CONCERN worldwide

PILOT PROGRAMMATIC PARTNERSHIP

# *Rethinking Responses to Chronic Health and Nutrition Emergencies in Fragile Contexts*

## Concern International Learning Event, May 2023
## Background Paper

### Introduction

The scale of wasting[1] is massive: across the world, 45 million children under five are wasted[2], and only 25% of these children receive adequate care. The drivers of wasting in fragile and conflicted affected countries (FCAC) include conflict, poverty and climate change, as well as gender norms which are often detrimental to the nutrition and health of children and pregnant women. Instead of improving, world hunger figures are rising. The situation is worsening given the current overlapping global crises of conflict, climate change, the economic fallout of the COVID-19 pandemic and the global rise in food prices. According to the 2022 Global Hunger Index, in Sub-Saharan Africa, the prevalence of malnutrition and the rate of child mortality are higher than in any other world region[3]. The 2022 Global Nutrition Report sets out the global burden of malnutrition, estimating that: 14.6% of infants have a low weight at birth; 22% of children under 5 years of age are affected by stunting; and 6.7% by wasting. Higher operational costs and commodity prices put further pressure on limited humanitarian budgets. The outlook for Sub-Saharan Africa for 2023 is increasingly worrying. Despite significant commitments to reduce child stunting and wasting prevalence by 2030 under the Sustainable Development Goals, many fear targets in this region will not be met.

### Enhanced Responses to Nutrition Emergencies (ERNE) Programme (2020-2023)

Concern's Enhanced Responses to Nutrition Emergencies (ERNE) programme is an ambitious three-year programme, concluding at the end of May 2023. ERNE was designed to tackle child wasting in fragile contexts by using a nexus-based approach which combined immediate and flexible lifesaving responses with longer-term capacity and resilience building of health systems, as well as national and community-based early warning systems. Through ERNE, Concern aimed to increase the scale, efficiency and effectiveness of its nutrition emergency responses by working with local services and communities to implement proven and innovative solutions in fragile, conflict affected and disaster-prone contexts in Democratic Republic of Congo (DRC), Ethiopia, Niger, Republic of Sudan and South Sudan.

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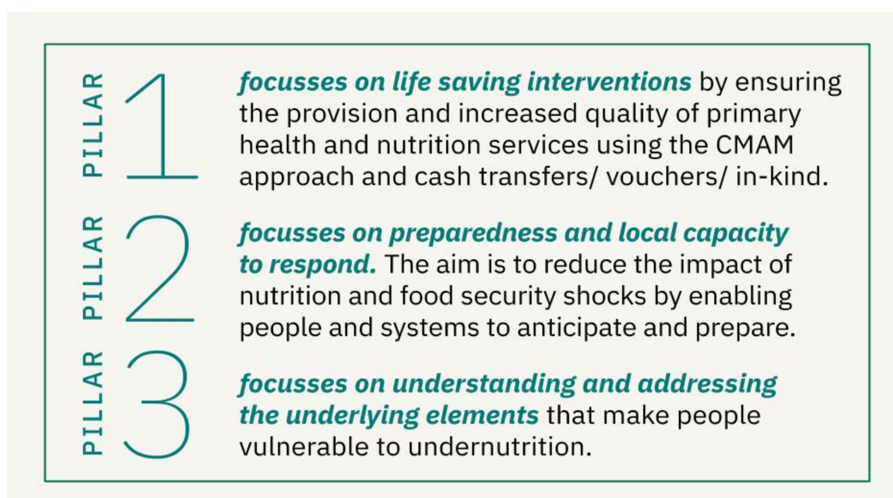
[1] This paper uses the term 'wasting' as an abbreviated term to refer to child wasting (according to low weight for height or mid-upper arm circumference) and/or nutrition oedema. Similarly, severe wasting refers to severe wasting and/ or nutritional oedema. This is in keeping with the recent shift towards using the term wasting at global level rather than the term acute malnutrition (see related WHO statement here).
[2] https://data.unicef.org/topic/nutrition/malnutrition/
[3] https://www.globalhungerindex.org/trends.html

Based on the three pillars outlined in Figure 1 below, ERNE combined lifesaving emergency nutrition treatment and prevention and preparedness activities to build community resilience to wasting in the longer term. The programme spanned more than 22 health districts in eight regions/ provinces/ states across DRC, Ethiopia, Niger, South Sudan and Sudan[4]. While all would be considered fragile, the nature and degree of their fragility differed as did the capacity of the government health system in each context. A range of vulnerability indicators were used to identify the focal regions and states for the ERNE programme, in line with the ECHO Humanitarian Implementation Plans (HIP) for each country. Within those areas, Concern worked with government health authorities to identify districts with the greatest vulnerability to wasting (using prevalence data and other info where available), the greatest pressure on the health system, and where no or few other NGO partners were supporting.

