Conference on Government experiences of Community-based Management of Acute Malnutrition and Scaling Up Nutrition

Conference Report

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Prepared by the Emergency Nutrition Network (ENN)

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Film still from video address by Haile Gebrselassie to the CMAM Conference, 2011.

Acknowledgements

The CMAM/SUN conference was the culmination of over a year of detailed preparation involving numerous highly skilled people to bring about a successful meeting of senior Government delegates, UN agency, non-governmental organisations, academics, private sector representatives and individual experts. The conference was the first international occasion for Governments to be at the forefront of sharing their lessons of CMAM scale up and as such, provided a unique and rich insight into the achievements and obstacles Governments face in addressing high levels of acute malnutrition in their countries.

The Government of Ethiopia graciously hosted the conference in Addis Ababa and entertained delegates on the evening of Day 2 providing them with the opportunity to experience Ethiopian cuisine and music. The tireless efforts of the Ethiopian Government's Senior Nutrition Advisor, Dr Ferew Lemma, ensured that the conference planning and content had leadership and direction. We thank Dr Ferew most sincerely for his vision and guidance. Dr Ferew worked on a day to day basis throughout 2011 with two ENN members of staff, Emily Mates and Mulualem Mesene. Emily took overall responsibility for conference planning and, critically, worked closely with the nine country case study authors to document their lessons of CMAM scale up. Mulu, with the support of Thom Banks, the ENN Oxford based Project Officer, oversaw all aspects of the conference administration and together, they did an excellent job of this. Joining Emily and Mulu were the conference filming (Mango Productions plc) and IT crew who recorded the sessions and quickly uploaded footage onto the CMAM conference website on a daily basis. The conference was enabled from afar by the support of the ENN Team in Oxford (Matt Todd (Finance Manager), Katherine Kaye (Mailing Assistant) and Chloe Angood (Nutritionist).

Lola Gostelow was the conference facilitator and without question, provided the glue that kept us all working together with a clear steer and with enthusiasm and dedication over four enjoyable days. Abigail Perry did an excellent job as conference rapporteur. The ENN Technical Directors, Jeremy Shoham, Carmel Dolan and Marie McGrath were involved in every element of the conference in a wonderful team effort that worked to all strengths.

We thank all nine case study presenters for sharing their stories, and for the huge work they and their colleagues put into their preparation. We would also like to acknowledge the India delegates for their honest insights into the situation in their country, the additional twelve countries for their overviews of CMAM and all the participants for their rich contributions. We appreciate the work of the co-authors of the paper synthesising lessons learnt about CMAM scale up, Tanya Khara Latimore and Andres Meija Acosta.

The many 'friends of ENN' who behind the scenes provided technical support before and during the conference, led additional evening and afternoon sessions for delegates, and posted daily blogs for those unable to attend the conference, are warmly thanked. A note of thanks to Ceri Whitby, who collated agency video footage and went the extra miles to produce the memorable CMAM Film shown on Day 3. And special thanks to Aida Ashenafi and the team at Mango Productions Plc for their professional filming of the conference and their key role in securing the motivational video contribution of Haile Gebrselaisse.

We appreciate greatly the opening and closing speeches by H.E. Dr Kebede Worku, State Minister for Health, Ethiopia, a man with a very busy and demanding schedule, as well as the contributions from the key note speakers, His Excellency Dr Michael Hissen (Minister of Health for South Sudan), Her Excellency Dr.Nadeera Hayat Burhani (Deputy Minister of Public Health, Islamic Republic of Afghanistan), Her Excellency Michelle Levesque (Ambassador to Canada), Dr Steve Collins (Valid International), Biraj Patnaik (Principal Adviser, Office of the Indian Supreme Court Commissioners on the Right to Food) and Dr Manohar Agnani (National Rural Health Mission, Madhya Pradesh). We thank David Nabarro for a huge effort to join us on Day 4 and for listening to experiences and concerns raised on Days 1, 2 and 3, with a view to how the SUN movement may enable Governments to better overcome the obstacles they are facing. And notable also are those who contributed in their absence through video addresses to the conference - Dr Mary Robinson, President of The Mary Robinson Foundation - Climate Justice, and Haile Gebrselassie, Ethiopian Athletics legend.

Without the generous funding from Canadian International Development Agency (CIDA), UK Aid (Department for International Development (DFID)) and Irish Aid (IA), the conference would not have taken place. The conference donors' openness enabled more Government delegates to attend than previously envisaged and whose presence added to the very rich and important Government-to-Government conversations.

This report provides a brief account of the presentations and rich discussions four day conference. Video footage is available at www.cmamconference2011.org and on DVD (send requests to office@ennonline.net). A synthesis of the lessons of Government experiences of scale up of community-based management of acute malnutrition has also been produced[1]. All nine country case-studies will be included in a special issue of Field Exchange (due out June 2012).

Our allegiance to the welfare of the public should be above and beyond any shadow of doubt. Let us join hands and make undernutrition history and determine our professional destiny towards a better vista.

Dr Ferew Lemma, MOH Ethiopia, Ethiopia case study presentation, 15th November, 2011

[1] Government experiences of scale-up of Community-based Management of Acute Malnutrition (CMAM). A synthesis of lessons. ENN. January 2012. Available at www.ennonline.net and www/cmamconference2011.org

Contents

Common abbreviations

CMAM	**Community-based Management of Acute Malnutrition. Examples of other abbreviations include IMAM, PRN**
CSO	**Civil Society Organisation**
ENN	**Emergency Nutrition Network**
GAM	**Global Acute Malnutrition**
GoE	**Government of Ethiopia**
HIS	**Health Information System**
IMAM	**Integrated Management of Acute Malnutrition**
IYCF	**Infant and Young Child Feeding**
NGO	**Non-Governmental Organisation**
MAM	**Moderate Acute Malnutrition**
MDG	**Millennium Development Goal**
MoH	**Ministry of Health**
MUAC	**Mid Upper Arm Circumference**
OTP	**Outpatient Therapeutic Programme**
PRN	**Programa de Reabilitação Nutricional**
REACH	**Renewing Efforts Against Child Hunger**
RUTF	**Ready to Use Therapeutic Food**
SAM	**Severe Acute Malnutrition**
SC	**Stabilisation Centre**
SFP	**Supplementary Feeding Programme**
SUN	**Scaling Up Nutrition (movement)**
SWAps	**Sector Wide Approach**
UNICEF	**United Nations Children's Fund**
UNHCR	**United Nations High Commission for Refugees**
WFP	**World Food Programme**
WHO	**World Health Organisation**

1 Background

Since 2000, the treatment of Severe Acute Malnutrition (SAM) has been revolutionised with the development of Community-based Management of Acute Malnutrition (CMAM). CMAM programmes were first piloted in Ethiopia and a body of evidence has since been compiled demonstrating the effectiveness of the approach. This revolution culminated in 2007 in the endorsement of CMAM as the treatment of choice in a joint UN agency statement. CMAM programmes have since been rapidly scaled-up by actors in humanitarian relief contexts.

The CMAM approach is based on sound public health principles of access and coverage. With Ready to Use Therapeutic Food (RUTF) enabling recovery from SAM to take place at home, it has been possible to decentralise treatment services rapidly. This has maximised impact and coverage by bringing services closer to the household and, crucially, reducing the opportunity costs for patients and their caregivers. The CMAM approach also has an important preventive element in that greater access translates into earlier presentation of SAM thereby reducing the caseload of 'complicated' SAM.

The scale-up of CMAM programming across the world continues at a rapid pace with Government and multi-donor support. In light of the increased allocation of resources to CMAM programming, in 2010 the Emergency Nutrition Network (ENN) identified the need for a forum to share experiences from countries already undertaking scale up of CMAM to facilitate learning between countries that are or that plan to roll out CMAM.

In November 2011, ENN, in collaboration with the Government of Ethiopia (GoE) hosted a 4-day conference in Addis Ababa at which Government representatives from 22 countries in Africa and Asia, as well as members of international non-governmental organisations (NGOs), UN agencies, the private sector, academic institutions and donor agencies came together to share experiences and to identify lessons for further future CMAM scale up. A full list of conference delegates is provided in Annex 1. The conference and the participation of Government representatives was made possible with financial support from the Canadian International Development Agency (CIDA), the UK Department for International Development (DFID) and Irish Aid (IA).

The goal of the conference was to provide a learning forum for Government representatives on CMAM scale-up, to identify enabling factors and processes which allow successful scale up, and the challenges that hinder scale up. Specifically, the conference focussed on the policy environment, coordination, technical and supply considerations as well as the funding mechanisms that are required to establish, expand and sustain CMAM service provision at national level.

The first three days focused on sharing country experiences with CMAM scale up from nine case study countries which had been through a process of writing their 'story' on scale up prior to the conference, sharing from India as a special case study, as well as unique insights from a further twelve countries attending the conference. The final day provided the opportunity for conference delegates to consider the findings of the CMAM experiences in the context of the Scaling Up Nutrition (SUN) Movement and the implications of the SUN Framework for Action for CMAM scale up.

The conference agenda is included in Annex 2 and key points from all the presentations[2] and plenary discussions are integrated in this report.

Case study countries: Ethiopia, Pakistan, Niger, Somalia, Kenya, Ghana, Sierra Leone, Malawi, Mozambique.

Special case: India

Additional countries: Nepal, Afghanistan, Bangladesh, Cambodia, South Sudan, Sudan, Zambia, Uganda, Nigeria, Zimbabwe, Liberia, Tanzania.

A note on terminology
CMAM may take different shapes and forms at national level. Different names and acronyms are used to describe the same approach. Country-specific acronyms are explained in the text and a non-exhaustive list is given as examples in common abbreviations (see p5).

[2] All presentations are available at www.cmamconference2011.org or on request from the ENN: office@ennonline.net

2 Setting the scene (Day 1)

The conference was opened by His Excellency, Dr KebedeWorku, State Minister for Health, Government of Ethiopia. His Excellency noted that although CMAM has been shown to be effective, its scale-up is not straightforward, particularly in light of competing priorities. He emphasised that the CMAM conference was Government-centred, since it is Governments that set priorities and that it was the responsibility of all those present to share and to learn from each other.

Her Excellency Michelle Levesque, Ambassador to Canada, then welcomed delegates on behalf of CIDA, DFID and Irish Aid. Her Excellency identified that there is a need for commitment to scale up interventions shown to be effective at tackling undernutrition. She noted that Canada, the UK and Ireland will remain committed to address undernutrition, and will encourage all sectors to champion nutrition in their development work.

His Excellency Dr Michael Hissen, Minister of Health for South Sudan, and Her Excellency Dr.Nadeera Hayat Burhani, Deputy Minister of Public Health, Islamic Republic of Afghanistan, made a few opening comments, underscoring the importance of Government leadership in the successful management of undernutrition. Both also highlighted the value of cross-country learning for the development of CMAM, as well as their commitment to strengthening programmes to address undernutrition in their countries.

Marie McGrath, ENN Technical Director, then welcomed delegates on behalf of the ENN. Marie noted that ENN was originally established with the objective of capturing lessons from humanitarian programming and that ENN's history with CMAM was extensive. She commented that scale up of CMAM has happened rapidly over the last five years and that Governments have a pivotal role in this process. She concluded by saying that the conference aims to capture key lessons of scale up and that ENN will share these lessons widely.

With the welcomes complete, Lola Gostelow, the conference facilitator, introduced the 22 country delegations and the representatives from the other organisations present. She noted that the conference was a rare opportunity for structured Government-to-Government exchange. Lola reminded delegates that the goals of the conference were to identify what is required to establish, expand and sustain CMAM and to link to the wider agenda of the SUN movement. She emphasised that the conference would require delegates to use their leadership and visionary qualities to define a way forward for CMAM scale up over the following four days.

3 Government experiences of CMAM scale up

3.1 Overview

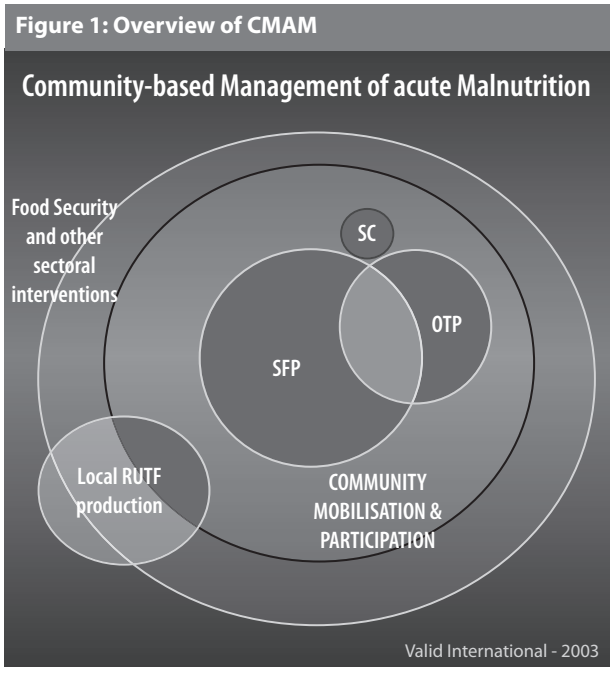
The first 1.5 days of the conference provided the opportunity to learn about and reflect upon country experiences with CMAM. Following an orientation to the CMAM approach, nine Government representatives presented an overview of CMAM scale up in their countries, based on detailed case studies prepared in advance of the event. The remaining 12 country delegations were also given the opportunity to provide a brief overview of CMAM in their contexts. In addition, Biraj Patnaik (Principal Adviser, Office of the Indian Supreme Court Commissioners on the Right to Food) presented the unique experiences of CMAM in India. Time was provided between presentations for questions from conference delegates and these discussions helped link to the next stage of the conference, which involved a synthesis of lessons learned to date regarding CMAM scale up (see Section 4).

3.2 An orientation on CMAM

Dr Steve Collins (Valid International), one of the pioneers of CMAM, provided an overview of the approach (See Figure 1). He highlighted the following five key points:

- The delivery mechanisms for CMAM are critical. In recent years, there has been an over-emphasis on RUTF supplies and an under-emphasis of the importance of mobilising communities.
- Evidence is key when moving forward, particularly when it comes to the current gap in understanding of how to address moderate acute malnutrition (MAM).
- The single most important indicator of success for CMAM programmes is coverage, in terms of proportion of SAM cases reached.
- Integrating CMAM as part of standard health care package takes time. This necessitates continuity of funding and a move away from short-term emergency funding.
- CMAM is implemented through public health systems that are often already struggling. It is important to consider how to support these systems to ensure effective CMAM programming.

