ENU
EMERGENCY NUTRITION UPDATE

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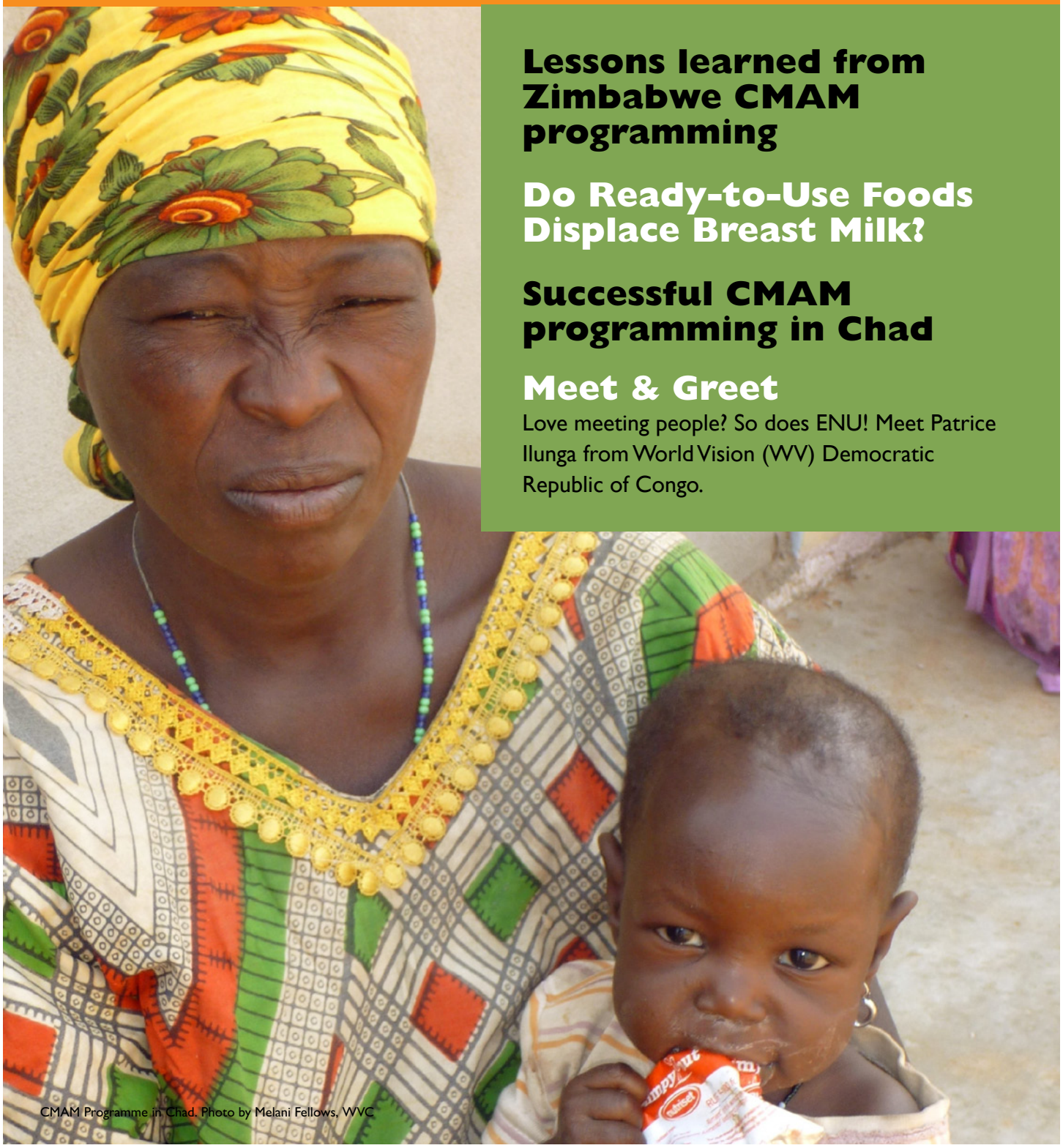
In the Spotlight

CMAM Scale Up Lessons Learned



CMAM Programme in Chad. Photo by Melani Fellows, WVC

Lessons learned from Zimbabwe CMAM programming

Do Ready-to-Use Foods Displace Breast Milk?

