

**The management of
acute malnutrition
at scale:**

**A review of donor
and government
financing
arrangements**

**Summary Report
March 2013**



Acknowledgements

This review was undertaken by Jeremy Shoham and Carmel Dolan, ENN Technical Directors, and Lola Gostelow, an independent consultant engaged by the ENN.

This review was made possible by funding from CIDA and Irish Aid; the ENN gratefully acknowledge the support of both agencies in this regard. The views expressed herein are those of the ENN and can in no way be taken to reflect the official opinion of Irish Aid or CIDA.

Numerous people (and too many to mention here) have given freely of their time and insights into the successes and challenges of CMAM scale up and we warmly thank them all for their contributions. These include government nutrition staff, key donors, UN and NGO agencies, academia and individuals.

The section on Official Development Assistance was supported by Lydia Poole and Mariella Di Ciommo from Development Initiatives and we thank them for their valuable contributions.

In particular, we thank the Governments of Kenya and Ethiopia and their supporting partners (UNICEF, WFP, and international NGOs) for hosting the visits for the case studies. We also thank Theresa Banda (seconded to ENN by Valid International) for allocating some of her time whilst working in Malawi and Nigeria to understanding the financing situation for CMAM in these countries.

We thank Marie McGrath for carefully reviewing the document and adding substantial material and insights on UN agency roles and responsibilities around the treatment of acute malnutrition.

Contacts: Jeremy Shoham, ENN Director, shoham@btinternet.com and Carmel Dolan, ENN Director, carmel@ennonline.net

Electronic versions of this summary report, as well as the main report, are available at www.ennonline.net

Citation: Shoham J, Dolan C, Gostelow L, ENN (2013). The Management of Acute Malnutrition at Scale: A Review of Donor and Government Financing Arrangements. Summary Report. March 2013.

 Canadian International Development Agency  Agence canadienne de développement international

 **Irish Aid**
Rialtas na hÉireann
Government of Ireland



The ENN is a UK registered charity whose activities include lesson capture on nutrition and food security programming in emergencies and high burden contexts to inform practice and research. See full profile of activities at www.ennonline.net

Cover picture credit: L Matunga/UNICEF, Somalia, 2011

This review responds to concerns identified by countries scaling up nutrition

This review focuses on the financing arrangements for programmes that manage acute malnutrition¹ at scale through the community based management of acute malnutrition (CMAM) approach. It follows up on an international conference on CMAM co-hosted by the Government of Ethiopia and the ENN in Addis Ababa in 2011. At this four day event, government representatives from 24 African and Asian countries shared their experiences of CMAM scale up and highlighted the challenges they face with current financing arrangements in terms of resource predictability and sustainability.

This review considers the enabling and constraining aspects of humanitarian, transition and development financing, the contexts and rationale in which severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) are jointly addressed in CMAM programming; the role of key United Nations (UN) agencies in enabling programme integration and coordination; individual donor policies and strategies for supporting CMAM in emergency, transition and development contexts; and opportunities for achieving greater impact of efforts to manage acute malnutrition. The review involved country case

¹ Wasting or oedematous malnutrition

studies from Kenya, Ethiopia, Malawi and Nigeria (developed based on interviews with government and other stakeholders, plus review of essential documents); in-person and telephone interviews with donors, UN agencies and foundations involved in CMAM financing, programming and research¹, grey literature review; and donor feedback (CIDA and Irish Aid) on findings.

The conclusions and recommendations contained in this review are based on a process of synthesising the experiences and perspectives of the many stakeholders highlighted above but are aligned in particular with the views of governments faced with the challenges of scaling up CMAM programming. Where recommendations are made by the ENN specifically, these are indicated.

Undernutrition is receiving unparalleled attention internationally

Acute malnutrition is a life-threatening condition affecting approximately 60 million children globally at any point in time. This caseload comprises approximately 20 million children aged below 5 years with SAM and 40 million under-five children with MAM. Children with SAM have a nine times greater risk of dying than well-nourished children and children with MAM have a three times higher risk of dying.

