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| --- | --- |
| Nutrition Emergency Response Preparedness (ERP) plan  **Zwantipolis**  **December 2022**  Risks covered: Floods, cholera outbreak, and conflict. | Please note this Nutrition ERP plan is an example developed for an imaginary country called Zwantipolis |
| **2023** | Prepared by the GNC |

[Strategic summary 1](#_Toc121061329)

[Country Overview 2](#_Toc121061330)

[Nutrition ERP planning 4](#_Toc121061331)

[1. Risk analysis and monitoring 4](#_Toc121061332)

[2. Crisis Scenario 7](#_Toc121061333)

[3. Existing response capacities 10](#_Toc121061334)

[4. Response analysis and Strategy 12](#_Toc121061335)

[5. Operational arrangements 21](#_Toc121061336)

[6. Preparedness actions 25](#_Toc121061337)

[7. Funding requirements 25](#_Toc121061338)

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| --- |
| 11,636  Est. number of people in need  of Nutrition humanitarian assistance  as of 07/2023 |
| |  |  | | --- | --- | | 33% |  |   of total population   |  | | --- | | 6,897  Preliminary number of people targeted as of 09/2023 | | |  |  | | --- | --- | | 20% |  |   of total population | |

$ 0.94 million funding estimate (US$) for Preparedness and Response

STRATEGIC SUMMARY

Zwantipolis is an imaginary country prone to multiple hazards where several forms of malnutrition coexist, driven by multi-dimensional underlying causes such as food insecurity, sub-optimal child care and feeding practices, and lack of quality health care services. The Nutrition Cluster included as part of its priorities to strengthen Nutrition Emergency Response Preparedness (ERP) in collaboration with the Ministry of Health to support its strategy for emergency response management. This Nutrition ERP plan covers preparedness measures and early response actions for three anticipated crisis scenarios expected to occur in 2023, i.e., monsoon floods, civil unrest/armed conflict and cholera outbreak. According to the ERP plan, it is estimated that in addition to the annual Nutrition PIN (HNO 2023), 11,636 children and women will be in need of Nutrition support during the period of April through September 2023. Preparedness mesures have being identified, prioritized and compiled in a [costed workplan](https://docs.google.com/spreadsheets/d/1lQu_3Ylgl1pfhoVvm09aLQ5tI5G7hUDJ/edit?usp=share_link&ouid=106279911202404355368&rtpof=true&sd=true). While 54,000 USD are required to invest in these preparedness efforts during the first quarter of the year; it is estimated that an addintional 0.89 million USD will be required to respond to the expected surge in Nutrition needs. The plan outlines the early response plan toward scaling up the Nutrition response and ensure a continued access to treatment of acute malnutrition, to strengthening preventive nutrition interventions, evaluate and monitor the nutrition situation in affected areas, and support mechanisms for Nutrition coordination and information management at subnational level. A summary of the ERP plan is available also available as a [dashboard](https://app.powerbi.com/view?r=eyJrIjoiYjhiZGJjMmYtMjQxNi00NjQ5LTg1YTItNjYyNzVmMmVmOTcxIiwidCI6IjVlZjFhZDQ4LWJkZTgtNDY0My1hODlhLWVkMTQyNmI0NGJjMyJ9&pageName=ReportSection).

This is in lieu of a map for Zwantipolis country.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sea | Bordering country | | | Mountainous area |
|  |
|  |
| Village 10 | Village 11 | Village 12 |  |
| Village 9 | Village 8 | Village 7 |  |
| Urban area 1 | Urban area 2 | Village 5 |  |
| Village 3 | Village 4 | Village 6 |  |
| Bordering country | | | |  |

|  |  |  |
| --- | --- | --- |
| Capital city administration | District 1 | Urban area 1 |
| Urban area 2 |
| Province A | District 2 | Village 3 |
| Village 4 |
| District 3 | Village 5 |
| Village 6 |
| Province B | District 4 | Village 7 |
| Village 8 |
| District 5 | Village 9 |
| Village 10 |
| Province C | District 6 | Village 11 |
| Village 12 |

Country Overview

1. Situation overview

Zwantipolis is a lower middle-income country prone to multiple hazards. In the mountainous part of the country, landslides and floods are common during the monsoon season, which increasingly impact lives and livelihoods of communities residing on the foots of the mountains.

The country coastline is a tsunami-prone area, it is particularly vulnerable to sea-level rise, especially around the capital city that is a densely populated urban area (more than 25% of the population live in the capital city administration). Zwantipolis is visited by an average of three to four tropical storms/typhoons every year.

Since 2021, there was a sustained increase in the price of basic foodstuffs, as well as of fuel, propane gas, agricultural inputs and electricity, which reduced the purchasing power of households, limiting access to food and other basic necessities. Activities of armed extremists’ movements are on the rise.

Repeated shocks due to natural hazards, eroded livelihoods, and recent the economic crisis further exacerbated preexisting vulnerabilities. There are multiple forms of malnutrition in Zwantipolis, driven by multi-dimensional underlying causes such as food insecurity, sub-optimal child care and feeding practices, and lack of quality health care services.

According to the 2019 DHS, the highest prevalence of stunting and wasting was among children living in rural areas and in the poorest quintile. The highest proportion of children affected by wasting was observed in Province A where the prevalence was at 15.8%; the prevalence of wasting was 13.4% in Province B and 12.2% in Province C. The prevalence of stunting was around 30% in all 3 Provinces.

In 2020, a study from the national health research center showed there was a significant underestimation of disability across the country. Persons with disabilities make up 15 per cent of the global population (10 per cent of children). There is a disproportionate impact of emergencies on children with disabilities, as they face a number of barriers to accessing assistance.

1. Nutrition ERP planning process and Responsibilities

There is a multi-sectoral contingency plan for floods, jointly developed by the Zwantipolis government and OCHA. This plan includes Health and Wash components to respond to a cholera outbreak often occurring few weeks after the flood’s onset. The plan doesn’t include a Nutrition-specific component. Nutrition Cluster partners are not familiar with the existing Flood contingency plan and priority activities for Nutrition look similar to regular programming. Preparedness actions are vague and hence, not implemented.

The Nutrition Cluster included as part of its priorities for 2022 to strengthen the level of Nutrition Emergency Response Preparedness in collaboration with the Ministry of Health to support its strategy for emergency response management.

It was agreed among Nutrition partners that the task force established for the drafting of the HNO and HRP will also be responsible to drive the ERP process of the Nutrition Cluster. Collectively, the Nutrition Cluster partners aim to strengthen cluster capacities to respond in a timely and coordinated manner to a range of different situations through a broad set of preparedness measures. This very document is the multi-risk ERP plan that together with the Preparedness Actions workplan build on identified challenges and lessons learned from past events to determine priorities in the various levels of planning (Coordination, IM, Assessments, response provision) and guide the Nutrition partners’ effective Nutrition response.

