CMAM 2021
22-25 March
VIRTUAL CONFERENCE

CONCERN worldwide
Irish Aid
An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

Summary of workshop outcomes so far…. Day 4

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What the conference set out to do:

Focusing on:

scale up* of services for the management of *wasting* *in fragile contexts

Identify/ agree:

1. **Key barriers and enablers** to scaling up
2. **Practical considerations** for scaling up **new adaptations**
3. **Priority actions to address barriers** to scale up
4. **Advocacy priorities and upcoming opportunities** to support scale-up

Where we are now?

THE CMAM PROMISE
20 years ago CMAM promised access, scale, coverage

COVERAGE
Still far too low

COMMUNITY
Put ‘C’ back in CMAM.
Medical & technical issues eclipsing community engagement

SIMPLIFY
Needed for scale
The ideal/ perfect is often the enemy of the good!

REDUCE RUTF COST
Unlock the competition
Cost-efficient local production & plant based recipes
Gather more evidence on new formulas & costs

ADAPTATIONS – WELL ADVANCED
Family MUAC is ready to go
Others - huge potential for coverage but implications
Some need more operational piloting before scale

ROLE OF GOVERNMENT
Harmonising approaches and evidence (often of NGOs)
Ownership means allocating some resources

PREVENTION OF MALNUTRITION
Essential to ‘stem the flow’ of new cases
But treatment still needed: integrate the nutrition package

COVID
Spurred innovation/ adaptation, what next?

FINANCING
We need more funds
We need more efficiency
We need to focus on what is ‘mission critical’