This is a problem of global public health significance and one set to escalate. Climate change and the economic downturn are expected to lead to an increase in the acute malnutrition caseload over coming years. Thus, the treatment of acute

malnutrition will unfortunately remain necessary until other interventions are implemented at sufficient scale to prevent undernutrition and to reduce the prevalence of acute malnutrition.

Globally, political interest in food security, global hunger and nutrition² is greater than it has been for decades. The development of the Scaling Up Nutrition (SUN) movement, the Hunger Summit in London on the margins of the 2012 Olympic games and various high-level SUN events and actions at country level are testament to an unparalleled momentum in the nutrition sector.

Though expensive, CMAM is a cost-effective, scalable intervention

Until the late 1990s, treatment of SAM was through therapeutic feeding centres in hospitals and health care centres. Performance was poor, coverage was extremely limited (<5%), mortality was often in excess of 30% and recovery rates were poor. The advent of ready to use therapeutic foods (RUTFs) in the late 1990s made it feasible to manage SAM in the community instead of in centres, and led to the development of the CMAM approach. The community mobilisation and ownership of the programme is the cornerstone of the approach. CMAM allows early detection and referral of 'uncomplicated' SAM cases to out-patient centres (whilst cases of 'complicated' SAM continue to be managed as in-patients by health sector staff), and their progression to targeted supplementary feeding programmes (SFP) so as to maximise full recovery.

Over the past 12 years, CMAM programmes have been implemented to varying degrees of scale in over 65 countries. The latest UNICEF mapping report estimates that 2 million out of an estimated 20 million SAM cases are now being treated. While this is a significant increase in SAM treatment, it represents just 10% of the global SAM burden. MAM treatment, however, has often not kept pace with the scaling up of SAM treatment. The pace of increasing coverage for in-patient treatment of complicated SAM is not monitored and therefore, is also unknown. It is important to note that many countries with very high caseloads of acutely malnourished children – such as India, Nigeria and Indonesia – have extremely low CMAM coverage. Should CMAM be scaled up in such countries, global coverage of treatment will substantially increase.

² Specifically: undernutrition, which encapsulates acute malnutrition, stunting and micronutrient malnutrition.

Undernutrition – acute malnutrition and stunting – demands a coherent response

Children being treated for acute malnutrition can take up to 100 days to recover (or even longer when they relapse). Untreated children with MAM who do not deteriorate to SAM will take far longer to recover. During this period of recovery, the linear growth of a child will be curtailed. There is strong evidence demonstrating that the first 1000 days of life (700+ days ex-utero) are a critical window of opportunity for addressing stunting. Yet, since prolonged or recurrent periods of acute malnutrition most commonly affect children within these first 1000 days (especially those aged 12 to 24 months), it is likely that this will block a significant proportion of the period for optimal child growth. Furthermore, the results of recent research show that there may be an additive or cumulative risk of mortality when a child has acute malnutrition and is also stunted. It therefore makes sense to consider acute malnutrition and stunting together and this is increasingly being emphasised by the SUN movement.

In addition to these biological reasons, there are also sound geographical and contextual reasons to make the link. Over half of the world's acutely malnourished children live in a small number of countries (e.g. India, Bangladesh, Pakistan, Nigeria and Indonesia) and these countries also suffer from very high levels of stunting. Furthermore, a number of

other sub-Saharan African and Asian countries affected by conflict, chronic or acute crises have been unable to reduce prevalence of undernutrition; they therefore bear significant burdens of acute malnutrition as well as stunting.

