COVERAGE MONITORING NETWORK

WHAT DO WE KNOW NOW: A DECADE OF COMMUNITY BASED TREATMENT OF SAM

Conference Report 17-18/10/2013

Acknowledgements

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Foreword

In 2010, a group of nutrition organisations (ACF, Save the Children, Concern Worldwide, International Medical Corps, Helen Keller International and Valid International) came together to create the Coverage Monitoring Network (CMN), aiming to increase the capacity of nutrition programmes to assess their treatment coverage and to understand the main barriers and boosters to access. Coverage was seen as an important measure of accessibility of treatment, and in turn, a reflection of the relationship between a series of key factors and processes including RUTF supply chain, community engagement and health system strengthening, amongst others. The CMN championed the use of coverage as a proxy measure of the health and robustness of SAM treatment services, and in measuring it, the CMN started to provide a picture of the quality of SAM treatment services today.

One of the stated objectives of the CMN project was to build on this growing evidence, creating spaces in which trends are reviewed, common barriers are identified and assessed, and lessons can be learned, through the implementation of coverage assessments around the world. To do so, however, the project would need to go beyond coverage and explore the factors influencing it. This realisation led the CMN to open these learning spaces to the review of emerging lessons on SAM treatment as a whole.

The first of such events took place in London on October 17th and 18th, 2013, as a co-sponsored event between the CMN, UNICEF, CMAM Forum and World Vision. Under the title "What We Know Now: A Decade of Community-based SAM Treatment", the conference brought together over 170 academics, practitioners and policy makers from a range of NGOs, UN agencies, academic institutions and national governments. What began as a simple 'lessons learned' exercise rapidly grew into a broad review of the state of SAM treatment today, and the start of a process to identify key areas for future action. At the end of the two-day conference, a series of priority areas were identified, divided in six different streams (Advocacy, Financing, Government, Nutrition Information and Supply Chain, Treatment and Community, Access and Demand.), and in the weeks following the conference, partners continued to refine these areas of future work and begun making specific commitments to contribute to their development and implementation. The conference was thus the beginning of a process to strengthen SAM treatment through prioritisation and coordination of efforts by the international humanitarian community.

We hope that this summary of the presentations and discussions will serve to further disseminate the ideas and work presented at the conference, encouraging nutrition stakeholders around the world to collaborate and engage in the global dialogue about the past, present and future of SAM treatment.

The CMN Team

Wth support from

Day One

Time			
09:00 – 09:30	**Registration**		
09.30 – 10.30	**Opening Session: What do we know now?**		
	Panel Speakers: Steve Collins (Valid International) Andre Briend (Affiliated with the University of Tampere) Diane Holland (UNICEF) *Facilitator: Katy Murray*		
10:30 – 11:00	**Tea & Coffee Break**		
11:00 – 12:15	**Session A: Scale-Up of SAM Treatment** *Facilitator: Katy Murray*		
	Abigail Perry & Anne Philpott, DFID (15 mins) *Scaling up Community based management of acute malnutrition but doing it differently*		
	Carmel Dolan And Jeremy Shoham, ENN (15 mins) *Managing Acute Malnutrition at Scale: A review of donor and government financing arrangements*		
	Sylvester Kathumba, MoH Malawi and Kate Golden, Concern Worldwide (15 mins) *CMAM Advisory Services in Malawi: Seven years of Scaling Up*		
	Q & A and Learning Groups		
12:15 – 13:15	**Lunch**		
13:15 – 14.45	**Session B: Treatment Protocol & Outcomes** *Facilitator: Kate Golden, Concern Worldwide*	**Session C: Performance** *Facilitator: Rebecca Brown, CMAM Forum*	**Session D: Design & Implementation** *Facilitator: Diane Holland, UNICEF*
	Nuria Salse & Raman Mahajan, MSF – Spain (15 mins) *Mean Upper Arm Circumference (MUAC) 120mm as a simple, safe and effective discharge criteria for Severe Acute Malnutrition (SAM) in Bihar, India*	Meredith Dyson, CRS Sierra Leone (15 mins) *Getting more children into treatment: improving CMAM referral uptake with systematic referral tracking and follow up*	Senendra Raj Uprety, MoH Nepal & Ojaswi Acharya, ACF Nepal (15 mins) *Scaling Up CMAM in Nepal*
	Paul Binns, Valid International (15 mins) *Safety of using mid-upper arm circumference as a discharge criterion in community based management of severe acute malnutrition in children aged between 6 and 59 months*	Caroline Abla, International Medical Corps (15 mins) *Two-Pronged Screening Approach to Increase Coverage*	Krishna Belbase and Eric Kouam, UNICEF (15 mins) *Key Findings from a Multi-Country Evaluation of Community-based Management of Acute Malnutrition (CMAM)*
	Cécile Salpeteur, ACF (15 mins) *An alternative delivery model for the treatment of severe acute malnutrition leads to better programme outcomes*	Paluku Bahwere and Katja Siling, *Valid International (15 mins)* *The nature, causes, and impact of defaulting from a CMAM program in Nigeria*	Anne-Dominique Israel & Maureen Gallagher, ACF (15 mins) *From Vertical to Horizontal: Experiences & Recommendation in integrating SAM treatment*
	Q & A	Colleen Emary, World Vision (15 mins) *Using Community Volunteers to deliver treatment services for acute malnutrition in Angola*	Q & A
		Q & A	
14.45 – 15.15	**Tea & Coffee Break**		
15:15 – 16.15	**Session B: Treatment Protocol & Outcomes** Priority Setting (Group Work) Aim: Identify priority areas for future research, analysis and action	**Session C: Performance** Priority Setting (Group Work) Aim: Identify priority areas for future research, analysis and action	**Session D: Design & Implementation** Priority Setting (Group Work) Aim: Identify priority areas for future research, analysis and action
16.15 – 16.30	**Room Change**		
16.30 – 17:15	Plenary Feedback & Learning Groups Evaluation/Feedback *Facilitator: Katy Murray*		

4

Opening Session
What do we know now?

The day commenced with three presentations from Dr Steve Collins (Valid International), Dr Andre Briend (University of Tampere) and Diane Holland (UNICEF). These opening presentations set the scene for the conference, summarising what the last ten years has meant for CMAM programming and identifying areas where more needs to be done.

What do we know now?
Valid International

Steve Collins began by elaborating upon the importance of the CMAM model and what it has meant for programming; particularly the shift from a supply to a demand-driven model. This has required asking ourselves four main questions:

1. *Are beneficiaries aware of, and do they understand, the programme?* A key question for the coverage of programmes.
2. *Do they have sufficient access to it?* This remains relevant as most programmes operate out of health facilities, which can still mean great distances for beneficiaries to travel. **We need to keep in mind the public health principles of CMAM;** if we focus too much on the 'difficult to treat' cases, then we get lured back into the clinical model of treatment and a low coverage of treatment for the wider population.
3. *Are the resources required available?* Particularly relevant for local production of RUTF; despite strong efforts from UNICEF to increase local production, the market remains unhealthy (11 out of 20 suppliers belong to one corporate brand). There is a juxtaposition of the customer (UNICEF) acting as certifier of the product they are to purchase, which can appear inconsistent with transparent market practices. **It is Valid's view that an independent certification process is vital.**
4. *Are we adequately assessing impact at the population level?* **It is vital to use direct measures of coverage** (e.g. coverage surveys) rather than indirect (e.g. via nutrition surveys). The CMN network therefore has a crucial role in pushing forward the direct methods of estimating programme coverage.

In summary, programming has clearly come a long way in the last 10 years (with approximately 3 million SAM children treated last year). But with this level of scale-up, threats also appear. It was suggested that the current model of CMAM needs to change in order to:

- continue empowering communities to bolster demand
- reduce opportunity costs for beneficiaries, and
- ensure real competition and transparency in local production of RUTF.

