CCCs. This is however a crucial micronutrient intervention to be provided. During emergencies risk of diarrhoea is often exacerbated due to poor access to clean water, poor sanitation, overcrowded/inadequate living conditions, poor access to health care, poor food hygiene practices. Zinc supplementation in diarrhoea is a proven cost effective treatment that reduces length and severity of diarrhoea thereby preventing severe dehydration, malnutrition and death.

KEY ACTIONS:

Preparedness:

- Ensure zinc supplementation included in national protocols/guidance for the treatment of diarrhoea in line with international standards.
- Develop culturally appropriate and relevant printed materials to be given to caregivers alongside zinc/ORS supplementation
- Develop messages on zinc supplementation to be included in relevant BCC activities
- Include training on zinc supplementation within any capacity development on micronutrient interventions in emergencies
- Include zinc supplies within with contingency and procurement and distribution plans.

Response:

- Ensure zinc supplementation is provided as part of standard treatment for diarrhoea
- Ensure IEC materials/BCC is provided to caregivers - include messages on zinc in relevant BCC activities.
- Maintain adequate supplies of zinc to health facilities/ treatment centres

Early Recovery:

- Ensure national capacities for zinc supplementation are supported for sustained routine intervention.

UNICEF/WHO (2004) Joint statement on the clinical management of acute diarrhoea.

http://www.unicef.org/publications/files/ENAcute_Diarrhoea_reprint.pdf

WHO (2005) The treatment of diarrhoea. A manual for physicians:

http://apps.who.int/iris/bitstream/10665/43209/1/9241593180.pdf

7.1 Preparedness Actions

The focus of preparedness actions for micronutrients in emergencies is on strengthening existing systems and capacities to build a stronger national programme. The presence of a comprehensive, at-scale programme with established national guidance on the various micronutrient interventions, good partnerships and integrated activities with adequate numbers of trained and skilled health workers and community agents provides the foundation for addressing micronutrients in the event of an emergency. Developing a stronger programming in 'normal' times will help to improve the micronutrient status of the population, making them more resilient to the effects of the emergency.

Micronutrients should be included in a country's emergency preparedness and response plan as well as within UNICEF specific preparedness planning.

FROM THE CCC'S

CCC Preparedness Actions for Micronutrients in Emergencies:

Establish guidance on micronutrient supplementation and set up partnerships to implement emergency micronutrient activities.

Form a contingency plan and mechanism for procurement and distribution of all necessary supplies for emergency micronutrient interventions (vitamin A, iodised salt, multiple micronutrient supplements), including stockpiles or standby arrangements with providers of micronutrient supplements.

PREPAREDNESS ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
A. **Understand the existing context regarding micronutrients in country.** ▪ Review available secondary information on micronutrient status of the population in country: micronutrient surveys/assessments, DHS data, HMIS data, partner reports ▪ Undertake mapping of existing national programmes and capacities for micronutrient interventions to identify gaps and define opportunities for strengthening existing systems. ▪ Undertake analysis of specific risks and vulnerabilities of system and communities in relation to potential emergencies. ▪ Based on mapping, develop and implement a plan for strengthening existing capacity and programmes for micronutrients to build a strong programme foundation for emergency response.	**GNC IM TOOLKIT CAPACITY MAPPING TOOL:** http://nutritioncluster.net/topics/im-toolkit/ **UNICEF TECHNICAL NOTE: EMERGENCY RISK INFORMED SITUATIONAL ANALYSIS 2012:** http://www.unicefinemergencies.com/downloads/eresource/docs/KRR/Guidance%20Risk%20Informed%20SitAn%20FINAL.pdf **RISK ANALYSIS GUIDANCE** https://unicef.sharepoint.com/teams/Communities/RiskResilienceFragilityPeacebuilding/_layouts/15/WopiFrame.aspx?sourcedoc=%7B00D3F22D-8C59-43BF-9325-9334628CB0E6%7D&file=M2_GRIP_Risk%20analysis_23_May.docx&action=default **RISK INFORMED PROGRAMME GUIDANCE** https://unicef.sharepoint.com/teams/Communities/RiskResilienceFragilityPeacebuilding/_layouts/15/WopiFrame.aspx?sourcedoc=%7BD8ABC738-3172-4BF2-A397-809E7B089490%7D&file=M1_GRIP%20May%208.docx&action=default

PREPAREDNESS ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
B. **Work with all relevant stakeholders, to ensure national guidelines on the following micronutrient interventions, including in emergencies, are established and up to date with latest evidence and international standards and local context.** ○ *Vitamin A supplementation in children 6 to 59 months (in conjunction with measles vaccination)* ○ *MNPs for children 6 to 59 months* ○ *Iron folate supplementation in PLW/WRA* ○ *Multiple micronutrient supplements for PLW* ○ *Iodised salt* ○ *Zinc supplementation in diarrhoea* ○ *Deworming for children 12 to 59 months* ○ *Associated public health measures: immunisation, malaria prevention control and treatment* ▪ Establish if national guidelines exist through consultation with MoH and partners ▪ If guidelines do exist, review guidelines to establish if they are up to date with latest evidence/international standards and local context and include guidance for emergencies. ▪ If guidelines do not exist or require updating, ensure the overall process of developing/ updating guidelines is as inclusive and participatory as possible, with full engagement of national authorities, NGOs, UN. ▪ Use review/development process as an opportunity to build on and strengthen national capacity on routine and emergency micronutrient interventions and guideline development. ▪ Consider establishing a technical working group to review/develop guidelines with regular feedback to wider stakeholder group. Consider there may already be existing bodies/ coordination mechanisms from which this can evolve. e.g. National Micronutrient Control Committee ▪ Include guidance on how routine programming may need adaptation for potential emergency contexts e.g. age categories of beneficiaries, types of supplementation required ▪ Include guidance on different potential scenarios and take into account existing information on micronutrient status of the population, risks and vulnerabilities - see preparedness action A ▪ Ensure guidance includes the integration of micronutrient supplementation with other health interventions. Refer to Good to Know Box for explanation and opportunities for integration ▪ Consult national and local authorities, such as the MoH, on the acceptability of different products and approaches for a given setting. Some products may not be usable in countries where product approval and licensing has not taken place. ▪ In relation to above, specification for supplies should be reviewed to ensure in line with national standards for nutrition commodities.	**WHO NORMATIVE GUIDELINES FOR MICRONUTRIENTS CAN BE ACCESSED AT:** http://www.who.int/nutrition/publications/vitamins_minerals/en/ **HFTAG MNP PROGRAMMATIC BRIEF:** http://www.hftag.org/assets/images/site/hftag/HF-TAG_Program-Brief-Dec-2011.pdf
C. **Develop accompanying IEC materials, tools and job aids for the implementation of micronutrient interventions, in line with new/updated national guidelines** ▪ Develop and pilot accompanying IEC materials, tools and job aids related to implementation of guidelines and programme management, including agreed monitoring and reporting formats, supervision checklists, job aids. ▪ Ensure finalised IEC materials and tools are disseminated widely.	**FOR IEC MATERIALS:** **UNICEF BCC IN EMERGENCIES TOOLKIT ESPECIALLY CHAPTER 6 ON MEASLES & VITAMIN A:** http://www.unicef.org/ceecis/BCC_full_pdf.pdf

PREPAREDNESS ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
D. **Initiate training and sensitisation on new/updated guidelines and tools, within an overall approach to strengthening national capacity on micronutrients** ▪ Initiate orientation and sensitisation of all relevant partners on new/revised guidelines and associated materials. ▪ Conduct in-service trainings on updated guidelines and tools so relevant MoH staff at all levels are prepared and familiar, as part of wider capacity development strategy on micronutrient malnutrition and interventions.	**HTP MODULE 4 ON MICRONUTRIENT MALNUTRITION** **TRAINERS GUIDE:** http://files.ennonline.net/attachments/1953/HTP-module-4-trainers-guide.pdf **HTP MODULE 14 ON MICRONUTRIENT INTERVENTIONS** **TRAINERS GUIDE:** http://files.ennonline.net/attachments/2060/HTP-v2-module-14-trainers-guide.pdf
E. **Support the development of good partnerships for the implementation of micronutrient interventions within an overall approach of strengthening existing programme** ▪ Ensure partnerships are collaborative between government bodies, humanitarian agencies and communities. Being prepared with existing partnerships provides an extensive network from which to scale up coverage in response to sudden high demand for supplements in the event of the emergency. ▪ In particular, foster good partnerships between health and nutrition sectors as health system and structures at facility and community level provide key delivery platforms for routine and emergency micronutrient interventions. Public health interventions - immunisations, diarrhoea & malaria control and treatment - are also key interventions to protect micronutrient status ▪ Agree/clarify roles and responsibilities of partners across the various programme interventions (vitamin A, iron, iodine, zinc and MNPs, deworming and malaria prevention and treatment): logistics, distribution, awareness & social mobilisation campaigns, advocacy and education, monitoring and evaluation. ▪ Work in partnership with WFP or FAO or relevant Government body that will lead any food aid / GFD interventions, to calculate theoretical nutrient gaps according to different scenarios e.g affected population has no access to other foods so100% of nutrient requirement required, affected population has access to other foods, so 75% or 50% or 25% of needs required provided. Use available software e.g. NutVal, Nutrisurvey. ▪ In the absence of an existing programme, initiate preparatory work on providing MNPs in emergencies in line with WHO/WFP/UNICEF Joint Statement 2007. See Conceptual Framework in Good to Know Box. Follow detailed guidance and checklist on planning MNP interventions from HFTAG MNP toolkit. ▪ Specific partnerships, including public -private partnerships may be required to implement recycling and waste management from products e.g. UNICEF, GAIN and private companies.	**JOINT WHO/WFP/ UNICEF STATEMENT 2007: PREVENTING AND CONTROLLING MICRONUTRIENT DEFICIENCIES IN POPULATIONS AFFECTED BY EMERGENCIES** **NUTVAL CAN BE DOWNLOADED FREE OF CHARGE FROM** http://www.nutval.net/ **MNP TOOLKIT:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **MNP PROGRAMME PLANNING CHECKLIST:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **HF-TAG PLANNING FOR PROGRAM IMPLEMENTATION OF HOME FORTIFICATION WITH MNPS: A STEP BY STEP MANUAL. MAY 2015 AT:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

