CONFERENCE REPORT

AISLING DALY
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Acknowledgements

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 review emerging lessons on SAM treatment as a whole. The first of such events took place in London on October 17th and 18th, 2013, under the title "What We Know Now: A Decade of Community-based SAM Treatment", the conference produced many results and recommendations, one of which was to provide these learning spaces to regional and national colleagues.

It is in this within this framework that this conference was organized in Bangkok on December 12th and 13th: to bring together academics, practitioners and policy makers who work in SAM treatment in Asia. Seven countries were represented through a range of NGOs, UN agencies, academic institutions and national governments: Philippines, Bangladesh, Myanmar, India, Nepal, Pakistan and Yemen

We hope that this summary of the presentations and discussions will serve to further disseminate the ideas and work presented at the conference.

The CMN Team

Agenda

Time	Day One
09:00-09:30	Registration
	Session A: Introduction
09:30-09:45	Welcome and Introduction
09:45-10:15	The CMN and Conclusions from London Conference
10:15-10:30	Q&A and Discussion
10:30-11:00	Morning Break
	Session B: Status of CMAM in SE Asia
11:00-11:30	**Nepal:** Scaling up CMAM in Nepal
11:20-12:00	**Yemen:** Overview of CMAM Implementation in Yemen
12:00-12:30	**Pakistan:** Treatment Protocols and Outcomes and Scale up of CMAM
12:30-13:30	Lunch
	Session C: Key Operational Issues
13:30-14:00	**Bangladesh:** Follow-up of children with SAM treated with RUTF
14:00-14:30	**India:** Treatment, response and long-term outcomes using CMAM in Bihar, India
14:30-15:00	**Bangladesh:** Local production of RUTF
15:00-15:10	*Assigning groups for group work*
15:10-15:30	Afternoon Break
	Session D: Working Group
15:30- 16:15	**Group Work:** Country-specific themes; opportunities, challenges and actions
16:15-16:45	Report back from group work
16:45-17:00	Conclusion of Day One

| Time	Day Two
09:00-09:30	Welcome and Recap of Day One
	Session E: Coverage in CMAM programs in SE Asia
09:30-10:00	Introduction to coverage in CMAM and Monitoring Coverage in the region
10:00-10:15	Coverage Case Study: Nepal
10:15-10:30	Coverage Case Study: Bangladesh
10:30-11:00	Morning Break
11:00-11:30	**Bangladesh:** Accessing children with acute malnutrition in Bangladesh
11:30- 12:00	**Philippines:** Presentation of findings from SQUEAC 2013
12:00-12:10	*Assign groups for group work*
12:10-13:00	**Group Work:** Lightening discussion on Coverage Surveys
13:00-13:30	Feedback from Group Work
13:30-14:30	Lunch
	Session F: Integrating CMAM into Regional Health Systems
14:30-15:00	Transferring CMAM from Africa to Asia: a few challenges
15:00-15:30	Lessons learned in SAM management in Bangladesh
15:30-16:15	Interactive group feedback and comments
16:15-16:30	Wrap up and conclusions
	Afternoon snacks

Day One

Opening Session

Dr Jose Luis Alvarez, CMN Project Coordinator, gave an introduction on the Coverage Monitoring Network (CMN) explaining its main activities and the areas of activity. The Ripple Graph below shows the widespread effect of the CMN project, ranging from direct support for coverage surveys in the field, to remote support from headquarters and eventually moving out to the third level of independently run coverage surveys *(Figure 1).* Jose Luis Alvarez also shared information found on the CMN website (http://www.coverage-monitoring.org/) including clips from the International Conference held in London in October 2013.

The relationship between the CMN and UNICEF was explored revealing that even though not partners, they work in close collaboration. The need to advocate more for Asian countries in CMN's upcoming activities was also discussed and taken in to consideration.