**Figure 1: ERNE Programme 3-Pillar Framework and Results**




**Principal Objective =>** To contribute to reducing malnutrition morbidity and mortality among children under five

**Specific Objective =>** To increase scale, efficiency and effectiveness of humanitarian preparedness and response for food and nutrition security in targeted countries

**Result 1 =>** Increased coverage and improved quality of treatment in the regions with the highest prevalence
**Result 2 =>** Severe deterioration of food security of most vulnerable households affected by crises is avoided
**Result 3 =>** Shocks in targeted districts are anticipated and prepared for
**Result 4 =>** Improved behavioural practices impacting nutrition of children under 5 in target communities
**Result 5 =>** Learning and evidence from the ERNE Programme influences dialogue and policy debate amongst the wider humanitarian community

[4] An additional six districts were also covered in Niger with health and nutrition support by COOPI and ACF, Concern's ERNE consortium partners.

Strengthening health systems to better deliver essential health and nutrition services, including community-based management of acute malnutrition (CMAM) approach has been central to the programme. CMAM, over the last twenty years, has been endorsed as a cost-effective public health intervention that treats wasting in a community setting.[5] In particular, ERNE has sought to support health systems and communities to better anticipate and prepare for shocks by scaling up CMAM Surge[6], piloting Health Surge[7], and setting up an Early Warning Early Action (EWEA) approach. Under Result 2 of the programme, there was pre-positioned funding to support the delivery of cash transfers in response to anticipated or sudden onset emergencies through either early action or emergency rapid response. Lastly, behaviour change towards optimal nutrition practices was promoted through support to mother and father care groups.

## Concern - ECHO Pilot Programmatic Partnership (PPP) – a more strategic funding modality

The ERNE Programme was supported under an innovative Pilot Programmatic Partnership (PPP) arrangement with ECHO, which provided multi-annual, strategic funding of €30 million in place of the short-term cycles of funding which are often the norm in humanitarian aid. This was coupled with "enhanced dialogue" between Concern and ECHO at Country and HQ level with a view to building trust between the two organisations, supporting flexibility and sharing learning. The PPP aimed to increase the efficiency and effectiveness of humanitarian aid in line with Grand Bargain commitments.

Concern was one of only four international non-governmental organisations (NGOs) selected to pilot this new partnership approach with ECHO.[8] This strategic, multi-annual funding enabled Concern to implement a wider reaching and longer-lasting form of humanitarian response. In addition to providing emergency response, the programme was able to work with communities and governments in very conflict-prone and climate-affected countries over a longer timeframe to address some of the root causes of poverty and hardship with a view to greater sustainability of interventions.

### Learnings from the PPP

Throughout the PPP lifetime, the four participating INGOs collaborated with ECHO to share and document learning on the experience of the pilot during various consultations and events. Based on these discussions, it has been acknowledged that there were a number of limitations inherent in the setup under the Pilot including that although the partnership agreement itself and the ERNE programme were multi-annual, funding allocations were agreed on an annual basis. In addition, as it evolved, the programme shifted to become more aligned with ECHO country level priorities under the HIPs rather than with global priorities as originally conceived. Since ECHO's priorities and focus differed across the five ERNE countries and final funding available for the programme was less than what had been envisaged during the proposal design phase, multi-year planning and overall coherence of the programme design were affected. In particular, the scale up of the EWEA cash component in year three was less extensive than foreseen. These factors in turn

[5] See further: https://www.concern.net/cmam2021

[6] CMAM Surge is an enhancement of CMAM which strengthens local capacity to anticipate, prepare for and respond to increased demands in acute malnutrition services at peak times.

[7] Health Surge applies a similar approach to key childhood morbidities, so that services may become more resilient.