There is a pervasive misconception that acute malnutrition is a short-term problem of concern to humanitarians whereas chronic malnutrition (stunting) is a long-term development problem. This is undoubtedly fuelled by current terminology which demarcates the two. However, stunting and acute malnutrition are linked biologically and therefore need to be linked programmatically. Children with acute malnutrition or with declining nutritional status are at a higher risk of linear growth retardation or stunting. Therefore, an untreated chronic or repeated state of acute malnutrition will very likely reduce efforts to prevent or reverse stunting. In addition, programmes which address the causes of one of these conditions will in all probability have a positive impact on the other condition, as both share common (though not all) elements of the malnutrition causal pathway. The emerging understanding of linkages between acute malnutrition and stunting, however, are at a very early stage in relation to programmes and agency roles and responsibilities.

CMAM tends to be funded as a 'humanitarian response'

The World Bank estimated³ the cost of scale up to address 80% of the acute malnutrition burden in 36 high burden countries to be US\$6.2 billion. This represented over half the total cost for scaling up the 13 direct nutrition interventions demonstrated to be effective by the Lancet Series of 2008. The way in which these costs were estimated assumed no cost savings through integration with government health systems and other child health and nutrition programmes, such as the integrated management of acute malnutrition (IMCI) and infant and young child feeding (IYCF).

There has been little concrete discussion around the degree to which different governments can afford to finance programmes to treat and prevent acute malnutrition. As a result, there are no current estimates for the external (donor and private) resources required for scale up globally, though this is likely to be substantially lower than the US\$6.2 billion figure.

There are varying country based estimates of per capita costs for treatment of SAM and MAM ranging from US\$70 for the treatment of SAM in Nigeria, to US\$150 for the combined treatment of SAM and MAM in Kenya to US\$110-200 for the treatment of

³ Scaling Up Nutrition. What will it Cost? Susan Horton et al. World Bank 2010.

SAM and MAM in Ethiopia. An important determinant of cost is whether it is for starting up a programme as in an emergency or for expansion of a programme to meet a chronic need.

At least half of the cost of SAM treatment is for RUTF. Dried skimmed milk (DSM) powder represents around one-third of the RUTF cost, largely because it is a high cost imported commodity. The remaining CMAM programme costs are (in no particular order of cost magnitude) for antibiotics, measuring equipment, training, outreach, community mobilisation and referrals, monitoring and evaluation, and reporting.

Governments and supporting partners are still at an early stage of reliably estimating the costs of CMAM scale up. A number of countries, including many that are partners in the SUN movement, have recently or are in the process of costing CMAM in tandem with other high impact direct nutrition interventions, as well as a range of nutrition sensitive strategies aimed at preventing undernutrition. The new joint UN 'one health tool' could also help governments to ascertain more reliable and standardised estimates of costs as part of a package of nutrition and health interventions.

In most cases, the costs for treating SAM and MAM far outstrip the current domestic government budgets allocated to nutrition. Country-led efforts to reduce the cost of CMAM through establishing RUTF local production have largely been unsuccessful. In the small number of countries where significant local production has been achieved (e.g. Ethiopia), costs have decreased by around 20%, but in other countries, like Malawi, locally produced RUTF has been more expensive than RUTF produced by the main global manufacturer in Europe. Predictions for the future cost of RUTF (as currently formulated) suggest it could increase further, due to the increasing price of DSM on the global market. However, local production brings other advantages besides costs, including speed of delivery which reduces likelihood of stock-outs. Local production of RUTF at higher than current levels of CMAM coverage may allow for greater economies of scale and cost reduction. Furthermore, research into the development of alternative RUTF formulations using local foods in India may bring down costs even more dramatically. It may also be the case that where RUTF is put on government medical supplies lists, prices will decrease as this will obviate importation taxes.

The limitations of current financial tracking means it is not possible to state how much of the external financing for scale up to address acute malnutrition is

coming through development or humanitarian budgets of donor agencies. In many cases, however, scale up has occurred following the onset of an emergency. Furthermore, close to 70% of all humanitarian funding is going to the same group of countries, year in, year out. By definition this funding is short-term (6-9 months) and has to be renegotiated each year. This has created a number of problems for governments and partners attempting to scale up programmes: for example, stop-start programming, managing different funding cycles, difficulties integrating CMAM with other preventive nutrition actions and negotiating the different administrative and contractual requirements of donors. This has been the case in Ethiopia and Kenya, where virtually all costs for CMAM, since it was first implemented, have been covered through humanitarian funding.