Successful CMAM programming in Chad

Meet & Greet

Love meeting people? So does ENU! Meet Patrice Ilunga from World Vision (WV) Democratic Republic of Congo.

Talking about CMAM Scale Up

Submitted by Sisay Sinamo, East Africa Regional Office Nutrition Advisor

With an estimated 20 million children affected, severe acute malnutrition is one of the biggest public health problems and responsible for more than one million deaths among children under five every year. The traditional in-patient care model for addressing acute malnutrition (hospital wards or therapeutic feeding centres) proved to be a low impact and costly intervention that did not achieve high rates of coverage and was not well liked by caregivers. However, in the last ten years, a new model for the treatment of acute malnutrition was developed, focused on community delivery of efficient treatment services, using an effective product and empowering caregivers.

The community-based management of severe acute malnutrition (CMAM) approach has proven to be highly effective, showing significant impact at relatively low cost. The evidence base for CMAM programmes was established by 2006, with the publication of an analysis of 21 programmes implemented between 2001 and 2005,[1] and CMAM was endorsed in a 2007 United Nations Joint Statement.[2] As a result, this approach has been implemented in many countries and remains an effective approach used extensively within World Vision (since 2006) and externally. A UNICEF mapping report disseminated by UNICEF and VALID in March 2011 indicated that by mid-2010, 55 countries were implementing CMAM, with more than one million children treated annually.[3]

From its initial use in emergency contexts, CMAM is increasingly being integrated into development contexts and the primary health care system. Challenges include unpredictable funding cycles and funding gaps, inadequate supply chain for ready-to-use therapeutic food (RUTF) distribution and local production, and the overall capacity of health systems in the developing countries to extend provision of services in the community while maintaining quality and adequate coverage.

In November 2011, at the CMAM scale up conference led by Emergency Nutrition Network (ENN) and the Ethiopian government, some of these issues were discussed and recommendations for CMAM scale up were identified as follows (http://cmamconference2011.org):

- Government leadership and support at supra-sectoral level (i.e. Executive level) in order to command authority across ministries/sectors.
- International coordinating mechanisms, like SUN and REACH support of setting up of such high-level coordination bodies.
- Donors to increase efforts that bring alignment of international organisations (UN) with government strategies.
- More evidence on effective mechanisms to manage MAM.
- Include CMAM in a variety of pre-service training.
- Dissemination of tools, materials, training programmes and other relevant resources directly to governments.
- Facilitation of cross-country learning and networking.

BACKGROUND

World Vision started its CMAM programming in 2006 in three countries in Africa; Ethiopia, South Sudan and Niger. Currently, WV implements CMAM in 12 countries in Africa. CMAM programmes contributed to saving hundreds of thousands of lives during the recent Horn of Africa drought response in Somalia, Ethiopia, Kenya and Tanzania, as well as the cyclical food crisis in the West African Sahelian countries of Niger and Mauritania.

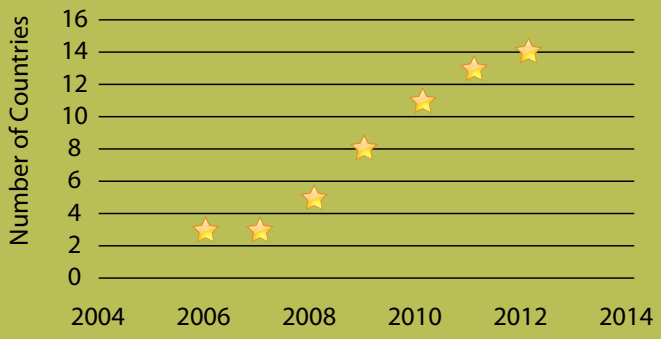
1. Collins, et al., Management of severe acute malnutrition in children, The Lancet, vol. 368, no. 9551, 2 December 2006, pp.1992–2000.