Opening Session
What do we know now?

10 years of Community-based treatment of SAM
UNICEF HQ

Diane Holland explained that UNICEF has been heavily engaged in supporting CMAM scale-up, although the role is mainly a supportive one. ***The trend of global scale-up has been dramatic,*** showing that, with sufficient investments from a range of partners, it is possible to scale-up over a short period of time. ***Treatment coverage does however remain low*** (between 7-13% of the identified need). The process of mapping services is important as it reveals crucial information, such as that the countries where programmes are being implemented are not necessarily the areas with the highest burden (e.g. South Asia).

Equitable access remains an important issue, creating constituency and enabling empowerment. It was recognised that ***UN sister agencies need to coordinate better***, especially considering the issue of various mandates as it creates difficult situations for governments and partners to engage. ***There is an urgent need to improve the engagement with the good health system platforms*** that exist. Improvements in the capacity to deliver therapeutic supplies (e.g. development of product specifications) will help to increase quality of services. Nutrition information systems are also in need of improvement, and it is crucial that coverage data is integrated into routine information systems.

In summary, while the prevention of malnutrition remains crucial to future plans, treatment for SAM is especially vital in the interim period until preventive measures can effectively reduce the burden of SAM seen in many contexts across the developing world.

10 Years of CMAM: What did we learn? What are the remaining Challenges?
University of Tampere, Finland

Andre Briend suggested that the 'ingredients' of CMAM were already in place 10 years ago, we have learnt that it 'works' in both NGO and government-run programmes; however, ***ensuring high coverage remains a challenge.*** We need therefore to act on the key factors that affect coverage; more frequent screening is required (monthly MUAC measurements), minimising the stock-outs of supplies, and maintaining quality of care.

Political will from policy makers and governments is the key challenge for SAM, as its profile in the international health agenda remains extremely low. As an example, SAM only briefly featured in the UN 2012 World Health Assembly document (2 lines in a 14 page document). This demonstrates an advocacy failure. Currently the focus is on stunting as it is considered a more important cause of death in children than wasting, largely because it is reported using measures of prevalence. While the recent Lancet series was very good on many levels, there was a failure to record the scale of the problem of wasting, as incidence measures of wasting were used (therefore underestimating SAM deaths by a factor of 2 to 8, compared to stunting). ***We urgently need to move towards assessing incidence for wasting, as this would give us a clearer picture of its extent and impact***. Additionally, kwashiorkor is not assessed at all – oedematous children are currently ignored by the public health community; they have no voice at all. There is an urgent need to 'educate' donors and policy makers about the importance of using incidence to accurately assess wasting; which will only be possible through repeated large scale surveys (using MUAC and oedema assessments) or programme data.

Finally it was highlighted that our field tends to be highly conservative which can adversely affect the pace of change in programming.

Session A
Scale-up of SAM treatment

Presentations were made by DFID, ENN, and the Ministry of Health Malawi in conjunction with Concern Worldwide, which focused on funding mechanisms and challenges for CMAM, and the experience of using an advisory service to facilitate national scale-up in Malawi.

Scaling up Community based management of acute malnutrition but doing it differently
DFID

Anne Philpott and Abi Perry explained that DFID is increasing nutrition investment, as articulated in the 2011 position paper which states the aim to reach 20 million pregnant and lactating women and children under 5, and the recent (June 2013) co-hosted 'Nutrition for Growth' summit. CMAM is a major part of humanitarian programming, but increasingly CMAM has been programmed within longer term interventions, through budget support and sector reform programmes with government ministries.

Four country examples were provided of how DFID is 'doing CMAM differently': Malawi, India, Ethiopia and Kenya. While each of the examples had their own unique aspects of CMAM evolution, there were commonalities with HSS for acute malnutrition programming. Particularly for crisis prone countries, ***innovative funding strategies have been put in place to help shift CMAM from emergency-style programming to longer term approaches.*** Multi Year Funding (MYF) is becoming the 'norm' for DFID to try and prevent 'stop/start' programming, to bridge the humanitarian and development divide and with considerations of 'how to reduce risk within the development spend'.

However, the varying contexts in which CMAM is implemented ensures ***that there is no 'one size fits all' solution to funding challenges*** and DFID identified an urgent need for dialogue and experience sharing with other donors, to overcome some of the challenges being faced.

DFID responded to questions regarding funding by stating that ***they have committed to triple funding for nutrition by 2020***, including a greater proportion going towards nutrition sensitive programming. Questions were also posed regarding the particular sensitivities of scaling up CMAM in countries where there has been some reluctance to implement it, including resistance towards the use of imported RUTF. DFID have utilised a 'careful but ambitious' approach to working within Bangladesh and India (the CMAM conference in Addis Ababa in 2011 was highlighted as a catalytic moment in helping 'move things forward' in India), by using strategic funding approaches and also ***learning important lessons about the need to use caution and broker relationships within complex political environments.***

Session A
Scale-up of SAM treatment

Managing Acute Malnutrition at Scale: A review of donor and government financing arrangements
ENN

Carmel Dolan and Jeremy Shoham presented the ENN's recent review of global and country level financing arrangements for CMAM. The review came about as a result of the CMAM conference held in Addis Ababa in 2011, where financing arrangements were highlighted as a major challenge for scale-up. In total, 15 countries were looked at in some detail, with in-depth case studies collected from 4 countries (Ethiopia, Malawi, Nigeria, Kenya). While CMAM remains a relatively expensive intervention (estimates between 70 – 200 USD per child cured), it is a cost-effective child survival programme. The cost of RUTF is 50% or more of the overall cost for treating SAM, largely because of the need to import dried skimmed milk. UNICEF is the major purchaser of RUTF, and efforts to scale up local production have unfortunately largely failed to significantly bring down the cost of production.

CMAM is mostly funded through humanitarian sources, often because many programmes started on the back of an emergency, but this also reflects a divide in thinking, where wasting is seen as an emergency concern, and stunting, a development one. Where CMAM remains dependent on humanitarian funding it is by nature short term, which creates numerous challenges. Even in stable contexts, the majority of funding goes through UN and NGO agencies, which inevitably impacts on the level of government ownership and, possibly, domestic or government allocations. Encouragingly, there are a few examples where governments are committing some earmarked domestic resources for CMAM, such as Malawi and Kenya (approximately 10-20% of CMAM costs). It is clear however, that a great deal of ground needs to be gained if we are to sustainably finance an increase in treatment coverage from the current 15% to 50 or 80%.

The ENN suggested that ***a paradigm shift needs to happen around thinking for acute malnutrition; it is endemic in non-emergency situations and is therefore a development concern***. A vision is needed for financing and sustaining scale-up, or there are real risks that the gains of CMAM scale-up will be lost. There is an urgent need for Multi Year funding (MYF) and other new mechanisms, such as the mixing of humanitarian and development funding particularly in contexts of repeated crises. There is a need to move away from short term and unpredictable financing towards funding through governments (i.e. budget support, pooled funding, etc.). Lastly, there is a need to review the current situation where three UN agencies are responsible for different severities of the same condition and the economic efficiency/ transaction costs of this approach.

In response to questions, the ENN suggested that it is the role of the SUN donor group to lead on discussions about how funding can be altered and adapted, for example: pooled funding, shadow budgeting, policy convergence and use of effective ways to audit government spend. More clarity on the different roles of the SUN lead group versus the SUN donor group was requested by the participants. In terms of how the various UN agencies have responsibility for different aspects of the same disease, the question arises of what overview is in place to ensure accountability.

