Managing Malnutrition and Emergencies response programmes overview

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1. Key Facts
2. UNICEF Response
3. Achievements
4. Challenges
5. Way Forward
Nearly 24 million children under five worldwide suffer from Severe Acute Malnutrition (SAM)
The vast majority live in Africa and Asia (8 million are in India).
The risk of mortality is 9 times higher than a well nourished child.
This risk increases with diarrhea to 12.5 times, pneumonia 8.09 times and malaria 9.49 times (Caulfield et al, American Journal of Clinical Nutrition, 2004).
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*
Key Facts: Changing World

- Increase frequency and intensity of natural disasters: 100 (1975) to 321 (2008)
- Tripling in number of people affected by natural disasters.
- 7 out of every 10 of these disasters are climate-related food insecurity and nutrition crisis.
- Conflicts more protracted leading to complex emergency situation (HoA)
- Countries in transition, fragile peace
- Most affected are vulnerable groups (women and children).

Source: ISDR
Key Fact: Rates of Severe Acute Malnutrition in Children increase in Emergencies.

Non-Emergency
Capacity to manage severe acute malnutrition strengthened in ongoing health and nutrition programs within existing health system.
Community based prevention nutrition programs. SAM identified in GM and screening through MUAC.

Emergency Levels
GAM and SAM above seasonal norms
(Exceed MoH capacity)
Facilitate MOH to cope with increased numbers (in-country rapid response).

Post emergency
High numbers reducing MoH resumes normal programming within existing health system.
Link outpatient and inpatient care with health/nutrition community based programming.
CMAM approach has evolved from an emergency response intervention to a key child survival intervention integrated to health systems.

Scaling Up Nutrition (SUN) strategy highlights treatment of SAM with Ready to Use Therapeutic Food (RUTF) as one of the key direct nutrition interventions to contribute to the achievement of MDG1.

CMAM is critical to tackling the problem of child malnutrition and therefore increasing coverage is a major priority.
Community-based Management of Acute Malnutrition (CMAM)

- SFP
- OTP
- Inpatient
- RUTF

Links with preventative interventions
CMAM APPROACH - UN Agencies share responsibilities

Acute malnutrition

Severe acute Malnutrition-SAM with complications*

Severe acute Malnutrition-SAM

Moderate acute Malnutrition- MAM

Inpatient Care

Outpatient Care

Supplementary Feeding

WHO

UNICEF

WFP

ADRESSING SAM

REDUCE MORTALITY

ADRESSING MAM

REDUCE SAM
UNICEF

Programmes:

1. CMAM

Support countries with high levels of SAM to scale-up coverage for treatment through Community-Based Management of Acute Malnutrition (CMAM).

Achievements.

But still very low Coverage: only around 10%
Rapid scale-up of programming, 55 countries implementing CMAM, 7 planning

Support development of integrate monitoring and evaluation systems to track progress (Monitor coverage, assess potential impact, identify supply & logistics

- GLOBAL CMAM MAPPING- Valid International- programme information, country activities, policy, financing & coordination, training / capacity development, drugs & therapeutic supplies, caseload, prevalence & coverage, performance indicators, constraints & recommendations
- Greatest focus is in countries with acute malnutrition rates > 10%
- Despite of the tremendous effort and progress only 10% of these children are reached
CMAM programmes: 2000-2010

- Planned: Cambodia, Lao PDR, Mongolia, India, Iraq, South Africa,
- Ethiopia, Sudan Juba, Sudan Khartoum, Malawi, Uganda, Zambia, Haiti, Niger, Bangladesh

Year:
- 2000
- 2001
- 2002
- 2003
- 2004
- 2005
- 2006
- 2007
- 2008
- 2009
- 2010

Number of countries:
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18

46 programmes
East and Southern Africa 40%
West and Central Africa 49%
Asia 8%
Middle East 2%
Latin American 1%
Achievements (2).

Policy

- Provide global guidelines and support capacity development plans at regional and country level. This includes the development of training resources.

- Visible policy documents and joint statements (WHO/UNICEF), 95% countries have national guidelines/protocols for acute malnutrition.

- Support setting up of integrated facility- and community-based management of SAM. (MSF, Valid International and Ngo partners)

Integration / sustainability

- 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 (3)

**Capacity Development**

- Training resources available including incorporation of infant feeding

- 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
Achievements (3).

