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Addressing Undernutrition in Emergencies

Accompanying the document

COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL

Enhancing maternal and child nutrition in external assistance: an EU policy framework

{COM(2013) 141 final}

TABLE OF CONTENTS

I. INTRODUCTION

In accordance with the orientation of the Humanitarian Aid Consensus and to promote best practice in the provision of humanitarian assistance for nutrition in emergencies, this Staff Working Document (SWD) is intended to complement Commission Communication on 'Enhancing maternal and child nutrition in external assistance: an EU Policy Framework'XXX to increase the effectiveness and efficiency of humanitarian assistance . In particular, this document seeks to:

- Clarify the objectives, priorities and principles of the Commission's humanitarian assistance for nutrition with regard to populations facing humanitarian crises;
- Identify issues and approaches that enhance the effectiveness of humanitarian assistance for nutrition in humanitarian crises whilst highlighting the necessary linkages with longer-term support;
- Contribute to the elaboration of an EU strategic framework on undernutrition in developing countries.

The scope of this document covers the support already provided by the Commission to improve the nutrition outcomes of its humanitarian assistance. It therefore embraces the multiple sectors that collectively help avoid a negative nutrition impact in situations of humanitarian crises, including health, humanitarian food assistance, and water, sanitation and hygiene responses.

This SWD marks an important step in the process of developing guidelines for the Commission’s humanitarian assistance in the area of nutrition. It is also a further step towards elaborating a common perspective on principles and priorities that support the integration of nutrition objectives across all the sectors of humanitarian assistance. To this end, this SWD explores: The issues and trends that need to be considered (Section One); the conceptual framework and key challenges (Section Two); the objectives, priorities and principles driving humanitarian assistance for nutrition (Section Three); the operational scope of assistance, with a focus on criteria for entry and exit (Section Four); the programmatic responses (Section Five); and shared concerns (Section Six). The SWD also draws on relevant experiences from the rapidly evolving field of humanitarian assistance for nutrition. Such experiences are presented as operational case studies throughout the paper, in order to offer the reader valuable technical insights into issues of programming, implementation and coordination.

Note on Terminology

A **humanitarian crisis** is an event or series of events which represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people. A humanitarian crisis can have natural or manmade causes, can have a rapid or slow onset and can be of short or protracted duration.

The term **undernutrition** covers short-term (acute) or long-term (chronic) situations, and includes several physiological conditions which frequently co-exist: i) wasting (low weight for height) and nutritional oedema (a form of severe acute undernutrition); ii) stunting (low height for age, an indicator of chronic undernutrition); iii) intrauterine growth restriction which leads to low birth weight; and iv) deficiencies of essential micronutrients. The causes of undernutrition are multiple and context-specific.

The term **malnutrition**, in its exact meaning, refers to any form of physiological impairment caused by the body's use of nutrients, i.e. overnutrition as well as undernutrition. However, in the past, it has been used synonymously with undernutrition. It is for this reason that certain acronyms denote 'malnutrition' rather than the more correct term 'undernutrition' – such as CMAM, GAM, MAM and SAM (community-based management of acute malnutrition; global acute malnutrition, moderate acute malnutrition; and severe acute malnutrition, respectively).

(In Annex A, the Glossary provides a fuller description of all technical terms used in this document.)

II. SUMMARY

More than a third of deaths in children under five years old worldwide are attributable to undernutrition.

An estimated 52 million (8%) children under five years old are wasted. 70% of them lived in Asia[1].

Undernutrition in childhood makes children more susceptible to diseases and prevents proper brain development. Irreversible damages caused by undernutrition of individuals have indirect repercussions in terms of loss of national productivity and economic growth.

Undernutrition is an increasing global priority. In 2008, the Lancet series on maternal and child undernutrition played a crucial role in raising international awareness on undernutrition in developing countries. Each year, the European Commission allocates well over EUR 100 million to humanitarian assistance actions that are explicitly associated with specific nutrition objectives. The allocation to nutrition interventions in the Commission Humanitarian assistance has doubled between 2008 and 2011.

Undernutrition and deaths related to undernutrition are largely preventable. Key high impact nutrition interventions have been clearly identified. However the commitment, the capacities and the resources to scale up the interventions to address undernutrition still lack. Wasting has decreased only by 11% since 1990[2].

Undernutrition is the result of multiple immediate, underlying and structural causes, yielded in various sectors: food security, health, water and sanitation, care and their enabling environment. Addressing undernutrition requires a multi-sectoral approach and a joint humanitarian and development framework.

The present document reaffirms the Commission's commitment to address undernutrition in humanitarian crises and sets the framework for these interventions.

The Commission's **objective** is to **reduce or avoid excess[3] mortality and morbidity due to undernutrition in humanitarian situations**. EU humanitarian policy is also concerned with addressing the immediate and underlying causes of undernutrition.

In addition to the humanitarian principles of neutrality, independence, impartiality and humanity, the Commission upholds a set of more specific principles already outlined in its Communication on Humanitarian Food Assistance[4].

Nutrition interventions need to:

- Respond to the needs of the individuals the most vulnerable to undernutrition : mothers and children under 5;
- Use methods and tools which have demonstrated their efficiency and cost-effectiveness;

[1] [2] UNICEF-WHO-WB joint child malnutrition estimates - 2012

[3] "Excess" is considered to combine absolute measures in relation to establish emergency thresholds as defined by the SPHERE handbook, UNICEF, and the UN Standing Committee on Nutrition (SCN), and relative measures in relation to context-specific baselines, see Communication on Humanitarian Food Assistance

[4] Communication from the Commission to the Council and the European Parliament on Humanitarian Food Assistance COM (2010) 126

- Respond to well-defined humanitarian risks as well as immediate emergency needs;
- Promote a multi-sector approach, which is essential to tackle the causes of undernutrition;
- Promote a joint humanitarian and development approach to help build resilience.

Specifically, in emergency situations Commission interventions strives to:

- Reduce levels of moderate and severe acute undernutrition, and micronutrient deficiencies, to below-emergency rates, through timely, efficient and effective humanitarian response;

- Prevent significant and life-threatening deterioration of nutritional status by ensuring access by crises-affected populations to adequate, safe and nutritious food, through food and non-food responses depending on the context;

- Reduce the specific vulnerability of infants and young children in crises through the promotion of appropriate child care, with special emphasis on infant and young child feeding practices;

- Reduce specific vulnerability of pregnant and lactating women in crises through appropriate support of maternal nutrition;

- Address the threats to the nutritional status of people affected by crises from an inadequate public health environment, by securing access to appropriate health care, safe water, sanitation facilities and hygiene inputs.

Other areas of possible support have been identified as key to reach the above objectives, namely information systems, quality programming, capacity building, research and advocacy. However, these are neither entry points nor stand-alone activities.

1 Background

1.1 The scale[5] of the problem

The following information illustrates the extent to which undernutrition constitutes a massive crisis in its own right – one that is global and persistent in nature. Undernutrition kills thousands of people on a daily basis all over the world, including in many countries that are widely considered to be stable and on a positive development trajectory.

- Although undernutrition is largely preventable, it is the underlying cause of over a third of the deaths of children under five years of age worldwide, taking the lives of an estimated three million small children and over 100,000 women every year.
- Around 52 million (8%) of the world's children under the age of five are wasted. 70% of them are in Asia. Around 165 million (26%) of children suffer from stunting globally.[6]
- Stunting, severe wasting, and intrauterine growth restriction are estimated to be responsible for 21% of disability-adjusted life years lost. In an analysis that accounted for co-exposure of these nutrition-related factors, together they were found to be responsible for about 11% of the global disease burden.
- Undernutrition also causes sub-optimal physical and cognitive development, lower resistance to infections and hinders the productivity of adults, thereby lowering the economic potential of societies and perpetuating poverty.
- Micronutrient deficiencies, essential for the growth and development of individuals, affect almost two billion people worldwide, also in developed countries.
- Suboptimum breastfeeding, especially non-exclusive breastfeeding in the first 6 months of life, results in 1.4 million deaths and represents 10% of the disease burden among children under the age of five.
- Progress in the achievement of the relevant Millennium Development Goals (MDG) (1,4 and 5) is still slow:

    - MDG 1 'Eradicate extreme poverty and hunger' has shown some progress as extreme poverty decreased in every region, even if some regions have seen more progress than others. Hunger remains a global challenge. The most recent FAO estimates of undernourishment set the mark at 850 million living in hunger in the world in the 2006/2008 period - 15.5% of the world population. This continuing high level of undernourishment reflects a lack of progress on hunger reduction in several regions, even where income poverty has decreased.
    - Although MDG 4 'Reduce Child Mortality' has gained momentum, progress is still too slow to meet the target: Sub-Saharan Africa and Oceania have experienced child-mortality reductions of only around 30%, less than half of what is required by the MDG. Southern Asia is also lagging behind with a 44% decline in the child mortality rate between 1990 and 2010 - insufficient to achieve a two-third reduction by 2015.
    - MDG 5 'Improve maternal health' has shown progress as maternal mortality has nearly halved since 1990. Nonetheless, current maternal mortality levels are still far from the target set for 2015. An estimated 287,000 maternal deaths occurred in 2010 worldwide, indicating a 47%decline from 1990 levels. Sub-Saharan Africa (with 56 percent of

[5] Unless otherwise stated, figures presented in this section are from the first paper in the Lancet series: Black R.E. et al. (2008): Maternal and Child Undernutrition: Global and regional exposures and health consequences. Lancet 371, 243-260. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61690-0/fulltext.

[6] UNICEF-WHO-The World Bank joint child malnutrition estimates (2012)

these deaths) and South Asia (29 percent) together accounted for 85% of the global burden in 2010, with a joint total of 245,000 maternal deaths.[7]

1.2 Undernutrition as an increasing global priority

In recent years, and with the growing realisation of its significance in terms of MDG progress, considerable advancement has been made in re-energizing the fight against undernutrition. As a result, new strategies and initiatives for tackling undernutrition in developing countries are underway in several EU member states.[8]

Due attention should also be devoted to recent publications[9] presenting evidence on the most effective interventions to address undernutrition. In particular, a landmark publication in *The Lancet* in January 2008 (five papers, referred to as the Lancet Series, cited above), gave new momentum to the fight against undernutrition. Much of this momentum is embodied in the *Scaling up Nutrition* movement (SUN).[10] This initiative aims to build a multi-stakeholder and multi-sectoral alignment to support national-level strategies and efforts to address undernutrition.

Each year, the Commission allocates well over EUR100 million to humanitarian assistance actions that are explicitly associated with specific nutrition objectives. This funding supports nutrition interventions in emergency contexts implemented by United Nations Agencies, the Red Cross/Red Crescent Movement and International Non-Governmental Organisations. Furthermore, the promotion of more effective nutrition outcomes in all response sectors is increasingly recognised as a core priority.

The Commission has adopted a Communication on Humanitarian Food Assistance[2] which addresses undernutrition concerns associated with inadequate food consumption. The Commission has also adopted two other Communications[11] (one on health and one on food security) that call for more comprehensive strategies to tackle undernutrition and for a strengthened link between health and food security (both transitory and chronic) to bring about more effective responses.
Furthermore, a Commission Reference Document on Addressing Undernutrition in External Assistance[12] was adopted, providing practical guidance on how nutrition objectives can be incorporated into different sectors, thematic areas and funding modalities.

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[7] http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2012/English2012.pdf

[8] For instance: 'The neglected crisis of undernutrition: DFID's Strategy' (http://collections.europarchive.org/tna/20100423085705/http://dfid.gov.uk/Documents/publications/nutrition-strategy.pdf); the French government strategy: 'Nutrition dans les Pays en Développement — Document d'Orientation Stratégique' (www.diplomatie.gouv.fr/fr/ministere_817/publications_827/enjeux-planetaires-cooperation-internationale_3030/documents-strategie-sectorielle_20004/les-pays-developpement-nutrition_1287987.html); Ireland's *Hunger Envoy Report 2010* (http://www.irishaid.gov.ie/uploads/Hunger_Envoy_Report.pdf); and Germany's strategy *Rural Development and its Contribution to Food Security, 2011* (http://www.bmz.de/en/publications/type_of_publication/strategies/Strategiepapier302_01_2011.pdf)

[9] For example: World Bank 2010: *Scaling up Nutrition. What will it Cost?* By S. Horton et al. and Save the Children 2009: *Hungry for Change. An eight-step, costed plan of action to tackle global child hunger*.

