

UNICEF

MANAGEMENT OF SEVERE ACUTE MALNUTRITION

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Outline

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3. Achievements
4. Challenges
5. Strategic Priorities

Key Facts

Severe Acute Malnutrition



- ❑ Nearly 24 million children under five worldwide suffer from Severe Acute Malnutrition (SAM)
- ❑ The vast majority are located in Africa and Asia (8 million are in India alone).
- ❑ A child with SAM is nine times more likely to die than a well nourished child
- ❑ SAM is one of the top three nutrition related causes of death in children under five
- ❑ Estimates of deaths directly attributable to severe acute malnutrition varied from 0.5 million to 2 million annually*

If the MDGs of reducing children mortality and malnutrition by 50 % by 2015 are to be met, SAM needs to be addressed seriously

* Bhutta Z. Treating acute malnutrition where it matters. Lancet 2009.

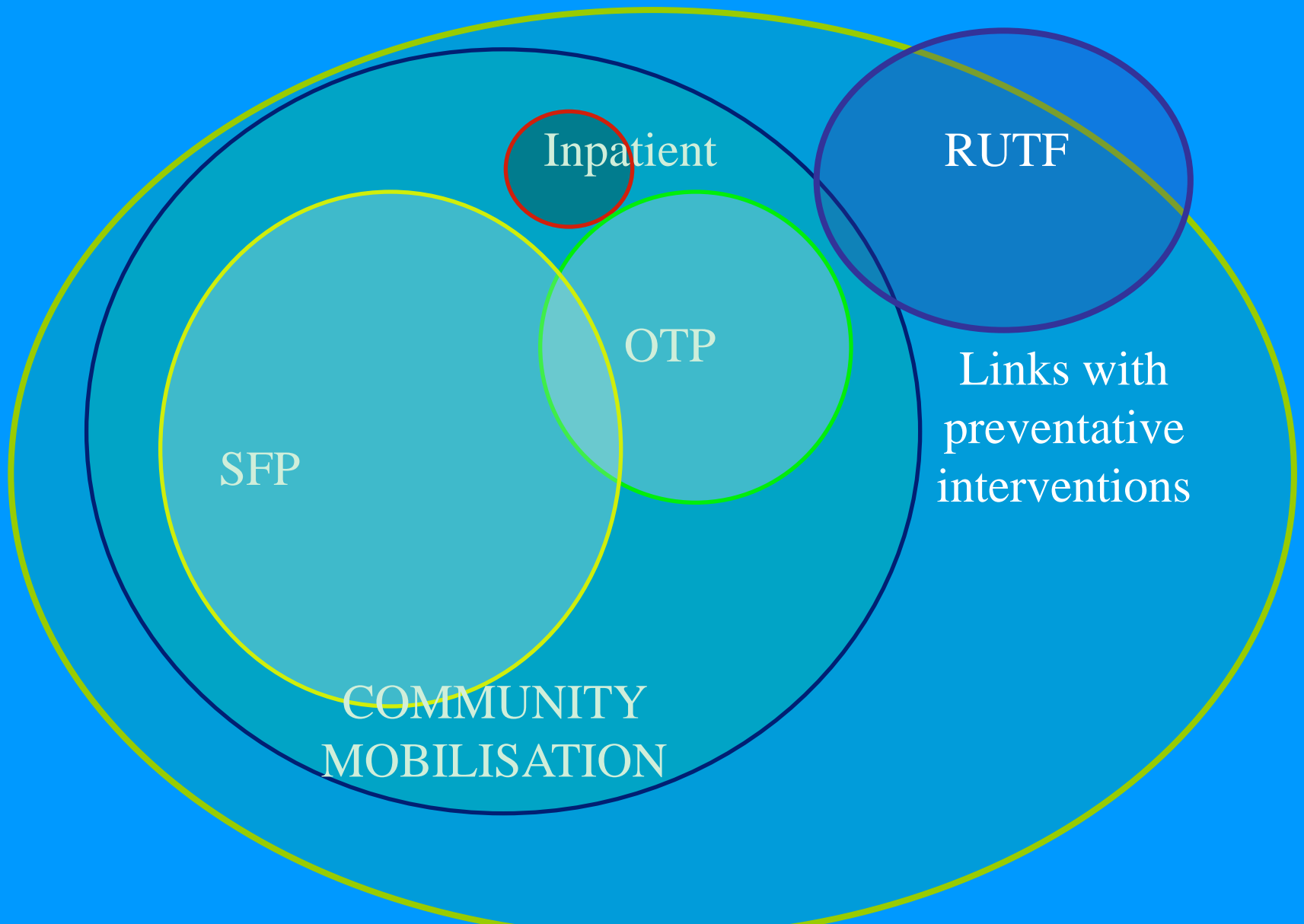
UNICEF Response

Address Severe Acute Malnutrition

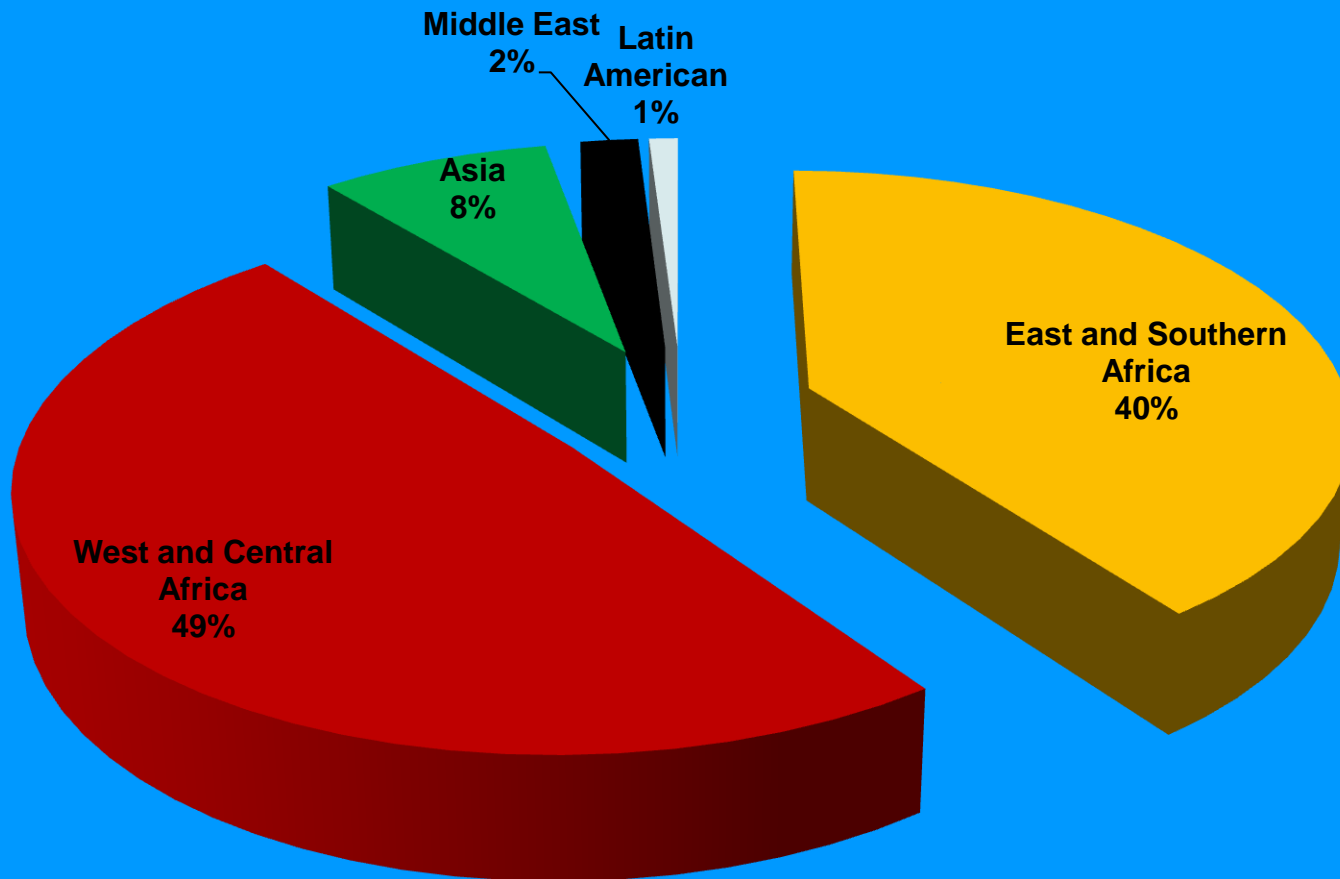
- ❑ Support countries with high levels of SAM to scale-up coverage for treatment through Community-Based Management of Acute Malnutrition (CMAM)
- ❑ Preventing acute malnutrition in children and women through increasing coverage of high impact interventions (e.g. IYCN, micronutrients)



