

## In the Spotlight

# Nutrition Surveillance

Welcome to the fifth edition of WV's Emergency Nutrition Update and the launch of our ENU spotlight themes. As well as our usual selection of updated tools and guidelines, news from the field, research pieces and staff updates, our ENU's will now also be including a section specifically focusing on a key theme / area.

This edition's Spotlight theme will be Nutrition Surveillance and help readers to understand further what does the literature and field experience say about these systems and what systems are currently recommended for use in WV programming.

## TOOLS, GUIDELINES & RECOMMENDATIONS

### *Food Security Briefs for 30 Countries Now Available from FAO*

Food security has a significant impact on nutritional status. Published by the FAO and EU, food security briefs, updated every three months, provide a snapshot of the food security situation in over 30 countries. These briefs are part of the EU/FAO program 'Linking Information and Decision Making to Improve Food Security' designed to assist Governments, Donors, implementing agencies with decision-making related to food security issues. Each country brief covers topics such as cereal and livestock prices; and factors affecting the current food security situation.

They are available at: [http://www.foodsec.org/pubs\\_country.htm](http://www.foodsec.org/pubs_country.htm)

### *Inter-Agency Standing Committee (IASC) Gender E-Learning Course – Different Needs Equal Opportunities*

As gender is a key cross-cutting issue in nutrition programming the following free 3 hour self-paced online course is being highlighted here. Based on the 2006 Interagency Standing Committee's (IASC) Gender Handbook - "Women, girls, boys and men, different needs - equal opportunities", the IASC Gender online course launched in March 2010 enables course participants to:

- Learn how to effectively integrate gender equality into humanitarian programmes
- Have the opportunity to practice their skills through an interactive, online, simulated humanitarian crisis
- Earn a certificate in gender mainstreaming in humanitarian settings

To find out more go to: <http://www.iasc-elearning.org/home/>



Child in Mali Photo by Justin Douglass 2009

# ENU SPOTLIGHT

## Nutrition Surveillance

*What is nutrition surveillance, what methods are used, what work is World Vision doing in nutrition surveillance?*

**Nutrition Surveillance** is the “continuous collection and analysis of nutritional status data in order to give warning of impending crisis or to make policy and programmatic decisions that will lead to improvement in the nutrition situation of the population. This ongoing scrutiny generally uses methods distinguished by their practicality, uniformity and frequently their rapidity, rather than complete accuracy. Its main purpose is to detect changes in trends or distribution in order to initiate investigative or control measures.”<sup>1</sup>

### Objectives of Nutrition Surveillance

- To better inform and influence programming decisions
- To monitor the condition of the population
- To identify potentially at risk areas (as an early warning system)
- To identify trends in nutrition status over time.
- To monitor intervention outcomes.
- To build capacity for monitoring nutrition status of the population.
- To facilitate information sharing.

On a national level, Nutrition Surveillance systems are most often established by the Governments, with information provided by various partners including NGOs. In crisis situations or areas of high vulnerability where Government systems are not functioning or where additional support is required, nutrition surveillance systems have been set up by non-governmental partners e.g. UN agencies or NGOs. The Food Security Analysis Unit for Somalia (FSAU, <http://www.fsasomali.org/>) managed by FAO is one such example.

### Data Sources for Nutrition Surveillance Systems

Information for nutrition surveillance systems comes from a variety of sources these include, nutrition surveys, health facility information-including clinic-based growth monitoring, rapid assessments, community-based growth monitoring and sentinel site surveillance. Information on the wide range of factors affecting nutrition is also collected including, health, food security, water.

### World Vision's Contribution to Nutrition Surveillance

World Vision most commonly contributes to Government nutrition surveillance systems by sharing reports from nutrition surveys and rapid assessments with government authorities. World Vision also works with local health officials to strength community-based growth monitoring and promotion systems. World Vision has plans to undertake a nutrition surveillance project, using sentinel site monitoring in East Africa in partnership with CDC – read below for further details.