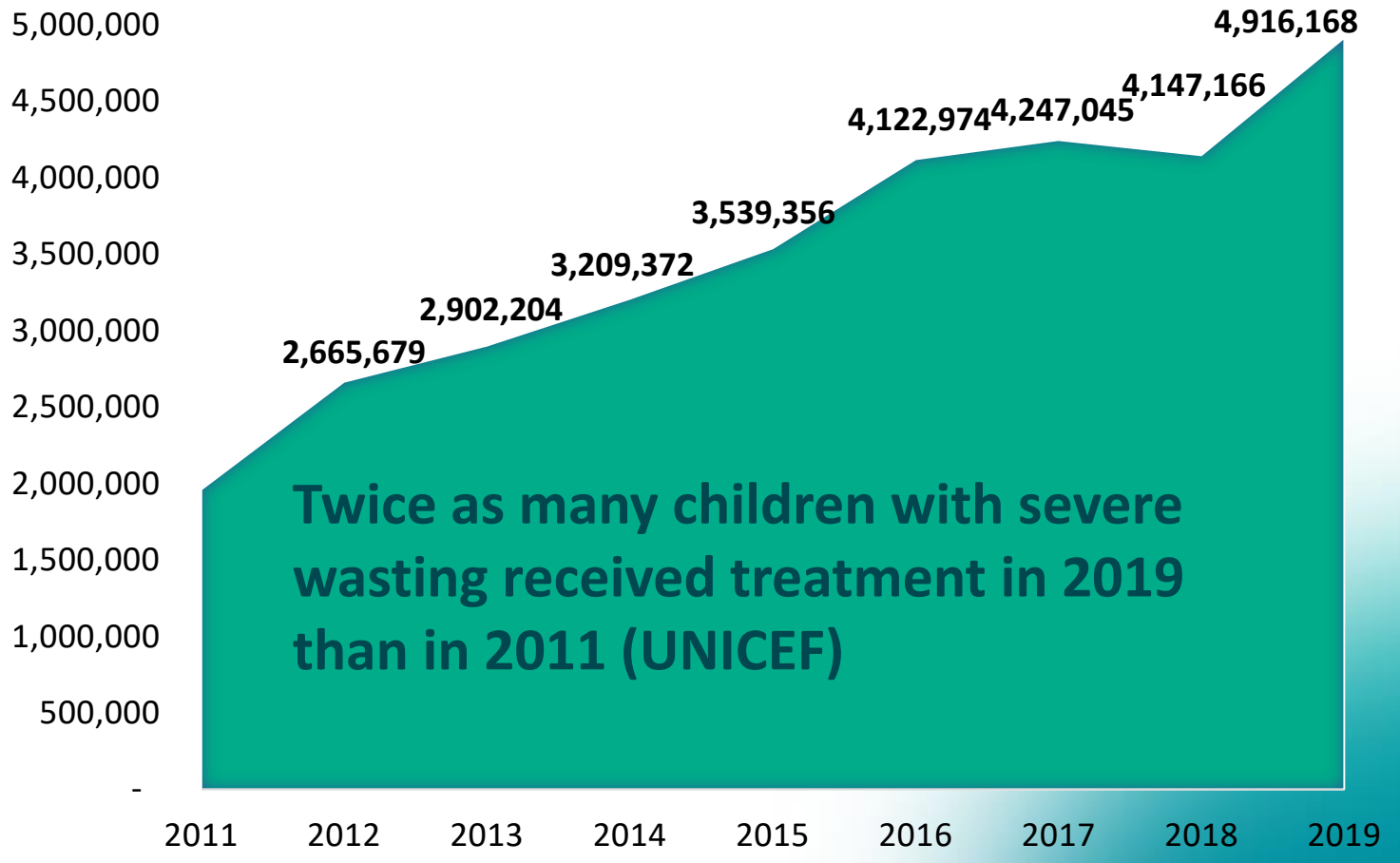
Progress on scale up

Coverage has improved:
10 fold increase since 2000

But ~80% of wasted children are *still not* reached

70 countries now have CMAM in their national policies

But many barriers remain to policies in practice & integrate wasting treatment into routine health services