CMAM Approach



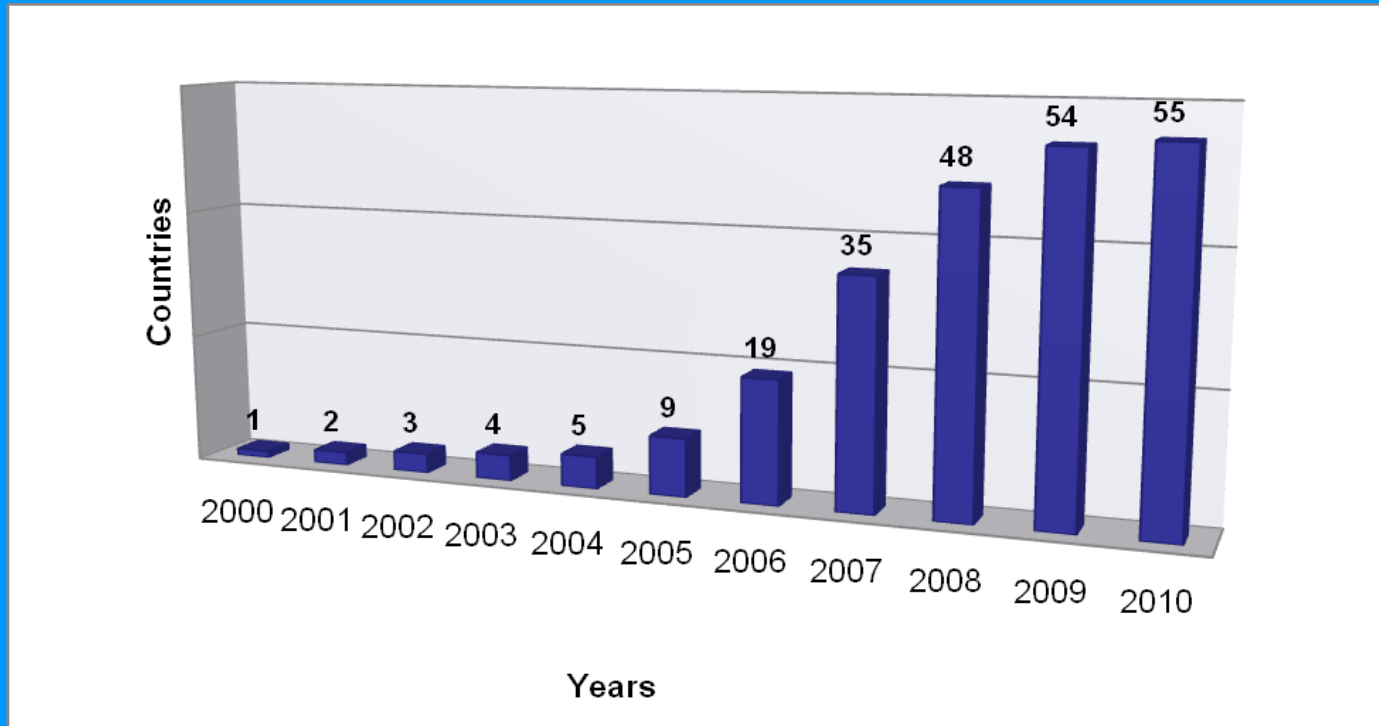
CMAM Programmes by Regions



Scale-up of Management of SAM

- ❑ Support setting up of integrated facility- and community-based management of SAM . Important actors in this effort are MSF and Valid International.
- ❑ Support development of integrate monitoring and evaluation systems to track progress (Monitor coverage, assess potential impact, identify supply & logistics)
- ❑ Provide global guidelines and support capacity development plans at regional and country level. This includes the development of training resources.
- ❑ Forecasting tool and provision of commodities for both facility (F-75/F-100) and community-based management (RUTF). UNICEF provides at least 80% RUTF in 70% of countries; 100% in 43% countries.
- ❑ Clinton Health Access Initiative -CHAI is a major donor for supplies in several countries (100% in Botswana, Namibia, Swaziland; 99% in Mozambique) and UNITAID is the key donor in Zambia.
- ❑ Support resource mobilization and alternative options for in kind donation of RUTF.