CMAM Advisory Services in Malawi: Seven years of Scaling Up
MoH Malawi and Concern Worldwide

Sylvester Kathumba from the Malawian MoH and Kate Golden from Concern Worldwide then presented the 'CMAM Advisory Service (CAS); Seven years of scaling up'. Although the mandate of the CAS was to provide technical assistance and build the capacity of the MoH for the national scale-up and institutionalisation of CMAM, ***the project embraced a significant coordination and mentoring role*** to support the operationalisation of tools and policies as well as a national monitoring and evaluation system that included CMAM indicators.

Successes of the project were reported as:
- facilitation of rapid scale-up of CMAM, development of a costed CMAM operational plan,
- learning forums initiated as exchange and review platforms,
- updated training curricula developed.

While the overall objectives of the CAS were achieved, challenges identified were that;
- CMAM is still delivered in a parallel manner,
- the database is only slowly integrating into the broader HMIS system,
- the costed operational plan needed more monitoring and commitment,
- no national coverage assessment was conducted
- the CAS support strategy was focussed too much at the national level.

In response to questions, the Malawian MoH stated that the total cost of CAS was in the region of approximately 200,000 USD per year. ***The government managed to overcome the view that CMAM was a responsibility of NGOs***, by leading the roll out at district and community level and locating CMAM within routine primary health services. Further detail was given of how the CAS was managed and the importance of partners in the process, including UNICEF and WFP.

Session B
Treatment Protocols and Outcomes

Presentations were made by MSF Spain, Valid International and ACF, which described the safety and efficacy of using MUAC as a discharge criterion in two programmes, and the success of using a protocol of less RUTF (once the child had partially recovered) in a programme in Myanmar.

Mean upper arm circumference (MUAC) ≥120mm as a simple, safe and effective discharge criteria for severe acute malnutrition (SAM) in Bihar, India

MSF Spain

Nuria Salse described a programme implemented in India which uses admission criteria for children aged 6-59 months of MUAC <115mm and/or Weight-for-Height Z-score of <-3SD, and oedema. Rather than using the current WHO guidelines[1] for discharge of 15% increase in body weight (from admission weight), for MUAC admissions, a cut off of ≥ 120 mm was used for discharge. Data from a large number of children (>2,000) was collected and retrospectively analysed. The analysis concluded that it was acceptable to use this discharge criterion, although it resulted in long length of stay, both for children who entered the programme with a low MUAC and for those < 65 cm in height.

Additionally, a follow up survey of around half of these children was conducted to assess relapse rates; with ***results showing that the majority of children discharged as cured remain cured in the long term***. The higher risks of relapse during the first 3 months (rates of 10%) were associated with the season of greater food insecurity.

Safety of using mid-upper arm circumference as a discharge criterion in community based management of severe acute malnutrition in children aged between 6 and 59 months

Valid International

Paul Binns explained that MUAC has recently been considered for use as a potential alternative discharge criterion as there is concern when using proportional weight gain (e.g. 15% weight gain) due to it resulting in the most malnourished receiving the least treatment. This study, based in Malawi, assessed children 6-59 months who had been admitted to the programme with a MUAC of <115mm, given treatment according to national protocols and discharged when they had achieved a MUAC of ≥ 125mm for 2 consecutive visits. Following discharge as cured, the child was followed up every 2 weeks for a 3 month period by a community health agent trained in the study protocols.

The study met the standard (< 10%) established for relapse and non-accidental, non-violent death in the 3 months following discharge from treatment. It concluded that a ***MUAC discharge criterion is an improvement upon one of proportional weight gain, as the most malnourished receive the most treatment***. It also suggested that the MUAC criterion of ≥125mm represents a safe discharge criterion at 3 months post-discharge. A further observation was that it is worth investing in case-finding, as the study showed that the earlier children were admitted into the programme, the shorter the length of stay and the better the outcomes were.

[1] Shortly after the CMN conference in November 2013, the WHO issued updated recommendations for discharge criteria as follows; to not use % weight gain, instead to use MUAC >=125mm for those admitted by MUAC and WHZ >=-2 for those admitted by WHZ criteria.

Session B
Treatment Protocols and Outcomes

An alternative delivery model for the treatment of severe acute malnutrition leads to better programme outcomes
ACF

Cécile Salpéteur described the severe logistical constraints of, and the change to, the use of WHO 2006 Growth Standards, which resulted in shortages of RUTF in Myanmar 2009 and led to ACF deviating from the internationally established protocol for the treatment of SAM. These constraints did, however, provide an opportunity to assess the effectiveness of an Alternative Protocol (AP), whereby ***delivery of reduced amounts of RUTF were given, once the child had partially recovered*** (i.e. reached MAM classification, using Weight for height). Complementary activities, such as encouraging the mother to give additional food to the child at home (along with the RUTF), were provided. Excellent programme performance results were reported (better even than those of a similar programme in 2008, implemented using the standard treatment protocol), which suggest that the provision of different service delivery models might be more important than the dosage of therapeutic foods itself. Further research on this is required.

Session C
Performance

Presentations were made by CRS, IMC, Valid International and World Vision which focused on referral procedures (through tracking and intensifying screening), assessing high defaulter rates in a programme in Nigeria and an innovative approach of training health activists to treat acute malnutrition in the community.

Getting more children into treatment: improving CMAM referral uptake with systematic referral tracking and follow up
CRS Sierra Leone

Meredith Dyson explained that CRS had identified that approximately 1 in 3 children referred for SAM treatment did not subsequently enrol in the programme. In response, CRS developed and tested a referral tracking system to better address the identified barriers to referral uptake. The tracking system included two-part referral slips, where the caretakers receive the referral slip and the community health volunteer (CHV) retain the stub, allowing comparison of the unique identification numbers on each slip with the retained stubs, to confirm whether the caretakers sought treatment. Tracing of children who were not treated at the facility was then possible and appropriate measures could be taken. ***Referral uptake improved from 69% to 93% once the tracking system had been implemented***; it was therefore concluded that a systematic referral tracking system, can help to address barriers and improve treatment uptake and coverage rates of CMAM programmes in Sierra Leone.

Session C
Performance

Two-Pronged Screening Approach to Increase Coverage
IMC

Caroline Abla explained that during a programme implemented in 2 refugee camps in Ethiopia, IMC instigated a '2 pronged' screening approach for children 6-59 months to improve programme coverage. It was recognised that some malnourished children with low weight for height Z-scores (WHZ) were not being identified through MUAC screening. MUAC screening was conducted monthly, while every 3 months those children with an 'at risk' MUAC were further screened using WHZ. Children with WHZ >3SD and <-2SD are admitted to TSFP and children with WHZ <-3 were admitted to OTP, regardless of their MUAC.

IMC concluded that ***in the Somali populations of these two camps, it is important to screen for malnutrition using both MUAC and WHZ***. Effectiveness and appropriateness of this approach in a non-camp setting and availability of resources for conducting the screening (and treating the additional cases) will need to be further investigated.

The nature, causes, and impact of defaulting from a CMAM programme in Nigeria
Valid International

Paluku Bahwere outlined the efforts made to investigate high defaulting rates seen in a CMAM programme in Nigeria (up to 50% of cases defaulting) using various methods: exploratory retrospective analysis of routine data at CMAM facilities, retrospective follow up of defaulters in three districts and an adapted 'defaulter SQUEAC' survey.

The results indicate that ***a very high proportion of defaulting occurred early in the treatment***, defaulting was associated with a significantly elevated risk of acute malnutrition as well as a six-fold increase in mortality, compared to the expected background levels of mortality. The causes of defaulting included explanations from both the demand-side (reluctance of caregivers to travel to facilities, cultural constraints on mothers' movement in public) and the supply-side (lack of information about SAM and proper use of RUTF provided to caregivers), as well as a strong effect of the presence/absence of active community volunteers to improve understanding of the programme and conduct follow-up visits in the home.

