Welcome to the sixth edition of WV’s Emergency Nutrition Update.

In this edition, advocacy and emergency nutrition is the Spotlight theme focus. We explore why advocacy is important and what we as World Vision can do at various levels to advocate in the area of emergency nutrition. A recent example from WV Niger highlights just some of the various opportunities for advocacy in an emergency response.

Look out also for reference to the new WV Measuring Child Growth Tool, upcoming research and find out who this edition’s Meet & Greet staff member is. Can you guess?

Child in Niger - Photo by Ann Birch 2010

NEW! WV Measuring Child Growth (Anthropometry) Tool

ON NO, MY BOSS WANTS ME TO DO ANTHRO TRAINING, I DON’T HAVE THE TIME TO DEVELOP ALL THE MATERIALS!

HEY! I CAN USE THE NUTRITION TOOLKIT - IT’S ALL READY!!!

WOO HOO!!! PROBLEM SOLVED!!! I’M GONNA GET PROMOTED FOR THIS!!!

BY YANNIXS WWW.BITSTRIPS.COM

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ENU SPOTLIGHT
Advocacy & Emergency Nutrition

Addressing Acute Malnutrition Through Advocacy

Submitted by Colleen Emary, Technical Specialist, Emergency Nutrition, WV Nutrition Centre of Expertise

With an estimated 11 percent of children under five years of age in the developing world suffering from acute malnutrition and severe acute malnutrition affecting 26 million children globally, there is a critical need to advocate for policies and programs for both the prevention and treatment of acute malnutrition\(^1^,\(^2\)."

Why it matters:
Severe acute malnutrition (SAM) is a life-threatening condition requiring urgent treatment. It is responsible for approximately one million child deaths every year\(^3\). When compared to well-nourished children, children with severe acute malnutrition are five to 20 times more likely to die\(^4\). Children who recover from SAM are at greater risk of developing chronic undernutrition (stunting, vitamin and mineral deficiencies) which have long-term consequences on physical and mental development.

What needs to change:
Addressing the global burden of acute malnutrition requires the collective efforts of global, national and community partners. The following outlines advocacy efforts that are required by all partners\(^5\):

At the Global Level
- The universal adoption of common standards for emergency nutrition response (i.e. as defined by the Sphere Project) by humanitarian agencies.
- The United Nations to renew the global commitment for the eradication of hunger and malnutrition with a specific focus on countries affected by conflict and fragile states.
- The World Food Programme and all emergency response and relief agencies to be held accountable for ensuring emergency food provisions meet the nutritional requirements of the affected population, including vulnerable groups such children, pregnant and lactating women and people living with HIV.
- Donor Governments, Institutions and Foundations provide dedicated financial support for operational research on emergency nutrition operation and implementation to drive evidence-based improvements to field programme models.

At Regional and National Level
- National nutrition strategy and guidelines are developed and/or revised to include disaster preparedness plans that will reduce community vulnerability and improve nutritional status.
- CMAM protocols (including use of MUAC) are included into National health policies, including allocation of the necessary budget to operationalise CMAM, including ready-to-use therapeutic foods (RUTF) purchase or production, medicines, staffing and logistical costs within national health budgets.
- The development of national capacity for ready-to-use food (RUF) production using local ingredients is promoted throughout the National Government Ministries, and the private sector is encouraged to participate.
- Improvements to Health Service infrastructure and systems are prioritised to those areas where the likelihood of displacement due to natural disasters (e.g. areas that flood annually) is increased.
- Surveillance systems used to monitor trends in early warning systems of food insecurity and acute malnutrition are provided with ongoing support and given high prominence.
- National governments accept responsibility for the coordination and facilitation of acute malnutrition and disease control interventions. Where a national government does not have the resources to respond, they continue to take a leading role in coordination of partners and emergency nutrition interventions.

At the local community level
- All community-level health workers are trained to screen and report on severe acute malnutrition (SAM) and other illnesses that may increase during an emergency or during food shortages.
- Health promotion campaigns are undertaken to provide parents/caregivers/volunteers with the skills to identify severe acute malnutrition within their communities and how to respond to SAM.
- Local health policies include the development of logistic systems (using existing or new) to support the provision of RUTF to the community.
- Local government health infrastructure integrates CMAM protocols within their normal operating environment.
- All local Health Plans include education and promotion activities to empower people with knowledge of nutritional deficiencies in their own communities and consequences of undernutrition. This may include activities on rights to adequate health care and nutritious food in specific contexts.
- Trained community level workers provide consistent Timed and Targeted Counselling of mothers in care and feeding of infants – especially with regard to exclusive breastfeeding and complementary feeding practices.
- District health systems collate and monitor data from regular and correctly implemented growth monitoring needs and are included in official Ministry of Health reporting requirements.