Figure 1: Overview of CMAM



3.3 Government experiences of CMAM scale up

A summary of each of the nine country case study presentations *(Ethiopia, Pakistan, Niger, Somalia, Kenya, Ghana, Sierra Leone, Malawi, Mozambique)* detailing CMAM scale up achievements and key lessons and challenges from the perspective of Government is given in Box 1. The CMAM Conference afforded also a valuable opportunity to hear from the additional twelve countries representatives about their country's experiences of CMAM implementation. These overviews, shared in plenary, were necessarily brief but provided a snap-shot of CMAM scale up experiences to date. In essence, the twelve additional countries *(Nepal, Afghanistan, Bangladesh, Cambodia, South Sudan, Sudan, Zambia, Uganda, Nigeria, Zimbabwe, Liberia and Tanzania)* are at varying stages of scale up. At one end of the spectrum, countries like Bangladesh and Cambodia are still at the planning stage, while countries such as Sudan, Uganda and Nigeria have affected considerable scale up in a short space of time covering wide geographic areas. In the case of Sudan, initial CMAM programming began in 2003 (initiated by international NGOs) while in Afghanistan programming only started in 2010. The experiences of these 12 countries share many similarities with the nine country case study countries, as well as some unique elements of programming. Details are included in the CMAM Conference Synthesis Report.[3]

Box 1: Scale up achievements, key lessons and challenges (case study countries)

Ethiopia

Presented by Dr Ferew Lemma, Senior Nutrition Adviser, Government of Ethiopia

The first pilot studies of CMAM in Ethiopia were undertaken in 2000. CMAM has since been scaled up nationally with 90% of health posts in the country now providing CMAM services. CMAM scale up has been directed by the Health Sector Development Programme through the Health Extension Programme and the National Nutrition Strategy / Programme (NNS/ NNP). The programme is exceeding Sphere standards: on average (from a total of more than 700,000 children treated) the cure rate is 82%, the death rate is 0.7%, and the default rate is 5%. The key factors to success include; Government ownership/leadership, the Health Extension Plan (which has enabled greater reach to communities), the establishment of local production of RUTF and robust information systems. Challenges include the lack of logistical capacity to store and transport large quantities of RUTF, difficulties forecasting the need for RUTF and inadequate supervision structures in the health system. A key concern is the sustainability of financial support from donors in 'non-emergency' periods.

Kenya

Presented by Valerie Wambani, Programme Officer Emergency Nutrition, Ministry of Public Health and Sanitation

Integrated Management of Acute Malnutrition (IMAM)[4] programming started in earnest during 2007 led by the Ministry of Public Health and Sanitation (MoPHS), UNICEF and WHO. Through gradual expansion of services, geographical coverage of the IMAM programme increased from 50% for SAM and 39% for MAM in 2009, to 73.9 and 60% in 2011. On average the programme is meeting Sphere standards. Partners are coordinated through the Nutrition Technical Forum (NTF), which is chaired by the MoPHS and co-chaired by UNICEF. IMAM is predominantly funded through emergency budgets, provided by both the Government of

[3] See footnote 1.
[4] IMAM is synonymous with CMAM.

Kenya and partners. The factors contributing to the success of the programme include the leadership and oversight for IMAM implementation by the MoPHS, partnerships and coordination at all levels, community strategy implementation and the nutrition sector response plan which focuses on increasing outreach sites to improve coverage. Major challenges include inadequate capacity of health facilities to undertake the full IMAM package due to high staff turnover, incomplete integration within the health system, insufficient active case finding, pipeline breaks and concerns with the quality and storage of commodities.

Niger

Presented by Dr Maimouna Guero, Director of Nutrition, Ministry of Public Health

CMAM was partially introduced for the first time as part of the emergency response to the 2005 food and nutrition crisis. The integration directive issued in 2008 made it compulsory for all partners involved in the management of SAM to integrate their activities into the existing Government-run health system. Scaling up CMAM in Niger was gradual, mostly happening in response to food crises developing across the country and consistently high levels of acute malnutrition. To date, CMAM is fully integrated and the service is provided by Government staff, with surge capacity from NGOs when need arises. Of the 800 health centres in Niger, 772 provide treatment for SAM without medical complications, 850 provide treatment for MAM and treatment for SAM with medical complications is available in all 50 hospitals in the country. The factors contributing to success include increased political commitment for nutrition, strong leadership from the Ministry of Public Health, technical support and assistance from partners and the development of longer-term strategies to address malnutrition. The main challenges include: maintaining quality care in all treatment centres, sustaining adequate supplies of expensive therapeutic products, and scaling up MAM programmes across the country.

Malawi

Presented by Sylvester Kathumba, Principal Nutritionist, Ministry of Health

CMAM started in Malawi during the 2001 food crisis. In 2002, Valid International and Concern Worldwide conducted operational research to test the safety and efficacy of the approach and in 2003 the MoH added one more district to the research. In 2004, the MoH organised the first National CMAM dissemination workshop for District Health Officers (DHOs), NGOs and other partners. The DHOs demanded the programme be started in their districts and the MoH added three more districts in 2005. Gradual scale up to cover all 28 districts of Malawi has continued since then. The success of CMAM in Malawi is the result of (1) political commitment, (2) involvement of the CMAM Advisory Service in scale up, integration and quality service delivery, (3) effective coordination and networking, (4) local production of RUTF, (5) commitment for Government to take over financing of the CMAM programme and (6) development of CMAM Operational Plan. The main challenges include: resource instability, retention of volunteers, capacity development and monitoring/reporting.

Somalia*

Presented by Leo Matunga, Nutrition Cluster Coordinator representing Somalia

Despite the difficult circumstances and limited access for staff in Somalia, IMAM services rapidly expanded throughout the whole country from 2007-2011. This scale up has been possible through partnerships with local NGOs, UN agencies, international NGOs, donors and the Governments of Somaliland and Puntland. The factors that have enabled this expansion include: third-party monitoring, improved field coordination, mentoring of local NGOs by international partners, and UNICEF (in partnership with local NGOs) supporting targeted SFPs following the withdrawal of WFP and international NGOs. The challenges include: (1) limited

first-hand monitoring due to the lack of access for international staff, (2) insufficient capacity of local partners, (3) the short term nature of funding which means agencies try to implement too much too soon affecting the quality of service provided (4) access and clan issues in the South Central Zone means that established partners are unable to expand services and it is necessary to work with local partners who have access but lack experience and skills, (5) sustainability of the expansion in the unstable context and with short term funding mechanisms and (6) insecurity resulting inlimited pre-positioning of supplies, looting and corruption.

Sierra Leone

Presented by Jeneba Kamara, Nutritionist, Ministry of Health and Sanitation

CMAM started in 2007 as a pilot project in four districts, in response to continuing high rates of malnutrition in the post war years. Since then, the programme has been gradually scaled-up, with the establishment of more OTPs and SCs and the establishment of SFPs. The initial targets for scale-up were achieved: at least one OTP per chiefdom by 2010, to achieve better coverage of remote areas and to cater for the increased case-loads expected following the adoption in 2010 of the WHO growth standards. The MoH leads health sector partners and chairs quarterly coordination meetings with UN agencies and NGOs implementing CMAM. The factors that have contributed to the success of the programme include: effective coordination among partners, Government commitment, the leadership of the food and nutrition division of the MoH in coordinating the programme and the existence of an effective monitoring system including coverage surveys that enable targeted corrective actions in areas of low performance. The major obstacles include: getting nutrition on the official list of Government priorities and keeping it there, inadequate community mobilisation, low coverage and inadequate service delivery as a result of limited numbers of skilled health staff.

Ghana

Presented by Michael Amon Neequaye, Nutrition Department Head, Ghana Health Service

CMAM was first introduced in Ghana in June 2007 at a workshop organised by the Ghana Health Service in collaboration with UNICEF, WHO and USAID. The MoH/GHS then adopted CMAM for the management of SAM by establishing learning sites in two districts in April 2008. The learning sites were later expanded to one more district in March 2009. These learning sites provided accessible practical experience and an opportunity to refine the strategy for the scaling-up of CMAM in phases. CMAM integration and scale up has been planned in a two-phased approach: phase 1 (which started in 2010) targeted five regions and phase 2 (which is expected to start in 2012) will target the remaining five regions. The SAM Technical Committee (TC) manages the operational strategy for CMAM at national level and at regional level, CMAM roll-out is overseen by support teams working under the regional health director. The factors that have contributed to success include: (1) consensus building prior to roll out, (2) integration of outpatient care into the Reproduction and Child Health service package (3) establishment of a SAM TC, (4) integration of CMAM supplies into the GHS supply chain system and (5) the training strategy. Key challenges include: commitment and funding to support phase 2 scale-up, weak community outreach, high default rates, volunteer fatigue, community perceptions of SAM as a spiritual disorder and establishing national production of RUTF.

Mozambique

Presented by Edna Possolo, Head of Department of Nutrition, Ministry of Health

Following floods in 2002, the MoH in Mozambique revised the programme known locally as the Programa

de Reabilitação Nutricional (PRN- Nutrition Rehabilitation Programme) and introduced CMAM as a key component. Outpatient treatment for SAM without complications was introduced in Maputo City in 2004 as part of HIV treatment services for children. It was incorporated in to general health services and expanded to other provinces in 2007. The health directorate of one district in Nampula Province initiated a full package of treatment for acute malnutrition as a pilot in 2007. This pilot was successful and subsequently expanded to other districts. By 2010, five districts had established a pilot learning centre. As of mid-2011, 191 out of 1280 health facilities in the country provide inpatient treatment for SAM and 229 provide outpatient treatment. However, as yet, not all facilities or districts have been trained in the updated 2010 protocols. The factors contributing to success of CMAM in Mozambique include: strong commitment by Government, good integration in health programmes, increasing interest and support from the communities and successful set-up of local production of RUTF. Key challenges include: maintaining quality of training at all levels, recording and reporting, supply chain management, short funding cycles of donors and ensuring appropriate nutrition counselling in all components of the programme.

Pakistan

Presented by Dr Baseer Khan Achakzai, Director General, National Institute of Health,Cabinet Division, Pakistan

Since 2003, small community-based nutrition programmes have been implemented in Balochistan for Afghan migrants and host communities. In 2007, UNICEF initiated CMAM in the flood prone areas of Balochistan and Sindh. In 2008/09, these interventions were expanded to earthquake-affected districts in Balochistan, flood-affected districts in Punjab, conflict-affected areas in the area formerly known as the North West Frontier Province and food insecure areas in other provinces. These programmes were effective in terms of high coverage, high cure rate, low death and low defaulter rates. CMAM was then rapidly expanded across the country in response to the 2010 floods. Examples of factors that have contributed to CMAM success in Pakistan include: leadership at Federal level, strategic planning (Punjab), NGO involvement (Khyber Pakhtunkhwa), communication (Balochistan) and research (Sindh). The main challenges have included: resources (financial, human and supplies), coordination, lack of definition of cluster member roles and UN agencies''war of mandates'.

*Presented morning of Day 2.

3.4 CMAM in India: challenges and opportunities

The experience of CMAM in India has been markedly different to that of many other countries. For this reason, Biraj Patnaik was invited to provide a more detailed presentation of India's specific challenges and opportunities to the conference. Dr Manohar Agnani (National Rural Health Mission, Madhya Pradesh) then provided an overview of CMAM in the State of Madhya Pradesh (MP). The key points arising from these presentations were as follows:

- Despite rapid economic growth, 46% of children and one-third of adults in India are undernourished and 20% of infants are born low birth weight (<2.5kg). There is approximately the same number of acutely malnourished children in India as in the whole of Africa.
- Nutrition programmes are provided via the Integrated Childhood Development Service (ICDS). A number of interventions are included in the package provided but the programme mainly targets children above 3 years of age, there is a lack of capacity to deliver interventions and the package does not yet include CMAM. The ICDS is not administered through the Department of Health and there is poor coordination with health services.
- Concerns regarding the role of the private sector in CMAM in India have been a significant barrier to CMAM scale up, fuelled by the absence of a comprehensive governance framework for the private sector.

- India first initiated discussions about CMAM in 2006/07 as a result of concerns about the use of RUTF. An initial pilot study using RUTF, undertaken by UNICEF, was stopped by the Government because the regulatory approvals were not yet in place for use of the product. Indian civil society was particularly concerned about the approach being product driven without a strong community component. It was felt that CMAM should be seen as one component of a larger continuum of care, including preventative activities and links to other relevant programmes, such as social protection.
- There is a strong tradition of rights-based approaches in India and CMAM advocates are now trying to fit it into this agenda.
- A Supreme Court Order has been passed specifying that the nutritional quality of foods provided as part of the ICDS be improved. However, the Supreme Court has banned the involvement of private sector for provision of supplementary foods, including RUTF, because of concerns of corruption and regulation.
- There is now much more consensus on what needs to be done to move forward. Evidence based scale-up for the India context is needed including trials to compare different approaches (including non-RUTF), the involvement and ownership of local communities and the elimination of the private sector from RUTF production. A clear distinction between therapeutic treatment and IYCF must be made.
- MP and other States have introduced protocols for the inpatient treatment of SAM in Nutrition Rehabilitation Centres (NRCs). However, caseloads far exceed the capacity of the NRCs.
- MP has developed a State strategy with facility and community based interventions. This will first be piloted in two districts and scaled up to cover the state based on experiences. The Government has recently approved piloting of local production of RUTF through the public sector. To give a sense of scale, around 200,000 frontline service providers must be trained in MP to enable scale-up.
- Approaches to address MAM continue to be a concern.

3.5 Questions and issues emerging from country experiences of CMAM scale up

A number of questions were posed to the presenters of the country case studies and Dr Steve Collins and Biraj Paitnaik (as Day 1/2 keynote speakers). A summary of these is given below, grouped in to six thematic areas. In addition, conference delegates were asked at the end of Day 1 to submit any outstanding issues and comments about what they had taken from the conference so far. These are summarised in Table 1.

Community engagement

Numerous questions were raised related to the involvement of communities in CMAM programming and approaches used to reach out to communities. Many of the countries recognised that the community component was often weak and in some contexts it was being rolled out after the facility-based components of the model were in place. Community Health Workers (CHWs) and Volunteers (CHVs) were mentioned as being responsible for active case finding in many of the countries, but there was a general concern about the reliance on volunteers. There was a discussion of strategies to engage volunteers by providing non-financial incentives. It was noted that in the Somalia setting, there is no volunteerism and instead partners give incentives for work in the community, use in-kind payments (cash-for-work, training) or provide a salary to community workers. In Niger strategies are being considered to motivate volunteers, while in Malawi it is envisaged that in the longer-term, there will be a shift to using salaried HEWs to manage the community component.

The importance of engaging communities from the start of a CMAM programme was emphasised. One recommendation was to use anthropological studies to identify how communities conceptualise malnutrition and the barriers to treatment, another to negotiate with traditional healers to enable them to contribute to early identification of acute malnutrition. In Malawi, the approach involves engagement of the community before starting and frequent planning meetings with communities in order to get input and provide feedback.

Programme protocols

A number of questions were asked about the specific protocols employed. One delegate asked about target groups and it was apparent that there is a wide age range for the groups that are currently eligible for treatment, e.g. children up to 10, 12 or 15 years of age and in some cases infants <6 months. In Niger and Malawi, pregnant and lactating women are targeted while several other countries discussed the inclusion of treatment of malnutrition and provision of RUTF to adolescents and adults with HIV/AIDS and TB.

Different admission/discharge criteria are being used. For example, Ghana uses mid upper arm circumference (MUAC) and oedema for admission and 15% weight gain for two consecutive weeks for discharge. Meanwhile, in Niger children are discharged using WHO Z-score <-2.

A number of strategies for reducing relapses were highlighted. For example, in Malawi relapses were reduced by 'strengthening linkages/integration'. Inn Niger, the process of negotiating with the mother where treatment could be provided closer to home with mothers had improved adherence and reduced readmissions.