Encouragingly, some donors are beginning to approve multi-year funding in chronic emergencies where both acute malnutrition and stunting levels are high. However, very few donors are managing to combine humanitarian and development funding to allow not only longer term planning but also more integrated and sustainable programming, linking prevention with treatment within a nutrition resilience framework. This is largely due to the compartmentalisation of humanitarian and development departments within the same donor organisations.

Longer-term financing arrangements for nutrition programmes are multi-faceted, complex and poorly tracked. Only in a very few instances are donors financing nutrition through health or dedicated nutrition SWAps (sector-wide approaches). There can also be several funding sources within the development sections of individual donors providing funds for different elements of the CMAM approach or different actors implementing CMAM. In short, the mechanisms are complex and opaque.

Very little financing to treat acute malnutrition is being channelled through government. Whether it is humanitarian financing or longer-term financing, it is mainly channelled through the multilateral agencies (notably UNICEF and WFP) and non-governmental organisations (NGOs). Whilst there are numerous financing mechanisms that donors deploy for other sectors (e.g. pooled funds/SWAps and more general budget support), this is not the case for nutrition in those countries where CMAM is being scaled up. Further, there are very few examples of the main CMAM commodities being integrated into

government medical supply systems. It is questionable whether this approach to financing fosters increased nutrition governance in these countries.

While the humanitarian imperative has driven CMAM onto the agenda of many countries, the remit of

development actors has generally not included the treatment of acute malnutrition. This is despite the evidence that for many countries, acute malnutrition is a long-term and widespread problem requiring concerted prevention and treatment efforts if child mortality is to be reduced.

Management of acute malnutrition faces ongoing challenges due to the division of UN agencies' roles and responsibilities

Three UN agencies – UNICEF, WFP and WHO – have significant responsibilities for acute malnutrition treatment in non-refugee contexts. UNICEF is responsible for the treatment of uncomplicated SAM and WFP has recently assumed responsibility for the prevention and treatment of MAM (and prevention of stunting). In principle (yet to be reflected in a global agreement), WHO has responsibility for complicated SAM treatment, as well as providing normative guidance on treatment protocols and programme design for governments and implementing partners. In refugee settings, UNHCR has responsibility for SAM treatment and WFP/UNHCR Memoranda of Understanding (MOUs) govern co-operative arrangements regarding programming.

This review finds that the division of roles and responsibilities between the UN agencies supporting efforts to address acute malnutrition (in non-refugee settings) makes it difficult to ensure coherent and well coordinated programmes – particularly with regard to children suffering from MAM. There are many examples where WFP are not present in a country where UNICEF is implementing the SAM component of CMAM and there are countries where WFP is present and UNICEF is not. Whilst the most recently agreed division of labour between both

agencies (2011) allows for UNICEF to implement SFPs in WFP's absence, arrangements for this are proving highly context specific, and in many cases limited. Even where all UN agencies are present, programmes may not converge geographically or institutionally.

Governments and their partners report considerable confusion with stop gap measures being employed by partner agencies on the ground to treat MAM, such as discharging children at higher cut off points or relying on IYCF counselling for MAM children where SFPs are absent. Unfortunately, there is no global mapping of the extent to which outpatient therapeutic programmes (OTP) and SFP programmes converge within CMAM programming and therefore no global overview of the coherence of SAM and MAM programming. What is clear is that the separation of UN agency roles needs to be re-appraised in light of multiple negative country programmatic experiences. The 'One UN' approach, being piloted in various countries in Africa and Asia, provides an opportunity for WFP, UNICEF and WHO to coordinate their efforts around the treatment and prevention of acute malnutrition, and deliver programming addressing MAM and SAM through "one leader, one programme and one budget at country level."