4. Ibid
Opportunities and World Vision’s Response

Addressing undernutrition, including acute malnutrition is included as a focus within World Vision’s Global Child Health Now Campaign. As part of the 5 year campaign, World Vision will be raising the profile of undernutrition and its impacts upon child health and survival in various international forums. For more information on the campaign refer to [https://childhealthnow.com](https://childhealthnow.com).

What can I do?

- Review World Vision’s Child Nutrition Technical Brief which provides up to technical information on the causes and consequences of undernutrition with a focus on stunting, wasting and underweight.

Contact [loria_kulathungam@worldvision.ca](mailto:loria_kulathungam@worldvision.ca) for the report.

**TOOLS, GUIDELINES AND RECOMMENDATIONS**

*(Continued from Page 1)*

**New! WV Measuring Child Growth (Anthropomery) Tool**

Version 1 of the tool is now complete. This tool has been developed to use as a training package for a 3-day face-to-face training to build capacity for field level staff in the essential components of quality anthropometric data collection, interpretation and use.

The Measuring Child Growth Tool contains all the essential information that you need to conduct a face-to-face training to build skills and competency around anthropometry. The topics include:

- Overview and Introduction to Anthropometry
- Information about Sex and Age of Children Under-5
- Weighing Technique Using Hanging Scales and Standing Scales
- Technique for Measuring Length and Height
- Mid-Upper Arm Circumference
- Standardisation Exercise
- Using Data to Improve Individual Child Growth
- Counselling
- Using Data to Understand Population Nutritional Status

To download the tool go to [WV Central](http://www.wvcentral.org) or email the Nutrition Centre of Expertise at [nutrition_coe@wvi.org](mailto:nutrition_coe@wvi.org).
Malnutrition Context in Niger

As one of the poorest countries in the world, Niger has huge development challenges: notably an arid climate, recurrent drought, locust attacks, demographic pressure and scarcity of resources that make survival a challenge for families, especially in resource-scarce rural areas. Despite modest improvements over the last decade, infant and child mortality rates remain very high and about 1 in 4 children in Niger [may] die before reaching 5 years of age where malnutrition is an underlying cause of 1/3 of those deaths. However, it is important to highlight that malnutrition in Niger is endemic, structural, and cyclical—it is ever present, with seasonal fluctuations.

Recent Nutrition Crisis

Hopes ran high across the country when there were good harvests during three consecutive years (2006-2008); which supported improvements in the nutritional situation of children under 5 years of age nationwide. But unfortunately, the 2009 harvest was very poor due to drought and a subsequent lack of running water. Results from the recent agro-pastoral harvest in 2009 have shown that the situation is more alarming than previously thought and that agricultural production was down by 31% when compared to the production level of the previous season. A December 2009 rapid assessment conducted by the government’s Early Warning System (SAP) indicates that 7.8 million Nigeriens, or 58% of the population, are currently in a situation of food vulnerability. According to the last classification from CCA (Comite Consultative de Alertes), the most affected zones are respectively Diffa, Zinder, Maradi, Tahoua and Tillaberi.

In response, WV Niger with partners carried out a nutrition and food security assessment. The findings from this assessment were that the failed harvest is a significant factor in the current food security and nutrition crisis, but this is not the whole picture. The crisis is a nutrition crisis that affects primarily children under the age of 5 over the long-term; with major consequences in terms of their human development (physical and mental) impacting on education and productivity on a generational scale. It is due partly to environmental factors such as unreliable rains, drought, poor soils, high malaria incidence etc and partly behavioural with some structural issues contributing as well. Chronic malnutrition among under-5s causing stunting (40% according to UNICEF) together with seasonal food shortages from July to October, each year, causes high acute malnutrition rates because of the high background vulnerability.