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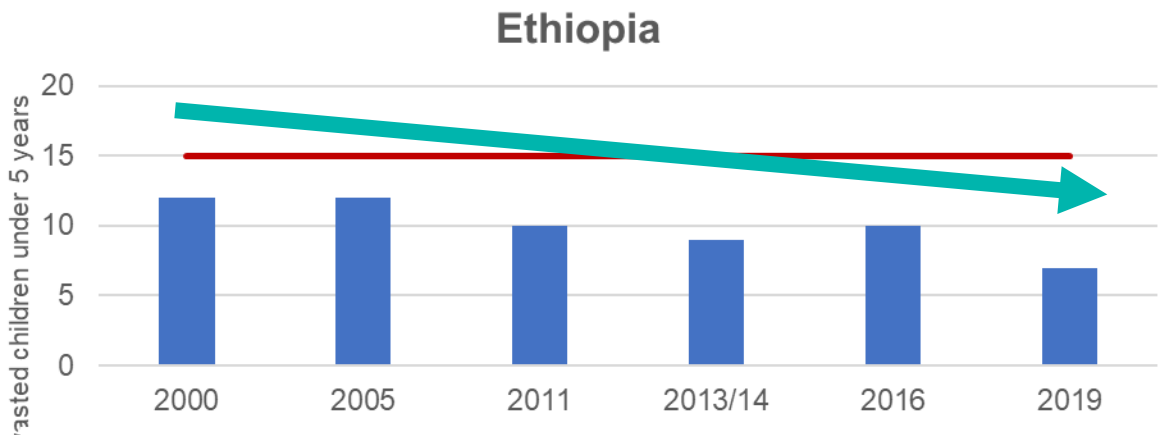
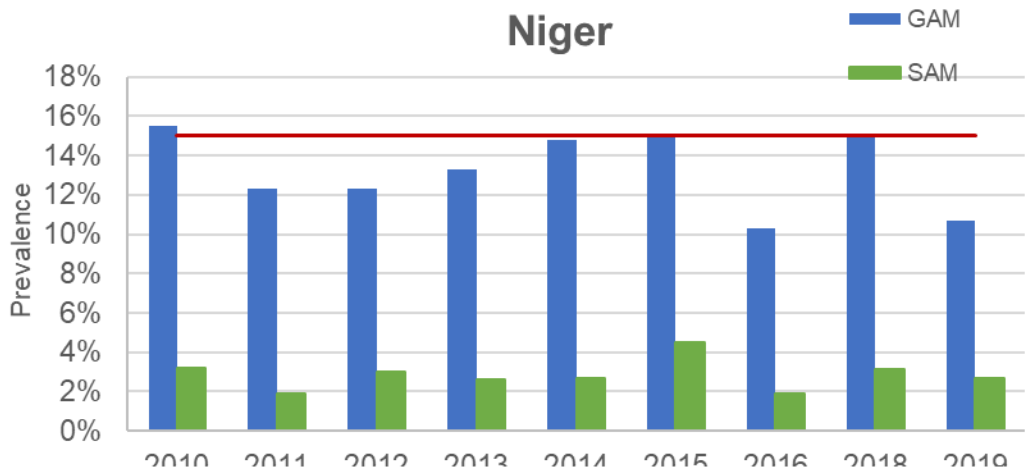
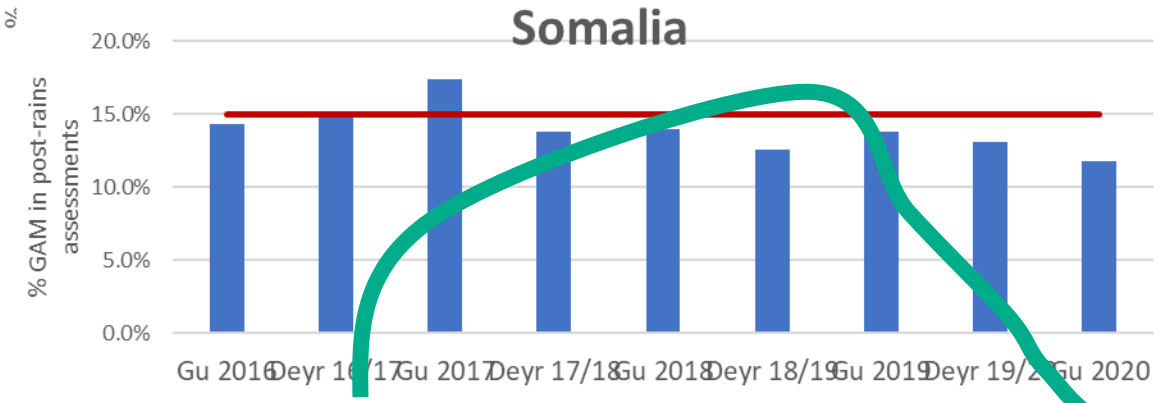
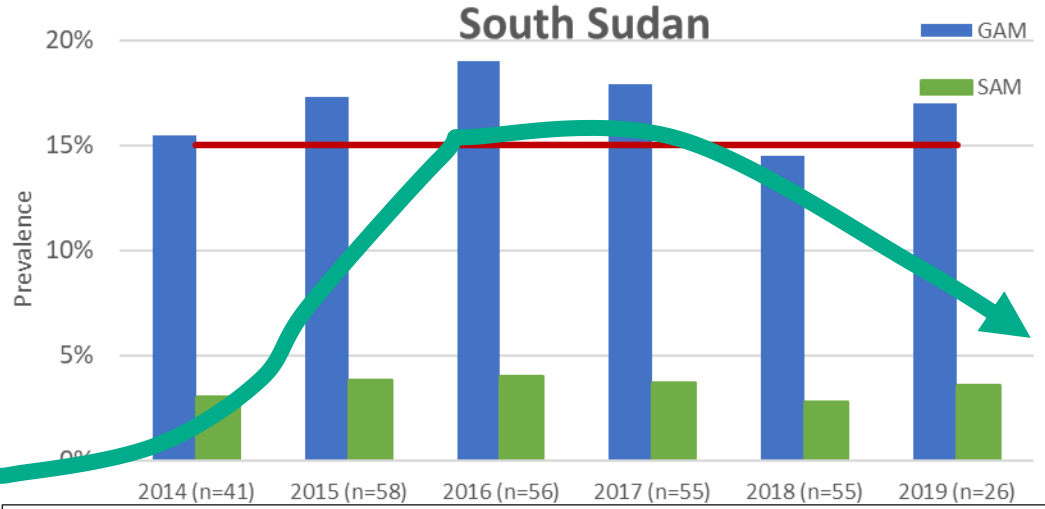
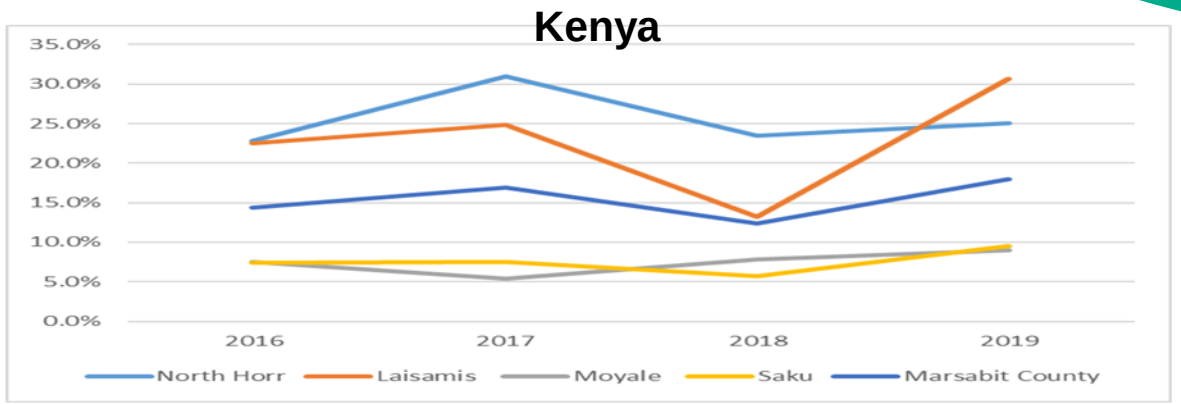
Progress: prevalence of wasting in 6 of our case study countries