These findings suggest that developing ***a model for sustained community mobilisation and follow-up in Nigeria should be a high priority*** for State governments and their development partners. Furthermore, that quality of delivery is not only critical for achieving acceptable programme outcomes but also for reducing risk of relapse and death.

Community case management of SAM in Angola
World Vision

Colleen Emary explained that a situation with few operational NGOs and limited government capacity to implement CMAM programmes in Angola led to World Vision training and supporting community health activists (CHAs) to provide screening and treatment services for SAM and MAM children 6-59 months. More than 2,000 CHAs were trained across 4 provinces. Both ***programme results and coverage rates were excellent, demonstrating that the CHAs were capable of identifying cases early and successfully treating SAM and MAM cases***. Low mortality rates indicate that they were also adept at referring children with complications to health facilities for additional treatment.

Although there were clear benefits in taking treatment down to the level of community workers, the challenges identified included: gender balance issues (most CHAs were male), levels of literacy required, deviance from international treatment protocols and weaknesses with reporting, monitoring and evaluation systems.

Session D
Design and Implementation

Presentations were made by ACF (Nepal), UNICEF and ACF (France and USA HQ), describing various experiences: the integration of CMAM to IMAM in Nepal, UNICEF's 5 country evaluation of CMAM, and ACF's attempts to move CMAM from horizontal to vertical programming.

CMAM to Integrated Management of Acute Malnutrition (IMAM) in Nepal

ACF

Ojaswi Acharya elaborated the high levels of acute malnutrition that Nepal experiences and explained that it is not currently on track to reach the Millennium Development Goals (MDGs), except for on infant mortality. There are three distinct geographical areas in the country and widely varying underlying and basic causes of malnutrition, many of which are very difficult to address.

Following pilots of CMAM implemented in 5 districts, scale-up has been underway in other areas of the country using the IMAM approach. Services are now being offered in 11 out of the 70 districts, with plans to scale-up further (reaching 35 districts by 2017). Encouragingly, ***management of SAM has been included in the Multi Sector Nutrition Plan (MSNP) developed by the Government of Nepal***. A high level steering committee oversees the operationalisation of this plan and reports into the Prime Minister's office, hence ***there is good government 'buy-in' and commitment***. The plan will be monitored and results measured from the details outlined in the logical framework.

Key findings from a multi-country evaluation of CMAM

UNICEF

Khrisna Belbasse and Eric Kouam presented the UNICEF multi-country CMAM evaluation conducted in 2010-11 covering 5 countries; Pakistan, Nepal, Ethiopia, Kenya and Chad. As UNICEF had invested more than 100 million USD in CMAM by the time the evaluation was commissioned, there was great interest to see what the results of this funding were and how successful the various strategies put in place had been. Two independent consultants were recruited and five national teams identified. An evaluation framework was developed, based on the CMAM 'theory of change'. A number of challenges were faced during the evaluation (intra-country variance of context and time spans of intervention, lack of baseline, outcomes and impact data, no comparison with alternative SAM treatment models). Findings were presented using three themes: equitable access, quality of services and nutrition information.

The issue of equitable access was found to be problematic, with disjointed planning and poor coverage measurements and assessment found across the countries. Capacity development and active case finding (including community sensitisation) had promoted quality of services, however ***long term funding for outreach and community involvement was lacking***. Outpatient services were effective in SAM recovery; inpatient services less so, due to a number of weaknesses. Lack of harmonisation of reporting systems and poor data recording and analysis for community activities were found to affect regular and reliable nutrition information.

Additional findings were that challenges remained for: ***moving CMAM from a 'stand-alone' to an integrated programme within health ministries***, improving national supply and delivery chains, the sourcing of ongoing funding, scaling up and promoting local production of RUTF. Overall, the evaluation recommended that UNICEF continue to promote and support CMAM as a viable approach to preventing and addressing SAM, with an emphasis on prevention; through ***strengthening community outreach and integrating CMAM both into national health systems and with other interventions***.

Session D
Design and Implementation

From vertical to horizontal: Experiences & recommendations in integrating SAM treatment to the health system

ACF

Anne-Dominique Israel and Maureen Gallagher described the need to improve coverage of SAM management services by ensuring availability of and access to treatment, at all levels of the health system. ***Lessons can (and should) be learned from other large global health programme experiences targeting specific diseases***. Often these initiatives have taken a vertical approach, leading to problems with parallel treatment and reporting systems and challenges when external financing mechanisms cease. Recognising that vertical programming can actually weaken health systems, many have now moved to a more horizontal approach of health system strengthening using the 'six building blocks' approach. It was recommended that SAM treatment should move towards this, possibly taking a diagonal approach to begin with (two case studies of Nigeria and DR Congo were presented as illustrations of this diagonal approach). A number of strategic and practical implications were presented as potential positive developments of this approach. Furthermore, it was suggested that this could *help us stop being 'part of the problem' through our habit of 'siloing' nutrition and our lack of understanding of, and engagement with, the health sector.*

Sessions B, C and D
Group Work

During the afternoon, participants broke into groups and discussed two issues for each of the 'themes' of the sessions: i) research and ii) analysis and action. A series of priorities and recommendations were made, which were collated and added to the 'emerging themes'. (For more information please refer to "Emerging Themes" section at the end of the Report)

Day Two

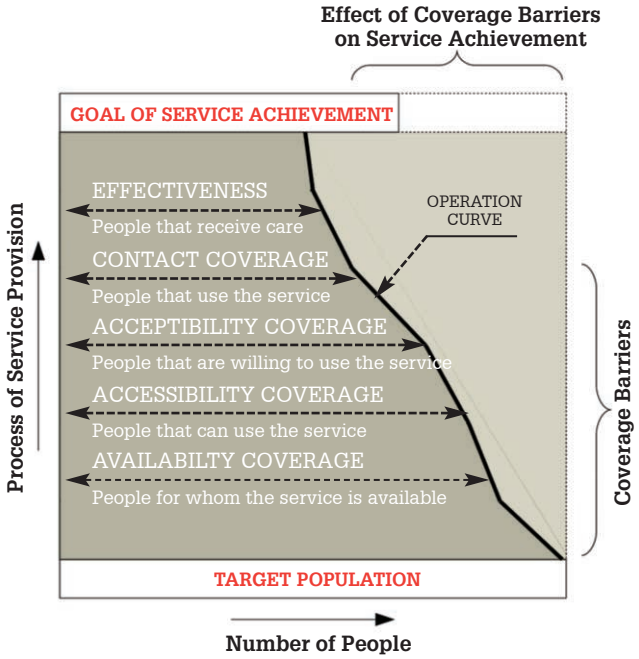
Time	
08:45	**Doors Open**
09:00 – 09:10	Welcome – Today & Learning Groups *Facilitator: Katy Murray*
09:10 – 09:30	Recap of Day One: Key Themes at an Individual & Programme Level *Facilitator: Emergency Nutrition Network (ENN)*
09:30 – 11:00	**Session E: Coverage Assessments** *Facilitator: Tanya Khara*
	Mark Myatt, BrixtonHealth (15 mins) *Coverage Assessment at the National Level*
	Jose Luis Alvarez, Coverage Monitoring Network (15 mins) *The Usual Suspects: Barriers to Access and its impact on SAM treatment coverage*
	Ernest Guevarra, Valid International (15 mins) *Using S3M to operationalize the audit cycle framework for monitoring and evaluating CMAM coverage in Ethiopia*
	Robert Johnston, UNICEF (15 mins) *Using S3M to operationalize the audit cycle framework for monitoring and evaluating CMAM coverage in EthiopiaCoverage Surveys – challenges; the current utility and usage vs routine data*
	Q & A and Learning Groups
11:00 – 11:30	**Tea & Coffee Break**
11:30 – 13:15	**Session F: Nutrition Information** *Facilitator: Katy Murray*
	Hedwig Deconinck, CMAM Forum (15 mins) *Monitoring & Evaluating the use of Nutrition Information*
	Diane Baik, World Vision (15 mins) *Development and rollout of an online system that improves CMAM program performance and operations*
	Emily Keane, Save the Children (15 mins) *Minimum Reporting Package and Use of Standardised Nutrition Indicators*
	James Hedges, UNICEF (15 mins) *National nutrition information systems – some examples and experiences*
	Q & A and Learning Groups
13:15 – 14:15	**Lunch**
14:15 – 15:15	**Working Session: Nutrition information – the strategic way forward** Priority Setting (Group Work) Aim: Identify priority areas for future action, research and analysis
15:15 – 16:00	**Review of Priority Areas** Open Forum – Remaining Issues & Considerations *Facilitator: Saul Guerrero – ACF-UK*
16:00 – 16:30	**Tea & Coffee Break**
16:30 – 17.00	**Closing Session: Where do we go from here?** Key Issues & Way Forward Final Questions/Comments Closing Words