[10] http://www.scalingupnutrition.org/

[11] The EU Role in Global Health (COM(2010)128) and An EU policy framework to assist developing countries in addressing food security challenges (COM(2010)127)

[12] Reference document n°13 "Addressing undernutrition in external assistance" http://capacity4dev.ec.europa.eu/topic/fighting-hunger

In addition, the recently renegotiated Food Assistance Convention[13] reflects the nutritional aspects of food assistance and effectively integrates nutrition in its principles and objectives.

1.3 Undernutrition in crises

Crisis situations, whether acute or protracted, impact on a range of factors that can increase the risk of undernutrition, morbidity and mortality. They may involve: the large-scale destruction of property and infrastructure; the erosion of livelihood strategies and purchasing power; a breakdown of and reduced access to essential services including health services, water supply and sanitation; and displacement of large numbers of people. Emergencies can also disrupt social systems and the quality of care/feeding practices. Household access to food may be negatively affected and people may find themselves in over-crowded settlements with their families being divided. As a result, at the individual level, there is often an increased risk of deteriorating health and nutritional status, resulting in a greater likelihood of death (see Figure 1: Conceptual framework).

Young children and pregnant and lactating women are particularly vulnerable to undernutrition from a physiological point of view, due to their increased nutrient requirements for growth and development. Young children are also exposed to a higher risk (compared to other population groups) of contracting infections, which can further increase nutrient requirements, impede nutrient use and reduce appetite. For this reason, young children often demonstrate the fastest nutritional deterioration in crisis contexts, as well as the highest rates of disease and undernutrition-related mortality. Young children are therefore considered a primary target group for assistance. Furthermore, older and disabled people, as well as people living with chronic illness such as HIV and AIDS may also suffer from reduced appetite, difficulties in chewing and difficulties in accessing food, which increase their nutritional vulnerability.

Gender also plays an important role in determining individual vulnerability to undernutrition. Women/girls and men/boys face different risks in relation to the deterioration of their nutritional status during crises as a consequence of both their different nutritional requirements and a variety of socio-cultural factors related to gender:

- Undernutrition has particularly serious consequences for women, as stunted women face higher risks of complications during childbirth; Anaemia (the most widespread nutritional problem affecting girls and women in developing countries) is responsible for a significant proportion of maternal mortality.
- Maternal acute undernutrition is associated with intrauterine growth restriction and constitutes a risk factor for poor neonatal health.
- Undernutrition has an intergenerational cycle, as undernourished adolescent and adult mothers are more likely to give birth to low birth-weight babies. This in turn, increases the risk of undernutrition in early childhood.

Gender and nutrition vulnerability during crises

- When food is in short supply, women and girls are **more likely** to reduce (voluntarily or as a result of external pressure) their intake in favour of other household members, thus worsening their own nutritional status.
- Women may face constraints in accessing essential humanitarian services as a result of insecurity, cultural discrimination and limited mobility.
- Pregnant and lactating women are particularly exposed to undernutrition due to their increased

[13] Document "Food Assistance Convention – 25 April 2012"

physiological requirements.

- While remaining the primary caregivers of children and other dependents, women undertake additional activities during crises, particularly where male heads of households are absent. This often leads to the disruption of infant and young child feeding practices and care.
- Men who are single heads of households may be removed from their normal support structures during crises and if they do not know how to cook or care for young children, this results in a greater risk of acute under-nutrition for themselves and their children.

2 Scope of Nutrition in Emergencies

2.1 The conceptual framework of undernutrition

There are numerous possible causes of undernutrition, many of which impact on both acute and chronic undernutrition. These causes are usually analysed at three levels: immediate, underlying and basic. These three levels are based on the conceptual framework developed by UNICEF in the 1990s, which is still regarded as a valuable guideline today (see Figure 1).

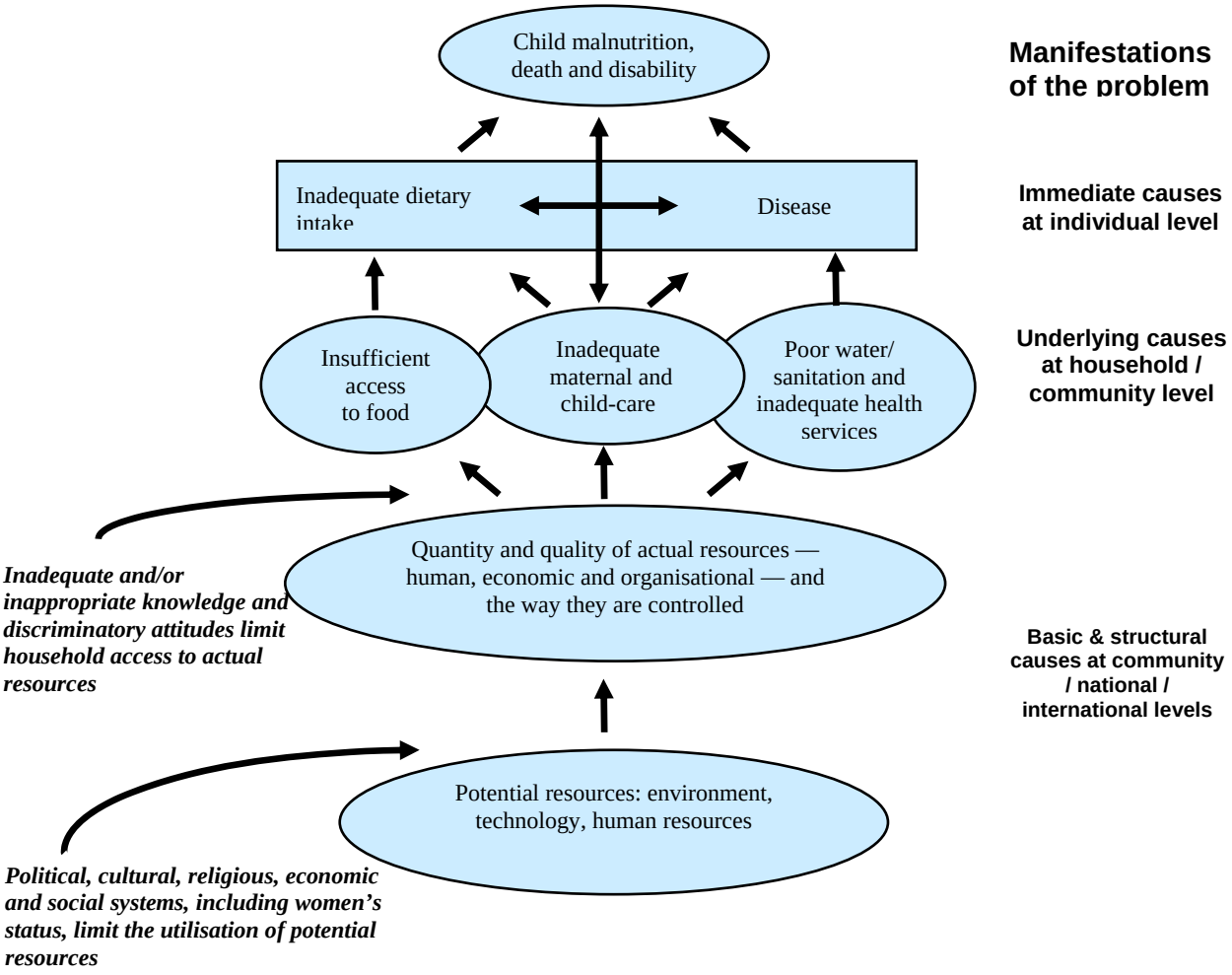
The humanitarian assistance for nutrition provided by the Commission is primarily aimed at preventing and alleviating the short-term consequences of maternal and child undernutrition by addressing their immediate and underlying causes at the individual and household levels.

- Immediate causes are to be found at the individual level and have two dimensions: dietary intake and the presence of diseases. This distinction emphasises the limitation of the term 'hunger' in denoting undernutrition, as hunger may or may not be a cause of undernutrition. The Commission's humanitarian interventions address immediate causes of undernutrition by providing immediate access to food, in order to improve food intake, and free access to life-saving healthcare.
- Underlying causes operate at the household and community levels. They comprise three categories: (i) household food security, (ii) care for children and women and (iii) health environment and health services. Income poverty affects all three. Household food insecurity can be alleviated through measures aimed at durably increasing household food availability, accessibility (e.g. purchasing power) and utilisation (e.g. cooking). Inadequate care practices can be addressed through measures aimed at ensuring maternal nutrition and appropriate and regular feeding of infants and young children, as well as providing safe feeding spaces. Unhealthy environments can be addressed through water, sanitation and hygiene measures as well as through the provision of accessible health services and disease control measures (e.g. long-lasting insecticide-treated mosquito nets, environmental interventions).
- Basic causes include a range of factors operating at the sub-national, national and international levels, ranging from the availability of natural resources, to social and economic environments, to political contexts.[14] Basic causes that are linked to political, cultural, religious, economic, educational, demographic, and social systems can only be addressed through long-term development strategies.

Undernutrition therefore has to be understood as a multi-sectoral challenge, requiring a sound understanding of the specificities of each context of intervention.

[14] Source: Reference Document n° 13 "Addressing undernutrition in external assistance"

Figure 1: Conceptual Framework of Malnutrition showing the relationship between poverty, food insecurity, and other causes of maternal and child undernutrition



Source: The State of the World's Children, UNICEF 1998

Figure 2: The underlying causes of undernutrition (adapted from the Communication on Humanitarian Food Assistance)

Household Food Insecurity
Lack of safe access to adequate and safe food throughout the year through:

- Food production
- Purchase/barter
- Gifts, other sources
- Food safety and quality
- Cash transfers

Inadequate Care

- Maternal nutrition
- Maternal Care (workload, gender imbalance etc.)
- Child care
- Infant and young child feeding
- Eating habits
- Food preparation
- Intra-household food distribution
- Capacity to care for dependent individuals

Unhealthy Household environment and lack of health services

- Water quality and quantity
- Hygiene and sanitation
- (Free) access to and use of health services

2.2. Recent advances in the management of undernutrition in crises

The following important developments in recent years have taken place:

(i) The publication of new WHO growth standards (2006), based on the growth of children under conditions of optimal nutrition and health from a variety of countries, provides a better tool for diagnosing undernutrition, and defining and identifying nutritional risk and nutritional needs.

(ii) The emergence and expansion of Community-based Management of Acute Malnutrition (CMAM). Extensive evidence is now available on the heightened efficiency and effectiveness of such approach compared to models that only offer inpatient treatment. This is linked to an improvement in the identification of cases and in the mobilization of communities around situations of undernutrition, as well as to a reduction in the barriers to accessing treatment as a result of better resourced and managed programmes.

This approach uses a new classification of severe acute malnutrition (SAM), which categorises children either as suffering from SAM with complications or without complications, based on clinical symptoms. The latter can be treated as outpatients with ready-to-use therapeutic foods (RUTF), while children with medical complications are treated following specialised medical protocols through the administration of therapeutic milk in inpatient facilities.

(iii) An increasing focus on the quality of food inevitably contributes to nutritional improvements. The adaptation of therapeutic milk into RUTF, and the development of improved formulae of fortified blended foods and specialized ready-to-use supplementary foods (RUSF) are playing a key role in this sense. Use of these products has been extended into other areas such as the treatment of moderate acute undernutrition, the prevention of undernutrition, the nutritional rehabilitation of acutely ill patients, etc. Such advances provide an opportunity for the development and adaptation of new intervention strategies.

(iv) The recognition that children under five years of age constitute the most vulnerable age group in terms of acute malnutrition. Although in humanitarian settings the provision of assistance should be guaranteed to all nutritionally-vulnerable age groups, particular emphasis should be given to children under five years of age.

