ENU
EMERGENCY NUTRITION UPDATE

World Vision®

October 2012 – March 2013 ISSUE 15

DOUBLE ISSUE

Designing an Effective CMAM Capacity Building Strategy

Capacity Building through GTRN, CMAM Database and in West Africa

New
Technical Note: Calculating Caseloads for a CMAM Programme

New
Capacity Building Opportunities: e-Learning and F2F

Call for Abstracts for International CMAM Conference

Meet & Greet: Aristide Madagasha from WV Burundi

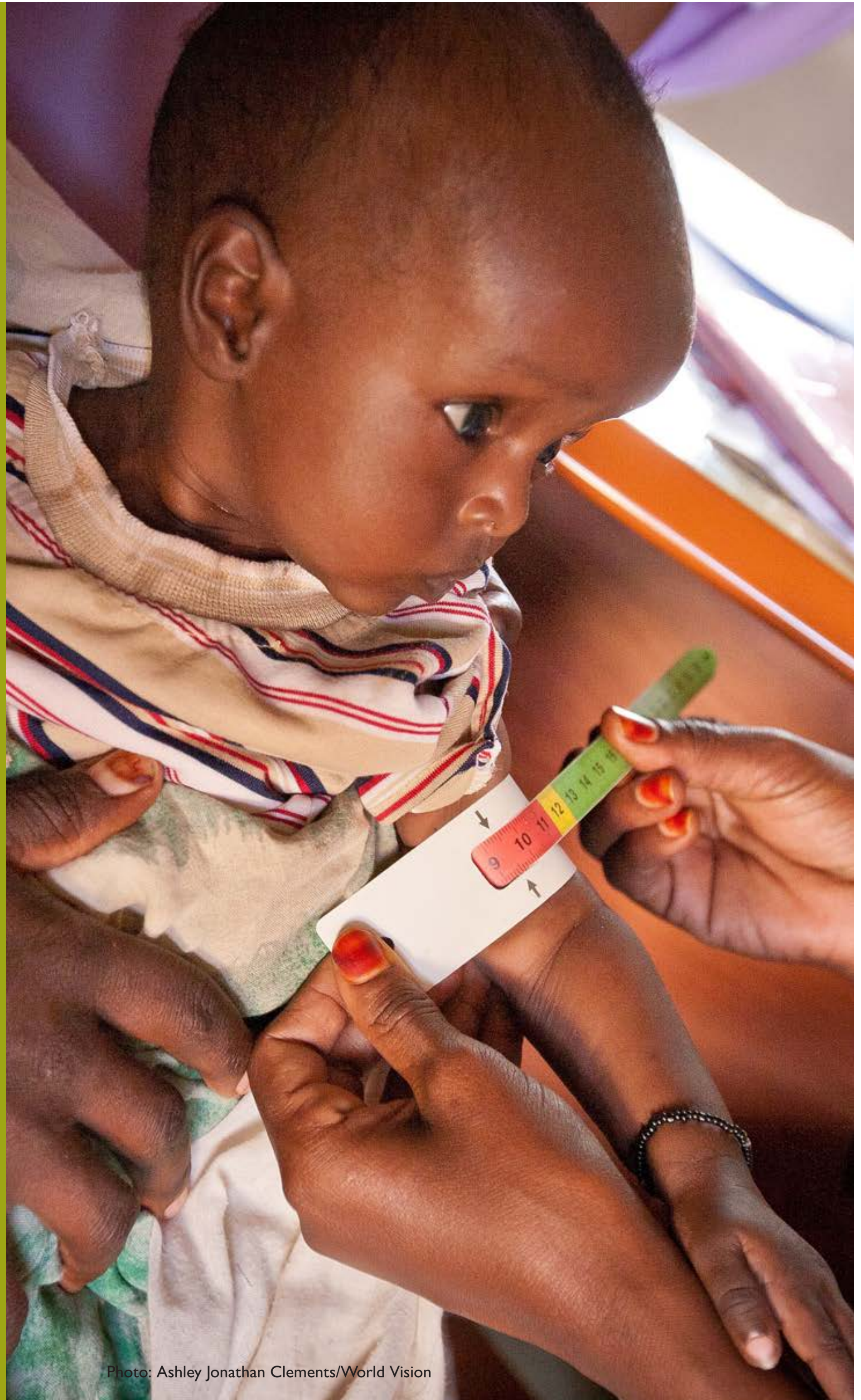


Photo: Ashley Jonathan Clements/World Vision

In the Spotlight
Emergency Nutrition
Capacity Building

In the Spotlight

Designing an Effective CMAM Capacity Building Strategy

Submitted by Sarah Carr, Emergency Nutrition Technical Specialist, WVI

A high quality Community-based Management of Acute Malnutrition (CMAM) programme can be implemented in the World Vision (WV) working context. After eight years of CMAM implementation, it is clear that a significant level of investment (both financial and human), complemented by an effective CMAM capacity building strategy, is necessary to achieve high quality standards in any CMAM programme. Additionally, a concerted effort is required to bring all implementing stakeholders together at the onset of designing a CMAM programme. Perhaps this is obvious to many, but in practice, it has not happened—until now. Stakeholders need to be sensitised on the following aspects of CMAM to ensure a collective commitment, including budget alignment, is completed for the design and rollout of an effective CMAM capacity building strategy and programme.