Figure 1: CMN Ripple Graph
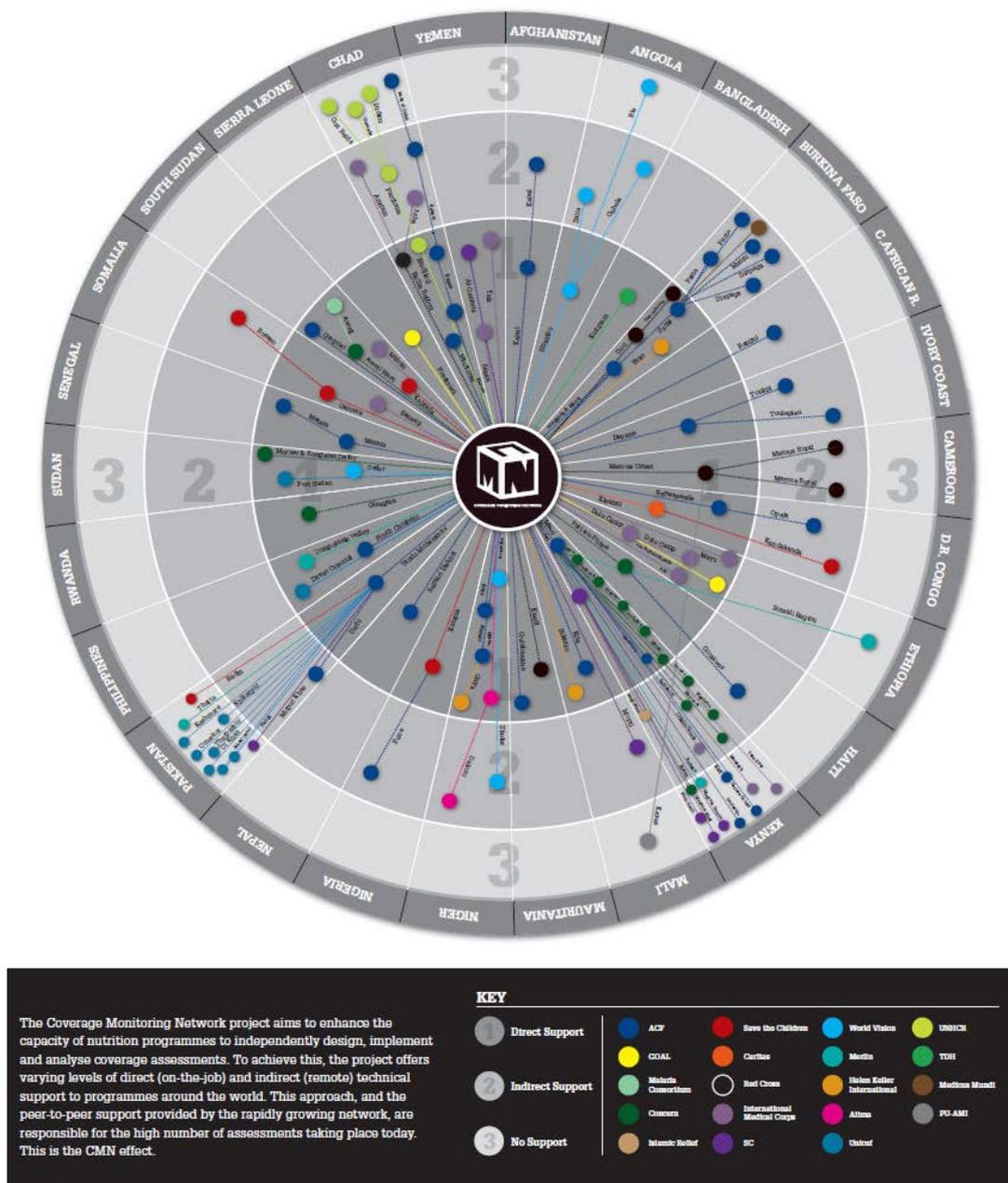
Nepal: Scaling up CMAM

Dr. Ojaswi, ACF Nepal, shared the experience of CMAM in Nepal and how it has become strongly integrated into the government agenda, showing the strength of the integrated nutrition and health system in Nepal. The main challenges faced in Nepal were resource based, with a lack of funding partly due to the fact that Nepal is not seen as an emergency context, making it less attractive to humanitarian donors. However, commitment to resolving malnutrition from the government is good. The government have a strong understanding of the problem which is very helpful, but work is needed to ensuring more financial buy-in to the country. Nepal provides a good example of an integrated approach to malnutrition within the national health system.

Although not directly, related this presentation led on to a large debate around admission criteria and the use of MUAC. Many raised the point that the context is highly different from Africa (stunting is stronger in Asia than wasting) and therefore a re-assessment of MUAC needs to be carried-out. In addition, is MUAC is used for admission criteria it should also be used for discharge criteria.