1. Lessons learned from previous emergencies

In March 2022, the monsoon rains led to floods of severe impact that washed away infrastructure, farmlands, homes and livelihoods, and have displaced hundreds of thousands of people. More than 10,000 homes, numerous roads and essential infrastructure have been destroyed.

Ten days after the flood’s onset, there was an outbreak of acute watery diarrhea among young children of displaced households having resettled in temporary shelters in villages 8 and 9 of Province B. One week later, the first cholera cases were reported. One month later, the number of cholera cases went up sharply and in the same locations, concomitantly, the number of SAM cases started to increase significantly. Locally, health and nutrition services were quickly overwhelmed.

The Province B contingency plan had not anticipated the increase of SAM cases hence, health facilities quickly ran out of medicines and RUTF. No preparedness measures anticipated the management of concomitant SAM and cholera.

In addition, other challenges faced during past emergencies in delivering a timely Nutrition response included notably:

* Delays in the provision of a comprehensive response to protect, promote and support adequate infant feeding practices.
* Lack of data and information on the severity of the Nutrition needs.
* Weak coordination mechanism for Nutrition at local level.
* Gaps in human and financial resources.

Nutrition ERP planning

1. risk analysis and monitoring
2. Hazards identification

The country’s geographical location contributes to its high-susceptibility to hydro-meteorological events such as tropical storms/typhoons, sea level rise, storm surges, landslides, flash flooding, especially during the monsoon season.

* Hydro-meteorological (Tropical Storms, Typhoons, Heavy rainfall leading to floods)

Tropical cyclones and its sequential effects of rain and windstorms, as well as floods are the most prevalent types of hydro-meteorological hazards.

* Civil unrest and conflict

The political situation in the capital city and Province A of Zwantipolis deteriorated sharply over the past 2 years. There is a history of social unrest and activities of armed extremists’ movements in the suburban areas of the capital city.

* Epidemics

Measles and cholera outbreaks are risks arising as consequences of above-mentioned crisis.

1. Risks ranking

|  |  |  |  |
| --- | --- | --- | --- |
| **Risks** | **Impact[[1]](#footnote-1)** | **Likelihood** | **Score[[2]](#footnote-2)** |
| 1. Floods | Severe | Very likely | 20 |
| 2. Conflict | Moderate | Likely | 12 |
| 3. Epidemics | Moderate | Likely | 12 |

1. Risk analysis

* Hydro-meteorological (Tropical Storms, Typhoons, Heavy rainfall leading to floods)

Analysis of trends of tropical cyclone occurrence show that an average of 3 to 4 tropical cyclones per year. Moreover, in the past few years, the monsoon season had a devastating impact causing floods and landslides due to heavy rainfall. During the last monsoon floods, in Province B, highways were blocked, communication networks restricted due to falling of electrical and telecommunication poles. Furthermore, the heavy rainfall led to crops damage and reduction in harvest yields. In such crisis scenario, it is expected to observe a rise in food insecurity and malnutrition.

* Civil unrest and conflict

The country is on the verge of economic collapse, price inflation has increased significantly and reached 20% during the second quarter of 2022, which led to a significant decrease in purchasing power. Social unrest and activities of armed extremists’ movements are on the rise, especially in the sub-urban areas of the Capital City leading to population displacement and reduction of access to essentials goods and services. Altogether, in such crisis scenario, malnutrition is expected to increase significantly.

* Epidemics

From theindirect consequences of crisis caused by the hazards described above, such as poor conditions in evacuation centers (during Typhon response) and/or in overcrowded settlements, difficulties to access to food and health care, all in all increase the susceptibility to infectious diseases such as cholera and measles. In March 2022, the Ministry of Health declared a cholera outbreak in resettled in temporary shelters in villages 8 and 9 of Province B. Meanwhile in the Capital City administration there was a measles outbreak with over 1,300 cases and 21 of which led to death. In such crisis scenario, it is anticipated that measles and cholera outbreaks will contribute to aggravate the dire nutrition situation.

*Please also see the simplified seasonal calendar of Zwantipolis in section 4a.response analysis.*

1. Risk monitoring

* Hydro-meteorological (Tropical Storms, Typhoons, Heavy rainfall leading to floods)

During the monsoon season, the Nutrition Cluster will use the Flood Forecasting Centre warning system that monitors river water level daily at preselected locations.

During the cyclone seasons, the Nutrition cluster will rely on the national Meteorological Department issues early warnings in relation to some of the risks identified and to decide whether the hazard has reached a certain threshold in order to activate elements of the ERP plan.

|  |  |  |
| --- | --- | --- |
| **Disaster risk: Floods** | | |
| **Risk monitoring indicator** | **Stage of warning** | **Action required** |
| Normal water level status | Normal - no alert | Minimum preparedness actions |
| Warning water level status | Flood alert, flood is possible and probable | Advanced preparedness actions[[3]](#footnote-3) |
| Flood level | Flood is expected | Immediate action required; response plan triggered |

|  |  |  |
| --- | --- | --- |
| **Disaster risk: Cyclone** | | |
| **Risk monitoring indicator** | **Stage of warning** | **Action required** |
| Time forecast in advance of cyclone landfall: 72h | Alert | Advanced preparedness actions and national cyclone contingency plan actions 1 to 3 |
| Time forecast in advance of cyclone landfall: 36h | Warning | national cyclone contingency plan actions 4 and 5 |
| Time forecast in advance of cyclone landfall: 24h | Danger | national cyclone contingency plan actions 6 to 8 |

* Civil unrest and conflict

The Nutrition Cluster will follow the Ministry of interior and public security’s recommendations and the conflict early warning system of the national security services.

|  |  |  |
| --- | --- | --- |
| **Disaster risk: Conflict** | | |
| **Risk monitoring indicator** | **Stage of warning** | **Action required** |
| Normal situation, normal level of incidents | Normal - no alert | Minimum preparedness actions |
| Warning level of incidents (number of fatalities) | Alert level | Advanced preparedness actions3 |
| Outbreak of armed conflict | Conflict-induced emergency declared | Immediate action required; response plan triggered |

* Epidemics

The Nutrition cluster will rely on the national institute of Epidemiology Disease Control and its early warning system monitoring disease outbreak.

|  |  |  |
| --- | --- | --- |
| **Disaster risk: Epidemics** | | |
| **Risk monitoring indicator** | **Stage of warning** | **Action required** |
| Normal status; incidence of measles, malaria and acute watery diarrhea below alert thresholds | Normal - no alert | Minimum preparedness actions |
| Alert status, increased cases of infectious and water borne diseases | Alert | Advanced preparedness actions3 |
| Outbreak declared; epidemic threshold exceeded | Response required | Immediate action required; response plan triggered |

1. Crisis Scenario
2. Impact and humanitarian consequences

**Scenario 1: Flash floods and landslide**

The national Meteorological Department predicts that the next monsoon season will likely bring above average rains for an extended period and will cause intense flooding in 3 villages of Provinces B and C of Zwantipolis (Villages 9, 10 and 11). It is assumed that over 60,000 people will be affected and 18,000 people displaced from villages 10 and 11 into village 9 of Province B with only 50% of them hosted in makeshift shelters located across parts of Province B.