## Planned Nutrition Sentinel Sites Surveillance System in Africa

*Submitted by Cyprian Ouma – WV Africa Region CMAM Advisor*

### Background

Most ADPs do nutrition and health surveys in periods ranging from every four to five years. These are long gap periods whereby the nutrition and food security status could deteriorate without being reported on a timely basis to allow for immediate intervention. In order to address this, WV is planning to pilot a Sentinel Sites Surveillance System in Africa. This system focuses on undertaking surveillance in a limited number of sites or population for the specific purpose of detecting trends in the overall wellbeing of the community. The sites may be specific population groups or villages which cover populations at risk.

Compared to one off surveys, such a system has various potential advantages including:

- Reduced cost – Large surveys costs as much as \$20,000 compared to less expensive surveillance systems
- Close monitoring of chronically vulnerable

populations and Registered Children

- Provision of trends over time
- More in-depth information on other indicators like market trends and disease outbreaks
- Reduced data turn-around time whereby data is readily available at the site itself
- Data to trigger more detailed nutritional surveys as and when required
- Implementation with relatively little capacity and integration into longer term monitoring system

It is anticipated that the setting up of such a nutrition surveillance system to collect, analyse, interpret and report on information about the nutritional status of populations will assist to inform appropriate response strategies and improve an understanding of a range of things including:

- who are the people at risk

- location of the people at risk
- approximate number of people who are affected
- what is happening to them and how is it happening
- severity of the situation
- evolution of the crisis over time
- what is already done by the households and communities plus the government, and other partners (food – non food)
- required assistance (food – non-food)

### Pilot

WV is currently planning to undertake a 12 month pilot surveillance system in partnership with CDC in Rwanda, Kenya and two other African countries to be decided, with funding from WV East Africa Regional Office.

The pilot sentinel sites will be established in vulnerable ADPs based on TDI report and other documents. Data will be collected on





# Statement on the Use of Alternative Sampling Designs for Nutrition Surveys in Emergency Settings

Emergency Nutrition Working Group, Nutrition Centre of Expertise – February 2010

## Background

Government and humanitarian agencies need population-based data to understand the aggravating and underlying causal factors of undernutrition and to select the most appropriate actions to improve the health, nutrition and survival of the population. In many cases, information on the severity of the situation and the causal factors of undernutrition is needed before there can be any allocation of resources or planning of interventions. In an emergency situation, certain areas may need to be assessed recurrently over a relatively short time period in order to determine what type of assistance may be required and for how long. Survey methods for use in emergency settings therefore need to be both time- and resource-efficient.

*The Alternative Sampling Designs Guide for Emergency Settings: A Guide for survey planning, data analysis and planning*, published by FANTA-2, outlines 3 different sampling designs, all of which are appropriate for emergency settings, where the time spent collecting data should be limited but must be sufficient to obtain the necessary information about the population. The three designs were developed to provide reliable methods for rapid assessment of the prevalence of acute malnutrition and useful measures of secondary indicators relevant to needs assessment and response planning, including child and household-level indicators such as morbidity prevalence, vaccination coverage, household food security, and access to water and sanitation. These designs can be used to measure changes in these indicators overtime, so are appropriate for evaluating program impact. The three sampling designs (33x6, 67x3, sequential design) described in the guide and are each hybrid designs combining aspects of cluster sampling and Lot Quality Assurance Sampling (LQAS).

Field applications have shown that these designs provide meaningful and valid results, and require substantially less time and cost for data collection than is required for carrying out a 30x30 cluster design. As of 2008, the designs are sufficiently validated for wide-CONTINUED scale adoption, so that real data collection needs can be met in a time- and cost-efficient manner. The guide provides detailed instructions for the planning, implementation, and analysis of data collected by the 3 designs.

The development, testing and validation of the three alternative sampling designs was completed by FANTA-2 with Catholic Relief Services (CRS), Ohio State University (OSU), Save the Children US (SC/US), and a team of statistical experts at Harvard School of Public Health (HSPH).

In light of the release of this guide in September 2009, and the on-going capacity building efforts within WV on monitoring and evaluation methodologies (e.g. SMART and LQAS), there is a need for guidance as to if and when alternative sampling designs should be used in the context of WV programs.