PREPAREDNESS ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
F. **Support the integration/addition of micronutrient indicators into the existing health reporting system** ▪ Engage all relevant stakeholders to achieve buy-in and reach consensus on integration/ addition of key micronutrient indicators, under the leadership of MOH. ▪ Define each indicator, its calculation, data collection methods/sources of data, frequency and timing of data collection and the target and quality control measures. ▪ Support the adaptation of tools, resources and training materials within the existing reporting system to include the agreed upon micronutrient indicators. ▪ Pilot the implementation of integrated indicators adapted system and refine tools as necessary. ▪ Train relevant MOH staff at all levels and roll out the integrated system. ▪ Maximise opportunities to strengthen national capacities on micronutrients and the health reporting system.	
G. **Provide necessary support to supply and logistics colleagues, (both UNICEF and government focal points, where relevant) to develop contingency plans and mechanisms for procurement and distribution of all necessary supplies for emergency micronutrient interventions,** building on & strengthening existing supply chain systems ▪ Use risk analysis tools to develop different scenarios for contingency planning - most likely, worst case, best case - and for each scenario, estimate expected caseloads for each micronutrient. ▪ For contingency planning estimates, link the contingency planning to country specific preparedness stocks in line with the country specific national micronutrient guidelines. ▪ Use the UNICEF Emergency supply calculator which includes formulas for the calculation of estimates for each micronutrient. ▪ Contingency plans should be reviewed annually. For procurement, consider the following: ○ *Consider all options for sourcing required supplies - local procurement, from partners, cross border, off shore procurement.* ○ *Bear in mind locally produced supplies may be cheaper but there may be quality control issues.* ○ *Vitamin A is considered an emergency supply item and if necessary can be shipped out within 24-48 hours, even air freighted.* ○ *Identify and strengthen import and quality control procedures.* ○ *Registration of MNPs should be in line with national policies - see MNP Policy and Classification checklist* When developing distribution strategies, consider the following: ○ *Distribution mechanisms need to account for local context and depend on ability reach the intended target group with the desired frequency, the capacity and motivation of personnel to implement, communicate and monitor the distribution, and the cost and sustainability.* ○ *Where possible, plan to use existing systems and work to strengthen these in preparation.* ○ *Consider stockpiling in specific areas, centrally or locally, depending on security and access, and transport infrastructure bearing in mind associated cost.* ○ *Ensure basic information on appropriate storage of micronutrients is widely disseminated. e.g. heat damage to micronutrients.*	**UNICEF TECHNICAL NOTE: EMERGENCY RISK INFORMED SITUATIONAL ANALYSIS 2012:** http://www.unicefinemergencies.com/downloads/eresource/docs/KRR/Guidance%20Risk%20Informed%20SitAn%20FINAL.pdf **UNICEF ESSENTIAL SUPPLY LIST FOR EMERGENCIES:** http://www.unicef.org/supply/files/Emergency_Supply_List.pdf **UNICEF EMERGENCY SUPPLY CALCULATOR:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **MNP POLICY AND CLASSIFICATION CHECKLIST, MNP TOOLKIT:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

GOOD TO KNOW!

Conceptual framework for improving the quality of complementary foods

The 'Conceptual framework for improving the quality of complementary foods' can support discussion and decision-making on the introduction of MNPs during the preparedness phase. The framework demonstrates how MNPs are indicated when foods with adequate macronutrients are available and accessible but foods with adequate micronutrients are not.

http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

7.2 Response Actions

Response actions are based on the need to prevent the development of micronutrient deficiencies in the affected population, through ensuring adequate intakes, health care and a healthy environment; and treat existing cases appropriately, while ensuring the balance with potential harmful effects of excessive intakes.

Although not mentioned specifically by CCCs, the implementation of any micronutrient response intervention should be based on an initial assessment of the current micronutrient situation of the population, including vulnerable groups. Guidance and actions should be informed by a contextual analysis of the situation, existing micronutrient situation of population and risks of deterioration according to quality of food intake and public health and hygiene situation. UNICEF should work in partnership with WFP or Government body leading general food distribution, on understanding the nutrient gap.

FROM THE CCC'S

CCC Response Actions for Micronutrients in Emergencies:

According to the context, ensure provision of high-dose vitamin A supplementation with vaccination for all children 6-59 months old and de-worm all children (12-59 months old) in collaboration with health sector workers.

Ensure that iodised salt is included in the emergency food basket. If this is not possible, and household consumption is less than 20 per cent, consider iodised oil supplement distribution for children 6-24 months old and women of child bearing age.

Ensure provision of multiple micronutrient preparations for children 6-59 months old - unless fortified complementary foods are provided - and multiple micronutrient supplements for pregnant or lactating women.

RESPONSE ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
H. **Assess how the emergency has affected systems and communities, and work in partnership with WFP/government so nutrient gap information is available and helps guide the design or modification of micronutrient interventions.** ▪ Assess how the emergency has affected communities access to an adequate diet. ▪ In collaboration with WFP/government body leading food distribution, understand the nutrient gap for specific target groups in the affected population and use information to guide decisions on design or modification of micronutrient interventions. In collaboration with WFP, if Blanket Supplementary Feeding Program (BSFP) is planned, coordinate coverage and timing in relation to ongoing or planned home fortification using micronutrient powder (MNP) or for children 6- 59 months to avoid overlaps ▪ If not done under Preparedness Action E, use available software for the calculation of theoretical nutrient content of food aid ration and likely nutrient intake based on different scenarios & accounting for contextual factors: e.g. NutVal, Nutrisurvey. ▪ If WFP is not present in country, consult with WFP technical resources at regional level and work with other partners with relevant expertise, in consultation with the government focal point.	**'FILL THE NUTRIENT GAP' TOOL** http://documents.wfp.org/stellent/groups/public/documents/communications/wfp288102.pdf **NUTVAL CAN BE DOWNLOADED FREE OF CHARGE FROM** http://www.nutval.net/

RESPONSE ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
I. **Work closely with health colleagues to ensure integration of micronutrient interventions within health response actions and the provision of associated public health measures, building on & strengthening national capacities.** ▪ Assess & understand how the emergency has affected pre-existing delivery platforms for routine micronutrient interventions. ▪ Use existing government and community systems and structures where possible rather than parallel programmes to deliver micronutrient activities through the health response.	
J. **Establish if the context meets the criteria for high dose vitamin A supplementation and if so, support implementation together with deworming, in collaboration with health workers.** High dose Vitamin A Supplementation is indicated if: ○ *The population affected originates from an area that is known or presumed to be deficient in vitamin A.* ○ *Vitamin A supplementation programmes were being implemented pre emergency.* ○ *Clinical signs of vitamin A deficiency (night blindness, Bitot's spots, corneal scarring) were present in the population in pre-emergency population surveys* ○ *Malnutrition and/or diarrhoeal diseases are currently prevalent.* ○ *Measles has been identified in epidemic proportions.* ○ *High under-five mortality.* ▪ Although WHO guidelines stipulate that children known to have received a vitamin A supplement in the past 30 days should not receive additional vitamin A, in emergency campaigns it is often impossible to verify this. Vitamin A should therefore be given to all children receiving measles vaccine, even if their vitamin A status is unknown. ▪ Consider there may be specific contexts where vitamin A supplementation is indicated in different age/vulnerable groups e.g. measles outbreak affecting older age groups, adolescents and adults ▪ Support delivery of de-worming in conjunction VAS as vitamin A deficient children usually have worms. De-worming is indicated in all at-risk groups living in endemic areas. ▪ Build on existing delivery systems where possible, strengthening national capacity in the process.	**VITAMIN A GUIDELINES:** http://www.who.int/nutrition/publications/micronutrients/guidelines/vas_6to59_months/en/ **WHO GUIDELINE VITAMIN A SUPPLEMENTATION IN PREGNANCY 2011** http://nutritioncluster.net/wp-content/uploads/sites/4/2013/12/VitA-suppl-pregnant-wom_eng.pdf **HOW TO ADD DE-WORMING TO VITAMIN A DISTRIBUTION WHO/UNICEF 2004:** http://nutritioncluster.net/wp-content/uploads/sites/4/2013/12/WHO_CDS_CPE_PVC_2004.11.pdf
K. **Where a measles campaign is being implemented, work with health colleagues to ensure Vitamin A distribution accompanies measles vaccination in children 6 to 59 months,** as standard practice to prevent night blindness and reduce measles related and diarrhoea mortality. ▪ If not already done, carry out preparedness action C on developing appropriate IEC materials for mass campaign. ▪ Work with health sector colleagues to ensure messages on Vitamin A are included within any public awareness campaign on measles vaccination. ▪ Target mothers as primary care givers and make effort to reach vulnerable and hard to reach. ▪ Oral vitamin A should be given at the time the child vaccinated against measles.	**REDUCING MEASLES MORTALITY IN EMERGENCIES JOINT STATEMENT WHO UNICEF 2002** http://www.unicef.org/publications/index_19531.html **UNICEF BCC IN EMERGENCIES TOOLKIT FROM CHAPTER 6 ON MEASLES & VITAMIN A:** http://www.unicef.org/ceecis/BCC_full_pdf.pdf

RESPONSE ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
L. **Support WFP/Government to provide iodised salt in the emergency food ration. If not possible, and household consumption is less than 20%, consider iodised oil supplement distribution to defined target groups.** ▪ Verify the salt provided in emergency food ration is iodised. Packages should clearly state the salt has been iodised. Salt may be tested with rapid test kits, available to country offices by direct order. ▪ If salt is not iodised, make arrangements with the WFP/Government for it to be replaced with iodised salt. ▪ If it is not possible to provide iodised salt, consider iodised oil supplementation in line with WHO/UNICEF Guidance 2006, and in consultation with HQ or RO. ▪ Where iodised salt is provided, assess household access to iodised salt vs. theoretical ration. If sustained pipeline or distribution problems result in less than 20% households have access to iodised salt, consider iodised oil supplementation as above.	**PREVENTING AND CONTROLLING MICRONUTRIENT DEFICIENCIES IN POPULATIONS AFFECTED BY AN EMERGENCY:** http://www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf http://www.who.int/nutrition/publications/micronutrients/WHOStatement__IDD_pregnancy.pdf?ua=
M. **In line with WHO/WFP/UNICEF Joint Statement 2007, ensure provision of multiple micronutrient preparations/supplements to children 6 to 59 months and PLW, according to context.** ▪ Based on response action A, using nutrient gap information, make an informed decision whether to provide MNPs - see Good to Know box ▪ If MNPs are to be provided, build on preparedness actions E. Follow detailed guidance and resources on planning and implementation available in the MNP Toolkit. ▪ If cost/resources are a limiting factor, delivery of MNPs to 6 to 23 months age group should be prioritised over older age group. ▪ Continue delivery of MNPs until emergency phase is over and adequate access to micronutrient rich foods is achieved. In many cases, there may be need for continuation. **In case BSFP is planned, phase out MNP temporarily in those specific locations.** ▪ Pregnant and lactating women should be given MMNs providing one RNI of micronutrients daily, whether they receive fortified rations or not. Iron and folic acid supplements, when already provided, should be continued. MMNs recommended even in the presence of fortified food and IFA which should be continued. ▪ Where possible, integrate delivery of MMNs within existing ante and post - natal care services. ▪ Work with Supplies team to ensure adequate supplies of multiple micronutrient preparations are available and distributed. ▪ Ensure adequate monitoring to assess coverage and adherence and evaluation. To the extent possible, programmes should use and build on the monitoring systems that are already in place, strengthening national capacity to deliver. ▪ Ensure good advocacy and communications activities are implemented alongside multiple micronutrient programmes. They are essential to good coverage and effective uptake.	**PREVENTING AND CONTROLLING MICRONUTRIENT DEFICIENCIES IN POPULATIONS AFFECTED BY AN EMERGENCY:** http://www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf **WHEN DECIDING ON MNP, EXTENSIVE RESOURCES CAN BE FOUND IN MNP TOOLKIT, INCLUDING CHECKLISTS AND TOOLS AT:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **MNP PROGRAMME PLANNING CHECKLIST:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **HF-TAG PLANNING FOR PROGRAM IMPLEMENTATION OF HOME FORTIFICATION WITH MNPS: A STEP BY STEP MANUAL. MAY 2015 AT:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit **WHO GUIDELINE 2012 DAILY IRON & FOLIC ACID SUPPLEMENTATION IN PREGNANT WOMEN:** http://apps.who.int/iris/bitstream/10665/77770/1/9789241501996_eng.pdf

RESPONSE ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
N. **Ensure reporting and surveillance systems include indicators for essential micronutrients services during the response** ▪ Identify which indicators to be included according to micronutrient services being provided. ▪ Define each indicator, its calculation, data collection methods/sources of data, frequency and timing of data collection and the target, analysis, feedback and quality control measures. ▪ Support the inclusion of indicators into tools, resources and training materials of reporting & surveillance system and the training of relevant staff.	