[8] The other INGOs were Acted, International Rescue Committee (IRC) and Save the Children

impacted on the level of evidence and learning that could be generated on the effectiveness of the overall ERNE Model.

Despite the limitations experienced during the pilot phase, the Programmatic Partnership approach has been shown have significant unique benefits, for example:

- *Multi-annual partnership and funding* has enabled: i) more flexibility to respond to crises and more strategic interventions ii) longer-term capacity building of health facilities in hard-to-reach, fragile contexts ii) enhanced relationship-building with Concern partners[9] and communities over time iii) greater staff retention and consolidation of programme-specific technical and management capacity year-on-year
- *Increased flexibility* to pivot and respond to sudden onset crises because of increased trust between ECHO and Concern built through the enhanced dialogue component and the use of pre-positioned flexible funds for emergency cash transfers. This worked particularly well in Ethiopia, Niger and South Sudan where Concern, in dialogue with ECHO, was able to respond at scale to major crisis which emerged during the programme lifetime such as conflict, flooding and disease outbreaks.
- *Administrative efficiencies* as there were no requirement to re-apply for annual HIPs in the five ERNE countries and there was consolidated reporting across the countries against standardised indicators
- Opportunity to *test and learn* from a new strategic model of emergency nutrition response in partnership with ECHO based on a harmonised set of indicators; in-built learning component has promoted cross-country exchange and learning

Much of this learning has informed the design of the subsequent phase of Programmatic Partnerships which has been rolled out under ECHO's 2023 HIPs.

## ERNE Programme - Key Results[10]

- Supported a total of **1.2 million poor and vulnerable people with lifesaving health and nutrition services** and helped over 100,000 children **to recover from wasting** in five countries.

- Supported **304 health facilities in hard to reach, conflict affected areas, in five countries** through capacity building, logistical and technical support, provision of equipment and rehabilitation of health facilities, particularly WASH infrastructure. Over seventy percent **of these facilities reported an improvement in their capacity at the end of the programme**

- **Built the resilience of health services by introducing the "Surge" approach in 275 health facilities.** This enabled health workers to proactively monitor trends in wasting and common childhood diseases, and to predict and prepare for spikes in demand for healthcare. This helped ensure staff can take anticipatory action, for example by deploying more health staff to the area or pre-positioning more supplies of medicine or RUTF/RUSF. As a result, 72% of facilities were able to maintain recovery rates for children with severe wasting during peak periods.

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[9] Under ERNE, country level partners included Ministries of Health in all countries, ACF and COOPI in Niger, Local NGOs SAWA and MAARIF in Sudan. At global level, the programme partners were Red Cross Climate Centre (RCCC) and Sonke Gender Justice.
[10] Provisional results to end February 2023

- **Enabled communities to set up early warning monitoring systems in 33 hard to reach localities across the five countries**. Concern engaged with volunteers in these communities to identify local early warning signs of impending drought, disease outbreaks or other risks that could lead to increased wasting and to raise alerts so that anticipatory actions can be taken at the community and household level before the situation deteriorates.

- **Provided shock-responsive interventions** (cash transfers) to 31,000 households in response to multi-hazard sudden onset disasters such as flooding, displacement, dry spells leading to drought and conflict. As a result, the percentage of the targeted households with **acceptable Food Consumption Scores increased on average by 33%** across the five countries.

- **Engaged more than 18,000 parents of young children (including 2,777 fathers) in sessions to improve nutrition, health, and hygiene knowledge and practices,** including gender transformative behaviours.

## Learning and Promising Practices[11]

Result 5 of the ERNE programme focussed on generating learning and evidence of good practice. Programme learning has been developed through regular reviews and reflections at country level and cross-country, case studies and learning events held throughout the programme lifetime. This forum constitutes the Final Learning Event under Result 5 and the outputs of the day will feed into the final learning document and final evaluation of the programme.

**1. The integrated, shock-responsive model piloted under the ERNE programme holds promise for a more effective type of nutrition emergency response**

Underpinned by flexible, multi-annual funding from ECHO, the ERNE programme has been able to go beyond traditional emergency nutrition programming towards a more multi-sectoral and shock-responsive model. Learning to date indicates that the ERNE model, with some adaptations and simplifications, holds promise as a more efficient and effective way of delivering emergency health and nutrition response.