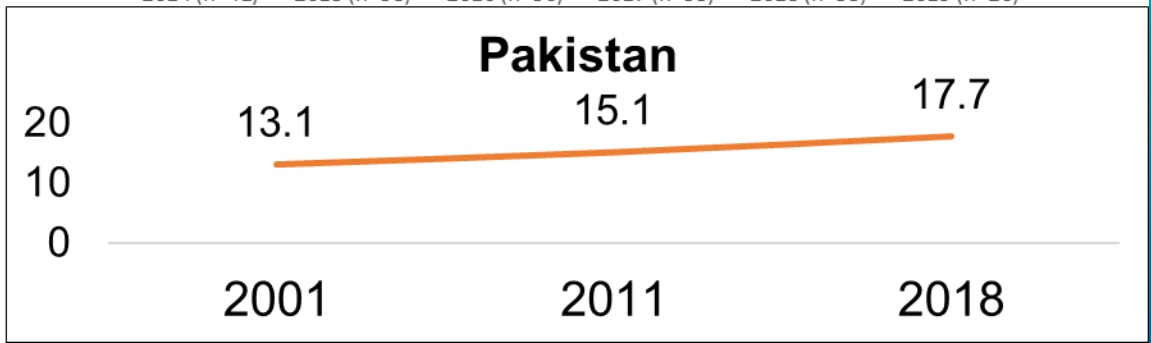




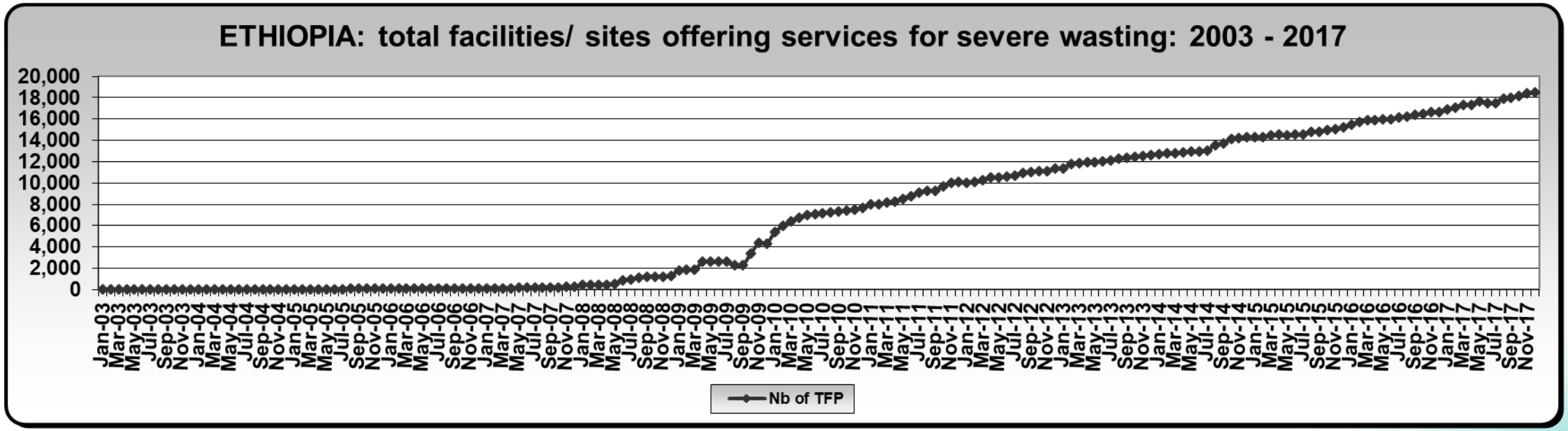


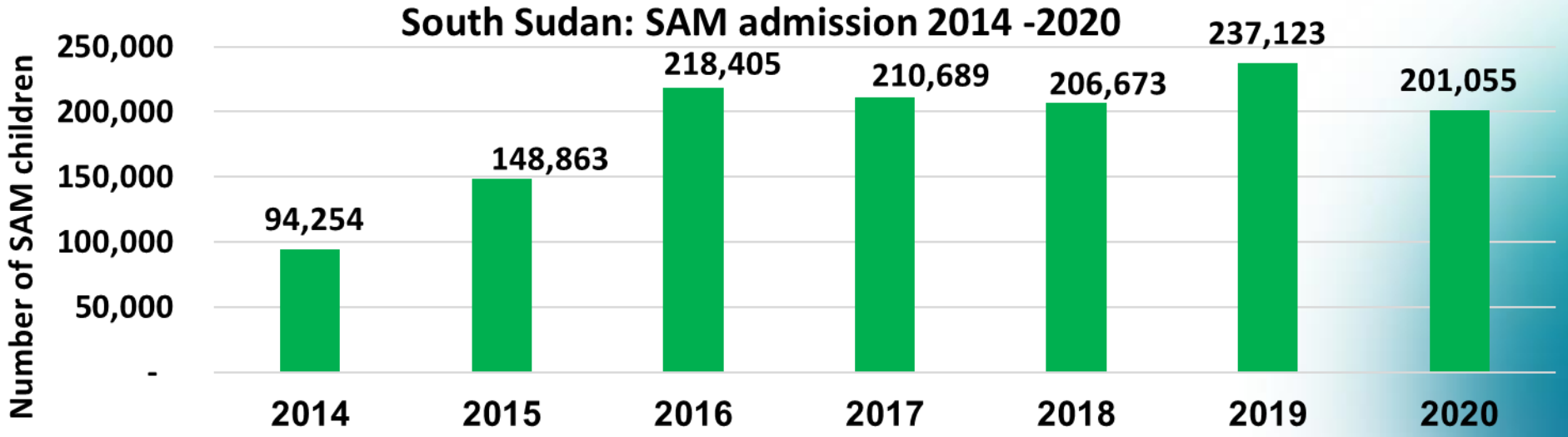






But treating more children: Ethiopia and South Sudan





Barriers

Finance

- Not enough funds, especially for moderate caseload
- Often still rely on short term emergency funds/ NGOs

Supply chains

- Better where UNICEF/ WFP supporting heavily but not sustainable
- Cost of RUTF
