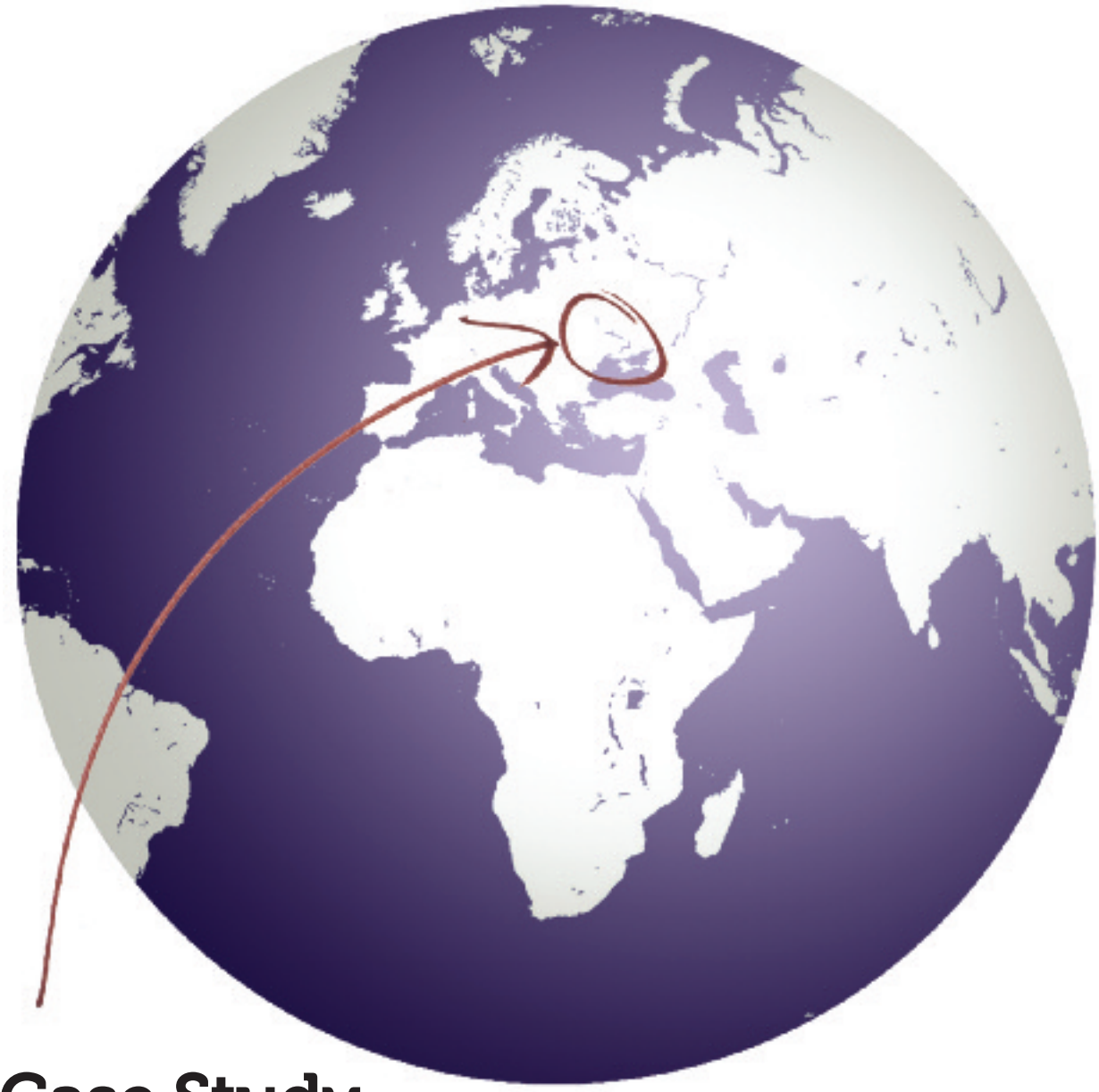


Case Study

Ukraine

Nutrition coordination in Ukraine:

Experiences as a sub-cluster of health

ENN Global NUTRITION CLUSTER unicef

Case Study

Ukraine

Nutrition coordination in Ukraine:

Experiences as a sub-cluster of health

This case study is one of six case studies produced through a year-long collaboration in 2015 between ENN and the Global Nutrition Cluster (GNC) to capture and disseminate knowledge about the Nutrition Cluster experiences of responding to Level 2 and Level 3 emergencies. They each provide very rich insights into the achievements of the cluster approach and the challenges of working in complex environments.

The findings and recommendations documented in this case study are those of the authors. They do not necessarily represent the views of UNICEF, its Executive Directors or the countries that they represent and should not be attributed to them.

Authors & Acknowledgments

Anna Ziolokovska, Information Management Officer, Global Nutrition Cluster Rapid Response Team, UNICEF. The ENN team supporting this work comprised Valerie Gatchell (ENN consultant and project lead), with support from Carmel Dolan and Jeremy Shoham (ENN Technical Directors). Josephine Ippe, Global Nutrition Cluster Coordinator, also provided support.