2. Joint Statement by World Health Organization (WHO), World Food Programme (WFP), United Nations Standing Committee on Nutrition (SCN) and the United Nations Children's Fund (UNICEF). Geneva/New York/Rome, June 2007: http://www.who.int/nutrition/publications/severemalnutrition/9789280641479/en/index.html

3. UNICEF, Valid International. Global mapping review of Community-based Management of Acute Malnutrition with focus on Severe Acute Malnutrition. March 2011.

ENU SPOTLIGHT

CMAM Scale Up In Africa



The Key Principles in WV CMAM Operation

- Strengthen existing community-based health systems, including health workers and volunteer community health workers to provide quality services;
- Equip health facilities with pharmaceuticals, medical supplies, logistics, equipment and volunteers necessary for CMAM implementation;
- Build the capacity of the Ministry of Health (MoH) and of communities;
- Integrate emergency to long-term development interventions.

Key Success Factors

- Focus on strengthening health systems: working closely with the national and local health structures to identify the needs and build capacity of partners;
- Build the capacity of health workers within MoH: we work with national and local MoH structures to train community health workers and volunteers to actively conduct case identification, referral and follow up;
- Work with national and international partners to harmonise programmes and resources;
- Leverage financial resources with gift-in-kind essential medicines needed for outpatient therapeutic programmes (OTP), supplementary feeding programmes (SFP) and stabilisation centres (SC).
- Linkages with longer term programmes.

Emerging Approach

- More features on CMAM data base: currently CMAM online data is rolled out in the region to monitor performance of the programme as compared to international standards. Additional features will be developed to monitor other indicators such as staff capacity building and RUTF consumption.
- Generating evidence through operational research: together with our partners we started integration of infant and young child feeding (IYCF) support into CMAM and Positive Deviance (PD) Hearth programming in the context of CMAM and Essential Nutrition Action.

Challenges of scaling up CMAM

- Supply chain management. Stock-outs of RUTF and essential medicines.
- Maintaining acceptable programme coverage – when NGO inputs into CMAM are scaled up as government responsibilities increase, programme coverage rates often drop.
- Overburdened health workers and community volunteers due to many competing priorities.
- Funding: lack of funding to provide the minimum support package.
- Chronic food insecurity and recurrent drought moving donors' attention towards short-term response in drought-affected geographic areas.
- Insecurity and war resulting in programme discontinuation.
- Lack of mainstreaming of the CMAM interventions in ongoing ADP programmes.

WV CMAM Programme in Africa 2011/12

Country	S. Sudan	Kenya	Burundi	Ethiopia	Somalia	Zimbabwe	Sudan	Niger	East DRC	West DRC	Zambia	Mauritania	Chad
# of projects/locations	5	9	2	30	1	2	7	17	2	9	2	5	
Cure rate	89%	80%		93.3%	81.3%	70%	81.9%	85%	90%	84%	67%	90%	
Default rate	10.3%	15.7%		4.9%	14.8%	19.9%	18.0%	7.8%	5%	6%		7.8%	
Death rate	1%	3%		<1%	0%	2%	0%	2%	2%	3%	0%	1.3%	

CMAM Programming Experiences from Zimbabwe

submitted by Mjabuli Jamela, Nutrition Coordinator, WV Zimbabwe

After seven years of implementation, the public health and nutrition authorities in Zimbabwe are satisfied with the results of CMAM programming.

Since 2008, World Vision Zimbabwe has partnered with the Ministry of Health and Child Welfare in implementing CMAM in Gwanda before expanding to Lupane, Bubi, Umguza, Nkayi and Rushinga districts.

Malnutrition in Zimbabwe has multiple contributors but experts point to food insecurity and high HIV/AIDS prevalence as the main causes. The statistics show a high prevalence of HIV/AIDS among malnourished children. Food insecurity in parts of the country has become a chronic issue because repeated droughts reduce the capacities of the communities to feed themselves. The marketing pattern within the communities is also skewed towards urban centres, leaving vulnerable rural communities with limited access to food.