**2. It is critical to build an understanding of seasonality and local pressures on the health service to empower health workers to better anticipate and prepare for peak periods.**

FCACs see variable trends in health service usage caused by food insecurity, disease outbreaks, time pressure on health workers based on seasons, as well as displacement. Building resilience into the health system is vital, so that services are able to anticipate, prepare for and adapt to often rapidly changing needs and local capacities. Seasonal and situational information must be shared between actors (e.g. livelihoods, early warning and health) if timely and coordinated early action is to be taken. The Surge Approach (previously known as the CMAM Surge approach) is particularly relevant for Sahelian countries, such as Niger, where wasting and child illness (particularly malaria) often peak during certain times of the year. The eight step Surge approach provides a framework and set of tools to help health workers and District Health Management Teams better anticipate when these peaks will happen (by reviewing past caseload trends and

[11] Detailed learning papers are being produced and will be informed by and made available after the Final ERNE Programme Learning Event on May 23rd 2023. This paper presents a summary of key learnings and promising practices to date to inform discussions at the event.

seasonal calendars), plan for adaptations and external support when caseloads exceed capacity (setting caseload thresholds based on existing capacity, above which adaptation and support will be actioned), and trigger a scale down when the situation normalizes.

**3. Mobile health and nutrition services provide a lifeline to people during mass displacement or where health facilities have been damaged during conflict, but a clear scale down plan must be in place to guide the return of routine health services as soon as access to static facilities is restored**

**In South Sudan**, flooding in Unity State which started shortly after the ERNE programme commenced in 2020 grew to extraordinary and unprecedented levels during the rainy season in mid-2022, submerging an estimated two-thirds of the country, affecting more than a million people, and causing mass displacement. In response, Concern and the County Health Department swiftly shifted from supporting mostly static health facilities (one of which was completely washed away by floods) to providing mobile health and nutrition services from tents established in the locations where people were fleeing to, keeping pace with communities as they fled to safety on higher ground amid rising flood waters. Such a fluid approach to health service provision was critical but required intense consultation with communities, the County Health Department and other supporting NGOs to anticipate where populations were moving and ensure health and nutrition services were available there. As the 2023 flood season approaches, the Concern team is preparing for possible redeployment of mobile health services, including transporting people and supplies by boat. A clear strategy on mobile health and nutrition services, however, is needed to guide health and nutrition actors working in contexts such as Unity State regarding where and when mobile services should be activated and scaled down, the standard package of services and staffing, and the budget required.

In **Ethiopia**, the Federal Ministry of Health has been supporting mobile health and nutrition teams (MHNTs) to meet the needs of hard-to-reach populations for nearly two decades. Concern along with other NGOs and UNICEF have been supporting MHNTs, particularly in response to the conflict in Tigray, the resulting displacement and extensive looting of health facilities and health worker exodus. They have been a critical strategy to bring essential health and nutrition services in these periods of crisis. Communities and government health teams have highly valued the services provided, which were free of charge. However, they are costly and largely unsustainable to run. MOH guidelines are a core resource, but a clearer strategy for scaling down and transitioning services back to health facilities is needed. Coordinated efforts and funding to restore services at static health centres and health posts must be made alongside MHNTs and services shifted back to those facilities as soon as possible.

**4. Significant investments in global RUTF production in response to the global food crisis are starting to yield results, but more investments are needed to increase availability of specialised nutritious foods for moderate wasting and improve last mile delivery of these essential products to health facilities.**

Significant breaks in the pipeline of ready to use supplementary foods (RUSF) for moderate wasting to the ERNE target districts were experienced in the Ethiopia and Sudan programme areas in 2022. Breaks in RUTF supply to ERNE districts were also experienced on a smaller scale in several countries. In response to the global food crisis, USAID invested 280 million USD to tackle wasting, a large portion of which was directed to UNICEF to increase global production of

RUTF which has increased global availability of the essential therapeutic food.[12] Last mile delivery, however, from the Health District level to health facilities remains sub-optimal. Once delivered to District level, arrangements for management of RUTF and RUSF and onward delivery to health facilities differs considerably by context. In the ERNE programme areas in Ethiopia, Niger and Sudan, for example, the MOH was responsible for onward distribution of RUTF, while in DRC and South Sudan, UNICEF had a direct agreement with Concern to manage it. For RUSF, WFP generally awarded field level agreements directly to Concern to manage and deliver the commodity to health facilities.