December 2015

This case study was produced by ENN,
www.ennonline.net

Summary

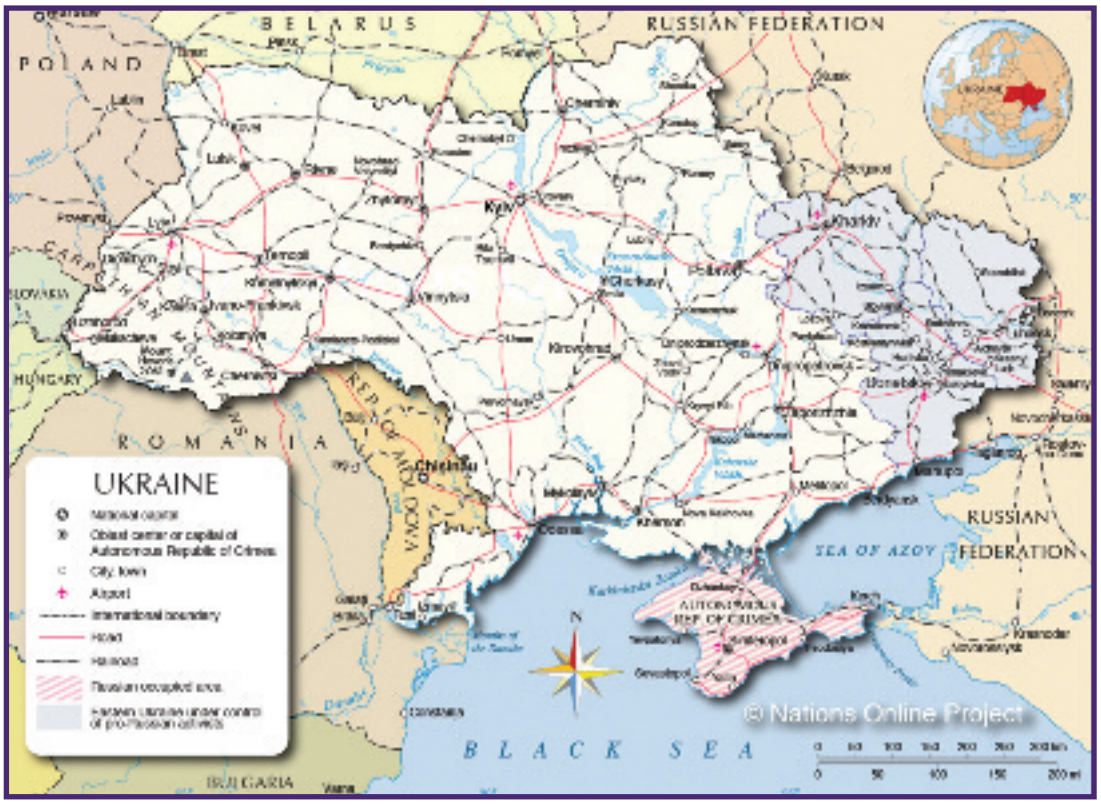
This case study underlines how the lack of nutrition coordination and information management capacity in conjunction with limited expertise of partners on the ground made it difficult to implement a comprehensive response, even though activities were costed in the response plan. It also highlights the lack of nutrition capacity to address nutrition issues beyond acute malnutrition in the Ukraine response, i.e. IYCF, Complementary Feeding, stunting and non-communicable diseases (NCD). In addition, there was a failure to programme for all vulnerable populations (i.e. older persons) or advocate across sectors and with local NGOs to consider nutrition as part of their responses.

Background

Political unrest began in March 2014 in the Donbas region of eastern Ukraine (Donetsk and Luhansk oblasts) with heavy clashes between government forces and pro-Russia supporters. Fighting and insecurity forced many people to flee their homes, settling in densely populated urban areas. Despite the ceasefire agreement signed on 5 September 2014 and the nine-point Memorandum agreed in Minsk, ceasefire violations continued. Violence has escalated significantly since mid-January 2015, with rocket explosions and indiscriminate shelling killing civilians and further destroying infrastructure.

In August 2015 the de facto authorities mandated an accreditation process for all agencies working in these areas and only MSF was given access. Other agencies were instructed to suspend operations until the accreditation process was complete.

It is estimated that more than five million people have been affected and 68 children have been killed since the start of the conflict. Over 1.4 million people are officially registered as internally displaced people (IDPs). Approximately two million people living along the conflict line are reliant on assistance and face persistent threats and insecurity.



Impact of the conflict

In conflict-affected areas, basic services have been disrupted and there is need of medicines, food, basic household items and shelter. Reports indicate that many of those remaining in the conflict zone close to the frontline are living in unhygienic, overcrowded, underground shelters with no WASH (water, sanitation and hygiene) facilities and electricity. Limited access to the population has hampered the movement of humanitarian aid.

In non-government controlled areas (NGCAs), the banking system has collapsed and pensions and social benefits are unavailable. Restriction of movements across the frontline due to the introduction of special permits exacerbates the situation. Many of those who have managed to leave the conflict-affected area and are now registered as IDPs have exhausted their financial resources and face difficulties in paying for accommodation, heating, food and non-food items.

Humanitarian response

In response to the humanitarian need, the cluster approach was activated on 23 December 2014 and the following clusters were established: Education (led by UNICEF); Emergency Shelter & NFIs (led by UNHCR); Food Security & Nutrition (FS&N, co-led by WFP and UNICEF); Health (led by WHO); Livelihoods/Early Recovery (led by UNDP); Protection (led by OHCHR/UNHCR); and WASH (led by UNICEF).

A Humanitarian Response Plan (HRP) was developed in November 2014 targeting 900,000 people for humanitarian assistance in the various sectors. Given the deterioration in the situation, numbers were revised in February 2015 to target 3.2 million of the five million estimated to be affected.