Lessons from this review

Misconceptions around acute malnutrition need to be challenged. There is need to prioritise prevention and treatment programmes as part of integrated and long-term high impact direct nutrition intervention packages (for example with IMCI, IYCF) alongside nutrition sensitive strategies.

In order to encourage a broader conceptualisation of the problems amongst governments and other stakeholders, advocacy needs to emphasise how acute malnutrition reduces the window of opportunity for addressing stunting. Furthermore, when the two conditions exist in the same individual

there is a significant cumulative risk of mortality⁴. In addition, advocacy to promote the development of costed plans for scale up of CMAM need to emphasise that these are not fixed costs, since other preventive activities should lead to a reduction in the acute malnutrition caseload; thus costs should diminish over time as treatment programmes are scaled down. Countries prone to emergencies, however, should be aware of the need to retain capacity and resources to scale up if the prevalence of acute malnutrition increases, in order to address the consequences of both immediate and longer term malnutrition.

Current financing arrangements from multiple sources and through multiple supporting and implementing partners inevitably pose challenges for government in coordination, in making resource allocation decisions and in ensuring alignment of programmes with national policies. Exceptionally, the World Bank is increasingly providing significant loans directly to governments for CMAM programming, including RUTF purchase (e.g. in Nepal and Kenya).

The current donor agency financing arrangements for CMAM (and nutrition more generally) largely flow through the multilateral agencies and non-governmental organisations (NGOs), which is likely to inhibit the leveraging of domestic budgets by nutrition departments in ministries. Treasuries therefore tend to view CMAM programmes as external to their financial considerations.

Governments may need support to develop well costed national nutrition plans. Once these have been developed, many countries will need considerable external financial support to implement them. At the same time, there are a number of countries who can and should be able to allocate significant domestic resources to cover scale up costs. Clarity and agreements are needed on the realistic split between domestic and external resource requirements and how this should change over time on a country specific basis. Cost sharing by donors and governments should, where possible, offer a route to leveraging greater domestic budget allocations to finance nutrition scale up, including CMAM.

The remit of development actors has generally not included the treatment of acute malnutrition. However, the persistence of chronically high levels of

acute malnutrition should be recognised as both a development and humanitarian issue, and needs to therefore become a key concern of development actors (implementing partners and donors alike).

The onset of emergencies in a context where governments allocate regular domestic resources for treatment could dictate that humanitarian financing be deployed to deal with surges in cases of acute malnutrition and in this way, guarantee alignment of these resources with existing government arrangements.

A significant impediment to scaling up CMAM is the cost of RUTF. Although local production is increasing globally, it is unlikely to significantly lower costs. Local production will however confer other advantages, e.g. improved supply chain and economic benefits for local farmers. Exploration of options to bring down the cost through research into different RUTF formulations and RUTF alternatives is on-going but needs much greater emphasis and rapid dissemination of findings. There is the potential to put RUTF on the essential medical supplies list thereby obviating import taxation and further reducing prices.

It is likely that the transaction costs of multiple UN agencies and implementing partners (NGO) involvement in the treatment and prevention of acute malnutrition is considerable and that costs can be reduced by streamlining responsibilities. Furthermore, the overview and process for setting roles and responsibilities needs to be reviewed and clarified with respect to how a condition like acute malnutrition is 'carved up' and then allocated to multiple agencies, without full consideration as to how their respective programmes are to be coordinated.

Over the longer term, it is highly unlikely that governments and supporting donors and partners can afford the cost of treatment of MAM alongside SAM as envisaged in the original CMAM model, i.e. using ready to use foods. There is limited understanding of whether current approaches to the treatment of MAM are effective, affordable and feasible. Research into the prevention and treatment of MAM needs to become a funding priority for multiple stakeholders with a focus on non-food (for example IYCF counselling, cash and vouchers) as well as food based approaches.