These floods are expected to be more severe than the ones of previous years in terms of crops damages and harvest losses.

The Wash Cluster predicts that these floods will also compromise access to safe drinking water and sanitation facilities at household and community level hence, the affected population will be exposed to environmental and health problems.

Therefore, acute malnutrition that is already above 12% in Province C is expected to increase among the affected population during the July thru September period.

**Scenario 2: Armed conflict and politically motivated violence**

The political situation in the capital city and Province A of Zwantipolis recently deteriorated, price inflation remains high, social unrest and activities of armed extremists’ movements are on the rise.

In the capital city and in Province A, people flee their homes to seek a safer environment.

Acute malnutrition was above 15% in Province A prior the eruption of violence. As households flee, assets are left behind, minimal possessions are carried. Population movements are expected to increase and to head mainly towards the bordering Province B.

An influx of 50,000 IDPs into Province B is to be predicted. Displaced people will stay in temporary shelters that will likely quickly become overcrowded, exposing the population to public health threats. Health services in the area will be overwhelmed, local authorities likely not in a capacity to provide assistance to the required scale.

The Protection Cluster already predicts that women will face barriers in accessing services. With delays in the delivery of food assistance, a rapid deterioration in the nutritional situation of the population is expected, and in particular those most vulnerable including children under five years, pregnant and lactating women, and the elderly.

Due to ongoing violence in the capital city and province A, blockade of main roads and airport, the transportation of food assistance, health and nutrition supplies and movement of emergency surge personnel to Province B will likely become a challenge during the next 6 months.

**Scenario 3: cholera outbreak**

The risk analysis recently done by the national institute of Epidemiology Disease Control of Zwantipolis anticipate that in lights of the increasing emergencies faced in the country, the risk of epidemics will rise when multiple shocks will be faced, leading to significant population movements and crowding in temporary shelters, when frequent disruption of water and sanitation systems compounded with inadequate access to healthcare services.

Based on previous crisis and history of cholera outbreaks, the Health Cluster works on the assumptions that cholera and measles outbreaks are expected especially in peri urban area 2 of the Capital City and in village 8 of province B, with up to 1,000 cholera cases in the span of few months.

As these cholera outbreaks will occur in locations where acute malnutrition is prevalent, it is expected to see a significant number of children with concomitant cholera and severe acute malnutrition, especially during the July thru September period.

1. Estimated key immediate needs and PIN

Scenario 1: It is expected that malnutrition will increase and peak in 3 weeks’ time after flood onset. In addition to the cases planned for in the annual HRP, this scenario factors for additional cases, i.e., a rise in SAM and MAM cases of 30% (compared to baseline cases) and a Nutrition response must be scaled up for a period of 3 months (July – Sept) in 3 villages in priority.

Scenario 2: It is expected that malnutrition will increase and peak in 4 weeks’ time, Province B will see a rise in SAM and MAM cases of 40% and a Nutrition response must be scaled up in for a period of 3 months (April – June).

Scenario 3: This scenario focuses on the management of concomitant SAM and cholera cases in the peri urban area 2 of the Capital City, during the July – September period.

Predicted immediate needs include:

* Infant Feeding in Emergencies
  + It is expected that unsolicited donations of BMS will be made from the early days of the emergency declaration;
  + Health workers will request support to deal with non-breast infant and orphaned infants;
  + Mothers will report difficulties breastfeeding and accessing food for complementary feeding;
* Prevention and treatment of acute malnutrition
  + It is expected that SAM and MAM cases will increase calling for intensification of active case finding, referrals, and I/CMAM services will have to be scaled up
  + Health workers will request support with the diagnosis and management of complicated SAM and concomitant cholera
  + Targeted supplementary feeding will have to be scaled up in priority locations
  + Blanket supplementary feeding will have to be tied to Food distribution points where prevalence of wasting is very high
  + Pregnant and Lactating Women (PLW) will be supported by cash/voucher interventions in priority locations
* Evaluation of needs in affected locations
  + There will be a need for rapid Nutrition assessments to be conducted in the early weeks of the emergency to evaluate severity of Nutrition situation and where to scale up the response in priority;
* Coordination and IM
  + It is expected that more personnel will have to be identified and mobilized including staff for supporting Nutrition coordination and information management.
* Resources
  + In addition to mobilizing more personnel for the emergency response, additional supplies will have to be dispatched and more funds allocated. It is anticipated that advocacy will have to be done vis a vis local government for adding essential nutrition services in MoH mobile health units for rapid response.

Estimated PIN per scenario

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Crisis scenario** | Total number of affected people | Nutrition PIN | Geographical locations | Priority population groups | Duration of crisis |
| **Floods** | 60,000 | 3,489 | Villages 9 and 10 of province B; village 11 of province C | General population and IDPs (children and women) | 3 months |
| **Armed conflict** leading to population displacement | 100,000 | 8,047 | Villages 8 and 9 of province B and IDPs from Province A | General population and IDPs (children and women) | 3 months |
| **Epidemics** | 97,988 | 100 | Peri urban area 2 of Capital City | Children and women | 3 months |

The PIN was estimated using the following parameters:

Scenario 1: Floods

* + Affected geographical locations: Villages 11, 10 and 9
  + Total population in affected locations is 60,000 including 18,000 IDPs in village 9
  + Under five children represent 15% of the total population; under 2 represent 40% of under 5
  + Acute malnutrition was at 13.4% among population of villages 9 and 10 and at 12.2% in village 11
  + Baseline cases of wasting estimated in the HRP for a 3-month period was 1,421 SAM and MAM cases.
  + Expected surge of wasting at 30% increase (in addition to baseline cases already included in the HRP)
  + PIN (calculated for a 3-month period, baseline + surge cases) = 3,489 children and women, includes SAM and MAM cases as well as mother-baby pairs (U2) in need of IYCF support.