"After realising the problems that came with therapeutic feeding centres to treat malnourished children with inpatient care, the Ministry of Health and Child Welfare adopted CMAM as the strategy for managing acute malnutrition," said Phenias Sithole, Nurse Matron for Mpilo Paediatric Hospital in Bulawayo. "Administering high energy milk to malnourished children was inconvenient because it caused congestion in hospitals and exposed children to the risk of contracting infections. The decentralisation of services brought by CMAM makes it possible to reach the needy malnourished people at the grassroots, using empowered health workers in the communities," Sithole commented.

Under CMAM, which is offered free of charge, community health workers identify malnourished people (both children and adults) and refer them to the local outpatient treatment centre. They will only be referred to an inpatient health facility if they have acute malnutrition coupled with a serious medical complication. "This has decongested inpatient health facilities as treatment is done locally. Local treatment has reduced the number of defaulters as it involves less resource from the parents, unlike when central hospitals were used," said Mrs Katuruza, the provincial nutritionist for Matabeleland North. Before CMAM implementation, Bulawayo's Mpilo Central Hospital had an entire building with three floors dedicated to treating the malnourished, but they now have only a handful of malnourished patients. Mrs Katuruza added that CMAM is also economical from the government's perspective as the cost of administration is reduced because of decentralisation.

(Zimbabwe - Continues on Page 9)

CMAM DISTRICTS SUPPORTED BY WORLD VISION ZIMBABWE SINCE 2008

Mrs. Djane Marie is satisfied with the effect of the programme on her child Priscille.

"When I brought my child at the nutrition centre two months ago, I could not imagine that she will recover very quickly like this. It is a miracle and I am very thankful to World Vision for bringing this programme in our community."

CMAM Programme in Chad. Photo by Djimte Guerimbaye Salomon

Successful CMAM Programming in Tara, Chad to be Scaled Up

Submitted by Melani Fellows, Regional Health Technical Specialist

World Vision Canada

The successful programming in the CMAM project in Tara ADP is setting a high standard for replication in other ADPs in Chad. At this site, some dynamic traditional birth attendants (TBAs) have been mobilised and are actively screening children in the community. The TBAs explain that through their interaction with caregivers in the communities they saw the children looking very sick and after they received the training on CMAM they were so encouraged to have the opportunity to do something about it. In addition to regularly screening the children in the community using MUAC, the TBAs asked the ADP to provide some pictures of malnourished children so they can provide education to the mothers about malnutrition and then share information on nutritious complementary food. The TBAs include mothers with well-nourished children in their interactions by encouraging them to continue their good practices and giving them suggestions on how to prevent their children from becoming malnourished.

The transformation these TBAs are making in their communities is visible in the positive response from mothers, with many women explaining the dramatic healthy changes they have seen in their children. One woman described the change in her child this way:

> *"My child was just a skeleton and ready to be thrown out, but since I have joined this programme, my child has recovered and is in good health now. My child is getting back to his normal shape."*

The mothers also explain that before this interaction with the TBAs and World Vision, they didn't know what to do with their children and they are so thankful that through this education, they now feel more confident that they can take care of their children and do not have to sit and watch them slowly fade.

World Vision Chad also has CMAM programmes operating in Koro Hills, Sategui and Garden ADPs and has plans to conduct experience sharing visits in FY12 so that these ADPs can replicate the success from Tara ADP.

Photo by Chris Sisarich

Do Ready-To-Use Foods Displace Breast Milk?

Submitted by Colleen Emary, NCOE Emergency Nutrition Technical Advisor

The expanded use of ready-to-use foods (RUF) for both the treatment and prevention of malnutrition has led to a concern that consumption of a highly nutrient dense RUF may displace breast milk from a young child's diet. The risk of breast milk displacement with RUF is hypothesized to be greater due to the high nutrient density of RUF compared to cereal-based supplementary foods. This article will summarise the research findings on this issue.