GOOD TO KNOW!

Additional information to guide decision-making on starting MNPs in emergencies.

When taking the decision whether to start MNPs also consider the following caveats:

- If fortified complementary foods being provided, consider the effectiveness of the programme, including quantities provided, the target age group (blanket? 6 to 23 months only?) and sharing of ration within household may affect actual intake. MNPs may still be appropriate if fortified complementary foods are not effective and being shared between whole family.
- Balance above against whether there is a risk of exceeding the intakes of any micronutrients if MNPs are introduced.
- MNPs are still safe in the context of biannual vitamin A supplementation and when iodised salt is provided in the general food ration.
- If national guidelines on MNPs already exist, the dosage stated may not be appropriate if emergency affected population are receiving fortified general food ration for example.
- MNPs should not be distributed without the needed BCC on its use and importance. Advocacy and communications are essential to the uptake and use of MNPs http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit
- In malaria endemic areas, ensure provision of MNPs to children is in line with latest guidance and recommendations and supplementation is accompanied by measures to prevent, diagnose and treat malaria.
- Combining it with other specially formulated products, such as RUTF (ready-to-use therapeutic food) for treatment of SAM (severe acute malnutrition), RUSF (ready-to-use supplementary food) or fortified blended foods such as WSB++ (wheat-soy blend) or CSB++ (corn-soy blend) for treatment of MAM (moderate acute malnutrition), or small-quantity LNS (lipid-based nutrient supplement, ≤= 20 g/d, providing ≤=120 kcal/d) is not appropriate, because those products already contain a similar or higher amount of micronutrients. In this case, one can recommend keeping the MNP for later, when the other products are no longer used (2011, HFTAG Programmatic Guidance)

7.3 Early Recovery Actions

Early recovery actions are focused on ensuring the gains of the emergency response are translated into longer-term actions for the sustainable prevention and control of micronutrient deficiencies.

FROM THE CCC'S

CCC Early Recovery Actions for Micronutrients in Emergencies:

Ensure that micronutrient activities build on and support existing national capacities, and initiate discussion of long-term strategies to provide micronutrients and potentially incorporate new approaches introduced during the emergency.

EARLY RECOVERY ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
O. **Ensure early recovery actions focus on development and strengthening of national capacities to implement micronutrient programmes** in line with context and latest international guidance. ▪ If not already on board, involve existing bodies on micronutrients e.g. National Micronutrient Council ▪ Restore delivery of routine programmes but use opportunity to improve the integration of micronutrient supplementation into regular health services e.g. vitamin A, zinc supplementation in treatment of diarrhoea and de-worming. See Good to Know Box on Integration ▪ Maintain BCC activities to increase communities' awareness and understanding of micronutrient deficiencies and interventions.	**UNICEF BRIEF ON INTEGRATION OF NUTRITION & PUBLIC HEALTH INTERVENTIONS:** http://www.unicef.org/eapro/Brief_HealthNutrition.pdf **UNICEF BCC IN EMERGENCIES TOOLKIT:** http://www.unicef.org/ceecis/BCC_full_pdf.pdf
P. **Initiate discussions on establishing/strengthening national food fortification and salt iodisation programmes** ▪ Where there are existing food fortification and salt iodization programmes, assess effectiveness and provide support to strengthening as necessary. ▪ If no existing food fortification and salt iodization programmes, begin process of advocating for and supporting their adoption and implementation. ▪ In advocacy, aim for engaging strategic, executive level national support - Office of President or Prime Minister - to enhance momentum on adoption of national micronutrient programmes. ▪ Link with SUN Initiatives and/or 1000 Day advocacy efforts to ensure micronutrient interventions are part of broader agenda to address undernutrition in country and don't remain standalone interventions.	**EXAMPLE OF UNICEF GUIDANCE ON SALT IODISATION FROM SOUTH ASIA AT:** http://www.unicef.org/rosa/Iodine.pdf
Q. **Where MNPs have been introduced during the emergency, initiate dialogue with relevant national partners on adoption/scale up as a routine programme.** ▪ Refer to HFTAG resources for guidance on engaging stakeholders. ▪ Aim to include MNPs within national IYCF strategies and ECD programmes as they should be part of wider programme to prevent micronutrient deficiencies not a parallel programme ▪ Consult the HFTAG MNP Toolkit Programme Planning Guidance and Checklist for detailed guide to the steps and processes. ▪ Consider initial pilot programme, sub national or use experience in emergency to advocate for introduction/continuation, including pilot monitoring system to demonstrate impact.	**ENGAGING STAKEHOLDERS** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

EARLY RECOVERY ACTIONS FOR MICRONUTRIENTS IN EMERGENCIES	EXAMPLES/RESOURCES
R. **Where MMNs for pregnant women have been introduced during the emergency, and multiple micronutrient deficiencies are known to be a persistent problem, initiate dialogue on possible replacement of routine iron folate supplementation programmes for PLW.** ▪ Initiate discussion with relevant stakeholders on incorporation/replacement of routine iron folate supplementation programme with MMNS based on experience during emergency. ▪ Refer to HFTAG resources for guidance on engaging stakeholders, as also relevant to MMNs. ▪ Use latest evidence to strengthen advocacy efforts.	http://www.hftag.org/page.asp?s=hftag&content_id=33988 **LATEST EVIDENCE AVAILABLE AT:** http://www.who.int/elena/titles/micronutrients_pregnancy/en/ **WHO RECOMMENDATIONS ON ANTENATAL CARE FOR A POSITIVE PREGNANCY EXPERIENCE** http://www.who.int/nutrition/publications/guidelines/antenatalcare-pregnancy-positive-experience/en/

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GOOD TO KNOW!

Importance of integration of micronutrient supplementation into other health services

In general, the benefits of integrated models of service delivery include: improved quality of care and clinical outcomes, improved patient satisfaction and better targeting of resources. Integration of services provides a more holistic package of care to an individual. Micronutrient deficiencies often coexist with other forms of malnutrition e.g. stunting or wasting. Furthermore, micronutrient supplementation is not a stand-alone approach to the prevention and control of micronutrient deficiencies needs to be delivered in conjunction with other approaches including public health interventions to be effective. E.g zinc with ORS, vitamin A and measles immunisation and deworming, Iron supplementation and malaria control.

The downside to integration is health professionals can become overloaded, demotivated and can lack certain required specialist skills, leading to poor quality of services and poor outcomes, but bearing this in mind, integration should still be prioritised during preparedness and early recovery actions. Integration may not always be appropriate or feasible in certain humanitarian contexts.

Opportunities for integrating micronutrient interventions into other health services

CHILD HEALTH DAYS

- Twice-yearly vitamin A supplementation to children 6 to 59 months
- Twice-yearly deworming to children
- Childhood Immunisations

ROUTINE HEALTH SERVICE CONTACTS

- Counselling on optimal infant young child and maternal nutrition & good hygiene practices
- Treat malaria, pneumonia and other illness
- Therapeutic zinc for diarrhoeal disease management

SICK/WELL CHILD HEALTH CONTACTS

Risk analysis guidance

- Deliver/encourage full course childhood immunisations
- Treat malaria and other illnesses
- Deliver vitamin A supplements and deworming to children
- Provide therapeutic zinc for diarrhoeal disease management
- Counselling on optimal infant young child and maternal nutrition & good hygiene practices

ANTENATAL CARE (ANC) CONTACTS

- Deworming after first trimester
- Iron folate or Multiple Micronutrient supplements for pregnant women
- Counselling for optimal maternal nutrition and early initiation & exclusive breastfeeding to 6 mths

DELIVERY CARE

- Delayed cord clamping to improve infant's iron stores
- Promotion of early initiation & exclusive breastfeeding to 6 months

POSTNATAL CARE (PNC) CONTACT

- Iron folate supplements to lactating women
- Counselling on exclusive breastfeeding for 1st six months & optimal complementary feeding
- Continued feeding during illness and catch up feeding after
- Promotion of good hygiene practices, including hand washing with soap

COMMUNITY OUTREACH

- Community mobilisation on good nutrition and treating malnutrition
- Promotion and counselling for optimal maternal, infant and young child feeding
- Identification and referral of cases of diarrhoea, fever and respiratory tract infections
- Promotion of good hygiene practices, including hand washing with soap

KEY RESOURCES FOR MICRONUTRIENT PROGRAMMING

PREVENTING AND CONTROLLING MICRONUTRIENT DEFICIENCIES IN POPULATIONS AFFECTED BY AN EMERGENCY:
http://www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf

VITAMIN A GUIDELINES:
http://www.who.int/nutrition/publications/micronutrients/guidelines/vas_6to59_months/en/

HTP MODULE 4 ON MICRONUTRIENT MALNUTRITION:
http://www.ennonline.net/htpv2module4

HTP MODULE 14 ON MICRONUTRIENT INTERVENTIONS IN EMERGENCIES:
http://www.ennonline.net/htpv2module14

UNICEF E-LEARNING NUTRITION IN EMERGENCIES TRAINING RESOURCE, SECTION 4:
https://www.unicef.org/nutrition/training/list.html

WHEN DECIDING ON MNP, EXTENSIVE RESOURCES CAN BE FOUND IN MNP TOOLKIT, INCLUDING CHECKLISTS AND TOOLS AT:
http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

ONCE DECISION MADE TO IMPLEMENT AN MNP PROGRAMME, USE THE MNP PROGRAMME PLANNING CHECKLIST:
http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

HF-TAG PLANNING FOR PROGRAM IMPLEMENTATION OF HOME FORTIFICATION WITH MNPS: A STEP BY STEP MANUAL. MAY 2015 AT:
http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

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Communication

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Nutrition Commitment 6:

Children and women access relevant information about nutrition programme activities.

Benchmark 6:

Communication activities providing information on nutrition services (including how and where to access them) and entitlements are conducted in all emergency-affected areas.