Nutrition situation

Based on the available data (mostly 15 years old), pre-crisis stunting and acute malnutrition rates were perceived to be low, while anaemia prevalence was 24.1% nationwide (MoH statistics, 2014), with substantial variations between oblasts. Poor infant and young child feeding (IYCF) practices existed (MICS 2012), and there are widespread violations of the International Code of Marketing of Breastmilk Substitutes (the Code).

An IYCF-E (Infant and Young Child Feeding in Emergencies) survey conducted by the Centers for Disease Control (CDC) with support from UNICEF[1] in June 2015 did not find any cases of severe acute malnutrition (as measured by MUAC) and the same survey found 0.5% moderate acute malnutrition in children under two. The survey also highlighted a low exclusive breastfeeding rate (25.5%), noting that the majority of mothers (42.4%) stopped breastfeeding without any specific reasons; 30% of cessation was due to conflict-related stress. Poor IYCF practices are manifest, with early introduction of non-milk fluids and widespread bottle-feeding practiced by IDPs in eastern Ukraine. Mothers are often told by doctors to give their children water, formula or other complementary foods before six months, with some health providers even offering formula in the birth clinic if the baby cries or is perceived to be hungry. The majority (70.5%) of the families surveyed received baby food in the food basket as part of the humanitarian assistance, while more than half (51.2%) of the families with an infant less than six months received infant formula.

[1] Conducted among IDPs in Kharkiv, Dnipropetrovsk and Zaporizhia oblasts by the Centers for Disease Control with

People in Need, an international non-governmental organization (NGO), conducted a survey in December 2014 that indicated that 71% of those surveyed regularly face food shortages. Lack of cash to buy food was the main reason highlighted. This is due to exhaustion of financial resources, unemployment, lack of access to savings, non-payment of pensions and benefits, increased food prices and rising energy prices. Pensioners, the elderly, the socially vulnerable and people living in active fighting zones and NGCAs are particularly at risk of food insecurity.

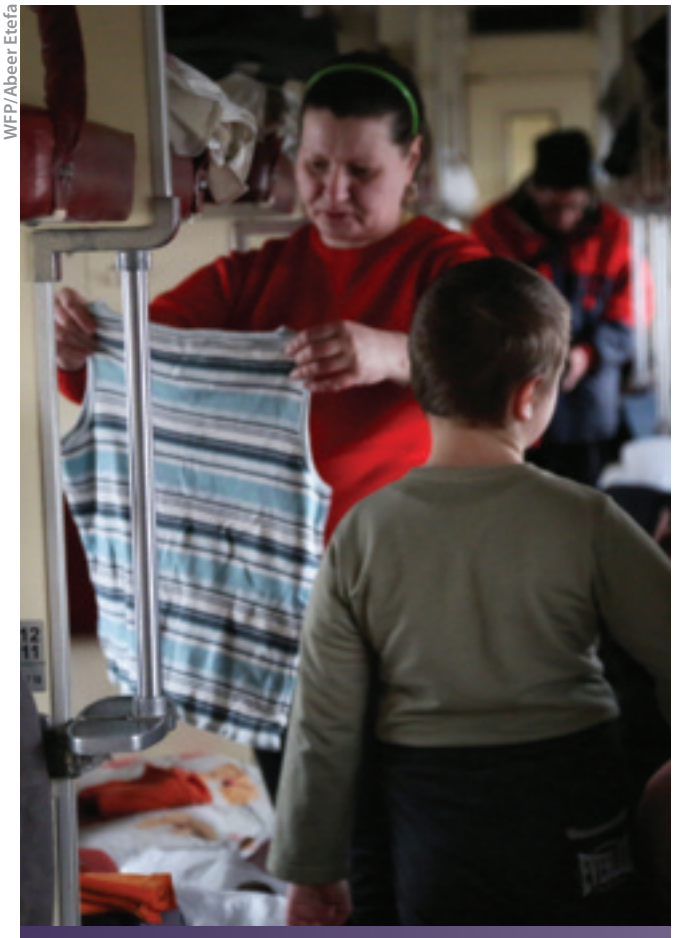
Water supplies are available; however they are irregular due to the damage to the water network caused by shelling. Maintaining the quality of water is a concern due to lack of access to the main water sources, which are very close to the front line.

Basic health services have been significantly disrupted. At least 32 hospitals in NGCAs are not functioning, while 17 have been shelled and damaged but continue to offer limited care. There are risks of shortages in electricity and water supply in hospitals and lack of fuel for ambulances (ACAPS, 30 January 2015). In addition, between 30 and 70% of health staff have fled the conflict-affected areas of Donetsk and Luhansk oblasts. Low vaccination rates heighten the risk of outbreaks of vaccine-preventable diseases, as evidenced by the outbreak of polio in the west of the country in September 2015.

The drug and medical supply chain have totally collapsed and stocks are depleted. About 71% of people in Donetsk oblast reported having no access to medicine and 85% reported having no access to medical treatment (December 2014, People in Need).