Management of MAM was also discussed. Delegates from Somalia, Niger and Sierra Leone noted that management of MAM was part of the CMAM programme and that WFP provides support for this. In Ghana, supplementary feeding for MAM is only provided in some areas and the Government is liaising with WFP to develop guidelines for MAM management.

Production of RUTF

There was a lack of clarity regarding the term 'local production' with some delegates perceiving this to involve micro-scale production of RUTF within communities. It was emphasised that 'locally' produced RUTF needs to adhere to minimum quality standards and thus need to be produced in factories with the appropriate conditions. Any formulation for which there is no evidence-base needs to be subjected to efficacy trials.

Concern was expressed by a number of delegates about the barriers to achieving local production, including a perceived shift to investment of production of RUTF in high-income countries. It was pointed out that RUTF is now part of the USAID Title II Food Aid portfolio and will thus be increasingly manufactured in the US. It was noted that it is difficult to manufacture RUTF of high quality locally without significant financial investment and good infrastructure. Furthermore, there needs to be a strategy linking procurement, supply and logistics as well as integration with local agriculture. A representative from Nutriset stated that a licence to produce the Plumpy'nut® formula can be obtained via an online application process[5] , so that local production should not be constrained by patent law.

Several country delegates commented that despite the establishment of local production, RUTF was still a significant financial burden for Governments. One idea put forward was that RUTF should not be seen as different to any other drug that Governments procure and supply. A representative from Sierra Leone noted that RUTF had been incorporated into the countries essential drug list. However the WHO representative cautioned that classifying RUTF as a drug is not desirable, as the process of drug classification is typically lengthy and included strict quality assurance measures during production that would have resource implications. This would likely act as a disincentive to local producers. Including RUTF on a national essential commodities list is more feasible without these disadvantages.

Information systems

The country case studies prompted a number of questions about monitoring and surveillance in relation to CMAM. In terms of surveillance, the consensus was that one or two well-collected indicators (e.g. measurement of MUAC) were preferred to numerous poorly collected measures. In terms of monitoring, examples of systems to promote information flow from community to national level were given from Ethiopia and Mozambique. In Somalia, a third-party approach has been used to monitor CMAM programmes remotely in insecure areas of the country. It was acknowledged that management of programme monitoring in general was a challenge and a number of countries mentioned that there have been weaknesses in programme data.

The value of coverage (proportion of target cases reached) as an indicator was re-iterated and some of the newer methods to measure coverage, e.g. SQUEAC (Semi- Quantitative Evaluation of Access and Coverage), were mentioned.

[8] http://www.nutriset.fr/en/access/patents-for-development/online-patent-usage-agreement.html

Political commitment, coordination and integration

The first part of the conference prompted debate concerning how to promote political commitment and effective coordination of CMAM, as well as what 'integration' of CMAM involves. These issues were discussed in further detail during the third and fourth days of the conference (see below). Delegates noted that the country case studies identified 'political commitment' as being central to the success of their programme and requested more information about what this entailed. Examples given included the inclusion of CMAM funding into national budgets and in some cases, actual provision of funding by Government. The Ghana delegates described the process by which the Government of Ghana led the implementation of CMAM, having been shown the impact of the approach in other countries. There was also recognition that much of the existing CMAM programming was initiated in response to humanitarian emergencies.

When asked to expand on the coordination process, a number of countries identified the value of technical coordination groups. Some mentioned that coordination functions had been put in place to promote links to other sectors and programmes (including social protection, water/sanitation as well as specific health initiatives such as malaria and HIV/AIDS programmes). In Kenya, for example, multi-sectoral coordination of nutrition is through a body within the office of the executive, whilst links between programmes are realised at district level through inter-sectoral district planning teams.

There was a lack of consensus on what the term 'integration' meant in relation to CMAM. Some delegates thought that integration related to the incorporation of CMAM into health services, whilst others considered it more broadly as links with other sectors. A comment was made that 'integration is about achieving buy in, commitment and involvement of all relevant stakeholders'. Because of the different interpretation of 'integration,' a group of technical experts volunteered to develop a 'working' definition that could then be used for subsequent discussions in the conference (and perhaps a starting point for further work on a definition post conference):

Integration within the context of CMAM:

- *[Management of] SAM and MAM are integral parts of CMAM*
- *CMAM is one of the basic health services to which a child has access – delivered by the same means by which other services are delivered.*
- *This is embedded as part of a broader set of nutrition activities (IYCF, micronutrients etc.)*
- *This, in turn, is integrated within a multi-sectoral approach to tackle the determinants of undernutrition.*

3.6 Concluding points on Government experiences of CMAM scale up

The presentation of Government experiences of CMAM gave considerable insights into the opportunities and challenges for scale up. Headlines included:

- CMAM scale up has been happening at a rapid pace, particularly over the past five years in a highly diverse range of country contexts and often off the back of emergencies.
- Most country programmes are reaching internationally-agreed targets.
- Governments have taken much greater ownership of CMAM and are encouraging other stakeholders to facilitate greater capacity to escalate decentralisation.
- The community sensitisation and mobilisation elements of CMAM have lagged behind implementation of the other components of the approach.
- A great deal more learning is needed about how to integrate CMAM into broader essential health and nutrition programmes, as well as how to establish links with other sectors.

These observations provided a platform for the next stages of the conference, which involved break-out time for the delegates to reflect on what had resonated with them from the country presentations. A summary of the key points fed back to plenary from these breakout sessions are presented in Table 1.

Table 1. Plenary feedback on key points learned or 'burning issues' that emerged from the country case study presentations

Scale of the problem and progress made	Importance of information systems and issues of indicators	Political commitment	Prevention
• Learnt about the magnitude of the problem of malnutrition globally. • Speed of take up of CMAM and expansion has been extraordinary.	• Important for each country to have a national survey to have a firm understanding of the scale of undernutrition. • Each country needs a strong surveillance system in place to generate information and evidence. • Data management and M&E as we move from crisis to routine programme of CMAM, there needs to be a system to track and collate data. Good performance indicators being outlined – important to have systems for standardising / reporting performance and ensuring quality of data so resources are allocated correctly. • Include MAM/SAM together in outcome indicators. • Standardisation of monitoring is very important to ensure quality and comparable data, particularly considering number of stakeholders involved.	• A high political commitment is important. • Very important to ensure commitment from the Government – particularly because of short term nature of funding. • It seems that increased political engagement is key to increase CMAM. Any insight into mechanisms by which malnutrition entered on to the political agenda? Any thoughts on the risk that this high level Government engagement contributes to shift away from development to 'food aid' approach? (i.e. is CMAM seen as a politically acceptable response to complex (often politically contentious) determinants of undernutrition (e.g. gender, land entitlements etc.) • Government ownership to provide policy/strategy/ coordination is critical. • Presentations show how CMAM links to events (emergencies) – visibility of wasting in emergencies increases political and donor interest. • Political commitment is essential to increase drive and coordination is also essential.	• CMAM is about managing malnutrition but we feel that we need to move forward to look at prevention – which is where the SUN framework comes in (prevention and management). • Need to get donors to fund preventative activities. Funding is more attached to health facility activities tied to cure. Donors are more interested in immediate results. We need to put funding for long term preventive actions with milestones. • There is a need to get donors to think more about preventive activities for IYCF, hygiene etc. • CMAM is about managing malnutrition however it must now be seen as an integral part of nutrition programming focused on prevention and management. • SUN movement – nutrition specific and sensitive as part of comprehensive approach.
Challenges to 'integrating' into health systems	**Production of affordable products locally**	**Importance of community involvement**	**Multi-sectoral nature of malnutrition**
• Health system strengthening? No information about the different contexts in terms of the strength	• The quality of local production is crucial. • Local therapeutic diet needs further efficacy research – there needs to be evidence. • Are commercial interests impeding affordable and sustainable local production? • What is being done to ensure that developing countries can produce quality and affordable RUTFs and micronutrient powders (MNPs)? • How can local production be stimulated? • CMAM discussion implies it is RUTF or nothing – what about indigenous foods – would like more exploration of this. • Technology transfer from companies that are supporting local production. • Products are expensive, availability of local product is important for sustainability – with trend to reduce cost.	• Involvement of communities? We want to have organised system at community level when it comes to building capacity and engaging communities. • There needs to be clarity on terms 'community', 'management', 'local'. Would like to hear more about how communities got involved with the process. • How do we use the community structures more for sustainability and for preventative purposes? • Strong community network critical for success of CMAM. • How to engage traditional practitioners? • It is striking how little community there is in CMAM! • Would like more stories of how communities are involved in planning and delivery. • Not enough focus on communities and their involvement.	• A lack of multi-sectoral people in this meeting, yet when we consider the causes of malnutrition and so when we are leaving out key people we are losing out to make progress in this area. • The missing stakeholders include community groups, logistics, farmers/agricultural groups with links to local production.

(Cont'd next page)

Table 1. Plenary feedback on key points learned or 'burning issues' that emerged from the country case study presentations (Cont'd)

Scale of the problem and progress made	Importance of information systems and issues of indicators	Political commitment	Prevention
	• Local production is a subject to address to ensure sustainability. • Local production mentioned but no solutions given –what about Government role in facilitating importing of product when needed? • Where are examples of successful local production, improvement of markets and engagement of local farmers – please give details. • What does 'local' mean in local production?		
Funding	**Capacity**	**Scale up**	**Other**
• How can donors get more interested in long-term activities, preventative activities rather than simply CMAM with just the cure? • Very important to ensure commitment from the Government – particularly because of short term nature of funding. • Sustainable financing of CMAM – how can this be achieved? • Resources to ensure quality? • What proportion of national budget is for health and what proportion of this is allocated to nutrition? • Programming presented appeared to be very donor driven – how sustainable is CMAM? • CMAM described as very expensive without donor support – what about options other than RUTF?	• Human resource problem: lack of staff availability, lack of training, retention of staff • No-one talked about involving academic institutions	• Many of the constraints mentioned apply to the broader health system – other services meet the same problems. We need to have a broader debate on this involving other partners before we can go so far with CMAM scale up. We need to join forces and learn lessons and not think of CMAM in isolation.	• No differentiation made between SC and OTP in presentations despite these being so different and having different challenges • More information needed on coverage surveys (SQUEAC, CSAS etc.) • Coverage high for SAM but low for MAM • Is quality or coverage of CMAM more important in an emergency? • What is meant by 'management' in CMAM? • How do you avoid 'double counting' of cases/ relapses etc. – are repeated treatments due to seasonal food scarcity accounted for? • What are volunteers expected to do? Why is volunteer fatigue common? • Gender dimension of CMAM programme, many issues related to women/ children, particularly referral/admission, women not able to leave children behind, what is the role of men in CMAM as we move forward?

4 Taking Stock (Day 2)

4.1 Overview

The day began with a video address from Dr Mary Robinson, President of the Mary Robinson Foundation - Climate Justice (MRFCJ), to the conference. She spoke about the particular impact of climate change on the food security of many of the countries represented and about the situation in Somalia.

The remaining two country case studies and the India experience were presented in the morning of Day 2. The afternoon focused on bringing together lessons learned from CMAM scale up and the identification of key constraints. The session started with a presentation of a draft synthesis paper by Carmel Dolan and Jeremy Shoham, ENN Technical Directors and Andrés Mejía Acosta from the Institute of Development Studies. This synthesis was based on the nine country case studies, some background to the India 'story' and a review of the CMAM literature. Day 2 also included a presentation by Peter Hailey and Dr Tewoldeberhan Daniel of a conceptual model for an alternative approach to emergency CMAM response. The afternoon involved a panel discussion with representatives from UN agencies (UNICEF, WFP, WHO and the REACH initiative) to clarify the role and responsibilities of UN agencies in the scale up of CMAM, and to take questions regarding the UN role from delegates.

4.2 Synthesis of key lessons learnt

Carmel began the presentation of the synthesis of lessons learnt by noting that the synthesis report would be updated and finalised based on the proceedings and outcomes of the conference and feedback on the draft paper from the case study authors[6].

Getting CMAM onto the national agenda

CMAM becomes part of the national agenda primarily because of humanitarian emergencies and the priority given to acute malnutrition. The tendency in emergencies to measure acute malnutrition helps to expose the scale of the problem. Emergencies also bring organisations with CMAM expertise into countries. The fact that emergencies trigger CMAM does mean there has been a reliance on short-term funding, but this has also enabled innovation. In all case study countries, pilot projects were identified as a key factor for getting CMAM onto the agenda. These provided the opportunity for Governments to learn how to undertake CMAM in their own countries, which also enabled 'buy in' and facilitated scale up.

Keeping CMAM on the national agenda

Dialogue with national and international experts is crucial for maintaining commitment to CMAM. Ongoing discussion with Government, advocacy

[6] Government experiences of scale-up of Community based Management of Acute Malnutrition. A synthesis of lessons. Khara T, Mejia Acosta A, Dolan C, Shoham J, ENN, Jan 2012. Available at www.ennonline.net

and the use of CMAM champions all emerged as having contributed to keeping CMAM on the agenda. Technical fora were also identified as playing an important role in the promotion of CMAM and the identification of opportunities to embed CMAM in existing policies. However, one critical factor is that technical groups promote a unified message about CMAM. The inclusive development of single CMAM guidelines involving all key stakeholders creates additional momentum and advocacy for CMAM.

CMAM planning

Almost none of the case study countries had a scale up plan for CMAM, although some had implementation plans. The reliance on short term funding is felt to be inhibiting longer term planning. The lack of good costing information is likely preventing the development of budgets for CMAM scale up. All case studies revealed an inherent tension regarding decentralisation (crucial for achieving coverage) and the capacity to implement programmes of appropriate quality.

Integration

The only concrete entry point for CMAM integration was into HIV programmes. The integration process into other health services (for example, IMCI, Growth Monitoring and Promotion) still needs to be explored. Integration with other sectors is also poorly understood. The country case studies also revealed challenges for the integration of programmes for the management of MAM into the overall CMAM package. It was not clear how this can work outside the emergency response arena.

Capacity and capacity strengthening

Lack of capacity (human, logistical, monitoring and evaluation) is one of the most inhibiting factors to CMAM scale up and this process must be considered in parallel with health system strengthening. The country case studies demonstrated that the NGO community is moving away from direct implementation and towards capacity development. There has been apparent shift to on the job training for CMAM, which has been shown to be effective. High staff turnover continues to be a problem and major capacity gaps were found for management, monitoring, reporting, supervision and planning. There is very little pre-service training in CMAM that needs to be addressed by incorporating it in to relevant course curricula.

Community mobilisation

A recurrent theme from most country case studies is that the community element of CMAM has lagged behind the implementation of other components of CMAM. The reasons are likely to be that the importance of the 'C' in CMAM has not been clearly emphasised or understood and in some cases, CMAM has been wrongly viewed as a vertical programme.

Speed and modality of scale up

Here, the presentation was handed over to Jeremy Shoham. The country case studies indicated that CMAM scale up has been rapid and it is difficult to ascertain the implications for quality and true coverage of the programmes (i.e. the proportion of SAM cases being reached). The case studies reveal more about geographical coverage than caseload coverage, as few countries have measured programmatic coverage. A gradual build-up of coverage is best achieved by identifying constraints to access to services. It is possible that the increased availability of resources during emergencies can result in scale-up taking place too quickly, jeopardising quality.