Effective communication is an integral part of preparing and responding to emergencies. It allows 'individuals or an entire community to make the best possible decisions about their well-being' in a timely manner, while helping 'people accept the imperfect nature of choices during the crisis'. Emergencies disrupt normal services and normal day to day life. Affected communities need information to understand what they can access, where. Communication is also essential to support communities in adopting appropriate behaviours prior to, during and following emergencies and to help them cope with unfamiliar situations.

In particular, nutrition communication in emergencies may have the following purposes:

- Familiarisation with the use of new products or services
- Promotion of good and avoidance of undesirable behaviour
- Community sensitisation and investigating barriers to service uptake
- Advocacy to influence policies, practices and behaviours that safeguard and improve the nutrition of communities affected by emergencies.

Examples of each of these are given in Good to Know Box.

UNICEF takes a leading role in communication efforts. It uses the power of communication to promote child survival, development, protection and participation. Working in partnership with national governments, civil society organizations and development agencies, UNICEF engages in a mix of three communication approaches: social mobilization, advocacy and behaviour and social change.

The following chapter provides guidance on the key actions that should be taken to ensure that UNICEF is able to fulfil its commitments on nutrition communications in preparedness and response to emergencies and in the early recovery phase. Checklist 6 provides and overview of how those suggested key actions directly contribute to fulfilling UNICEF's commitments. Whilst actions are presented as discrete in this chapter, there is obvious overlap and linkages to actions described in specific nutrition programme chapters, in particular, IYCF-E, management of acute malnutrition and micronutrients, where communication strategies are integral to supporting the implementation of effective programming. Following Checklist 6 there are three distinct sub-chapters on preparedness, response and early recovery going into more detailed descriptions of the essential actions.

GOOD TO KNOW!

Examples of how Communication is essential for Nutrition in Emergencies

Familiarisation with the use of new products or services.

- In many emergency settings, new resources are introduced e.g a new type of food, RUTF, MNPs, extended service delivery platforms.
- The acceptability of a new resource in an emergency setting depends on several factors including its quality, status and similarity to known resources.
- Information about new resources is as important as the resource itself as without appropriate and well-communicated information, the resource may be misused or it may not be utilised at all.

Promotion of good and avoidance of undesirable behaviour.

- Promotes recommended feeding and care practices e.g exclusive breastfeeding
- Aims at avoiding the use of bottle feeding where possible and appropriate
- Aims at protecting positive behaviours: breastfeeding is sometimes disrupted in emergencies because of misconceptions that in emergencies mothers can no longer breast feed adequately due to stress or inadequate nutrition.
- Promotes the consumption of specific food or supplement to prevent micronutrient deficiencies.

Community sensitisation and investigating barriers to service uptake

- Nutrition communication can be used to enhance the effectiveness of a programme by increasing programme uptake and promoting the appropriate use of nutrition services and products.
- To enhance the nutritional benefit of cash distribution, a campaign may include key messages on the cultivation of fresh fruit and vegetables, the consumption of micronutrient-fortified foods or the purchase of micronutrient-rich foods from local markets
- Also used for increasing coverage of CMAM programmes through the investigation of barriers to uptake of services.

Advocacy to safeguard and improve nutrition of individuals and communities

- Advocacy to decision-makers for the introduction of MNPs where emergency context indicates.
- Advocacy to donors for additional resources to scale up services for management of SAM where caseloads are increasing and children's lives are at risk.
- High level advocacy to government on International Code of Marketing of Breastmilk Substitutes in emergency situations where donations of infant formula are a problem.
- Advocacy to community leaders to support the protection and promotion of appropriate breastfeeding practices within their communities.

Adapted from HTP Module 19. Working with Communitiesv

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CHECKLIST 6 Essential actions for nutrition communications

PREPAREDNESS FOR NUTRITION COMMUNICATIONS		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR PREPAREDNESS FOR COMMUNICATIONS**	
	Map community capacities and existing communication channels to identify the most effective ones for nutrition information	Draft appropriate nutrition messages to be incorporated into multi-sectoral communication initiatives
Form a nutrition communications task force or working group if not already established, and establish links with multi-sector communication platforms		✓
Understand the context: the key behaviours, risks, hazards and vulnerabilities to identify needs that will shape communication needs and channels in the event of an emergency	✓	
Engage with communities in planning and preparing for nutrition communication in emergencies, mapping existing capacities and communication channels	✓	
Develop and pre-test generic nutrition messages based on contextual analysis so critical information can be released quickly		✓
Strengthen the capacity of service providers and communities to engage in nutrition communication activities	✓	
Establish agreements with key partners to support community-based communications activities to facilitate going to scale rapidly in the event of an emergency	✓	✓
Support advocacy efforts at national, sub-national and local level to influence policies, practices and behaviours that safeguard and improve the nutrition of communities prior to an emergency	✓	✓

RESPONSE FOR NUTRITION COMMUNICATION		
ESSENTIAL ACTIONS	**UNICEF CCCS FOR RESPONSE FOR COMMUNICATION**	
	Consult with the community for development and implementation of the programme	Include relevant and evidence-based nutrition messages in all programme communication activities
Work closely with other sections within UNICEF and partners to ensure adequate nutrition participation in multi-sector communication activities		✓
Conduct Rapid Situational Analysis of how emergency has impacted on communities and communication channels	✓	
Develop a detailed communications strategy/plan in consultation with affected community, if not already done	✓	
Continue to engage with communities in the planning, design, implementation and monitoring of communication activities	✓	
Develop evidence based nutrition messages in consultation with & relevant to issues/needs of the affected community	✓	✓
Communicate priority messages to affected community through identified trusted communication channel	✓	✓
Develop a simple M&E plan, according to specific objectives of nutrition communications strategy/plan	✓	✓
Review and reassess communication strategy, messages and channels as emergency evolves	✓	✓
Support advocacy for mobilisation of sufficient resources and appropriate enabling environment for an effective emergency nutrition response	✓	✓

EARLY RECOVERY FOR NUTRITION COMMUNICATIONS	
ESSENTIAL ACTIONS	**UNICEF CCCS FOR EARLY RECOVERY FOR COMMUNICATIONS**
	Adapt the communications strategy for nutrition activities for routine use in health facilities and outreach services and consolidate such activities to increase coverage and respond to changing situations
Adapt communications strategy and messages for routine use in health facilities and outreach services and identify opportunities for integration with other sectors	✓
Continue Community Engagement activities to understand barriers to uptake of services and behaviour change	✓
Where new approaches have been introduced during the emergency, advocate for their adoption and integration into routine services	✓

8.1 Preparedness Actions

FROM THE CCC'S

Preparedness Actions for Nutrition Communication:

Map community capacities and existing communication channels to identify the most effective ones for nutrition information, and draft appropriate nutrition messages to be incorporated into multi-sectoral communication initiatives

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The key focus of preparedness actions for nutrition communication is to have a strong existing communications plan/strategy in place to form the foundation from which to act in response to an emergency. Pre-identified communication channels, pre developed and tested nutrition messages, established partners and trained, skilled community agents, a good existing engagement with communities and understanding of their behaviours and vulnerabilities all contribute to being in a stronger position communicate effectively and quickly in the event of an emergency. If the community is already aware and engaged, they are more resilient to the effects of emergency.

PREPAREDNESS ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
A. **Form a Nutrition Communications Task Force or Working Group, if not already established and establish links with multi sector communication platforms** ▪ Involve key stakeholders from government, UN agencies, NGOs and humanitarian agencies. ▪ Develop TORs for the group and define what kinds of communication support and resources the team will need. ▪ Work closely with other sections within government, UNICEF and partners to ensure adequate nutrition engagement in multi-sector communication initiatives, including advocacy efforts. ▪ Support working group to prepare a communications plan/strategy - follow steps 1 - 7 BCC Toolkit page 35. ▪ If available, use existing C4D strategy/plan to inform the preparation of nutrition communication actions for emergencies	**BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES TOOLKIT UNICEF 2005: STEPS 1 -7 PAGE 35** https://www.unicef.org/ceecis/BCC_full_pdf.pdf **MNP BEHAVIOUR CHANGE INTERVENTIONS CHECKLIST:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit

PREPAREDNESS ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
B. **Understand the context and the community: the key behaviours, risks, hazards and vulnerabilities that will shape communication needs and channels in the event of an emergency.** ▪ Use available information from existing C4D activities e.g. KAP surveys, other sectors e.g. health, WASH, and previous emergencies to understand what will be the key information needs. ▪ Use available communications data collection and survey tools to support collection of relevant information. ▪ Collaborate with initiatives with other sectors. ▪ Use information gathering as entry point to engaging with communities (see Preparedness action C).	**DATA COLLECTION AND ANALYSIS CHECKLIST:** https://www.unicef.org/cbsc/index_44255.html **CHAT SURVEY TOOL: COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015** http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf
C. **Engage with communities in planning and preparing for nutrition communication in emergencies, mapping existing capacities and communication channels.** ▪ Use Community Enquiry or CHAT Survey Tool as methods of framing community engagement and to map community capacities and existing communication channels. ▪ When identifying existing channels of communication, recognise how these may be for different target groups. ▪ Ensure community engagement extends widely across the community and includes not only community leaders, religious leaders, existing women's and youth groups, schools but extends also to vulnerable, hard to reach groups who often have the greatest needs.	**FOR COMMUNITY ENQUIRY SEE ANNEX B (PAGE 78) UNICEF PROGRAMME GUIDANCE ON MANAGEMENT OF SAM** **AND MODULE 3 FANTA/VALID/UNICEF CMAM TRAINING MODULES FOR METHODS: FANTA, ET AL., 2008, 'COMMUNITY OUTREACH TRAINING MANUAL. MODULE 3',** http://www.severemalnutrition.org/en/resource-library/Ge **COMMUNITY ENGAGEMENT FOR CMAM:** http://www.severemalnutrition.org/
D. **Develop generic nutrition messages in consultation with the community & based on contextual analysis (B) so critical information can be released quickly.** ▪ Develop pre-prepared generic messages for nutrition information, using available guidance and information from Preparedness action B ▪ Ensure messages are targeted to specific intended groups. ▪ Messages can include awareness raising of issue or nutrition service or reinforcement of existing knowledge & practices. Examples include breastfeeding promotion, mass vitamin A supplementation, sensitisation on services for acute malnutrition. ▪ Base messages on relevant materials from existing C4D activities, where appropriate. ▪ Pre-test messages for their relevance, comprehension, appeal, acceptance and involvement - see CHAT guidance page 55 ▪ Have generic messages pre-prepared as downloadable files ready for printing. ▪ Disseminate widely and ensure harmonisation of messages across partners - consistency is key.	**CREATING A MESSAGE BRIEF PAGE 32: A GLOBAL COMMUNICATION FOR DEVELOPMENT STRATEGY GUIDE FOR MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION PROGRAMMES UNICEF 2015** https://www.unicef.org/cbsc/ **COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015** http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf **CHAPTER 8 PARTICIPANT GROUPS AND MESSAGES: TIPS FOR DEVELOPING MESSAGES -FIGURE 3 PAGE 54** **AND** **PRETESTING MESSAGES STEPS 1- 8 PAGE 55**