Nutrition sub-cluster coordination

Before the crisis, the UNICEF programme in Ukraine did not have a strong nutrition component. This is typical of most UNICEF programmes in middle-income countries where nutrition is not perceived to be a priority. Additionally none of the typical international NGOs involved in Nutrition in Emergencies (NiE) had programmes in Ukraine before the crisis. Health programmes existed but capacity was low. When the cluster approach was activated, the UNICEF Health Specialist assumed responsibility for nutrition coordination. In January 2015 this Health Specialist left the position. In the absence of an official Nutrition Cluster Coordinator (NCC) and technical nutrition programme, staff in UNICEF Ukraine, the Global Nutrition Cluster (GNC) Coordination Team, in coordination with the Country Office, deployed a Ukrainian-Russian-speaking Rapid Response Team (RTT) member to Ukraine for two weeks (3-14 February) to review the nutrition situation, partner capacity, gaps in response and working arrangements for nutrition coordination[2]. Based on the needs identified, the RRT member returned for an additional eight



WFP/Abeer Etefa

[2] Report of the Global Nutrition Cluster Scoping Mission to Ukraine, 3-14 February 2015.

weeks (March to May 2015) to provide coordination support. A Senior Advisor at CDC was also deployed to Ukraine during this time to support design of assessments and provided technical assistance to the Nutrition sub-Cluster.

The RRT member provided coordination support for Ukraine while in the country for a total of ten weeks and provided remote support for four weeks from May-June 2015 via Skype meetings and following up with partners on issues raised during the visits. This focused support resulted in active engagement, follow-up on issues and bringing together of partners.

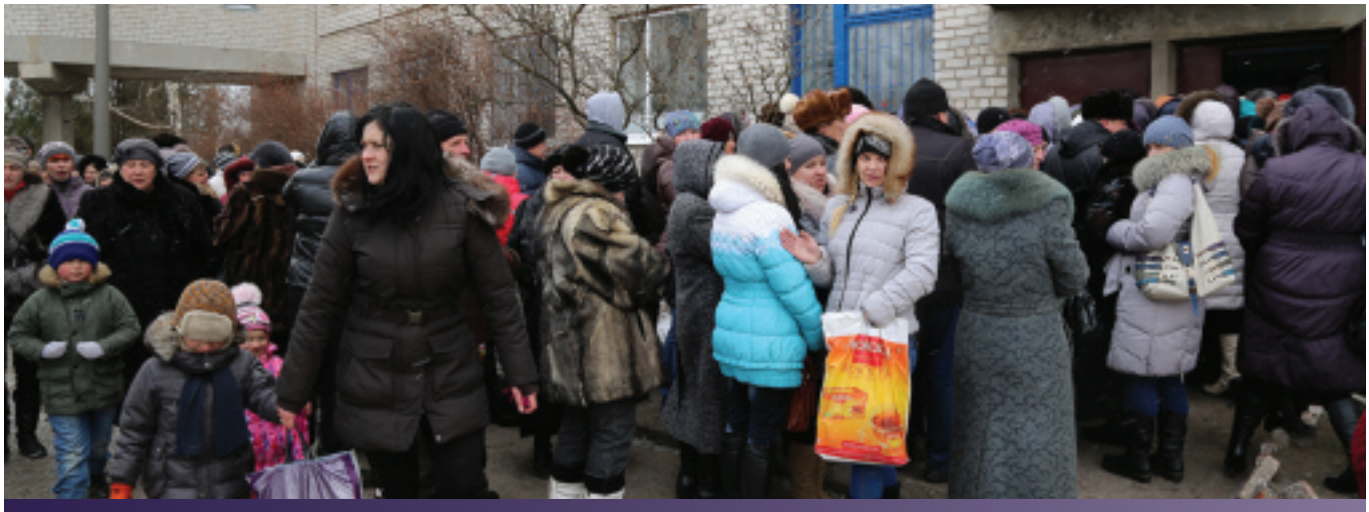
An Information Management Officer (IMO) employed by UNICEF supports nutrition and WASH coordination as well as UNICEF programmes.

Nutrition coordination

In December 2014 when the clusters were officially activated, nutrition was included as part of the Food Security and Nutrition (FSN) Cluster. During the scoping mission, the RRT member (acting as an NCC) reviewed the effectiveness of nutrition coordination under the FSC and identified other potential mechanisms to improve nutrition coordination. It was agreed that, while there were advantages for the Nutrition Cluster (NC) to continue as part of the FSC (e.g. this promoted closer engagement with partners on complementary and supplementary feeding programmes and ability to monitor more closely violations of the Code in general ration distributions), there could be significant advantages to shifting nutrition coordination to the Health Cluster, such as:

- *Existing systems* – The Ministry of Health (MoH) had an existing system/structure and staff that IYCF activities could build on in terms of capacity development.
- *Nutrition expertise* – Many partners in the Health Cluster have nutrition expertise globally which could allow for greater discussion around nutrition issues.
- *Funding potential* – Donors are well represented in the Health Cluster meetings, allowing for a higher profile for nutrition.

Based on these arguments, it was agreed in February 2015 that nutrition coordination would best be supported under the Health Cluster with the Nutrition sub-Cluster providing day-to-day management of the nutrition coordination and holding separate nutrition coordination meetings, yet providing updates to the larger Health Cluster in their meetings. The proposed structure was presented to the Emergency Relief Coordinator who formally approved the Health and Nutrition cluster in Ukraine in February. Based on agreement among partners, the scoping mission recommended revisiting the need for a stand-alone nutrition when developing the 2016 HRP.



WFP/Abeer Etefa

To support various technical issues and discussions, the Nutrition sub-Cluster established a Complementary Feeding (CF) Task Force in March and an IYCF Advocacy Task Force (TF) in April. The CF TF completed its aim of designing the composition of the complementary feeding ration and has ended. The IYCF Advocacy Task Force continues to develop advocacy documents.

After the RRT deployment, UNICEF, as the Cluster Lead Agency for Nutrition, tried to maintain both nutrition programmatic and coordination capacities through a series of surge and technical support from UNICEF HQ, other UNICEF offices and CDC. However no dedicated nutrition coordination capacity has been identified (as of November 2015). This has resulted in significant gaps in nutrition coordination and the inability to sustain various efforts of surge staff.