Scenario 2: Conflict

* + Affected geographical locations: Villages 8 and 9 receiving an influx of IDPs fleeing from Province A
  + Total population in affected locations is 50,000 + influx of 50,000 IDPs
  + Under five children represent 15% of the total population; under 2 represent 40% of under 5
  + Acute malnutrition is at 15% among host and displaced population
  + Correction factor to take incident cases of wasting into account at 2.6
  + Expected surge of wasting at 40% increase (in addition to baseline cases)
  + PIN (calculated for a 3-month period) = 8,047 children and women, includes SAM and MAM cases as well as mother-baby pairs (U2) in need of IYCF support

Scenario 3: epidemics

* + Affected geographical locations: peri urban area 2 of Capital City
  + Total population in affected locations is 97,988
  + Under five children represent 15% of the total population
  + Acute malnutrition is estimated at 15.8%
  + Baseline cases of severe acute malnutrition estimated in the HRP for a 3-month period was 302 SAM cases
  + PIN (calculated for a 3-month period) = 100 children with concomitant SAM and cholera

1. Mapping existing response capacities
2. Coordination capacities

Humanitarian structure

* Main humanitarian actors include Government (National, Provincial, District and Village administrations and their respective bureau of health and nutrition), UN agencies; International and local NGOs, Church and Private Sector
* At national level, the Humanitarian Country team is co-led by OCHA and UNDP. The emergency coordination unit of the Government is led by its Ministry of Interior and supported by OCHA. No such coordination platforms exist at subnational level.
* OCHA leads the intercluster coordination group at national level and there is only one ICCG hub at subnational level located in Province B. In other Provinces, the cluster approach per se is not established.
* At national level, the MoH leads the Nutrition Cluster and Unicef co-leads with dedicated personnel in the role of Nutrition Cluster Coordinator. An international NGO is part of the coordination team playing a dual role of Deputy Nutrition Cluster Coordination / IM role. At province level, the province’s bureau of health and nutrition leads the Nutrition coordination group, with support from Unicef and / or NGOs (depending on Province).

Coordination platforms

* At national level, the Nutrition Cluster has a functional SAG, with members elected on annual basis. The ToR was not updated in the past years.
* There are two active TWG on Wasting and IYCF-E. A multisectoral task force is about to be officially created jointly with the Wash and Health clusters.
* At subnational level, there is no TWG, and the coordination platform for Nutrition relatively weak, i.e., coordination meetings do not take place on a regular basis, are poorly attended and serve more as a platform for information sharing.

IM capacities

* At national level, there is a staff dedicated for IM for the Nutrition cluster but not at subnational level.
* There is a lack of reliable population data at village level that is the lowest level of admin planning unit in Zwantipolis.
* Overall, the health and nutrition information system is relatively weak.

1. Assessment capacities

* A Nutrition information WG is active with up-to-date ToR and co-led by Unicef and the MoH. It is the entity responsible for survey design, protocol and results validation, focusing on SMART surveys and CMAM program coverage evaluation.
* A Nutrition assessment specialist is working fulltime to facilitate the work of the NIWG that is also involved in IPC analysis (for both AM and acute food insecurity)
* Protocols for rapid nutrition assessments are being developed as well as SOPs for MUAC screening with support from the CDC.
* Nutrition partners have been recently trained on the SMART methodologies and about 2 to 3 INGOs are in capacity to conduct SMART surveys and do so jointly with Government staff.

1. Capacities for Nutrition response

Ongoing interventions and partners mapping

The Zwantipolis Nutrition 4W is available on its humanitarian response info page[[4]](#footnote-4) (link here: https://www.humanitarianresponse.info/en/operations/yemen/document/yemen-nutrition-cluster-4ws-matrix-2020) and the resulting map[[5]](#footnote-5) is available here: <https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/feb_2021_nutrition_cluster_partners_presence_map.pdf>

Nutrition guidelines and protocols, training materials

Each TWG (NIWG, Wasting WG, IYCF-E TWG) of the Nutrition cluster maintains a list of protocols and guidelines and are responsible to ensure these protocols are up-to-date and validated/endorsed by Government.

|  |  |  |
| --- | --- | --- |
| **Guidelines** | **Current status** | **Recommendations** |
| National IMAM guidelines | Endorsed | Refresher training needed |
| Simplified protocols for the management of acute malnutrition at times of emergencies | Draft stage | Will have to be included in the national I/CMAM guidelines as an amendment |
| Protocols for the management of concomitant SAM and cholera | Do not exist/to be developed |
| MUAC screening tool | SOPs being drafted | To be approved by MoH |
| IYCF-E guidelines | Finalized but not yet approved by MoH | Planning of official launch ongoing |
| Joint statement on IFE | Draft stage | Not yet endorsed |
| Micronutrients in emergencies guidelines | Out-dated | ToR for the revision these guidelines is under development |
| Rapid Nutrition Assessment guidelines | Draft stage | Ongoing with the NIWG |
| SMART survey guidelines | Endorsed | Refresher training needed |

Supplies and equipment

The Nutrition Cluster IM focal point maintains a list of essential Nutrition supplies and equipment at national level (see list of items below). For these supplies, information is available on what is in the pipeline, in stock at national level, and dispatched at Province level.

* + Breastfeeding kit (feeding cup with cover, food container with spoon and fork, 1-liter glass tumbler with cover, IEC materials, birth registration form)
  + Vitamin A capsules (100,000 IU and 200,000 IU)
  + Multiple micronutrient powders
  + Iron with folic acid tablets
  + MUAC tapes (Child and Adult)
  + Weighing scales
  + Reference tables (weight-for-height/length, height/length-for-age, weight-for age)
  + Height boards
  + Therapeutic milks F75 and F100
  + Ready-to-Use Therapeutic Food (RUTF)
  + Ready-to-Use Supplementary Food (RUSF)
  + Antibiotics, deworming tablets
  + IEC materials for nutrition

The Nutrition Cluster maintains up-to-date a more detailed list of supply stocks and it is [available on this link.](https://www.nutritioncluster.net/resources/capacity-mapping-tool-nutrition-cluster)

Response modalities

As described in the HRP, the main response modalities currently used by Nutrition partners are:

* Support the needs of local health facilities to ensure re-establishing/ maintaining essential health and nutrition services with HR, drugs, supplies, equipment and capacity building needs, support IM and stock management
* Ensure IDPs access services, immediate focus on early identification and referral of acute malnutrition and IYCF-E;
* Use of mobile units where IDPs are far from health facility (or if damaged)
* Targeted SFP scale up at certain period of the year in priority locations
* Blanket SFP where and when level of acute malnutrition is very high
* Community mobilization, sensitization, among IDP communities on key health, nutrition, and wash practices

Nutrition Cluster staffing

A list of staffing is provided on the Zwantipolis ERP dashboard ([link here](https://app.powerbi.com/view?r=eyJrIjoiYjhiZGJjMmYtMjQxNi00NjQ5LTg1YTItNjYyNzVmMmVmOTcxIiwidCI6IjVlZjFhZDQ4LWJkZTgtNDY0My1hODlhLWVkMTQyNmI0NGJjMyJ9&pageName=ReportSection)) under Step 3 tab.

NiE HR trained

Each TWG (NIWG, Wasting WG, IYCF-E TWG) of the Nutrition cluster maintains a list of trained personnel on NiE, IYCF, IMAM, as well as on SMART survey and IPC. A list of Trainers of trainers is provided on the Zwantipolis ERP dashboard ([link here](https://app.powerbi.com/view?r=eyJrIjoiYjhiZGJjMmYtMjQxNi00NjQ5LTg1YTItNjYyNzVmMmVmOTcxIiwidCI6IjVlZjFhZDQ4LWJkZTgtNDY0My1hODlhLWVkMTQyNmI0NGJjMyJ9&pageName=ReportSection)).