Stakeholder Sensitisation Point #1

Understand the History

WV implemented their first CMAM programme in Niger in 2005/2006. Before that time, WV treated acute malnutrition in the traditional and centralised therapeutic feeding centres. Although the international community endorsement of CMAM did not come until the 2007 Joint Statement written by WHO, WFP, UNSCN and UNICEF, WV's earlier experience with CMAM programming allowed all programmes to build from the cutting edge knowledge and experience that was being shared in the international emergency nutrition community at that time. Since 2007, WV's programmes have grown exponentially both between and within countries. To date, WV has implemented CMAM programmes in 15 countries, the majority within Africa. Discussions are ongoing about the possibility of implementing a CMAM programme in the Asia Pacific Region.

Stakeholder Sensitisation Point #2

Know Your CMAM Experts

In 2005/2006, it was recognised that WV needed external support to build capacity in CMAM programming. WV signed onto an institutional agreement with Valid International in 2006 in order to build WV's institutional capacity in the CMAM approach for the treatment of acute malnutrition. Since that time, specialised CMAM advisors working for Valid have assisted WV in all aspects of CMAM and emergency nutrition programme implementation. This includes advice and assistance in planning, training, set up, management, monitoring and evaluation of CMAM programmes. Due to the success of this partnership with Valid, the Institutional Agreement with Valid was renewed in 2008 and, again, in 2011.

Since the 2007 global endorsement of CMAM, it was not only Valid's capacity building initiatives that contributed to WV's in-house CMAM capacity. Additional CMAM trainings provided by UNICEF, local MOHs and other agencies strengthened the global CMAM capacity available in human resources. WV has been fortunate to benefit from these trainings as new qualified CMAM staff joined the WV team, in addition to the existing and new WV staff whose capacity has been built through internal, UNICEF and/or MOH trainings as well. Altogether, WV's internal capacity existing within many WV entities (such as Regional, National, Global) can be mobilised to assist with the provision of technical support to CMAM programs, pending their availability and time.

Lastly, we are developing a roster of qualified independent consultants who can provide CMAM capacity building expertise. Following a review of our existing CMAM capacity building initiatives and the surge of available CMAM experts, WV will be sourcing independent consultants for various trainings in order to provide the same quality service at a lesser expense.

Stakeholder Sensitisation Point #3

Appreciate the Assortment of CMAM Programmes

WV has worked with the same "Menu of Consultancy Activities", commonly called Technical Assistance (TA) Matrix, for the past eight years of CMAM implementation. The different consultancy activities focus on technical support at the key phases of the life-cycle of a CMAM programme. They are necessary to achieve and maintain programme quality. An individualised country TOR is written for each activity to ensure that a 'cookie-cutter' approach is not imposed inappropriately on the different CMAM programmes.

CMAM programmes are classified under three different groupings in the Menu of Consultancy Activities (Table 1). The table accounts for the variability of capacity within and between countries that are implementing CMAM programmes. It outlines the characteristics of each group, the directions for choosing the different technical assistance activities recommended for each group and the respective menus of consultancy activities.

Groupings: CMAM Capacity Building	Group One	Group Two	Group Three
Characteristics of Group:	•New CMAM programme •no previous CMAM programme implemented by WV in the past •CMAM may not be 'new' to the MOH	•CMAM programme implemented by WV in the past •MOH staff received training (WV and/or MOH, UNICEF) •WV staff retention issues; recent staff departures and new staff on board	• Existing CMAM programme continued (new funding cycle •WV + MOH staff have received training (from WV and/or MOH, UNICEF)
Directions on how to develop a CMAM Capacity Building Plan	•Budget for Activities #1,2, 5, 6 •Determine whether or not a budget for Activities #3 & 4 is necessary based on capacity of national CMAM Programme Manage	•Budget for Activities #2 & 3 as a bare minimum •Determine whether or not a budget for Activity #1 is necessary based on capacity of new CMAM staff	• Budget for Activities #2 & 3 as a bare minimum •Determine whether or not a budget for Activity #1 is necessary based on capacity of existing need
CMAM Technical Assistance (TA) Package of Activities:	1. Preparation & Assessment	1. Technical Support: Nutrition and Community Mobilisation Mentorship	1. Technical Support: Nutrition and Community Mobilisation Mentorship
	2. Combined Visit: Set-up, Design & Implementation + Community Mobilisation	2. Coverage Survey/Midterm Review	2. Coverage Survey/Midterm Review
	3. Nutrition Technical Follow-up Visit: to be conducted only if requested and required	3. Final Evaluation	3. Final Evaluation
Additional Considerations: • IYCF into CMAM • CMAM database • SMART	4. Community Mobilisation Follow-up Visit: to be conducted only if requested and required		
	5. Coverage Survey/Midterm Review		
	6. Final Evaluation		

Table 1

Stakeholder Sensitisation Point #4

Understand the Budget Costs

The bad news—CMAM Capacity Building is not cheap! It is imperative that National Offices (NOs) recognise these costs up front and plan for them at the onset of programme planning and proposal writing. Different Regional and Support Offices (ROs and SOs) can help support NOs by recommending these activities and supporting these additional costs. Here is an example of CMAM TA Budget for Group One (see table), conducted by Valid International.

Stakeholder Sensitisation Point #5

Recognise the Necessity of Administrative Support

The Nutrition Centre of Expertise (NCoE) has an in-house CMAM Desk Officer. This position aims to reduce the overall administrative burden associated with the execution of the chosen technical assistance package – for ROs, SOs and NOs. The CMAM Desk Officer acts as the intermediary between the RO/SO/NO and the CMAM experts.