(v) The understanding that the period between conception and 2 years of age is crucial in defining the future nutrition and health status of the individual. This period provides a critical window of opportunity in which the impact of interventions to improve maternal and child undernutrition - including measures to improve micronutrient intake in the under twos (U2s) - on the survival, growth and development of young children is maximised [15].

(vi) A focus on population-based strategies to prevent moderate undernutrition is combined with more common interventions targeting individuals. These range from blanket distributions of (fortified) supplementary foods to social protection schemes such as cash transfers. For example, there is increasing evidence of the value of integrating household and community food security and livelihood support with nutrition rehabilitation interventions. At the same time, access to free medical services has also proved to have a great impact on nutrition, as nutrition security is not exclusively linked to food security.

[15] However, this understanding has served to highlight the opportunities for enhanced synergies with longer-term efforts by the Commission to prevent undernutrition, by underscoring the crucial requirement to intervene both to save lives and to avoid long-term adverse outcomes for this age group. This understanding has also heightened attention to potential evidence regarding specific challenges that can be associated with ensuring access to nutritional assistance for children under two years of age.

(vii) The standardisation of survey methods to assess the prevalence of undernutrition in emergencies, in particular the Standardized Monitoring and Assessment of Relief and Transition (SMART) methodology, and progress towards new survey techniques to assess programme coverage (e.g. SQUEAC).

(viii) The recognition of the importance of acute undernutrition in non-emergency contexts such as areas with persistently high levels of undernutrition in the long term, or during 'seasonal hunger gaps', and of the need, therefore, to integrate undernutrition prevention and treatment into national food security and healthcare systems, as well as cross-sectoral development planning.

(ix) A consensus on the importance of Infant and Young Child Feeding practices in Emergencies (IYCF-E) in order to save lives and improve health and the development of children. This includes measures that assess the IYCF-E context; the integration of breastfeeding and IYCF-E support into other services for mothers, infants and young children; and the provision of food that is suitable for infants and young children. Although the promotion of breastfeeding is a priority, in certain humanitarian situations it is preferable to support formula feeding. The importance of preventing and avoiding donations of breast-milk substitutes, bottles, teats and other milk products in emergencies is also recognised.

(x) There are several key areas where progress has been made which, despite not being 'new', have a bearing on how undernutrition should be managed in crisis contexts. These include: a better understanding of the multifaceted causes of undernutrition, the identification of links between HIV and Tuberculosis and nutrition/undernutrition, the identification of the benefits of a holistic multi-sectoral approach and a heightened understanding of the importance of tackling micronutrient deficiencies in the management of undernutrition and in the improvement of health conditions.

2.3 Key Challenges in Addressing Undernutrition in Emergencies

The following list presents the key challenges to be faced when addressing undernutrition in emergencies:

- **Good coordination**, which requires effective leadership and the establishment of mechanisms to build consensus for an appropriate and context-specific strategy. Such a strategy must be able to ensure multi–sectoral capacities and commitment to clearly identified nutrition objectives.
- **Accurate analysis of the causes of undernutrition and interpretation of information** from multiple sectors including gender and age disaggregated indicators of food and/or nutrition security, to feed into timely and appropriate responses. Challenges include the absence of regular and reliable monitoring mechanisms for nutritional status, especially in areas where, despite SAM being a persistent or recurrent concern, it is not adequately recognised or addressed by concerned governments or development partners.
- Availability of skilled **human resources** (human resources shortage) and strengthened **capacity** to respond to nutrition emergencies (emergency preparedness).
- **Promotion and scaling-up of effective interventions** such as community-based approaches for the prevention and management of acute undernutrition, while ensuring adequate attention and resources for other crucial sectoral response options.
- **Promotion of quality management** of humanitarian assistance for nutrition through evidence-based decision-making and implementation. This requires cross-sectoral approaches; collection and analysis of gender and age disaggregated data; innovations in programme design

(including, for example, adapting effective local practices); sound management; good documentation; and investment in research to fill evidence gaps.

- Ensuring a **gender-sensitive approach** to the assessment of needs and nutrition programming, particularly in the areas of community consultation and participation, awareness raising and nutrition education.
- Contributing to efforts to **build an evidence base**, in order to assess the impact of interventions; development and dissemination of new survey methods that are easier to undertake in difficult contexts; diagnostic tools to analyse micronutrient deficiencies without requiring sophisticated laboratory analyses; and treatment of infant acute undernutrition in emergencies.
- **Measuring impact** in relation to reducing and preventing undernutrition and mortality in emergencies and drawing lessons to inform future responses. The absence of standardised reporting mechanisms for programme performance (including programme coverage) is an important constraint on impact monitoring.
- Taking advantage of the opportunities and resources that humanitarian assistance can bring to **strengthen national capacity** for the prevention and management of undernutrition – while at the same time striving to secure long term strategic planning and investment in capacity-strengthening.
- **Ensuring long-term, sustained support from development actors** for tackling undernutrition prior to, during and after an emergency.
- **Developing a holistic and integrated approach to undernutrition**
- **Ensuring availability of appropriate capacities for sectoral and/or multi-sectoral coordination in addressing both existing and upcoming needs**

In the sections below, these challenges will be further discussed and emerging experience regarding how best to address them will be presented to chart the road ahead.

3 OBJECTIVES, PRIORITIES AND PRINCIPLES OF THE COMMISSION'S ASSISTANCE TO NUTRITION IN EMERGENCIES

Considering all these recent developments and challenges, and building on existing policies, the Commission identifies the following objectives, priorities and principles for its work on nutrition in emergencies.

3.1 Principal objective

The principal objective is *to reduce and avoid excess mortality and morbidity caused by undernutrition in humanitarian situations.*

3.2 Specific objectives

The principal objective is to be achieved through the following specific objectives:

- To reduce levels of moderate and severe acute undernutrition to below-emergency rates, and prevent/correct micronutrient deficiencies through timely, efficient and effective humanitarian responses.
- To prevent significant and life-threatening deterioration of nutritional status by safeguarding the availability of, access to and consumption of adequate safe and nutritious food while protecting livelihoods and promoting conditions for the restoration of self-reliance.
- To reduce the threats to the nutritional status of people affected by crises stemming from an inadequate public health environment, by securing access to appropriate healthcare, safe water, sanitation facilities and hygiene inputs.
- To reduce the specific vulnerability of infants and young children in crises through the promotion of appropriate child care, with special emphasis on infant and young child feeding practices.
- To reduce the specific nutrition vulnerability of pregnant and lactating women/women of reproductive age.[16]
- To reduce the specific nutrition vulnerability of most affected groups (such as the elderly, disabled, HIV- positive, children over five, and adolescents).
- To strengthen the capacities of the international humanitarian aid system to enhance efficiency and effectiveness in the delivery of humanitarian assistance for nutrition.

3.3 Strategic priorities

In populations affected by emergencies, the priority focus is on acute (moderate and severe) undernutrition, which is associated with a higher risk of mortality and morbidity.
In line with the above objectives, the Commission responds to underrnutrition and its causes in emergencies by funding interventions that meet the following strategic priorities:

i) Interventions to treat MAM and SAM

ii) Interventions through the nutrition, health and food assistance sectors that tackle the immediate causes of undernutrition (inadequate dietary intake and disease);

[16] Note: Throughout this document, where reference is made to pregnant and lactating women and their associated physiological nutrition vulnerability, it is acknowledged that this overlaps considerably with the nutrition vulnerability of 'women of reproductive age' and 'adolescent girls' and that such considerations can have significant operational implications.

iii) Interventions through the nutrition, health, food assistance and WASH (water, sanitation and hygiene) sectors that tackle the underlying causes of undernutrition (food insecurity, inadequate care practices and inadequate access to healthcare and environmental health);

iv) Integration of nutrition interventions within an overall resilience strategy in coordination with development partners.

3.4 Principles that guide the Commission's assistance to nutrition in emergencies

In pursuit of the above-mentioned objectives, the following principles underscore the Commission's support to nutrition in humanitarian situations:

i) The nutrition interventions aiming at treating and preventing undernutrition are based on individual needs. The individual nutritional status is assessed using standard methods, measures and threshold. The preventive interventions and indirect interventions on the causes of undernutrition are based on appropriate needs assessment, using standard indicators such as GAM and SAM prevalence, access to food and access to basic health care.

ii) The choice of the most appropriate intervention(s) and instrument(s) must be based on evidence: the needs assessment, the nutrition causal analysis, the context analysis and the response analysis. The design of any response should compare alternative activities and modalities on the basis of cost-effectiveness for meeting identified needs. Interventions should be regularly reviewed on the basis of local dynamics and situation changes.

iii) Nutrition interventions respond to well defined humanitarian risks. They are targeting individuals particularly vulnerable to mortality and morbidity related to undernutrition: children under 5, the pregnant and lactating mothers, elderlies and chronically ill.

iv) Understanding the causes of undernutrition and enabling environment is crucial to identify the appropriate combination of activities to address undernutrition and its causes. Causes of undernutrition are often multiple. Adopting a multi-sector approach and coordinating humanitarian and development actions are thus essential.

v) The Commission seeks to incorporate systematically gender perspectives into its humanitarian nutrition assessments. It also considers the gender implications of its emergency nutrition interventions, recognising the importance of gender roles in caring and feeding practices, livelihoods, the use and allocation of food at household level, and beneficiaries' utilisation of food assistance resources.

vi) Nutrition assistance upholds the principles of Linking Relief Rehabilitation and Development (LRRD). Where possible and appropriate, the Commission works with its development partners to maximise the sustainability of interventions by promoting their integration into national policy frameworks and plans (e.g. in health policy, emergency response plans, national protocols for the treatment of undernutrition, etc.).

vii) The Commission strives to do no harm through its humanitarian assistance for nutrition. This is especially important in relation to the safety of innovations and the use of specialized nutrition products. The Commission always ensures that all available evidence is considered fully, and that the best interests of the beneficiaries remain central.

viii) The Commission promotes those practices that are efficient and effective in managing undernutrition. The care given, quality of food products used and reliability of information[17]

[17] For example, high case-fatality rates of severe acute undernutrition have been attributed to inappropriate case management and poor knowledge of medical staff. Wider implementation of the WHO guidelines through in-service training and incorporation into medical and nursing curricula is the key to substantially decreasing case-fatality rates of SAM. Collins S. et al. Management of severe acute malnutrition in children. *The Lancet*, Vol. 368

that guides programme design follow international standards – such as Sphere, WHO, or guidance from the Global Nutrition Cluster.

(9551), page 1992-2000, 2 December 2006. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69443-9/abstract

4 OPERATIONAL SCOPE OF ASSISTANCE

4.1 Entry and Exit Criteria

In line with the Commission's Communication on Humanitarian Food Assistance, the Commission follows the entry and exit criteria for operations outlined below, always mindful of the commitment to supporting appropriate transition through LRRD (Linking Relief, Rehabilitation and Development).

Entry criteria for operations

- The Commission may trigger nutrition support when emergency rates of mortality or acute undernutrition (U5 mortality rate >2/10,000/day, GAM >15%, and GAM rates >10% with aggravating factors) have been reached or exceeded, or are anticipated, on the basis of firm forecasts. Such "anticipation" should be based on early warning indicators that show a critical deterioration in the food security and/or health environment, which, unless responded to, will become life-threatening within a timeframe that is consistent with the Commission's humanitarian remit.

- Recognizing that a food crisis sometimes begins, calling for a reaction before the nutritional status deteriorates further, the Commission does not necessarily wait for rising rates of acute undernutrition before providing humanitarian food assistance and nutritional support, and respond to well-defined humanitarian risks that pose a threat to life. The Commission does not require a formal disaster declaration in order to respond to an emergency.

- In considering whether and how to respond to a given crisis, the Commission pays close attention to the comparative advantages and disadvantages of the humanitarian instruments at its disposal. This requires: a careful analysis of the existing needs and the causes of the crisis; a consideration of the type of response that will address those needs in the most appropriate way without causing any harm; and a close review of the alternative assistance mechanisms that are available.

