

Managing acute malnutrition at scale

A review of donor and
government financing
arrangements

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Attribution

Throughout this document, quotes from interviewees are indicated in *italic text* within quotation marks. These quotes have purposely been left unattributed to individuals, as agreed at the outset of this review. Quotes from documents are also in quotation marks, but text is not in italics and the reference is given in an accompanying footnote.

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List of acronyms

ARTs	Anti-retroviral therapies
ASALs	Arid and Semi-Arid Lands
BCC	Behaviour change communication
BMI	Body Mass Index
CAP	Consolidated Appeals Process
CERF	Central Emergency Response Fund
CHAI	Clinton Health Access Initiative
CIDA	Canadian International Development Agency
CMAM	Community-based management of acute malnutrition
C-SAM	Community-based treatment of severe acute malnutrition
DALY	Disability-Adjusted Life Years
DFID	UK Department for International Development
ECHO	European Commission Humanitarian Aid and Civil Protection
ENCU	Emergency Nutrition Coordination Unit (Ethiopia)
EPI	Expanded Programme on Immunization
EC	European Community
EU	European Union
FANTA	Food and Nutrition Technical Assistance
GAM	Global acute malnutrition
HINI	High Impact Nutrition Interventions
HIV	Human Immunodeficiency Virus
HPF	Health pooled fund
ICCM	Integrated Community Case Management (Ethiopia)
IMAM	Integrated Management of Acute Malnutrition
IP	Implementing Partner
IYCF	Infant and Young Child Feeding
KSH	Kenya Shillings
MAM	Moderate acute malnutrition
MDGs	Millennium Development Goals
MNP	Micronutrient powders
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NGO	Non-Governmental Organisation
NNP	National Nutrition Programme (Ethiopia)
NRU	Nutrition Rehabilitation Unit
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development

OFDA	US Office of Disaster Assistance
OTP	Outpatient Therapeutic Programme
RUTF	Ready to Use Therapeutic Food
SAM	Severe acute malnutrition
SFP	Supplementary Feeding Programme
SHARE	Supporting Horn of Africa Resilience
SWAp	Sector Wide Approach
TSFP	Targeted Supplementary Feeding Programme
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children’s Fund
UNSCN	United Nations Standing Committee on Nutrition
USAID	United States Agency for International Development
WACRO	West and Central Africa Regional Office (UNICEF)
WASH	Water, Sanitation and Hygiene
WFH	Weight for Height
WFP	World Food Programme
WHO	World Health Organisation

Glossary of nutrition terms

Acute malnutrition	Acute malnutrition, also known as wasting, develops as a result of recent rapid weight loss or a failure to gain weight. In children it is measured through the weight for height nutritional index (WFH) or mid-upper arm circumference (MUAC). In adults, it is measured by body mass index (BMI) or MUAC. The degree of acute malnutrition is classified as either moderate or severe.
Chronic malnutrition	Chronic malnutrition, also known as stunting, develops over a long period of time. In children and adults it is measured through the height for age nutritional index.
Community-based management of acute malnutrition (CMAM)	An approach to treat acute malnutrition that includes the management of severe acute malnutrition in in- and out-patient care, the management of moderate acute malnutrition and community outreach (for community mobilisation, early detection and referral of acute malnutrition and home follow-up of problem cases). Also known as CTC and IMAM.
Community-based Therapeutic Care (CTC)	As above. The term is sometimes used interchangeably with CMAM.
Community-based treatment of severe acute malnutrition (C-SAM)	An approach for managing severe acute malnutrition that includes in- and out-patient care (different to CMAM, which manages both severe and moderate acute malnutrition).
Disability Adjusted Life Year (DALY)	A measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.
Global acute malnutrition (GAM)	A population-level indicator referring to overall acute malnutrition defined by the presence of bilateral pitting oedema or wasting defined by WFH <-2 z-score (WHO standards or NCHS references) for children 6–59 months. Global acute malnutrition is divided into moderate and severe acute malnutrition (GAM = SAM + MAM).
Infant and Young Child Feeding	The feeding of infants (aged less than 12 months) and young children (aged from 12 to <24 months).
In-patient care (in CMAM)	The care of patients whose condition requires admission to hospital. Patients with complicated severe acute malnutrition are treated in in-patient care before continuing treatment in out-patient care. Alternative terms are Inpatient therapeutic care, Phase I, therapeutic feeding unit, therapeutic feeding centre or stabilisation centre.
Micronutrient Powder (MNP)	Single-dose packets of iron and other vitamins and minerals in powdered form that can be sprinkled onto any ready to eat semi-solid food to increase the micronutrient content in the individual's diet without changing their usual dietary habits.
Moderate acute malnutrition (MAM)	Moderate acute malnutrition is defined by a MUAC between 115mm and <125 mm or a WFH between -3 z-score and <-2 z-score of the median (WHO standards) or WFH as a percentage of the median 70% and $<80\%$ (NCHS references).
Outpatient Therapeutic Programme (OTP)	A component of CTC or CMAM where children with severe acute malnutrition without medical complications are treated in a community health facility through the provision of routine medical treatment and nutrition rehabilitation with Ready to Use Therapeutic Food (RUTF). Children attend out-patient care at regular intervals (usually once a week) until recovery is achieved (usually two months). The term OTP is sometimes used to describe CTC or CMAM.
Ready to use food (RUF)	RUFs can be eaten without further preparation or cooking. Most RUFs have very low moisture content and so can be stored without refrigeration. They are typically energy-dense, mineral- and vitamin-fortified foods, used for the treatment or prevention of undernutrition.
Ready to Use Supplementary Food (RUSF)	Energy-dense, mineral- and vitamin-fortified foods for the treatment or prevention of moderate acute malnutrition. RUSFs can be eaten without further preparation or cooking and are given as a supplement to the ordinary diet. They have very low moisture content and so can be stored without refrigeration.
Ready to Use Therapeutic Food (RUTF)	Energy-dense, mineral- and vitamin-fortified foods for the treatment of severe acute malnutrition. Most RUTFs are lipid-based pastes that can be consumed easily by children from the age of six months without further preparation or cooking. RUTFs have very low moisture content and so can usually be stored without refrigeration. RUTFs are not suitable for Phase 1

	treatment of complicated severe acute malnutrition in a TFC or SC, where a liquid feed, such as F75, is required.
Scaling-up Nutrition (SUN) Movement	A country-led movement, begun in 2009, that brings organisations together across sectors to support national plans to scale up nutrition by helping to ensure that financial and technical resources are accessible, coordinated, predictable and ready to go to scale.
Selective feeding programmes	Targeted supplementary feeding or therapeutic care programmes that admit individuals based on anthropometric, clinical or social criteria for the correction of acute malnutrition.
Severe acute malnutrition (SAM)	A child with severe acute malnutrition is highly vulnerable and has a high mortality risk. Severe acute malnutrition is defined by the presence of bilateral pitting oedema or severe wasting, defined by MUAC <115mm or a WFH <-3 z-score (WHO standards) or WFH <70% of the median (NCHS references).
Stunting	Stunting, also known as chronic malnutrition, is where a child fails to grow in height over a long period of time. The definition of being stunted is length/height-for-age <-2 z-score and of severe stunting length/height-for-age <-3 z-score.
Supplementary feeding programme	Supplementary feeding programmes provide food to the nutritionally or socially vulnerable in addition to the general food distribution to treat or prevent malnutrition. Supplementary feeding programmes can be blanket or targeted.
Therapeutic care	Feeding and medical treatment to rehabilitate severely malnourished children.
Therapeutic feeding centre	Centres for the in-patient care of patients with complicated severe acute malnutrition. Alternative terms are in-patient therapeutic care, Phase I, therapeutic feeding unit, nutrition rehabilitation unit or stabilisation centre.
Therapeutic milk	Milk-based products developed to meet the energy, macronutrient and micronutrient needs of severely malnourished children and promote metabolic balance (F75) and weight gain (F100).
Undernutrition	An insufficient intake of energy, protein or micronutrients, that in turn leads to nutritional deficiency. Undernutrition encompasses stunting, wasting and micronutrient deficiencies.
Wasted	Weight-for-length/height or BMI-for-age below the -2 z-score line. Severely wasted is below the -3 z-score line.
Wasting	See Acute malnutrition.
Z-score	An indicator of how far a measurement is from the median, also known as a standard deviation (SD) score. The reference lines on growth charts are called z-score lines; they indicate how far points are above or below the median (z-score = 0).