Session E
Coverage Assessments

Presentations were made by Brixton Health, the CMN (ACF), Valid International and UNICEF. These explained the different types of coverage that can be measured, the development of a cost-effective large area coverage survey, the interesting issues when trying to overcome barriers to good programme coverage, and the importance of ensuring accurate and quality programme data to complement coverage assessment data.

Coverage Assessments at the National Level
Brixton Health

Mark Myatt explained that whilst coverage might appear a simple concept, it is actually far more complicated, largely because ***there are many different types of coverage and definitions can be confusing if they are not clearly articulated***. A useful model to assist with understanding the various types of coverage is the Tanahasi model (1978), which identifies 5 types; effectiveness, contact, acceptability, accessibility and availability.



In CMAM, the coverage that is often quoted is availability coverage (geographical coverage), although it is vital to be clear on what definitions are being used (and stated) to prevent misleading information. It could be useful to measure coverage at each level of health service hierarchy (e.g. regional, district, facility) as this could provide more detailed and diagnostic information about how successfully the programme is rolling-out at each level. If blanket measures of geographical coverage are used, it could be masking problems at one or other tier of service delivery (e.g. good coverage at district level, but problems at facility level).

Spatial mapping of geographical coverage is particularly useful, as it tends to be clearer and easier to interpret than information presented in tables. Geographical coverage represents the maximum contact coverage that a programme can achieve, although it can overestimate contact coverage (people who use the service) for various reasons. These include: use of improper numerators, improper denominators, incomplete spatial coverage of facilities and misspecification of catchment areas.

Indirect measures of contact coverage and effectiveness coverage can be used, however multiple problems arise with the calculation of 'need', as estimates tend to be imprecise and potentially inaccurate. It is therefore far superior to use direct survey methods, of which a number are now available: S3M, SLEAC and SQUEAC.

S3M provides national level data (see later presentation for more information), while SLEAC and SQUEAC utilise a small sample classification method using 3 tier LQAS indicators. In depth data on barriers and boosters can be identified and acted upon.

In summary, ***routine data can, at best, provide information on availability and possibly accessibility coverage, while S3M, SLEAC and SQUEAC can provide information on all 5 types of coverage*** identified in the Tanahasi model, at reasonable cost. Mechanisms for skills transfer (currently available in Valid and the CMN) should be articulated and implemented.

Session E
Coverage Assessments

The Usual Suspects: Barriers to Access and its impact on SAM treatment coverage
ACF-CMN

Jose Luis Álvarez described the Coverage Monitoring Network's work over the last year; ***coverage assessments have been carried out in 24 countries***, mostly in Africa (to date there has been more demand for assessments to be conducted in Africa than in South Asia). The CMN has been able to respond to all requests for surveys due to the flexible partnership ethos that makes up the network.

When collating the information from 48 coverage assessments, patterns have appeared; for example, common principal barriers to good coverage include lack of awareness of malnutrition or the programme, high opportunity costs, distance, etc. Interestingly, when these barriers are removed, others can appear, which can result in coverage remaining low. ***Coverage will not organically improve over time without proactive measures being taken***. Useful actions have been identified, such as offering detailed practical guidance, particularly for two key priority areas; improving awareness and reducing opportunity costs. NGOs can play a key role in addressing these identified priority areas.

Using S3M to operationalize the audit cycle framework for monitoring and evaluating CMAM coverage in Ethiopia
Valid International

Ernest Guevarra presented on the experience of Brixton Health, Valid and Concern Ethiopia when devising and implementing a large scale coverage survey in Ethiopia; S3M (simple, spatial, sampling method), which is an adaptation of the Centric Systematic Area Sampling (CSAS) method. ***S3M uses improved spatial sampling and more effective use of data***.

A pilot study in two zones in Ethiopia used a two-stage sampling design to test and compare the strengths of S3M over the conventional CSAS method. First stage sampling was a systematic spatial sample using triangular irregular networks to identify communities to survey. The second stage was active and adaptive case-finding to find all (or nearly all) SAM cases within the communities selected and to ascertain whether they were enrolled in the CMAM programme or not. Collection of additional indicators, such as exclusive breast feeding practices and age-appropriate dietary diversity was also conducted during the S3M survey.

The pilot study showed that CSAS provided similar results to S3M, with S3M and CSAS taking similar amounts of time and surveyors to complete, including the additional indicators. However, there was a large financial benefit from the S3M method; the survey costing approximately three times as much to implement while the area surveyed increased by 11 times. S3M provided spatial distribution applicable to a large area and a detailed map of coverage showed where more effort on programme intervention was needed. It was concluded that ***S3M is able to provide a timely and more cost effective coverage assessment at-scale, when compared to CSAS; the closest comparable spatial method available.***

Session E
Coverage Assessments

Programme Data and Coverage Surveys; Challenges to improve programming

UNICEF

Robert Johnston asserted that coverage is critical for nutrition programming but our current knowledge concerning annual national caseloads and coverage estimates is not sufficient to ensure comprehensive care for those suffering from severe acute malnutrition.

From 2010, nutrition clusters in various countries defined their own methods to calculate annual SAM caseloads, but in 2012, standardised estimates were made across the Sahel region. While this is considered best practice, it forces a standard model to be applied to countries with very different conditions. It is safe to say that the annual number of potential SAM cases cannot be accurately predicted. This is evident when Northern Nigeria reported in 2012 to have met 100% of the annual caseload of the northern states with only about 30% of geographic coverage.

The situation becomes more complex, when coverage estimates are entered into the equation. Maradi in Niger is considered to have one of the strongest management of SAM programs in sub-Saharan Africa. In 2011, there were a reported 102,500 new admissions in Maradi. The coverage estimates collected from Oct 2011 to Feb 2012 reported 24% coverage. Correcting the expected annual caseload (assuming no over-reporting) with the percent coverage gives an estimated 425,000 new cases per year. This number corresponds to 68% of the region's 6-59 month old population. While we do not know the incidence, this is impossible considering the SAM prevalence of 1.6%.

Analysis of coverage survey estimates and programme data produces irreconcilable results. There are problems with estimates of SAM prevalence, population counts and the prevalence to incidence conversion factor, but these do not sufficiently explain the problem. Coverage survey data are convincing at the village level, but can be tricky when making estimates and results should be validated whenever possible.