India: The Status of CMAM and Future Strategies

Prof. Umesh Kapil was unfortunately unable to travel, but in his place Rita Bhatia gave an overview of the situation in India. She described the complexity for the states to cooperate and for the government to take malnutrition on as a serious problem. India is not limited for money and resources but lacks the political will and cooperation to make nutrition treatment a real possibility.

Malnutrition is not as visible in Asia as in Africa, however it is still widely present. India has a very high burden of malnutrition with 9 million children suffering from the disease within the country, however the situation is not considered an emergency. There is the need for the collection of evidence for the CMAM interventions on Indian children before being able to move forwards. Malnutrition should be presented as an issue within the country context for it to be acknowledged as an issue. There are lots of pilots are in place to build this evidence which should help the progress at policy level.

There are many issues with RUTF in India, as we also heard from many other countries in the region. It has been agreed that there is a need for SAM treatment but that it cannot come from abroad. However, the manufacture and commercialisation of RUTF is rejected by the Indian government. On a state level, RUTF is often refused if it is not manufactured within the state borders. This creates a difficult environment for RUTF within India. Even though Nutriset is based in India and other countries buy RUTF from India, India itself doesn't want to buy from them as they are considered the private sector. Local production of RUTF should be considered.

Finally, again there are many ongoing discussions around the use of MUAC and W/H cut off points which need to be explored.

YEMEN: CMAM

Dr. Aida Alsadeeq from the Ministry of Health Yemen gave an interesting overview of CMAM in Yemen, which is a young country with regards to CMAM services. SAM management started with Inpatient care in 2006, followed by Outpatient care in 2009, and since then lots of progress has been made in the detection of acutely malnourished children at community level, but a lot more can still be done.

In the country, poor socioeconomic and an unstable political situation have a strong effect on malnutrition status. In addition in certain areas with high levels of IDPs the situation is aggravated. MUAC and oedema are used for identifying SAM at community level. W/H, MUAC and oedema are used to identify acute malnutrition at health centres. There are high defaulter rates across the board which need to be addressed through increased community

based activities. In addition there is poor understanding of the importance of exclusive breastfeeding in Yemen (11.5% and decreasing).

The information systems regarding MAM management and community outreach appear to be lacking, in part due to issues with WFP, as well as security difficulties in the country, poor communication between I-NGOs, local foundations and the MOH, and a lack of technical knowledge. Information systems for nutrition in country need to be improved. More specifically a community component needs to be added. Bangladesh has a well-developed info system but lacks nutrition indicators, for which it needs input from UNICEF. There was agreement with poor communication, stating that the WFP focussed mainly on emergency situations.

It is clear that treatment of children with SAM is effective, but perhaps Yemen can learn from other country examples to really move their CMAM program forward.

Pakistan: Treatment, protocols and outcomes

Dr. Rashid from the Department of Health in the Punjab presented a modified system for CMAM adapted to the Pakistan context. As a result, RUTF is well accepted as a medicine and treatment for SAM, there is strong government ownership and they have an e-monitoring system in place using text messages to ensure follow up and treatment of children right from birth. In Pakistan malnutrition is not strictly limited to poverty with 21% of the cases of stunting coming from the top quintile.

The main CMAM approach is a woman focussed approach using Lady Health Workers (LHWs) to follow children through their treatment leading towards very low defaulter rates. In general activities are geared towards preventing acute malnutrition even before the child is born. Lady health workers also give breastfeeding support, awareness raising sessions and technical advice on issues. A manual specific to Pakistan for IYCF has also been developed. It was noted as very important by the LHWs to communicate what RUTF is to the mother, medicine not a replacement food.

Pakistan has a strong integrated approach to preventing SAM with strong political buy in across several sectors, creating a more sustainable model for prevention. In addition, there is good coordination between ministries with a variety of technical working groups, at district level as well as a MUAC addressing committee.

> There have also been trials with the local production of a high density treatment diet developed in Karachi and scaled up in 3 districts which has been written up in to a report.

Bangladesh: Follow up of Children with SAM treated with RUTF

Dr Charulatha Banerjee, Terres des Hommes, presented a study conducted in Kurigram in Northern Bangladesh looking in to the follow up status of children treated for SAM using RUTF, identifying how many had relapsed after 3 and 6 months. This study used secondary data to highlight the importance of follow up of children to ensure they do not relapse. Only 21% children had a normal nutritional status at 3 months after discharge, 39% had normal status after 6 months. 15% weight gain is not good enough for discharge. If they leave after 15% weight gain without being formally discharged, they are classified as defaulter.