(Continues page 12)

Fees	Days	Rate ($)	Total ($)
1. Preparation & Assessment	7	$544.00	$3,808.00
2. Set-up, Design & Implementation	21	$544.00	$11,424.00
3. Social Development Survey/Community Mobilization	14	$544.00	$7,616.00
4. Nutrition Technical Follow-up Visit	10	$544.00	$5,440.00
5. Community Mobilization Follow-up Visit	10	$544.00	$5,440.00
6. Coverage Survey (average of CSAS or SQUEAC)*	25	$544.00	$13,600.00
7. Midterm Evaluation	10	$544.00	$5,440.00
8. Final Evaluation	10	$544.00	$5,440.00
Fees Subtotal			**$58,208.00**
Travel			
International flights/visa costs*	7	$2,000.00	$14,000.00
Other Costs			
Communications, printing, miscellaneous	7	$21.50	$150.50
Valid Desk Officer days	7	$475.00	$3,325.00
Subtotal			**$75,683.50**
Administration @10% (Valid) on fees			$5,820.80
Total			**$81,504.30**

Table 2

*The Coverage Monitoring Network (CMN) offers free technical support to nutrition programmes worldwide in the design, implementation and analysis of coverage assessments. WV entered into a partnership with CMN in December 2012. CMN is a high quality option for cost-savings on the assessment of coverage.

GTRN

Global Technical Resource Network

Emergency Nutrition Response

submitted by Claire Beck, Emergency Health, Nutrition & WASH Team Leader, HEA, WV Australia

Have you wanted to respond when there is a large-scale emergency? Have you wondered if you have the skills?

Now here is your chance to find out. The World Vision partnership had developed a global roster of people who have the skills to respond to emergencies at a national and international level. This roster is staffed from the Global Technical Resource Network (GTRN) found on wvcentral at https://gtrn.wvcentral.org/Default.aspx

What skills do I need?

Have you managed or set up a nutrition programme in your own country? These are the skills you need, plus some understanding of the international humanitarian system and WV's Humanitarian and Emergency Affairs (HEA) standards and systems. The GTRN has three levels of responder: national responder (someone who can lead a smaller response in their own office); implementer (field-based responder in another office or country) or manager (overall strategic level responder at an international level).

What is the difference between these roles in reality?

National responders can lead a small scale nutrition response in their own country. They have some understanding of HEA standards and systems and WV nutrition models and can assist in some technical advice to HEA and programme staff in programme development.

Implementers have some experience setting up and coordinating nutrition programmes in their own offices, and can work with HEA and other sectors. They are aware of different nutrition components such as CMAM, IYCF in emergencies, food aid and can set up a number of these models at the field level. This role would suit someone who could lead a small scale response (level 1) in their own office. They would be working under an experienced nutrition or health manager and would probably have the role of a nutrition coordinator at a zonal or district level in a large-scale international response.

Nutrition Managers have extensive experience in nutrition and emergencies and feel confident that they could work internationally and set up large-scale nutrition programmes often in multiple sites with multiple components (e.g. CMAM, IYCF, SFP in a food aid programme, and nutrition promotion). They are also aware of the international humanitarian systems and are willing to participate in interagency coordination groups and the nutrition cluster if functioning. This role includes managing staff, developing policy and strategy, programme design, budgeting and proposal writing for the whole response. They usually report to the health and nutrition manager.

A full list of the experience, skills and competencies required for each can be found here https://gtrn.wvcentral.org/Standards/FullESRStandardView.aspx?SectorId=149

I am really interested so, how do I get onto the register?

You need to register and set up a profile for yourself. If you are already a Subject Matter Expert (SME) for a nutrition component, you just need to update the profile and apply for the emergency responder (ER) positions. If not, you will have to set up a profile and the GTRN website will walk you through the process. Once you register, agree to the core humanitarian competencies and provide evidence, then apply for the positions you want. Try to answer the questions with some detail and provide examples to illustrate that you have that skill or competency.

What if I don't have all the skills?

You can still apply as a national responder or implementer; this way we know that you are interested in emergency response, and you can be linked with an experienced emergency nutrition staff member for coaching, information updates and links to training opportunities. Any time and and cost required for training will have to be agreed with your manager and your goals need to be included in your performance agreement. Your office would need to cover the costs for any training fees or expenses.

What happens after I complete my application?

Your manager will be sent an email to approve your application and a technical specialist will look at your application and assess your skills. They may contact you to get further information by email and they may make a time to talk to you over Skype to better understand your skills and any capacity development you may need. You will be informed when your application is validated or informed if you need to develop more skills. Once you are validated your profile is available to offices looking for nutrition staff to respond to an emergency. If you are available and an office wants your help, you will be given a TOR and plans will be made to get you to the response. (The costs of your deployment will be covered by the response, not your office).

Where can I go for more information?

The GTRN webpage has a help section where you can ask for help, and they respond promptly with information. If you need more information about the nutrition roles, you can contact Antony Peter at antony_peter@worldvision.ca or Claire Beck at Claire.beck@worldvision.com.au

West Africa Emergency Nutrition Capacity Building (CMAM)

Submitted by San-San Dimanche, WAR Combating Child Malnutrition Learning Centre Director

Since the early 1970s, the Sahel band of Africa—Chad, Mali, Mauritania, Niger, Senegal and Burkina Faso—has suffered from chronic food shortages caused by economic crisis, poverty, desertification and climate changes. At the same time, population rates have been some of the fastest growing in the world. In 2012, an estimated 7.7 million people required assistance. The food insecurity and malnutrition situation in West Africa is worrying, in particular due to the chronic and cyclical nature of crises. In a non-crisis year, an estimated 645,000 children die in the Sahel, with 226,000 of these deaths being directly linked to malnutrition[1].