Funding

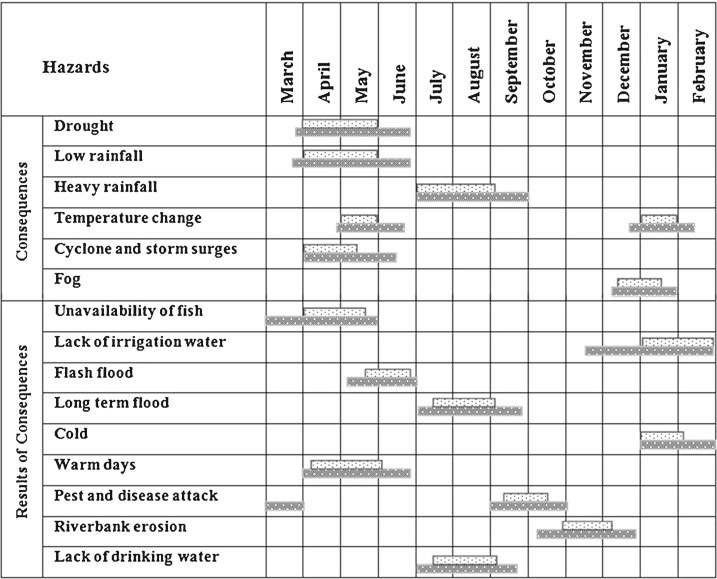
As per the 2022 HRP, $2.2 million were estimated to be needed for the nutrition response, 85% of which is for therapeutic foods such as RUTF, therapeutic milk (F75 and F100), specialized nutritious foods (SNFs) such as RUSF and Super Cereal Plus, Micronutrients Powders (MNPs), medicines and disbursements of cash/vouchers. Nutrition supplies costs included logistics costs for their shipment, storage and distribution/ dispatch. 6% of the budget were to provide surge support from nutrition partners via mobile teams in 3 priority villages*.* Community sensitization and advocacy campaigns*,* capacity building and training costs, budget for nutrition-related assessments and support to nutrition coordination mechanisms at national and sub-national levels represented less than 2% of the total budget.

Based on previous years, on average the Nutrition cluster response is usually funded at 70%.

1. Response analysis and Strategy
2. Response analysis

A summary of the Nutrition situation in Zwantipolis is described in the 2022 Humanitarian Needs Overview (HNO) analysis.

The graph below is a schematic representation of the seasonal calendar of Zwantipolis[[6]](#footnote-6)



In addition, during the HNO analysis, the Nutrition Cluster reviewed several sources of information to review Protection-related risks that must be mitigated from the design of the nutrition response. The issues identified during this pre-crisis analysis are compiled in the below table:

|  |  |  |  |
| --- | --- | --- | --- |
| **Sources of information** | **Geographical areas** | **Issues identified** | **Actions for response design** |
| NGO X **safety audit assessment** undertaken in June 2022 | District 4 of Province B | The majority of Health and Nutrition services sites are inaccessible and unsafe for girls and women due to their distance from the villages and exposure to risks when accessing services | To establish mobile units or satellite sites to reduce distanced travelled (as well as minimize crowding and waiting time) |
| A **Disability inclusion research study** done by the national health research center in 2020 | Nation wide | There is a significant underestimation of disability across the country. Persons with disabilities make up 15 per cent of the global population (10 per cent of children). There is a disproportionate impact of emergencies on children with disabilities, as they face a number of barriers to accessing assistance. | Collaborate with AAP focal points to engage persons with disabilities in emergency preparedness and response. Meet and consult with organizations of persons with disabilities (OPDs) and involve them in the Nutrition Cluster ERP work to mitigate risks and barriers affecting children and adults with disabilities. |
| NGO Y ‘s **feedback and complain mechanism** information | Across Province B | PLW benefiting from the Nutrition program (especially from TSFP where TSFP commodities such as CSB++ are provided) are at risk of GBV and/or at an increase exposure to sexual harassment and assault | i) Increase the number of Protection risk analysis undertaken by Nutrition partners; ii) Sensitize all stakeholders about these Protection risks and necessary mitigation measures iii) Consult women in the Nutrition project design stage and throughout the emergency program cycle iv) Map, use, maintain GBV referral pathways v) Recruit female staff and volunteers as much as possible vi) Complaint and feedback system and committees in place vii) Train, orient, sensitize Partners’ staff, government officials and health care practitioners on Protection from Sexual Exploitation and Abuse (PSEA) so that sensitization and orientation on PSEA continued to be reinforced. |
| **Consultations** with selected stakeholders and key informants | Across the country | There is a risk that children living with disabilities affected by malnutrition may not be identified and referred to the CMAM program | Through active case finding (MUAC screening at community level), and through sensitization of community health workers and communities, during the implementation of the Family MUAC approach and other community-based programs, to ensure malnourished children with disabilities have equitable access to nutrition treatment |
| **Nutrition Cluster inputs and NGO X’s Rapid Gender Analysis** among IDPs in July 2022 | Village 7 of District 4 of Province B | There is too little consultations and participation of communities in the design of the Nutrition response for example, the design of the Family MUAC approach is currently taking place only among Nutrition experts despite the fact it aims at empowering mothers/parents to monitor the nutritional status of their children with the use of MUAC tape. Another example is the fact that gender dynamics are not taken into consideration at response design stage | i)   To ensure consultations with community health workers and communities (mothers and fathers) related to the Family MUAC approach to understand relevant community perspectives to take into account in the design ii) To advocate for consultations to be undertaken with women, men and camp leaders in IDP sites to explore how to promote an increased level of women participation and decision making in community meetings |
| **UN Agency X’s end user monitoring** June 2022 | Across the country | Concerns for the dignity of the women/mothers of children affected by malnutrition with for example 15% of women beneficiating from MIYCN counseling at health facility level being unsatisfied by the services because the IEC materials are not practical and/or because of the waiting time versus the time the health worker spends with the patient is found inadequate | To ensure programmatic adjustments are made to address the concerns of beneficiaries understood from complaint and feedback system and End User monitoring |

1. Response design and strategy

The overall Nutrition response strategy of the Nutrition cluster is described in the 2022 Humanitarian Response Plan (HRP), its strategic objectives (SO) and main activities are summarized in the below table