The study shows that it is very difficult to follow children after they are discharged. CMAM programmes technically end with formal discharge, but this should not be the case, as the children need to be followed up to ensure sustained. There is the need for donors to fund a period of time following the CMAM program in addition to including follow up monitoring in CMAM programmes. Furthermore, it is important to clarify the definition of "relapse", is it currently the children are recorded as a new case or the same case again. These issues with information management and registration need to be ironed out.

The conclusions drawn were on the importance of follow up measurements, the need for a food secure environment after discharge from the programme, and also the crucial importance of good IYCF practices to prevent further development of malnutrition. A Holistic overall model is needed; IYCF promotion is still essential to continue adequate nutrition following discharge from a program, a circle of good nutrition must continue.

India: Results from a MSF programme in Bihar

Dr Prince Mathew, MSF India, spoke about the use of MUAC in Bihar India and how it can be used successfully for discharge criteria as well as for admission. He in fact made the point that it **should** be used for discharge if the patient was admitted by MUAC. Admission and discharge should be based on the same measurement criteria.

Dr Mathew also explored the fact that malnutrition is often considered a social issue rather than a medical issue impacting on the way it is viewed. He discussed the idea of incentivised community health volunteers with performance based incentives: 100rp to identify a child, another 100rp to follow child and ensure they are referred, another 100 rp when child is cured. However questions of sustainability were raised in response.

Finally Dr Mathew raised the importance of food security, food supplement, and the idea of taking home ration for the 3 months following discharge to avoid relapse.

Bangladesh: Local Production of RUTF

Dr. Santhia Ireen, ICDDR,B, presented on the local production of RUTF in Bangladesh. ICDDR,B is running a trial on two nutritional products based on rice, lentils, chickpeas, oil, milk powder and sugar and have found so far that in all aspects it is identical to the commercially produced Plumpy nut in terms of nutritional value, shelf life, microbiological safety. They use lecithin as an emulsifier to ensure shelf life - cereal based product might not have same shelf life as other RUTF products.

They are in the process of conducting the efficacy trial in a hospital setting and effectiveness trials of the best products at community level. It will be very interesting to see the results of these as the product offers a lot of potential. There has been no cost analysis yet.

In Bangladesh CMAM programmes are restricted to NGO groups in specific areas, there is no national program. However they are hoping that the government will take ownership of the product once it is developed. It is unclear whether this will work, but ICDDR,B are not willing to sell it through UNICEF. Comments from the audience suggested that it should not be on the open market.

Day Two

The CMN and Coverage Data in the Region

Jose-Luis Alvarez introduced the topic of Coverage using a variety of international data. He highlighted the need to communicate/advocate for accurate coverage figures. Asian figures appear to be reported more accurately compared to African countries; coverage figures are still low and are reported as low.

The debate moved into the Indian situation. India is a very complex context, where health is a federal state issue, not nationally governed, therefore there needs to be buy in from each state government. It would be better to focus on programme coverage to start with. One strategy could be to start with high burden states and look at coverage of SAM children there rather than start with full national coverage. Also, it would be a good idea to do a coverage assessment on the ICDS programme in India itself before going into CMAM, to gain advocacy from the beginning.

Coverage Case Studies:

Nepal, Rita Bhatia

Rita gave a case study example of conducting a SQUEAC coverage survey in Saptari District in Nepal. As the programme in Saptari was relatively new, the low coverage estimate compared to SPHERE standards may not be fully applicable. General recommendations include ensuring consistent supply of RUTF and Amoxycillin, to implement a follow up SQUEAC before 2015, research the optimal discharge criteria, and establish another OTP in Rajbirj. We also heard a comment from Dr. Ojaswi , ACF Nepal, who said the SQUEAC survey was extremely beneficial in helping them improve the programme.

Bangladesh, Lovely Amin

Lovely presented a similar case study in Bangladesh to highlight the usefulness of conducting coverage surveys to help improve programmes.

Philippines, Ray Anthony Banglos

We heard about the CMAM programme in the Philippines which has a different approach to most other countries. In general, the Philippines is quite a resource rich country but is severely prone to many natural disasters each year, meaning their CMAM programmes generally tend to be more of an emergency context. 3 SQUEACs have been conducted.