For coverage surveys, there are often no other results from direct methods, making validation of the estimates impossible. However, there are other estimates of infant and young child feeding (IYCF) indicators. A review of IYCF indicators collected using LQAS methods compared to results from surveys using population based sampling was presented. For exclusive breastfeeding estimates in Nigeria and Liberia, the LQAS estimates were 2-9 times higher than results from regional MICS surveys. While this may be partly explained by seasonality and other confounding issues, it cannot explain the magnitude of difference between the findings. The major lesson to be learned (and which should be applied to coverage surveys) is that sampling methods that require employment of large numbers of teams complicates training, standardisation and supervision of data collection and often lead to serious data quality issues.

To ensure the quality of coverage data, it was suggested that data quality indicators should be included as standard into survey reports, such as:

- analysis of number of identified cases by data collection points (min, max, mean, median),
- age and sex of child,
- MUAC measures,
- population size of sampling points,
- GPS validation of survey sampling points,
- results of standardization of anthropometric measures,
- validation of child in programme with demonstration of follow-up cards or RUTF, etc.

It could also be helpful to include information on the number and names of coverage survey data collectors, to facilitate development of a pool of qualified data collectors in countries.

Coverage is critical, but without quality programme data, coverage estimates are less relevant.

In most countries, we often know a great deal about the service delivery conditions without collecting coverage data. For more real-time information to adjust programming, accurate programme data is critical, for monitoring admissions and exit trends, stocks usage, validating programme operations and triangulating the quality of reported information. These data are also essential to support the integration of SAM management into regular health care delivery.

To address these data challenges, UNICEF requests the development of an improved analysis framework for better understanding of annual caseloads and programme data compared to coverage estimates. It is also important to ensure timely analysis of data to support critical programme management decisions especially prior to the hunger season.

For Coverage Surveys of large scale programmes (national or regional) it is recommended to have:

- Standardized robust and cost appropriate sampling methods
- Data collection in one month
- Standardized reporting models using globally accepted indicators and data quality measures

Session F
Nutrition Information

Presentations were given by the CMAM forum, World Vision, Save the Children UK and UNICEF. These presentations described the various systems that have been set up in attempts to standardise information gathering; in order that programmes implemented in various contexts and programme performance data can be compared in a more meaningful way. The importance of linking any information system with government run systems and encouraging of government ownership of data was highlighted.

Information on CMAM; how can we do it better?
CMAM forum

Hedwig Deconinck described the CMAM forum's role as a multi-stakeholder initiative for improved information sharing, to support quality improvement and the scale-up of the management of acute malnutrition. It has ***developed a monitoring and evaluation plan and framework to measure and improve both intermediate and long term outcomes***. The forum currently has more than 1,000 members (50% from NGOs) in 79 countries, although these are mostly drawn from the nutrition community. The main barriers identified were firstly how to identify the target audience who are not using the forum and secondly language, as less than 10% of the resources are in French.

To assess country level application of the forum, a case study was conducted in Kenya with the objective of assessing current audience, reach, usefulness and use, and to identify opportunities for improvement. Results showed limited coverage of the target audience, limited downloading of literature from the website and too narrow a focus on CMAM. Credibility was good however, and good user satisfaction was reported. Suggestions for improvement included: increased use of social media, better linkages with other websites, provision of more accessible and appealing summaries of information and to ***ensure limited duplication with other fora and resource portals to enhance collaboration and transparency.***

Experience in the development, roll-out and uptake of an online system that improves CMAM programme performance and operations
World Vision

Diane Baik presented the process that World Vision has undergone when developing an online system for CMAM reporting within the organisation. To address the problems of inaccurate reporting due to human error and staff turnover, a database was developed, with 14 countries currently utilising it. Functions include the input of monthly tally sheets, generation of reports and graphs as well as the ability to export raw data to Excel.

Along with the standard analysis of programme exits (across sites, areas or countries), ***the system allows for additional analysis, for example, correlation between programme size and outcomes***. The system has led to improved collection, accuracy and accessibility of data and has facilitated prompt feedback to field level, which has assisted with both decision making and improving programme quality. Additional features are planned to be added to the system including: tracking of RUTF consumption, data validation and components for Blanket SFP. Additionally a 'mHealth' package is under development, where mobile phones will be used to input/collect data.

Session F
Nutrition Information

Minimum Reporting Package and Use of Standardised Nutrition Indicators
Save the Children UK

Emily Keane described the inconsistencies, inadequacies and bias that were highlighted during a 2008 review of Supplementary Feeding Programmes (SFP). In response to this a 'Minimum Reporting Package' (MRP) was developed to support standardised reporting for emergency SFPs, in order to improve programme management decisions, accountability and assist the learning for improving the effectiveness of programing. The MRP tool uses Access based software and includes categories for the reporting of all tiers of acute malnutrition treatment (SAM, MAM, SC). It is currently used by 7 NGOs in 15 countries.

Analysis was conducted of SFP and OTP data collected between January 2012 and July 2013. A total of 14,995 admissions were included in the OTP analysis, from 3 NGOs, supporting 11 programmes in 8 countries (Burkina Faso, Chad, Ethiopia, Ivory Coast, India, Kenya, Somalia, and Yemen). Results showed an overall recovery rate of 80%, with 5 programmes reporting recovery rates above 90%. SFP data was analysed from 4 NGOs, supporting 10 programmes in 7 countries (Burkina Faso, Chad, Ethiopia, Ivory Coast, India, Kenya, Somalia), with 15,496 records included in the analysis. Again, performance indicators showed overall recovery rates of 87%, with 6 programmes reporting recovery rates above 90%. ***Analysis of a larger data set is planned for 2014.***

While some challenges remain (questions regarding data quality, 'bugs' with software, etc.), it was suggested that ***the MRP provides a comprehensive package for standardised monitoring of CMAM treatment in both emergency and development contexts***. It can act as a ready-made system in contexts where no other reporting system exists, or elements of the package can be incorporated to strengthen existing systems.

National Nutrition Information Systems
UNICEF

James Hedges presented on the importance of having national Nutrition Information Systems (NIS) for CMAM programmes; to help integration into national systems and to better link with preventative programmes. Components of a NIS include: situation and early warning, delivery and performance (CMAM information systems focus on the delivery and performance aspects). As of 2012, 51 UNICEF country offices reported that there was a CMAM reporting system; 34 of which are run by government.

Two country systems were used as examples: Pakistan and Vietnam. In Pakistan there are a number of issues, including lack of standardisation of information systems (different systems being used in different provinces) and problems of quality and content. In Vietnam, the reporting system was described, highlighting the complexity of reporting lines from district to province to national level. ***For any national system, the three areas of data generation, analysis and utilisation are vital elements*** that implementers must be aware of. Kenya has provided a good example of where CMAM reporting has been fully integrated into the national routine health management information system. Reviews of routine systems do not occur very frequently; therefore opportunities must be taken as they happen.

Government leadership and ownership of national systems is strongly recommended to ensure sustainability and coherence with other programmes, initiatives and sectors. However, data can be powerful and the risks of potential politicisation and manipulation of data must be recognised.

Emerging Themes

Throughout the conference, 'Emerging Themes' were documented on an interactive "Learning Wall". These themes were identified through Question and Answer sessions, active group work sessions as well as participants adding their thoughts directly on to the wall.

As the Conference progressed, the Learning Wall took more shape and was split in to 6 key areas:

1. Advocacy
2. Financing,
3. Government
4. Nutrition Information and Supply Chain,
5. Treatment and Community,
6. Access and Demand.

At the end of the conference these Emerging Themes were transformed into priority actions. Participants were asked to identify which priority actions they would be interested in taking forward, either as individuals or on behalf of their organisation.