Concern has identified two areas requiring coordinated effort to improve last mile delivery of nutrition supplies. The first is to more clearly define roles and responsibilities of the MOH, UNICEF and supporting NGOs like Concern in managing RUTF at District and health facility level. The ideal, sustainable scenario is that RUTF will be managed via MoH supply systems. However, in FCAC, MoH capacity to manage and transport RUTF and other supplies is often overstretched. Agreeing and formalising complementary roles of the respective actors in the management of RUTF could enhance efficiency. The second area for improving practice is to devise a more standardised system across MoH, UNICEF, and NGOs to better monitor stock levels at health facilities, and forecast and communicate stock needs relative to caseloads in more real time. Ideally, this would be a digital system that can work in areas with weak network coverage, and it will require close collaboration between MoH, UNICEF and NGO partners.

**5. Simple action plans can promote better integration of severe wasting treatment into routine health service delivery at health facility level, but governments and donors must commit to integrated systems and funding at District and National level.**

The degree to which services for severe wasting are functionally integrated into delivery of the essential health service package at facility level differed considerably across the ERNE contexts. In **South Sudan** for example**,** nutrition services are still run quite parallel to health services. A legacy of emergency nutrition response that was largely NGO supported means that treatment services for wasting are often still delivered at nutrition units that are outside health facilities. This divide between health and nutrition services is reinforced by parallel funding streams. In the ERNE programme area in Guit County, Concern, health facility staff and the County Health Department developed an intentional integration plan to overcome the siloed approach and promote more efficient service delivery. A matrix included practical actions ranging from removing the fence separating the health facility and nutrition unit to more joint training and a system to track, analyse and increase cross referrals.[13]

In **Niger**, the ERNE programme shifted from the CMAM Surge approach to a more holistic Surge approach that helps health teams better anticipate, prepare for and respond to seasonal peaks in both child wasting and child illness, particularly malaria and diarrhoea.[14] This shift to a Surge approach encompassing both wasting and illness has been highly valued by health workers who find it helps them better manage their whole workload and is preferable to CMAM Surge alone.

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[12] https://www.unicef.org/press-releases/over-half-billion-dollars-pledged-tackle-severe-wasting-july-unprecedented

[13] For more information, see Concern's case study on integration in South Sudan on the ERNE programme hub here.
[14] Previously known as the CMAM Surge approach, the term 'Surge approach' will be used going forward as it works to support services not only for the community based management of acute malnutrition (CMAM) but childhood illness. The new Surge guidelines coming in May 2023 will reflect this more holistic model.

The Ethiopia MOH has developed a national action plan for integrating early detection and treatment of wasting into routine health care services and the impact can be seen at all levels, including practical integration of severe wasting management into guidelines for the integrated management of new-born and child illness, responsibilities of health workers and health information systems. Donors such as ECHO and BHA require their implementing partners to deliver support to an integrated package of health and nutrition services. Similar efforts to integrate funding and delivery systems for health and nutrition are needed across many FCACs.

**6. In the extremely fragile ERNE contexts, transfer values for Early Action cash transfers needed to be higher than 30% MEB in order to be effective, even as part of a no-regrets approach, though further testing is needed**

Under the ERNE programme design, the amount for cash transfers for Early Action was set at 30% of the Minimum Expenditure Basket (MEB) based on a minimal, no-regrets approach. There was provision for scale-up in case of need. In practice, 30% was found to be too low to be effective in the extremely fragile and often rapidly deteriorating contexts of the ERNE countries which experienced largescale sudden onset crises such as extreme drought, flooding and conflict-induced displacement. In most cases, a much larger transfer was required and Concern in fact pivoted from early action to rapid response. This meant using Early Action to prevent negative coping strategies leading to increased malnutrition (as per the programme theory of change) could not be tested at scale over the 3 years. Nevertheless, the use of lower value transfer values and progressive scale up remains a promising approach to explore though likely a higher starting value than 30% would be required to generate impact. Lower value transfers also have more potential to generate more government buy-in and make stronger links with shock responsive social protection approaches than the transfer values typically used for rapid emergency responses.