A group work session was conducted on coverage, the key points from these discussions are detailed below:

1. **Nepal:** Integrate SQUEAC into regular CMAM programmes
2. **Philippines:** Focus in high burden regions, provinces, towns. Look in high risk disaster areas at specific age groups. No national coverage survey due to pockets of malnutrition in Philippines.
3. **Bangladesh:** Good reporting system, quick and easy access to data.
4. **Myanmar:** Very little information on nutrition situation in country, very few programs implemented due to this.
5. **India:** There is not a good overview of where the programmes are and what the national nutrition situation is. They are looking to use indirect methods for advocacy cases rather than measuring coverage at this stage. There are additional issues with the confusion at central level between acute malnutrition and underweight.
6. **Pakistan:** Integration of nutrition programmes into health systems. S3M methods and others can be applied to other health interventions allowing the techniques to be fully incorporated into health systems.

The CMN should work towards finding proxy indicators for coverage which will make assessments and monitoring much easier and regular.

Accessing Children with Acute Malnutrition in Bangladesh

Dr. Talukder from the Centre of Women and Child Health in Bangladesh began by giving an overview of the importance of access to SAM treatment services in Bangladesh. Thousands of children are dying or disabled from the effects of malnutrition, due to suboptimal IYCF practices, early weaning and the abundance of formula milk on the market. Numerous barriers to access were identified. However, there is potential to use an already well-established system to prevent and treat SAM, the *EPI programme*. This programme is already very well established throughout South-East Asia with extremely high levels of immunisation coverage. Mothers bring their children for vaccinations at certain points in their development, and this can be used more favourably to increase knowledge and behaviour on IYCF practices, to screen and identify malnourished children at an early stage and allow successful treatment and prevention of further SAM development. The potential is enormous; it now needs to be tested and established.

The integration of CMAM with IMCI has not yet done but is being thought about. A specific suggestion was to intervene during the first week after birth to promote breastfeeding. This is already being done to some extent by CHWs who visit pregnant and lactating women to give counselling and information. However, it is complicated to integrate IYCF counselling into the job description of health workers as the EPI do not want others to ruin their high performing program. However, as a health system all services should be provided. There is a need to keep working to include SAM treatment and counselling into the job descriptions.

Transferring CMAM from Africa to Asia: Challenges

Jean-Pierre Papart from Terres des Hommes gave a presentation on the differences in malnutrition and CMAM services between Africa and Asia. The main differences lay within the idea that stunting may be an epigenetic adaptation in Asia, caused by long term food insecurity, which could explain why less severe form of SAM cases are found in Asia. This presentation took into account only Tdh's experiences across both contexts so the conclussions presented were based on TdH programs´ data only. Within the concept of food insecurity, wasting and stunting often get confused, with wasting only really occurring in food secure environments that experience a sudden state of food or nutrition insecurity. The difference with CMAM programmes in Asia is that the children in Asia are epigenetically different to the children in Africa, and it might not be the best to simply move CMAM and RUTF protocols from Africa to Asia; the protocol may need to be adapted to the setting. Perhaps providing a lower dose of RUTF over a longer period to avoid the situation of overfeeding, which may lead to potential epidemic of metabolic syndrome in the future. This needs to be strongly considered when setting the CMAM protocol in Asia. We have to ask the question: what needs to change? In addition, should efforts go into countries producing their own RUTF product or should efforts go into revising and adapting the tools for treatment?

SAM Management in Bangladesh: a successful program

Dr. Gulshan Ara Khanom, from ACF-Bangladesh, presented on lessons learned and field experiences on management of Severe Acute Malnutrition in Satkhira District South-West part of Bangladesh. Satkhira is a hazard prone district; approximately 72 % of the population falls under acute food insecurity according to the Household Food Insecurity Access Score (HFIAS). In August 2011 excessive rains caused major water logging for almost three months. The water logging had a dramatic effect on the nutrition status of children U5, pregnant and lactating women. The GAM rate of children 6-59 months was 6% in Oct 2011 (SAM 0.2%) and increased up to 27% (SAM 1%) in Nov 2011[1]. ACF carried