- In this regard, the Commission's humanitarian assistance does generally not respond to permanently high levels of undernutrition (whether stunting, wasting and/or micronutrient deficiencies) except where non-intervention poses an imminent humanitarian risk of significant scale and severity and where other more appropriate actors are either unable or unwilling to act, and cannot be persuaded to act; and where, in spite of its comparative disadvantages, positive impact can be expected within the time limitations of the intervention by the Commission. In such cases, the delivery of humanitarian assistance for nutrition is anticipated by advocacy, dialogue and appropriate coordination with relevant development actors.

Exit criteria for operations

- The Commission considers phasing out its humanitarian nutrition assistance when indicators of acute undernutrition and related mortality are stabilised below emergency levels, or are expected to stabilise there in the foreseeable future, independently of the Commission's humanitarian support.
- The Commission also considers phasing out or transitioning its humanitarian support where non-humanitarian players (e.g. State or development actors) are able to respond to the nutritional needs of the populations at risk, therefore mitigating the level of humanitarian risk associated with withdrawal; or when the humanitarian needs of the population are fully covered by other humanitarian donors and actors.
- The Commission, at all times, evaluates its humanitarian exit strategies on the basis of its comparative advantage relative to other actors. The Commission seeks to avoid creating disincentives to the engagement of other actors by delaying its own exit. It advocates instead

for other, more appropriate, actors across the relief and development spectrum to respond, according to the specific context and needs.

- The Commission also considers exiting from humanitarian nutrition assistance operations when its core principles cannot be respected, particularly if the risk of doing harm outweighs the potential benefits of remaining engaged.

4.2 Additional aspects necessary to achieve the Commission's Objectives

The Commission's humanitarian mandate, its capacity and priorities all give it a specific comparative advantage to respond to the above-mentioned undernutrition challenges in crises. The Commission recognises, however, that in order to achieve the greatest benefits in terms of improved nutrition, it is also necessary to address two other persistent challenges in emergencies:

i) The production of reliable information to guide decisions, with special emphasis on situation and response analyses that are sensitive to gender and age-related inequalities; and

ii) The strengthening of capacities for efficient and effective delivery of humanitarian assistance for nutrition.

These two areas are therefore included here so as to enable the achievement of the Commission's objectives. However, they are not included as stand-alone areas or entry points for response.

4.2.1 Information Systems

Where they exist, health, nutrition and food security information systems regularly collect nutrition information (including anthropometric data) that can be used in decisions about policies and/or guide strategies and monitor interventions

Such information systems require long-term support, with national or regional ownership and careful consideration of economic and political perspectives. It is therefore imperative that any humanitarian support in this area is coherent with a longer term strategy by the Commission and/or other donors and national systems.

The closely related activities of situation analysis (including nutrition causal analysis) and response analysis are crucial in securing the overall effectiveness of an intervention.

The Commission recognises the value of applying a nutrition ‘lens’ to assessments, problem and response analysis, as well as to the monitoring and evaluation of all multi-sectoral projects.

The Commission facilitates the integration of nutrition data into other information systems and projects, such as the IPC project (Integrated Food Security Phase Classification),[18] while continuing its support to the Household Economy Approach in relation to the Cost of Diet analysis.[19]

Finally, gender analyses should be integrated in any situation and response analysis, and it is crucial to ensure that specific capacities are in place to achieve this goal.

[18] http://www.ipcinfo.org/

[19] http://www.savethechildren.org.uk/resources/online-library/the-household-economy-approach-a-guide-for-programme-planners-and-policy-makers; http://www.savethechildren.org.uk/resources/online-library/the-cost-of-the-diet

THE SIGNIFICANCE OF GENDER ANALYSIS IN THE PLANNING OF HUMANITARIAN ASSISTANCE FOR NUTRITION

The commitment to strengthening a gender-sensitive approach is enshrined in the European Consensus on Humanitarian Aid which highlights the importance of: (i) integrating gender considerations, (ii) incorporating protection strategies against sexual and gender-based violence, and (iii) promoting the active participation of women in humanitarian assistance.
Rationale: Crisis situations, whatever their cause, are not gender neutral. Women, girls, boys and men face different risks of deterioration in their nutritional status. These different vulnerabilities are related both to their differing physiological nutrition requirements and to socio-cultural factors related to gender.[20]
Why gender and age matter:[21] Gender-blind actions are less effective because they neglect the diversity of needs, capacities and coping mechanisms of different groups of beneficiaries. Good nutrition programming must take due account of gender issues at all stages of the project cycle. In particular, there must be attention to ensuring a gender perspective in situation and response analysis. Experience shows that poor child feeding practices, lack of access to health services, economic and livelihood insecurity, cultural practices and gender inequality more broadly tend to be inadequately incorporated into national vulnerability analyses and strategic programming. A gender analysis is undertaken to better understand the division of roles, responsibilities, constraints and access to resources, mobility, specific vulnerabilities, needs and risks faced by women, girls, boys and men, including sexual and gender-based violence.

To maximise the quality and effectiveness of nutrition-related interventions, the Commission emphasises the value of utilising the full project management cycle: needs assessment, response analysis, planning (programme identification), appraisal, financing, implementation, and monitoring and evaluation.[22]

The Commission, especially in crisis-prone countries, pays specific attention to the collection of quality nutrition data, and promotes implementation of nutritional assessments according to standardised methodologies.[23] Such assessments may include, other than anthropometry, data that will help to identify the likely causes of undernutrition (most notably linked to health, food security and the environment).[24]

4.2.2 Capacity Building

In the high-pressure context of humanitarian crises, the imperative to respond quickly and professionally requires the presence of capacity to do so. At the same time, the nutrition field is advancing very quickly, creating additional pressure on staff to know the latest evidence that can inform the design of humanitarian responses for nutrition. The Commission recognises the challenges and

[20] http://oneresponse.info/crosscutting/gender/Gender%20Marker%20Materials/Nutrition%20Gender%20Marker%20Kit.pdf

[21] http://sites.tufts.edu/feinstein/2011/sex-and-age-matter

[22] DG ECHO (2005) Manual Project Cycle Management. Brussels

[23] Such as SMART (Standardized Monitoring and Assessment of Relief and Transitions): http://www.smartmethodology.org/index.php?option=com_content&view=article&id=1084&Itemid=298&lang=en

[24] See Emergency Nutrition Assessment: Guidelines for field workers. Save the Children, November 2004.

opportunity costs of such a widening gap between theoretical knowledge and operational capability, and will seek to prioritize efforts to bridge this gap.

In order to maximise the effectiveness of nutrition assistance, the Commission recognises the need to invest in supporting institutions and developing the capacity of key stakeholders involved in the management of acute undernutrition in crises. While responding to humanitarian needs, it is possible to develop policies, systems and skills that are compatible both with emergency and development contexts. The Commission's support aims to enhance local and national capacities to manage undernutrition in emergencies and to face seasonal peaks, and to build resilience to face existing and upcoming shocks.

Where possible and appropriate, the Commission works within the timeframe of its humanitarian operations to simultaneously enhance national capacities for: i) nutritional surveillance; ii) nutrition surveys; iii) health, food security & nutrition data monitoring; iv) cross-sectoral causality studies and assessments and; v) enhance the capacity for the implementation of nutritional activities. Such investments should be coordinated with other Commission aid instruments to ensure continuity when the humanitarian intervention is concluded (see section 6.3 on Coherence, Coordination and Complementarity).

4.2.3 Integration into national systems

A central challenge facing humanitarian assistance for nutrition involves the need for timely engagement and rapid intervention, while ensuring that minimum standards of quality are consistently maintained. Experience suggests that, as far as possible, this challenge can be best met through effective preparedness measures in the framework of an integrated 'system-strengthening' approach. Despite the fact that humanitarian crises do not take place in a vacuum, the humanitarian imperative to provide immediate life-saving response frequently leads to a focus on the establishment of new mechanisms for delivery, leading to the neglect of pre-existing local systems (not only in the health sector, but also within other relevant local institutions and community structures).

Where appropriate, the Commission therefore encourages the inclusion of programming to address nutrition within the broader context of national systems (including provisions for the adaptation of national protocols for surge programming). This in turn highlights the need for a thorough assessment of national capacities and resources prior to intervention, as well as a commitment to reinforce government ownership and capacity where this is conducive to the achievements of the objectives of humanitarian assistance.

4.2.4 Advocacy

The Commission recognises that both acute and chronic undernutrition and micro-nutrient deficiencies are prevalent and often co-existing, to varying degrees, in many stable contexts. Given the consequences of such persistently high burden of undernutrition on infant and child mortality, child development, and longer-term economic growth prospects, the Commission insists that all forms of undernutrition be firmly placed at the centre of the development agenda.

Advocacy and public awareness building are essential to secure better policies and the development of appropriate actions to respond to undernutrition. Key targets in this process are national government authorities, civil society and development partners. A major focus is placed on initiatives to improve the understanding of those measures that are required in order to achieve the MDGs of reducing hunger, and child and maternal mortality.

Although the Commission has a specific remit and a comparative advantage in humanitarian action, as opposed to some local actors, the humanitarian imperative to save lives and reduce rates of acute undernutrition should be responded to, whenever feasible, in a manner that does not undermine local capacities or neglect national policies. Local capacity for the routine management of persistent burdens

of acute undernutrition and for the management of future crises, should therefore be supported and strengthened whenever possible.

4.2.5 Research

With a growth in awareness of the multi-sectoral causality of undernutrition and an expansion in the programmatic options to respond to the phenomenon, the collection of robust and up-to-date evidence on the efficiency and effectiveness of different forms of assistance becomes today more essential than ever before.

The Commission acknowledges the need to contribute to the evidence base on the efficiency and effectiveness of various interventions to address undernutrition, taking into account the diversity of contexts (urban, pastoral, agricultural, acute/chronic, situations of displacement, etc.) and the needs of specific population groups (women/men; different age groups; persons with disabilities; ethnic and other socio-cultural groups; economically diverse groups). The Commission therefore continues supporting operational research on nutrition under the following conditions:

- Research is not the entry point for any operation - operations should be justified by humanitarian needs and not by research
- The context should allow for research to be conducted effectively - the research location should be accessible and stable for the duration of the research period in order to ensure adequate quality outcomes
- Partners must be running ongoing quality operations in the proposed project area and have the technical expertise that is necessary in order to conduct any proposed research
- Partners' research should respect international research standards including the validation of research protocols by an international ethical review board and, if possible, by a national one, through the appropriate involvement of local authorities and communities.
- Transparent documentation and dissemination of research findings must be ensured at all times.

5 PROGRAMMATIC RESPONSES

The Commission supports comprehensive life-saving nutrition strategies to address emergency levels of undernutrition**.** These include interventions that have been demonstrated to be effective and efficient in tackling both moderate and severe acute undernutrition, as well as specific micronutrient deficiencies.

Other programmes are required to address the immediate and underlying causes of undernutrition (see Conceptual framework), which also help to create the foundations and enabling environment that are necessary in order to sustain nutritional gains over time. These include interventions that have been demonstrated to be effective at addressing the underlying causes of undernutrition such as improving access to safe water and improving household food security through agriculture and livestock interventions.

Operational Case Study

Niger: "Cost of Diet" - an analytical tool to inform nutrition interventions

In May 2011, Save the Children UK (SC UK) conducted a "Cost of the Diet (CoD) assessment" in the Zinder Region of southern Niger. The aim was to better understand the underlying economic causes of malnutrition.

The CoD analytical tool, developed by SC UK with support from the Commission, is designed to calculate the cost of the cheapest diet that meets the nutritional requirements of families and exclusively contains locally available food. The CoD combines data on food prices, consumption, and availability with information from interviews with household members about their eating habits and lifestyle. It can be used to estimate the proportion of households in a region that are unable to afford a nutritious diet, as well as the size of the gap between current income and the amount of money needed to meet the needs of a household.

In Zinder, nutritious food was available in the market. CoD analysis found, however, that during the lean season, the minimum cost of this diet is far beyond the income levels of poor households. By identifying the size of this income gap, SC UK and other partners could tailor programming accordingly (for example, through cash and voucher assistance).

Lesson learnt: There is no "one size fits all" answer to a specific situation of undernutrition in any given emergency. Depending on the social and economic situation of a household, the functioning of the market, the livelihood assets and the level of resilience, humanitarian interventions for nutrition can vary. The CoD tool can be very useful for understanding the difficulties of crisis-affected households in accessing nutritious food, and particularly for the promotion of IYCF practices for children older than 6 months based on appropriate complementary foodstuff that is available at local markets.