## Use of Alternative Sampling Designs in World Vision Programs

In emergency settings, population-based surveys are conducted to fulfil two main objectives: 1) to assess the severity and magnitude of the situation; and 2) to obtain data for problem analysis and response planning. Objective 1 is usually accomplished by measuring levels of acute malnutrition. The second objective can be fulfilled by collecting information on indicators related to morbidity, coverage of vaccination services, household food security, and water and sanitation. The use of alternative sampling designs for field surveys is appropriate when time spent collecting data must be limited (e.g. a survey using SMART methodology is not possible), but information on acute malnutrition and related indicators is required.

Mortality estimates can provide valuable information in emergency setting; however, the alternative sampling designs as described in this guide are not appropriate for measuring mortality. The sample sizes of the 33x6 and 67x3 designs are too small to provide a useful epidemiologic measure of a rare event such as mortality. Work to develop and validate new methods to assess mortality—some of which may be appropriate for use in complement with the 33x6 and 67x3 designs—is ongoing.

The decision to use alternative sampling designs in WV field programs must be made on a case-by-case basis in consultation with a nutrition technical advisor. If it is determined that an alternative sampling design is appropriate, the methods outlined in the FANTA Guide should be followed.

## Resources

FANTA-2 Project. *Alternative Sampling Designs for Emergency Settings: A Guide for Survey Planning, Data Collection and Analysis*. Food and Nutrition Technical Assistance Project II (FANTA-2), Academy for Educational Development, Washington DC, 2009. <http://www.fantaproject.org/publications/asg2009.shtml>

## Nutrition: The Shift of WFPs Strategic Focus

*‘WFP has revised its food basket to provide commodities that can better prevent and treat undernutrition including micronutrient deficiencies.’*

*Submitted by Marianna Stephens – Nutrition Advisor, WV Food Programming Management Group (FPMG)*

Hunger affects an estimated one billion people around the world, mostly in Africa, India, and Southeast Asia. Hunger takes its toll on the individual and society from increasing the prevalence of chronic diseases and higher mortality to impaired mental and physical development to higher healthcare costs to lower economic output. If we want to achieve the Millennium Development Goals, we must urgently and effectively address undernutrition.

World Vision FPMG and WFP have worked alongside one another for 10 years to tackle hunger related malnutrition, developing an understanding of the problem, and both having been very active in building awareness of the problem and available solutions. This past January, WFP released their Nutrition Improvement Approach (NIA) which has shifted its strategic focus from food security (providing enough calories) to including nutrition security (providing nutrient-rich food). The new strategy places more focus on specific target groups. These include children younger than two years, pregnant and lactating women, moderately malnourished populations, people suffering from micronutrient deficiencies and people with chronic illnesses (HIV/AIDS, TB).<sup>2</sup>

**(Focus - Continues on Page 5)**

# Accountability in Nutrition Programming Help Desks in DRC

Submitted by Crispin Baderha WVDRD DM&E & Claire Beck WV GRRT Health & Nutrition Specialist

## Introduction

In response to the Internally Displaced People (IDP) crisis in EDRC in September 2008, WV EDRC expanded their operations to various sectors including Health/nutrition. The nutrition component covered expansion of new and ongoing Community based management of acute malnutrition (CMAM) nutrition activities and with additional funding from WV Canada, accountability activities in the CMAM areas.

Accountability is defined here as the responsibility to demonstrate and to provide evidence to all partners that a programme or project has been carried out according to the agreed-upon design, including any legal (contractual) and financial requirements, and that it addressed the specific need for which it was intended to an acceptable level of quality. An acceptable level of quality means all relevant technical/sectoral standards are met and beneficiaries agree that there has been a positive change in their lives. In the case of this project, accountability activities included helpdesks (HD) and feedback mechanisms at the CMAM centres to provide a pathway for information to and from the community about the project.