PREPAREDNESS ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
E. **Strengthen capacity of service providers and communities to engage in communications activities** ▪ Prepare a training package for health workers and community agents on interpersonal communication skills - how to engage, inform, motivate, encourage people affected by emergencies. ▪ Include training on key nutrition messages and where appropriate rapid MUAC screening. ▪ Support implementation of training package in high risk locations. ▪ Strengthen existing outreach networks through training and supportive supervision.	
F. **Establish agreements with key partners to deliver community based communication activities to facilitate going to scale rapidly in the event of emergency.** ▪ Develop communication protocol and partnerships that will collaborate in communication efforts ▪ Agree with key partners and have a plan which outlines how communication efforts will be coordinated, how information will be managed and consistency of information being provided ▪ Consider partnerships with local media, NGOS with strong communications expertise, mobile phone companies etc.	
G. **Support advocacy efforts at national, sub-national and local level to influence policies, practices and behaviours that safeguard and improve the nutrition of communities prior to an emergency.** ▪ Identify and prioritise the key issues/policies/practices/behaviours where advocacy will strength preparedness for nutrition in the event of an emergency. ▪ Work with existing platforms and partnerships (e.g SUN, REACH) to create synergies and strengthen efforts. ▪ Working in partnership, develop an advocacy strategy for the prioritised issues. Step by step guidance can be found in the Nutrition Cluster Advocacy Toolkit from page 11 onwards	**NUTRITION CLUSTER ADVOCACY TOOLKIT 2016** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/03/Nutrition-Cluster-toolkit-low-res.pdf

8.2 Response Actions

Response actions build on communication plans/strategies developed in the preparedness phase. Response actions should be grounded in the reality of the emergency and how it has affected the community and communication channels. Communication response actions should be designed to support the effectiveness of the overall humanitarian response. Through community engagement, nutrition communication provides the framework to meet responsibilities on accountability to affected populations across nutrition programmes. Advocacy efforts should focus on mobilising sufficient resources and an appropriate enabling environment to protect and improve the nutrition of communities affected. Depending on the context, there may be need to advocate for particular underfunded interventions e.g. IYCF-E, micronutrients or specific neglected groups e.g older people.

FROM THE CCC'S

Response Actions for Nutrition Communication:

Consult with the community for development and implementation of programme communication, and include relevant and evidence-based nutrition messages in all programme communication activities.

RESPONSE ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
H. **Work closely with other sections within UNICEF and government and other key partners to ensure adequate nutrition participation in multi-sectoral communication & advocacy initiatives.** ▪ Build on links established under preparedness action A.	
I. **Conduct rapid situational analysis of how emergency has impacted on communities and communication channels** ▪ Work closely with other sectors/clusters and partners to gather information. ▪ Use analysis to determine priority nutrition information needs and available communication channels.	**COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015 PAGE 17** http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf
J. **If not undertaken in preparedness action A, develop detailed communication plan/strategy.** ▪ Follow guidance in BCC in Emergencies Toolkit and/or Strategic Design Checklist. ▪ Where a communication plan has been pre-prepared, review and tailor it to the particular needs of the actual emergency.	**BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES TOOLKIT UNICEF 2005: STEPS 1 -7 PAGE 35** https://www.unicef.org/ceecis/BCC_full_pdf.pdf **STRATEGIC DESIGN CHECKLIST AT** https://www.unicef.org/cbsc/index_44255.html **MNP BEHAVIOUR CHANGE INTERVENTIONS CHECKLIST:** http://www.hftag.org/downloads.asp?s=hftag&c=Toolkit
K. **If not undertaken in preparedness action C, engage with communities in planning design, implementation and monitoring of nutrition communications.** ▪ Where engagement activities already undertaken, build on lines of engagement and strengthen to adapt to the specific context of the emergency and response actions needed ▪ Ensure Community Engagement supports meeting commitments on Accountability to Affected Populations across nutrition interventions.	**NUTRITION CLUSTER FRAMEWORK:** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/01/Nutrition-Cluster-Framework_AAP_WEB.pdf
L. **If not undertaken in preparedness action D, develop evidence based nutrition messages relevant to issues/needs of affected communities.** ▪ Where nutrition messages pre-prepared, review and tailor to particular needs of actual emergency, targeting specific at risk or relevant groups. ▪ Messages required may be to provide information on the implementation of specific activities e.g. sensitisation on mass vitamin A supplementation, or awareness raising on availability of new services e.g. OTP, or promotion of specific behaviours e.g. breastfeeding. ▪ Ensure to pre-test messages for their relevance, comprehension, appeal, acceptance and involvement.	**CREATING A MESSAGE BRIEF PAGE 32:** **A GLOBAL COMMUNICATION FOR DEVELOPMENT STRATEGY GUIDE FOR MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION PROGRAMMES UNICEF 2015** https://www.unicef.org/cbsc/index_65738.html **COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015** http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf **CHAPTER 8 PARTICIPANT GROUPS AND MESSAGES: TIPS FOR DEVELOPING MESSAGES -FIGURE 3 PAGE 54 AND** **PRETESTING MESSAGES STEPS 1- 8 PAGE 55**

RESPONSE ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
M. **Communicate priority messages to the affected communities using identified trusted communication channels and ensure a feedback mechanism for two-way dialogue** ▪ Where possible, build on and strengthen capacities of existing channels of communication and programme activities. ▪ Where appropriate include nutrition messages in multi-sectoral communication initiatives. ▪ Always use multiple communication channels to reinforce messages see Good to Know Box on different communication options. ▪ Ensure communications are delivered in a timely manner to maximise effectiveness e.g. sensitisation regarding mass Vitamin A campaign on a particular day.	**COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015** http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf **A GLOBAL COMMUNICATION FOR DEVELOPMENT STRATEGY GUIDE FOR MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION PROGRAMMES UNICEF 2015 PAGE 28** https://www.unicef.org/cbsc/index_65738.html
N. **Develop a simple M&E plan according to specific objectives of nutrition communication strategy/plan.** ▪ Monitor communication activities to understand if they are being effective i.e. are increasing awareness or changing behaviours or improving uptake of services and modify communication activities accordingly. ▪ Ideally use community monitoring systems among affected population groups. ▪ Programme and service delivery data can also be used to inform necessary modifications to communication activities and messages e.g. poor attendance at OTP could indicate need for increased community sensitisation of the service. ▪ Use monitoring information to revise communication activities appropriately, in consultation with the community.	**COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT (CHAT) UNICEF 2015 STEP 2F PAGE 23** http://www.adelaide.edu.au/accru/projects/effectivecomms/ **NUTRITION CLUSTER FRAMEWORK: ACCOUNTABILITY TO AFFECTED POPULATIONS: PAGES 12-15** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/01/Nutrition-Cluster-Framework_AAP_WEB.pdf
O. **Review and reassess appropriateness of communications strategy, messages and channels as the emergency progresses** ▪ Continue communication activities for some time after emergency is over and communities begin to recover. ▪ Revise nutrition messages and channels of delivery and activities according to the evolution of the emergency and recovery. Information needs will change to more development focused issues. ▪ Ensure feedback from communities is taken into account when making revisions.	
P. **Support advocacy for mobilisation of sufficient resources and appropriate enabling environment for an effective emergency nutrition response** ▪ Support Nutrition Cluster partners in identifying key issues and needs and providing the evidence-base for advocacy efforts. ▪ Refer to the Nutrition Cluster Advocacy Toolkit for detailed guidance on specific approaches and activities that can be undertaken to strengthen advocacy on a particular issue.	**NUTRITION CLUSTER ADVOCACY TOOLKIT 2016** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/03/Nutrition-Cluster-toolkit-low-res.pdf **NUTRITION CLUSTER ADVOCACY FRAMEWORK 2016:** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/02/Nutrition-Cluster-Final-Advocacy-Framework-v2.pdf

GOOD TO KNOW!

Options for communication in nutrition emergency responses

Remember, emergency communication is most effective when high quality, evidence-based messages are communicated through multiple channels or options.

- Interpersonal: face-to-face, meetings, counselling, peer communication;
- Participatory: street theatre, participatory video, dance;
- Print material: newspapers, posters, leaflets, flyers, newsletters; consider written or visual print depending on literacy level of communities.
- Radio: community, national and international, across all genres from drama to news;
- Television: community, national and international, across all genres from drama to news;
- Film and video: focusing on detailed analysis and projecting in communities;
- Digital/Internet-based: crisis mapping, citizen media, blogs, social media and networking, data collecting;
- Mobile phone-based: SMS warnings and information relays, SMS-based data gathering mechanisms.

Source: Communication for Humanitarian Action Toolkit 2016

8.3 Early Recovery Actions

Nutrition communication activities should continue throughout the emergency, evolving in response to the changing situation, and then be adapted and mainstreamed for use in routine nutrition programme activities.

FROM THE CCC'S

Early Recovery Actions for Nutrition Communication:

Adapt the communications strategy for nutrition activities for routine use in health facilities and outreach services, and consolidate such activities to increase coverage and respond to changing situations.

EARLY RECOVERY ACTIONS FOR NUTRITION COMMUNICATION	EXAMPLES/RESOURCES
Q. **Adapt communications strategy and messages for routine use in health facilities and outreach services and identify opportunities for integration of activities with other sectors especially health and WASH.** ▪ Hold feedback meetings with all relevant stakeholders, including affected communities, to review communication strategy to draw lessons learned, identify gaps and priority areas. ▪ Use results from feedback meetings to inform adaptations for routine use. Make sure lessons learned are documented and feed into routine activities and integrated into any pre-existing C4D Strategy ▪ Analyse results to understand how communication efforts supported the emergency nutrition response and recovery and ensure lessons learned are used to inform the development of future emergency preparedness and response plans.	
R. **Use community engagement to understand barriers to uptake of services and behaviour change.** ▪ Incorporate feedback on barriers to make necessary adaptations to programmes to increase access, uptake and coverage of nutrition programmes.	**COMMUNITY ENGAGEMENT FOR CMAM:** http://www.severemalnutrition.org/ **ACCESS FOR ALL: WHAT FACTORS INFLUENCE ACCESS TO COMMUNITY BASED TREATMENT FOR SAM:** http://www.severemalnutrition.org/
S. **Where new approaches have been introduced during the emergency, begin to advocate for their adoption and integration into routine services.** ▪ If possible, compile and present evidence of the effectiveness of the new approach (e.g MNPs, CMAM), building a case for its adoption as a routine programming. ▪ Refer to UNICEF and Nutrition Cluster Advocacy Toolkits for more detailed guidance on advocacy approaches and activities. ▪ As for preparedness, work in partnership with existing nutrition platforms in country e.g SUN, REACH, to maximise opportunities and synergies and strengthen advocacy efforts.	**NUTRITION CLUSTER ADVOCACY TOOLKIT 2016** http://nutritioncluster.net/wp-content/uploads/sites/4/2016/03/Nutrition-Cluster-toolkit-low-res.pdf **UNICEF ADVOCACY TOOLKIT 2010, CHAPTER 7 BUILDING RELATIONSHIPS & SECURING PARTNERSHIPS** http://www.unicef.org/evaluation/files/Advocacy_Toolkit.pdf

KEY GENERAL RESOURCES ON NUTRITION COMMUNICATION

UNICEF 2015 COMMUNICATION FOR HUMANITARIAN ACTION TOOLKIT
http://www.adelaide.edu.au/accru/projects/effectivecomms/6-C4D-CHAT_Proof-2.pdf

UNICEF 2015 A GLOBAL COMMUNICATION FOR DEVELOPMENT STRATEGY GUIDE FOR MATERNAL, NEWBORN AND CHILD HEALTH AND NUTRITION PROGRAMMES
https://www.unicef.org/cbsc/index_65738.html

UNICEF 2005: BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES TOOLKIT
https://www.unicef.org/ceecis/BCC_full_pdf.pdf

HTP MODULE 19: WORKING WITH COMMUNITIES IN EMERGENCIES
http://www.ennonline.net/htpv2module19

NUTRITION CLUSTER ADVOCACY TOOLKIT 2016
http://nutritioncluster.net/wp-content/uploads/sites/4/2016/03/Nutrition-Cluster-toolkit-low-res.pdf

UNICEF ADVOCACY TOOLKIT 2010
https://www.unicef.org/evaluation/files/Advocacy_Toolkit.pdf

9

UNICEF Administrative Issues

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GOOD TO KNOW!