Chapter 1

Introduction

This review is concerned with the financing arrangements for programmes that address acute malnutrition at scale through the community-based management of acute malnutrition (CMAM). The CMAM approach is geared towards the early detection, treatment and counselling of moderately and severely acutely malnourished children, in the community, by community agents.

Until the late 1990s, treatment of severe acute malnutrition (SAM) was through therapeutic feeding centres in hospitals and healthcare centres. Performance was poor, coverage was extremely limited (less than 5% of the SAM population), mortality was often in excess of 30% and recovery rates were low. The CMAM approach was first piloted in Ethiopia in 1999 as an alternative to the centre-based model. Development of the approach offered the prospect of dramatically increased access to successful treatment and coverage.

CMAM has been adopted in over 65 countries. In 2011, just under two million children under five years of age with SAM were reported as being admitted to CMAM programmes, compared with just over one million in 2009.¹ While this large increase partly reflects improved reporting, it is also indicative of the ongoing scaling up of treatment of

SAM. Even so, total reported admissions represent just 10–15% of the estimated 20m global SAM cases annually. Treatment of moderate acute malnutrition (MAM) has not kept pace with the scaling up of SAM treatment, and coverage for in-patient treatment of SAM children with infection and/or oedema is unknown. Many countries with very high caseloads of acutely malnourished children, such as India, Nigeria and Indonesia, have extremely low CMAM coverage.

Scope of this review, definitions and process

This review is a follow-up to an international conference on CMAM co-hosted by the government of Ethiopia and the Emergency Nutrition Network (ENN) in Addis Ababa in 2011, co-funded by the UK Department for International Development (DfID), the Canadian International Development Agency (CIDA) and Irish Aid.² At the conference, 24 government representatives from Africa and Asia shared their experiences of scaling up CMAM, and in particular the challenges posed by unpredictable and unsustainable financing arrangements.

This review, co-funded by CIDA and Irish Aid, focuses on financing arrangements for CMAM, both globally and at the national level. It covers humanitarian financing, as well as



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A mother at an Outpatient Therapeutic Programme site in Northern Nigeria

¹ The number of children treated for moderate acute malnutrition (MAM) through CMAM programmes is not known.

² ENN, *Conference on Government experiences of Community-based Management of Acute Malnutrition and Scaling Up Nutrition*, Conference Report, January 2012.

financing through transitional and development channels. Financing is about much more than the simple flow of resources: ‘Financing affects behaviour, aid architecture, the power and influence of different groups, priorities and capacity development. It signals approval or disapproval. There is no neutral choice – making a financing decision always creates consequences that go far beyond the time scale and scope of the funded activity’,³ and so this review also looks at the management, organisation and funding channels for CMAM.

The review focuses on programmes that identify, treat and prevent acute malnutrition and related mortality at scale. During the review, the interplay between acute and chronic malnutrition (stunting) also emerged as a consideration. For the purposes of this review, ‘at scale’ is defined as the ‘widespread achievement of impact at affordable cost’. Increased impact is a function of the coverage of a population, programme effectiveness (quality

³ OECD, *Transition Financing: Building a Better Response*, OECD Publishing, 2010.

of implementation and efficacy of interventions employed), efficiency (cost per beneficiary), sustainability (continuity, ownership) and equity (reaching those in need).

The process of producing this review was three-pronged. First, telephone and face-to-face interviews were undertaken with government and agency (UN, donor, foundations) representatives involved in nutrition policy, financing and CMAM programming. Second, case studies were developed following visits to Kenya and Ethiopia and from interviews carried out by an ENN consultant in Malawi and Nigeria. The case studies explored financing arrangements in greater depth, and were selected based on the extent of CMAM programming, as well as the level of country interest in the review. Third, published and grey literature relating to CMAM and financing was reviewed. The ENN review team made a series of presentations to UN agencies and donors to share the preliminary findings and to discuss emerging issues. These were followed by presentations at a number of high-level nutrition-related meetings. In total, 152 people were interviewed during the course of this review.

Chapter 2

The financing environment

Globally, political interest in food security, global hunger and nutrition (or rather undernutrition) is greater today than it has been for decades. The development of the Scaling Up Nutrition (SUN) Movement, the Hunger Summit in London on the margins of the 2012 Olympic Games and various high-level SUN events and meetings at country level are testament to an unparalleled momentum in the nutrition sector. The year 2013 is set to be a critical one in furthering this global impetus. A second series of articles in *The Lancet* on nutrition is expected to provide more up-to-date evidence and analysis on the effectiveness and efficiency of a wide variety of interventions combating undernutrition. Decisions around how nutrition should be approached in the post-2015 Development Agenda will form the basis for the next chapter of global human development targets and investments, and the G8 summit in June 2013 is expected to provide political backing to international and national efforts.

Despite this significant momentum, levels of financial investment in proven (direct) nutrition interventions are extremely low. A recent report⁴ estimates that just 1% of the \$11.8 billion required to tackle undernutrition, as estimated by the World Bank in 2010, is being invested in direct nutrition interventions.⁵ Official Development Assistance (ODA) to the category 'Basic Nutrition' increased by 32% over 2000–2008 and doubled in 2008–2009.⁶ However, levels of basic nutrition ODA are small compared to emergency and development food aid. In 2009, when basic nutrition ODA peaked, it stood at \$539 million, whereas development food aid amounted to \$1.9bn and emergency food aid totalled \$3.2bn.⁷ Furthermore, aid is not necessarily directed to the countries where most of the world's undernourished children live, particularly in Africa. Compared with other sectors, ODA for basic nutrition is disproportionately channelled via international actors,

⁴ ACF, *Aid for Nutrition: Can Investment To Scale Up Nutrition Actions Be Accurately Tracked?*, ACF, 2012.

⁵ According to the World Bank, the financing gap is slightly less (\$10.3bn) as \$1.5bn is expected to come from private sources.

⁶ The term 'Basic Nutrition' is a purpose code used in the OECD 'Creditor Reporting System (CRS) Data Base'. It is distinguishable from emergency food aid and development food aid and is considered to be part of health sector programming.

⁷ It should be noted, however, that some nutrition interventions may have been reported under other CRS codes, and an exact quantification of nutrition interventions is not available. D. Coppard and A. Zubairi, *Nutrition Advocacy Landscaping in Europe: An Analysis of Donor Commitments*, Development Initiatives, 2011.



Filling RUTF jars in the RUTF factory in Mozambique

© Maaike Arts, UNICEF

Box 1

The *Lancet* nutrition series

The first *Lancet* nutrition series, published in 2008, recommended global scale up of 13 high-impact nutrition interventions: treatment of acute malnutrition (SAM and MAM), promotion of exclusive breastfeeding for the first six months of life, promotion of optimal complementary feeding for infants after the age of six months, vitamin A supplementation (two doses per year for children between six and 59 months), zinc supplementation for diarrhoea management, multiple micronutrients for children under five years, de-worming for children (two doses per year for children 12–59 months), iron-folic acid supplementation for pregnant mothers, promotion of improved hygiene practices, including hand washing, salt iodisation, iron fortification of staple foods and behaviour change communication.

predominantly civil society and multilateral agencies, with just 24% going to governments. Within countries, national budgets for nutrition financing are often very limited.

The international aid architecture rigidly compartmentalises humanitarian and development aid, and each is governed by different principles, rules and regulations and standards, and often managed by different departments of the same donor agency or organisation. This arrangement does not correspond to reality on the ground, which requires simultaneous and

coordinated funding for humanitarian, transition and development activities. National and regional organisations in particular perceive the lines that the international aid system has drawn between preparedness, relief, recovery and development as artificial and counterproductive. Although the conceptual model of a linear 'continuum' from relief to development has been replaced by a 'contiguum' that envisages the simultaneous reality, practices have not yet shifted accordingly. The upsurge in thinking and programming for building resilience may, however, result in better preparedness, response and recovery in emergency-prone countries.

Most humanitarian aid tends to bypass government structures, while development aid is usually predicated on working with and through governments. The largest share of all reported humanitarian resources is still in the form of grants from donor governments to provider organisations (i.e. the UN agencies, international non-governmental organisations (NGOs) and the Red Cross/Red Crescent). Around 5% of humanitarian funding between 2006 and 2011 was channelled through humanitarian pooled funds (including the global Central Emergency Response Fund (CERF) and country-level Emergency Response Funds and Common Humanitarian Funds). Pooled humanitarian funds typically operate on annual funding cycles and may align with national priorities, at least to a limited extent.