**Supplies and logistic**

- Consolidated procurement system supporting a large scale supply distribution at global level
- Bringing manufacturing capacity closer to the final beneficiaries
- Introduction of a 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.
- Alternative options for in kind donation of RUTF.
Local suppliers (8)
Global suppliers (12)
Hub (stock pre-positioning)
UNICEF

Programmes:

EMERGENCIES

acute and protracted
Protect nutritional status of vulnerable and deprived populations affected by emergencies is essential to prevent acute malnutrition, micronutrient deficiencies, disease and death.

Support countries affected by humanitarian crisis to ensure an effective and predictable response in line with the CCCs.

- Ensure monitoring of the situation of children and women
- Respond in defined programme sectors where resources and partners allow
- Advocate with governments and partners to ensure that benchmarks are achieved
- Ensure minimum preparedness in defined in programme sectors and within UNICEF
What are the CCCs?

UNICEF’s core humanitarian policy to uphold the rights of children affected by humanitarian crisis.

Promote predictable, effective and timely collective humanitarian action.

A framework based on norms and standards, around which UNICEF seeks to engage with partners.
What are the Nutrition commitments?

For COs in humanitarian situations:
1. Review each Commitment and related benchmark
2. Determine if Nutrition programme needs to be adjusted with Response and Early Recovery Actions
3. Determine challenges to be resolved and next steps to integrate in Nutrition programme (AWPs)

For COs not in humanitarian situations:
1. Review each Commitment and related benchmark
2. Determine what Preparedness Actions need to be implemented (for interagency coordination mechanisms and UNICEF programmes)
3. Determine challenges to be resolved and next steps to integrate in Nutrition programme (AWPs)
How does UNICEF fund the CCCs in response?

- Reprogram Regular Resources within the country programme budget, or reprogram Other Resources;
- Request internal loan – Emergency Programme Fund
- Apply to CERF (UN Central Emergency Response Fund)
- Appeals – IND (Immediate Need Document), Flash
- CAP (inter-agency) and HAR (UNICEF)
Challenges to scale up CMAM (1)

**Information System**

- Lack of strong, up-to-date reliable global, regional and country data to monitor the quality and scale of programmes, to identify best practices and capacity gaps.

**Political Commitment**

- Limited understanding of SAM as public health problem: No SAM indicators in Surveillance Systems and HMIS. IMCI no anthropometric indicator for SAM (only visible wasting)
- Weak service delivery system, particularly in hard to reach areas.
- Political resistance of some governments to use imported RUTF e.g. India
- Constraints in operating environments. (eg. Somalia).
- Difficulties in evolving from treatment approach to wider preventative interventions
Operational Integration of CMAM Components

- Limited inpatient care deliver wide-scale benefits: Low coverage of cases <10% (30% even in best emergency programmes) due to poor access and high opportunity costs, High default rates and late presentation of cases leading to high CFRs in hospitals (20-30%).

- Limited capacity to deliver coordinated Supplementary Feeding Programmes when required and agreed WFP phase out strategies.

Inter-sectoral linkages

- Missing link with food security and other sectors: Need for mid & long-term contingency planning to reduce the impact of short-term emergencies on children nutritional status
Challenges to scale up CMAM (3)

Technical /programmatic Capacities

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

Funding

- Unpredictable funding – large proportion still from humanitarian response for acute emergencies averting multi year planning.
- Donors lack of flexibility to support programmes beyond the emergency response.

Supply

- Long lead-time: Geographical distance of manufacturers from the final beneficiaries
- Proliferation of suppliers with poor quality control systems.
- Difficulties in setting up long term supply plans to ensure that RUTF needs are met.
- Lack of buffer stocks of supplies
Way Forward

**Information System**
- Develop a Global Information System to track progress of CMAM programme
- Address information gaps & constraints in CMAM data collection system
- 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
- Strengthen surge capacity for emergency response
- Integration of training in the approach into national and international health worker training curricula

**Preparedness**
- Incorporate Disaster Risk Reduction (DDR) focus/ contingency planning into programming. Specially in protracted emergencies (Sahel/Horn of Africa)
**Way Forward**

**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**
- Support prevention of SAM though improved approaches to treat moderate acute malnutrition.
- Expand the component of management of SAM integrating key follow up components.
- Participate in the development of a new joint intersectoral approach to address food and nutrition security in protracted emergencies in line with DRR.
Thank you