**Overall response strategy**

|  |  |
| --- | --- |
| SO1 | Objective 1: To ensure continued access to treatment of acute malnutrition among children, pregnant and lactating women |
| * Activity 1: Intensify MUAC screening activities for early identification and referral of acutely malnourished children * Activity 2: Provide surge capacity support to the delivery of SAM and MAM treatment (through static and mobile support), in collaboration with the health cluster |
| SO2 | Objective 2: To strengthen preventive Nutrition interventions including at times of emergencies |
| * Activity 1: Scale-up actions toward protecting adequate Maternal nutrition, IYCF and care practices * Activity 2: Establish provision of Multiple-micronutrient supplements (integrated to IYCF-E interventions) * Activity 3: Tie the implementation of preventive Blanket SFP and Cash/voucher interventions to Global Food Distribution (in collaboration with the Food Security cluster) where and when acute malnutrition and mortality are very high |
| SO3 | Objective 3: To evaluate and monitor the Nutrition situation in risk-prone areas |
|  | * Activity 1: Contribute to multisectoral initial rapid needs assessments in affected areas * Activity 2: Conduct Nutrition SMART surveys |
| SO4 | Objective 4: To support mechanisms for Nutrition coordination and IM at national and sub-national levels |
| * Activity 1: Support the local government in strengthening coordination and IM for Nutrition * Activity 2: Strengthen Nutrition Emergency Response Preparedness (ERP) at decentralized levels |

**Early response plan**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First 24h following emergency declaration** | | | | | |
|  | **Early response actions** | **Purpose** | **Responsible** | **Constraints** | |
| 1 | Attend emergency coordination platform meetings (OCHA-led and / or Government-led meetings) | Ensure Nutrition Cluster is represented in relevant emergency management meetings | NCC and Deputy NCC | Many meetings where Nutrition must be represented. Lack of representation at subnational level. | |
| 2 | Organize first Nutrition cluster/sector meeting, and activate / adjust coordination arrangements and responsibilities | Mobilise Nutrition actors | Coordination team | Support to subnational nutrition coordination platform will likely be needed | |
| 3 | Liaise with subnational Nutrition Cluster/sector in affected locations and update the:   * Situation analysis and immediate needs of locally and vulnerable groups * mapping of local partners with capacities to scale up * Status of mobile health and nutrition units’ activation by the local authorities * Potential supply gaps | Refine the definition of key immediate needs  Trigger early response actions | NCC and IM Specialist; Nutrition partners; subnational Nutrition coordination focal point | Multiple interlocutors at subnational level; communication gaps | |
| 4 | Mobilize technical working groups to ensure:   * Emergency protocols for the management of wasting are approved / triggered * IFE statement released * Preparation for initial needs assessments ongoing * Communication and dissemination of key messages launched | Activation of WGs and of emergency protocols for timely response and scale up. | TWG chairs and co-chairs | HR gaps | |
| 5 | Retrieve and review last inventory of essential nutrition supplies; update and liaise with Logistics and Supply staff for dispatch, storage and for emergency procurement as necessary | Enable timely response and scale-up | Coordination team | Potential physical access constraints and/or lack of storage capacities at subnational level | |
| 6 | Prepare for the mobilization of additional surge personnel for:   * Needs assessments * Coordination and IM * Skilled IYCF support * Scale-up of I/CMAM | Enable timely response and scale-up | Coordination team and TWGs chairs | Delays in the identification of surge support needs and delays in the procedure to mobilize SBP | |
| **First 48h** | | | | | |
| 7 | Establish contacts and gather additional critical information, identify immediate priorities including in areas where the Nutrition situation may worsen | Anticipate on areas where to respond in priority | Coordination team and SAG | Delays in the definition of prioritization criteria | |
| 8 | Mobilize Nutrition personnel to take part of the team composition for rapid initial needs assessments | Nutrition is included in multisectoral initial rapid evaluation of needs | The Nutrition Information WG jointly with the OCHA Assessment WG | Lack of available trained personnel | |
| 9 | Mobilize Nutrition personnel to take part of the team composition for rapid response mechanisms via mobile units | Nutrition response is included in rapid response mechanism (RRM) | Coordination team, MoH and nutrition partners involved in the RRM | Delays in the launch the RRM | |
| 10 | Update 4W matrix including who will scale-up where | Identify gaps in response provision | IM specialist and NCC | 4W matrix at subnational level not in place | |
| 11 | Liaise with the Health cluster to obtain the list of functional hospitals and health facilities | Refine the priority locations for the mobile health and nutrition units | Coordination team and MoH | Fragmented information on health facility functionality | |
| 12 | Contribute to first sitrep report | Response monitoring and resources mobilization | Coordination team | Delays in the data flow | |
| **First week** | | | | | |
| 13 | Contribute to rapid initial assessment data collection, report writing and dissemination | Identify needs and response prioritization, resources mobilization, advocacy | The Nutrition Information WG | | Delays in the production of final report |
| 14 | Draft/update the immediate response plan and refine key figures for PIN, targets and funding requirements for the initial phase of the response | Response planning, resources mobilization | NCC and SAG | | Delays in the production of PIN, target and budget figures |
| 15 | Contribute to flash appeal and concept notes for emergency funds and liaise with donors | Resources mobilization | NCC and SAG | | Very short turn around |
| 16 | Adjust frequency of coordination meetings, of reporting, etc. | Response coordination, response monitoring | Coordination team in consultations with partners | | Fragmented communications; heavy workload; multiple solicitations |
| 17 | Provide support to coordination mechanisms for Nutrition in affected locations as well as to IM functions | Response coordination, response monitoring | Coordination team | | Lack of personnel |
| 18 | Organize meetings with IDP sites leaders and/or CCCM cluster to encourage women participation, consultations and convey key messages on Nutrition | Key Nutrition messages are conveyed early on through various channels | Nutrition partners | |  |
| 19 | IYCF -E   * Screening for breastfeeding counseling needs is integrated to relevant sites * Breastfeeding corner/spaces are established at IDP settlements, * Skilled IYCF one on one support is provided at food distribution points. * IFE statement dissemination follow-up and intensify the monitoring of BMS code violation jointly with health authorities * Organize the management of infants who are not breastfed and of orphaned infants * Ensure support to breastfeeding and complementary feeding practices is implemented early on * Launch the communication strategy to disseminate key messages on infant feeding * Coordinate with other sectors to ensure IYCF support is included where possible | Immediate response implementation as per guidance of the technical working group | With the IYCF-E TWG  Nutrition partners | | Lack of standardized tool for Simple Rapid Assessment (for breastfeeding counseling);  Lack of skilled personnel;  Lack of actors implementing IYCF-E;  Lack of pre agreed IEC materials; |
| 20 | Management of wasting   * Initiate rapid MUAC screening and referral of cases * Ensure MUAC screening and referral of cases are integrated into other sectors interventions * Activate the mobile health and nutrition units to scale-up the provision of treatment * Scale up the treatment of SAM children with medical complications, where required * Identify locations where to establish/ scale-up the management of moderate acute malnutrition, where required | Immediate response implementation / scale-up of basic nutrition package | With the CMAM TWG  Nutrition partners | |  |
| 21 | Contribute to reporting, to funds mobilization and allocation, liaise with donors | Resources mobilization | Nutrition Coordination team | |  |
| **Week 2 to 4** | | | | | |
| 22 | Finalize Nutrition response plan for short- and medium-term response with targets and budget requirements for priority affected locations | Response implementation, prioritization and resources mobilization | Nutrition coordination team and SAG | |  |
| 23 | Orient surge personnel deployed to affected locations | Response scale-up | Nutrition Coordination team | |  |
| 24 | Activate the Nutrition assessments in emergencies SOPs:   * Establish contact with key informants and staff in affected areas and gather information on access * Mobilize trained personnel to be in-charge of Nutrition survey design, implementation and reporting and identify enumerators for data collection * Request necessary approvals for data collection * Gather necessary documents, anthropometric equipment and other materials (including logistics means for data collection). | To conduct Nutrition assessments and evaluate the severity of the situation | The Nutrition Information WG | | Lack of recent information on access in affected location  Delays in the approvals for data collection  Difficulties mobilizing necessary materials, logistics and personnel |
| 25 | Continue support to nutrition services delivery   * MUAC screening activities intensified * Rapid response mechanisms up and running, mobile health and nutrition units functional * Ensure inpatient care is available * Maintain referral systems between nutrition services * IYCF-E counseling ongoing and additional counselors being oriented and deployed * Prepositioned stocks of supplies, medicines, and equipment reached destination, stored and are used for rapid response * BMS code violation monitored, reported and counteracted * Continue communication strategy and community sensitization to promote access to nutrition services including of children with disability | Ensure the essential package of nutrition services is delivered early; response monitoring | TWGs and Nutrition partners | | Delays in the mobilization of Nutrition partners in worse affected locations;  Weak flow of information |
| 26 | Liaise with Food security cluster and relevant actors where to tie GFD to blanket SFP in priority locations | Provision of intersectoral emergency response | The Nutrition coordination team jointly with FS cluster and GFD implementers | | Delays in the selection of priority locations;  Delays in the definition of eligibility criteria |
| 27 | Initiate the Cash/voucher-based interventions to support eligible HHs with PLW and 0 – 23-month children in priority locations | (and pre-agreed eligibility criteria; using pre-selected vendors, pre-defined transfer modalities, etc.) | Nutrition partners and Multipurpose Cash WG | | Delays in the selection of households  Delays in the provision of the cash/voucher |