## Design

The HD structure was designed based on experiences drawn from Zimbabwe WFP projects and the Sri Lanka Tsunami accountability program. A questionnaire was developed for health and nutrition staff already engaged in CMAM activities in the area, focusing on staff's opinions on

1. What the community needed to know
2. How this information could be shared
3. What they wanted the community to tell them
4. How they would like to receive the information.

A similar questionnaire was devised for the community and was trialled in the CMAM catchment area and then taken to 2 communities where CMAM was already being offered. Community questions were asked either to individuals at health centres or as part of an open focus group discussion with people who were either at the health centre or lived nearby. From the information gained, the Community Mobilization supervisor determined the tools that would be used and developed a training component for the

CMAM Community Mobilization training. The trained Community Mobilizers (CM) also received brochures about the project and the HD to take and share with their communities. At the end of the training of HD, communities stated that they:

*'...were delighted to learn about World Vision and discover many things that they had considered as secret only for the humanitarian actors.'*

## Implementation

- The HD was called 'The place for suggestions/ questions' (to avoid negative terminology such as complaints desk).
- The desk itself was to be staffed on CMAM operational days by 2 senior CM from the health committee.
- The CM recorded any comments/ complaints of the community in a comment book and provided the community member with a receipt for the comment which had an approximate date of when their request would be processed.
- The CM would collate all the comments and bring them to the CM supervisor so they could be addressed either in the field or from the program office.
- In addition a suggestion box was also provided at each centre for people who wanted to make comments when the HD was not operational.

Originally the nutrition staff had felt that a suggestion box would not work as most beneficiaries were illiterate and therefore would not be able or want to write their comments. However the community liked the idea as it enabled them to make anonymous comments or have their comments relayed without fear of them being censored. After the HD were set up, there were also meetings with the community on distribution days to get their comments about the program and the HD.

## Community Feedback

Examples of community feedback included:

- There was not enough food for the child's family compared to the former approach, (WFP reduced its ration size per beneficiary)
- WV should have done a general food distribution (to all community not only the malnourished):
- Why did we receive only 18 kg maize flour for each beneficiary instead of the whole 25 kg bag?

*'FPMG has a very strong commitment to its partnership with WFP and continue to be a lead NGO partner with WFP. I am really proud of the progress of our work in food/nutrition security and the addition of our Nutrition Advisor to the team.'*

*Walter Middleton, Vice President*

## (Focus - Continued From Page 4)

FPMG looks forward to working with WFP together to address the nutrition needs on longer-term food recovery program planning, with an emphasis on nutrient-rich food, especially reaching children. Nutritious foods with essential vitamins and minerals mean better future for millions of people. This shift is moving from their 2007 nutrition strategy where 20-25% of the food basket was focused on food fortification to the 2010-2012 Projected WFP Nutrition strategy/approach that increases this food basket to include 80-100% of micronutrient and other nutritional needs met. This is an exciting report that once again confirms the importance of nutrition when talking about food aid.

FPMG will continue to work closely together with WFP and partners to build further awareness among world leaders and the broader public about the problem of malnutrition and the need to deliver global nutrition security. We realize the changes being made to the food basket and the chosen target groups. These measures are to be used in combination with interventions that focus on food security, water and sanitation, promotion of appropriate (breast) feeding practices and preventive health services. *'Strategic partnerships are essential to solving global hunger, which affects more than one billion people around the world today. No one sector – public nor private – can solve hunger alone.'* said Josette Sheeran, WFP Executive Director. WFPs Nutrition Improvement Approach can be accessed here: <http://home.wfp.org/stellent/groups/public/documents/resources/wfp214222.pdf>



- Malnourished children cannot take the RUTF easily as it is food they are not accustomed to
- I received damaged / rotten food,
- Suspicion of discrimination in the community when some children were rejected from the program when the parents felt that they should be included.
- Beneficiaries food taken by non beneficiaries

*As a result of this 4 month intervention some of the benefits and challenges of the program were:*

### Benefits

1. The community appreciated being listened to. It secured their interest in the project and they felt that they could engage with WV as a partner rather than just a recipient with no rights.
2. It put an end to rumours and lack of accurate information about what the project, who would benefit etc.
3. It enhanced the partnership with the field as WV was seen to be more open and transparent with the community.
4. It improved WV status in the community and increased their security<sup>3</sup>. For example; there were no security incidents committed against WV while other NGO were targeted in the same area.
5. The community and government were able to plan how they would respond to

reduced food packages rather than having it imposed from WFP and WV.