Partners and technical capacity

In addition to the MoH there are 18 Nutrition sub-Cluster partners including UN agencies, international NGOs and local charity organisations. The three UN agencies (UNICEF, WFP and WHO) are based in Kiev with sub-regional offices in affected areas. Of the 14 non-UN agency partners, five are local and nine are international. However, none of these partners have technical capacity in nutrition in their Ukraine country teams.

The Ukrainian MoH also has very limited nutrition capacity; the only staff member with such capacity is the focal person for MCH and nutrition who is also the head of the Maternal and Child Health Department. The MoH has limited engagement in cluster discussions and activities as the department is in a state of flux.

UNICEF has limited technical capacity in nutrition as there is no full-time nutrition programme staff in the country, both pre and post-crisis. Nutrition technical support for WFP was initially provided by the Regional Bureau, although it has recently (September) recruited someone based in Ukraine.

Local organisations are playing an important role in the response efforts. Two very large local charities, Akhmetov Foundation (AF) and Alexander Romanovsky Foundation (ARF), are providing significant amounts of food, medical and social support in affected areas, largely funded by private donors and other governments. Both agencies have extensive local volunteer networks (over 1,000 volunteers in ARF) in affected areas and attend Nutrition sub-Cluster meetings. In addition to these organisations, other local organisations with no technical expertise in nutrition are involved in food distribution.

Nutrition response

The 2015 Strategic Response plan (SRP) developed in November 2014 had a very limited focus on nutrition. The only nutrition activity listed was “capacity building on food security and nutrition”. Nutrition was not considered a priority due to the lack of acute malnutrition[3]. Based on gaps identified in the scoping mission, nutrition activities were expanded in the revised HRP (February 2015) to include needs assessments, IYCF support, complementary food support to young children, capacity development (including training of healthcare workers on IYCF, orientation of partners on nutrition and best practice in IYCF), continued monitoring of at-risk groups (children under two, pregnant and lactating women and older people) and advocacy across sectors for a nutrition-sensitive response. Additionally, various assessments were planned/conducted and mechanisms for surveillance of older people and anaemia were proposed.

[3] Meeting 24 December 2014, where UNICEF Health and Nutrition staff informed partners that no severe acute malnutrition had been reported and that individuals have a high coping capacity and resilience.

Food assistance

General distributions[4] as well as cash and vouchers are being implemented by several FSN cluster partners. In NGCAs, as of August, WFP was distributing general rations to 200,000 food-insecure individuals for three months. Given that no fresh fruit, vegetables or fortified complementary foods for children are being provided, the Nutrition sub-Cluster has advocated the provision of complementary food baskets to young children. WFP has plans to distribute these complementary feeding baskets to 20,000 children aged 6-23 months for six months once funding and access are secured.

Two large local charities continue to distribute food rations to the affected population. They have developed sophisticated systems for registration and monitoring of IDPs and distributing appropriate commodities (food, non-food, medical, etc.) to relevant age groups through the use of text messages and multiple distribution sites across the affected areas. Baby-food baskets have been provided as part of their programmes.

A review of the components of the local charity food baskets during the scoping mission highlighted that breast milk substitutes (BMS) were being distributed alongside food baskets to children of all ages. As a result the Nutrition sub-Cluster Complementary Food Task Force, with support from UNICEF headquarters and WFP RO, developed guidance on the composition of complementary food baskets[5] for children aged 6-23 months, with recommendations to separate complementary food baskets for children 6-11 and 12-23 months. The Nutrition sub-Cluster is advocating with WFP to disaggregate data to facilitate ease of monitoring of the food baskets going to various age groups.

IYCF

BMS use in the affected population prior to the crisis was widespread. However, the limited cash reserves and lack of availability of BMS in the market, particularly in the NGCAs, has significantly constrained access after the conflict started. Based on the Humanitarian System Monitoring report of December 2014, infant formula was the most highly requested food item by the conflict-affected population; however access to safe water and fuel for safe preparation of BMS is limited. The scoping mission also found that, due to the shortage of BMS supply, mothers have been found to dilute BMS to prolong use.

The IYCF Advocacy Task Force, in collaboration with the IYCF in emergencies (IYCF-E) Core Group at global level, developed a statement on the promotion of safe and appropriate IYCF practices. The statement was signed by the UNICEF Representative (on behalf of Nutrition Sub-Cluster), the WHO Representative (on behalf of the Health and Nutrition Cluster) and the MoH. It was issued in August 2015. A two-day workshop on IYCF was conducted by the Nutrition sub-Cluster with support from UNICEF HQ for partners and government staff in July 2015.

Micronutrient deficiencies (MND)

It was expected that anaemia prevalence in women and children would increase post-crisis and there are anecdotal reports of 60% anaemia in women in

[4] As of February 2015 the WFP food basket consisted of canned beef, canned sardines, noodles, sunflower oil, ground rice, sugar, beans, salt and tea consisting of 2,600 kcal per person per day (recommended kcal for winter months). Other partners provide oil, sugar, tea, cookies, flour, pasta, wheat porridge, oat flakes, semolina, buckwheat, rice, canned meat products, sardines in oil, canned sprats, chicken liver paté, cheese, beans, dried peas and tomato paste.

[5] See Key communication messages on IYCF in emergency in Ukraine, 13 May 2015.