5.1 Health and Nutrition

5.1.1 Management of moderate and severe acute undernutrition

Where indicated by an assessment of needs, and where not covered by existing health provision, it can be necessary to specifically intervene in the management of moderate and severe acute undernutrition for the most vulnerable (generally children under five and pregnant and lactating women). Strategies to manage acute undernutrition in crisis contexts must be closely linked to efforts to promote the nutritional security of the entire emergency-affected population.

The choice of intervention depends on the prevalence of acute undernutrition (moderate and severe), any aggravating factors, the local context and the dynamic of the crisis (particularly in terms of the possibility to gain access to affected groups). The Commission emphasises the relevance of:

- Early detection of acute undernutrition at the community level and intensive case finding through community mobilisation;
- Provision of outpatient treatment for individuals suffering from severe acute undernutrition without medical complications. The caseload of SAM without complications is estimated to be 80-90% of the total SAM caseload;
- Facility-based treatment of individuals suffering from SAM with medical complications (estimated at 10-20% of total SAM caseload). This might include therapeutic feeding centres, hospitals or stabilisation centres; appropriate identification of medical complications and access to the appropriate (lifesaving) treatment; and appropriate follow-up after referral and after discharge, particularly in the management of severe acute malnutrition (at stabilisation centres and through outpatient programmes);
- Supplementary Feeding Programmes treating those with moderate acute undernutrition;
- Concomitant access to free healthcare..

The Commission welcomes the advances made in recent years through the introduction and scaling up of community based approaches for CMAM. The Commission particularly recognises the value of ready-to-use therapeutic foods, which have been integral to the success of this approach. CMAM aims to provide effective treatment for all children with both severe and moderate acute undernutrition by decentralising treatment nearer to those that need it, removing the need for long inpatient stays and stimulating understanding and engagement of the target population around acute undernutrition. Barriers to accessing treatment are reduced and early diagnosis of the condition occurs more frequently. Early diagnosis of acute undernutrition in combination with effective treatment at the community level can largely reduce fatality rates and increase coverage of the affected population.

The burden of undernutrition in emergencies is felt in terms of numbers affected (more children have moderate acute undernutrition) and in terms of mortality (the risk is greatest for those with severe acute undernutrition). The management of acute undernutrition, therefore, needs to consider strategies for MAM alongside those for SAM, so that there can be coherence and sustained progress. Crucially, a multi-sectoral approach is necessary to address moderate acute malnutrition, e.g. through humanitarian food assistance, improved access to healthcare and improved access to sanitation and drinking water.

Operational Case Study

Ethiopia: Strengthening of the capacity of the Ministry of Health for more effective humanitarian response and improved resilience

Ethiopia has one of the highest under-five mortality rates in the world and is chronically vulnerable to food and nutrition crises.
In 2003/4, a widespread food and nutrition crisis highlighted the low capacity of existing Therapeutic Feeding Centres for the treatment of severe acute malnutrition. This situation prompted the Ministry of Health (MoH) to begin working with partners to scale-up services dealing with nutrition across the country. The international non-governmental organization Concern Worldwide launched a programme to support the MoH in establishing adequate services to treat a large number of children with SAM during 'normal' times. The intervention included the strengthening of capacities in order to enable these services to rapidly scale-up at times of crisis. The project aimed to mitigate delays in setting up new therapeutic programmes in response to crises.
The programme provided a package of 'minimal support' to the MoH, consisting of training, joint supervision, experience-sharing visits, workshops and community mobilisation assistance. In addition, support was provided for the incorporation of CMAM into the National Nutrition Strategy and its guidelines.
In 2008, a dramatic increase in the prevalence of SAM was recorded across two regions in Ethiopia, primarily due to the effects of drought. In many districts the magnitude of caseloads overwhelmed treatment capacities. The MoH made the decision to decentralise CMAM services to primary healthcare posts through the employment of health extension workers. This was rapidly achieved by mobilising

support from a number of agencies (UNICEF, WHO, and NGOs). The results have been striking:

- Within 4 months, 455 health posts (50% of the districts) in the two affected regions were managing outpatient therapeutic programmes (OTP), reaching over 27,000 children with SAM. The results[25] fulfilled Sphere standards. This prompted an acceleration of major efforts to scale-up CMAM across other regions.
- Extensive CMAM scaling-up has enabled increased access to information on SAM admissions in a considerable proportion of the country. Programme monitoring data increases the potential for humanitarian actors to respond in a timely manner to increases in the prevalence of SAM, rather than having to rely on the longer-term completion of nutrition surveys. In March/April 2011, CMAM reports showed a 90% increase in the number of admissions, which led UNICEF and implementing partners to trigger a humanitarian response using contingency/reserve funding while discussions for additional support were still under way.

Lesson Learnt: This case highlights the gains associated with a "system approach" where nutrition interventions in emergencies build on existing capacity. This approach is only possible in the presence of an appropriate funding mechanism that promotes bridges between humanitarian and development interventions.

Infant and young child feeding in emergencies (IYCF-E)

In the context of humanitarian assistance for nutrition, IYCF refers to a range of nutrition and care interventions that improve child survival and growth. These include appropriate and evidence-based support for (exclusive) breastfeeding and counselling, formula or emergency feeding interventions when necessary, nutrient-dense complementary feeding interventions for children > 6 months, support for improved care practices, child development and child protection. In more general terms, IYCF covers maternal and child nutrition, including the management of acute undernutrition in infants. Special attention should be paid to address any cultural practices surrounding breastfeeding and feeding that may discriminate girls.

The Commission seeks to uphold the provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHO Resolutions (and requires its partners to uphold the same standards). Inappropriate in-kind donations (such as infant formula, powdered milk or bottles and teats) are discouraged by the Commission, in accordance with the Operational Guidance on IYCF-E and the International Code on the Marketing of Breast-milk Substitutes.

In a humanitarian crisis, other less recognised influences on IYCF practices must be addressed including security, privacy and shelter for mothers. The psychosocial components of nutrition (including the psychological, emotional and social dimensions of a child and mother's health and well-being) are of crucial importance, as they can have a considerable impact on nutritional status. Nutrition has extremely close links with care practices and a child's nutritional status is often determined as much by feeding practices, home environment and the attention received from primary caretaker as by the food consumed. Evidence also indicates that inclusion of psychosocial stimulation for mothers and children in programmes for the treatment of undernutrition can improve long-term health and development of children.[26]

The recent review of the Management of Acute Malnutrition in Infants (MAMI)[27] confirms that a high prevalence of wasting in infants below 6 months of age is a public health problem requiring a

[25] 77.6% recovery, 0.7% mortality and 4.2% default rates.

[26] Nahar; B., Hamadani, J.D., Ahmed, T., Tofail, F.; Rahman, A.; Huda; S.N.; et al (2008): Effects of psychosocial stimulation on growth and development of severely malnourished children in a nutrition unit in Bangladesh. European Journal of clinical nutrition; September 2008.

[27] Management of Acute Malnutrition in Infants (MAMI) Project commissioned by the Global Nutrition Cluster; Summary Report. ENN; October 2009.

humanitarian response. There is an urgent need to increase our knowledge on how to diagnose acute undernutrition in this age group, improve understanding of causes and consequences, and improve interventions to treat it. More specifically, there is a need to explore the modalities, costs and impact of integrating IYCF support in CMAM programmes, and interventions addressing acute undernutrition in infants need to be updated through innovation, research and the considerations of past lessons.

Operational Case Study

Myanmar: The experience of a young mother during the 2008 cyclone and subsequent floods

Jasmine's mother was nearing the end of her pregnancy when the cyclone hit. She and her four boys were hit by the storm while they were at several days' walk from her village. She sought refuge in a monastery where she met a woman who had three boys of her own, all over 8 years old. When they were forcibly evacuated from the monastery, Jasmine's mother knew she was too close to giving birth to make the journey back to her village with her boys. So she stayed with the family she had met at the monastery. When Jasmine was born, weighing 2.5kg, her mother decided she could not care for her and left her with the family she had been staying with. Six weeks later, Jasmine weighed 2.3kg.

Breastfeeding counsellors were supporting Jasmine's foster mother to re-lactate for about 10 days. She was instructed to put Jasmine to the breast as often as she could during the day (at least every 2 hours) and to allow her unrestricted access to the breast all night (the whole family slept on one mat under the only mosquito net in the house). The foster mother was also instructed in the preparation of powdered infant formula and cup feeding. She was told to feed Jasmine enough formula to satisfy her (about 6 or 7 times a day) and to drink any leftovers herself or give it to one of the boys. When Jasmine was observed breastfeeding, it was evident that she was transferring milk from the breast effectively (active rooting followed by long slow sucks, big swallows, relaxed expression, hand becoming more open through the feed, and sleepy after the feed). Her bowel movements also indicated that she was getting a significant amount of breast-milk. From that point, Jasmine's foster mother was instructed to reduce the number of times she offered her formula during the day. Under two weeks later, Jasmine's foster mother stopped offering formula milk altogether.

Jasmine is now exclusively breastfed, and has regained and exceeded her birth weight.

Lesson learnt: this example demonstrates the importance of prioritising IYCF-E. Through expert and dedicated support, vulnerable infants can be prevented from deteriorating nutrition situations to the extent where therapeutic feeding would be required.

Acute undernutrition in adolescents and adults

Although the management of acute undernutrition in children under five years of age has improved considerably in the last decade, there are still gaps in evidence concerning the treatment of acute undernutrition in adolescents and adults. Experience shows that the specific nutritional needs of adolescents and adults require adapted life-saving strategies beyond food assistance. It is therefore imperative that undernourished adolescents and adults have access to appropriate treatment and support.

Women and adolescent girls can be particularly vulnerable due to their productive, reproductive and social roles.[28] Undernutrition in women contributes to maternal deaths and is directly related to faltering nutritional status and growth retardation in children. Maternal undernutrition is also linked to low birth weight, which in turn results in higher infant morbidity and mortality as well as long-term disability and chronic illness. The Commission therefore encourages systematic attention to interventions that address

[28] Women are the primary carers of children and the main decision-makers with regards to their children's dietary consumption. Women's education and status in society are directly linked to the nutritional status of the children in their care.

undernutrition among women in reproductive age, particularly during pregnancy and lactation in the framework of all humanitarian contexts and closely monitors the quality of the work of those partners whose work has a specific impact on this group.

The Commission also ensures that the special needs of other specific groups within its beneficiary caseload (e.g. disabled, elderly, chronically ill) are integrated into the design of humanitarian nutrition responses.

5.1.2 Management of micro-nutrient deficiencies (MND)

The Commission acknowledges the growing international evidence gathered in recent years in relation to MND and their specific impact on children's morbidity, mortality and cognitive development. Over 10% of deaths among children under five years of age are attributed to deficiencies in Vitamin A, zinc, iron and iodine.[29]

On the basis of assessed needs, the Commission therefore supports nutrition strategies to both treat and prevent MND during emergencies. The combination of response options adopted depends on the level and severity of the problem:

- Provision of fresh food items that are complementary to a general food ration (e.g. through fresh food vouchers);
- Provision of fortified food aid commodities[30] such as fortified cereal, CSB+/++ (corn soya blend), lipid-based nutrient supplement and iodized salt and/or powders or sprinkles for home fortification in the general ration;
- Special attention to the quality of complementary feeding for children under two years of age;
- Distribution of micronutrient supplements[31] either as single micronutrient (e.g. Vitamin A for children, iron/folic acid for pregnant women) or population-level supplementation[32] in the case of widespread deficiencies of specific micronutrients, such as scurvy (vitamin C deficiency), pellagra (niacin deficiency) and beri-beri (vitamin B and thiamine deficiencies);
- Integration of micronutrients into the prevention and treatment of certain diseases. Zinc has been shown to be effective in the management of diarrhoeal diseases (prevention of future episodes as well as reduction in the duration of current episodes), which in turn can have serious nutritional consequences;
- Provision of vitamin A alongside, for example, measles vaccinations, can help to protect children against infection. The Commission therefore supports interventions aimed at incorporating zinc and vitamin A into delivery of healthcare services (e.g. through the provision of zinc with low-osmolality oral rehydration salts (ORS).