- Delivery of RUTF

Limited service reach in vast, difficult, often insecure terrains

Community Health Workers

- Not formalised, overburdened
- Need a living wage and a sustainable funding strategy and policy

Health facility workforce

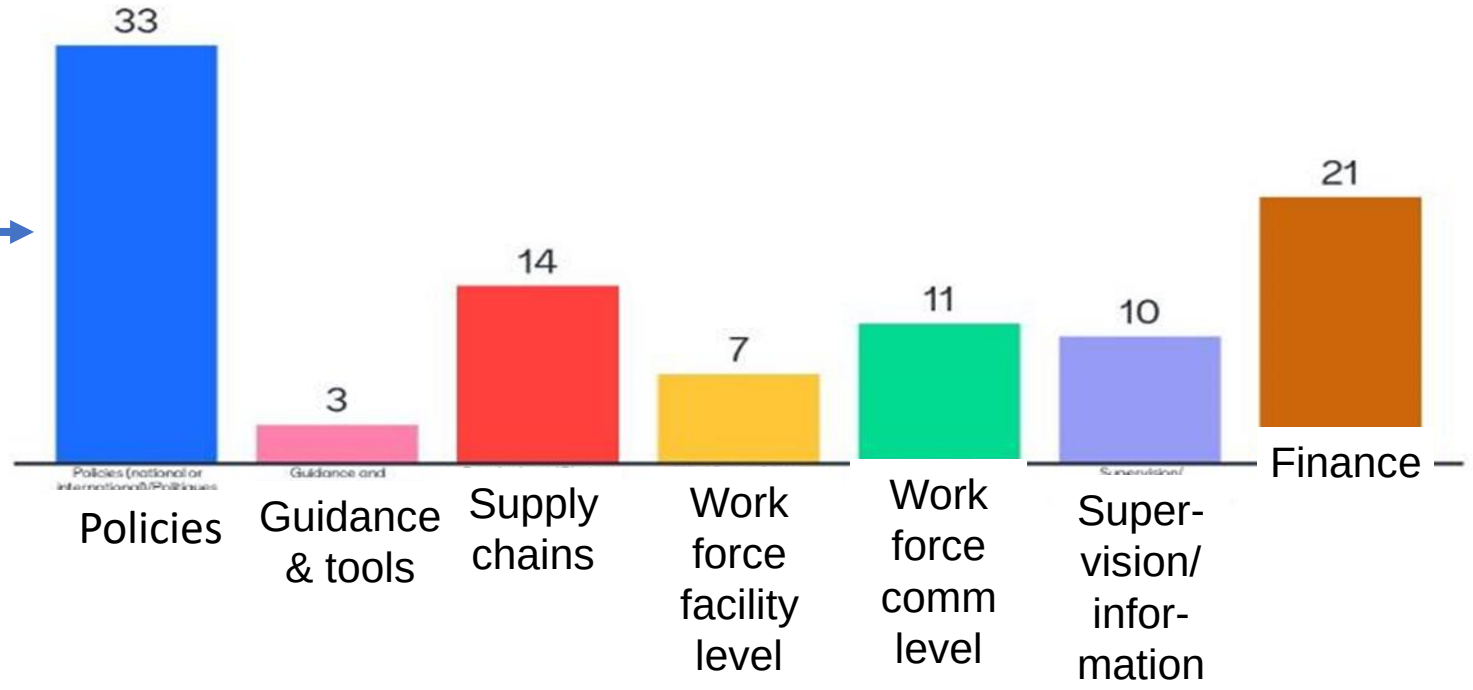
- Overburdened, especially in hardest to reach areas
- No coordinated pre-service training on severe wasting in many countries