Monitoring

Monitoring is clearly a challenge, although not only for CMAM. The case studies revealed some innovative approaches, including the use of SMS and third-party monitoring. The main challenge concerned reporting formats, which need to be simplified to ensure that only the indicators that are needed are included. Another common challenge was the inclusion of CMAM indicators into national Health Information Systems (HIS). There is the potential to include one or two of the most crucial indicators into these systems. A number of the country case studies indicated that programmes were meeting Sphere standards, although in most cases coverage (proportion of SAM cases reached) was not being measured. It is possible that coverage targets need to be modified to include a timeframe for reaching particular thresholds during the scale-up process.

Financing

The country case studies indicated that the majority of funding for CMAM comes through emergency mechanisms, although the percentage of funding from different sources is not known. This compromised longer-term capacity development and planning. Some case studies noted that emergency funding was a barrier to scale up.

Funding for chronic emergency contexts was more predictable, but this tended to be directed to UN agencies and NGOs rather than through the Government. It was not clear if emergency funding has resulted in a 'stop-start' of programming. There is a lack of clarity on funding initiatives for CMAM and there is a need to understand how bilateral support for health systems can take into account CMAM. It is possible that SUN will provide mechanisms for longer term funding for CMAM.

The provision of a continuous and predictable funding stream is a key requisite for ensuring a sustained CMAM scale up. Ensuring a continuous and transparent flow of funds for CMAM scale up poses two challenges for implementing countries: to move away from emergency funding and into predictable funding cycles and to move away from donor dependency and towards greater Government ownership of CMAM funding.

There is a dramatic lack of consistent and comparable cost and coverage data relating to CMAM. This lack of data is especially problematic to identify the size of scale up challenges and the strategy to overcome these. Improving the quality and availability of costing information for CMAM scale up is a key prerequisite to help improve Governments' ability to manage CMAM funding. Improved costing information and mapping would also help to identify and maximise the benefits of existing synergies between CMAM and other lifesaving and nutrition enhancing interventions.

RUTF

Pipeline breaks for RUTF were common in the country case studies. However, these tended to be the result of difficulties with storage and supply systems, low buffer stocks, inadequate forecasting, insufficient planning, and use of RUTF for other target groups. If RUTF is registered as an essential commodity, it can be easier to import and to store as part of Government health stocks. Forecasting problems arise from problems with calculating caseloads. The case studies featured extensive discussion about local production of RUTF, particularly in relation to cost. On average, RUTF forms 50% of the overall cost of a CMAM programme. Eight out of the nine case study countries are currently working towards local production (Somalia being the exception). Limiting factors to local production include a lack of peanuts that are of sufficient quality, the cost/availability of milk powder, as well as quality assurance processes.

A recent World Bank paper set out the elements that are needed to foster local production, which include the involvement of private sector and links with farmers/agriculturists.

Much of the challenge to enhance Government ownership is to find alternative sources for the production and funding of RUTF. Local production of RUTF is in many countries believed to be the most appropriate complement if not replacement to global supplies.

Nutrition governance

As part of the synthesis of lessons on CMAM scale up, an analysis was undertaken by applying a nutrition governance framework. This was presented by the lead author on this analysis, Andrés Mejía Acosta. The framework was adapted to capture the specific policy challenges required for CMAM and focused on three dimensions of nutrition governance: 1) the inter-sectoral cooperation between the central Government, the MoH, and the donor community, 2) the vertical coherence between community based interventions and centralised and decentralised branches of Government and 3) the CMAM financing mechanisms, including the provision of RUTF and the interaction between donors and Governments.

- The evidence suggests that the xecutive, i.e. the President or Prime Minister's Office, can play a critical role in placing nutrition high onto the national development agenda (although not necessarily including the issue of SAM), strengthening the mandate of the MoH, and ensuring the continued and coordinated financing of such programmes.
- CMAM scale up is more easily achieved where CMAM is firmly rooted in over-arching health policies, and coverage and impact are greater if there is a strong community base. Strategic advocacy for incorporation in wider policies will be required in order to reflect the approach in its entirety.
- The executive can facilitate inter-sectoral coordination to tackle the basic and underlying causes of all forms of undernutrition, including SAM. Political leadership is key to coordinate the interests and strategies of different stakeholders.
- The effective decentralisation and implementation of CMAM at the local level is another key factor for a successful scale up. While it is important that the executive remains involved in national level programming, it is also critical that the Government strengthens the potential for

programme ownership at the district level. Some of the common lessons on effective implementation of decentralisation are:

- It is facilitated in a more decentralised country context.
- There are multiple alternative drivers to facilitate decentralisation.
- Effective CMAM implementation and scale up is likely to emerge where there is increased local ownership.

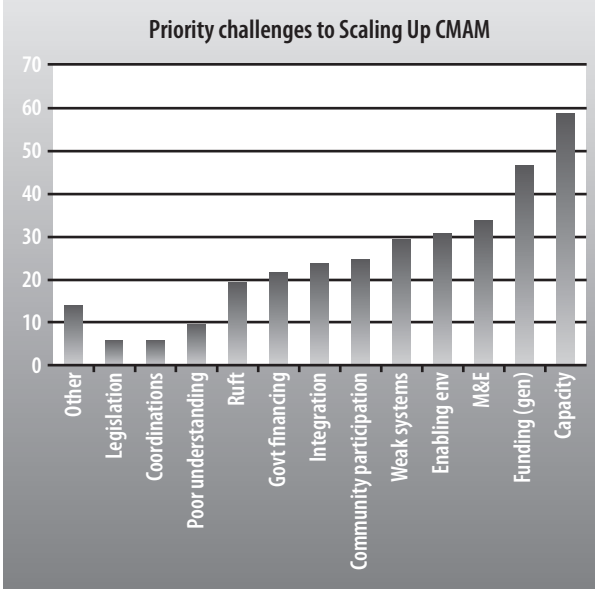
4.3 The initial response to the synthesis of lessons learnt presentation

The following points were raised by delegates following the synthesis presentation:

- Donors are supporting implementation of CMAM but not integration. It was acknowledged that this is an issue and that there does need to be consideration given to the level of support provided by donors to health system strengthening, for example. It was also noted that it is not yet clear how CMAM can practically be integrated within existing child survival activities and that this is one area for on-going discussion.
- CMAM scale up is not just about providing a service, but also about creating demand for services by involving communities. The crucial role of communities to CMAM scale up featured strongly in the synthesis report.
- Is it better to seize opportunities to act at scale with CMAM and address issues of quality later? Scale up can be done in a moderate, planned way, citing the examples of Ghana and Mozambique, and scale up should not take place just because the resources are available.
- If the international community places too much emphasis on CMAM, will this jeopardise efforts to strengthen investment in the underlying causes of malnutrition? Treatment for SAM should be seen as a right and a key part of a functioning health system.

In addition to the plenary discussion, a set of questions that had emerged from the synthesis was circulated to delegates towards the end of Day two (see Annex 4). These questions had been prepared in advance by the synthesis authors to help guide the working group discussions on Day 3. Delegates were asked to add any additional questions that they felt should be addressed during these discussions. To further support the Day 3 working group activity, delegates were asked to identify the key constraints to CMAM scale up and to rank these in order of importance. These were compiled and presented back in advance of the Day 3 discussions and are reflected in Figure 2.

Figure 2: Constraints to CMAM scale up and their relative importance as identified by conference delegates



4.4 Bridging emergency and development for CMAM integration and scale up

Following the synthesis presentation, Peter Hailey and Dr Tewoldeberhan Daniel made a timely presentation that began by challenging the conventional conceptual 'start-stop' model for decision making on the initiation and duration of 'emergency' management of SAM, and highlighted the shortcomings of the emergency-dominated perception of CMAM programming. The classic

conceptual 'start-stop' model makes a number of assumptions that are outdated in the current CMAM landscape. The model treats acute malnutrition management as similar to disease outbreak where development /regular programmes cover non-epidemic caseload. It implies excess caseload will be managed when the situation passes beyond a given threshold, in reality, 'non-excess' cases are also treated. It assumes there is limited, or no Government involvement. There is also a timings issue - the peak of the emergency response often misses the peak of need and furthermore, risks overshooting capacity given the 'one size fits all' approach. Reliance on single prevalence-based thresholds of GAM to intervene with CMAM add to the distorted picture.

The need for CMAM is continuous but when an NGO led programme closes, there may not be the capacity to hand over to Government. The start-stop model gives inadequate consideration to existing Government capacity and how to develop it.

Peter and David went on to present a new design framework for CMAM programming (originally published in Field Exchange 39[7] and shared with delegates) that requires capacity based thresholds for action, rather than prevalence based thresholds (though they still have a role). It involves analysis of caseload and capacity of the health system to cope with the caseload is needed and so is tailored to need. It is modelled on the disaster risk reduction approach and so speaks to reducing excess mortality and strengthening capacity of the public health system on a sliding scale to cover capacity gaps identified. It takes the emphasis away from dichotomy of emergency versus non-emergency contingent on a single threshold. It redefines the role of partners, explicitly recognising the fundamental role of Government, and can be used as advocacy tool to convince donors to look and fund CMAM in a new way that will help to bridge the existing emergency-development divide.

4.5 The UN and CMAM scale up

The majority of country case studies identified UN agencies as having a critical role to play in terms of provision of supplies and input to guidelines and standards for CMAM programmes. Several case studies also noted difficulties that can arise at country-level because of the lack of clarity in mandates of relevant UN agencies. In an attempt to enable delegates to gain a better understanding of the roles of the UN agencies and their perspectives on CMAM scale up, a panel of UN representatives was convened towards the end of Day 2. Questions were submitted in advance and reviewed by panel members before the session. The panel comprised Ilka Esquivel (Senior Advisor, Nutrition Security and Emergencies, UNICEF), Purnima Kashyap (Head of Programme, Ethiopia, WFP), Zita Weise Prinzo (Public Health Nutritionist, WHO) and Bjorn Lundquist (REACH Coordinator).

Panel members started with a brief outline of the role of their respective agency in relation to CMAM:

- WHO is currently updating guidance for hospital-based care of SAM and training for hospital management. Various areas of research are also underway, including identifying optimal treatment approaches for SAM in cases of HIV and the formulation of new products, particularly for the management of MAM. Guidance on this and guidelines on the implementation of CMAM are due to be published soon.
- UNICEF procures large quantities of RUTF (including from local producers) and has been developing training tools and guidance (including e-learning). In addition, they are developing reporting tools and undertaking capacity development. UNICEF has also undertaken a mapping of CMAM programming[8] and is involved with ongoing evaluation. They are also supporting the integration of CMAM into IMCI algorithms and into IYCF programmes. UNICEF is also the nutrition cluster lead.

[7] Peter Hailey and Daniel Tewoldeberha (2010).Suggested New Design Framework for CMAM Programming. Field Exchange, Issue No 39, September 2010. p42. Http://fex.ennonline.net/39/suggested.aspx

[8] Field Exchange 41 (2011). Global CMAM mapping in UNICEF supported countries. Summary of review. p10-11.

- WFP focuses on the prevention and treatment of MAM. Provision of supplementary food to mothers and children is central to activities but WFP also supports programmes aimed at preventing malnutrition, including by improving the quality of the food basket, applying a nutrition lens to broader programmes and by increasing partnerships with other stakeholders. WFP has transferred technology to produce fortified blended foods using local resources. They have also been involved with innovations using cash/vouchers and SMS for monitoring the implementation of programmes and for monitoring cases of malnutrition.
- REACH does not have a direct involvement with CMAM but works at country level to develop coherent nutrition policies and programmes and to create links with resources and partners at global and regional level. CMAM has always been high on the REACH agenda and is recognised as one of the key nutrition interventions.

Following the agency introductions, questions were posed to the panel. These were grouped into four thematic areas and the responses summarised below.

RUTFs

A group of questions to the UN panel related to the production of RUTF and how the UN agencies are supporting local production. UNICEF and WFP emphasised that there has been a shift in investments from high-income countries, where much of RUTF is currently manufactured, to developing countries. However, manufacturing is expensive to set up and it is difficult to ensure quality of local ingredients. It is also difficult to dictate where production is located. UNICEF aims to provide in-kind Title II RUTF in countries where there is no local production capacity so there is no threat to local manufacturers. WFP procures a lot of resources for nutrition products in country and work with small farmers to establish market links and to develop products for use in SFPs. Work is needed to ensure appropriate quality control from the raw material to the distribution of products.

Clarification was sought on whether there was sufficient RUTF production capacity to meet demand for RUTF. According to UNICEF representatives, production capacity can increase to meet needs but the focus needs to be on maintaining the quality of the product. One delegate commented that the recent plateau of global sales of RUTF could indicate that capacity to reach and treat cases of SAM is the limiting factor, rather than production capacity. There was further discussion on the cost of RUTF. UNICEF Supply Division noted that the cost of RUTF has reduced since 2005 but that factors such as high import tax on powdered milk continue to make it challenging for local producers to reduce prices. As UNICEF hands procurement of RUTF over to Governments, it will be necessary to understand what contributes to the high price of the product, including the impact of VAT and import taxes.

Agency mandates

The issue of conflicting agency mandates was the topic of another set of questions to the panel. REACH commented that it is simple to sort out mandates in principle at global level but that at the operational level, agencies have different capacities and thus different abilities to fulfil mandates. The UN has established mechanisms to deal with this but has discovered that strong Government leadership and appropriate coordination structures help to define roles and gaps. UNICEF explained that there is a global Memorandum of Understanding (MoU) between WFP and UNICEF, which was reviewed in March 2011. However, this cannot reflect specific national situations and that national MoUs should be developed to reflect actual capacity and relative roles on the ground.

Funding

The question of how UN agencies can help to secure more predictable funding for CMAM prompted a detailed discussion with input from other conference delegates. UNICEF acknowledged that it is difficult to secure funding for RUTF in non-emergency contexts and that there is a need to advocate to donors for increased support in these settings. Governments and their partners have been successful in securing funding for CMAM in development settings. Several comments were made emphasising that CMAM needs to be presented as part of the package of broader nutrition interventions that should be scaled up, and that this package should then be included in Government budgets.

Integration

The panel discussion concluded with a question about how UN agencies are contributing to the integration of CMAM into health services. WHO noted that a number of countries have already

incorporated MUAC screening and referral to outpatient therapeutic programmes (OTPs) and stabilisation centres (SCs) into the IMCI algorithms. WHO is currently updating the IMCI, including the components relating to CMAM, and WHO is incorporating management of SAM in to pre-service training. WHO do not have collated data on inpatient caseload, hence we do not know if inpatient care is keeping pace with referrals from OTP (or if the demand is actually less due to earlier identification not requiring inpatient treatment). Strengthened monitoring systems are needed regarding this.

5 Drawing conclusions (Day 3)

5.1 Overview

Day 3 of the conference was dedicated to working group discussions aimed at drawing conclusions and identifying the next steps for CMAM scale up. These discussions were continued on Day 4, putting the future of CMAM scale up into the context of the SUN movement. During the morning, two films were shown[9]: a short CMAM film compiled for the conference provided a snapshot of CMAM in action, featuring collated video footage and interviews from many of those countries represented. Following the morning session, a welcome and motivational video address from Haile Gebrselassie, the Ethiopian athletic legend, to the conference was very well received.