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[1] Even though SAM prevelance was low ACF decided to open a programme as the main was to strengthen capacity of system. Fewer cases were treated than targeted. 97% (148) of identified SAM cases were admitted (Feb- Sep 2013) and treated. Using MUAC as admission criteria might be responsible for identifying fewer cases than targeted. In addition, the programme started during an emergency, and there is lower prevalence now.

out an emergency response intervention for vulnerable populations with the assistance of a local partner. Prolonged consumption of a small quantity and poor quality of food led to a deterioration of the nutrition of the children as well as the pregnant and lactating women. An integrated approach was proposed based on an evaluation of the needs to mitigate the impact of water logging on all sectors in 4 Sub-Districts in Satkhira District with the assistance of a local partner and WFP in collaboration with the Government authorities, financially supported by European Commission of Humanitarian Aid and Civil Protection. The program has both strong preventative and curative approaches, as well as strengthening the capacity of MOH staff. The CMAM approach is used with stabilisation centres, outpatient treatment centres, supplementary feeding programmes, home visiting, health and nutrition education programmes, behaviour change communication and a community outreach programme. Water logging in Satkhira continues to impact on the food security, livelihoods, safe water, sanitation and nutrition of this population. ACF conducted SMART survey in December 2012 which showed GAM rate 7.8% (SAM 1.1%) in children 6-59 months through WHZ (post-harvest period). A further nutrition survey in Sep-Oct 2013 in working areas in Satkhira District showed GAM rate 11.9 % (SAM 0.6%) in children 6-59 months through WHZ (pre- harvest period). The successes of the programme included good referral compliance and early identification through community screening, establishment of a standardized treatment and a comprehensive nutrition programme, strong staff and supportive environment with continual monitoring. A number of common operational challenges and some contextual challenges were experienced with political instability and water logging etc. However, as a lessons learned experience, it was found that closely linking the OTP and SFP programmes through the CMAM approach reduced the rates of SAM as measured by MUAC. ACF is working on handing over to the government, but due to technical and operational limitations, a greater longer term emphasis on Health System Strengthening to be able to incorporate nutrition programs is required.

Emerging Themes

The conference raised some very interesting discussions around the local production of RUTF, the difficulties with using W/H and MUAC measures for admission and discharge, the importance of communicating RUTF as a medicine not just a food, challenges with malnutrition and wasting seen as an African problem and how stunting may be more of a deeper issue in the Asian context, difficulties with government buy in and cooperation, and many more which we have hopefully captured below in the Learning wall summary.

The 5 mains themes emerging identified were: (*see Table 1*)

- **Financing**
- **Institutional Architecture/Integration**
- **RUFT &Supply chain**
- **Community access & treatment protocols**
- **Nutrition Information**

See below for a more comprehensive breakdown of these issues.

Table 1: Learning Wall

Main theme	Specific details
Financing	Specific Funding for GAM Treatment More Longer-term funds Lack of functioning PHC centres and trained staff (Yemen)
Institutional Architecture/Integration	Lack of HR and trained staff at MoH level (Yemen) Coordination between ministries National Guidelines Importance of stunting in Asia (not so much wasting) Do not wait for Govt to act (Yemen, Myanmar) Lack of functioning PHC buildings (staff, water, electricity) (Yemen) Define who is responsible for nutrition within Govt. External Development Partners (EDPs)
RUTF & Supply Chain	Local Production of RUTF Private/Public/Community production and ownership? Supply chain breaks through WFP/UNICEF Need for more studies Cost-effectiveness? New product needed or adapted treatment protocol?
Community Access and Treatment Protocols	Need more trained personnel Integration of SAM and MAM Prevention and Stunting **NB** Importance of IYCF Stronger community mobilisation and outreach Incentivised and non-incentivised CHWs Define discharge criteria for SAM and MAM, using MUAC and/or W/H Tracking and Follow-up Qualitative understanding of barriers Behaviour change communication Potential use of EPI centres Adapting protocol to Asian "epigenetically-adapted" situation Combining CMAM and IYCF together – CPAM
Nutrition Information	National survey needed No platform for information sharing – National or International Stronger monitoring of problems Rapid assessments needed (Yemen, Philippines) Early warning systems Lack of community-level data Need more trained personnel Facility-based and Community-based information Technology and IT- supported systems Direct Nutrition Indicators (DNIs) HMIS Nepal (Nutrition Surveillance Working Group)