RUFs, by definition, are any foods that do not require home preparation. RUF products do not require refrigeration, and have low moisture content to prevent bacterial growth. They do not require cooking or dilution. The most commonly used RUFs for prevention and treatment of acute malnutrition are lipid-based, made from peanuts, although other formulations, such as chickpea and cashew, do exist. RUFs are fortified with vitamins and minerals and are used for both treatment and prevention of malnutrition. Children receiving treatment for severe acute malnutrition consume a ready-to-use therapeutic food (RUTF), 200g/kg body weight/day, as their primary food source during the course of treatment. Caregivers are encouraged to continue breastfeeding as usual. RUF is also used as a supplemental food for prevention or treatment of moderate acute malnutrition and underweight. A typical ration provides an additional 200 to 300 kcal/day as a supplement to a child's usual household diet.

The effect of RUF consumption on breast milk intake is not well researched. The few studies that do exist have investigated the use of RUF as a supplement; complementary food, rather than therapeutic. This is an important distinction to consider, as a child's RUF intake in the case of therapeutic treatment is much greater than the quantity of RUF consumed in supplementation programmes. Therefore, the risk of breast milk displacement by RUF may differ between therapeutic and supplementary programmes.

The use of RUF in either a therapeutic or supplementary feeding programme should not replace breast milk. Two studies that compared breast milk intake in children receiving either RUF or a cereal-based fortified blended food as part of a supplementary

(Continues next page)

4 Galpin L, Thakwalakwa C, Phuka J, et al. Breast milk intake is not reduced more by the introduction of energy dense complementary food than by typical infant porridge. J Nutr 2007;137:1828-33.

5 Owino VO, et al. Breast-milk intake of 9-10-mo-old rural infants given a ready-to-use complementary food in South Kivu, Democratic Republic of Congo. Am J Clin Nutr. 2011 Jun; 93(6):1300-4. Epub 2011 Mar 30.

6 Flax VL, et al. Feeding patterns of underweight children in rural Malawi given supplementary fortified spread at home. Matern Child Nutr. 2008 Jan; 4(1):65-73.

7 Flax VL, et al. Feeding patterns and behaviors during home supplementation of underweight Malawian children with lipid-based nutrient supplements or corn-soy blend. Appetite. 2010 Jun; 54(3):504-11. Epub 2010 Feb 11.

feeding programme, found that breast milk intake did not differ between the two groups.[4,5] Other studies have assessed the impact of RUF supplementation on breastfeeding frequency. In two studies in Malawian children, a RUF supplement did not decrease the daily frequency of breastfeeds.[6,7] The current research suggests that the use of RUF for supplementary feeding may not interfere with breastfeeding practices; however, more studies are needed to confirm these findings. In addition, there remains a significant knowledge gap as to the impact of RUF use on breastfeeding practices in therapeutic programmes.

Implications for Programming

Good breastfeeding practices play a critical role in preventing and treating malnutrition in young children. While the impact of RUF on breastfeeding practices remains unclear, it is evident that further effort is needed to strengthen IYCF interventions in field programmes. Activities to strengthen and support good IYCF practices should be integrated into supplementary and therapeutic feeding programmes. Programme staff should be trained on IYCF support, including how to counsel women to address common breastfeeding problems. Programme monitoring and evaluation should include IYCF indicators.

What's happening in World Vision?

The international nutrition community has recognised the need to strengthen IYCF interventions in the context of CMAM programming. However, little is known on 'how' to do this within a programmatic setting. Save the Children, Emergency Nutrition Network, Nutrition Policy and Practice and World Vision are participating in an operational research study to explore the feasibility of integrating IYCF support into CMAM programming, including considerations of cost, quality of care and effectiveness. This study is currently taking place in Ethiopia and will conclude in 2013.

NEWS FROM THE FIELD – The Sahel Countries

West Africa Regional Office Food Security and Nutrition Updates

Submitted by Magalie Nelson, NCOE Nutrition Advisor

The Sahel countries are facing a severe food crisis caused by poor rainfall, failed harvests and increased food prices. It is estimated that more than 15 million people are affected with over one million children less than five years of age at risk of malnutrition and death.