**7. The inclusion of MUAC screening data, and data on key under 5 morbidities linked to wasting (rather than wasting admissions data) in Early Warning Systems has been shown to be a feasible way of forging links between existing surveillance systems.**

This has improved the analysis of the seasonal drivers of wasting and the anticipation capacity needed for preparedness. More work would be needed for linking the responses so that they are also more nutrition-sensitive and use Cash Plus[15] approaches. The relevance of including other diseases such as cholera and measles in EWS remains inconclusive. Only one cholera outbreak was recorded and responded to during the implementation of ERNE. Including health outbreak data from existing integrated disease surveillance and response systems alongside climate shocks may be a promising practice to pursue further.

**8. Early Warning Systems as a component of integrated programming in fragile contexts need to be agile and therefore simple to use.**

In ERNE, the multi-hazard Early Warning Systems were designed with six risk categories that included climate, conflict, health and nutrition-related risk. In practice, this approach proved to be too complex within the programme operational areas. Acute events can be easier to identify than slow-onset emergencies. This makes multi-hazard EWS less sensitive to gradual changes in structural vulnerability and to responding to localized stressors, the very pathways to increased wasting.

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[15] Cash Plus is generally defined as the combination of cash transfers with complementary interventions. It implies that cash is pre-supposed as the core component, rather than determining all modalities via response analysis.

**9. Community level EWS complement national systems best when there is stronger emphasis on strengthening systems from local to district to national level, for both information sharing and decision-making.**

This requires local level decision-making systems and resources in place to act to local events. If there are no Early Action Plans (or equivalents) in place to respond to the information being generated, there is no incentive to maintain the system.

**10. Community/departmental risk profiles and mapping carried out by local and national actors and structures have proved to be a successful tool for effective risk analysis and stakeholder buy-in for early warning.**

The challenge remains in linking these to broader emergency response mechanisms responding to widespread crises. These mechanisms tend to use national level geographical prioritization and targeting approaches, which are still poorly understood by community-level structures and leave them feeling they have been missed out of externally supported responses.

## Stakeholder Recommendations

### *Policymakers (Donors, National Governments, the UN)*

1. *Provide flexible, long-term funding for health and nutrition responses in fragile contexts*: Whilst the role of short-term humanitarian aid to respond to chronic health and nutrition emergencies in poor and vulnerable countries remains crucial, policymakers and donors should also scale-up funding for innovative programmes like ERNE that seek to bridge the development-humanitarian nexus and include anticipatory action to prevent wasting.
2. *Partnerships*: Participate in and support long-term collaborative action across humanitarian actors to address the root causes of nutrition crises, including new partnerships between traditional humanitarian and development donors
3. *Integrated funding and coordination*: Develop and support mechanisms that will result in funding streams and coordination for integrated health and nutrition services, including supply chains.
4. *Strengthen nutrition supply chains* at all levels and commit to addressing significant pipeline breaks, particularly for RUSF
5. *Increase long-term investment in health systems*, especially i) investing in training health workers and ensuring an adequate level of remuneration and ii) investment in WASH and infrastructure
6. *Surge Approach*: Continue to invest in building local capacity of health systems and health actors to respond to shocks and protect the quality of service delivery.

### *Implementers (health workers/ managers and supporting NGOs)*

1. *Map health systems actors* and how each may interface with nutrition services at different levels, use this to develop a contextualized integration plan
2. *Map nutrition supply chains* in each context and clarify responsibilities for nutrition commodity management between MoH, UN agencies and supporting NGOs
3. *Support existing mechanisms to fund* health worker incentives and facility running costs, where possible, while maintaining free health care for the most vulnerable
4. *Strengthen capacity of health workers to understand seasonal peaks* and pressures on health services – consider integrating the Surge approach to help health workers better plan for, and manage, services during these periods
5. *In coordination with the MoH, plan for flexible, mobile services* where target populations are at risk of displacement or conflict threatens to damage static facilities or compromise access to them but agree on a clear plan to scale mobile services back into routine service delivery as soon as possible
6. *Be ready to pivot* from a capacity-building role to more hands-on service delivery support when public health service capacity is compromised and back again when it is restored
7. *Increase the use of Cash Plus approaches* in nutrition programming to address the drivers of malnutrition

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