The largest single component of humanitarian aid is spending on food aid. Globally, after rising to 40% of the total in 2008 in response to the global food crisis, food aid represented 27% of the total in 2011. In specific crises, food aid can account for a huge proportion of the total humanitarian response. For example, up to 70% of the Horn of Africa appeals have focused on food since 2005. This leaves much smaller proportions of funding for other preventive and resilience-building interventions. Livelihood support (cash, vouchers, seeds, tools) over the same period represented just 15% of the appeals. Many of the largest recipients of humanitarian aid are in conflict-affected countries, presenting further obstacles to the development of medium- and long-term programming to strengthen national capacity.

The outlook for ODA, including humanitarian aid, is one of low or no growth in the immediate future. Between 2010 and 2011, ODA (excluding debt relief) from OECD DAC donors decreased from \$132.9bn to \$129.4bn, a fall of 2.7%. If nutrition ODA follows these global trends, then it will stagnate or fall. The Paris Declaration of 2005, the subsequent Accra Agenda for Action (AAA, 2008) and the Busan Partnership for Effective Development Cooperation (2011) saw donors commit to 'flexible, rapid and long-term funding modalities, on a pooled basis when appropriate, to bridge humanitarian, recovery and longer term development phases'.⁸ In practice, implementation of

8 The two largest donors of ODA, the European Commission Humanitarian Aid and Civil Protection (ECHO) and the US Office of Disaster Assistance (OFDA), do not support pooled funding. DAC governments remain the largest government contributors to humanitarian funding (95% of the total between 2001 and 2010). Together, the US and ECHO accounted for 45% of total humanitarian contributions recorded in 2010.

the Paris Principles has been variable, and donor behaviour is largely determined by the level of confidence a donor has in the government in question. Reconstruction and thematic pooled funds offer scope for greater alignment with national development priorities but require high levels of coordination, accountability and visibility. The findings from this review suggest that there has been little adherence to, or consideration of, the Paris Principles⁹ with respect to financing for CMAM scale up.

What does it cost to scale up CMAM?

Recent studies have estimated the cost-effectiveness ratio of treating SAM through CMAM programming at \$42¹⁰ per Disability Adjusted Life Year (DALY) averted. This is within the general range of cost-effectiveness ratios estimated for other priority child healthcare/survival interventions, such as case management of lower acute respiratory infections, universal salt iodisation and iron fortification. However, the costs of taking CMAM to scale are not clear and vary between countries. Costs for start-up, sustained coverage, personnel and community mobilisation and the cost benefits of integration or convergence with other programmes and sectors are not well established in many countries. The SUN Movement is supporting some governments to cost nutrition scale-up plans, and CMAM is part of this exercise in a number of these countries.

At the global level it is reported that the average cost of a case of SAM treated is \$200 per child, with RUTF alone accounting for at least half of that figure. The World Bank estimates that the cost for scaling up SAM treatment (achieving 80% coverage) is \$2.6bn annually. The overall estimated cost for scale up of the 13 direct nutrition interventions identified in the 2008 *Lancet* series is \$11.8bn. Treatment of SAM therefore accounts for one-fifth of the total scale up costs. If MAM is included, the total for global treatment of GAM is \$6.2bn, over 50% of the total annual estimate for scale up of all interventions. Whether these costs can be significantly reduced through local production of RUTF or by changing the formulation is unclear and a mixed picture emerges from the countries examined for this review. There is ongoing work on the viability of using alternative RUTF formulations and local much cheaper complementary or supplementary foods for treatment of MAM.

In Ethiopia, an exercise has recently been undertaken to provide a detailed costing of its OTP (CMAM) programme and to map which agency is providing financing for which part of OTP programming. Two key conclusions emerged. First, the OTP is largely dependent on unpredictable, short-term humanitarian emergency funding, making it difficult to integrate into overall planning and financing or to transition to a longer-

9 These principles are about the process of providing and receiving aid, not about what development seeks to achieve (i.e. country ownership, alignment of donor support behind national programmes, harmonisation of donor effort in order to reduce fragmentation and high transaction costs, managing for results and mutual accountability between donors and countries), and are in essence the agreed norms of good governance in development cooperation.

10 R. Wilford, K. Golden and D. G. Walker, 'Cost-effectiveness of Community-based Management of Acute Malnutrition in Malawi', *Health Policy Plan*, 27(2), 2012.

Box 2**RUTF production**

One of the major challenges to CMAM programming is the long-term provision of supplies (RUTF, therapeutic milk, antibiotics, equipment). As noted above, Malawi, the only country in the Africa that produces all its own RUTF, still faces challenges in this area. In Mozambique, the main challenge is the expense of procurement, logistics and storage, and the government lacks sufficient funds to meet demand. Likewise in Ethiopia it is difficult to secure long-term funding for RUTF, and UNICEF is considering establishing a central funding mechanism for securing the RUTF pipeline. The total annual cost for RUTF supplies has been estimated at \$21.5m, using an estimate of US\$66¹¹ per child.

There is a widely held view that most governments of poor countries will never be able to fully finance the treatment of acute malnutrition themselves, and will always need an element of donor or private sector financing. Greater competition amongst producers at international level may do little to bring down prices given the high costs of the ingredients, and local production can sometimes be more expensive than imported supplies due to import duties on raw materials, inefficient production processes and financing constraints. Work is ongoing into cheaper formulations of RUTF, in particular replacing the dry skimmed milk component. Trials show that these products have a similar impact on reducing mortality, but recovery

time is longer leading to higher default rates. Even with alternative formulations, the most optimistic forecasts are that costs will only be reduced by 20–25%.

Many countries with high demand for RUTF, such as Yemen, Pakistan and Chad, have no local production, and private sector organisations trying to produce RUTF in Kenya and Ethiopia face a number of obstacles, including sourcing high-quality ingredients. Nevertheless, in the right circumstances savings can be made. In Ethiopia, for example, UNICEF bought local RUTF in 2012 at \$50.66 per carton, compared to \$54.18 per carton internationally, plus the additional freight cost of \$6.65 per carton, totalling \$60.82 for the imported RUTF. Local production of RUTF is starting in West Africa, but it is acknowledged that it will only marginally reduce costs. In Ghana, where production is due to start in 2015, discussions are underway to 'ring fence' the cost of RUTF through the national health insurance scheme.

RUTF is viewed in many Asian countries with scepticism. Here, CMAM is seen as a 'Western construct' designed to push a particular product when cheaper local alternatives may well suffice. In Bangladesh, SAM is treated using a non-patented locally produced RUTF, and imports of international/UNICEF-approved RUTF are banned.

term development programme. Second, the sustainability of the OTP depends on the ability of the country to finance supplies of RUTF. The Ethiopian government has not allocated any resources for RUTF procurement and, given its high cost, it is unlikely that it will. Currently all RUTF supplies in Ethiopia are financed by external agencies.

Estimates of the costs of SAM treatment through the OTP in Ethiopia vary from \$66 to \$156 per child. This range reflects differences between the costs of start-up and scale-up of OTP sites, whether staffing, training and quality control components are included and differences in the costs of locally-produced RUTF and imported supplies. The treatment of MAM is estimated at \$44 per child. Thus, the

¹¹ The planning figure normally used is \$100/child, but this includes humanitarian start-up costs as well as programme maintenance, logistics, training and M&E. The UNICEF figure covers commodity procurement, logistics and M&E, but not administrative and staff costs or training.

combined cost, per child, of treating uncomplicated acute malnutrition is between \$110 and \$200.

In Kenya, the estimated costs of implementing the National Nutrition Plan of Action for the next five years are put at KSH 67bn (approximately \$760m). KSH 13bn (approximately 20%) is believed to be needed for the procurement of nutrition commodities (RUTF, therapeutic milks, micronutrient powders, equipment) on the basis of reaching 50% SAM treatment coverage. A 2011 evaluation report put the unit cost of managing a non-complicated case of SAM at approximately \$94 and \$57 for treatment of MAM in an SFP. Thus, the combined cost per child of treating uncomplicated acute malnutrition is \$150. The cost of treatment of SAM and MAM in 2011 was estimated to be around \$6.5m, with UNICEF accounting for 54%, WFP 30% and the government of Kenya the remaining 16%. In Malawi the unit cost of treating SAM is estimated at \$50 and in Nigeria \$71.50.