Following an overview of the key constraints to CMAM scale up identified on Day 2 (see earlier Figure 1), delegates were assigned to one of 12 working groups, each with a designated chairperson who was briefed in advance. Groups were asked to focus on one of three issues: CMAM funding, capacity strengthening and governance. A set of questions (updated from feedback on synthesis questions circulated in Day 2, see earlier) was used to help guide the working group discussions. During the afternoon of Day 3, representatives from donor agencies broke off from the main working groups to consider CMAM scale up from the donor perspective (see Annex 4 for details).

5.2 Feedback from working groups

The consolidated feedback from the working groups is presented in Table 2. A number of areas of consensus emerged during the presentations from the working groups:

- The importance of Government leadership to CMAM scale up was widely acknowledged.
- The critical role of communities was reiterated, with a particular emphasis on the need to generate demand for CMAM services.
- Recognition of the importance of interventions to prevent undernutrition, and the need to take a multi-sectoral approach.
- CMAM is just one service provided by a health system, it should be integrated into this system and scale up should be considered in the context of broader health system strengthening.

One working group identified a 'minimum' CMAM package that needs to be sustained by Governments, which should consider information management (surveillance and M&E), community mobilisation, prevention, capacity, and local production of RUTF and supply chain management.

[9] Available to view or download at: www.cmamconference2011.org

Table 2: Key issues and Next Steps Regarding CMAM Scale-Up: Financing, Capacity strengthening and Governance

(a) Financing

Funding mechanisms	RUTF and local production	Information management	Emergency/development
A multi-lateral funding facility would improve coordination and attract resources.	CMAM supplies should be included in essential drug lists, procurement plans, SWAps (Sector Wide Approaches).	Governments need the capacity to monitor and audit and this will require investment in modern technology.	Emergency funding can facilitate scale up and strengthen capacity but ownership needs to be shifted to Governments.
Governments need costed scale-up plans that are part of the development plans and that can be supported by donors.	Essential to look at supply chain management to ensure RUTF is always available and of good quality.	There is a need to strengthen information flows from facilities up to national level.	If there is good coordination and emergency funding plans are based on Government plans, then emergency funding doesn't need to be complicated. But confusion can happen when agencies implement parallel interventions.
Governments should demonstrate progressive financial commitment to CMAM.	Local production should be promoted and supported by Government (e.g. deliberate policy to promote local production, including tax exemptions for importation of equipment) to create demand for local production.	A simple set of CMAM indicators should be included in national HIS. Whilst HIS are being strengthened, parallel reporting should continue and CMAM indicators slowly integrated.	A mechanism is needed that can utilise emergency funds, and incorporate emergency coordination into existing coordination functions so that Governments can always be in control.
The cost of human resources is already incorporated into Government budgets but other components (training/ RUTF, products need to shift to Government budgets).	Incentives need to be provided by investing in local farmers and local capacity for production and research should be developed.	HIS needs to be standardised with clear indicators of how to measure nutrition routinely in all health centres.	A clear definition of roles/responsibilities of stakeholders in emergency response and strong leadership at all levels is needed.
Guidance should be provided for lower levels of Government on how to allocate funds for nutrition.	Participation of private sector should be enhanced by advocating for enabling environment, loans, tax relief, quality control guidance, etc.	Nutritional indicators should also be included in large national surveys.	Lessons learnt during an emergency need to be documented and used to inform preparedness.
CMAM needs to be included in national development agenda and operational health and nutrition strategic planning documents.	A continuous dialogue with all stakeholders (including private sector) is needed to increase responsibility for local and sustainable production of RUTF.	It is important to monitor the process of integrating CMAM.	Donor policies need to enable more work on DRR.
SFPs might not be sustained without innovative approaches for local production at low cost and/or nutrition education and other programmes.	There is a need to consider the role of donors in supporting/ facilitating local production of RUTF.		

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Table 2: Key issues and Next Steps Regarding CMAM Scale-Up: Financing, Capacity strengthening and Governance (Cont'd)

(b) Capacity strengthening

Training	Decentralisation	Use of volunteers	Management of MAM
Pre-service training for medics, health works and others should include CMAM training.	Decentralisation is common in many countries. District level should be the key point for capacity development as this is where everything gets translated into practice. Involvement of planning, finance, and other relevant departments is crucial.	Community mobilisation strategies are needed, reaching right down to grassroots level.	MAM should be managed along with SAM where GAM is high.
A balance is needed between pre-service and in-service training, and this should be seen as an ongoing process.	Policies need to be accompanied by a clear strategy and rolled out in a 'joined-up' way. Structures to coordinate nutrition need to be translated at all other levels	Existing structures at community levels, e.g. traditional leadership, should be utilised.	Clarification needed on admission/discharge criteria for MAM.
A cascade strategy is needed for Trainer of Trainers approaches.	'Horizontal' coordination is needed at all levels and social accountability should be part of planning processes.	There is a need to involve community but not with volunteers doing all the work. Volunteers should be able to stay within communities and not contribute to work at health centres.	Need more evidence-based research on MAM management.
There is a need to evaluate learning achieved through training and to ensure it is translated into practice.	Clear roles and responsibilities are needed at all levels to identify areas that are not working well.	Innovative ways to keep volunteers motivated should be identified. Incentives don't necessarily equate to cash but can be knowledge, status or equipment provision.	Innovative approaches are needed to make management of MAM cheaper so that donors/ Governments can support it.
It is necessary to train the whole sector and to include others, such as HIS staff.		Mass recruitment of volunteers with performance-based motivation could help address high turnover. Alternatively, more rigorous identifications of the most appropriate volunteers could have the same outcome.	Supplementary feeding is not sustainable at scale up by Government or donors and focus should be on prevention.
Re-enforcement of capacity to monitor and supervise is essential.		Links with the global health force workers alliance should be established/ explored. This is also likely to feature examples of working with volunteers.	A multi-sectoral approach to addressing MAM is required and further research needed to establish preventative activities without overloading community volunteers.
Capacity strengthening should emphasise the multi-causal nature of malnutrition to ensure this features in planning.			
More attention should be given to strategies for retaining staff within Government systems.			
Best practices and lessons learnt, as well as materials/tools, should be shared between countries and agencies.			

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Table 2: Key issues and Next Steps Regarding CMAM Scale-Up: Financing, Capacity strengthening and Governance (Cont'd)

(c) Governance			
Political commitment	**Leadership and governance**	**Coordination**	**Role of other stakeholders**
To generate political will, it is important to provide evidence-based data that relates to the political agenda.	Malnutrition is a reflection of poor governance. It reflects a failure of multiple systems.	International coordination (SUN/REACH) should support the set up of national coordination mechanisms.	UN agencies, donors and implementing partners (IPs) should, as a principle, be aligned to country-led priorities/ programmes to avoid duplication and contribute effectively to scale up and continuum of care.
Political will can be generated though identification of high level political champions using quantifiable evidence in simple language that appeals to the political agenda.	Leadership should come from a country itself and the leadership should have power to convene relevant sectors and stakeholders.	Those in charge of coordinating multi-stakeholders should have the power and mandate to make decisions and technical expertise to deliver results.	Actors are not aligned. In some cases, UN agencies compete for funding and do not coordinate well. In other cases, the Government is not taking the lead.
Global policy movements are valuable for mobilising donors and partnerships and to focus key priorities.	Nutrition could be governed from the executive level but can be undertaken by a planning body with sufficient power to convince other sectors.	National multi-sectoral coordination/decision making should go down through all levels and power should be devolved.	Some donors do not use country level systems and priorities and allocate funding through different modalities. Division of labour is not always clear.
	The President of a country is best placed to hold stakeholders accountable.	CMAM should be included in policies and programmes broader than just health.	Sectoral-wide approaches provide opportunities to align support. If a country has a strategic plan, partners should key in. If none exists, the partners should support the development of a plan.
	A central CMAM technical group is crucial with clear terms of reference, so they are able to advocate within the health sector and to link to other nutrition actors.	Common nutritional indicators can facilitate cross -sectoral working (e.g. indicators should be integrated into agricultural sector monitoring).	Donor support is needed to enable capacity development.
	Having a policy is not enough. Implementation requires resource allocation and champions to follow up as well as links between technical groups and regional states.	Lessons can be drawn from past experiences in cross cutting issues, e.g. gender.	
	Planning is not only necessary at high levels. Planning should come also from the ' bottom' up and demand should come from the citizens.		

Based on their working group session together, the donor group reflected to plenary that:

- CMAM should form part of a broader multisectoral approach to nutrition, including the SUN movement.
- Bilateral donors operate within political economies as well, and this affects funding strategies. Donors need to examine the underlying causes of their approaches to funding, especially funding modalities which maintain the emergency/development divide.
- Donors should (and are) use leverage to improve coordination, alignment and resource mobilisation, including the alignment of UN agencies. The SUN movement is helping with this.
- More progressive donors should speak to other donors, to share experiences of CMAM and mechanisms for approaching funding and supporting country-led efforts to scale up nutrition.
- A two-way process of accountability can be developed between donors and Government.
- DFID is undertaking work to increase access to medicines. As a result of the conference, DFID will look at what else can be done to improve access to RUTF.
- There is a need to create a donor coordination forum to prioritise CMAM.
- An inter-donor, lesson-learning meeting to address the current misalignment of CMAM funding mechanisms is needed.

6 Focus on the Scaling up Nutrition (SUN) movement and moving forward (Day 4)

6.1 Overview

Reflecting the switch of focus to SUN, a short film on the SUN movement was shown at the beginning of the day. Day 4 was opened by words from His Excellency, Dr KebedeWorku, State Minister for Health, Government of Ethiopia. He was followed by Her Excellency, Dr. Nadeera Hayat Burhani, who presented a summary of the suggestions from the working groups on next steps for CMAM scale-up (see Table 2), for the benefit in particular of Dr. David Nabarro (UN Special Representative for Food Security and Nutrition and focal point for the Scaling Up Nutrition movement) who joined the conference on Day 4. This acted also as a bridge between the specific discussions of CMAM scale up and the wider issues of nutrition scale up that are being addressed by the SUN movement. David Nabarro gave his initial reactions before handing over to Andrés Meija Acosta who presented findings from a review of the political economy of nutrition scale up conducted by IDS (Institute of Development Studies, UK). David followed with an update on the SUN movement and Bjorn Lundquist (REACH Coordinator) described the relationship between SUN and the REACH initiative. Delegates were then given the opportunity to pose questions to the three presenters

The final afternoon of the conference was dedicated to the development of country-specific action points relating to both CMAM scale up and SUN. Each country delegation was asked to present a key action point in plenary before the conference was officially closed by David Nabarro, ENN and the GoE.

6.2 Linking CMAM to SUN

Following an overview of the key points and conclusions of the working groups on Day 3 (see Table 2 earlier), Dr Nadeera Hayat Burhani presented the key outstanding questions relating to CMAM scale up and a set of recommendations identified by delegates during the Day 3 discussions:

Drawing conclusions

- CMAM is not, and must not, be presented or implemented as a vertical programme.
- Where there are clear Government priorities, donors, UN agencies and INGOs do not always align to support these.
- Resource mobilisation for CMAM should be in the context of a comprehensive, integrated nutrition approach. The SUN movement provides a good opportunity for this.

- Governments need to present clear costing of CMAM, demonstrate progressive financial commitment, and identify what elements of CMAM support need further resources.
- CMAM integrated in other health and nutrition packages helps to leverage funds from within Government and external sources.
- The community-level component of CMAM can be sustained by the Government through existing programmes.
- A national community mobilisation strategy, cutting across sectors, would support scale-up of nutrition and other basic services.
- Leadership and authority for nutrition scale-up must be decentralised to the district level, along with the necessary resources, in support of decentralised plans.
- In the event of emergencies, Governments are prepared with clear costed plans for surge scale-up to meet increased demand. This can help to limit the loss of Government ownership frequently seen in emergencies.
- Governments need to develop a clear policy on local production of RUTF that can lead to new partnerships, tax-dispensations and other cost-reducing measures.
- Donors are exploring different funding mechanisms to bring about stronger alignment of international actors in support of Governments.
- The key obstacle identified is the inadequate capacity of health systems, at all levels and across all elements (service delivery, workforce, HIS, access to essential medicines, health financing and leadership & governance). Specific challenges for CMAM include staff numbers, competencies, and motivation and over-reliance on volunteers.
- The HIMS (Health Information Management System) is critical in the flow of management information through all levels. CMAM needs to be incorporated but until then, Governments and partners may need to run parallel information systems or include a simple set of indicators in the existing system.
- MAM treatment through supplementary feeding is not a sustainable national strategy for Government. Therefore, there is a need to explore alternative means to address MAM through inter-sectoral approaches and nutrition-sensitive programming.
- CMAM scale-up requires Government leadership and support at the highest level in order to command authority across ministries/sectors.
- Evidence-based advocacy, e.g. by champions, about the value of nutrition programmes, needs to speak to development and political agendas.
- International coordinating mechanisms, like SUN and REACH, can support the setting up of such high-level coordination bodies.
- Independent coordination bodies can also undertake this role, but require that Governments enact legislation through acts of Parliament.

Outstanding questions

- What are the obstacles to and opportunities for classification of RUTF as an essential commodity and incorporated into the Essential Drug Programme (EDP)?
- Does SUN offer an opportunity for scaling up CMAM, or is there a risk that it becomes 'lost' in the stronger move towards tackling chronic undernutrition?
- Demand for RUTF has levelled out. Does this reflect that all needs have been met or that the systems to deliver it at country level are unable to cope with the caseload?

Recommendations

- Donors should increase efforts that bring about alignment of international actors (including the UN agencies) with Government strategies.
- CMAM should be located in a variety of pre-service training.
- All actors should actively disseminate good practices, tools, materials, training programmes and other relevant resources directly to Governments.
- Cross-country learning and networking should be facilitated.
- In situations where Government priorities are not set out, international actors need to facilitate the articulation of priorities/strategies and then align with these.
- Donors should convene a meeting to consider how and why their funding mechanisms perpetuate the emergency/development divide.
- More evidence is needed on effective mechanisms to manage MAM.

David Nabarro responded to the introduction by Dr Hayat Burhani first by emphasising that CMAM is seen by the SUN movement as a critical component of a wider strategy to reduce undernutrition. He noted that the issue of how best to manage MAM is one that needs to be further discussed in light of the impact of MAM on chronic undernutrition. Reflecting on the points raised, he felt that the SUN movement should particularly focus on how to

support the enabling environment for CMAM and wider nutrition work. He also highlighted that the donor community is particularly committed and could help to promote this enabling environment. He went on to say that integration of CMAM into health services and across sectors would be one indicator for the SUN movement. He commented that the CMAM conference was "like a dream" because he had thought for a long time that acute malnutrition was a subject that would never be treated seriously. He concluded that it is now imperative to get this issue into the speeches of Hilary Clinton and others who are championing nutrition and to make it part of their normal thinking and action.

6.3 Political economy of nutrition scale up

Andrés Meija Acosta presented the main findings of an IDS comparative project regarding the political economy challenges of reducing chronic malnutrition. The first step in the process of understanding the political economy is to consider the following questions:

- What type of political incentives, strategies and coalitions can enhance Government commitment and coordination to reduce undernutrition?
- When and why are Government officials willing to coordinate with one another?
- Why and when do elected officials become accountable to the needs of the most vulnerable?
- What is the role of non-Governmental actors, including civil society, international organisations, media and the private sector?