5.1.3 Prevention of disease-related undernutrition

Undernutrition can be caused and aggravated by diseases, therefore supporting free access to healthcare and promoting a healthy environment is an essential component of the prevention and treatment of acute undernutrition

The synergistic relationship between undernutrition, micronutrient deficiencies and various infectious and parasitic diseases is well known (including diarrhoeal diseases, HIV/AIDS, tuberculosis, Leishmaniosis, intestinal helminthic infection, respiratory infections, malaria and measles).

[29] See table 6 in: Black, R.E. et al, for the Maternal and Child Undernutrition Study Group. *Lancet 2008; 371: 243*

[30] See WHO/FAO 2006: http://www.who.int/nutrition/publications/micronutrients/9241594012/en/ and WHO 2009: http://www.who.int/nutrition/publications/micronutrients/wheat_maize_fortification/en/

[31] See WHO (2006): http://www.who.int/making_pregnancy_safer/publications/Standards1.8N.pdf

[32] See WHO/WFP/UNICEF 2007: http://www.who.int/nutrition/publications/micronutrients/WHO_WFP_UNICEFstatement.pdf

Undernutrition and micronutrient deficiencies facilitate infection, and some infections may result, directly or indirectly, in the development of undernutrition and micronutrient deficiencies. However, in the current programmatic structure of nutritional programmes, the importance of underlying diseases is often unaddressed.

While tackling undernutrition in emergencies, the Commission seeks to provide adequate emergency healthcare, taking into account the specific needs of children below five years of age and their mothers as well as pregnant women. These interventions may include:

- De-worming as part of integrated child health programmes,
- Prevention and early treatment of diarrhoeal diseases,[33]
- Prevention and early treatment of measles and malaria.[34]

Access to (basic) primary healthcare should be safeguarded for those who are most vulnerable to undernutrition. According to the Commission's position on user fees[35] in humanitarian situations, healthcare should be free at the place of delivery, in order to ensure, as much as it is possible, that access to healthcare is guaranteed to all potential beneficiaries.

The Commission seeks to ensure appropriate procurement (taking into account product quality and safety) and storage of the necessary medical and nutritional inputs required to prevent disease-related undernutrition. Regional prepositioning of essential supplies, or support to national emergency preparedness stocks can facilitate timely responses, if appropriately managed and supported by reliable information systems.

5.2 Humanitarian Food Assistance and Nutrition

Response options must be context-driven and could include:

General Food Assistance:

- Provision of free cash or vouchers (commodity-based or value-based) distributed on a blanket basis
- Distribution of free food commodities on a blanket basis (general food distributions) including the provision of appropriate fortified food items suitable for young children;

Targeted Food Assistance:

Targeted Food Assistance (TFA) aims at reaching the most food insecure households (regardless of whether General Food Distribution is under way). These interventions shall be informed by a Household Economy Analysis (HEA):

- Provision of targeted free cash or vouchers (commodity-based or value-based)

- Distribution of free food on a targeted basis (targeted food distributions);

- Distribution of food, cash or vouchers on a targeted and/or self-targeted basis, in exchange for a beneficiary's time or labour (e.g. cash for work, food for work, food for training, food for assets);

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[33] See Joint WHO/UNICEF Statement (2004): http://whqlibdoc.who.int/hq/2004/WHO_FCH_CAH_04.7.pdf

[34] See *Conclusions and recommendations of the WHO Consultation on prevention and control of iron deficiency in infants and young children in malaria-endemic areas* (2006, currently under revision) http://www.who.int/nutrition/publications/micronutrients/FNBvol28N4supdec07.pdf

[35] DG ECHO position paper on user fees for Primary Health services in Humanitarian crises, April 2009. "*In an emergency context, DG ECHO will promote access to healthcare for all and in particular for the poorest and those in greatest need and will discourage partners to apply any user fee system. If no alternative source of income is guaranteed for payment of salaries or the recurrent costs or for replenishment of drugs or medical supplies, DG ECHO has to make a well informed choice and to consider covering the financial gap. Any choice should be based on considerations of the national and political context and the possible consequences of abolishing user fees.*"

Blanket supplementary feeding distribution aims at reaching the most nutrition insecure individuals (particularly young children, pregnant and lactating women). These interventions shall be informed by sound nutrition surveillance.

Food security and livelihood interventions are potentially effective[36] instruments for the prevention of undernutrition (as outlined in the conceptual framework).

Where response analysis is appropriately performed, existing evidence suggests that cash transfers can have a positive impact on dietary intake and therefore should be considered as a key tool in the management of undernutrition. However, as is also the case with in-kind food aid, assessing the exact impact of these transfers on changes in nutritional status remains a challenge[37].

The Commission is committed to addressing this gap through: (i) the promotion of a systematic inclusion of nutrition-relevant objectives and indicators in the humanitarian food assistance operations it supports (including food security information systems); and (ii) consideration of operational research that contributes to the collection of evidence on comparative performance between different strategies and products. In the case of (i), this can be achieved for instance through anthropometric measurements or dietary diversity indices and food consumption scores.

Where addressing undernutrition is an important objective of food security interventions, the Commission starts intervening in those areas where the prevalence of acute undernutrition is highest.

Operational case study

Niger: The role of cash transfers in reducing undernutrition in extremely poor households

Save the Children UK (SC UK) piloted a cash transfer social safety net programme in the Tessaoua district of Niger's Maradi region in 2008. In collaboration with local authorities and with Commission funding, SC UK assisted 1500 of the poorest households to close the gap between the cost of food they needed to purchase and their income during the lean season.

Beneficiaries were identified on the basis of a Household Economy Analysis (HEA) and wealth ranking. Special consideration was given to households that included widows, people with disabilities, and mothers and caregivers of children under five. All beneficiaries lived in severely food insecure areas. One woman in each of the families received direct cash assistance in three equal distributions, contingent upon their participation in undernutrition and public health awareness sessions.

SC UK monitored 100 households three times: prior to the project, one month after the first cash distribution (at the peak of the hunger gap), and one month after the final distribution. Results showed that cash transfers allowed the poorest households to meet their minimum food needs while enjoying a more diverse diet. The injection of cash into the community stimulated petty trade and increased local wage rates as people receiving the transfer worked in their own fields rather than competing for work as wage labourers.

Children under five were found to have experienced an improvement in their nutritional status. This phenomenon, however, was not sustained throughout time. An explanation could be that cash transfers to families with young children may be more effective if accompanied by micronutrient supplements and disease prevention measures as cash alone might not address the complexity of nutrition insecurity. Nonetheless, families were better able to meet their energy requirements and less likely to take loans or mortgage assets during the hunger gap if they received cash transfers.

Lessons learnt: Cash transfers potentially have a positive impact on the stimulation of local markets and dietary diversity. However, they need to be accompanied by specific nutrition/health interventions to address the complexity of nutrition security, with a particular focus on children under five years of age.

[36] Bhutta Z. et al 2008: What works? Interventions for maternal and child undernutrition and survival. Maternal and Child Undernutrition Study Group. *The Lancet* 371 (9610) p417–440. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61693-6/fulltext

[37] Bailey, S, Hedlun, K. (2012): The impact of cash transfers on nutrition in emergency and transitional contexts, http://www.odi.org.uk/resources/docs/7596.pdf

With regard to the management of MAM, the requirement for evidence demonstrating the comparative advantage of specialised nutrition products (including RUSF, and improved fortified blended food) remains a priority. In general, however, supplementary food – as the name indicates – is meant to supplement an existing diet (when such diet is deficient in quantity and/or quality) and therefore a thorough situation analysis is required to justify this specific choice of response. The Commission recognises the potential effectiveness that improved fortified and/or nutrient-dense food products could have on the treatment and prevention of acute undernutrition. However, the Commission exclusively supports the use of specialised nutritional products where specific conditions are deemed to be appropriate and upon close monitoring of their effectiveness and impact.[38]

Furthermore, it is recognised that supplementary feeding should under no circumstances compete with or compromise breastfeeding (for children 6-23 months even though no longer exclusively breastfed). Therefore it is important that supplementary feeding is accompanied by measures aimed at promoting and monitoring the continuation of breastfeeding.

Operational case study

Somalia: Emergency cash transfer and food vouchers programme

The 2011 drought in the Horn of Africa had a very serious impact on vulnerable people in Somalia, who were already affected by the long-lasting war. On 20 July, for the first time in almost 30 years, the United Nations officially declared the presence of a situation of famine in two regions in the southern part of the country (IPC Phase 5). Children in Somalia continued to be caught up in chronic and recurrent malnutrition crises with a country-wide median Global Acute Malnutrition (GAM) consistently and considerably above the emergency threshold. To respond to the urgent needs of the most vulnerable population, UNICEF, with support provided by the Commission, launched its widest ever cash/voucher programme in an emergency situation:

- The programme targeted 360,000 people (60,000 households) - the direct beneficiaries being the severely undernourished children under five years of age and drought-affected families in Southern Somalia.
- The objective was to reduce to (at least) below the emergency threshold excess mortality caused by nutritional deficiencies.
- The intervention was based on the provision of nutritional supplies and the distribution of cash transfer/vouchers. UNICEF completed 6 rounds of distribution worth a total of 60 million USD, each monthly round comprising 58 USD in vouchers and 100 USD in cash given to individual households.

Given the high volume of funds devoted to cash transfer/vouchers and the novelty of cash interventions, the expectation in terms of results was very high:

After three cash distributions, the first signs of resilience recovery could be seen; the improvement of the purchasing power of the very poor households targeted caused an increase in the purchasing of food, livestock and small business investments.

The positive nutrition impact of the intervention was evident: the number of meals per day increased (from 1 to 2 for adults and 1 to 3 for children) and dietary diversity improved as well. Furthermore, between October 2011 and February 2012, SAM prevalence decreased from 12% to 8%.

Lessons learnt: Overall, large-scale cash-based programming can be successful.

- Large-scale, collaborative monitoring can be done also in complex conflict-affected

[38] Minimum standardised monitoring (e.g. SPHERE or national protocols); Minimum Reporting Package www.mrp-sw.com

environments
- Functioning, efficient markets and the Hawala system (local Western Union) were key factors that allowed for the rapid impact of the intervention
- Common monitoring improved programming and the assessment of the overall impact

5.3 Water, Sanitation and Hygiene (WASH) and Nutrition

Environmental factors can be major contributors to the occurrence and severity of undernutrition. Lack of safe water, poor sanitation and inadequate hygiene practices all contribute to the spread of infectious diseases. As such, they are directly linked with faltering growth, lowered immunity and increased morbidity and mortality.[39] The Commission therefore promotes the incorporation of nutrition-specific objectives into WASH humanitarian responses in crisis contexts where undernutrition is a major humanitarian concern.[40]

In these contexts, the Commission supports those basic sanitation and behavioural change interventions that are considered to be essential for the creation of a safe environment.[41] These include:

- Water supply interventions aimed at ensuring the provision of a clean and safe water supply, in sufficient quantities and in a short timeframe.
- Sanitation interventions focusing on immediate and safe excreta disposal. Priority is given to the protection of drinking water sources from possible contamination, particularly through human and animal excreta.
- Hygiene Promotion focusing on immediate actions that have the greatest potential to reduce the risk and spread of environmental health-related outbreaks (in particular hand washing).

Where possible, these actions are designed and implemented in coordination with all relevant stakeholders including community leaders and/or representatives and in accord with local/national authorities.

Equal participation of men and women in planning, decision-making and local management of Emergency WASH operations helps to ensure that the entire population obtains safe and easy access to WASH services and that access to these services does not negatively impact on the nutritional status of vulnerable groups, particularly women and children. There are important gender dimensions related to WASH that would need to be fully considered so as to prevent consequences that could be detrimental to women's (and children's) well-being. Such gender and nutrition-sensitive design supports, for instance, reduced burden and a shorter water collection time for women, as well as improved protection for women and young girls to be attained through an appropriate design of WASH facilities in refugee or displacement camps.