Chapter 3

Country-level experiences of CMAM financing

This section draws on the experiences of governments and supporting agencies interviewed for this review from a number of countries. More detailed information is provided from four countries actively scaling up CMAM, Kenya, Ethiopia, Malawi and Nigeria, in the short summaries below. The full case studies for Kenya and Ethiopia are available electronically on request.

Humanitarian financing

There is no overview available of the extent to which CMAM is funded via humanitarian channels versus long-term financing (from donors and governments' own budgets). In the past, many CMAM programmes began in response to an emergency event and received short-term funding for six to 12 months. Increasingly, at a global level, CMAM is being introduced in non-emergency contexts and gradually scaled up in stable contexts. However, many of these countries experience periodic emergencies, so funding remains largely humanitarian. For example, UNICEF Supplies in Copenhagen reports that approximately 90% of the global orders it receives are from emergency 'top-up' funds, and just 9% come from regular resources.

The current crisis in West Africa has mobilised resources for CMAM, but nearly all of these funding mechanisms are short-term and for an average of 12 months. The main donors in the region for CMAM are the European Commission Humanitarian Aid and Civil Protection (ECHO), DFID and the US Office of Disaster Assistance (OFDA). UNICEF plans to scale up IMAM in all 24 countries covered by its West and Central African Region Office (WACRO). The scale of treatment required in the region is enormous. For example, in Niger alone 300,000 SAM cases were being treated at the end of 2012, and UNICEF and the government aim to treat up to 400,000 in 2013. However, *'the sheer cost for countries like Niger and the Democratic Republic of the Congo (DRC) to treat SAM is too scary to even compute'*. Countries such as Sierra Leone, the Central African Republic and the DRC face enormous financing shortfalls for CMAM programming and are currently meeting only around 17% of funding needs. Furthermore, each donor has different funding cycles, creating 'real headaches as implementing partners have to manage these cycles to prevent supply shortages' (interview, UNICEF WACRO).

In the Middle East and North Africa, CMAM is being implemented in Yemen, Djibouti and Sudan. Here again, short-term funding has made it very difficult for UNICEF and its implementing partners to plan beyond eight-month time horizons. UNICEF spends a great deal of time seeking new funding and setting up new agreements with partners. Supplies such as RUTF can take two months to arrive in the region so, in some cases, UNICEF may only be implementing programmes for four months under a typical six-month humanitarian grant.

A key challenge for governments and implementing partners relying on humanitarian funding arrangements is the 'stop-start cycle'. Hard evidence of this is emerging in Kenya, Ethiopia, Somalia and Pakistan. In Ethiopia, where there has been significant OTP (CMAM) scale-up since 2005, most funding has come through humanitarian mechanisms. By 2011, at the peak of the Horn of Africa crisis, OTP was being delivered at more than 10,000 health posts and mobile sites. In 2012, which was a non-emergency year, international NGO support to OTP was reduced, casting doubt on whether the scaled up programme could be sustained. In Somalia there were fears that a number of local NGOs that were implementing OTPs with UNICEF support would have to close and that UNICEF would no longer be able to maintain all the mobile OTPs that it had been operating at the height of the 2011 crisis. However, in 2012 UNICEF managed to secure funding for most of the programmes facing closure. The remaining sites (many run by the international NGOs Merlin and Medair) obtained core funding from their headquarters on a month-by-month basis. Recently, a number of donors have agreed a multi-year financing arrangement for Somalia to overcome some of these problems.

Numerous other challenges associated with reliance on short-term funding for scaling up CMAM were identified during this review, and these are summarised below:

- Governments and their implementing partners (IPs) have difficulty planning for sustainable CMAM programming.
- Humanitarian funding nearly always bypasses governments so that programming is not integrated within government health systems and other national programmes. This reduces cost-effectiveness and sustainability.
- Implementing partners report that they need *'to shoe-horn in too much and too quickly'*, especially when funding is delayed, affecting the quality of CMAM programmes.
- Agencies and governments have to invest considerable resources in writing proposals for 6–9-month funding periods and accommodating the reporting and monitoring requirements of different donors.
- Certain elements of CMAM are less easy to get funding for, notably community mobilisation, referral from screening sites to stabilisation centres (vehicles and fuel) and monitoring and evaluation (M&E), as these activities are seen as a government responsibility (see below for more on this issue).
- Certain types of humanitarian funding, for instance the CERF, do not readily allow for disaster preparedness activities like stock-piling RUTF, although where existing stocks are used up at the start of an emergency CERF Rapid Response funding can be used to replenish stocks.

Box 3**CMAM scale-up in Malawi**

Until 2002, treatment of wasting in Malawi took place in hospital-based nutrition rehabilitation units (NRUs). The 2002 food crises, which saw an increase in the wasting caseload, gave rise to the implementation of a pilot CMAM, followed in 2004 by a national CMAM dissemination workshop for district health officers, NGOs and partners. In 2005, three more districts started implementing CMAM. In 2006, CMAM was adopted as the national approach for the management of SAM. Today, CMAM is being implemented in all 28 districts of Malawi with over 500 OTP sites, representing 82% of health facilities and 357 supplementary feeding programme (SFP) sites (58% health facility coverage). There are 100 NRUs where complicated cases of SAM are treated. Although the intention was to ensure that each OTP had an SFP programme for discharge of MAM cases, a lack of commodities has meant that this has not been possible.

The CMAM programme targets children under 12 years of age, and includes community-level case identification, referral and follow-up. SAM children without complications are treated in their homes using RUTF, with weekly check-ups in the OTP, and complicated SAM cases are admitted for in-patient treatment. Roughly half of MAM children are referred to the SFP. Moderately malnourished pregnant and lactating women are given dry take-home rations through the targeted supplementary feeding programme (TSFP). Scale-up of CMAM in Malawi has emphasised integration within existing institutions and structures so that acutely malnourished children receive the care they need through the same pathways that they routinely use to access treatment for other illnesses or infections.

Malawi is the only country in Sub-Saharan Africa producing enough RUTF (via two manufacturing plants) to meet all of its needs. The Ministry of Health has started purchasing RUTF from its own budget to supplement the supplies procured by UNICEF and other donors. It is estimated that 50% of RUTF procurement comes directly from the Ministry of Health budget. There are a number of challenges with local production of RUTF, including dependence on imported raw materials (powdered milk and the mineral vitamin complex), problems with aflatoxin contamination of the peanuts, reliance on testing and quality assurance of RUTF in Europe, which can mean long delays between production and test results, and a lack of working capital (in dollars) to ensure imports of the key ingredients. There is private sector support for RUTF production in Malawi, though this is largely

confined to the provision of equipment and technical help. The cost of Malawi's RUTF varies but on average is slightly higher than that of RUTF produced in Europe.

In the early to mid-2000s, CMAM was financed through humanitarian funding mechanisms channelled through international agencies. As the approach was adopted at national level, funding started to come through different sources including the Health Sector Wide Approach (SWAp), which allocates funding directly to the Ministry of Health and gives responsibility to the nutrition unit for procurement of supplies, including RUTF. The SWAp fund provides districts with money to cover the costs of training, monitoring and supervision. Currently, four parallel funding systems finance CMAM:

- The Health SWAp, used for the Essential Health Care Package, including nutrition activities. This is the preferred mechanism for most donors (though not USAID and the UN agencies).
- District partners who fund specific nutrition activities.
- Partners who fund other activities that include a nutrition component, for instance HIV/AIDS.
- Direct funding to the national Ministry of Health nutrition unit.

Coordination of these funding systems presents a challenge, though the launch of SUN in 2011 has seen the establishment of a Malawi donor group for nutrition, leading to better coordination and technical assistance for financing. Nonetheless, current financing arrangements in Malawi are not secure. The Clinton Health Access Initiative (CHAI), which has long funded CMAM supplies, intends to withdraw, and UNICEF plans to phase out its involvement. The government would like to see CMAM fully integrated into the SUN package as this would make it more sustainable. CIDA and the World Bank are contributing a total of \$43.1m for SUN implementation in 15 districts.

It is estimated that sustained longer-term funding of CMAM resources will require a total of \$45.7m over a five-year period (2011–2015). Currently, a large amount of financial and logistical support for CMAM is provided by international donors and CHAI. Most technical support has come through the CAS (a technical arm of the Ministry of Health). This raises questions around longer-term sustainability as health services are under-resourced and dependent on external funding.

Source: Theresa Banda, ENN Consultant seconded by Valid International.