Funding Options for UNICEF's Humanitarian Action

Reprogramming of existing country office resources (RR/OR/ORE):

Regular resource (RR) can be diverted immediately by a CO Representative according to the approved thresholds of up to US$ 200,000 if CO RR budget is greater than $2 million and US$ 150,000 is the RR budget is less than $2 million. Anything beyond these thresholds requires RO / HQ approval. Diversion of Other Resources (OR) can only be done with the approval from the donor.

UNICEF Emergency Programme Fund (EPF): The EPF is intended to support a CO's ability to meet the CCC's, pending donor contributions. It is approved within 24-48 hours and is considered a UNICEF loan; the funds must be repaid after contributions from donors become available.

Central Emergency Response Funds (CERF): The CERF is a stand-by fund established and managed by UN CERF Secretariat at OCHA. Only UN are eligible to submit proposals which is usually a partner consulted/coordinated proposal.

Fund raising appeals: There are a variety of funding appeals available to support humanitarian action such as the Immediate Needs Documents and Flash Appeal.

GOOD TO KNOW!

Addressing large scale emergencies

Simplified Standard Operation Procedures (SSOP) have been established for Level 3 and Level 2 Emergencies. They aim to streamline, simplify and clarify UNICEF procedures and to enable an effective response to major emergencies.

Level 3 (L3): the scale of the emergency is such that an organization-wide mobilization is called for. SSOPs for L3 emergencies were issued by the Executive Director on 6 March, 2012.

Level 2 (L2): situations where the magnitude of the emergency is such that a Country Office needs additional and prioritized support from other parts of the organization (Headquarters, Regional and Country Offices) to respond, and where the Regional Office (RO) must provide dedicated leadership and support.

SSOPs for L2 emergencies were issued by the Executive Director on 24 January, 2013.

Upon declaration of Level 2 and Level 3 emergencies fast-track procedures and simplifications are applied automatically:

- Automatic application of fast-track human resource procedures
- Quick and easy application of Programme Cooperation Agreements (PCAs)
- Simplified operational (financial and administrative) procedures

Both SSOPs are available at http://www.unicefinemergencies.com/procedures/index.html

9.1 Implementation Arrangements

Understanding the response implementation arrangements within UNICEF is critical to generating the greatest positive impact for women and children and to fulfilling the Core Commitments to Children in Humanitarian Action.

The delivery of UNICEF's programmatic response (for emergencies as well as development) is heavily dependent upon the capacity of national and international implementing partners, including government, non- governmental organizations (NGOs), civil society organizations (CSOs) and contractors. UNICEF's preparedness plan should therefore identify the most suitable partners prior to an emergency as well as activities to improve their capacity to respond. With respect to the transfer of resources for implementation, UNICEF has only a limited number of options, whose selection depends on both the type of organization with which UNICEF is liaising as well as the nature of results expected from the relationship.

Transferring resources to a governmental partner is done within the scope of the Annual Workplan signed with UNICEF. It is a relatively quick option for transferring funds, and implementation depends on the government's capacity.

Engagement with NGOs is possible through three different options: a **Project Cooperation Agreement (PCA)** and its "junior" version, the Small Scale Funding Agreement (SSFA); an **Institutional Contract;** or, through a **Long Term Arrangement (LTA).**

Each of these options has its own positive and negative aspects that need to be considered when choosing which is most appropriate for a given situation. Note that during a response, the use of an LTA will be possible only if this has been developed in advance, otherwise the partnership (PCA) or 'institutional contract options are the only options to use (for details on LTAs, see below). Ultimately, the decision should be based on the level of results expected from the arrangement. A brief summary of the implementation arrangements described follows:

Project Co-operation Agreement (PCA) – The PCA is the main type of agreement used for development- and emergency-related partnerships. It focuses on the collaborative implementation of a jointly developed intervention within the framework of the UNICEF Programme of Cooperation or set of supported humanitarian responses. Although specific processes can be established for the approval of PCAs during emergencies, their creation and administrative processes take time; hence, they should be developed as a

preparedness measure to be useful in the early stages of cholera outbreak.

While stand-alone PCAs can be developed for emergency responses, Country Offices are increasingly using them as contingency mechanisms prepared in advance of an emergency either as stand-by mechanisms activated when an emergency is declared or by introducing specific 'emergency clauses' into regular programme's PCAs. *See Box COUNTRY EXAMPLES OF USE OF PCAs FOR EMERGENCY PREPAREDNESS* for some examples of the uses of PCAs as preparedness mechanisms.

See PCA Template and PCA Monitoring Addendum for Humanitarian Interventions
https://www.dropbox.com/home/NiE%20Toolkit%20Resources/UNICEF%20Administrative/Implementation

Small-Scale Funding Agreement (SSFA) – An SSFA is similar in scope to a PCA, but smaller in scope and both simpler and quicker to develop and deploy because it does not require a committee/review panel approval process. This SSFA is used to provide cash transfers to a civil society organisation ("CSO") for activities within a UNICEF country programme that build the CSO's capacity to be an effective implementing partner of UNICEF's for this country programme cycle; Government counterparts and other CSOs could also participate in those activities. This form can be used when the total cash transfers to the CSO in question, from all sections and units in the UNICEF country office, are to be equal to or less than USD 50,000 for the year. For humanitarian response, this form can also be used to transfer up to 3 months of supplies for immediate distribution for the affected population to meet UNICEF's Core Commitment to Children.

Country Examples of Use of PCAs For Emergency Preparedness

KENYA: Kenya Red Cross was identified by the Kenya Nutrition Technical Forum as the preferred choice for 'first responder' in the event of an emergency. UNICEF signed a two year PCA with KRC for it to be their partner of emergency preparedness and response. Under the PCA, response actions are activated once emergency situation declared. In the meantime, KRC are responsible for preparedness activities including: ensuring awareness and circulation of latest guidelines, job aids and trainings for management of acute malnutrition throughout emergency prone counties; as a repository and with responsibility for buffer stocks of nutrition commodities.

PAKISTAN: On the basis of the PCA's effectiveness during the IDP and Floods response and during the 2010 and 2011 flood response, the contingency PCAs were activated to provide immediate relief assistance to flood affected communities in flood affected districts. UNICEF entered into a contingency Project Cooperation Agreement (PCA) with partners to facilitate collaboration in the event of a disaster in Pakistan for an immediate Nutrition response. This contingency PCA will valid for a 6 month period and reviewed annually. It will provide a framework for immediate collaboration, thus enhancing the capacity of both parties to respond rapidly and effectively to emergency situations with a focus on life saving activities in the 6 months of a response. The PCA shall remain dormant outside of any emergency except for the collaboration between parties regarding planning, specification, planning for prepositioning, replenishment and management of contingency stocks. Activation of this agreement shall take the form of a short summary Note for Record co-signed by the Representative for UNICEF and the country director for The partner. Efforts will be made to ensure this is co-signed as soon as possible following the onset of the emergency, preferably within 48 hours.

THE PHILIPPINES: In the event of a major natural or human-made emergency or disaster, within or outside the program areas of this PCA, UNICEF and MOH agree to immediate reprogramming a maximum of five percent of the budget to lifesaving emergency response activities to help ensure the Core Commitments for Children in Humanitarian Action. An additional ten percent of the total budget could also be reprogrammed for life saving emergency response activities upon a signed agreement by both parties. Based on need, UNICEF agrees to replenish the reprogrammed resources for this emergency in order to achieve the primary objective of this PCA."

GOOD TO KNOW!

The Use of Direct Cash Transfer (DCT) in Emergencies

A DCT is the means by which cash is made available to a partner (government or NGO/CSO) against a PCA, SSFA [for NGO/CSOs] or a request for emergency support [from government partners] to implement agreed activities. DCTs are usually paid on the basis of a 3 months implementation window schedule in one lump sum to each partner. DCTs have to be spent within 3 months and liquidated within 6 months – and any unspent money returned – within six months, otherwise the UNICEF financial system blocks further payment to the partner until the DCT has been cleared. Such a block has widespread negative impact because the financial system covers all UNICEF Programmes and Sections in a CO; 'therefore, a blocked payment to a partner stops any further payment by offices and sectors working with the same implementing partner in the country until the outstanding DCT is cleared.

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TABLE 2 Simplified Administrative Procedures

PROCEDURES	SIMPLIFICATIONS THAT APPLY TO L2 EMERGENCIES
Quick and easy application of Programme Cooperation Agreements (PCAs)	• The Head of Office is authorized to disburse funds to implementing partners with **Direct Cash Transfers (DCT) outstanding for periods over six months** but not exceeding nine months. In exceptional situations, authorization can be provided by the Regional Director for disbursements to partners with reports outstanding for periods over nine months. • The Head of Office is authorized to release **cash transfers to implementing partners for periods up to three months at a time.** A second three-month cash transfer can be released on request from the implementing partner, towards the end of the first implementation period, including in situations where financial reporting has not been provided by them to UNICEF for the first three-month transfer, provided that monitoring and assurance activities have been undertaken on the activities corresponding to the transfer issued for the first period. • Where required and applicable, **funds can be disbursed to an NGO's offshore account** primarily when the NGO does not have a local bank account or local banking facilities are not operational (payment to be processed through the Inter Office payment facility). • The Head of Office is authorized to **re-programme unutilized funds** as relevant/possible in the context of the revised work-plan priorities. The due date for the submission of the FACE is extended for the duration of the agreed implementation period (three months or exceptionally, up to six months). • The CO can decide to adopt a flat, uniform, percentage of PCA indirect costs at any level up to 25 per cent of total operating costs instead of parsing through each relationship to determine individualized percentages.