⁴ McDonald. C et al (2013). The effect of multiple anthropometric deficits on child mortality: meta-analysis of individual data in 10 prospective studies from developing countries. American Journal of Clinical Nutrition. Feb 20th 2013, doi 10.3945/ajcn.112.047639

Taking action to strengthen the management of undernutrition

1 Clarify the links between acute malnutrition and stunting

As an agency with the mandate to provide normative guidance on nutrition issues, WHO is well placed to compile a briefing note on the relationship between acute malnutrition and stunting based on the published literature. This note should be contextualised by providing an overview of the evidence for persistent high levels of acute malnutrition in many countries and the high burden of stunting in others. Based on this, the note should seek to clarify that 'acute malnutrition' is not simply a result of emergency events and should challenge interpretation or assumptions associated with the terminology to clarify misconceptions about its 'emergency' nature. Furthermore, the note should underscore the need for coherent approaches to the treatment and prevention of acute malnutrition over the long-term. Key areas for research could usefully be

highlighted, such as prospective studies using existing treatment programmes showing the impact of acute malnutrition on stunting and cognitive development.

The SUN Secretariat, along with others such as REACH, are encouraged to continue to clarify to governments the programmatic advantages of linking acute malnutrition and stunting and the theoretical underpinning of this. Key messages to relay are that acute malnutrition is a development concern in the interests of child survival and that it reduces the window of opportunity for addressing stunting and therefore future human capital and development. This necessitates prioritising prevention and treatment programmes as part of integrated and long-term high impact direct nutrition intervention alongside nutrition sensitive strategies.

2 Clarify and streamline donor policies and financing arrangements

There is an opportunity for donor agencies to develop clearer policy statements and operational strategies around the relationship between acute malnutrition and stunting and the implications for their investments in prevention and treatment of acute malnutrition. These policies could clarify that programmes for the prevention and treatment of acute malnutrition can be financed out of development funding windows where there is no emergency. Furthermore, where an emergency occurs, it is imperative not to displace development financing. In some contexts it may be appropriate to combine humanitarian and development funding.

In recurrent or chronic emergency contexts and in fragile states, where humanitarian funding dominates, donors can explore ways of instigating multi-year

funding and/or combining humanitarian and development funding to achieve greater CMAM scale and thus nutrition resilience. Each donor will have different sets of institutional and political challenges in achieving this, so good practice examples might be shared between donors to fuel ideas. If this ambition is underpinned by clearly articulated donor nutrition policies, which explicitly acknowledge that the persistently high prevalence or high burden of acute malnutrition in many countries is a development concern rather than a problem to be addressed through emergency response, then advocates of this type of financing arrangement will have greater leverage within their organisations to effect change.

3 Strengthen nutrition governance

In the interests of strengthening nutrition governance, donors could increasingly explore opportunities to fund CMAM (and nutrition programming in general) through direct support to governments in certain contexts (e.g. pooled or earmarked funds or direct budget support), rather than through UN and international NGO implementing partners. However, for this to occur, national CMAM plans/strategies need to be embedded in the pooled fund agreement so that nutrition managers have explicit access to these resources.

Where donors continue to fund through multilateral or international NGO partners, it would be advisable to consider the increased transaction costs of this approach and a clear exit strategy. Where the impediments to funding government are directly concerned with accountability, transparency and 'corruptability' efforts could be made over a realistic time-frame to address these, i.e. institution of an effective audit system.

In order to make progress on these issues, the ENN would advise that advocacy efforts are undertaken through high-level donor forums to develop joint statements of intent by donors. This process could be supported by ensuring the development of more sophisticated finance tracking mechanisms than currently exist so that donor financing arrangements can be monitored more closely. Again, the SUN movement offers a practicable avenue for this, where donors have already embarked on a process to develop a shared approach to tracking resources aimed at nutrition.

In addition, good practice examples of where donors have entered into a more equitable arrangement with governments for financing CMAM through formally agreed cost sharing should be actively shared between donor organisations.