Box 4**CMAM scale-up in Nigeria**

Levels of wasting in Nigeria were 17.6% in 1999, 11.2% in 2003 and 14.4% in 2008. Nigeria has the world's third-highest number of children under five years in need of treatment for SAM,¹² estimated at 2m in 2009, with the majority in the north of the country. CMAM was introduced in Nigeria by UNICEF with support from Valid International in 2008, and implementation started in 2009. By the end of 2009, two states were implementing CMAM. However, the 2010 food security crisis in the Sahel zone, which led to an increase in prevalence of acute malnutrition, necessitated a rapid scaling up of CMAM to 11 states by the end of 2011. The subsequent introduction of CMAM in three non-Sahelian states aimed at demonstrating that CMAM could be integrated within routine health and nutrition programmes. In each of the three states, implementation sites are intended to act as centres of learning for scaling up within the state.

Currently, CMAM includes management of SAM, but not MAM. Almost all funding for CMAM scale-up has come from the international humanitarian community. According to UNICEF, RUTF costs constitute over 90% of the total. The cost of RUTF per child treated is around \$71.50. States are able to provide routine drugs and, on occasion, funds for monitoring purposes, but have not funded RUTF. Only one state has allocated funds for the purchase of RUTF, though it did so for only a single year.

Implementation of CMAM through integration into the health system is managed by the National Primary Health Care Development Agency (NPHCDA), a parastatal institution created through the Federal Ministry of Health

to implement primary healthcare services including immunisation, growth monitoring, micronutrient supplementation and now CMAM. It has structures from federal, state and local government. Currently, the Ministry of Health does not have a budget line for nutrition, but is pressing for this with the government.

CMAM programmes do not admit MAM cases due to limited resources. MAM cases are reportedly counselled on feeding practices and treated for diseases where they are present. Although globally WFP has taken on the responsibility for MAM prevention and treatment, the agency is not operational in Nigeria. Complicated SAM cases are managed in state and referral hospitals and training is usually supported by WHO, although this support is sporadic and has not kept pace with the scale-up due to lack of resources. In some cases, UNICEF has trained staff involved in in-patient care of SAM cases. There is no official Memorandum of Understanding (MOU) between WHO and UNICEF on this. In states not affected by emergency, the state and local governments provide funding for routine drugs for treating SAM, training and some monitoring. At referral centres, the state has made arrangements for free medical care of complicated SAM cases. In some states finding funding for in-patient care is still a challenge, especially if the SAM case is referred to a tertiary-level hospital.

Implementing CMAM in Nigeria is largely dependent on donors, who provide funds through UNICEF, WHO (for in-patient care) and international NGOs. Donors do not directly fund the government, partly due to concerns over transparency and accountability.

Source: Theresa Banda, ENN Consultant seconded by Valid International.

Despite these challenges, there appears to be an intrinsic momentum to continue providing short-term funding for CMAM scale-up, as well as for agencies to seek this type of funding. This may simply reflect a pragmatic view that short-term funding arrangements offer the best prospect of financing CMAM for UN agencies and international NGOs. Shifting the funding status quo will require additional and collaborative effort. UNICEF, which procures approximately 80% of the global supply of RUTF for CMAM programming, is trying to move towards longer-term funding mechanisms. In Ethiopia, for example, UNICEF is soliciting donor support to establish a new pooled fund to secure predictable, multi-year financing for RUTF.

From a national government perspective, the challenges of relying on humanitarian funding may be even greater, especially where governments face frequent or periodic

¹² ACF Strategic Plan 2010–2015; WHO Global Database on Child Growth and Malnutrition; The Lancet's Series on Maternal and Child Undernutrition.

emergencies. There is a sudden need to scale up CMAM to respond to increases in acute malnutrition, but governments lack the institutional capacity to do this. In these situations, governments depend on access to short-term emergency funds and implementing partners to undertake the scale-up. The issue for governments then becomes how to link scaled-up programming to other programmes, and how to ensure coherence of funding and programming, as emergency and development programmes merge into or out of each other.

Transition financing and resilience

There is no strict definition of transition financing, although the term implies financing arrangements which allow 'transition' between humanitarian and development funding. The extent to which CMAM scale-up is being funded by transition financing arrangements is unclear. It is also unclear whether multi-year funding from humanitarian budgets falls under the umbrella of 'transition' funding or financing for resilience.

Box 5**Scale-up of the integrated management of acute malnutrition in Kenya**

The nutritional status of children under five years of age in Kenya is very poor. An estimated 2.1m are stunted, and at any one time over 400,000 are acutely malnourished. Until 2008/9, the treatment of acute malnutrition was largely confined to NGO projects in areas referred to as the ASALs (Arid and Semi-Arid Lands), where even in normal times levels of acute malnutrition are considerably higher than the national average. Short-term humanitarian financing has been the mainstay of these projects and, until very recently, they operated outside any coherent government framework and coordination structure.

Since 2010, the government has been scaling up High Impact Nutrition Interventions (HINI), with the support of donors, the UN and a large number of implementing partners. Essentially, HINI combines the treatment of acute malnutrition with interventions aimed at preventing acute malnutrition, stunting and micronutrient deficiencies in under-fives, and in pregnant and lactating women. IMAM, in budgetary terms the largest component of HINI, covers the management of SAM (in-patient and out-patient) and MAM. It is highly concentrated in the ASALs (North Rift Valley, Eastern and Coast Provinces), though it is also expanding in urban slum areas, which contain large numbers of acutely malnourished children.¹³ Eventually, the plan is to roll IMAM out to the whole country.

Precise annual costs for taking IMAM to scale in Kenya are not known. However, the National Nutrition Plan of Action provides an estimate of the total resources required

to achieve the goal and objectives outlined in the Food Security and Nutrition Policy. The cost estimates cover the five years of implementation, from 2011 to 2017, and are based on an ideal situation and standard costing models, rather than past programmatic experience. Overall, the projected total cost for implementing the activities of the Plan over the five years to 2017 is KSH 67bn (approximately \$760m). The overall government allocation to nutrition from the health budget currently stands at 0.5%.¹⁴ In 2008/2009, the budget allocation for nutrition programmes was 0.1% (KSH 114m), just 2.2% of the amount required. In 2009/2010 the nutrition component was allocated 0.4% (KSH 163m) of the total health budget.

UNICEF is the leading financial contributor to IMAM, followed by WFP and the government, whose main contribution to IMAM is in the provision of human resources, not money. IMAM is accordingly heavily reliant on donor financing. The main current donors are ECHO, DFID and OFDA. Funds are allocated to the main UN agencies (UNICEF and WFP), which in turn contract out some programme components to implementing partners. Some donors also directly contract implementing partners through a consortium arrangement. Until recently IMAM funding was entirely annual and short term, though this has changed in recent years and the main donors have instituted longer-term, more predictable financing arrangements through multi-year funds. Donors have also formed a Joint Planning Cell to coordinate their efforts and agree priorities and joint approaches.

The multi-year Consolidated Appeals Process (CAP) in the Occupied Palestinian Territories could be classified as transition funding, as might DFID's recent three-year nutrition grant for Yemen, which is resourced from both humanitarian and development budgets. In the latter case, DFID's decision to move from annual to multi-year funding is in recognition of the fact that acute malnutrition is not a new problem in Yemen and will continue for years. Since the same partners, UNICEF and DFID, were delivering development and humanitarian projects in Yemen, and the causal overlap between wasting and stunting was significant, closer alignment and integration was seen as necessary, and justified the combined use of emergency and development funding. DFID has also provided multi-year funding for the humanitarian response in Somalia, and has approved it for the ASALs in Kenya, to support a range of nutrition interventions, including CMAM.

With regard to European Union (EU) financing, work in the Horn of Africa is being funded through a new transition financing arrangement called Supporting Horn of Africa

¹³ It is estimated that, by 2020, 50% of Kenya's population will be urbanised.

Resilience (SHARE). In Ethiopia, SHARE is being used to fund a multi-year integrated approach to addressing undernutrition that combines aspects usually deemed as 'development' (such as policy and capacity strengthening) with 'relief' efforts, including OTP scale-up. More generally, ECHO recognises that its normal criteria for intervention, which are largely based on thresholds, are not conducive to effective recovery and stronger resilience, and new guidance is being developed. The EU is also providing three-year funding for Niger, Liberia and Guinea in the context of the drought in the Sahel.