Following the conference, an online survey was shared with all conference participants. The survey asked participants to rank each of the priority actions. A total of 54 survey responses were received. These responses were condensed in to the 17 priority areas presented in the table below. Meeting organisers agreed to continue working with interested parties in taking all High Priority actions forward and to report on progress over the next year.

Table 1

HIGH PRIORITY ACTIONS

LONDON CONFERENCE "WHAT WE KNOW NOW: A DECADE OF COMMUNITY-BASED SAM TREATMENT"

	#	Priority Actions	Who wants to be involved?
ADVOCACY	1	Develop stronger joint advocacy with health community	IMC, HelpAge, CMAM Forum, Save the Children, IRC, MSF, Concern Worldwide, Univ. of Montreal, ACF-Fr, UNICEF
	2	Advocate for the inclusion of wasting in post 2015 nutrition target/goal	World Vision, IMC, Save the Children, TdH, MoH-Namibia, Concern Worldwide, Washington University, UNICEF
	3	Advocate for the Integration of nutrition funding into health funding	DFID-Malawi, TdH, Save the Children, MoH-Namibia, IRC, MSF, IMC, Univ. of Montreal, UNICEF
	4	Advocate for higher funding for community mobilisation in AM treatment services	ACF-UK, TdH, MoH Namibia, ACF-Fr, UNICEF
	5	Develop a common nutrition stakeholders position/call on the changes needed	CMAM Forum, TdH, ENN, MoH-Namibia, IMC, Concern Worldwide, Univ. of Montreal, HelpAge, Washington University, ACF-Fr
	6	Develop and implement influencing and advocacy strategies	TdH, Save the Children, MoH-Namibia, IRC, MSF, IMC, CIFF, Concern Worldwide, Univ. of Montreal, HelpAge, ACF-Fr
FINANCING	7	Document ways/examples of reducing/optimising costs for SAM treatment at scale	Save the Children, Epicentre (S.Isanka), TdH, MoH-Namibia, IRC, Univ of Montreal, ACF-Fr, ACF-UK
GOVERNMENT	8	Integrate identification of acute malnutrition into IMCI and CIMCI	IMC, Andi Kendle, IRC (J. Bailey), Paul Binns, TdH, Save the Children, MoH-Namibia, Concern Worldwide, Univ. of Montreal, ACF-Fr, ACF-UK, HKI, UNICEF
	9	Integrate malnutrition (of children, women and other vulnerable groups) in to the national health curricula	Shirley Hinde, IMC, Help Age, TdH, MoH-Namibia, DFID Malawi, Univ of Montreal, FANTA Project, Washington University, HKI, ACF-Fr, ACF-UK, UNICEF

Emerging Themes

Table 1 Cont'd

HIGH PRIORITY ACTIONS			
LONDON CONFERENCE "WHAT WE KNOW NOW: A DECADE OF COMMUNITY-BASED SAM TREATMENT"			
	#	Priority Actions	Who wants to be involved?
NUTRITION INFORMATION & SUPPLY CHAIN	10	Improve nutrition information systems and their use for forecasting RUTF and other supply needs at national/district/facility level (e.g. mobile technology for monitoring and mapping)	World Vision, Save the Children, TdH, MoH-Namibia, MSF, UNICEF, CRS
	11	Promote the development and production of local RUTF recipes	Shirley Hinde, HelpAGE, IRC (J.Bailey), CIFF, MoH-Namibia, TdH, UNICEF (Coppenhagen), Washington University, ACF-UK, ACF-US
	12	Identify small number of key AM indicators to be integrated in to a national information system	TdH, MoH-Namibia, MSF, Univ of Montreal, ACF-Fr, ACF-UK, UNICEF
TREATMENT	13	Establish the impact of SAM treatment on stunting	Save the Children, IRC, TdH, ENN, Tanya Khara, MSF, Univ of Montreal, Epicentre, Washington University, HKI, ACF-Fr, ACF-UK, ACF-US
	14	Ensure MAM remains a central part of the acute malnutrition agenda	Save the Children, IRC, Helpage, IMC, CMAM Forum, TdH, DFID Malawi, Univ of Montreal, Washington University, HKI, ACF-UK
COMMUNITY, ACCESS AND DEMAND	15	Document lessons learned and good practices in community mobilisation, improving SAM care-seeking behaviour and develop practical guidance and resources to support its application	ACF-UK, Save the Children, Help Age, CMAM Forum, TdH, Shirley Hinde, Univ of Montreal, Anthrologica, UNICEF, CRS
	16	Document succesul experiences in the integration of CHWs into community-based SAM treatment programmes and develop practical guidance and resources to support its application	ACF-UK, TdH, Save the Children, MoH-Namibia, MSF, MSF-B, University of Montreal, HKI, World Vision, UNICEF, CRS
	17	Explore alternative service delivery models for the provision of SAM treatment beyond health facilities	MSF-B, ACF-UK, TdH, Tanya Khara, DFID Malawi, IRC, Univ of Montreal

What went unsaid?

Conference participants were given the opportunity to verbalise areas and questions that they felt had not been discussed in sufficient detail, due to time and other constraints, which are listed below:

- What are the common barriers? Those that are regularly seen across health services and initiatives as well as those that are specific to SAM management?
- The missing group at this conference was from government (only two representatives in the room). It was requested whether we could come to a common agreement; that any future meetings of this magnitude and importance include as a minimum, 20 – 30% government representatives.
- Very limited discussion of potential links with livelihoods and food security; more is required if we are serious about working with and across other sectors.
- The conference was marketed as 'what we've learned about management of SAM'; however no space was provided for discussion of RUTF and local production issues. SAM treatment is about more than the use of antibiotics, so the importance of discussing RUTF usage and production is vital. Additionally it was felt that some of the introductory remarks about RUTF market transparency were not objective.
- The conference focussed on discussion of SAM in children; it would be helpful to discuss SAM in adults, older people and other groups.
- Not enough time was allocated to discussing the 'C' of CMAM; the community aspect is vital and is often neglected; more attention is required for effective programming.
- CMAM includes treatment of MAM which was not discussed at this conference.
- Environmental enteropathy is increasingly implicated as a cause of malnutrition; discussion of this (and other WASH issues) is required.

Closing Session and wrap up
WHERE DO WE GO FROM HERE?

Saul Guerrero from ACF delivered a closing presentation, arguing that by next year, real progress needs to have been made. Accountability is a key issue; at the very least, the consolidation of agency-specific actions, particularly involving agencies that are responsible by virtue of their mandate.

Following the conference a prioritisation exercise was conducted to ensure that future investments would be targeted to the most relevant areas. Challenges do remain, however, in fostering synergy between stakeholders and ensuring that sufficient and robust information is widely shared.

Jean-Michel Grand, Chief Executive of ACF-UK, made the final closing remarks, highlighting the difficulties in keeping acute malnutrition in the spotlight and at the top of policy agendas at local, national and global levels. At the recent 'Nutrition for Growth' summit it was noticeable that only a few NGOs were actively attempting to keep CMAM on the agenda. This kind of forum is invaluable in maintaining interest, not only in the quality of services but also in the gathering of evidence and research for how to continually move forward. ACF is launching a collective campaign to promote acute malnutrition onto the agenda of the post-MDG initiatives and discourses that will be forthcoming over the next few years, in order to keep the commitment of a scaled-up quality public health intervention.

The wide range of presentations given at the conference highlighted that SAM treatment continues to evolve. Many organisations are conducting research to improve programme effectiveness, although it was emphasised that continued efforts must be made to address the community aspects to improve both access and coverage; the basic principles of the CMAM approach. The nutrition community cannot rest on its laurels; while the lives of many children have been saved through CMAM programmes, treatment services must be scaled-up even further. We must ensure that programmes become more horizontal in nature, integrating them into local health systems, with further consultation with health system experts helping to assimilate lessons learned and minimise the duplication of efforts.