Over the past two years, the West Africa Region (WAR) Health and Nutrition team conducted a health and nutrition technical review of National Offices (NOs) in the region. The review found that all of the seven WAR NOs lacked the technical skills required to support nutrition rehabilitation, in compliance with international standards and national nutrition protocols. Although WV supported CMAM programming in Niger, Mauritania and Sierra Leone, these programmes faced a variety of operational challenges. To address this issue, WAR benefited from a one-year CMAM capacity building project, funded by World Vision Canada, which aimed to provide technical assistance to NOs implementing CMAM programmes. The goal was to improve the quality of CMAM interventions and to develop leadership within NOs for nutrition programming. The capacity building project provided classroom based trainings, NO orientation workshops, field-based technical support and mentoring of NO staff, and national advocacy to ensure the necessary supports are in place, both within WV and its partners, to ensure the delivery of high quality CMAM programming at the community level.

As a result of this project, two additional countries (Mali and Chad) have rolled out CMAM programming and approximately 43 WAR NO staff were trained in CMAM programming, along with 128 partners from MOH and other NGOs. All four countries most affected by the 2012 food and nutrition crisis are implementing CMAM (Mali, Niger, Mauritania and Chad).

The experience in implementing CMAM programming in the West African Sahelian environment is closely monitored by WAR's Combating Child Malnutrition Learning Centre, based in the WV Mali office. As nutrition is one of the three main intervention sectors defined by WAR's strategy, this example serves as a lessons learned exercise in building staff capacity in nutrition programming.

Photo: Justin Douglass/World Vision

1. ACF, FAO, OCHA, UNICEF, WFP. 2012 Strategic Document, Version 2: Response plan addressing the food and nutrition crisis in the Sahel. Inter Agency Standing Committee on Nutrition, February 2012:5

http://reliefweb.int/sites/reliefweb.int/files/resources/Full_Report_3569.pdf

CMAM Database Capacity Building

Submitted by Diane Baik, NCoE Nutrition Technical Advisor, WVI

BACKGROUND

Since the initial implementation of CMAM, data was tracked using excel spreadsheets. However, due to many limitations with this method, the online CMAM database (db) was developed by the Nutrition Centre of Expertise (NCoE), in 2010.

Objectives of CMAM database

The purpose of the CMAM db is to improve monitoring of World Vision (WV) CMAM programmes by increasing:

1. accuracy of data with features such as automated calculations, generation of summary reports and graphs, flagging of inaccurate data;
2. time savings in obtaining data for all WV offices and addressing donor requests on a timely basis;
3. data retention with frequent staff turnover common to CMAM programmes;
4. feedback of data to the programme level to assist in operational decision making;
5. standardised indicators across partnership, in alignment with Ministry of Health (MoH).

Method to roll-out CMAM database

The NCoE developed a three-day CMAM db training package by contextualising and adapting the CMAM-FANTA module to the WV context and by developing a protocol for all WV offices to access support. The training package was developed in both English and French (see Training Topics sidebar on next page). The NCoE trained Regional Nutrition Advisors and Valid consultants in 2010, and have since been working together to conduct NO trainings and to ensure all historical CMAM data is input into the CMAM db.

A one-day CMAM db orientation is also provided for SOs, GC, and NO-level staff who do not enter or edit CMAM data, but who primarily generate summary reports and graphs and use raw data to conduct further data analysis.

Results from the roll-out of the Online CMAM db

To date, the CMAM db has been rolled out in 12 countries[2], including: Burundi, DRC, Ethiopia, Kenya, Mali, Mauritania, Niger, Pakistan, South Sudan, Sudan, Somalia and Zambia.

Photo: Diane Baik/World Vision

WV's Online CMAM db has been compared to other online db systems developed by external actors, such as the Minimum Reporting Project (initiative led by Save the Children) and UNICEF. Users found WV's CMAM db to be more user-friendly and time-efficient. Although the roll-out is a 'work in progress' as not all CMAM data is entered on a timely basis, NOs using the database have commented that it is a great tool for ongoing monitoring of their CMAM programmes and providing timely data for report writing. It also ensures the retention of CMAM data, despite frequent staff turnover. SOs use the database for trend projections for GIK planning, reporting to donors and advocating for new funds or GIK supplies to support CMAM programmes. In addition, the GC uses the Online CMAM db to determine WV's overall impact in addressing acute malnutrition and to share this information internally and with external stakeholders. WV contributed

2. Not all 12 countries have ongoing CMAM programmes

to a global meta-analysis on the effectiveness of treatment programmes by sharing programming data from the CMAM db.

Conclusions

The Online CMAM db is the first db across the WV partnership to track outcome indicators and it is proving to be a highly valued tool. However, improved diligence is needed to enter all CMAM data online in a timely manner in order for the database to reach its optimal potential and benefit all users. In addition, some National Offices enter only some of their projects on the CMAM db. We encourage NOs to enter data for all projects in order to provide a better picture of WV's global contribution to addressing acute malnutrition. Field staff have requested that additional features be added to the Online CMAM db, such as the tracking of Ready to Use Therapeutic Food (RUTF) usage and data entry using mobile phones, to further improve their ability to monitor CMAM programmes. The NCoE is investigating ways to meet these requests.