6. Reported theft and misappropriation of forms were able to be investigated and dealt with.

### Challenges

1. Not all donors are willing to fund accountability activities. The DME unit needed to supplement costs from their M&E budget.
2. The project was rapidly introduced so there was a lot of confusion from the nutrition staff, who thought that the HD was a policing activity to control what they were doing. It took time for the DME unit to explain the importance of the HD to staff.
3. Only the health committee, HD staff, and CMAM beneficiaries knew about the accountability component. The wider community were unaware of the program.
4. HD members felt that they should receive some remuneration for their involvement.
5. Some of the complaints could not be dealt with by WV. This included the reduced pipeline from WFP and took longer than the project life to resolve.
6. Security was an issue and within the Rwanguba project area and the staff were not always able to get into the community to respond to their comments.

### Conclusion

HDs can be included with a CMAM program, but in the initial stages of an emergency response, time needs to be taken to ensure that all staffs understand the importance of accountability. If the concept of HD or some other way of community sharing can be included in all sectors of the response, the staff will more readily see its benefits. In the process of setting up the project, the community discussions were revealing as the community members said that no-one (this includes other NGOs working in the area as well) had ever asked them how they would like a project to be implemented or come to listen to their issues. With the development of the Quality and Accountability section in the EDRC programme, community engagement will be reinforced. To ensure the uptake of accountability within the organisation the DME team has been organising periodic orientation sections on Sphere, HAP principles and the Good Enough Guide. Now all projects are designed to deliberately include outcomes and indicators on accountability.

The CM training package would benefit from some information of accountability and ways that information can be collected from the community to improve the project. Due to the short implementation period (4 months) and on-going security issues which limited the access of WV staff to the area, it is difficult to say that the HD were effective. However, it is worth trying it in other CMAM projects to develop protocols and procedures that can be rolled out in future programs.

## NEWS FROM THE FIELD – CMAM

# Impact of General Food Distribution pipeline disruptions on CMAM programme functional indicators in Baringo Kenya

*Submitted by Joel Atuti, Project Manager, Viddah Owino, Nutrition Officer, Nicholas Musembi, CMAM medical officer and Cyprian Ouma – Africa Regional CMAM advisor*

The Baringo Integrated Nutrition project started in May 2009 with the aim of reducing morbidity and mortality associated with acute malnutrition among children 6-59 months of age. The programme targets 6 divisions in Baringo with estimated population of 132,215. The project includes outpatient and inpatient therapeutic care that is provided primarily through household based rehabilitation using ready-to-use therapeutic food and routine medical treatment. The programme operates through 17 MOH units and village volunteers are responsible for screening and follow-up of severely malnourished children at home. The initial program did not include a supplementary feeding component, although general food rations were provided through WFP due to widespread food insecurity in the area.

Due to insufficient food stocks, general food distributions were halted for 3 months (September to December 2009). During this same period, there was a noticeable increase in relapse cases from the program. The percentage of relapsed cases ranged from 0-6.3%



3. OCHA report 2009 (WV has not been target/ no incident has been committed against our staff in the field during the year.)

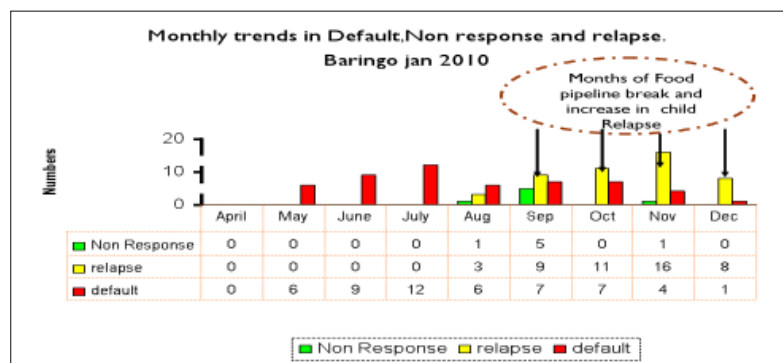


Figure 1

household food available to meet the nutritional needs of the family – and thus prevent acute malnutrition from recurring. Household sharing of the RUTF may account for the reduction in the number of children cured observed during the GFD pipeline disruption.