In general, it is in the interests of all stakeholders that there is greater transparency around donor financing of nutrition, including prevention and treatment

programmes for acute malnutrition. Existing mechanisms could help make donors more accountable, such as the annual report submitted by the SUN movement to the UN Secretary General; the annual reports to the G8 and African Union on the New Alliance on Food Security and Nutrition⁵; reports submitted to the World Health Assembly as part of the monitoring of the agreed global 2012 target to reduce stunting by 40% by 2025; as well as specific analyses of these trends undertaken by specialist agencies such as Development Initiatives.

Looking forward, there may also be scope to incorporate such donor accountability in the post-Millennium Development Goal (MDG) framework⁶, either in association with a specific nutrition target or as part of a wider priority around child mortality, aid effectiveness or good governance. Donor accountability could also be strengthened under the auspices of the EC; following the same process that is being prepared currently within the SUN movement, the EC could track and report on nutrition spending by all EU member states (many of whom are not members of the SUN movement), thereby broadening the reach of such accountability systems.

The importance of nutrition governance also plays out at country level. In Ethiopia, for example, the government's strategic leadership on nutrition is beginning to address the historical schism between how undernutrition is understood, monitored and managed. Options are currently being explored as to how best to bring all aspects of undernutrition together coherently.

⁵ There are five objectives agreed to by the New Alliance, including one on nutrition and one on accountability. <http://www.whitehouse.gov/the-press-office/2012/05/18/fact-sheet-g-8-action-food-security-and-nutrition>.

⁶ The current Millennium Development Goals expire at the end of 2015. Although much will have been achieved over their 15-year life span, many of the targets set for each of the eight goals will not have been reached. A process is underway to consider whether new global goals should be set for 2016 onwards and what these should cover.

4 Clarify UN roles and responsibilities

Treatment of MAM is not always considered or included as a core component of CMAM. WFP, which has assumed responsibility for addressing MAM, is absent from many of the countries with high prevalence rates or high burdens of MAM. Where WFP is not present in a country, clarity is needed as to whether and how UNICEF needs to be resourced to fulfil the role of supporting children with MAM having graduated from SAM treatment, a responsibility implicated in the WFP/UNICEF matrix of collaboration (2011). Equally, in areas where UNICEF is not present but WFP is, clarity is needed as to how uncomplicated SAM cases should be treated.

Given that CMAM scale up relies on integration into existing health systems and good inpatient support for the complicated caseload, the role of WHO in enabling this, in terms of global overview as well as country level support to government, needs strengthening. The current situation whereby WHO

has to seek funding for this role from other UN agencies will need to be addressed

In addition, and as a minimum, there is an urgent need for the global mapping of OTPs, which is currently carried out by UNICEF annually, to be complemented by mapping of SFPs and stabilisation centres within CMAM programmes. This could be informed by a country based analysis showing each agency's presence and the burdens of MAM and SAM and would assist donors in determining whether to invite or support new proposals. This type of mapping could be supported by WFP and WHO respectively, or where these agencies are absent or lack capacity, with the support of UNICEF. Without this information, it is impossible to know the extent to which the current UN tripartite arrangement is providing the level of support needed to scale-up on a country by country basis or where critical gaps exist which need to be filled.

5 Inform country level strategies for funding CMAM scale up

Given the recent surge in costing exercises for scaling up national nutrition programming, including CMAM, it is very important that such calculations are based on integration of CMAM programmes into existing health services, and take account of the decline in acute malnutrition as prevention efforts achieve impact. Good examples of this type of costing should be captured and disseminated for replication in other countries, with donors supporting governments in undertaking these exercises. The World Bank is well placed to offer such support, having led the international costing efforts to date and been instrumental in supporting the development of national costed plans in specific countries. The SUN movement is another critical actor in this area, having catalysed a great deal of the country costing work undertaken in the last two years. Members of the SUN Donor Network will play a key role in furthering such efforts.