Specific measures to strengthen the linkage between WASH and nutrition interventions and improved nutrition outcomes include:

- The promotion of a Minimum WASH Packages in health facilities (including mobile clinics) to improve the health environment;

[39] The Lancet Series includes hand-washing and hygiene interventions among the core measures that reduce the risk of diarrhoea. The hygiene and hand washing dimensions of food preparation are an important part of the 'childcare' component of nutrition programmes, especially in areas where water and sanitation are poor. Guidelines on hand washing and hygiene are at: http://www.unicef.org/wes/index_43084.html

[40] The Lancet Series include hand-washing and hygiene interventions among the core measures that can reduce the risk of diarrhoea. The hygiene and hand-washing dimensions of food preparation are an important part of the 'childcare' component of nutrition programmes, especially in areas where water and sanitation are poor. Guidelines on hand-washing and hygiene are at: http://www.unicef.org/wes/index_43084.html

[41] WHO/FAO 2006: *Guidelines on food fortification with micronutrients.* At: http://www.who.int/nutrition/publications/guide_food_fortification_micronutrients.pdf

- Ensured access to water for the poorest through the avoidance of user fees or, for example, the provision of cash transfers to cover the costs associated to minimum levels of consumption;[42]
- Latrine construction should avoid the risk of contamination by ensuring adequate distance from food preparation, drinking water, storage of utensils, etc.; Latrines should be properly constructed (e.g. concrete slab) to prevent helminthic infections.
- The integration of nutrition awareness in hygiene promotion strategies;
- Analysis of the significance of water sources for livelihoods and the household economy prior to interventions, in order to establish drinking water supply services and avoid tensions between the potentially competing priorities of different groups;
- Harnessing humanitarian WASH operations as an opportunity for conditional cash or food transfers, through the engagement of beneficiaries in the construction of their own WASH services.

[42] The humanitarian priority is that any user fee must be accompanied by a commitment to ensuring that the needs of the most vulnerable are covered and that no one shall be excluded from accessing WASH services.

6 HUMANITARIAN AND DEVELOPMENT ACTORS' SHARED CONCERNS

While it is important that pre-existing high levels of chronic undernutrition are taken into account in the design of any emergency response, this alone does not generally grant the triggering of humanitarian mechanisms to provide nutrition assistance. In contexts that are characterised by either chronic undernutrition (stunting) or persistently high rates of acute undernutrition (wasting), or both, a longer-term approach is required in order to ensure predictable funding modalities and close cooperation with national government authorities.

Understanding that such contexts are primarily the outcome of serious structural factors lying outside the scope of humanitarian assistance is essential. However, it is also crucial for all actors involved to recognise that high levels of persistent undernutrition imply an increased risk of morbidity and mortality and that the burden of undernutrition associated with underdevelopment is far greater than the one associated with crises of short duration.

This section of the paper discusses those aspects of nutrition crises that are best addressed by combining interventions of humanitarian and development actors.

6.1 Chronic undernutrition (stunting) in emergencies

Although it is recognised that high levels of stunting can lead to an increased risk of morbidity and mortality, stunting is the effect of sustained nutritional deficit and development failure, and it is not by addressing its effects alone that the phenomenon can be halted. Contrasting stunting requires a long-term approach, with predictable funding modalities and close cooperation with national government authorities.

Humanitarian assistance for nutrition offers no comparative advantage in this regard. Therefore, the Commission, in principle, does not resort to humanitarian assistance in order to address chronic undernutrition, and instead advocates for other instruments/actors to respond.

Although not justifying an emergency response, pre-existing high levels of chronic undernutrition are taken into account in the design of responses, as they can indicate the vulnerability of any given population.

6.2 HIV/AIDS

HIV infection can cause nutritional deficiencies in the form of reduced intake, higher metabolic needs, and impaired nutrient use. Poor nutritional status may accelerate the progression towards AIDS-related illness, undermine the use of and response to antiretroviral therapy, and exacerbate the socioeconomic impact of the virus. This in turn may have even broader impacts, as HIV infection reduces economic productivity and thus food security.

The Commission recognises the positive impact that adequate food and nutrition can have on the management of HIV and AIDS.[43] HIV-infected children require special attention to secure their additional needs for growth and development, in line with the WHO guidelines.[44]

In accordance with its guidelines on support to people living with HIV/AIDS[45] in humanitarian situations, when nutrition or food crises occur in areas with high prevalence of HIV/AIDS, the

[43] The 2001 UN General Assembly Special Session *Declaration of Commitment on HIV/AIDS* and the 2006 *Political Declaration on HIV/AIDS*, recognise that food security and nutrition are interlinked with HIV. In particular, Article 28 of the Political Declaration resolves "to integrate food and nutritional support" in responses to HIV, "with the goal that all people at all times, will have access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life, as part of a comprehensive response to HIV/AIDS".

[44] WHO 2009. Guidelines for an integrated approach to nutritional care of HIV-infected children (6 month-14 years); http://www.who.int/nutrition/publications/hivaids/9789241597524/en/index.html

[45] DG ECHO HIV Guidelines, adopted on 8 October 2008.

Commission considers expanding its nutrition support to HIV/AIDS affected persons (through adapted nutrition interventions, or through food supplements in conjunction with anti-retroviral treatment). The entry point for the humanitarian assistance for nutrition, however, must be the threat or presence of a food or nutrition crises, and not the prevalence of chronic illness with nutritional implications.

The link between HIV/AIDS and nutrition

HIV can exacerbate the effects of humanitarian crises. Likewise, displacement from a stable environment, food insecurity and poverty may increase vulnerability to HIV. Humanitarian disasters often occur in areas of high HIV prevalence. In emergencies, there is reduced access to basic food, health services, water and sanitation. These factors represent particular problems for people living with HIV who have specific nutrition needs. People living with HIV (even those without symptoms) have increased energy requirements, so access to food is of particular importance for them. In emergencies, the essential health services and HIV support and treatment services are often disrupted. Antiretroviral treatments, home-based care programmes, nutritional support programmes, and palliative care programmes are therefore likely to be in disarray. The health status of people living with HIV can deteriorate rapidly under these conditions, causing an additional burden on already strained emergency services. As gender inequalities may also be exacerbated in emergencies, there is a considerable probability that such inequalities may result in a disproportionate increase in the vulnerability of women to HIV, as opposed to the rest of the population. Furthermore, emergencies often result both in the separation of families and the breakdown of social support systems for individuals outside traditional family structures, which can have a particular impact on people suffering from HIV.

Important activities to be supported

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;
5. Treatment of severe acute malnutrition;
6. Support networks, including livelihood support and home-based care;
7. Food hygiene, sanitation, water, shelter;
8. Protection

Specific recommendations for maternal and infant health and feeding

- Exclusive breastfeeding for the first 6 months should be recommended for all infants regardless of HIV exposure (*note: minimum requirements for safe formula feeding for babies born from HIV-positive mothers are usually not applicable in crisis settings)*.
- HIV testing should be performed within maternal health services to identify HIV-positive women. HIV-positive women should receive *ART* (antiretroviral therapy) during pregnancy and delivery to reduce the likelihood of transmitting the virus to their children.
- HIV-positive women should be encouraged to continue breastfeeding for 12 months along with the introduction of complementary feeds. When breastfeeding women are HIV-positive, both mothers and infants should receive ART for the duration of breastfeeding and for one more week after breastfeeding has stopped.
- Because these women and children are at increased risk of malnutrition, they should be regularly screened for growth, nutritional status and illness.

Adapted from: Global Nutrition Cluster, Harmonized Training Package/Module 18, 2011

6.3 Coherence, Coordination and Complementarity

6.3.1 Being more effective in coordinating humanitarian and development aid: steps towards Resilience

In line with the new political framework on resilience and the Commission Communication on Resilience[46], the Commission stresses the need to maximise sustainable, inter-sectoral, multi-stakeholder support to undernutrition over the longer term, and to avoid the isolation of efforts within humanitarian response, with the aim of strengthening the resilience of the most vulnerable communities.

In particular, while respecting the difference in principles and objectives, this should include joint analysis and planning with development partners, in order to increase synergies.[47]

The Commission ensures as far as possible that short term and longer-term nutrition-related needs are addressed in an integrated and articulated way to prevent gaps in assistance, avoid duplication, ensure continuity and maximise sustainability. To do this, close coordination is promoted with other international donors and national actors. For instance, the work that is currently underway in global and regional initiatives such as SUN may present significant opportunities for more effective joint planning. In order for interventions to be effective, however, each country situation should be analysed individually and interventions should be designed according to needs and the comparative advantages of available actors.

The Commission strives to operationalize the commitments and principles laid out in the 2007 Consensus on EU Humanitarian Aid[48] and in the Commission Communication on Resilience. In particular, attention is given to articulating the different Commission aid instruments and ensuring appropriate consideration of nutrition issues in the Commission's development policies and planning, with a specific focus on the relevant country strategy papers.

Operational Case Study

Pakistan: Joint humanitarian-development programming in a natural disaster situation

The major floods in Pakistan in 2010 shed light on the serious situation of undernutrition that was already prevalent in the country, both at chronic and acute levels.

In this context, most of the international humanitarian responses were usually concentrated on addressing acute undernutrition through food-based responses, with limited attention to those longer-term investments that are necessary in order to prevent such decline. Support to food security, livelihoods and agriculture was not explicitly linked to combating undernutrition.

DG ECHO and the Delegation of the European Union (DEU) in Pakistan acknowledged the need for more explicit attention on programme design in order to better address undernutrition.

On the "Humanitarian side", the Commission's interventions in nutrition and food assistance are based on a comprehensive mix of activities addressing the likely causes of the undernutrition in flood-affected areas of Pakistan. These include:

[46] http://ec.europa.eu/europeaid/what/food-security/documents/20121003-comm_en.pdf

[47] As an example, see the 'Humanitarian Development Framework – a joint methodology between DG ECHO and DEVCO, 2012

[48] EU Humanitarian Consensus, 2007: Section 2.4, Article 22; Section 3.4, Article 53; Section 5; Annex.

- Support to the CMAM programme through UNICEF and NGOs

- Support to WFP for large-scale food and cash distributions (mostly conditional on work programmes)

- Flexible food security programmes designed according to the local context through an alliance of 6 international NGOs

On the "Development side" the following interventions are supported by the Food Security Thematic Programme (FSTP)

- Conditional cash transfers for flood-affected communities
- Integrated protection, offering women and their children a safe place where they could take part in nutrition and childcare related discussions
- Monitoring of child acute undernutrition and women's diet

Challenges: this ongoing experience indicates that systematic, informed and structured exchanges between humanitarian and development actors are necessary for addressing the immediate, underlying and basic causes of undernutrition.

The Commission therefore strives to achieve better coherence and complementarity between humanitarian and development interventions. To this end, and taking into consideration the holistic approach required when tackling acute undernutrition, the Commission encourages, whenever possible, the adoption of a robust policy and the promotion of programme dialogue between all emergency and development stakeholders who are directly or indirectly involved in the nutrition field.

Preparedness measures play a vital part in ensuring the connectivity between the fields of development and humanitarian action. Efficient avenues of work should emphasise training, capacity-building, awareness-raising, the establishment or improvement of local early-warning systems and contingency-planning – all of which are highly relevant to nutrition assistance.

Operational Case Study

Mali: Joint Humanitarian-Development programming in Nutrition

The separation between emergency and development can create challenges in the design of appropriate responses to any given context. In Mali, for example, a firm distinction between emergency and development interventions is not always possible for several reasons:

- Nutrition crises triggered by a shock (e.g. increases in food prices or droughts) are the result of both entrenched chronic poverty and vulnerability. The same shock in a less poor/vulnerable context may not lead to any crisis (or to crises of a similar magnitude).

- Given their frequency, these crisis situations have become 'chronic' and a regular feature of the Malian landscape.

- The ordinary levels of wasting in Mali, outside crisis conditions, tend to be above commonly accepted emergency thresholds.