PROCEDURES	SIMPLIFICATIONS THAT APPLY TO L2 EMERGENCIES
Simplified operational (financial and administrative) procedures	• The Head of Office has the **authority to sign an office, guesthouse or warehouse lease agreement**10 for periods up to six months, without prior approval of Division of Finance and Administration (DFAM), Administration Management, although consultation is encouraged, but it must comply with all of the following: ▪ Consult with the Regional Office since it has primary responsibility for oversight of this in an L2 emergency. ▪ Give preference to sharing premises with other UN agencies. ▪ Obtain security clearance from the UN Department of Safety and Security (UNDSS). ▪ Confirm funding availability to meet the financial commitments of the lease and Minimum Operating Security Standards. ▪ Use the UN standard lease agreement approved by UN Office of Legal Affairs. ▪ Have the lease reviewed by the contracts review committee (CRC) if it exceeds local CRC limits. ▪ Promptly notify DFAM (Deputy Director Administration Management) of all such leases. ▪ Identify and acquire adequate facilities. • In emergency situations, **staff can arrange travel, on reimbursable arrangement, with airlines directly** if a travel agency is not accessible, making all efforts to obtain lowest airfare. This arrangement should be done only at the express request of the receiving CO or supervising RO. Authorization to procure own ticket should be noted in the travel authorisation. No travel should be undertaken without prior security clearance. • If the system cannot be accessed directly or remotely for financial management and accounting purposes, the Head of Office can: ▪ **Revert to manual accounting system** to prevent delays. This includes the use of manual, basic cash books, cash verification reports, cash request vouchers, deposit slips and statement of receipts. These must be sent to the nearest office (safe haven) and should be recorded promptly. ▪ **Delegate to another office a specific budget allotment** as to allow issuance of requisitions/commitments. • **Third party cash providers (including other UN Agencies and well- established organizations) may be used to make payments or to replenish cash accounts** with approval from DFAM (Deputy Director Finance). In situations where there are no banking facilities, cash accounts must be replenished with banknotes brought in from another area (another UNICEF country office in the region or from well-established organizations). • Bank accounts: In instances where there are less than three staff members with delegated financial authority, **a single signatory bank account can be used** with DFAM approval. • In L2 emergency situations, a UNICEF Representative can **change the way the Contract Review Committee (CRC) works** to help expedite the review process including: ▪ Location: A sub-CRC can be convened at a zone office. ▪ Composition: The composition of the CRC can be changed by the UNICEF Representative to include as members/alternates any appropriately experienced staff member that joined the country office following the emergency. ▪ Quorum of CRC: It must have three voting members even in emergencies; but members can be "polled" (by email) to approve contracts. The emergency submission must be submitted the next meeting to be recorded. ▪ Frequency of meetings: As frequently as needed in an emergency. ▪ Other UN Agency staff members can be included as members of the CRC when securing a quorum proves difficult or there are insufficient qualified staff members (UNICEF is encouraged to provide the same service to other UN agencies.) The emergency submission must be submitted to the next meeting to be recorded.

PROCEDURES	SIMPLIFICATIONS THAT APPLY TO L2 EMERGENCIES
Automatic issuance of a US$2 million EPF	• The allocation (to the CO or RO) is to be used for the UNICEF programmatic response. A portion of the allocation (to be determined by consultation between the EMOPS Director, the relevant RO and CO, upon issuance) should be used to build CO capacity for cluster coordination, information management and humanitarian performance monitoring. • In the case of multi-country emergencies, there is only one automatic US$2 million EPF allocation for the whole emergency. The RO receives the funds and allocates to COs based on priorities, clearly communicating to COs reimbursement procedures and tracking where funds are allocated. The RO should also inform EMOPS of country allocations. • The automatic allocation will not apply to countries that have received an EPF allocation during the six weeks preceding their designation as L2 emergencies, and/or countries that appear on the list of L2 emergencies for a second or third consecutive time, as well as those emergencies being downgraded from L3 to L2. In such cases, the CO must apply for an EPF allocation, if needed, under normal procedures. • If the automatic allocation is not sufficient and additional funds are required, a normal EPF application is necessary, based on existing guidelines. • The automatic US$2 million EPF is reimbursable by the concerned office as funds become available. Uncommitted funds will automatically be recovered after three months.

Source: UNICEF Procedure for Level 2 Emergencies Annex 1 to CF/EXD/2013-003

Tips for Simplified Administrative Procedures for Clusters

DO include coordination activities in the annual UNICEF programme work plans. This will mean that humanitarian coordination activities will be explained transparently, resulting in subsequent ease of allocation and release of funds against the articulated activities and monitoring of progress within the context of the UNICEF annual work plan.

DO include cluster coordination functions (salaries and core activities) in UNICEF project submissions to the SRP and in the relevant project proposals submitted through the various pooled funding mechanisms (e.g. Central Emergency Response Fund, Common Humanitarian Fund) and also, when appropriate, in UNICEF programme proposals submitted to bilateral donors. Funding may also be requested from UNICEF emergency programme funds managed by EMOPS (although this must be reimbursed).

DO make the mechanisms for release of cluster funding straightforward and streamlined with timely disbursement by UNICEF.

DO make the processes for fund disbursement clear to the cluster coordinators (many of whom do not have experience of UNICEF processes). Cluster coordination finance is in the section's respective budgets and the release of funds requires the authorization of the budget holder/chief of section.

DO ensure that programme and cluster staff have a mutual understanding and agreement on work priorities of shared staff to ensure that resources are shared effectively and without conflict.

DO have the UNICEF country office pre-vet potential partners in an emergency response (as identified through preparedness planning). This will facilitate the speedy creation of project cooperation agreements so that funds for the response can be distributed in a timely manner.

See more tips on simplified administrative procedures in:
UNICEF Simplified Standard Operating Procedures (SSOPs) for Level 3 Emergencies (2015)

http://www.unicefinemergencies.com/procedures/index.html

UNICEF Cluster Coordination Guide for Country Offices (2015)

9.2 Human Resources for Programmatic Response

Coping with an emergency requires an immediate and effective response and qualified staff to carry it out. Having a staff mobilization plan in place before the emergency occurs is an essential first step to identifying staff deployment needs in the event of an emergency. The plan is part of each office's annual emergency preparedness and response exercise. To increase human resources in an emergency options are (see Table 3 for more details):

- **Internal re-deployment** (in-country and other UNICEF offices): In an emergency, offices should first redeploy and utilize existing staff in-country. The country office should request the immediate support of the regional office in emergency needs assessment and identifying staff that can be redeployed to the country concerned.

- **Standby partners:** EMOPS, Geneva office, is responsible for securing additional personnel through arrangements with UNICEF's standby partners.

- **Short term surge deployment:** Offices should also contact the Global Nutrition Cluster that can mobilize immediate rapid response personnel to provide technical support in assessments, IYCF-E, MAM and social behaviour change.

- **External Recruitment:** UNICEF also has the ability to recruit supplemental human resources through Individual or institutional contracts, Temporary Assignment (TA) or Fixed Term (FT) positions. Individual and Institutional Contracts offer the easiest and quickest of these hiring options, although professionals on this contract modality do not have authority to manage internal UNICEF administrative systems. Although the organization is moving towards reducing the length of contracting process, a TA might require up to 4 to 6 weeks from the time of request to fulfilment. And, an FT post can take 6 months or longer to recruit, so its use for emergency response is limited.

TABLE 3 Overview of Options for Additional HR Support

OPTIONS	WHAT TO DO
Internal Redeployment	• Prepare terms of reference for required additional staff using sources on the Intranet. Generic profiles of many emergency-related positions are available on the Intranet. • Prepare funding source for additional needs: cash requisition (CRQ) number, programme budget allotment (PBA) number and programme and project codes. • Review profiles of candidates for internal redeployment using available systems and rosters. Contact the human resources emergency focal point at New York headquarters to activate internal redeployment. The relevant geographic cluster should be copied from the outset.
Regional Office Deployment	• Contact the regional emergency officer to request his or her support to work with the office on a rapid needs assessment. • Contact the regional human resources officer to request the immediate redeployment of staff from other offices within the region.
ERT Deployment	• Contact the emergency focal point in DHR and the director or deputy director of EMOPS to consider mobilizing staff from the Emergency Response Team. Make a formal request directly to the director of EMOPS. • Contact the regional communication adviser and copy the director of DOC to consider mobilization of communication staff.

OPTIONS	WHAT TO DO
External Recruitment	• Prepare Terms of Reference for required additional staff using sources on the Intranet. • Prepare funding source for additional needs, including CRQ number, PBA number, and programme and project codes. • Contact the emergency focal point in DHR, New York headquarters, to process the recruitment. • Review external recruitment candidates on the Roster as well as from other available sources, such as referrals from staff members, local nongovernmental organizations (NGOs) and other UN agencies. • Contact potential candidates and find out whether they are interested and available. Notify the emergency focal point in DHR and the regional human resources adviser about candidates under review. • For temporary fixed-term contracts,[20] send a request to the emergency focal point in DHR to initiate recruitment of the external candidate(s), in coordination with the relevant geographic cluster in DHR • Coordinate the process for obtaining the candidate's visa for travel to the emergency country if travel is not out of New York (travel out of New York is coordinated by DHR). DHR also coordinates medical clearance of all candidates.
Standby arrangements	• Prepare terms of reference for required additional staff using templates on the Intranet. • In the event that UNICEF funds are required, identify a funding source for additional needs: CRQ number, PBA number, and programme and project codes. • Contact the EMOPS focal point in Geneva to request support through partner standby arrangements and for related guidelines.

Source: UNICEF Emergency Field Handbook Section 6.3

TABLE 4 Simplified HR procedures for L2 and L3 emergencies

PROCEDURES	SIMPLIFICATIONS THAT APPLY TO L2 EMERGENCIES
Automatic application of fast-track human resource procedures	• As per 'Recruitment and Staffing in Emergency Situations 2010' guidance
Deployment of RO staff, ERT or similar capacity	• The RO will make staff available within 48 hours as needed and possible, using regional rosters, RO staff, standby capacity, etc. • The CO will be offered possible deployment of ERT or equivalent capacity for minimum of one week during the first few weeks of the response. The deployment should be agreed in dialogue between the RO, receiving office, and EMOPS. The deployment is paid for by the receiving office, and could come from the US$2 million EPF allocation. • This capacity can be deployed to RO or CO.

Source: UNICEF Procedure for Level 2 Emergencies Annex 1 to CF/EXD/2013-003

20 It is generally preferable to recruit external candidates on temporary fixed-term contracts and not consultant contracts. Temporary fixed-term contracts provide staff with benefits to which UN staff members are entitled, such as UN laissez-passer, coverage under malicious acts and relocation costs. Consultants are not entitled to benefits.

9.3 Human Resources for Coordination

While various options for temporary surge staff provide significant support for country offices, it must be recognized that the overall responsibility for funding and recruitment of staff for clusters falls on the country offices.