Over the past few years, there has been growing awareness that political coordination is key to understanding why nutrition initiatives work in some countries and not in others. Particular issues considered included the nature of inter-sectoral cooperation (including across donors, civil society and donors), the nature of vertical coherence/ articulation, and the degree to which funding mechanisms facilitated inter-sectoral and vertical cooperation. Despite specific differences in the nature of interventions and support required, there are at least three key implications that the political economy analysis of chronic malnutrition can bring to better understand the challenges of scaling up CMAM:

Centralised coordination. The comparative analysis of cases in the IDS work suggests that Government efforts around nutrition are more effective when there is direct involvement of the executive branch (the president or prime minister) in the design, formulation and implementation of policies. Executives can create formal or informal coordination bodies to consult with other donors, to pool funds or establish monitoring mechanisms across multiple sectors including health, social development, education, agriculture, etc. Executive involvement is also key to connect nutrition initiatives and targets to national development plans.

Local ownership and political accountability. The centralised coordination effort at the national level should not undermine the ownership of nutrition programmes at the local level. Elected and non-elected political elites can play a significant role to respond to the needs of local populations and promote the effective delivery of services in a transparent way. This relationship of accountability is more likely to work in the long run when citizens vote for political elites that deliver effective public services.

Funding fragmentation leads to policy fragmentation. Inter-sectoral coordination and vertical implementation of nutrition programs is likely to endure when the funding mechanisms and fund allocations are also coordinated.

6.4 Perspectives on the SUN movement: evolution and prospects

David Nabarro provided an overview and update of the SUN movement noting that 22 countries had committed to join the initiative and others were set to come on board. The SUN stewardship plan has also recently been submitted. He emphasised that it was important to get country-level experience of the process to date and to understand the concerns of

those working in countries and within Governments. Bjorn Lundquist reiterated that REACH is one mechanism for facilitating solid, harmonised support for the Government scale up process.

Both presenters then addressed questions and concerns from conference delegates. There was some discussion from Government representatives about how countries can engage with SUN in practical terms. David emphasised that all a Government has to do is write a letter expressing a wish to be part of SUN, indicate that a multi-sectoral strategy is being planned/implemented and nominate a focal point for taking the work forward. In the case of decentralised systems, engagement can take place at state/province level (e.g. Indian States are likely to join SUN individually rather than under a country umbrella). There was also a request for further clarification of how SUN and REACH interact at country level. In response, Bjorn and David developed and presented a draft diagram articulating this during the afternoon of Day 4.

Questions were posed about the evidence base in terms of costing for CMAM scale up, and analysis of the economic impact of addressing SAM. There was a consensus that attention needs to be given to the cost element of CMAM scale up. David noted that the SUN stewardship plan includes a proposal to create an additional task force to foster innovation in areas where there is still a gap in evidence of best practice.

There was a set of comments relating to CMAM in emergency contexts and the links between emergency and development programming. It was noted that in the developmental context, the focus should be on the right to treatment for SAM rather than on the prevalence of acute malnutrition. David noted that the links between emergency and development need to be strengthened and emphasis should be placed on building resilience among communities and systems. He also responded to a question from Somalia concerning when countries/regions in 'emergency' situations should start to undertake longer term planning and how SUN can support this. He believed that it was possible to start planning for the long term in the middle of a crisis and Bjorn also noted that there are opportunities to undertake sustainable development in an emergency, citing Ethiopia and Niger as featuring some good examples.

One conference delegate asked if there were any lessons that could be learnt from other sectors in terms of driving forward an issue such as undernutrition. David felt that it was possible to achieve the same for nutrition as has been achieved for chid health over recent years. However, he emphasised that this required the nutrition community to present a united, committed, credible and confident picture to politicians. He noted that fragmented messages in nutrition have been a problem and that this conference was a good example of united action.

There was a further discussion of the crucial role of communities in CMAM and wider nutrition scale up. David reiterated that women and children are at the centre of what is being done. Andrés commented that in Brazil, everyone realised the benefit of improving nutrition as they began to see healthier, wealthier communities.

6.5 The way forward for country delegations

The remainder of Day 4 was dedicated to the development of specific action points for each of the 22 country delegations. Delegates were grouped according to country, with representatives from the NGO, UN, academic, donor and private sector joining the most relevant groups. Each country was asked to develop a number of points arising from the conference that they will put into action in the coming months. Table 3 summarises areas of action agreed on by country delegations, with actions detailed in Annex 5.

Table 3: Areas of action for country delegations (summary)

Country	Areas of action
Afghanistan	Action planning with detailed costing of resources required Dissemination of meeting outcomes Political commitment for funding Institutional arrangement
Bangladesh	Institutional arrangement
Cambodia	Political commitment through existing strategy Integration with existing programmes Fundraising Expansion into districts not covered Monitoring and reporting
Ethiopia	Increased coverage and targeting Coordination Integration
Ghana	Designate nutrition champions Integration with upcoming events Regional commitment Advocacy In-service training Scale up in designated regions
India	CMAM forum Piloting and testing of RUTF Planning and strategy Political commitment Local production of RUTF Pilot programmes
Kenya	Join SUN movement Action planning and costing Political commitment through launch Development of structures for devolved system Measuring programme coverage Scale up into non emergency settings Integration with health services Monitoring quality of nutrition products
Liberia	Planning Integration strategy CMAM guidelines CMAM technical working group Advocacy for budget allocation In-service training Establish stabilisation centres at designated sites Establish OTP at designated sites
Malawi	Integrated training Community mobilisation Identification of gaps and linkages to strengthen integration Inter-sector coordination Training Recruitment Joint planning and budgeting Mobilization of resources Gap analysis and mapping Documentation of best practices for scale up Operation research

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Table 3: Areas of action for country delegations (summary). (Cont'd)

Country	Areas of action
Mozambique	Mapping of interventions Definition of minimum package with indicators and required resources Planning Advocacy for political commitment Establishing working groups
Nepal	Planning and costing for scale up Advocacy for political commitment and funding Integration with existing programmes Linking with existing nutrition framework
Niger	Develop an advocacy plan to make nutrition a priority of the Government, donors, local authorities and communities
Nigeria	Governance and political commitment Capacity development Costing and budgeting
Pakistan	Development of technical document Planning Political commitment and funding Implementation
Sierra Leone	Inter-sector coordination Scale up of sites to increase coverage and access Logistics for monitoring and supervision Community mobilisation and sensitisation through training Feedback and dissemination of conference outcomes
Somalia	Coordination of stakeholders Political commitment Buy-in from external agencies Capacity building and training of staff
South Sudan	Integration with health and nutrition services Vertical and horizontal coordination Pre-service training On the job training for health providers Political commitment
Sudan	Advocacy for Government commitment to CMAM as part of nutrition package Secure resources to enable country-wide CMAM scale by 2015 Update community outreach strategy Develop country based evidence through research
Tanzania	Reviewing of implementation plan Planning and budgeting Community mobilisation in selected districts Feedback from this conference
Uganda	Planning Formation of national food and nutrition secretariat Implementation of existing policy Advocacy for funding Community mobilisation and sensitisation Support implementation in 15 districts
Zambia	Political commitment Scale up
Zimbabwe	Feedback on conference outcomes Political commitment Development of nutrition policy Strategy for scale up Planning and costing Integration into health services Strengthening of capacity and knowledge using NGOs Advocacy for funding Community mobilisation Integration with other programmes Integration of indicators Investigate local production

6.6 The way forward for the donor community

Following the presentation of action points by country delegations, the donor representatives were asked to reflect on the points made and the ways in which the donor community can support countries.

- Fiona Quinn (IrishAid) commented that the level of country preparedness to scale up CMAM specifically and to scale up nutrition had struck her, in particular. She said that the onus was now on the donors, civil society the private sector and others to enable this to happen, and that she hoped that they could step up to the mark to de liver this.
- Anne Philpott (DFID) acknowledged that DFID had been relatively slow off the mark for nutrition but that they are increasingly committed. Rob Hughes (DFID) also noted that there were encour aging signs regarding ways to negotiate some of the complicated political processes and that it was positive that the conference had not been dominated by the voice of the donors.

6.7 Official close of the conference

David Nabarro emphasised that the way forward is not straightforward, but that over time, we learn how to act more skilfully and to achieve real change. He noted that there is a responsibility for SUN, donors and partners to support Governments. He concluded by saying that there are always a small number of amazing people who do more and more work to tackle undernutrition and that these people are the heroes. Dr Ferew Lemma closed on behalf of the GoE with final words (below) and thanks. Carmel Dolan and Jeremy Shoham (ENN) gave particular thanks to the conference presenters, case study authors and contributors, ENN staff, organisers, film crew and IT support staff and the Government of Ethiopia in realising the conference.

If a man begins with certainties, he shall end in doubts,
but if he will be content to begin with doubts,
he shall end in certainties

Francis Bacon, The Advancement of Learning, 1605
Closing remarks by Dr Ferew Lemma, MOH Ethiopia,
15th November, 2011

Annex 1: Conference delegates list

Country	Name	Title	Organisation
Afghanistan	**H.E. Nadeera Hayat Burhani**	**Deputy Minister for Health Care Services Provision**	**Ministry of Public Health**
Bangladesh	**AFM Saiful Islam**	**Additional Director General(Admin), Directorate General of Health Services**	**Bangladesh Health Services**
Bangladesh	**S M Mustafizur Rahman**	**Nutritionist**	**Ministry of Health and Family Welfare**
Bangladesh	**M D Rahman**	**Professor**	**Bangladesh Govt**
Cambodia	**Mary Chea**	**Deputy Manager of National Nutrition Program**	**NMCHC, MoH**
Cambodia	**Prak Sophonneary**	**Deputy Director**	**National Maternal and Child Health Centre, MoH**
Canada	Karine Tardif	Analyst	CIDA
Denmark	Jan Komrska	Contracts Specialist, Essential Medicines & Nutrition	UNICEF Supplies Division
Ethiopia	**Abdulaziz Ali**	**HIV/Nutrition Expert**	**Federal Minisry of Health /FANTA**
Ethiopia	Akiko Sato	Nutrition Officer	WHO
Ethiopia	Ayuba Sani	Nutritionist	Irish Aid
Ethiopia	Belaynesh Mulugeta	IYCN project Country coordinator	IYCN
Ethiopia	Belete Argaw	Managing Director	Hilina Enriched Foods
Ethiopia	**Beyene Haile**	**Food Security Directorate**	**Ministry of Agriculture**
Ethiopia	**Cherinet Abuye**	**Research Director**	**EHNRI**
Ethiopia	Daniele Nyirandutiye	Foreign Service Health and Nutrition Officer	USAID
Ethiopia	**Ferew Lemma**	**Senior Nutrition Advisor**	**Federal Ministry of Health, Ethiopia**
Ethiopia	Emily Mates	Senior Consultant	ENN consultant/Lead Conference Researcher
Ethiopia	Frew Tebeke	Nutrition Programme Manager	World Bank
Ethiopia	Getahun Teka	Nutrition Officer	WHO
Ethiopia	Gloria Kusemererwa	Nutrition Advisor	WFP
Ethiopia	**Gulelat Desse**	**Associate Professor**	**Addis Ababa University**
Ethiopia	Habtamu Fekadu Lashtew	COP for ENGINE	Save the Children
Ethiopia	Henock Gazahang	Country Director	Micronutrient Initiative
Ethiopia	**Hiwot Abebe**	**Lecturer**	**Hawassa University**
Ethiopia	Isaack Manyama	ENCU Team Leader	DRMFSS/UNICEF
Ethiopia	Israel Hailu Taddele	National CMAM Programme Coordinator	Concern Worldwide
Ethiopia	Jutta Neitzel	Head of Nutrition, Education and HIV	WFP
Ethiopia	Leuseged Asfaw	Nutritionist	Irish Aid
Ethiopia	**Melkiey Idries**	**Professor**	**Gondar University**
Ethiopia	Mesene Mulualem	Admin & Finance Manager	ENN Administrator
Ethiopia	**Mesfin Beko**	**Nutrition Focal Person**	**Federal Ministry of Health, Ethiopia**
Ethiopia	**Negussie Retta**	**Dean & Professor**	**Addis Ababa University**
Ethiopia	Pankaj Kumar	Assistant Country Director	Concern Worldwide
Ethiopia	Purnima Kashyap	Head of Programme	WFP
Ethiopia	**Senait Zewdie**	**Health and nutrition expert**	**FAO**
Ethiopia	**Sherry Hornung**	**First Secretary**	**CIDA**
Ethiopia	**Sisay Sinamo**	**Nutrition Advisor, East Africa Region**	**World Vision**
Ethiopia	**Sylvie Chamois**	**Nutrition Specialist**	**UNICEF**

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Country	Name	Title	Organisation
Ethiopia	**Tareke Aga**		**Ministry of Health, Ethiopia**
Ethiopia	**Tefera Belachew**	**Professor**	**Jimma University**
Ethiopia	**Telahun Teka**	**Senior Nutrition and HIV Specialist**	**Federal Ministry of Health**
Ethiopia	Teweldebrhan Abrha	Senior Country Director	Alive & Thrive Ethiopia
Ethiopia	Tewoldeberhan Daniel	Nutrition Officer	UNICEF
Ethiopia	Willemieke ud Broek	Medical Coordinator	MSF
Ethiopia	Joan Matji	Head Nutrition and Food Security	UNICEF
France	Andre Briend	Nutrition Expert	Independent
France	Anne-Dominique Israel	Senior Nutrition Advisor	Action Contre la Faim
France	Hedwig Deconinck	Senior CMAM and Emergency Advisor	FANTA-2/FHI 360
France	Stephane Doyon	Nutrition team leader	Médecins Sans Frontières (MSF)
France	Svenja Jungjohann	Nutrition Research Leader	Nutriset
Ghana	**Michael Neequaye**	**Nutrition Department Head**	**Ghana Health Service**
Ghana	**Winfred Wunu**	**Deputy Chief Nutrition Officer**	**Ghana Health Service**
India	Anne Philpott	Nutrition and Health Advisor, DFID India	DFID
India	**Arti Ahuja**	**Commissioner and Secreatry**	**Women and Child Development Department, Orissa, India**
India	**Biraj Patnaik**	**Principal Advisor**	**Office of the Supreme Court Commissioners**
India	**Manohar Agnani**	**Mission Director**	**National Rural Health Mission Madhya Pradesh**
India	Rajesh Singh	Sr. Health Advisor	Public Health Specialist
India	Samit Tandon	Consultant	Children's Investment Fund Foundation
India	Swapan Bikash Saha	Senior Nutrition Expert	CARE India
Italy	Bjorn Lundquist	REACH Coordinator	REACH
Ireland	Fiona Quinn	Development Specialist	Irish Aid
Ireland	Gwyneth Cotes	Nutrition Advisor	Concern Worldwide
Ireland	Hatty Barthorp	Nutrition Advisor	GOAL
Ireland	Martin Gallagher	Third Secretary	Irish Aid
Ireland	Mary Corbett	Nutritionist	Irish Aid
Ireland	Steve Collins	CMAM Expert	Valid International
Kenya	Juliane Friedrich	Sector Expert Nutrition	ECHO
Kenya	Noel Marie Zagre	Regional Nutrition Adviser, ESARO	UNICEF
Kenya	**Valerie Wambani**	**Programme Officer, Emergency Nutrition**	**Ministry of Public Health and Sanitation**
Lebanon	Caroline Abla	Director, Nutrition and Food Security	International Medical Corps
Liberia	**Chea Wesseh**	**Assistant Minister for Statistics**	**Ministry of Health and Social Welfare**
Liberia	**Jestina Johnson**	**CMAM Coordinator**	**Ministry of Health, Liberia**
Malawi	**Catherine Mkangama**	**Director of Nutrition, HIV and AIDS**	**Office of the President and Cabinet, Malawi**
Malawi	**Sylvester Kathumba**	**Principal Nutritionist**	**Ministry of Health, Malawi**
Malawi	Julita Manda	Nutrition Advisor	CIDA
Malawi	Ruth Butao Ayoade	Hunger and Nutrition Advisor	Irish Aid
Malawi	Theresa Banda	Africa Regional Manager	Valid International
Mali	Ouassa Sanogo	Health Advisor	CIDA
Mozambique	Christine Faveri	Head of Cooperation	CIDA
Mozambique	**Leonardo Chavane**	**Deputy National Director**	**Ministry of Health, Mozambique**
Mozambique	**Edna Possolo**	**Head of Department of Nutrition**	**Ministry of Health, Mozambique**