Next Steps

1. Data Validation System
2. Tracking Blanket Supplementary Feeding and RUTF usage
3. Capacity Building Indicators
4. Community Mobilisation Indicators
5. Potentially including Nutrition Survey Data (e.g. SMART surveys)
6. Exploration of mobile technologies for individual-level monitoring (mHealth)
7. Average Weight Gain (AWG) and Average Length of Stay (ALoS) to be automated
8. Integrating CMAM database to Horizon and/or GIS

CMAM db Training Topics

Day 1:

1. History of CMAM db
2. Principles of Monitoring System
3. Identifying country data transfer mechanism
4. Purpose of Support and Supervision Visits and Role of Supervisor/Mentor – creating a reporting/accountability system
5. Introduction to the Online CMAM db (Rationale, db functions, benefits of using db)
6. Overview of online db

Day 2:

1. Introduction to protocols and complementary documents (templates needed to be used)
2. Review of country breakdown
3. Online exercise
4. Reviewing country's CMAM reporting formats (align WV's standardised indicators with National indicators)
5. Historical data entry

Day 3:

1. Continue to enter historical data online
2. How to analyse and interpret reports and graphs using online db
3. Analyse and interpret ADP, programme site, or country data
4. Review Data Transfer Mechanism again
5. Next Steps

Breastfeeding Support in Emergencies

An estimated 1.4 million child deaths annually are attributed to poor breastfeeding practices. Infants less than six months are six times less likely to die from diarrhoea and from respiratory infections if exclusively breastfed (WHO 2000).

In crisis situations, increased disease risk, limited food availability, heightened stress, unregulated distribution of breast milk substitutes, and disrupted social networks can impact significantly upon infant feeding practices. There is consensus globally that breastfeeding needs to be protected and promoted during emergencies.

This study explored the attitudes, practices and understandings of breastfeeding in the post-earthquake situation in Haiti. Using a household survey, mothers of children less than 24 months of age were interviewed. Key informant interviews and focus group discussions with mothers, grandmothers, traditional birth attendants, fathers and health care professionals were also conducted.

In Haiti, breastfeeding is the preferred practice; however, mixed feeding is the norm. Eighty-six percent of the children in the study had received powdered milk. Breast milk was considered a dynamic substance, of which the quality would decline if a mother's diet was poor, if the mother was pregnant, or suffered from a psychosocial condition called *move san* or *colère*, or 'bad blood'. Respondents reported that although breast milk was considered best for the child, if a mother did not 'eat well' or at the 'right times' her milk would deteriorate and become harmful for the child. Exclusive breastfeeding was regarded as impossible without 'eating well'. Women who were breastfeeding at the time of the earthquake reported many stressors, including insufficiency of funds to purchase 'good foods.' In many cases, this led to mixed feeding as it was believed that the purchase of formula was less expensive than 'good food' and was considered less risky than providing poor breastmilk. The main barrier to breastfeeding following the earthquake was a lack of confidence in the quality of breastmilk and concerns about the impact of 'poor' quality breastmilk on a child's health. These findings, while unique to Haiti, suggest that understanding the perceptions and beliefs regarding breastfeeding is important for developing appropriate messages and interventions to support infant and young child feeding post-emergency.

Dörnemann, J. And Kelly, A. H. (2012), 'It is me who eats, to nourish him': a mixed-method study of breastfeeding in post-earthquake Haiti. Maternal & Child Nutrition.doi: 10.1111/j.1740-8709.2012.00428.x

Children Successfully Treated for MAM Remain at Risk for Malnutrition and Death in the Subsequent Year After Recovery

Acute malnutrition is a significant contributor to morbidity and mortality among children under 5 years of age. Moderate acute malnutrition (MAM), defined as weight-for-height Z-score (WHZ) < -2 and > -3, without oedema, affects 11% of children under 5 years of age globally. Children with MAM are three times more likely to die than well-nourished children and are at increased risk of infectious disease, and delayed cognitive and physical development. [3, 4]

A total of 1967 children aged 6-59 months successfully treated for MAM in rural Malawi following randomised treatment with corn-soy blend plus milk and oil (CSB++), soy ready-to-use supplementary food (RUSF), or soy/whey RUSF were followed for 12 months. This study compared clinical outcomes among the three treatment types one year after recovery from MAM. The hypothesis tested was that children treated with either type of RUSF would be more likely to remain well-nourished than those treated with CSB++. Well-nourished was defined as mid-upper arm circumference > 12.5 cm or WHZ > -2.

Sixty-three percent of the children studied remained well-nourished during the entire follow-up period, 17% relapsed to MAM and 10% developed severe acute malnutrition. Four percent of children died and 7% were lost to follow-up. Children who were treated with soy/whey RUSF were more likely to remain well-nourished than children treated with CSB++ or soy RUSF; however, using advanced statistical modeling did not identify an association between soy/whey RUSF consumption and remaining well-nourished. Seasonal variations in adverse outcomes were observed, with more children defaulting or dying during the hunger season compared to the rest of the year. The high prevalence of poor outcomes of children having recovered from MAM suggests that despite improvements in anthropometric measures, children's physiologic and immune status remains compromised. Children having recovered from MAM should still be considered at high risk. Future research should investigate the optimal duration of MAM treatment, what type of physiologic and or immune deficiencies remain following treatment, and test interventions to improve outcomes in this population.

Journal of Nutrition, Feb 2013. http://www.ncbi.nlm.nih.gov/pubmed/23256140 Chang CY, Trehan I, Wang RJ, Thakwalakwa C, Maleta K, Deitchler M, Manary MJ

3. Black RE, Allen LH, Bhutta AZ, Caulfield LE, de Onis M, Ezzati M, Mathers C, Rivera J. Maternal and child undernutrition: global and regional exposures and health consequences. Lancet 2008; 371: 243-60.