World Vision has declared multi-country, regional emergencies in West Africa due to the worsening food and nutrition crisis, placing Niger and Mali in Category III emergencies with a global response, and Chad, Mauritania and Senegal in Category II emergencies with national office responses. World Vision has 109 ADPs in West Africa, 76 of which are affected by the crisis with 3.5 million children and families in ADPs now at risk of food insecurity. CMAM is a priority intervention in the West Africa Regional Office response and CMAM is ongoing in Niger and Mauritania where WV has been implementing CMAM for over two years. WV Mali is in the start-up phase for CMAM programming and intends to implement CMAM in one or two health districts in 2012, which are host to over 11 ADPs. While WV Mali's start up has been delayed due to political unrest and insecurity, staff recognise CMAM as an immediate need due to the crisis and documented rates of acute malnutrition.

World Vision conducted a SMART survey in Niger in January 2012 which showed a global acute malnutrition (GAM) rate of 11% and a severe acute malnutrition (SAM) rate of 3%. Recent rapid assessments done in WV programme areas showed a GAM rate of 12% and a SAM rate of 3% in Chad; GAM 16% and SAM 2% in Mauritania; GAM 11% and SAM 2% in Mali.

World Vision's emergency response targets 1.1 million of the most vulnerable in the five affected countries and is appealing to raise US$60 million in cash or gifts-in-kind to provide for the immediate needs of the most affected population. WV response is ongoing in all five countries. Key interventions consist of improving food access by reinforcing the targeted government distributions to reach a greater number of people, reinforcing stocks in cereal banks, assisting to sustain farming around water points, cash and/or food for work with World Food Programme support, seed distribution with Food and Agriculture Organization support, capacity building of the Natural Risk Reduction Teams and continuation and scale up of CMAM programming. Long term disaster risk reduction and strengthening ongoing programmes is also essential considering the recurrent character of drought and food crisis in the Sahel, as highlighted in the report entitled *Escaping the Hunger Cycle: Pathways to Resilience in the Sahel.* This report was published in September 2011 by Peter Gubbles (Groundswell International) on behalf of the Sahel working group and can be accessed at:

http://www.groundswellinternational.org/wp-content/uploads/Pathways-to-Resilience-in-the-Sahel.pdf

Up-to-date information on WV's response in West Africa, including CMAM programming, can also be accessed through World Vision's Relief site at www.wvrelief.net.

Summary of Functional Indicators as of March 2012

Submitted by Cyprian Ouma – Africa CMAM Technical Advisor

Country	S. Sudan	Kenya	Ethiopia	Somalia	Pakistan	Niger	DRC	Burundi
Total number of sites	OTP=40	OTP= 67 SFP= 37	OTP=102	OTP=11	OTP=43 SFP=43	OTP= 36 SFP=36	OTP=23 SFP=17	OTP=4
Number of children admitted for Jan-March 2012 period	OTP=606	OTP=436 SFP =762	OTP= 1653	OTP= 320	OTP= 2854 SFP=8208	OTP=1595 SFP=9397	OTP=357 SFP=2229	OTP= 105
Recovered	73.7%	OTP=72.7% SFP=71.8%	97.8%	9.2%	OTP=94% SFP=97.5%	OTP=97.07% SFP=98.44%	OTP=78.4% SFP=83%	89.5%
Defaulted	21.9%	OTP =15,5% SFP=17.8%	1.3%	0%	OTP=5.6% SFP=2.4%	OTP=2.64% SFP=1.47%	OTP=21% SFP=16,7%	10.5%
Deaths in programme	0.7%	OTP=0% SFP=0 %	0.1%	0%	OTP=0.1% SFP=0%	OTP=0.35% SFP=0.31%	OTP=0% SFP=0%	0%

OTP: Outpatient therapeutic programme, **SFP:** Supplementary feeding programme, **CMAM**: Community-based management of acute malnutrition **DU**: Data unavailable