Progress CMAM Programmes Coverage



- ❑ Greatest focus is in countries with acute malnutrition rates $> 10\%$
- ❑ Despite of the tremendous effort and progress **only 10% of these children are reached**

Achievements (1)

Policy

- ☐ Policy formulation at country level, 95% countries have national guidelines/protocols for acute malnutrition
- ☐ Visible policy documents and joint statements

Coverage

- ☐ Rapid scale-up of programming, 55 countries implementing CMAM, 7 planning

Integration

- ☐ Progress in at least 50% to integrate CMAM with other primary health activities: IMCI, IYCF, HIV/AIDS
- ☐ Increasing adherence to a comprehensive integrated approach into health systems

Achievements (2)

Capacity Development

- ❑ Global guidelines and training resources available including incorporation of infant feeding orientation into trainings
- ❑ Collaboration on joint trainings WHO, UNICEF, UNHCR, FANTA and on support for planning and scaling up
- ❑ First Phase (regional) of the capacity development strategy for Nutrition in Emergencies completed in 6 regions
- ❑ E-learning training course available in English ,Spanish and French
- ❑ GLOBAL CMAM MAPPING country activities, capacity, supply planning, forecasting tool (2011)

Achievements (3)

MAM - Partnership WHO, UNHCR, UNICEF and WFP

- ☐ To improve overall policy and evidence-based programme guidance on management of moderate malnutrition, with specific emphasis on children with moderate wasting
- ☐ To identify knowledge gaps that should be addressed by research both in the area of dietary management and the modalities for providing that diet

Supplies and logistic

- ☐ Consolidated procurement system supporting a large scale supply distribution at global level
- ☐ Bringing manufacturing capacity closer to the final beneficiaries
- ☐ Adoption of country forecasting tool to improve supply planning
- ☐ Expand network of suppliers: UNICEF and partners (MSF, Clinton foundation) encourage more international suppliers and quality local production (Map)

RUTF Suppliers in 2012



← Global suppliers(12) ★ Local suppliers (8) ✕ Hub (stock pre-positioning)

Challenges (1)

Political Commitment

- ❑ Nutrition is often a low priority on the political agenda resulting in minimum or no budget allocation
- ❑ Weak service delivery system, particularly in hard to reach areas.
- ❑ Political resistance of some governments to use imported RUTF e.g. India
- ❑ SAM not always recognized as problem (not identified in surveillance systems).

Technical /programmatic Capacities

- ❑ Inadequate quality of CMAM program
- ❑ Lack of skills to ensure the deliver of a comprehensive package of services in emergencies (CMAM,IYCF and micronutrients).
- ❑ Poor information and reporting systems

Challenges (2)

Inter-sectoral linkages

- ❑ Link with food security and other sectors: Need for long-term solutions to prevent short-term emergencies

Funding

- ❑ Unpredictable funding – large proportion still from humanitarian response for acute emergencies averting multi year planning
- ❑ Difficulties in setting up long term supply plans to ensure that RUTF needs are met

Supply

- ❑ Long lead-time :Geographical distance of manufacturers from the final beneficiaries
- ❑ Proliferation of suppliers with poor quality control systems .
- ❑ Lack of buffer stocks of supplies

Challenges (3)

Key findings CMAM Mapping: Information gaps & constraints in CMAM data collection system

- Wide diversity of reporting systems, often complex
- Lack of harmonisation of templates/data collection in same country
- No systematic collection of information, limited database
- Global UNICEF (childinfo) databases do not include oedema or MUAC when estimating SAM prevalence
- Deficient information flow from field to national level
- Lack of consistency in the use of NCHS and WHO, reference standards
- Significant information gap on caseload data, performance indicators, country reports. Poor data quality.
- Reliance on short term or emergency funding delays /disrupts scale up
- Lack of standard guidance e.g. indicators, method of calculation of service provision and coverage
- Terminology confusion

Strategic Priorities

Information System

- ❑ Develop a Global Information System to track progress of CMAM programme
- ❑ Address information gaps & constraints in CMAM data collection system
- ❑ Support countries to measure Service Delivery & Coverage
- ❑ Develop a new simpler coverage monitoring methods to be integrated into national programmes

Capacity Development

- ❑ Promote and support development of capacity at Regional and Country Level and strengthen surge capacity for emergency response

Preparedness

- ❑ Incorporate Disaster Risk Reduction (DDR) focus/ contingency planning in to programming. Specially in protracted emergencies (Sahel/ Horn of Africa)

Strategic Priorities

Scale-up

- ❑ Strengthen Global partnership to scale up CMAM programmes at country level.
- ❑ Support resource mobilization for programme scale-up and effectiveness
- ❑ Increase countries adoption of WHO growth standards.
- ❑ Increase the integration of CMAM and key child survival programmes
- ❑ Develop/ produce evidences to advocate for prevention and treatment of SAM in countries with high prevalence of stunting .

Prevention

- ❑ Coordinate with partners to develop evidences through operational research on improved approaches to treat moderate acute malnutrition. Development of specifications for new products to respond to treatment MAM.
- ❑ New approach : Combined development and “humanitarian” programming on protecting and promoting **livelihoods** taking into consideration the vulnerability of the populations in line with DRR approach.



Thank you