4. Pelletier DL, Low JW, Johnson FC, Msukwa LA. Child anthropometry and mortality in Malawi: testing for effect modification by age and length of follow-up and confounding by socioeconomic factors. J Nutr. 1994; 124:S2082-105.

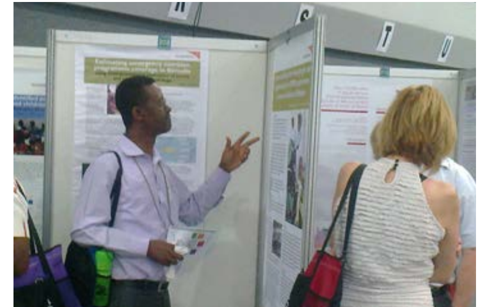
World Vision Presents Six Abstracts at Nutrition Congress of Africa (NCA)

Submitted by Dr. Sisay Sinamo, Regional Nutrition Advisor, EAR

Documenting lessons learned and best practices and conducting research, reflection and dissemination are two of the strategic objectives of the East Africa Regional Office (EARO) Health and Nutrition Learning Centre (LC). These objectives are achieved through collaboration between the National Office (NO) technical team and regional LC advisors in working with local partners and research institutes. In FY12, the EARO health and nutrition team collaborated with four NOs to identify the key health and nutrition promising practices and their impacts on child nutrition. Six abstracts were prepared and accepted for presentation at the NCA conference held in Bloemfontein, South Africa from October 1 to 4, 2012.

With support from the NCoE, the following abstracts were prepared as posters for presentation at the conference:

1. Impact of promoting locally identified positive practices on malnourished children in Western Kenya using Positive Deviance Hearth. Rose Ndolo, Celestina Asena, Sisay Sinamo.
2. Estimating emergency nutrition programme coverage in Somalia using semi-quantitative evaluation of access and coverage methodology. Anthony Abura.
3. Testing the plausibility of anthropometric measurements of children from monthly nutrition surveillance data collected by community health workers in rural Kenya. Cyprian Ouma, Dennis Mwambi.
4. Dietary risk factors of undernutrition among children under five in Gashoho community in rural Burundi. Jean Hatsindimana, Sisay Sinamo, Tamrat Haile.
5. Determining programme effectiveness in the management of acute malnutrition: A Case of Quachabira District, Ethiopia. Sisay Sinamo, Leteberhan Gemechu, Gedion Tefera.
6. Factors affecting rate of weight gain and length of stay in a CMAM programme in two rural districts of Ethiopia. Sisay Sinamo, Lemma Debela, Magalie Nelson, Gedion Tefera, Colleen Emary.



The NCA conference was an excellent opportunity to share WV's experience with an external audience. WV's work was well received by the conference participants. Congratulations to the abstract authors on their successful submissions.

Photo: Sisay Sinamo/World Vision

Seven participants, representing four national offices and EARO, attended the congress. Dr. Anthony Abura, WV Somalia Health and Nutrition Technical Advisor; Rose Ndolo, WV Kenya Nutrition Coordinator; Dr. Aristide Madagasha, WV Burundi Nutrition Specialist; Celestina Asena, WV Kenya Technical Advisor, Food Security and Nutrition, APHIAplus; Dr. Sisay Sinamo, WV EARO Nutrition Advisor, Lemma Debela, WV Ethiopia Nutrition Manager; Dennis Mwambi, WV Kenya Programme Officer, Maternal Child Health and Nutrition

Call for Abstracts for International CMAM Conference

The Coverage Monitoring Network (CMN) and Action Against Hunger (ACF International) are hosting a two-day conference entitled: **What we know now: A decade of community-based treatment of severe acute malnutrition**, to take place in London, UK from Oct 17-18, 2013. Through our engagement with the CMN, WV is participating as a partner in this meeting. Key themes of the meeting are equitable access, quality of service delivery and nutrition information. The NCoE is available to assist with abstract development - **please submit abstracts to Colleen Emary by Friday July 12, 2013.** http://www.coverage-monitoring.org/2013/05/21/community-based-sam-treatment-conference

Coverage Monitoring Network's (CMN) Website Launched

The CMN Project is an inter-agency initiative designed to improve nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing. The project is funded by the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and the Office of U.S. Foreign Disaster Assistance (OFDA) of USAID.

The website provides a unique, one stop shop for all matters relating to nutrition programme coverage. Check out the Interactive Map, offering real-time information about the implementation of coverage assessments at country and local level, as well as a Video, Blog, Events feature and Resource Section. http://www.coverage-monitoring.org/

Urban Humanitarian Response Portal Launched

The Urban Humanitarian Response Portal was developed by ALNAP and UN-Habitat to share resources that support learning and accountability efforts in urban disasters and conflict situations. Agencies are invited to contribute documentation, news and events to this searchable portal. www.urban-response.org

New Urban Programming Forum on en-net

Emergency Nutrition Network's en-net is a free and open online discussion forum on topics related to emergency nutrition and food security. A new forum area on urban programming has been launched and discussions will feature in a special 'urban edition' of ENN's publication, Field Exchange, planned for the first half of 2013, focused on nutrition and food security emergency programming in urban contexts. Click on urban programming topic at http://www.en-net.org.uk/