Where do you think the biggest barriers to scaling up services for the management of severe wasting still exist in fragile contexts?

Mentimeter

99 respondents

Implementation of policy



Enablers in brief

Building block	Key enablers	Best practice from case studies
Leadership & governance	**Position severe wasting management** within national *and sub-national* agendas & policies	Kenya- one of the 'big 4' priorities Pakistan – at the centre of National Stunting Reduction strategy
	Help **Maternal and Child Health departments 'own' wasting services** and to see the value of integrating them.	Most countries have integrated wasting into essential health package but ownership still lacking
	Strong nutrition coordination at national *and sub-national level*, with MoH leading	Kenya – very strong at County level Somalia – finally moved coordination into Somalia from Kenya

Enablers in brief

Building Block	Key enablers	Best practice from case studies
Health workforce	**Community health workers:** • Adequately budgeted for • Appropriately valued and remunerated • Functioning referral systems	– Mali – with ICCM+ – Kenya –decentralising budget & management of CHWs to Counties
Service delivery	**Integrate severe wasting into community health activity/ platforms**	– Niger – integrate MUAC screening into annual national malaria campaigns – huge numbers
	Anticipate fluctuating caseloads throughout the year via nutrition surveillance and facility data	– Kenya & Niger – CMAM/ IMAM Surge – Somalia does FSNAU
Information	**Include wasting data into existing health information systems**, including e-health platforms	Kenya, Niger, Ethiopia integrated Pakistan currenting integration into HMIS

Enablers in brief

	Key enablers	Best practice
Financing	**Accurate forecasting** – involve health specialists and nutritionists in national and sub-national costing exercises	??
	Look for longer term funding / innovative financing for health with wasting services embedded	??
Supplies	**New RUTF recipes** - alternative protein sources and locally available ingredients can reduce costs	Valid Nutrition has results for soya-maize-sorghum recipe in Malawi
	Local production of RUTF	Pakistan is
	Inclusion of RUTF in essential medicines list Better forecasting of demand	Most of the governments presenting