There has been a shift in approach in Kenya too, and a growing appetite to challenge the institutional tendency within donors to see acute malnutrition as a humanitarian (short-term) concern, and chronic malnutrition (stunting) as a development issue requiring (unlike acute malnutrition) long-term solutions. In Ethiopia the government and donors see support to OTP as part of the wider resilience-building agenda, including the need to tackle seasonal

¹⁴ Estimated per capita expenditure on health services has been rising, from \$6.90 in 1997 to \$34 in 2010. However, this is below the recommended investment levels required to deliver health services.

Box 6**CMAM scale-up in Ethiopia**

Ethiopia is one of the success stories in the integration of CMAM into national systems. Having hosted the first pilots of CMAM in 1999, the Ministry of Health has gone on to include CMAM (or OTP) as one of the service packages in Integrated Community Case Management (ICCM). The geographical coverage of CMAM has expanded dramatically, from fewer than 500 sites in January 2008 to nearly 11,000 in July 2012. Most of these are at health centres or posts, and there are very few mobile units.

The government's strong commitment to expanding OTP services across as much of the country as possible is in recognition that (severe) acute malnutrition is a long-term problem that requires an ongoing, integrated and inter-sectoral response involving a number of line ministries. In practice, however, the government provides very limited financial support for OTP, and financing has largely been secured through short-term humanitarian channels. Programming relies heavily on multilateral agencies: UNICEF for OTP and WFP for the supplementary feeding of moderately malnourished children. These two programmes are effectively separate, and the management of severe and moderate acute malnutrition is divided in terms of logistics, commodities and resources.

There are also divisions within the government, notably between the Ministry of Health and the Ministry of Agriculture. The Ministry of Health is concerned primarily with reducing stunting, while the Ministry of Agriculture is responsible for addressing acute malnutrition in crises. This reflects its wider remit, which is to oversee general disaster risk management in Ethiopia. The Disaster Risk Management and Food Security Section (DRMFSS) of the Ministry of Agriculture hosts the Emergency Nutrition Coordination Unit (ENCU) and the Nutrition Cluster Coordinator. Thus, while OTP delivery is integrated within the health system (through ICCM), monitoring is done by the ENCU. Similarly, data on the supplementary feeding programme is compiled by the Ministry of Agriculture, not the Ministry of Health. Thus, responses to malnutrition are

programmed by different agencies, under the coordination of different line ministries, with limited consolidation of the information systems used by each. It is hoped that current revisions to the National Nutrition Programme (NNP), and the increasing momentum of the SUN Movement in Ethiopia, will help bring greater coherence and alignment in how undernutrition is managed.

The costs of OTP are significant, raising concerns about the programme's long-term sustainability. UNICEF estimates the cost of the commodity component (RUTF) at \$21.5m per year,¹⁵ to treat around 300,000 SAM cases (i.e. \$72 per case or \$66 per case if administrative costs are omitted).¹⁶ Should coverage increase beyond the current 11,000 sites costs would accordingly rise; an increase to 500,000 SAM cases would require an annual budget of around \$35–38m for SAM treatment.

According to UNICEF's purchases – and bearing in mind that UNICEF supplies 95–98% of RUTF used in Ethiopia – RUTF costs amount to 80–90% of the overall programme costs for OTP. Even with increased local production, this proportion would remain high. Adding to the cost is the logistical challenge of supplying all 11,000 OTP sites with the necessary RUTF, medicines and equipment, and the limited capacity of the health extension workers that actually deliver OTP services. The UN agencies and NGOs offer vital support to the government on both of these fronts.

UNICEF has begun to consult on the possibility of establishing a central funding mechanism for OTP, which would secure a predictable, multi-year RUTF pipeline. There is potential for RUTF to be procured through an existing pooled funding mechanism (the MDG fund), and growing attention to resilience among donors may help to bridge the 'humanitarian/development divide' – both in terms of thinking and funding. There seems to be a new openness among donors for the Humanitarian Response Fund to commit to fund CMAM every year as part of a resilience-building agenda.

spikes in acute malnutrition and increase the intervals between them.

Development financing

There are multiple sources of funding in development contexts (bilateral, multilateral, private and domestic), but external financing for nutrition from development budgets is limited and tends to be 'projectised'. It is not possible to track the levels of funding from the different sources used to finance CMAM scale-up in development contexts. There are currently no databases that allow this type of analysis. However, it is clear that funding for CMAM can come from a variety of divisions and units within the same donor organisations,

and there may be little coordination or interaction between them. This lack of internal coordination is likely to be most pronounced between the humanitarian and development arms of a given donor. It is also clear that the vast majority of longer-term funding for CMAM scale-up from the main donors has been through multilateral agencies, as opposed to international NGOs. There are currently no mechanisms to determine the extent to which development financing

¹⁵ UNICEF Ethiopia, *Strengthening Resilience to Nutrition Insecurity by Ensuring Continuous Access to Quality Community Management of Acute Malnutrition/Therapeutic Food Financing*, Concept Note, November 2012.

¹⁶ These figures are broadly in line with the estimates calculated in the CMAM evaluation, which puts the average cost per child at \$73.



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A mother checks Mid-Upper Arm Circumference (MUAC) to determine nutrition status, Ethiopia

of nutrition is channelled through governments, rather than implementing partners or ‘third parties’, and how this compares with other sectors. The evidence obtained through this review, however, suggests that only a small percentage of this funding goes directly through governments.

Funding directed through governments

Where resources are channelled through governments, it is often through a pooled or common fund. Some of these funds can be very large; the MDG pooled fund in Ethiopia, for instance, amounted to over \$100m in 2011/12, and is set to nearly double in 2012/13. With political agreement, this could become an opportunity to secure longer-term financing for CMAM, though other competing government priorities may preclude this. In Nepal a pooled health fund financed by the World Bank is being used to help scale up CMAM.

The Liberia Health Pooled Fund (HPF) demonstrates that pooled funding is feasible in fragile contexts. The HPF was established to support Liberia’s reconstruction following the end of the civil war there in 2003. Although the HPF has been the least used funding mechanism by donors (only 10% of donor funding has so far gone towards the HPF, and it accounts for just one-sixteenth of total

health expenditure), it has been pivotal in strengthening institutional capacity, government leadership and donor coordination.

New thinking on financing arrangements

A recent review of financing mechanisms in fragile states echoes many of the findings given above with regard to donor financing arrangements, and argues against ‘business as usual’.¹⁷ It contends that more aid could be provided through government systems, delivering faster development outcomes better aligned with country priorities, strengthening the accountability of governments to their citizens and building legitimacy and increasing government capacity. Pooled funds allow for closer alignment with national priorities, build on national systems, consolidate small projects into scalable national programmes and harmonise and simplify the transaction costs of foreign assistance. Pooling funds also pools risks amongst donors. The review goes on to recommend that donors, whenever possible, publish information on spending at the same time as governments are setting their budgets, using the same classifications. This would then increase the likelihood that donors align their aid with government policies and priorities, making it easier for the government to coordinate aid spending with government spending.

Another recent study has looked at the enormous funding gap for scaling up nutrition interventions, including CMAM.¹⁸ The report highlights the historical precedent for burden-sharing, whereby national governments tend to meet labour and implementation costs, while donors supply materials. With regard to the 13 high-impact direct nutrition interventions, the report concludes that, while overall contributions from external funders and governments were approximately the same, the share varied widely between interventions, ranging from 90/10 to 10/90. The study found that MAM treatment appears to account for the largest share of costs among external funders (reflecting the food costs and the size of interventions). Using this model, analysis of the implied domestic contribution for CMAM on a per capita basis (rather than by percentages) shows wide variation; for instance, Vietnam is low at \$0.83 per head, while Burkina Faso is high at \$3.30. In fact, there is a negative correlation between per capita domestic contributions and per capita income, so that poorer countries might be required to make larger contributions than wealthier ones using this approach. The authors acknowledge that this may risk undermining government support for community interventions such as CMAM. A number of ways of resolving this are suggested, including asking external donors to fund total SAM costs rather than only material costs. As some countries with high SAM prevalence are not the poorest, donors could choose to only pick up all SAM costs in countries below a certain level of per capita income.

¹⁷ Marcus Manuel et al., *Innovative Aid Instruments and Flexible Financing: Providing Better Support to Fragile States*, ODI, 2012.

¹⁸ ACF, *Aid for Nutrition*.