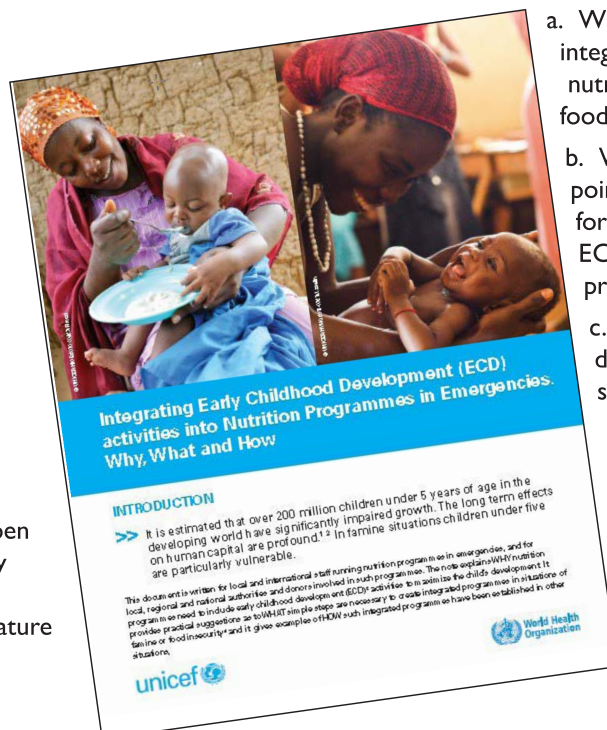
SQUEAC and SLEAC Technical Reference Guide

FANTA, in collaboration with Valid International, Action Against Hunger, Concern Worldwide, Tufts University and Brixton Health, has developed a technical reference guide for two new low-resource coverage assessment methods for evaluating access and coverage of Community-Based Management of Acute Malnutrition (CMAM) and other selective feeding programmes. The first method—Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)—combines routine programme monitoring data, an array of qualitative information, and small-sample quantitative surveys. The second method—Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC)—is a small-sample quantitative method that can be used to map and estimate coverage over large areas. The technical reference is available at http://www.fantaproject.org/publications/squeac-sleac.shtml

Guidance Note on Integrating Early Childhood Development (ECD) Activities into Emergency Nutrition Programmes

http://www.who.int/mental_health/emergencies/ecd_note.pdf

This 16-page Guidance Note from UNICEF and WHO contains useful resources and seeks to answer three key questions:



a. Why is it critical to integrate ECD into nutrition interventions in food-crisis settings?

b. What are the entry points and interventions for effectively integrating ECD into nutrition programmes?

c. How can this be done in emergency settings?

e-Learning

1. The London School of Hygiene and Tropical Medicine (UK) offers a free open-access course entitled ***Programming for Nutrition Outcomes distance-learning module***. This Master's-level module explores the complicated problem of undernutrition, highlights its multi-sectoral causes and identifies potential programmatic solutions. Some of the 17 self-study sessions are specific to emergency contexts, including nutritional assessment and early warning systems, infant and young child feeding in emergencies, and nutrition and health in emergencies,

   There is no certification or tutorial support provided, but there is a brief assessment at the end of each session to test your knowledge. http://ble.lshtm.ac.uk/course/view.php?id=26

2. The University of Southampton (UK) and the International Malnutrition Task Force (IMTF) offer a free online course, ***Caring for infants and children with acute malnutrition***,to train public health professionals in treatment and management of childhood malnutrition, based on WHO guidelines. The three modules can be completed at your own pace, resulting in a certificate of completion.

   https://www.som.soton.ac.uk/learn/test/nutrition/courses/courselist/course3.asp?courseid=3

3. ***Infant Feeding in Emergencies (IFE) e-learning lessons*** were produced as part of a package of resources to help in orientation on IFE developed by ENN, IFE Core Group members and collaborators. These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies, at national and international level. They can be used in self learning, in preparation for a face-to-face training, or as a group exercise. http://lessons.ennonline.net/

4. ***The UNICEF Nutrition in Emergencies Basic Concepts online course*** covers basic concepts around the humanitarian system and reform, undernutrition and response in emergencies, individual assessment and micronutrients. The package, produced by ENN, aims to increase the accessibility of information within key modules of the Harmonized Training Package: Resource Material for Training on Nutrition in Emergencies (the HTP) to strengthen the technical knowledge of individuals working in or aspiring to work in emergency nutrition. http://www.unicef.org/nutrition/training/

5. Global Governance for Hunger Reduction Learning Centre offers self-paced e-learning courses on a wide range of Food Security related topics. One is ***Nutritional Status Assessment and Analysis***, a two-hour course, which covers the basic concepts of malnutrition, describes how nutritional status is assessed, and identifies the most commonly used nutrition indicators, as well as the criteria to be used when selecting the indicators in specific contexts and situations.

   http://www.foodsec.org/dl/elcpages/food-security-courses.asp?pgLanguage=en&leftItemSelected=food-security-courses

F2F

6. Applications are being accepted for the next ***Nutrition in Emergencies (NIE) professional short course***, to be run by the Asian Disaster Preparedness Centre in Bangkok, Thailand from 7th to 18th October, 2013. In addition to general issues such as coordination, humanitarian standards and emergency preparedness, the course will cover key elements of NIE, including:
   - Assessments, surveys and surveillance
   - Food security and food assistance
   - Micronutrient interventions
   - Management of acute malnutrition
   - Infant and young child feeding in emergencies

   Application forms can be downloaded at http://www.nietraining.net/p/apply.html and for further details, please contact: ADPC-coordinator@nietraining.net

Reflection on Nutrition in Emergencies Short Course

"The course provided a good overview of many different aspects of emergency nutrition. It covered everything from the cluster approach to assessments, ration calculations, food security, and more. The evening sessions on Infant Feeding in Emergencies (IFE) were the most interesting for me. A real take home was the necessary country preparedness for IFE – having appropriate policies in place, trained staff, emergency protocols, and prepared statements and plans to engage media. I would recommend this course to anyone new to the field of emergency nutrition."