1. Targets

Scenario 1

The Nutrition targets for the 3-month flood-induced emergency response:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Priority Activities** | **Indicator** | **Target** |
| * SO 1 | * Life-saving support for treatment of acute malnutrition | * Number of SAM children admitted for treatment * Number of MAM children benefiting from targeted SFP | 384  1,090 |
| * SO 2 | * Prevent malnutrition and micronutrient deficiencies | * Number of mother-baby pairs counseled on breastfeeding who received Cash/voucher support | 1,300 |
| * SO4 | * Support to Nutrition coordination and IM at sub-national levels | * A Nutrition cluster is established in the affected province | 1 |

Scenario 2

The Nutrition targets for the 3-month conflict-induced emergency response:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Priority Activities** | **Indicator** | **Target** |
| * SO 1 | * Life-saving support for treatment of acute malnutrition | * Number of SAM children admitted for treatment * Number of MAM children benefiting from targeted SFP | 239  784 |
| * SO 2 | * Prevent malnutrition and micronutrient deficiencies | * Number of mother-baby pairs counseled on breastfeeding * Number of 6 - 59-month children reached by blanket SFP | 4,000  1,000 |
| * SO 3 | * Nutrition situation evaluated | * Number of Nutrition assessments | 2 |

Scenario 3

The Nutrition targets for the cholera outbreak response:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Priority Activities** | **Indicator** | **Target** |
| * SO 1 | * Life-saving support for treatment of acute malnutrition | * Number of children affected by SAM and cholera admitted for treatment | 100 |

1. Funding requirement for response

In addition to the $2.2 million required for the 2022 HRP, a total estimate of $892,040 will be needed to implement the nutrition response for all crisis scenario.

|  |  |
| --- | --- |
| Scenario | Funding requirements (response) |
| Scenario 1 | 457,200 |
| scenario 2 | 374,840 |
| scenario 3 | 60,000 |

1. Operational arrangements
2. Coordination

For scenario 1: Floods in Province B, it is anticipated and pre agreed that the provincial Health and Nutrition department will have to be supported with additional personnel to strenghthen the coordination of the nutrition response, in the likelihood of a Nutrition Cluster being activated.

The Nutrition Specialist of the CLA will become fully dedicated to support Nutrition coordination in a co-lead role with the Deputy Director of the Health and Nutrition department.

Nutrition coordination meetings will take place on a weekly basis.

For scenario 3: a member of the Nutrition Cluster SAG also involved in the Health Cluster will serve as a focal point for joint close collaboration during the cholera outbreak.

1. Information management

For scenario 1: Floods in Province B, it is anticipated and pre agreed that the provincial Health and Nutrition department will have to be supported with additional personnel to strenghthen the Nutrition related IM, in the likelihood of a Nutrition Cluster being activated.

The IM Specialist of the Nutrition cluster based at national level will be deployed for surge support in the first week while a request for an IM Specialist from the GNC Rapid Response Team be mobilized and deployed.

For scenario 1 and 2, the frequency of reporting in the 4W matrix will increase from monthly to weekly basis. Ongoing dicussions with OCHA and its IM working group on the adjusted communication flow for weekly sitrep.

1. Assessments

Multisectoral initial rapid assessments of needs:

The methodology is currently being finalized by the OCHA Assessment WG with contribution of all clusters. For the Nutrition cluster, there will be 1 Nutrition staff in each of the 4 rapid assessment teams. The Questionnaire includes qualitative questions related to Nutrition and observations (no MUAC screening during this initial assessments). Four Nutrition partners (2 local NGOs and 2 international NGOs) commited to make Nutrition staff available for these rapid assessments coordinated by OCHA.

Rapid MUAC screening in affected areas:

The NIWG of the Nutrition cluster will be using the CDC MUAC tool to ensure rapid MUAC screening exercises are standardized and produce data of optimum quality. NGO X will take the lead in organizing training of Nutrition partners on the use of these MUAC assessment SOPs.

SMART surveys

The NIWG has pre-selected Nutrition partners who will undertake SMART surveys in affected loations. Trainings on SMART methodologies are organized on a regular basis. A list of anthropometric equipment and other materials (including logistics means for data collection) are up-to-date and planned for. In risk prone areas, where Nutrition surveys will likely take place, a list of pre-identified enumerators is maintained.

1. Nutrition response provision

Modalities and packages of priority interventions tailored to different type of crisis:

The Nutrition Cluster is in the process of developing tailored response packages depending of crisis scenario shown in the below table (work in progress).