Non-Communicable Diseases (NCD)

NCDs were an issue before the crisis and remain such. The Health Cluster (through WHO) is looking at this, but reports particular challenges with regard to drug supplies. It is reportedly very challenging to bring medications into NGCAs as this requires government approval. Additionally there is reportedly significant 'leakage' in terms of who receives the drugs. The level of financial support and the quantity of drugs coming from the Russian Federation to NGCAs remain unknown, so it is difficult for WHO to plan supply needs, clear supplies with MoH for NGCAs, and then target those in need.

some areas, yet reliable data are not available. In March 2015 the Nutrition sub-Cluster proposed a surveillance system to document monthly reported cases of anaemia in pregnant women and infants from randomly selected health facilities in five priority oblasts in both government and NGCA's. UNICEF field monitors were to collect the data and develop the reports, although the system remains to be established.

Additionally, UNICEF proposed the distribution of multiple micronutrient powders (MMPs) for home fortification in the Nutrition Response Plan; however the product required MoH approval before being imported as it is not registered with MoH. Due to the lengthy process of new product certification in Ukraine, this activity has been dropped. This suggests the need for consideration of product certification as part of emergency preparedness, especially for products that are not routinely used in these countries.

Nutrition for other vulnerable groups

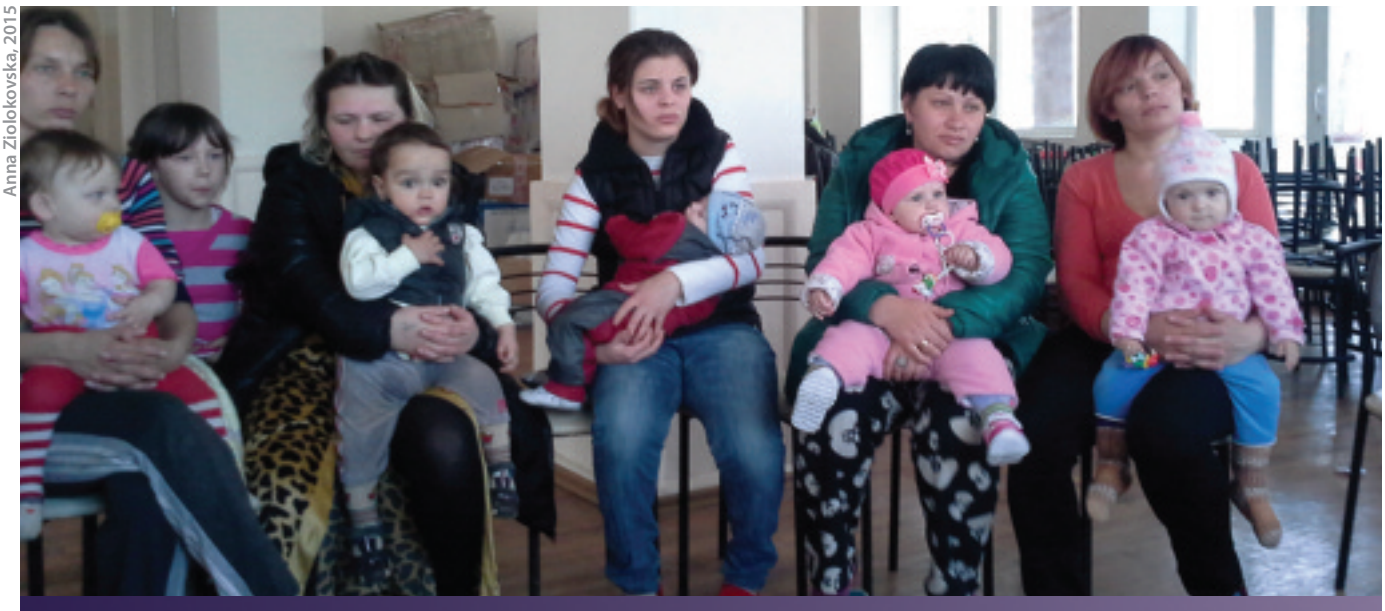
In addition to children under two years, older people and pregnant women are considered particularly vulnerable groups. The Nutrition Response Plan suggests that some of the needs of these groups might be met through food distribution activities of the FSC and social protection activities. It also recognises that the Nutrition sub-Cluster does not have the capacity to directly assess the nutritional status of older people[6], although it aims to review results from the nutrition screening of people over 70 in mobile health units conducted by WHO and develop a response if necessary. Additionally, the plan proposes anaemia surveillance for pregnant women. However neither of these activities have been conducted.

Monitoring and information management

An initial plan for monitoring and information management was established in the Nutrition Response Plan. However, as there have been no nutrition-specific programmes, there has been no programmatic information on which to report. While WFP received money for complementary food distribution and has identified partners, this has been halted due to the lack of access to the NGCAs (since August). The 4W (who, what, where, when) sheet remained largely un-updated from May until November due to the absence of a long-term NCC. In terms of capacity development, UNICEF NY supported a two-day orientation on NIE and IYCF in June-July; however no further capacity development has been conducted.

The monitoring of Nutrition sub-Cluster Coordination performance is planned through a standard Cluster Coordination Performance Monitoring (CCPM) exercise; however a date for conducting the CCPM has not been established.