Chapter 4

Sustainability, prevention and integration

The sustainability of the current level of CMAM programming and future planned scale-up is a considerable challenge given the very high costs involved. When asked about sustainability of CMAM, a commonly stated view amongst many of those interviewed was that the only route to sustainability is through the prevention of acute malnutrition – i.e. by reducing the number of cases needing treatment in the first place. ‘The challenge is to link up nutrition, not scale it up’ (interview, DFID Ethiopia).

Interest is also growing in the potential impact of reduced levels of stunting on levels of acute malnutrition, either

through the efforts of other sectors (for example WASH and social transfer programmes) or through other health and nutrition actions, such as infant and young child feeding, behaviour change communication and micronutrient supplementation. There is also interest in the impact of untreated acute malnutrition on levels of stunting. Indeed, an increasingly held view is that strategies to prevent acute malnutrition are largely similar to those aimed at preventing chronic malnutrition (stunting), as the causal pathways to these outcomes are likely to be similar. Concern has been raised that CMAM creates confusion ‘because the view is that this is somehow

Box 7

Links between acute malnutrition and stunting

The relationship and associations between acute malnutrition and stunting are not yet well understood. Undernutrition is a multifaceted process resulting from a complex web of interactions, from the molecular and microbiological level of the individual to the cultural and socioeconomic features of societies. While both types of undernutrition share similar causal pathways and are therefore unquestionably linked, limited evidence is currently available to describe the relationship and associations between them, and whether one precedes or predisposes the other.

Stunting has been shown to precede acute malnutrition in small infants (in Malawi). Less clear is whether wasting precedes (or predisposes the child to) stunting. However, it could be expected that periods of acute malnutrition might affect linear growth patterns if sufficient ‘catch up growth’ is not achieved after each episode of wasting. It could also be anticipated that, where a child suffers repeated episodes of wasting, they will be less likely to ultimately reach their optimal height, particularly if the next episode of wasting occurs during the period of catch up growth. Children being treated for acute malnutrition can take up to 100 days to recover (or even longer when they relapse). During this period of recovery, the linear growth of a child will be curtailed. There is strong evidence that the first 1,000 days of life (700+ days *ex utero*) are a critical window of opportunity for addressing stunting. Yet, since prolonged or recurrent periods of acute malnutrition most commonly affect children within these first 1,000 days (especially those aged 12 to 24 months), it is likely that this will affect a significant proportion of the period for optimal child growth. The results of recent research also show that there is an additive or cumulative risk of mortality when a child has acute malnutrition and is also stunted. It therefore makes sense to consider acute malnutrition and stunting together.¹⁹

A review of 175 studies examining the associations between stunting and acute malnutrition found that, while there was a correlation between the two conditions in Asia and the Eastern Mediterranean, there was low correlation in Africa and Latin America. As the review identified comparable degrees of stunting across these regions, the authors concluded that acute malnutrition and stunting prevalence may reflect underlying dietary insufficiency in different ways. Areas with high rates of wasting do have high rates of stunting, but areas with low rates of wasting can still suffer from high rates of stunting due to ongoing nutritional deficiencies; the prevalence of wasting does not therefore act as a good indicator for the prevalence of stunting.

The authors explained that stunting is far more common than the prevalence of earlier wasting instances can explain. It is likely that stunting is due to a mixture of exposures, some more to do with quality of diet or lack of specific micronutrients, others to do with environmental exposure or access to treatment for infectious diseases, and only some of these potential causes would involve wasting. The authors conclude that acute malnutrition in the form of wasting is associated with the process of stunting, and prevention of wasting could therefore potentially increase attained stature in children.

What is clear is that more evidence is required in order to better understand the complex relationships and associations between these two forms of malnutrition. Deeper understanding of changes in weight and length will mean that resources can be better targeted to combat malnutrition, reducing child mortality and ultimately leading to increased economic productivity and health gains in adulthood.

19 C. M. McDonald et al., ‘The Effect of Multiple Anthropometric Deficits on Child Mortality: Meta-analysis of Individual Data in 10 Prospective Studies from Developing Countries’, *AJCN*, February 2013.



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A Health Extension Worker testing the appetite of a malnourished child, Menkere health post, Tigray region, Ethiopia

completely different to tackling chronic malnutrition, but it isn't' (interview, World Bank, REACH, SUN Secretariat), and that 'CMAM needs to be seen as integral to the prevention of stunting'. In countries such as Ethiopia and Mozambique, the identification of children at risk of acute malnutrition at community level and in need of referral for treatment is 'nested in other community nutrition activities and is part of a broader nutrition management approach at community level' (interview, World Bank, REACH). Box 7 summarises current knowledge about the links between acute malnutrition and stunting.

The current separation of acute and chronic malnutrition along conceptual, programmatic, financial and institutional lines will need to be overcome to maximise any beneficial synergies through the integration of actions at country level. Many agencies are placing increased emphasis on prevention. For example, WFP is producing a new strategic plan which sees the treatment and prevention of MAM as a continuum. WFP states that 'in many countries, treatment of MAM is not sustainable', and that 'sustainability must be based on prevention'. UNICEF also emphasises prevention alongside treatment, and a recent meeting with WFP allowed discussions to take place as to how both agencies can 'combine efforts and link sectorally to prevent acute malnutrition' (interview, UNICEF HQ). The World Bank views acute malnutrition as a development issue and has concerns that 'any delay in the treatment of acute malnutrition will impact on stunting' (interview, World Bank HQ).

Whilst this emerging emphasis on the prevention of acute malnutrition and the need to integrate efforts to address acute and chronic malnutrition is unquestionably appropriate, the lack of predictable long-term funding for CMAM inhibits links within the health and nutrition sector and with other enabling sectors. Donor agencies interviewed during this review commented that CMAM is still often viewed as a 'one-off intervention which is not part of government plans' (interview, USAID/OFDA Headquarters), echoing the misconception that acute malnutrition is largely a humanitarian problem: 'persistent caseloads of acute malnutrition are not being dealt with through short-term methods and development funds are needed alongside emergency funds which then continue once the emergency is over'. Frustration that 'responsibility for CMAM largely resides in the humanitarian sector inhibits government capacity and imposes stop start programming and exposes CMAM to the vagaries of short term funding' leads to the widely articulated conclusion that 'longer-term development partners need to take much more responsibility for CMAM' (interview, Irish Aid, OFDA Kenya, DFID Kenya).

Another facet of CMAM financing as described above is that virtually all of it is going to multilateral agencies and international NGOs. This review found only limited examples of financing directly via government. The extent to which this is typical of broader financing for nutrition is unclear, but it is unlikely to be unique to CMAM. The effects of such donor behaviour on governments are hard to quantify, but one likely

consequence is that governments may come to view CMAM as ‘a donor-funded short-term programme for which they have little responsibility’, despite its inclusion in national plans. Another possible consequence is that ‘governments think they can get funding from UNICEF, CIFF and other agencies for CMAM, so don’t need to earmark domestic budgets for this programme’ (interview, World Bank).

Parallels can be drawn between the current situation of CMAM financing and the Extended Programme on Immunization (EPI), HIV, Vitamin A supplementation and malaria programmes of ten to 20 years ago, where ‘funding was largely externally held and donor driven’ (interview, World Bank). With respect to EPI, in the early 1990s governments were reluctant to cover the recurring costs, but this attitude changed over the next decade as governments were encouraged to include the medium-term costs in their public expenditure plans, and the case for these programmes was effectively made to finance ministries. As stated by one interviewee, a similar ten-year time horizon is needed for CMAM (REACH). In the early days of HIV scale-up, programming started on the back of emergencies and funds bypassed governments. Subsequently, the establishment of the Global Fund meant that resources went directly to governments; at the same time, there was considerable investment in reducing the cost of anti-retroviral therapies (ARTs). It should be noted, however, that HIV probably received global funding ‘because it was seen as a security issue and not a development issue and it had a huge civil society and human rights focus’ (interview, WHO). Today, global coverage of ART is an estimated 50%.

Concern has also been raised that the current financing arrangements mean that nutrition actors in government do not deal with funding on a regular basis. For example, in Ethiopia the donor funding for nutrition that goes into the government budgetary system (as opposed to the significantly larger amount that goes to multilateral partners) tends to be administered by the Ministry of

Finance and Economic Development rather than the Ministry of Health. Nutrition departments in government are often marginalised, and lack the confidence or capacity to negotiate robustly when budget decisions are being made. They also mainly communicate with UN agencies rather than directly with their own governments or the larger donors, where the real influence resides.