World Vision shared these program findings with WFP Kenya in order to advocate for a supplementary feeding component within the CMAM program. In response, WFP agreed to urgently support supplementary feeding in the Baringo program, which has commenced on a small-scale and will be expanded in May 2010.

These observations underscore the importance of protection rations in the form of supplementary feeding or general food distributions in food insecure areas in order to sustain the rehabilitation of malnourished children attained in CMAM programs.

While food distributions are a short-term solution to meeting immediate household food needs, long-term strategies to food insecurity problems should be sought in high risk communities.

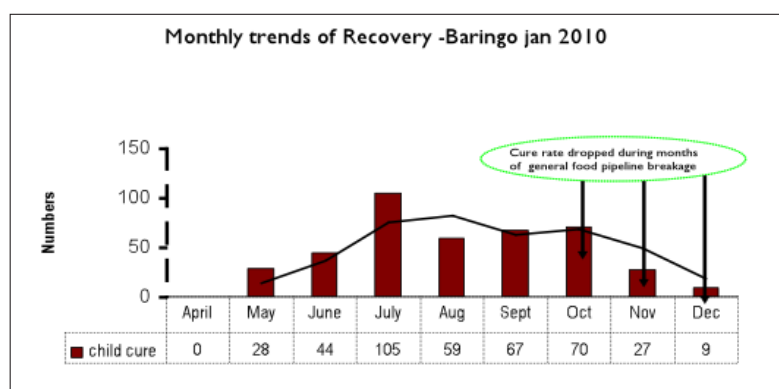


Figure 2

## CMAM Africa Update: Summary of Functional Indicators and Influencing Factors as of Feb. 2010

Submitted by Cyprian Ouma – Africa CMAM Technical Advisor

Country	S. Sudan	Kenya	Ethiopia	Somalia	Zimbabwe	Niger	EDRC	DRC
Project Areas / ADP's Covered	Tonj South and North	10	13	2	3	16	1	6
Project Status	Up to 2011	Up to Nov 2010	Ongoing	Ongoing	Up to Oct09	Ongoing	Ongoing	Up to Nov 09
Food Security Situation	Poor – receiving food aid	Poor – receiving food aid	Poor – receiving food aid	Poor – receiving food aid	Poor – receiving food aid	Poor – receiving food aid	Poor – receiving food aid	
General security	Poor	Poor	Good	Poor	Good	Good	Poor	Good
Access to population	Poor due to rains	Poor due to insecurity	Good	Poor due to insecurity	Good	Good	Poor	Good
Total number of sites	OTP=24 SFP=24	OTP=66 SFP=83	OTP=61 SFP=N/A	OTP=39 SFP=33	OTP=11 SFP=11	OTP=47 SFP=52	OTP=17 SFP=0	OTP=5 SFP=0
Number admitted since program setup	OTP +SC = 3,215 SFP=3,629	OTP=2,587 SFP=69,771	OTP=6,812 SFP=N/A	OTP=9,309 SFP=32,064	OTP=292 SFP=638	OTP=2,877 SFP=7,622	OTP=1,552 SFP=N/A	OTP=125 SFP=N/A
Number trained in CMAM	CV=218 MOH=10 WV=44	CV=280 MOH=53 WV=82	CV=560 MOH=173 WV=4	CV=1677 MOH=8 WV=95	CV=210 MOH=70 WV=6	CV=1,329 MOH=282 WV=16	CV=333 MOH=N/A WV=N/A	CV=125 MOH=89 WV=53
Recovered	84%	>80%	85%	78%*	67%	77%	95%	92%
Deaths in programme	<3%	<3%	<3%	<3%	<3%	3.9%	<3%	<3%
Default	11.9%	<15%	1.7%	10%*		13%	4%	8%
Coverage	67%	63%	67%		>50%	44%	76%	