Melani O'Leary, WV Canada

(Continues next page)

(Continued from page 11)

7. Wageningen UR-Centre for Development Innovation is offering a new course on ***Linking Emergency Aid to Food and Nutrition Security, to take place in Addis Ababa, Ethiopia from November 4-14, 2013***. The course offers participants a chance to gain insight in the inter-disciplinary and integrated nature of food and nutrition security in an emergency setting, in particular the role of stakeholders, institutions, and innovative governance/ donor interventions to build resilience. In addition, it stimulates participants to consider their own role as manager, policy maker or practitioner, making use of a wide range of principles and tools, to strengthen their interventions to make the transition from emergency towards food and nutrition security.

(Continued from page 3)

This person will guide you through your request for support from CMAM experts, the development of Terms of Reference (TOR), the provision of multi-stakeholder feedback for TA reports and a timely payment procedure for your CMAM expert's work. Any ongoing questions or concerns will be addressed promptly. The amount of time required to complete these administrative tasks should not be underestimated. All stakeholders will benefit from this and WV's overall CMAM capacity building initiatives will benefit from the ongoing interaction with all stakeholders.

Calling all CMAM stakeholders! Let's align our CMAM programmes with an appropriate capacity building strategy. Let's build upon the experiences gained in the past eight years of CMAM implementation and continue to improve the quality of our treatment programmes for acute malnutrition.

If you have any questions and/or need assistance please do not hesitate to contact the following NCoE team members: Colleen Emary, Sarah Carr and Diane Baik.

Technical Note

How Do I Calculate.....

How do I calculate caseloads for a CMAM programme?

The EN-Net forum has an interesting discussion thread on this topic (see http://www.en-net.org.uk/question/157.aspx) for the full discussion.

How do I estimate caseloads for year one of a new programme?

Caseload = (prevalence + incidence) x coverage

Incidence – the number of new cases that will be expected to develop during the year. Incidence is calculated as prevalence x duration of illness. In the case of SAM, the estimated duration is 7.5 months. Therefore 12/7.5 = 1.6

Incidence = Prevalence x 1.6

Coverage – the proportion of children requiring treatment, who are receive treatment. A 50% estimate of coverage is often used; however, if the community mobilisation component is functioning well, a higher estimate can be used for calculation purposes (>60%). Where community mobilisation is not extensive, a lower estimate (~20%) should be used.

How do I estimate caseloads for ongoing programmes?

To estimate future caseloads for ongoing programmes, it is useful to look back at caseload data from the previous year. The following calculation may also be helpful:

Cases treated since start-up – (prevalence x coverage)

Sample calculation for new programme

A sample calculation of caseloads for an OTP for a new programme:

1. Rural population of 150,000
2. Estimated population of children under 5 years is 20%
3. GAM is 15%, SAM is 2.5%
4. Estimate of coverage is 50%
5. Project implementation period is 18 months

150,000 x 20% = 30,000 children under 5

SAM cases: 30,000 x 2.5% = 750

Incident cases: 750 x 1.6 = 1200, over a 12 month period = 100 cases/month. For an 18-month programme: 18 x 100 = 1800

Caseload is (750 + 1800) x 50% coverage = 1275

1275 SAM cases are expected over an 18-month programme period.

Update on Patrice Ilunga Wa Tshihinga

We introduced Patrice in Issue 13 of ENU, and want to update that as of January 2013, he has transitioned from WV DRC to join the West Africa Regional Office as Emergency Nutrition Advisor and is currently based out of the Combating Child Malnutrition Learning Centre in Bamako, Mali.

In this new role, Patrice works closely with WV line ministries, such as HEA, FPMG and Advocacy, and provides technical support, management and coordination of Emergency Nutrition programming, including CMAM, in the region. His role includes needs assessments, training, and scaling up emergency nutrition implementation to address acute malnutrition; short term and ongoing technical support for nutrition surveys, data gathering and analyses; project design; supervision; and monitoring and evaluation. He has provided CMAM database training to WV Mauritania, WV Niger and WV Mali.

WV Emergency Nutrition Staff MEET

Aristide Madagasha

Aristide (in dark blue shirt) speaking during UNICEF regional field visit to PD/Hearth activities

Years with WV: 2 years.

Current position: Nutrition Specialist, WV Burundi

Current work location: Bujumbura, Burundi (National Office).

Main work responsibilities/ activities: Ensure and support quality implementation of nutrition projects; participate in and contribute to process of identification, assessment and design of nutrition projects; facilitate the introduction of new and innovative practices, methodologies and concepts to WV Burundi nutrition programmes; build partnerships, both externally (government, UN, donors, NGOs, research institutes) and internally (RO, SO, GC, other NOs).

Best part of your job/working in emergency nutrition: The feeling of doing and contributing to something which is right and that gives a sense of meaning to my life despite all the challenges related to the work in the humanitarian and emergency environment.

Most challenging part of the job: Time management and work-life balance

When you're not working what do you enjoy doing? Sports (swimming), spending time with family and friends, watching movies.

The Next ENU

If you have any suggestions, stories or reports which would be helpful to ENU readers, please email to loria_kulathungam@worldvision.ca by Wednesday July 24, 2013. Our theme for the next issue is Nutrition in Fragile States.

Global Health & WASH
Nutrition Centre of Expertise

For questions or contributions to the WV ENU, please contact the WV Nutrition Centre of Expertise
loria_kulathungam@worldvision.ca

NCOE is hosted by WV Canada.