In Mali, it is of paramount importance that a package of measures be implemented to respond comprehensively to the existing situation. Such measures shall include addressing chronic poverty, food insecurity and vulnerability alongside specific actions to prevent and treat undernutrition. Such a package has been provided through the combination of European Humanitarian and Development assistance:

-The European Humanitarian assistance funds the treatment of acute undernutrition; the provision of nutrition information and advocacy, calling on the government and development actors to give greater priority to nutrition.
-The European Development assistance funds UNICEF to:

- continue to support nutrition information and the treatment of acute undernutrition;
- enhance prevention work through, for instance, a government/UNICEF breastfeeding

campaign;

- expand advocacy work (e.g. through a series of national and international media events) to increase awareness on the existing nutrition problem and mobilise actors to address it (e.g. at central and decentralised government levels, among community networks); and
- strengthen the institutional setup and strategic environment that govern nutrition in the country.

These practical links between humanitarian and development interventions were made possible through the coordination of European development assistance in the health sector and humanitarian assistance for nutrition.

Lesson learnt: Effective coordination of humanitarian and development aid is not limited to technical complementarity, but requires a strong political commitment towards long-term strategic priorities in the field of nutrition.
To this end, the Commission is actively involved in the initiative AGIR (Alliance Globale pour la Résilience) in the Sahel.

6.3.2 Global Governance and Coordination for Nutrition in Emergencies

Effective coordination is paramount for the successful management of undernutrition in emergencies. To this end, the Commission supports the work of the Global Nutrition Cluster[49] (with UNICEF as the lead agency), the Food Security Cluster and the Health Cluster.
The Commission advocates for coherence and supports improved coordination for nutrition across all relevant sectors and through the engagement of all international actors who are involved in emergency nutrition activities.
In addition, coordination and cooperation need to go beyond operational contexts, in order to ensure coherence in the scientific evidence-base that informs policies and practice. For this reason, the Commission communicates with other global mechanisms which are concerned with nutrition such as the UN Standing Committee on Nutrition (UNSCN), SUN and the WHO's Nutrition Guidance Expert Advisory Group (NUGAG), as well as the Committee on World Food Security (CFS).

[49] http://oneresponse.info/GlobalClusters/Nutrition/Pages/default.aspx

Annexes

A.1 List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral therapy
BMI	Body-Mass Index
CFS	Committee on World Food Security
CFW	Cash for Work
CMAM	Community-based Management of acute Malnutrition
CoD	Cost of Diet
CSB (+/++)	Corn-Soy Blend (+/++ refers to the addition of micronutrient mix/micronutrient mix and dried skim milk powder – replacing the basic CSB)
DALYs	Disability adjusted life years
DEU	Delegation of the European Union
DFID	Department for International Development – British Aid
DG ECHO	Directorate General for Humanitarian Aid and Civil Protection
EDF	European Development Fund
EU	European Union
Fe	Ferrous/Ferric - Iron
FSTP	Food Security Thematic Programme
GAM	Global Acute Malnutrition
GFD	General Food Distribution
HEA	Household Economy Analysis
HIV	Human immunodeficiency virus infection
IASC	Inter-agency Standing Committee
INGO	International Non-Governmental Organisation
IPC	Integrated Phase Classification
IYCF(-E)	Infant and Young Child Feeding (in emergencies)
LRRD	Linking Relief Rehabilitation and Development
MAM	Moderate Acute Malnutrition
MAMI	Management of acute Malnutrition in Infants
MDG	Millennium Development Goals
MN	Micronutrient
MND	Micronutrient Deficiency
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-governmental Organisation
NUGAG	Nutrition Guidance Expert Advisory Group
ORS	Oral Rehydration Salt
OTP	Outpatient Therapeutic Programme
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
SAM	Severe Acute Malnutrition
SC UK	Save the Children, United Kingdom
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SUN	Scaling up Nutrition (imitative/movement)
TFA	Targeted Food Assistance
TB	Tuberculosis
USD	United States Dollar
U2s/U5s	Under two(s) (children under two/five years of age)
UNICEF	United Nations Children's Fund
UNSCN	United Nation Standing Committee on Nutrition
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

A.2 Note on Technical Terms

Nutrition is the science of how nutrients and other substances in food act and interact in relation to health. **Nutrition security**[50] encompasses good health; a healthy environment; good care practices and household food security (see Figure 1).

Food security occurs when people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life.[51] A family (or country) may be food secure, yet include individuals who are nutritionally insecure. Food security is therefore a necessary but not sufficient condition for nutrition security. **Hunger** is an outcome of food insecurity, where dietary intake, at population level, falls below minimum requirements (typically averaged as 2,100 kcal per person per day).

Nutritional status is the physiological condition of a person resulting from the balance between nutrient requirements, intake and the body's ability to use these nutrients. **Anthropometry** is human body measurement used as a proxy for nutritional status (as per nutrition surveys).

Malnutrition is a physical condition related to the body's use of nutrients. There are two forms of malnutrition: undernutrition and overnutrition. This document deals only with **undernutrition**, since it is that form of malnutrition that is of specific public-health concern in emergencies.

An **emergency** or **humanitarian crisis** is an event(s) which critically threatens the health, safety, security or wellbeing of a large group of people. The Commission defines an emergency based on a combination of absolute thresholds (such as Sphere or WHO) and relative indicators set against a contextual norm. A crisis is triggered by a hazard that may be natural or man-made, with rapid or slow-onset, and of short or protracted duration.

Undernutrition includes: i) intrauterine growth restriction which leads to low birth weight; ii) stunting; iii) wasting and nutritional oedema; and iv) deficiencies of essential micronutrients. The causes of undernutrition are multiple and context-specific.

Undernutrition can be short-term (acute) or long-term (chronic). **Acute undernutrition** in children under 5 years of age is characterised by wasting (low weight compared to height) and/or nutritional oedema. **Wasting** (**marasmus**) is a condition resulting from rapid weight loss, or a failure to gain weight, over a short period of time. Acute undernutrition can be moderate or severe. Together, these constitute the total (or 'global') rate of acute malnutrition (GAM). Moderate acute malnutrition (MAM) is defined as wasting > -3 and < -2 Z-scores[52] of the median weight-for-height of the reference population; severe acute malnutrition (SAM) is < -3 Z-scores and/or nutritional oedema (bilateral pitting oedema). Nutritional oedema may mask wasting and therefore weight-for-height may not be observed. An alternative rapid way to estimate acute undernutrition in children as well as in pregnant and lactating women is the measurement of the mid-upper arm circumference (MUAC).

The management of acute undernutrition may involve the use of specialised **nutritional products**[53] designed to supplement the diet with specific micronutrients, energy/protein or both. These foods are usually intended for home consumption, and are distributed through general rations, blanket distributions (to groups at risk) or programmes targeting acutely undernourished individuals.

Chronic undernutrition results in **stunting** i.e. low height compared to age (defined as <-2 Z-scores of the median height-for-age according to WHO growth standards for children). The longer time-scale

50 Gross, R. et al. (1998) in Community Nutrition: Definition and Approaches. *Encyclopaedia of Human Nutrition*. Ed. by Sadler, M., Strain S. and Caballero B. London.

51 World Food Summit, 1996

52 Z-score (or standard deviation score) is the deviation of the value for an individual from the median value of the reference population, divided by the standard deviation of the reference.

53 The terms ready-to-use food (RUF) and ready-to-use therapeutic food (RUTF) are often used.

over which height-for-age is affected makes it a better indicator for protracted nutritional deficiency. The measurement of stunting is more useful for long-term planning than for emergencies.

Micronutrient deficiencies (MND) are a form of undernutrition that is related to vitamins and minerals. Deficiencies of iron, iodine, vitamin A and zinc are amongst the top-10 leading causes of death through disease in developing countries[54]. Other deficiencies which are more specific to emergencies include those of thiamine (B1), riboflavin (B2); niacin (B3) and vitamin C.

Underweight in children is a non-specific indicator of undernutrition, since it includes children with low weight-for-height (wasting) or low height-for-age (stunting). It is defined as < -2 Z-scores of the median weight-for-age of WHO growth standards. Growth charts based on weight-for-age, are used for **growth monitoring** in health centres. In emergencies, weight-for-age can be used to indicate the presence of a problem if data on acute undernutrition is not available.

Adult undernutrition is usually assessed using Body Mass Index (BMI)[55] or Mid Upper Arm Circumference (MUAC). Undernutrition in pregnant and lactating mothers is identified through MUAC and clinical signs (lack of appropriate weight gain during pregnancy). Short stature in women resulting from past stunting (height below 145cm in females aged 15-49 years) can result in poor pregnancy outcomes.

Undernutrition and mortality are late indicators of a crisis. It is imperative that information on health, food security, water, sanitation and hygiene is used to interpret estimates of undernutrition. The WHO definition of **thresholds**[56] to guide such interpretation varies and has to be used with caution and specificity to the context (also, thresholds for the prevalence of moderate and severe acute undernutrition in children under five years of age are subject to adjustments in light of the revised WHO growth standards from 2006). Trend analysis can reveal a worsening situation even if thresholds have not been crossed. Nevertheless, the WHO definitions provide a reasonable starting point in assessing the severity of a crisis.

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[54] Black R. et al (2008): Maternal and Child Undernutrition: Global and regional exposures and health consequences. Lancet 371, 243-260. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61690-0/fulltext

[55] Weight divided by the square of height (kg/m^2)

[56] GAM emergency threshold > 15 %; Mortality emergency threshold >2/10,000/day, WHO

A.3 Policies and Guidelines in Support of this Staff Working Document

This document draws on numerous internal and external policies, norms and guidelines. These are listed here so that the present document can be read and understood within this context.

Internal

The legal basis of EU humanitarian mandate is defined in the ***Humanitarian Regulation*** (June 1996)[57]. In line with this, nutrition interventions in crises are provided to meet humanitarian needs, but include support to prevent or mitigate disasters and short-term post-emergency recovery.

The position paper incorporates the core principles, objectives and standards for EU humanitarian action which are delineated in the ***Humanitarian Aid Consensus*** (2008)[58]

The ***Commission Communication on Humanitarian Food Assistance Policy and its Staff Working Document***[59]provides a framework for securing adequate food consumption, necessary for nutrition security.

The ***Commission Communication on The EU Role in Global Health*** **and its Staff Working Document**[60]

The ***Commission Communication on An EU policy framework to assist developing countries in addressing food security challenges***[61]

The nutritional needs of specific vulnerable groups are addressed in ***DG ECHO HIV Guidelines*** (October 2008) and the ***Commission Staff Working Paper on Children in Emergency and Crises Situations*** (2008); and

The ***Commission Communication on Disaster Risk Reduction*** (2009) identifies the strengthening of capacities in disaster-prone contexts as an appropriate objective during humanitarian response.

External

The Sphere Project. Humanitarian Charter and Minimum Standards in Disaster Response. 2011

International Code of Marketing of Breast-milk Substitutes, WHO 1977

WHO (2004) ***Guiding Principles for Feeding Infants and Young Children during Emergencies***

UNHCR/UNICEF/WFP/WHO (2004) ***Food and Nutrition Needs in Emergencies***

Management of Acute Malnutrition in Infants (MAMI) Project Review. Project commissioned by the IASC Global Nutrition Cluster. Summary Report, ENN, October 2009.

Guidelines on ***Infant and Young Child Feeding in Emergencies***. IFE Core Group, Feb 2007

Community Based Management of Severe Acute Malnutrition. A Joint Statement by the World Health Organisation, World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund. May 2007.

Preventing and controlling micronutrient deficiencies in populations affected by an emergency. Joint statement by the World Health Organisation, the World Food Programme and the United Nations Children's Fund. 2007.

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[57] **Council Regulation (EC) No 1257/96 of 20 June 1996 concerning humanitarian aid** *OJ L 163, 2.7.1996, p. 1–6 (ES, DA, DE, EL, EN, FR, IT, NL, PT, FI, SV)*

[58] **European Consensus on Humanitarian Aid, 2007** *OJ L C25/01, 30.1.2008*

[59] COM (2010)126 final, March 2010

[60] COM (2010)128 final, March 2010

[61] COM (2010)127 final, March 2010

WHO Child Growth Standards and the Identification of Severe Acute Malnutrition in Infants and Children. A joint statement by the World Health Organisation, and the United Nations Children's Fund. 2009.