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Country	Name	Title	Organisation
Mozambique	Kirsten Havemann	Senior Adviser, Health and Nutrition	Danida
Mozambique	Jonas Chambule	Health Adviser	Irish Aid
Mozambique	Palmira Vicente	Rural Development Adviser	Irish Aid
Nepal	**Raj Pokharel**	**Chief, Nutrition Section**	**Child Health Division, Department of Health Services/MoHP, Government of Nepal**
Nepal	**Shyam Upreti**	**Director**	**Child Health Division, DoHS**
Niger	**Guero Maimouna**	**Director of Nutrition**	**Ministry of Health, Niger**
Niger	**Chegou Yami Mamadou**	**Nutrition Focal Point**	**Ministry of Health, Niger**
Niger	HAROUNA Souley	Acting General Coordinator	Forsani
Nigeria	**Philippa Momah**	**Director, Family Health Dept**	**Federal Ministry of Health, Nigeria**
Nigeria	**Beatrice Eluaka**	**Head of Nutrition Division**	**Federal Ministry of Health, Nigeria**
Nigeria	Stanley Chitekwe	Nutrition Manager	UNICEF
Pakistan	**Sohail Saqlain**	**Joint Secretary**	**Government of Pakistan**
Pakistan	**Baseer Khan Achakzai**	**National Manager Nutrition**	**National Institute of Health, Government of Pakistan**
Pakistan	Rob Hughes	Nutrition Advisor	DFID
Senegal	Helene Schwartz	Regional Nutrition Adviser, WCARO	UNICEF
Sierra leone	**Elizabeth Johnson**	**CMAM Officer**	**Food and Nutrition Programme**
Sierra Leone	**Jeneba Kamara**	**Nutritionist**	**Ministry of Health and Sanitation**
Somalia	***Leo Matunga***	***Nutrition Cluster Coordinator***	***UNICEF***
Somalia	***Peter Hailey***	***Senior Nutrition Manager - UNICEF Somalia Support Centre***	***UNICEF Somalia***
South Sudan	**H.E Michael Hissen**	**Minister of Health**	**Ministry of Health, South Sudan**
South Sudan	**Victoria Eluzai**	**Director of Nutrition**	**Ministry of Health, South Sudan**
Sudan	**Salwa Sorkatti**	**National Nutrition Programme Director**	**Federal Ministry of Health, Sudan**
Sudan	**Ebtihalat Elidrisi**	**CMAM Focal person**	**Federal Ministry of Health, Sudan**
Switzerland	David Nabarro	Special Representative of the UN Secretary General for Food Security and Nutrition	UNDP
Switzerland	Florence Lasbennes	Manager UN-HLTF	United Nations High Level Task Force
Switzerland	Patrizia Fracassi	Nutrition Policy Advisor	UN Office of the Special Representative for Food Security and Nutrition
Switzerland	Marzella Wüstefeld	Technical officer of the SCN Secretariat	UNSCN
Tanzania	Columba O'Dowd	Development Specialist	Irish Aid
Tanzania	**Helen Semu**	**Nutrition Officer**	**Ministry of Health and Social Welfare**
Tanzania	**Sabas Kimboka**	**Nutritionist**	**Tanzania Food and Nutrition Centre**
Uganda	**Gerald Mutungi**	**Principal Medical Officer**	**Ministry of Health, Uganda**
Uganda	**Albert Lule**	**Senior Nutritionist**	**Ministry of Health, Uganda**
Uganda	Caroline Laker	Social Development Advsior Irish Aid Uganda	Irish Aid
UK	Charles Bleehan	Investments	Children's Investment Fund Foundation
UK	Lola Gostelow	Meeting facilitator	ENN consultant/Conference Facilitator
UK	Tanya Green	Nutrition Programme and Policy Officer	DFID
UK	Abigail Perry	Nutrition Consultant	ENN consultant/Conference Rapporteur
UK	Alex Rees	Head of Hunger Reduction	Save the Children UK
UK	Andres Meija Acosta	IDS - Research Fellow - Political economist	ENN consultant
UK	Carmel Dolan	Technical Director	ENN
UK	Jeremy Shoham	Technical Director	ENN
UK	Kate Sadler	Assistant Professor	Tufts University & Valid International

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Country	Name	Title	Organisation
UK	Marie McGrath	Technical Director	ENN
UK	Marko Kerac	Academic Clinical Fellow	UCL Centre for International Health & Development
UK	Nicky Dent	CMAM Forum Co-Facilitator	CMAM Forum working group
UK	Rebecca Brown	CMAM Forum Co-Facilitator	CMAM Forum working group
UK	Sonny Bardhan	Investment Manager	Children's Investment Fund Foundation
UK	Thom Banks	Operations Officer	ENN
USA	Ilka Esquivel	Senior Advisor, Nutrition Security and Emergencies	UNICEF
USA	Josephine Ippe	Global Nutrition Cluster Coordinator	Global Nutrition Cluster
USA	Zita Weise Prinzo	Public Health Nutritionist	WHO
USA	Gunda Andrews	Advisor, CHAI Global Programmes	Clinton Foundation
USA	Carlos Navarro Colorado	Medical Epidemiologist	Centers for Disease Control and Prevention (CDC) Atlanta
USA	Ziauddin Hyder	Senior Nutrition Specialist	World Bank
Zambia	**Agnes Aongola**	**Chief Liaison Nutrition Officer**	**Ministry of Health, Zambia**
Zambia	**Bushimbwa Tambat-amba-Chapula**	**Deputy Director PHR - Epidemilogy and Disease Control**	**Ministry of Health, Zambia**
Zambia	Mwiya Mundia	Local Development Advisor	Irish Aid
Zambia	Silke Seco Grutz	Nutrition Advisor	DFID
Zimbabwe	**Tasiana Nyadzayo**	**Nutrition Emergency and Surveillance Manager**	**Ministry of Health and Child Welfare**
Zimbabwe	**Wisdom Dube**	**District Nutritionist**	**Ministry of Health and Child Welfare**
	Melanie Jacq		WFP

Delegates in bold are those representating national goverment from 10 case study countries (including India) and 12 additional countries. UNICEF delegates represented Somalia due to the absence of a national representative who could not attend.

Annex 2: Conference agenda

Monday 14th November 2011 DAY 1: Government experiences of CMAM Scale Up		
Meeting Facilitator: Lola Gostelow, ENN Consultant Meeting Rapporteur: Abigail Perry, ENN Consultant		
08.00-08.45	Registration and Country 'Meet & Greet'	
	Session 1: Introduction and Objectives	**Chair: Prof Teferra Belachew, *Jimma University***
08.45-10.30	Opening speech	His Excellency Dr Kebede Worku, *State Minister, Government of Ethiopia*
	Welcome from the Ambassador to Canada on behalf of Canada, United Kingdom and Ireland	HE Michele Levesque, *Ambassador to Canada*
	Address from Minister of Health, South Sudan	HE Michael Hissen, *Minister of Health, South Sudan*
	Address from Deputy Minister for Health Care Services Provision, Afghanistan	H.E. Nadeera Hayat Burhani, *Deputy Minister for Health Care Services Provision, Afghanistan*
	Introductions	Lola Gostelow, *ENN*
	A welcome from the Emergency Nutrition Network	Marie McGrath, *ENN*
	Agenda, Objectives, Housekeeping	Lola Gostelow, *ENN*
10.30-11.00	Break	
11.00-11.30	Keynote speech: *Orientation on CMAM*	Dr Steve Collins, *Valid International*
11.30-11.45	CMAM film	
	Session 2: Country Case Studies	**Chair: Prof Teferra Belachew, *Jimma University***
11.45-12.05	Country 1: *Ethiopia*	Dr Ferew Lemma, *Federal Ministry of Health*
12.05-12.25	Country 2: *Kenya*	Valerie Wambani, *Ministry of Public Health and Sanitation*
12.25-12.45	*Plenary questions and discussion on key issues emerging*	
12.45-13.45	Lunch	
	Session 3: Country Case Studies continued	**Chair: Theresa Banda, *Valid International***
13.45-14.15	Country 3: *Niger*	Dr Maimouna Guero, *Ministry of Health*
14.15-14.35	Country 4: *Malawi*	Sylvester Kathumba, *Ministry of Health*
14.35-14.55	Country 5: *Somalia*	Leo Matunga, *Cluster Coordinator*
14.55-15.30	Breakout session 1 *(discussion groups)*	
15.30-16.00	Break	
16.00-16.30	*Plenary feedback on key points from breakout 1*	
	Session 4: Country Case Studies continued	**Chair: Theresa Banda, *Valid International***
16.30-16.50	Country 6: *Sierra Leone*	Jeneba Kamara, *Ministry of Health and Sanitation*
16.50-17.10	Country 7: *Ghana*	Michael Neequaye, *Ghana Health Service*
17.10-17.40	*Plenary questions & discussion on emerging issues*	
17.40-17.50	**Session 5: Wrap up of Day One**	**Lola Gostelow, *ENN***
17.50-19.30	*Welcome drinks at Sheraton Hotel*	

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Tuesday 15th November 2011 DAY 2: Lessons Learned		
08.30-08.45	Key note video address from Dr Mary Robinson	Dr Mary Robinson, *Mary Robinson Foundation – Climate Justice*
08.45-08.55	Re-cap of Key Points from Day 1 and Day 2 agenda and objectives	Lola Gostelow, *ENN*
	Session 6: Country Case studies (cont.)	**Chair: Dr Andre Briend, *Independent***
08.55-09.15	Country 8: *Mozambique*	Edna Possolo, *Ministry of Health*
09.15-09.35	Country 9: *Pakistan*	Dr Baseer Khan Achakzai, *National Institute of Health in the Cabinet Division, Government of Pakistan*
09.35-10.00	Keynote speech: *CMAM in India: Challenges and Opportunities*	Biraj Patnaik, *Principal Adviser, Office of the Indian Supreme Court Commissioners on the Right to Food*
10.00-10.15	*Plenary questions /comments and discussion on key issues emerging*	
10.15-10.45	Break	
	Session 7: Shared country experiences	**Chair: Dr Andre Briend, *Independent***
10.45-11.45	Contributions from countries from the floor	
11.45-12.30	*Breakout session 2: What are the key constraints to CMAM scale up?*	
12.30-13.45	Lunch	
	Session 8: Taking Stock	**Chair: Anne Philpott, *DFID India***
13.45-14.30	Synthesis of lessons learnt from country case studies	Carmel Dolan & Jeremy Shoham, *ENN,* Andres Mejia Acosta, *ENN Consultant/IDS*
14.30-15.00	A view of CMAM integration and scale up	Peter Hailey Dr Tewoldeberhan Daniel
15.00-15.30	*Plenary Questions and Answers (Q&A) and discussion on key issues emerging*	
15.30-16.00	Break	
16.00-17.00	UN Panel: Q&A	WHO, UNICEF, WFP, REACH
17.00-17.30	**Session 9: Wrap up of Day Two**	
17.30-18.00	Official photograph	
19.30	Dinner hosted by Government of Ethiopia	

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Wednesday 16th November 2011 DAY 3: Drawing Conclusions & Moving Forward		
08.30-09.00	Summary Key Points Day 2, *Overview of breakout session 2 feedback*	Lola Gostelow, *ENN*
	Session 10: Discussion of key questions	**Chair: Dr Baseer Khan Achakzai, *NIH Pakistan***
09.00-10.45	*Breakout session 3: Discussing key questions*	
10.45-11.15	Break	
11.15-12.30	*Breakout session 4: Moving Forward*	
12.30-13.30	Lunch	
13.30-14.30	*Breakout session 4 (cont.): Moving Forward*	
14.30-15.30	*Plenary review of breakout session 4*	
15.30-16.00	Break	
16.00-17.00	*Plenary review of breakout session continued*	
	Session 11: Next Steps	
17.00-17.15	*Concluding comments from day 3*	
17.15-17.30	Scaling Up Nutrition film	
17.30-17.45	Official Closing (Days 1 to 3)	
18.00-19.00	*Optional sessions on special interest areas*	

Thursday 17th November DAY 4: Focus on the Scaling up Nutrition Movement		
	Morning session	**Chair: Dr Ferew Lemma, *Federal Ministry of Health***
0915-0930	SUN Film	
09.30-09.45	Formal opening, welcome and introductions	HE Dr Kebede Worku, *State Minister, Government of Ethiopia*
09.45-09.50	Agenda	Lola Gostelow, *ENN*
09.50-10.10	Capturing the themes from the conference to date	HE Dr Nadeera Hyat, *Deputy Minister for Health Care Services Provision, Afghanistan*
10.10-10.20	Q&A with David Nabarro to the conference	David Nabarro, *Special Representative of the UN Secretary General for Food Security and Nutrition*
10.20-10.45	Political economy of nutrition scale up	Andres Mejia Acosta, *Institute of Development Studies*
10.45-11.15	Break	
11.15-12.00	Perspectives on the Scaling Up Nutrition (SUN) global movement: evolution and prospects	David Nabarro, *Special Representative of the UN Secretary General for Food Security and Nutrition* Bjorn Lundquist, *REACH*
12.00-12.30	Q&A with panel	
12.30-13.45	Lunch	
	Afternoon session	**Chair: Joan Matji, *UNICEF***
13.45-15.00	*Breakout groups: linking CMAM and SUN* *Plenary feedback session for CMAM/SUN links*	
15.00-15.45	*Breakout groups: defining key next steps action points (including tea/coffee)*	
15.45-16.15	*Plenary feedback session on next steps*	Dr David Nabarro, Dr Ferew Lemma,
16.15-16.30	Official close	
15.45-16.15	Plenary feedback session on next steps	

Annex 3: Set of questions to guide Day 3 working group discussions

General

1. Is acute malnutrition (SAM and MAM) given pro portionate attention to other forms of undernutrition (stunting, underweight, micronutrient deficiencies) and if not, why not? What more can be done to get acute malnutrition (SAM and MAM) onto your Governments agenda?