The conference succeeded in its aim of creating a dynamic and fruitful debate around the past, present and future of community-based SAM treatment. The high number of participants and abstracts received suggests that formal fora for technical and strategic debate is needed, facilitating spaces where national and international nutrition and health practitioners can exchange emerging evidence and explore their implications on policy and practice. The priority actions identified during the conference also demonstrate that there is growing consensus about key areas for future research and action. The creation of more permanent spaces for debate would enable the sector to transform these priority actions into a concrete work plan and create the necessary systems to support and monitor its implementation over time.

Photos

All field photos are courtesy of Samuel Hauenstein Swan, taken at ACF programmes in West Pokot, Kenya - June 2013.

Cover: Mothers and Children waiting at OTP centre for weekly follow-up.
Page 2: Nancy, who lives in Kosholio village, brings 7 month old twins Joyline and Belinta to weekly follow up visits at ACFs OTP.
Page 4: Saul Guerrero, from Action Against Hunger, opens the first session of the conference.
Page 6: Abigail Perry delivers a presentation on Scaling Up Community Based Management of Acute Malnutrition
Page 8: ACF's community health worker traces Kiptoo at home to discuss way to get him back onto the lifesaving treatment.
Page 9: Elisabeth and her three children live in extreme poverty. After separating from her husband, she lost access to all their productive assets and now gets by with occasional work.
Page 12: Conference participants discuss key priorities and emerging themes from the various presentations in group work sessions.
Page 15: Doctor Chalis at Satori hospital examines Irene. Her MUAC was 10.5 on admission.
Page 17: Nancy gives Joyline RUFT after a long walk to the OTP centre
Page 18: Participants from the conference listen to the Nutrition Information Session
Page 19: Conference Learning Wall
page 23: At Lomut health centre a weekly Women's support group discuss ways of improving nutrition and learn about undernutrition.

Annex 1
Participants

Name	Organisation
Adele Sowinska	CRS
Aisling Daly	ACF - UK
Ali Maclaine	Save the Children UK
Amador Gomez	ACF - Spain
Andi Kendle	Independent Consultant
Andre Briend	Affiliate of the University of Tampere
Andrea Stranska	Magna
Andrew Prentice	Independent Consultant
Andrew Seal	UCL
Andy Prendergast	Barts and the London School of Medecine, Queen Mary University
Anna Kagstrom	Kings College London
Anne Bush	Independent Consultant
Anne Nesbitt	Independent Consultant
Anne Philpott	DFID
Anne Senquier	ACF - France
Anne Walsh	Valid International
Anne-Dominique Israel	ACF - France
Arine Valstar	CMAM Forum
Baljinder Heer	ACF
Basia Benda	Valid International
Ben Allen	ACF UK
Brian Ingle	Independent Consultant
Carlos Grijalva	UCL
Carmel Dolan	ENN
Caroline Abla	IMC
Casie Tesfai	International Rescue Committee
Catherine Mkangama	Save the Children
Cecile Salpeteur	ACF - France
Charlotte D'Elloy	Save the Children UK
Chelsea Coaklet	CIFF
Cinzia Lanfredi Sofia	University of Modena
Claire Harbron	CIFF
Claire Schofield	London School of Hygiene and Tropical Medicine
Colleen Emary	World Vision
Cynthia Dzingina	Independent Consultant
David Doledec	FANTA Project
Diane Baik	World Vision
Diane Holland	UNICEF
Domitille Kauffmann	FAO
Elena Rivero	ACF-Spain
Elise Becart	Nutrition Specialist
Ellie Rogers	ACF-UK
Emily Keane	Save the Children UK
Eric De Monval	ACF-France
Eric Kouam	University of Montreal
Ernest Guevarra	Valid International
Fabienne Rousseau	ACF - France
Fred Grant	HKI
Germana Comite	ACF UK
Glen Tarman	ACF - UK
Hatty Barthop	GOAL
Hedwig Deconinck	CMAM Forum
Hilde Liisa Nashandi	MoH Namibia
Hugh Lort-Phillips	ACF - UK
Ibrahim Oloriegbe	Save the Children Nigeria
Indi Trehan	University of Washington
Ioana Kornett	ACF - France
Issakha Diop	HKI
James Hedges	UNICEF
Jan Komrska	UNICEF
Jeanette Bailey	IRC
Jeremy Shoham	ENN
Jessica Bliss	PhD Student - Cornell
Jessica Meeker	IDS
Joan Wilson	British Red Cross
Jose Luis Alvarez	ACF - UK
Josephine Ippe	GNC
Judith Haase	World Vision
Juliet Bedford	Anthrologica
Karine Gatellier	IDS
Kat Pirrore	Results UK
Kate Godden	University of Westminster
Kate Golden	Concern
Kate Sadler	Valid International
Katherine Slee	ACF-UK
Katja Siling	Valid International
Katrina Mowbury	ACF-UK
Krishna Belbase	UNICEF
Kristine Albrektsen	Valid International
Lauren Vail	Kings College London
Lovely Amin	CMN RECO
Lydia Wisner	Save the Children UK
Mariacristina Armellin	World Vision
Mariana Merelo	ACF UK
Marijke Rittmann	MoH Namibia
Mark Myatt	Brixton Health
Matt Kletzing	ACF - UK
Maureen Gallagher	ACF - USA Senior Nutrition Advisor
Meredith Dyson	CRS
Meredith Stakem	Catholic Relief Services
Micheal Blaize	ACF - UK
Michelle Gibs	Surrey University
Miltos Ladikas	University of Central Lancashire
Morwenna Sullivan	ACF - UK
Moses Cowan	ACF - Sierra Leone
Nalini Tarakeshwar	CIFF
Nell Grey	Anthrologica
Nick Stanton	IMC
Nickki Connell	Goal
Nicky Dent	CMAM Forum
Nicole Henretty	Edesia Global Nutrition Solutions
Nuria Salse	MSF - Spain
Ojaswi Acharya	ACF - Nepal
Omoyemi Adegboye	PhD Student - Manchester Metripolitan
Paluku Bahwere	Valid International
Paola Vargas	CIFF
Pascale Delchevalerie	MSF Brussels
Pascale Fritsch	Help Age
Patrick Codija	UNICEF
Patrizia Fracassi	SUN Movement
Paul Binns	Valid International
Paul Boyreau	ACF - France
Paul Gunaratnam	CIFF
Pedro Barra	Kingston University
Phil James	Valid International
Rachel Lozano	ACF - France
Raman Mahajan	MSF - Delhi
Rebecca Aikman	Valid International
Rebecca Brown	CMAM Forum
Regine Kopplow	Concern
Rob Hughes	DFID
Robert Johnston	UNICEF
Rowena Fox	ACF-UK
Ruth Mwandira	DFID Malawi
Sabah Barigou	ECHO
Sabrina de Souza	Results UK
Safari Balegamire	Valid International
Samuel Hauenstein Swan	ACF - UK
Sarah Butler	Save the Children
Saskia Van Der Kam	MSF - Amsterdam
Saul Guerrero	ACF - UK
Sheila Isanaka	MSF
Shirley Hinde	Cardiff Metropolitan


time of treatment
Money
Children
Road
Distance

COVERAGE MONITORING NETWORK

ACF INTERNATIONAL · Save the Children · CONCERN worldwide · International Medical Corps · Helen Keller INTERNATIONAL · VALID

unicef · World Vision · CMAM Forum

Wth support from

European Commission · USAID FROM THE AMERICAN PEOPLE