Most of the mechanisms for temporary/surge support are for relatively short periods of time, so the issue of potential loss of continuity needs to be considered seriously. It is therefore highly recommended that the short-term options are used on an interim basis while arrangements for longer-term appointments are being processed. It is essential that the country office starts the process of recruitment for longer-term positions as a priority at the outset of an emergency – recognizing that the temporary/surge mechanisms are gap-filling measures to support the country office until they can recruit staff. All seconded staff should be fully integrated into the UNICEF country office and treated as equal members the UNICEF team. These staff members report to UNICEF and should be line-managed by UNICEF. Global cluster coordinators should be involved in pre-departure orientation of temporary or surge personnel sourced from these various options.

With a Level 3 emergency, no matter what coordination structures are already in place, additional capacity will be needed. UNICEF SSOPs for L3 outline the immediate deployment of CC and IM capacity to support all sectors/clusters where UNICEF has global leadership accountabilities. If it is later decided that UNICEF will not lead the nutrition sector, the surged capacity can be withdrawn. While this approach implies a cost in terms of deployment, this is preferable to previous approaches of waiting for country level decisions to be made on leadership and capacity gaps.

TABLE 5 Options for sourcing staff for coordination

GNC RAPID RESPONSE TEAM

The Global Nutrition Cluster's Rapid Response Team (RRT) is a partnership between the Global Nutrition Cluster (GNC) and five GNC partners to provide timely support for cluster coordination and information management.

WHAT	CRITERIA	HOW	COSTS	RESOURCES
The RRT consists of three of them are Nutrition Cluster Coordinators and three Information Management Officers. The RRT members can: • provide dedicated surge capacity to any country clusters based on the deployment criteria • deploy within 72 hours • be available for up to 8 weeks, with possible extension of up to 12 weeks.	The RRT members can deployed for: • A declared L3 emergency; • Rapid onset emergency or rapid deterioration of pre-existing situation; • Threat of forecast of L2 or L3 emergency; • Unpredictable and sudden loss of CC/IM capacity; • To strengthen underperforming CC/IM platforms.	✔ Requests should be made directly to the GNC and the UNICEF humanitarian partnership manager. ✔ Terms of Reference (ToR) must be provided with the initial request. ✔ No contract needs to be issued by the country office. ✔ The RRT personnel must be fully accommodated within the country operation.	UNICEF/Host country office will not pay any costs, except in-country travel and R&R (if applicable).	**GENERIC TORS ARE AVAILABLE TO FACILITATE THE DEVELOPMENT OF SPECIFIC TORS** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/4.%20MAM • National Cluster Coordinator • Sub-national Cluster Coordinator • Information Manager **REQUEST FORM FOR RRT MEMBER** https://www.dropbox.com/home/NiE%20Toolkit%20Resources/4.%20MAM **GNC WEBSITE RRT** http://nutritioncluster.net/gnc/rrt/

UNICEF INTERNAL MISSION may be agreed through bilateral negotiation between UNICEF representatives.

WHAT	CRITERIA	HOW	COSTS	RESOURCES
The UNICEF staff can: • Be deployed within a timeframe agreed to by the relevant country offices. • Usually deploy for up to 3 months.	UNICEF staff can be re-deployed for: • The requesting UNICEF office is operating in an emergency • The technical capacities of existing staff are inadequate to respond to the emergency. • Other deployment options are not available and/or the particular capacities of the requested staff member are extraordinarily suited for the response.	✔ The country representative makes a request and negotiates directly with the country representative from the seconding country.	Receiving country office responsible for all costs including salary (salary to be reimbursed to seconding country office).	

GNC COORDINATION TEAM can be available in the corporate activation of an L3 emergency

WHAT	CRITERIA	HOW	COSTS	RESOURCES
The GNC coordination team can: • Be available for deployment 48 hours after request • Usually deploy for a very short period of time to provide strategic support	Short term engagement in • Analysis/decision making on activation of the cluster • Cover cluster coordination functions until surge staff in place		Costs covered by EMOPS. Country office responsible for all costs in country.	**SSOPS FOR L3# EMERGENCIES**

STANDBY PARTNER arrangements between UNICEF and a number of agencies which maintain rosters of surge personnel with capacity in cluster coordination and information management (amongst other things)

WHAT	CRITERIA	HOW	COSTS	RESOURCES
The standby partner can: • Be deployed within 2 weeks after request • Usually deploy for 3-6 months, in some cases up to a year.	The following criteria should be met: • The requesting UNICEF office is operating in an emergency; • UNICEF is unable to meet additional staffing requirements with its own resources within the time constraints; • The technical capacities of existing staff are inadequate to respond to the emergency; • The services of Standby Personnel are only required for a short period of time (3-6 months).	✔ Employed by host agency and seconded to UNICEF ✔ Requests managed through the humanitarian partnership manager in consultation with the GNC. ✔ Terms of Reference (ToR) must be provided with the initial request.	Salary and costs for travel to country covered by host agency. Country office responsible for all costs in-country.	**REQUEST FORM** Can use the Generic ToRs to facilitate the development of specific ToRs.

UNICEF DIVISION OF HR EMERGENCY ROSTER provides surge support through internal deployments, talent pools and retirees.				
WHAT	**CRITERIA**	**HOW**	**COSTS**	**RESOURCES**
Provides access to staff with knowledge and experience of UNICEF systems. Deployment time is variable.		✔ Request made to UNICEF HQ HR when an L3 declared or where the country is priority for fast-track deployment	Country office responsible for all costs including salary.	Info needed on how to access the roster https://intranet.unicef.org/emops/emopssite.nsf/0/9A18D408EC7C6AAD852579E60053286B/$FILE/Summary%20Surge%20Guideline%20-%20revised%20version%2030%20June%202016%20-%20FINAL.pdf (INTERNAL)
DIRECT RECRUITMENT of dedicated cluster coordinators and information management officers				
WHAT	**CRITERIA**	**HOW**	**COSTS**	**RESOURCES**
	• Where there is a clear long term need for dedicated cluster coordination	✔ Cluster staff (coordinators and information management specialists) recruited by UNICEF may be employed on fixed-term, temporary assignment or special service assignment contracts, depending on the context.	Country office responsible for all costs including salary.	

Source: Adapted from UNICEF Cluster Coordination Guide for Country Offices (2015)

9.4 Supplies

This section focuses on UNICEF options for the procurement, storage and use of stocks. Challenges presented by supply procurement processes can create an emergency response bottleneck; therefore, preparedness activities can ensure the readiness and availability of necessary supplies for emergency response, including the identification of key supplies and agreement on the assignment of responsibility for procurement, insurance, storage and logistics. In addition to the regular in-country procurement process, UNICEF CO can access supplies from:

International procurement through Supply Division, Emergency Supply List and Supply Calculator: An **Emergency Supply List (ESL)** has been developed, comprising relief items essential for responding to the needs of 250,000 people. The ESL consists of 161 items allocated to staff support (35 items) and programme support (126 items). UNICEF regional warehouses maintain supplies of ESL items at all times.

A **Supply Calculator** is also available to estimate order quantities and costs of key supplies needed, including those from the ESL. It has built-in calculations that generate order recommendations, based on the size of affected population, as well as a freight cost estimator for shipments for international orders issued through UNICEF Supply Division (SD).

Note that international procurement through UNICEF SD is available for all Country Offices upon request. Supply Division has the ability to deliver ESL-listed items within 72 hours to the affected UNICEF CO's port of entry. However, this option is usually the most expensive and should be used as the option of last resort. Detailed information on how to initiate and place orders is available at the https://intranet.unicef.org/Denmark/DanHomepage.nsf **(INTERNAL).**

Procurement through PCAs with partners: It is possible to establish PCAs with partners that include shared access to emergency stocks (of both organisations) or supply transfers

by UNICEF to partners to be stocked and managed by them. Partners can also be cleared for direct procurement using UNICEF funding, reducing the burden on UNICEF as a procurement agency and speeding up the acquisition process in emergencies (especially for items which can be locally procured and which the implementing partner has the capacity to handle internally). Ideally the pre-clearance process should be undertaken as a preparedness measure. The Country Office-based Operations/ Supply function holds authority for clearance of implementing partners for in-country procurement, which usually includes a review/ audit of their procurement and logistical processes and capacity. Alternatively, Supply Division in Copenhagen must approve offshore procurement arrangements. See template for a request to procure internationally through UNICEF PCAs.

UNICEF contingency stocks: UNICEF Offices may hold contingency stocks of key items, especially those procured offshore and not readily available on the market. Nevertheless, due to the liabilities on International Public Sector Accounting Standards (IPSAS), funds used

for procurement of supplies are not considered spent – and therefore cannot be reported as used – until these supplies are delivered to beneficiaries/final users, reducing UNICEF's ability to maintain contingency supplies. One option is to consign these supplies to government or implementing partners, which implies that UNICEF cede ownership and management of these goods in order to be released from the accounting requirements. To make proper use of this feature, UNICEF should carefully evaluate a partner's capacity to store and manage stocks and build the necessary confidence to ensure these goods will be used as originally planned. **All transfer of goods to government and partners must be properly accounted for and reported via internal UNICEF systems.** In the case of implementing partners, the goods must be transferred under the scope of a PCA and reported accordingly.

KEY RESOURCES

CLUSTER COORDINATION GUIDANCE FOR COUNTRY OFFICES, UNICEF 2015 PROVIDES CLEAR GUIDANCE FOR UNICEF REPRESENTATIVES AND COUNTRY OFFICES ON WHAT UNICEF'S RESPONSIBILITIES ARE TO SUPPORT CLUSTERS AND COORDINATION
http://nutritioncluster.net/?get=003509|2015/05/Cluster-Coordination-Guidance-for-Country-Offices-Final-Report-2015.pdf

UNICEF SIMPLIFIED STANDARD OPERATING PROCEDURES (SSOPS) FOR EMERGENCIES (2015) CLARIFIES THE SIMPLIFIED AND STREAMLINED PROCEDURES THAT ARE PUT IN PLACE FOR THE RESPONSE TO A CORPORATE EMERGENCY. ANNEX 14 LIST OF TOOLS HAS MANY USEFUL RESOURCES.
http://www.unicefinemergencies.com/procedures/index.html

UNICEF PROCEDURE FOR L2 EMERGENCIES ANNEX 1 TO CF/EXD/2013-003

UNICEF EMERGENCY FIELD HANDBOOK PROVIDES GUIDANCE ON UNICEF ADMINISTRATIVE PROCEDURES FOR HUMAN RESOURCES, SUPPLIES AND FINANCES IN EMERGENCY CONTEXTS.
https://www.unicef.org/publications/index_28057.html

GNC WEBSITE PROVIDES INFORMATION ON THE GNC RAPID RESPONSE TEAM AS WELL AS A WEALTH OF OTHER GUIDANCE.
http://nutritioncluster.net/gnc/rrt/

UNICEF ADMINISTRATIVE RESOURCES:
https://www.unicef.org/about/partnerships/index_81428.html