Finance/Funding

2. Under what circumstances can donors directly fund governments to scale up CMAM?
3. How have current modes of funding for CMAM enabled or constrained government capacity to scale up and what would be the ideal funding mechanism/s for scale up to meet: RUTF/supplies, community mobilisation, capacity development?
4. Does emergency funding complicate coordination between government, donors and agencies? If so, how can this be addressed?
5. What are governments thinking about how you will finance RUTF and other CMAM treatments in the longer-term (e.g. making it an essential drug/commodity, putting into SWAp)? What are the incentives/barriers for government to engage in discussion about local production (e.g. issue of milk powder, quality testing and quality peanuts)?

Nutrition Governance

6. Is it important or helpful that the Executive (President or Prime Minister's office) plays a leadership role in CMAM scale up? If so, how should the executive be involved and if not, where should the leadership role for CMAM reside.
7. Is the incorporation of CMAM into existing or new health policies and plans sufficient for scale up on its own? If not, what other policy opportunities are there that are important for CMA, (e.g. policies that include nutrition, community mobilisation and national development plans) and how can you get CMAM into these policies?
8. How crucial is a central unit/CMAM group (technical, advocacy, steering) to scale up and where should such a group/body be positioned?
9. In your country, how important have individual advocates/champions within government been to scale up process and who were they influencing within government?
10. Are UN agencies sufficiently aligned, coherent and consistent in their programming, support, messages and priorities to government? What could be further improved?

Capacity

11. What elements of the health system need to be strengthened to implement scaled up CMAM programming?
12. What are the experiences of MoH and other staff with regard to community mobilisation and sensitisation as a key component of the CMAM model?
13. How is CMAM being monitored? Should/how many CMAM indicators be in- routine information systems (including HMIS) and how would this be achieved?
14. Which model for training in CMAM works best? How feasible is it for government to locate CMAM into pre-service training?
15. How best can partner agencies harness more predictable funding for longer term capacity development for CMAM scale-up? Would it be easier to do so if this was part of a sector wide capacity strategy?
16. What is your governments' policy or approach to addressing moderate acute malnutrition within the context of CMAM programming? Is MAM being adequately addressed and if not what are the possible solutions?
17. What do we feel are the outstanding operational research questions for scale up, e.g. MAM prevention/treatment, strengthening referrals?

Donor questions

18. If CMAM is incorporated in a national policy framework or strategy, are donors willing to finance it? Through what mechanism? Would it be appropriate to consider CMAM scale-up (if it is in the national plan) as a condition for budget-support transfers? If not, what measures could be negotiated to ensure sufficient attention to, and investment in, this component of a nation's strategy? Does it make (or would it make) a difference to your approach if you are part of the SUN Movement?

19. What additional information from government would assist donors in providing this type of support (e.g. cost and coverage data)?
20. Are there opportunities within current emergency funding windows to contribute towards longer-term and scaled up CMAM programming?
21. How can harmonisation be improved between emergency and development funding?

Annex 4: Detailed areas of action for country delegations (Day 4)

Country	Action points
Afghanistan	• Detailed and costed plan of action to scale up treatment of acute malnutrition to meet national target of 70% coverage of SAM (nationally) by 2015. • Decentralisation of target objectives via the ministry hierarchy through a series of meetings, look to feedback on the outcome of the CMAM conference and establish requirement to action progressive scale up. • Increase government commitment to health and nutrition funding in line with additional medium term donor funding. Critically, only 4% of annual government budget is allocated to health currently, but the intention is to increase this to 7% • Identification of increased resource requirements (human and material) to achieve objectives. This will include in-service training for min 70% of the 22,000 CHWs (working in 11,000 health posts) and secondary level staff training. RUTF/medicine and material needs must also be identified and costed.
Bangladesh	• Establish an institutional arrangement above sectoral level to ensure effective multi-sectoral approach towards nutrition programming at large (including CMAM).
Cambodia	• Development of the 2nd Strategic Framework for Food Security and Nutrition in 2012 is an opportunity to focus attention on making an intersectional approach operational. • Continue to implement management of acute malnutrition in seeking for integrating with IMCI, NIP, IYCF, Malaria, Safe Motherhood • Fundraising • Implementation of nutrition activities in other districts not yet covered • Strengthening monitoring and reporting system
Ethiopia	• Re-focusing / increasing geographical coverage and targeting, i.e. developing regional states and rural settings • Coordination, harmonisation, integration with sectors, programmes and partners a) Strengthen the nutrition multi-sectoral coordination of the NNP b) Scale up integrated nutrition package
Ghana	• Identify nutrition champions • National launch of SUN on 8th December 2011 by First Lady • Technical Committee Meeting on 9th December 2011 • Regional launches • Hold advocacy meeting to place nutrition on the agenda of district assemblies • In-service training in management of SAM in inpatient care for five hospitals (December 2011) • Continue scale up of CMAM (outpatient care) in districts within phase 1 regions
Kenya	• Write a request letter to join the SUN movement – Minister of Public Health and Sanitation to sign – consensus on focal point at country level (30th November 2011). • Finalise national nutrition action plan (NNAP), targets and costing • Launch NNAP – high level national nutrition symposium planned early in the year. • Food and nutrition security policy approved by Cabinet Technical working group developing structures for implementation of the policy linked with devolved system. • Endorse a systematic way of measuring programme coverage. • Expand CMAM in urban and non ASAL areas (move focus away from emergency areas) including facility HW and CHWs. • Increase integration with other health services – sensitise other programme managers at national and district levels. • Government to take stronger leadership in monitoring quality of products (RUTF, UNIMIX and others).
Liberia	• Finalise draft nutrition action plan and disseminate (with SCUK, UNICEF, WFP, WHO, ACF), March 2012 • Finalise draft CMAM integration strategy (with ACF, UNICEF, WFP), March 2012 • Review and validate CMAM guidelines (with WHO, UNICEF, ACF and WFP), December 2011 • Establish CMAM technical working group, December 2011 • Advocate for Government budgetary allocation for Nutrition (with TWG), December 2011 • CMAM in-service training for health workers (with UNICEF, ACF, WFP, etc), January 2012 • Establish stabilisation centres in 5 regional hospitals (with UNICEF and ACF), 2012 • Establish 20 OTPs in three countries (with UNICEF and ACF), 2012

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Country	Action points
Malawi	• Cascade integrated training that focuses on all the SUN interventions. • Implement the national education and communication plan that aims at mobilising the community systems and structures to promote optimal practices and demand for nutrition services at community level. • Organize a stakeholder's forum to look at what sectors and stakeholders are doing in line with SUN interventions to identify gaps and linkages, as well as operational modalities to strengthen the integrations. • Establish and train multi-sectoral nutrition coordination committees. • Cascade targeted training of nutrition program managers, coordinators, focal persons, front-line workers and NGOs from all the relevant sectors. • Facilitate filling of vacancies for established positions and lobby for additional positions whether permanent or non-established • Convene the district managers from all sectors and their partners for a joint planning and budgeting meeting to ensure inclusion of the SUN and CMAM in the district implementation plans (DIP) and budgets • Mobilise resources and support the districts through the SUN arrangement . • Train key sectors at district level in resource mobilisation. • Conduct a gap analysis study in line with all the 13 SUN intervention including CMAM. • Conduct the mapping. • Organise a national consultation and consensus meeting to discuss and document best practices that can be scaled up in line with MAM. • Strengthen operational research in MAM to identify alternative low cost modes of MAM treatment.
Mozambique	• Mapping of interventions already identified in multi-sectoral plan to reduce chronic undernutrition (including CMAM), what is already implemented, what is the coverage and who is doing what and where. • Define minimum package with key indicators that needs to be delivered now by all districts (and ap proved by high level of the government) and identify the capacity that is needed to implement that (human resources plan) – management, logistic, implementation (nation to local level). • After the mapping we will decide on what interventions will start and how. • As Ministry of Health, define advocacy plan within the government and partners. • Put nutrition into G19 agenda, that is under Ministry of Planning and Development • Following this, create nutrition working groups in specific sectors.
Nepal	1) Planning and advocacy for funding support for scaling up: • Hold CMAM technical working group meeting and develop costed scaling up plan for CMAM within January 2012 • Hold advocacy workshop with decision makers from national planning commission, finance ministry and with other relevant agencies for funding support – by end of February 2012. 2) Integration with IMCI and IYCF programme: • Assign technical working group to work for level and extent of integration and harmonisation with training package 3) Linking within multi-sectoral nutrition framework: • Hold meeting with national planning commission to scaling up CMAM and put CMAM within multi-sectoral approaches
Niger	Develop an advocacy plan to make nutrition a priority of the government, donors, local authorities and communities
Nigeria	*Governance:* • Disseminate report of this meeting with objective to put scale up nutrition on the political agenda (23rd to 29th November) • Forum 1) NMH (23rd November; 2) TMC (28th November); 3) National stakeholders (29th November); 4) FEC (December); 5) Governor's forum (January 2012) *Capacity:* • Mapping of who is doing what and where in nutrition (first quarter 2012) • Capacity assessment and then explore ways to enhance capacity at Federal, state and LGA (desk review and primary data collection) (first quarter 2012) *Finance:* • Develop a costed multi-sectoral scale up plan for nutrition, including local production of RUTF (first quarter 2011) • Incorporate into the national budget for 2013 (August 2012)

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Country	Action points
Pakistan	• Preparation of technical document/ 8C-1s, with consultation of all stakeholders/ provinces (nutrition cell/wing, partners and technical experts, 1 month) • Submission of PC-Ts to Cabinet Division (Nutrition cell/ wing, 2 weeks) • Forwarding to planning commission/ allocation of funds (Nutrition cell, cabinet division, 1 month) • Approval by ECNEC (Nutrition cell, cabinet division, planning, finance division, 2-3 months • Release of funds (Finance division, planning division, 1 month) • Implementation (Nutrition cell/ wing, Provinces, cabinet division, planning commission, 1 month)
Sierra Leone	• Government to establish coordination body in the office of the Vice-President to bring together line ministries, donors and partners to support the Nutrition Strategic Action Plan • To establish more OTP sites at least three to five per chiefdom in order o increase access and improve coverage. • Government to provide logistics support (vehicles and fuel) for monitoring and supportive supervision of all nutrition programmes at national, district and facility levels. • Government to provide support for effective community mobilisation and sensitisation by training community health volunteers, care groups (women and men), traditional healers, religious persons and all stakeholders in the community. • A comprehensive report about the conference will be submitted to the nutrition programme manager who will present the document to the chief medical officer in the Ministry of Health and Sanitation for onward submission to the Minister of Health and Sanitation.
Somalia	• Set up task force on nutrition on Somalia with a mandate to bring together all stakeholders. • Meeting with Ministers of Health from Somaliland and Puntland and transition government through the health sector meetings, then look at involving other sectors. • Involve INGOs and local NGOs to discuss scale up. • Capacity building of NGOs through training and skill transfer approaches. • Involvement of MSF and ICRC and other players to learn from their experiences. • No volunteerism.
South Sudan	1) MoH shall enhance the enabling environment for integration of SUN/CMAM through a number of actions: • Review current health policy to ensure strong inclusion of the nutrition component. • Ensure effective integration of a nutrition package in ongoing review of basic package for health and nutrition services (BPHNS). 2) MoH shall strengthen vertical and horizontal coordination among nutrition stakeholders through a number of actions: • Use opportunity to finalise nutrition policy to engage other sectors and players in nutrition to de fine their respective roles. • Convene a meeting with UN and donors to define roles and mandates and to reach consensus on how to support government capacity to lead at all levels. • Convene a consultative meeting with state governments to redefine and understand roles and mandates and reach consensus on appropriate coordination and communication modalities for effective decentralisation of SUN/CMAM packages. 3) MoH shall place greater emphasis on capacity building and ensure government leadership, ownership and accountability at all levels through a number of actions: • Review current pre-service curriculum to include nutrition for health providers. • Strengthen capacity and undertake on the job training for existing health providers. 4) His Excellency the Minister will make efforts to draw attention and support from high political level to support and invite the SUN movement in South Sudan.
Sudan	1) Advocate for national and state government commitments towards CMAM Programme as part of nutrition package. The commitments should include securing funding for CMAM supplies (RUTF), activation of MOH policy on free treatment for children <5 years with SAM and including RUTF in essential drug list. 2) Link with international donors and funding sources to mobilise resources for financing scale up of CMAM programme to cover whole the country by 2015, and support interventions for prevention of moderate acute malnutrition such as infant and young child nutrition, rather than the traditional Supplementary Feeding Programme . 3) Update the community outreach strategy for Sudan to reflect more integration with other health services and future sustainability of this component, based on the experiences of Sudan and other countries. Explore innovative ways to reward the Community Based Volunteers (CBVs). 4) Strengthen coordination with research institutes to draw country based evidence on CMAM and conduct research and studies to help the scale up and sustainability of CMAM services in Sudan.

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Country	Action points
Tanzania	• Tanzania recently launched a national nutrition strategy and implementation plan drafted. To be done: review the draft implementation plan for the NNS 2011 to 2016 and ensure that CMAM is properly in corporated. • Incorporate CMAM in the district planning and budgeting cycle for the 2012/13 financial year, focusing on regions with highest prevalence of wasting. • Strengthen the community element of the CMAM activity currently implemented in selected districts. • Give feedback to the technical working group the learning from this CMAM conference.
Uganda	• Hold a meeting of key nutrition stakeholders (Government and UN agencies, donors, NGOs, CSOs) to come up with an immediate action plan on SUN as reflected in Uganda Nutrition Action Plan. • Follow up on the presidential directive to form a national food and nutrition secretariat under office of the Prime Minister. • Lobby the parliament social services committee to hasten the enactment of the food and nutrition bill currently before parliament. • Advocate as part of the multi-sectoral committee on nutrition the creation of nutrition vote (budget item) under OPM. • Fast track the creation of community based ENA messages in 10 major local languages. • Prioritise 15 districts most hit with high levels of GAM and intensify CMAM activities.
Zambia	• To get the new government of Zambia to endorse their commitment to SUN and also to scale up CMAM to all provinces.
Zimbabwe	• Provide feedback on outcomes and recommended actions from CMAM conference – including briefing / workshop for cluster, CMAM working group, Food and Nutrition Council. • Zimbabwe is an early riser country (Sept 11), but more sensitisation needs to be done of different government ministries, civil society and other partners is needed – on the SUN movement, what it means to be part of it, what Zimbabwe wants to achieve through SUN. 'Sell it' to all stakeholders. This needs to be done at ALL levels. • Finalisation of Food and Nutrition policy (in finalisation stages – too late to align with SUN?). • Develop a strategy for scaling up CMAM to communicate at all levels. • Develop costed Nutrition Action plan including CMAM. • Communicate with Nutrition Policy Officer at Food and Nutrition Council on alignment of the Food and Nutrition policy with SUN. • Integration of CMAM into routine health services – identify Health System Strengthening initiatives in Zimbabwe and define opportunities to integrate CMAM into these. • Better use the opportunity of NGOs, other experts in country to strengthen capacity and knowledge in-country on CMAM – be more proactive in terms of expressing need for support. • Advocate for CMAM funds within the government nutrition budget. • Activate, strengthen, improve the community component of CMAM programme – sensitisation, screening, active case-finding follow-up. • Strengthen links between CMAM services and HIV services as well as IYCF services (all levels) – develop a robust referral system between the 2 (recognising SAM closely linked to HIV) • Integrate CMAM indicators in National HIS – MUAC, oedema, admissions, discharge. • Reinvigorate discussions with private sector on local production.

CMAM Conference delegates

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