[6] Nutrition Response Plan pgs 11-13



Anna Ziolokovska, 2015

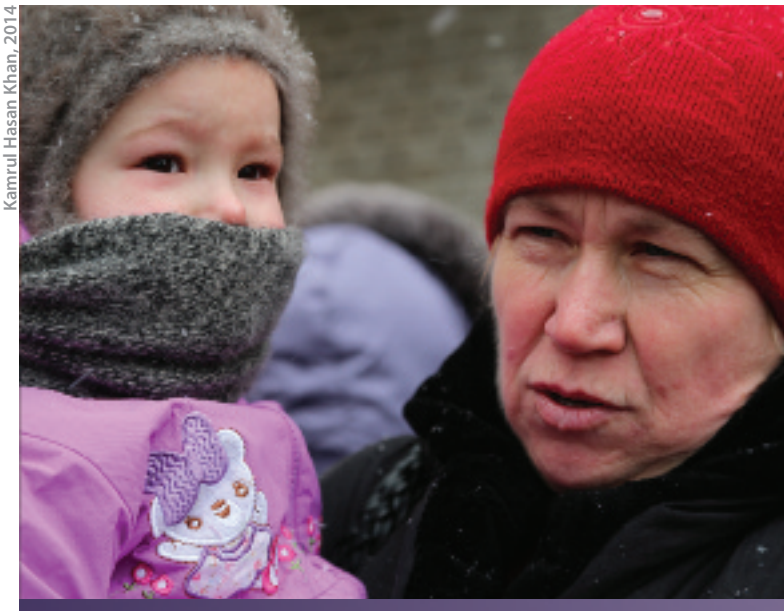
Funding

The cost of implementing the Nutrition Sub-Cluster Response Plan (February 2015) was estimated at USD 9.5 million, although this does not include funding secured by local organisations such as private foundations. The cost estimate in the HRP was based on the costs per activity (based on needs) as there were practically no agencies on the ground with capacity to submit proposals for nutrition projects in support of the HRP except for WFP, WHO and UNICEF. The Nutrition sub-Cluster costed all activities in the HRP because, while there were no partners to implement at the time, it was felt that partners may come if funds were raised. By February 2015 the Nutrition component of the Health and Nutrition Cluster HRP was zero per cent funded. The RRT member, providing surge support to Ukraine in February, advocated directly with GNC partner agencies to support a nutrition response, while UNICEF HQ, UNICEF Ukraine, WFP HQ and WFP Regional Bureau advocated for funding with donors directly. As of September 2015, USD 4.01 million (mostly for health) has been received against the overall Health and Nutrition HRP. In addition, DFID has provided 600,000 GBP for nutrition (to UNICEF) and WFP has received limited funding for CF distribution, but it has not started yet.

Challenges

Interviews conducted with a number of stakeholders identified the following challenges in effecting a coherent nutrition response to the Ukraine crisis:

1. **Nutrition has not been a priority for the humanitarian response** overall given the absence of acute malnutrition. Other nutrition issues (such as anaemia and stunting) are widely considered development issues and, as Ukraine is a middle-income country, many humanitarian actors believe these issues should be managed by the government. Some donors feel that the correlation between poor IYCF practice (particularly breastfeeding) and nutrition outcome/impact is not clear. A health and nutrition crisis (in terms of high levels of acute malnutrition) anticipated by some has not materialised. Currently MoH's prime focus is the management of a polio outbreak, which is seen as an acute crisis and health priority requiring urgent management.
2. **Geography of response.** The areas affected by conflict are on average 9.5 hours (690km) from Kiev, the capital of Ukraine. There is no visible impact on those in the capital and thus it is a relatively 'silent' emergency.
3. **Nutrition coordination is perceived to be falling through the cracks.** There is no dedicated capacity for coordination or information management and very limited partner capacity to implement nutrition programmes. Nutrition activities are not a priority of either the HNC or the FSC and these clusters remain weak and struggle with coordination themselves. Additionally, UNICEF nutrition technical capacity has been very weak, affecting their ability to support both coordination function and the CLA technical leadership function.



Kamrul Hasan Khan, 2014

4. **Lack of technical nutrition capacity** on the ground and rapid turnover of surge staff filling the NCC/UNICEF Programme Officer role has resulted in limited progress on many initiatives recommended in the Nutrition Response Plan, including capacity development, surveillance and cross-sectoral advocacy activities. The NCC position remains unfilled 11 months after the identified need for a NCC.
5. **There was no guidance on what to do for non-BF infants.** While all partners recognised this was a large challenge, there was limited leadership and authority on the ground (including agencies' headquarter technical nutrition staff) to make recommendations. This contributed to additional confusion among partners and the wider humanitarian community, including donors, and the population[7].

Learning from the Ukraine experience

6. **There is an inability to include MNPs as part of the intervention** as a home-based fortification strategy to enhance the dietary quality of rations for children and other groups. This is due to a lack of product approval from the government.
7. **There is a lack of international agencies with experience in nutrition** involved in the immediate response. No GNC partners were on the ground in January 2015 working in nutrition when the Nutrition sub-Cluster was established. Some agencies supported discussions around the Response Plan remotely but, with no technical nutrition capacity (of GNC partners) in Ukraine to directly implement and guide other clusters to implement nutrition actions, the ability to mount a nutrition response was severely constrained.