2. Adaptations:

practical considerations

& readiness for scale

Implications & readiness to scale

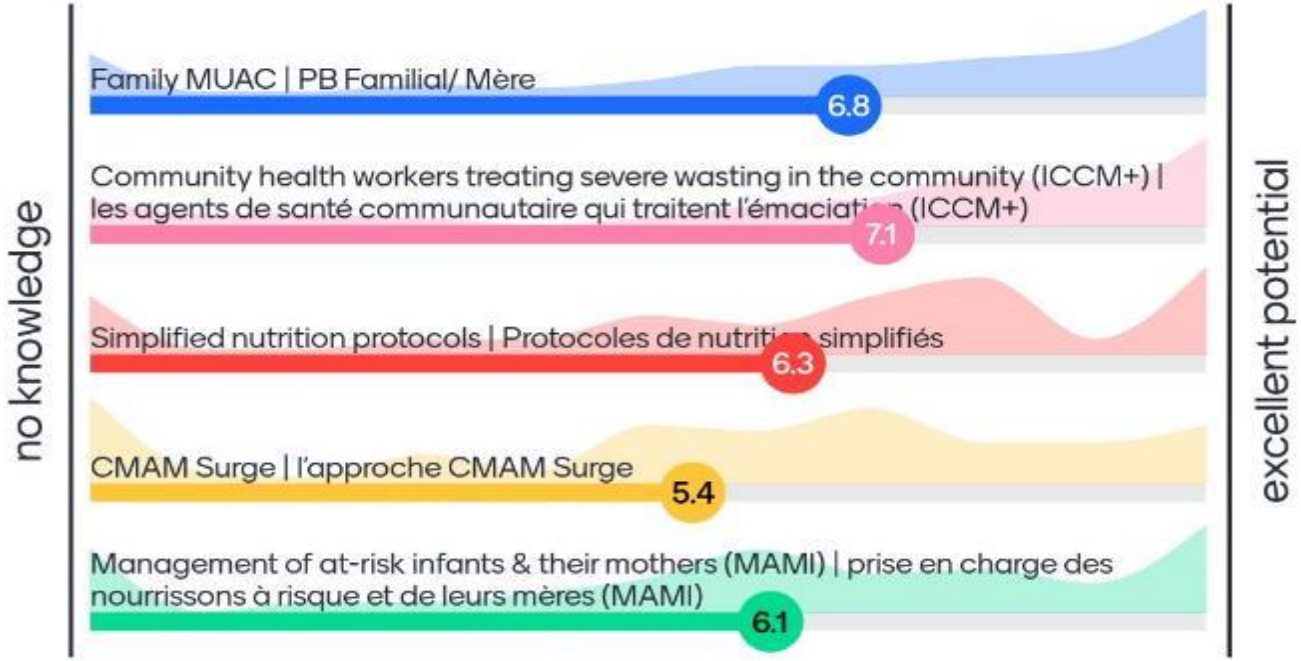
Approach	Advantages/ potential	Readiness for scale	Implications/ needs
Family MUAC	– Increase coverage – Earlier detection – Allows CHWs to do other things – Empowers caretakers	– Ready to go, already taking off – COVID boosted its importance – WHO guideline endorsement not needed (but could help)	– Supply of MUAC bands – Regular quality checks – Must integrate into existing platforms – CHWs may need convincing – Promote as *behaviour*
CHWs treating wasting	– Increase access/ coverage – Timely treatment	– Piloted on modest scale – CHWs have shown they can – Strong examples from Mali & Kenya – May need WHO guideline endorsement to move	– Major policy change – CHWs must be sufficient & supported & well distributed – Systems for RUTF supply management in community
Simplified Nutrition Protocol	– Increase access/ coverage – Treat a larger number of children	– Likely require WHO endorsement for scale – Need more robust cost projections with extra moderate cases	– Training in new protocol – More RUTF at health facilities because reaching more moderates – Can the health system take it?

Implications & readiness to scale

Approach	Advantages/ potential	Readiness for scale	Implications/ needs
CMAM Surge	– No additional supplies – Adds value if caseloads have seasonal peaks – Health workers accept – Better than start/ stop emergency response	– Currently in 12 countries – At scale in parts of Kenya, expanding in Niger – Needs further integration into each health systems	– Same supplies/ support are still needed during peaks – Approach needs better integration into national level health /contingency funding mechanisms
MAMI	– Addressing those with highest mortality - <6 months, previously overlooked	– Excellent set of integrated tools – Still operationalising / further testing some of the tools in a health worker setting	– Time of health workers – Linking health & nutrition services

What is the potential for each adaptation/approach to accelerate scale up of severe wasting services in fragile contexts?

Mentimeter



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Integration of severe wasting into health systems