OTP: Outpatient therapeutic programme, SFP: Supplementary feeding programme, ADP: Area development programmes, CMAM: Community management of acute malnutrition DU: Data unavailable

\*Average figure between SFP& OTP

## Importance of addressing Infant and Young Child Feeding issues in the context of treatment-focused nutrition programs

*The social context of childcare practices and child malnutrition in Niger's recent food crisis*

**Authors:** Katherine Hampshire, Rachel Casiday, Kate Kilpatrick and Cather Panter-Brick

**Source:** Disasters, Volume 33, Number 1, January 2009, pp. 132-151(20)

**Publisher:** Blackwell Publishing

After the Niger food crisis of 2004-2005, programs for community-based treatment of acute malnutrition found that the prevalence of acute malnutrition, although reduced from the level during the crisis, remained unacceptably high. In an anthropological study published in the January 2009 issue of Disasters, researchers investigated social factors that may increase the risk of acute malnutrition in infants and young children and contribute to its high prevalence. The authors used a variety of qualitative research methods to understand local understanding and coping practices, and they uncovered several harmful infant and young child feeding practices. The majority of mothers initiated breastfeeding late, failed to exclusively breastfeed, and stopped breastfeeding early. A new pregnancy was the most common reason for early breastfeeding cessation, leading mothers to wean their children abruptly. Complementary foods were diluted and contained large amounts of water, and, since children older than one year fed themselves from a common

plate, adults had little influence over what or how much children consumed.

The authors suggested that social factors influence decision-making about resource allocation for children and aggravate the situation. For example, families were reluctant to invest extra resources for a sick or malnourished child because of their persistent poverty and livelihood insecurity. Based on

the findings, the authors recommended that treatment-based nutrition programs should include long-term approaches to improve infant and young child feeding. Approaches, should build on knowledge of local realities, constraints, beliefs, and practices, and should support sustainable improvements for children's diets through agricultural approaches, or creation of local versions of nutritional rehabilitation foods.

## WV Emergency Nutrition Staff Updates

### MEET AND GREET

### Mariana 'Mari' Stephens



**Years with WV** – July 2010 will be 2 years

**Current position** – Nutrition Advisor for FPMG

**Current work location** – Based in the Philippines and covering FPMG programmes globally

**Main work responsibilities/activities**  
Using food as a resource to assist in health and nutrition outcomes. Recent focus is on Integrated School Feeding (e.g. Food for Education and Enhanced Development FEED) and exploring CMAM relapse prevention strategies.

**Best part of your job / working in emergency nutrition** – The best part of my job is the ability to work in a collaborative spirit with the Nutrition Centre of Expertise and other colleagues globally to address the

challenges around malnutrition in the current context of climate change.

**Most challenging part of your job?** – The most challenging part of my job is wishing I could be in 10 places at one time.

**When you're not working?** – When I am not working I enjoy spending time with my two amazing kids, supportive husband and pets. We like to explore the various islands in the Philippines (and the region) for snorkelling and swimming.

## Africa

### Regional Staff Update

The recent restructure of the Africa region from one region into three has also led to the appointment of a Nutrition Advisor for each region. The role of each of these advisors includes covering emergency nutrition, CMAM & 7/11:

East Africa - Sisay Sinamo

West Africa - San San Dimanche

Southern Africa - Lucia Mutowo

The CMAM technical advisor for Africa  
Cyprian Ouma

## Have Your Say

Do you have a story, suggestion and/or request for the WV ENU?

Contact us at [nutrition\\_coe@wvi.org](mailto:nutrition_coe@wvi.org)

Global Health & Nutrition

## Nutrition Centre of Expertise

For questions or contributions to the WV ENU, please contact the WV Nutrition Centre of Expertise  
[nutrition\\_coe@wvi.org](mailto:nutrition_coe@wvi.org)



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