The criteria that will be used to define where the scale-up TSFP and where a multi-sectoral approach is provided are being pre-agreed jointly with WFP and Nutrition partners and the intersectoral working group.

|  |  |  |  |
| --- | --- | --- | --- |
| **Host Communities, general population non displaced** | **IDP settlements** | **People on the Move** | **Hard to reach areas** |
| Support the needs of local health facilities to ensure re-establishing/ maintaining essential health and nutrition services with HR, drugs, supplies, equipment and capacity building needs, support IM and stock management  Implement the integrated Health, WASH and Nutrition minimum package  Linkages to food assistance and to nutrition-sensitive interventions including social protection scheme | Strengthen the nearby health facility; ensure IDPs access services, immediate focus on early identification and referral of acute malnutrition and IYCF-E;  Use of mobile units where IDPs are far from health facility (or if damaged)  TSFP scale up  BSFP if high level of acute malnutrition  Community mobilization, sensitization, among IDP communities on key health nutrition wash practices | Anticipate people movements to prevent defaulting from IMAM/CMAM program  Provision of necessaries medicines and nutrition supplies and referrals to other health facilities | Mobile health and nutrition units provide basic services |

In addition, jointly with the MoH and the Health Cluster, a mapping of local civil society organizations is ongoing to identify more local partners supporting access, demand and utilization of health and nutrition services at community level, including at times of crisis. Consultations are ongoing with representatives of organizations working with persons with disability to identify barriers to access to services, and derive mitigation measures accordingly.

Nutrition guidelines and protocols, NiE training materials

Building on the mapping done earlier under step 3, it was identified that a number of guidelines and protocols need to be either finalized, or endorsed and disseminated, in priority:

* Simplified protocols for the management of acute malnutrition at times of emergencies
* Protocols for the management of concomitant SAM and cholera
* MUAC screening tool

In addition, training must take place for the following:

* National IMAM guidelines
* Rapid Nutrition Assessment guidelines

In addition, the communication and community mobilization strategy is being updated and tools are being translated in local language jointly with the MoH.

Supplies and equipment

* A prepositioning strategy for essential nutrition supplies is framed for each crisis scenario and includes list of additional supplies required.
* The prepositioning strategy factors the surge in RUF needs for a scenario where the expended criteria/combined approach is anticipated to be implemented
* A mapping of the available warehouses in strategic locations, and of storage capacities among Nutrition partners is ongoing jointly with the Logistics Cluster. The prepositioning strategy includes a plan for the redispatch of supplies in case prepositioned supplies are not utilized.
* Roles and responsibilities for logistics and supply dispatch (last mile delivery) including the use of private transporters is being agreed upon with local authorities, MOH and pre-selected partners.

Partners and HR for surge response

* In consultation with Nutrition Partners, the ERP Task Force is pre-identifying who will be scaling up what interventions where, for each crisis scenario. Standby partnership agreement are being developed accordingly.
* Jointly with the MoH, the ERP Task force is finalizing the updating of the list of personnel available for surge deployment in locations and in health facilities where the caseload of SAM children with medical complications is predicted to peak.
* Local partners to play a role in the Nutrition response scale-up are being identified and trained on core NiE competencies
* Additional Nutrition personnel are being trained on the use of simplified protocols and on the management of concomitant SAM and cholera
* Refresher training are planned for the provision of cash and voucher assistance with pre-selected partners jointly with the Cash Working group.

Response monitoring

Jointly with the OCHA-led IM working group, trainings are ongoing to refresh knowledge of pre identified IM focal points on the use of adjusted IM instruments in emergencies.

1. Funding, advocacy and resources mobilization

* The ERP task force has developed a budget estimate for each crisis scenario. Funding requirements for both the response and the preparedness actions were included in the ERP plan. This costed plan has been presented by the Nutrition Cluster Coordinator to the Humanitairan donors forum.
* The Nutrition Cluster and the SAG have sensitized Nutrition partners on the funding mechanisms that will be made available in case of emergencies, including on how funding application to CERF and/or emergency pool funds work.

1. Gaps and constraints

The gaps and constraints identified during the ERP planning include notably:

* Lack of trained personnel on NiE at local level and lack of Nutrition focal points among the provincial health and nutrition departments due to vacant positions
* Delays in the dispatch of prepositioned of supplies to health facilities delivering primary health care services, lack of storage capacities
* Lack of coordination capacities for Nutrition response at local level
* Lack of pre agreed criteria for prioritization of intervention scale up
* Delays in the mobilization and disbusment of addition financial resources
* Lack of technical knowledge on managing children with SAM with concomitnant cholera at hospital level
* Lack of skilled personnel who are aware and know how to use the simple rapid assessment tools to identify breasfeeding difficulties
* Lack of technical knowledge on the acceptable medical reasons for the use of BMS
* Absence of referral systems between nutrition programs and interventions

1. PREPAREDNESS ACTIONS

The costed Preparedness actions workplan is available in a separate excel file ([here](https://docs.google.com/spreadsheets/d/1lQu_3Ylgl1pfhoVvm09aLQ5tI5G7hUDJ/edit?usp=share_link&ouid=106279911202404355368&rtpof=true&sd=true)). The ERP Task Force will monitor the implementation of the preparedness measures, update the workplan on a monthly basis and will present highlights on preparedness progress as a standing agenda point during Nutrition cluster meetings.

1. FUNDING REQUIREMENTS

|  |  |  |
| --- | --- | --- |
|  | Funding requirements | |
| Scenario | Preparedness | response |
| Scenario 1 | 54,000 | 457,200 |
| scenario 2 | 374,840 |
| scenario 3 | 60,000 |
|  | 54,000 | 892,040 |

1. Both likelihood and impact scales score from 1 to 5. Impact scale: 1 =Negligeable, 2=Minor; 3=Moderate; 4=Severe; to 5 Critical impact. Likelihood scale: 1=very unlikely; 2=unlikely; 3=moderately likely; 4=Likely; to 5=very likely. [↑](#footnote-ref-1)
2. Score = Impact x Likelihood. It gives a product indicating the gravity of the given risk from low (score 1 – 7), medium (score 8 – 14), to high (15 – 25). [↑](#footnote-ref-2)
3. See sets of MPAs and APAs in the Preparedness actions workplan <https://docs.google.com/spreadsheets/d/1lQu_3Ylgl1pfhoVvm09aLQ5tI5G7hUDJ/edit?usp=share_link&ouid=106279911202404355368&rtpof=true&sd=true> [↑](#footnote-ref-3)
4. For the sake of a real-life example, this is a 4W matrix from the Yemen Nutrition Cluster [↑](#footnote-ref-4)
5. For the sake of a real-life example, this is a map of the Somalia Nutrition Cluster operational presence. [↑](#footnote-ref-5)
6. # This calendar was extracted from a publication on climate change adaptation by the [Shahjalal University of Science and Technology](https://www.researchgate.net/institution/Shahjalal_University_of_Science_and_Technology) in Bangladesh and used as an example

   [↑](#footnote-ref-6)