Based on these costing exercises, donors will increasingly have an opportunity to work together on a country by country basis to agree a strategy and

vision for financing of CMAM within efforts to scale up nutrition generally. Donor coordination forums at country level could provide the impetus for this in 'signed up' countries. At the global level, donors may explore different strategies for how to support governments scaling up programmes for the prevention and treatment of acute malnutrition. These strategies will need to account for different elements of and contexts for programming, such as supplies versus human resources, relative gross domestic products (GDP) of countries and increasing domestic expenditure by governments over a realistically set time frame. These strategies can then be clearly articulated in donor policy documents.

6 Enable better technical coordination between donors

The ENN, in the course of this review have observed that there may be added value in greater technical coordination between donor organisations at global level and recommend that a regular technical forum for donor organisations working in the nutrition sector be convened. While the SUN Donor Network meets via teleconference on a regular basis, it is not clear whether this mechanism sufficiently allows donors to review nutrition policies and financing arrangements as a group. A global forum for technical discussion

would also allow donors to collectively prioritise key research areas and institutional arrangements for the delivery of nutrition programmes at country level. The SUN secretariat would be well suited to take a lead on this global forum, given the need to span development and emergency focused donors. The process could start with a small group of interested donors, perhaps involved in the SUN movement, with the UN Standing Committee on Nutrition (UNSCN) brought in as a partner to the process.

7 Priorities for donor research and study

Funding for research into different RUTF formulations and alternatives is a priority. The findings from on-going research in India need to be rapidly disseminated once available. It will also be important to more actively engage the support of the private sector in developing cost saving value chain models for local production of RUTF. Furthermore, product standards for treatment of SAM (SPHERE and World Health Organisation) may need to be revised if cheaper and more sustainably funded formulations are to be used.

Another priority area for research is cost-effectiveness of different approaches for preventing and treating MAM. The EC could lead on this research, building on ECHO's recent consultation on the prevention and treatment of MAM, but securing broader involvement across the humanitarian and development communities.

There needs to be a review of lessons learnt from the roll out and scale up of anti-retroviral therapy (ART) and malaria programmes globally, which have been underpinned by innovative financing arrangements. Lessons may well help inform efforts to scale up CMAM programming. One lesson had been identified already: "In the past decade, the great majority of additional funding for health has been through new vertical funds focused principally on specific diseases or interventions, such as vaccination. Important as these are, the record shows that their unintended consequences have included a neglect of broader health objectives and systems. In addition, because

the arrival of the new vertical funds was not accompanied by mergers, closures or acquisitions of existing organizations, they also contributed to a greater fragmentation of an already highly fragmented organisational framework."⁷ Indeed, the outcome document of the Fourth High Level Meeting on Aid Effectiveness (the 'Busan Partnership Agreement') seeks to address this, stating: "We will make effective use of existing multilateral channels, focusing on those that are performing well. We will work to reduce the proliferation of these channels and will, by the end of 2012, agree on principles and guidelines to guide our joint efforts."⁸

The ENN conclude that an economic and risk analysis should be undertaken to compare the transaction (and opportunity) costs of having several UN agencies and implementing partners responsible for acute malnutrition, with having a single agency with overall responsibility. The analysis will need look at the advantages and disadvantages of different options for ensuring optimal coverage for the treatment of acutely malnourished children. Based on these findings and a review of programming experiences in a number of countries, a high level meeting with UN organisations and donor organisations could be convened to agree a set of recommendations on UN agency responsibilities in this area. It will then be possible to identify how programmes to address acute malnutrition can be better aligned and coordinated within national contexts.

⁷ Keith A. Bezanson and Paul Isenman. 2012. "Governance of New Global Partnerships: Challenges, Weaknesses, and Lessons." CGD Policy Paper 014. Washington DC: Center for Global Development. <http://www.cgdev.org/content/publications/detail/1426627>.

⁸ Busan Partnership Agreement', Fourth High Level Meeting on Aid Effectiveness, 2011



**Produced by the ENN,
32, Leopold Street, Oxford, OX4 1TW, UK
Tel: +44 (0)1865 324996
Fax: +44 (0)1865 597669
email: office@enonline.net
www.enonline.net**