Tools, Guidelines and Recommendations

Nutrition Publication: FEX D

The Emergency Nutrition Network (ENN) has recently launched a new publication called Field Exchange Digest (FEX D). This is an annual publication, consisting of summaries and key highlights from the well-known Field Exchange publication. The target audience is practitioners working in nutrition and food security at national level with an emphasis on preparedness, emergency response, recovery and longer-term programmes. FEX D features field articles from many different countries and contexts and up-to-date news about key developments in the nutrition and food security sectors, including new guidelines, tools and training that may be relevant to your work. You can also contribute to this publication by submitting articles about the nutrition programmes you are working on or news from your country and region. The second issue of FEX D will be available in English in May 2012, with French and Arabic versions to follow. Printed copies have been funded by an OFDA grant for 11 countries: Afghanistan, Bangladesh, Chad, Ethiopia, Haiti, Kenya, Niger, Nigeria, Pakistan, Sudan and South Sudan. However, anyone can subscribe to an electronic version free of charge by accessing the link below: http://www.ennonline.net/digest/subscribe or emailing to: office@ennonline.net.

World Vision nutrition staff can also add their contact details to the ENN Global Contacts Database at http://www.ennonline.net/network/join to promote collaboration and partnership.

WV Emergency Nutrition Staff

MEET

Patrice Ilunga Wa Tshihinga

Years with WV: Patrice has held several different positions during his seven years with WV: nutritionist for Ankoro relief project, Kasungami ADP manager, Kimilolo ADP manager and nutrition champion, child survival and nutrition specialist at the WVDRC National Office.

Current position: Nutrition Coordinator, WVDRC National Office

Current work location: Kinshasa, the capital of Democratic Republic of Congo. He has recently spent a few months in secondment in South Sudan.

Main work responsibilities/activities: Supporting WV nutrition programming in DRC by designing appropriate nutrition approaches according to the needs and in compliance with international and national guidelines and donor requirements; supporting qualitative implementation; building health/nutrition staff capacity by training and supportive supervision; liaising with external partners and stakeholders.

Best part of your job/working in emergencies: To serve a malnourished child and see him or her recovering – it is fantastic for me.

When you're not working what do you enjoy doing?
Apart from my family, which I cherish very much, I like singing with my choir and praising God. I also like jogging for 35 to 45 minutes in the morning.

The Next ENU

If you have any suggestions, stories or reports which you think would be helpful for ENU readers, please email to nutrition_coe@wvi.org by Tuesday, July 3, 2012. Our theme topic for the April to June 2012 issue will focus on Mental Health and Psychosocial Support in emergency nutrition programmes.

WE ARE ALWAYS LOOKING

for WV emergency nutrition staff to profile in ENU.

Why not submit your details and be introduced to all ENU readers in the next edition? All you have to do is send an email to nutrition_coe@wvi.org with answers to the following questions and a profile picture of yourself.

Name
Years with WV
Current position
Current work location
Main work responsibilities/activities
Best part of your job/working in emergencies
When you're not working, what do you enjoy doing?

(Zimbabwe - Continued from Page 4)

World Vision Zimbabwe uses the existing community structures such as home-based caregivers together with village health workers to implement CMAM, thus ensuring the sustainability of the programme. "In Gwanda, for example, we also incorporated the traditional medical practitioners, since they are consulted in the event of an illness due to the local beliefs, as well as working with the traditional birth attendants. These were empowered so that they could identify cases of malnutrition and refer cases to the local treatment centres," said Mjabuli Jamela, Nutrition Coordinator for WV Zimbabwe. "Having made such achievements we need to widen our scope to include preventive approaches such as promotion of appropriate Infant and Young Child Feeding for a holistic programme," Jamela added.

Unlike with previous models, CMAM has a high recovery rate and a relatively low death rate. Its success can also be attributed to its community-based nature and use of Ready-to-Use Therapeutic Food (RUTF) which is widely accepted by the local community.

Global Health & WASH
Nutrition Centre of Expertise

For questions or contributions to the WV ENU, please contact the WV Nutrition Centre of Expertise
nutrition_coe@wvi.org

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