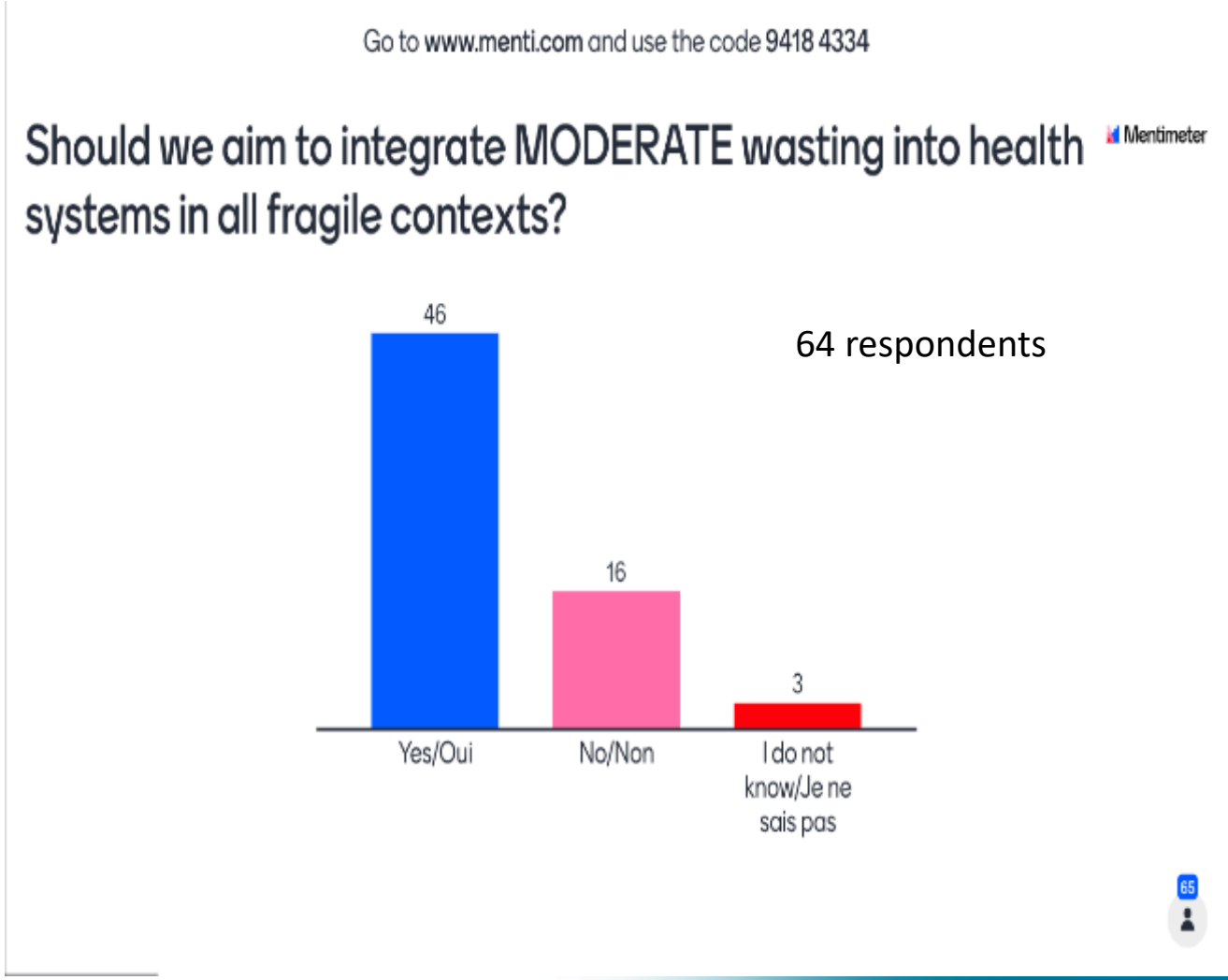
- Critical for scale
- Strengthen health systems first - needed most everywhere
- Strengthen community health platforms and then push some of the treatment to the community

Niger: national evaluation of CMAM (2020)

Health System Building Block	Degree of integration
Governance & Leadership	Achieved
Information	Achieved
Finance	Partial Achieved
Human Resources	Partial Achieved
Medicines, Supplies and Infrastructure	Partial Achieved
Service Delivery	Partial Achieved
Community	Partial Achieved

Moderate wasting services – how will we bring these to scale?

- Need alternatives where there is no WFP/ specialised nutritious food product
- Alternatives based on local foods/ support needs more investment & evidence review
- *Simplified nutrition protocols offer a huge potential* to unify wasting treatment along the continuum (severe to moderate)
- But who will pay for the moderate caseload treatment?



3. Priority actions

Priority actions: RUTF and finance

Area	Action	Who?
RUTF	• Prioritise/ collect more evidence on alternative formulations	
	• Support local production	
	• Unlock global/ local competition	
	• Food Systems summit an opportunity to discuss local solutions to the RUTF supply challenges	
Finance	• Global financing facility – could this be applied to wasting services?	Donors, Southern governments, for discussion in Panel today!
	• Explore regional government pooled procurement process for supplies (largely RUTF)	
	• Secure adequate funding for moderate caseload	

Priority actions: Health workforce

Area	Action	Who?
CHWs	• Advocate for sustainable funding and support strategy & secure funding	
Adaptations/ simplified approaches	• Bring into the discussions on national policy	
	• WHO to include as many in the evidence review for upcoming global wasting guidelines	
	• Need tools to project the possible increase in case loads – including moderates – simplified approaches may bring (via improved coverage!) and who will pay	

Priority actions: Adaptations (will come from group work)

Area	Action	Who?
Family MUAC		
CHWs treating wasting		
Simplified nutrition protocols		
CMAM Surge		
MAMI		

Next steps: conference outputs and follow up

End of April

- ‘Pathways to scale’ papers for each of the adaptations
- Conference report
- Follow up engagement to capture momentum on:

May June

  - RUTF cost/ supply chain (ACF may lead on this)
  - Community ‘C’ – back in CMAM
  - Food Systems Summit – convening dialogue on wiping out wasting
  - Existing technical coordination looking at each of these approaches

Evaluation and on to the next session

Thank you

For more information, please visit www.example.net

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