Response

To handle this nutrition crisis, an emergency nutrition team was set up including WV Regional Office Staff, Support Office program officers and National Office Emergency Response and Disaster Mitigation staff and, in line with WV HEA Guidelines, a Category III level II response was declared. Following this an advocacy plan was developed in order to ensure that the nutrition crisis was incorporated into the NO agenda, including the following key components:

Part 1. Affected people empowerment

**Aim** – To educate and mobilize the affected population to prompt policy change in nutrition programming

**Action** – Education sessions organized within WV Niger interventions zones throughout the country to inform people of their rights to proper food, the commitment of the Niger Government to meet MDG 1, 4 and 5, and on how to seek their fulfilment. Community mobilization sessions have been organized to equip and motivate people.

Part 2. Policy Influence

**Aim** - To highlight the issue of malnutrition and advocate for changes mainly regarding admission and discharge criteria and the use of the MUAC bracelet as the sole admission criteria for entry into Community Based Management of Acute Malnutrition (CMAM) Programs in order to align with international standards.

**Action** – Various meetings were organized with policy makers at the National level (MOH, Prime Minister etc) as well as with UN Body representatives. WARO H&N and HEA team met with key donors at the regional and national levels including ECHO, OFDA, UNICEF, WFP, FAO etc. and also with technical entities such as UN Body Organizations and peer agencies in order to share with them the situation analysis from WV’s perspective and what necessary interventions were needed.

**Result** - Some funding has already been received for supporting nutrition assessment, capacity building and CMAM programming for about 74,000 under 5 malnourished children. WV Niger is now implementing a CMAM Nutrition program with technical supports from Valid International, within all its 18 ADPs in an integrated manner within the public health facilities, involving beneficiary communities from 5 regions out of 8 in the country.
The 4th Africa Nutrition and Epidemiology conference, 4-8, October 2010, Nairobi

Congratulations to various WV colleagues who have had abstracts accepted for the 4th Africa Nutrition and Epidemiology Conference in October this year. The six abstracts accepted are:


2. The effect of general food distribution on the relapse children in community management of acute malnutrition programme (CMAM) in Baringo, Kenya – Cyprian O, Atuti J, Owino V & Musembi N.


6. Use of indigenous knowledge and locally available food resources to rehabilitate children with underweight in Mwanga Sub-county, Uganda: A Case Study. Sisay S & Mercy

WV Emergency Nutrition Staff Updates

MEET AND GREET
Claire Beck

Years with WV – 9 years
Current position – Health and Nutrition Specialist with the Global Rapid Response Team (GRRT)
Current work location – Based in Melbourne Australia (But can be deployed anywhere in a Cat III Situation)

Main work responsibilities/activities
My main job is to be available at 24 hours notice to respond to Category III emergencies. I can be deployed for up to 3 months at a time and during deployment I usually manage health and nutrition programs. This may involve starting up a new program in the disaster affected area (where possible working with the local health and nutrition staff, or hiring and training of new staff if this is needed). I also engage in health and nutrition assessments, capacity building of staff to manage the program when I leave, and liaison with other sectors to ensure that health and nutrition needs of the community are met. Sectors liaison may include WASH to ensure adequate water and sanitation for the affected population, shelter to ensure that our pregnant and new mums have adequate shelter, the commodities team to ensure LITN are delivered or the food team to look at targeting, food distribution and ration component.

In non-response times I continue to offer support to ongoing programs and look at the development of guidelines and support for health and nutrition staff in NO to respond to emergencies. I am happy to appraise proposals, look for technical resources and keep filling up people’s in boxes with interesting health and nutrition information that comes my way.

Best part of your job / working in emergency nutrition – I work with staff and communities in the field. Watching programs develop and staff take on more responsibility as they feel confident in their role.

Most challenging part of your job? – Arriving in a disaster setting, often with little or no language and trying to make sense of what capacity the NO has to respond, understand the health structure, find out what other agencies are doing, and making sure that WV is positioned well to respond and use its resources wisely. Many times I am called 2-3 months after the initial disaster which makes positioning WV very difficult in the environment where time is an essence to starting programs.

When you’re not working? – Spending time with my new husband (was married 5 months ago), reading, going for long walks in the beautiful parks and bush land around Melbourne, and shopping.

Next ENU
Infant and Young Child Feeding

If you have any suggestions, stories or reports regarding infant and child feeding in emergencies which you think would be helpful for ENU readers, please forward send to nutrition_coe@wvi.org by 20th September 2010.