- **Scoping mission.** The scoping visit was a crucial step in understanding the nutrition situation in Ukraine, particularly given that the RRT member conducting the mission spoke Ukrainian and Russian. The scoping report raised the profile of the nutrition situation and increased national and international awareness of the situation among agencies. It also galvanised support for assessments by INGO partners, including CDC.
- **Situational analysis and technical response.** Absence of acute malnutrition at the onset of the crisis indicated (incorrectly) to many in-country stakeholders that a nutrition response was not necessary. IYCF and CF issues were raised during the scoping visit and were subsequently included in the Nutrition Response Plan; however, the issues of stunting and non-communicable diseases in relation to the crisis were not discussed or included. Future situational analyses should review the range of nutrition issues from the outset, including stunting and NCDs, and consider how a deterioration in other sectors will impact all aspects of nutrition (including stunting, micronutrient deficiencies and NCDs) to guide the development of the response. Strong partner technical capacity is crucial to guide the development of the response and advocate for necessary capacity. There remains a question as to how emergency response should address a previously existing chronic problem (poor child feeding practices) pre-conflict.
- Cross-sectoral collaboration. Coordination with other clusters to enhance nutrition sensitivity of their interventions is recognised as crucial in Ukraine and many other emergencies in contexts with limited acute malnutrition. While suggestions on what to advocate for with each cluster were provided in the Nutrition Response Plan, the lack of consistency of coordination capacity in Ukraine prevented this from moving forward.
- **Coordination.** There are advantages and disadvantages of being a sub-Cluster of another independent cluster such as Health or Food Security. Experience in Ukraine suggests that dedicated coordination and information management support for nutrition is crucial, regardless where nutrition coordination sits (FSC, HNC or stand-alone NC). While it is recognised that adequately trained, experienced

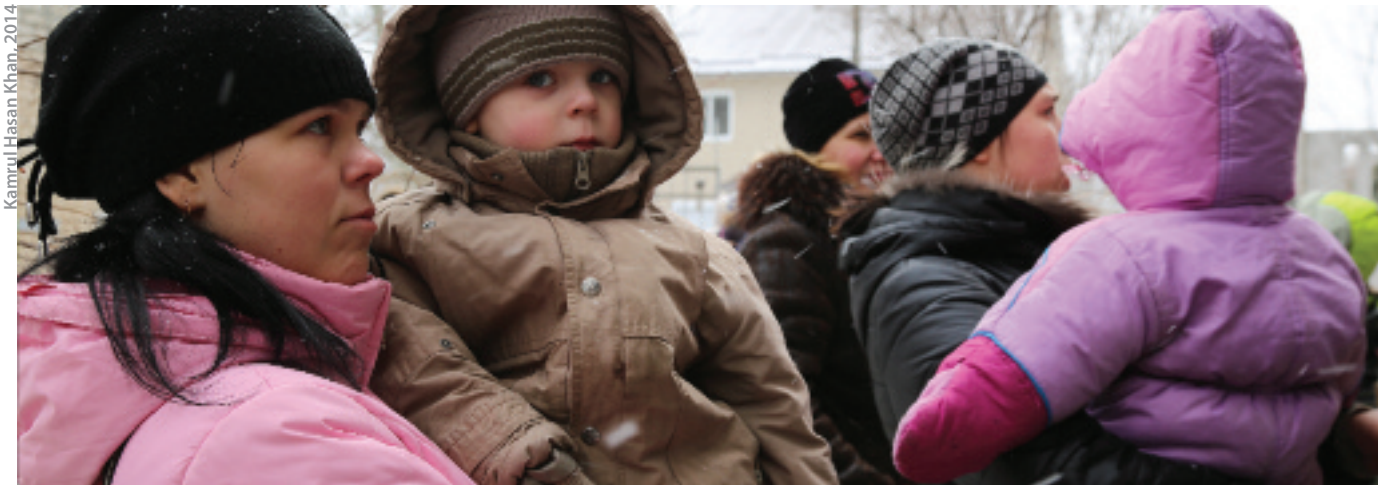
[7] Draft guidance has since been developed in relation to the European migrant crisis and work is underway at a global level to address this further in the coming year.

individuals are in short supply, coordination and information management capacity should be advocated for and prioritised in terms of UNICEF recruitment and funding processes.

- Target groups. Older people are a crucial vulnerable group, yet their nutritional status and the response for this demographic has not been a main focus of agencies working in nutrition. As a collective, the Nutrition sub-Cluster did not effectively advocate (due to lack of coordination and technical capacity on the ground) with the HCT for funding and support to conduct a proper assessment of older people's nutritional status. There is limited experience globally assessing the nutritional status in this demographic and the experience in Ukraine further highlights the need to adapt existing comprehensive assessment methods to include older people. Questions remain around the nutritional appropriateness of the food assistance (including cash) being provided to older persons as part of the humanitarian response.
- National NGOs. The proportion of local NGOs and CSOs to international NGOs is large and their reach is massive. It is recognized that local NGOs can have a considerable impact on nutrition. How clusters engage with local NGOs to support a coordinated response is largely determined on coordination capacity, which in the case of Ukraine has been extremely limited.
- Funding. The nutrition response (largely IYCF support) to the situation in Ukraine is believed to be largely underfunded (97%), according to the HRP. However, even if funding were provided, it would be a challenge to utilise it, given the lack of capacity of partners. The question remains whether clusters should develop funding requirements for a response based on assessed needs or on capacity to implement. The later, in the case of Ukraine, would have resulted in a much lower funding request, though would not have addressed actual need.

Conclusion

The GNC and the UNICEF Country Office are working together to recruit a NCC as soon as possible; however due to lack of funding for a purely coordination position, a Health and Nutrition Specialist position, which combines coordination with UNICEF programme functions, has been advertised. It is questionable how much time this person will be able to allocate to coordination of NiE response. In the interim, short-term support staff are still being deployed to cover basic technical and coordination functions.



Kamrul Hasan Khan, 2014