Another related consideration is that the transaction costs of funding SAM and MAM treatment and prevention through UN agencies and international NGOs, as opposed to directly through governments, may be considerably higher, although no analyses or modelling have yet been undertaken to test this. Questions were raised during this review about whether the current status quo may hinder increased government capacity in, and ownership of, CMAM. Similarly, questions arise as to whether UNICEF and other IPs are pushing the process of scale-up too hard and too quickly, thereby bypassing or avoiding a more ‘organic’ and advocacy-led process, whereby the government builds up political commitment and domestic support for embedding CMAM into the health system.

Another tension that may arise over the allocation of resources concerns the priority given to SAM over MAM. Whether and how donors plan globally and at country level to divide resources between SAM and MAM treatment and prevention is unclear, though it is likely that the unambiguous cost-effectiveness of SAM treatment, in contrast to the lack of such evidence for MAM treatment and prevention, is likely to be influencing resourcing decisions. There is concern amongst many donors and governments interviewed about the product-driven focus of MAM treatment and prevention. There are examples of governments and agencies discharging recovered SAM children into counselling programmes to continue their recovery (though the effectiveness of these approaches is not yet clear) in the absence of SFPs, which are often not available in development contexts.

Chapter 5

Division of responsibility between UN agencies for acute malnutrition

Global responsibility for acute malnutrition is divided between the four main UN agencies, UNICEF, WFP, WHO and UNHCR. UNHCR is responsible for SAM management in refugee contexts and has MOUs in place with WFP to govern areas of collaboration. Most critical to this review are the specific responsibilities of UNICEF, WFP and WHO. What appears to have begun as a pragmatic division of labour between UNICEF and WFP in the 1990s (WFP for food, UNICEF for more specialised commodities) has evolved into discrete areas of responsibility for MAM and SAM prevention and treatment between these two agencies. In 2005/6, UNICEF and WFP began the process of establishing a global MOU setting out that UNICEF would take responsibility for implementing or supporting the implementation of OTP to manage the uncomplicated SAM caseload, while WFP would take responsibility for implementing or supporting the implementation of SFP for MAM. In 2011 UNICEF and WFP renewed their MOU in the form of a revised technical matrix of collaboration to define roles and commitments for treating acute malnutrition, which should act as a guide to country-level MOUs. Both this agreement and the more recent WFP Nutrition Policy (2012) clearly state that WFP is the UN lead agency for MAM treatment and prevention and UNICEF (or UNHCR) for SAM treatment.²⁰ Amongst the UN agencies,

WHO has responsibility for complicated SAM (in-patient care) and is also the source of normative guidance for all UN agencies. The separation of acute malnutrition in this way between UNICEF, WFP and WHO is possibly a unique situation without parallel for other child survival-related conditions.

Agency roles and responsibilities for SAM and MAM are not mutually exclusive; provision is made for WFP to become involved in SAM treatment and UNICEF in MAM treatment in case the focal agency is not able to provide the service. According to the 2011 matrix, in general WFP coordinates the organisation of SFPs 'except in situations, agreed upon by both agencies, where UNICEF is in a better position to carry out this responsibility'. The procedure proposed is to negotiate this at country level (with HQ support if needed). Whilst WFP has a responsibility 'in consultation with partners to provide food for TFPs according to established UN protocols in areas where UNICEF is not able to do so', it is not clear if this includes therapeutic food, or how other elements of support that would be missing in UNICEF's absence would be delivered. Under this matrix, both MAM and SAM treatment are located within the CMAM approach. WFP is also increasingly taking responsibility for MAM in non-emergency contexts.



Mothers waiting with their children for an appetite test, Northern Nigeria

²⁰ UNICEF and WFP, *Updated Guidance on Mutual Areas of Responsibility and Collaboration for Nutrition. An Update to the UNICEF, WFP 2005 MOU*. See also WFP Nutrition Policy, WFP/EB.1/2012/5-A, February 2012.

Fulfilling roles and responsibilities within MOUs

Moderate acute malnutrition

Numerous interviews with government, UNICEF and donor staff indicate that WFP faces significant challenges in fulfilling its roles and responsibilities, particularly in non-emergency contexts. Although WFP is often able to implement MAM programmes in emergencies, there can still be confusion and inconsistent coverage of interventions in relation to OTPs in these contexts. For example, MAM programming in Kenya is only taking place in areas where OTPs are being implemented by UNICEF. Although the extent of overlap is not fully known, it is estimated that 20% of IMAM²¹ programming in Kenya excludes SFPs. The extent of overlap in Ethiopia is even lower. In Nigeria and Ghana, where WFP does not have a presence, the focus of implementing partners is on SAM treatment alone, with the management of existing cases of MAM being supported through IYCF interventions. In Malawi there was clear agreement between WFP and UNICEF regarding responsibility for MAM and SAM and the CMAM programme combines treatment of both, targeting children under 12 years of age and pregnant and lactating women. However, only 58% of OTPs have associated SFPs (see Box 3).

In Ethiopia there have been significant difficulties in providing a seamless connection between the management of SAM and MAM. These start at the monitoring/screening/referral stage, but are most significant in programme performance. Whilst the OTP has been effective in reducing mortality associated with SAM, the performance of the SFP has been seriously questioned. As a result, donors, with the notable exception of DFID, have been unwilling to continue funding the SFP until its performance improves. To this end, WFP has been piloting new approaches in selected areas through 2012, using underspend from the 2011 crisis. In the meantime, from January to October 2012, WFP implemented SFPs in 273 priority districts of the 600 or so districts that had an OTP (45%); the majority of OTP sites therefore have no linked supplementary feeding component. In Somalia 'WFP MAM programming has been ad hoc' (interview, UNICEF Somalia), and UNICEF has frequently had to take on this role for long periods. On many occasions children graduating from OTPs have had to be discharged with no SFP follow-up care. Where WFP has been absent, it has been difficult for UNICEF to provide the level of SFP support necessary. A similar disconnect between OTP and SFP programming was highlighted during the course of this review in Sierra Leone, Sudan, Yemen and Djibouti.

In West Africa, a regional protocol covering SAM and MAM is being developed. UNICEF will focus on scale-up plans for SAM only. Although there is a need for similar scale-up plans for MAM, these may be delayed as WFP is facing resource constraints. There is also confusion about the choice/effectiveness of products versus non-food-based approaches to treat and prevent MAM. In Mozambique, there are differences of opinion about how best to address MAM. USAID, for example, finances programmes that focus

on behaviour change communication around IYCF and some treatment, but does not support a product-driven approach to MAM.

There are many unanswered questions about how and what type of programming should be taking place for children with MAM in the context of CMAM programming. For example, it is unclear whether, under the recent MOU, WFP envisages taking responsibility for the entire MAM caseload in a given area, or whether the responsibility only applies to those MAM individuals who have recovered from SAM through OTP treatment. The former has far more significant resource and pipeline implications. It is also unclear to what extent community-based programmes to treat SAM are discharging cases at mild rather than moderate levels of acute malnutrition, and under what circumstances different cut-offs are being applied. What is clear is that there is a disconnect between UNICEF (and implementing partners and other supporting agencies), which promotes the OTP part of CMAM, and WFP, which has responsibility for the MAM prevention and treatment part of CMAM.

A UN agencies' meeting in Geneva in November 2012 examined the roles, mandates and operational capacities of the UN agencies with a view to strengthening cooperation and programme coherence in a number of areas, including CMAM. A decision was taken to examine more closely at least four UN agency programmes (Chad, Sudan, Bangladesh and Kenya) in order to determine how cooperation and coordination can be improved and whether current MOUs may need to be modified. All three main UN agencies in question are starting to discuss the programmatic terminology around acute malnutrition, and whether to move away from the term 'CMAM'.

Severe acute malnutrition

In most CMAM programmes, the medical component of complicated SAM is managed in a hospital setting, and it is often assumed that such facilities can take care of these cases. This, however, is not always the case, and health facilities may need additional support and capacity development, especially as caseloads increase with the scaling up and expansion of CMAM programmes. Recent mapping of CMAM scale-up by UNICEF does not indicate the extent to which in-patient care (through stabilisation centres and hospitals) has kept pace with scale-up in terms of caseload, capacity strengthening and resources, though anecdotal evidence suggests that it may not always do so. Furthermore, data on programme performance (as presented in UNICEF mapping reports) does not appear to disaggregate how children with uncomplicated malnutrition in OTPs fare, compared with children with complicated malnutrition.

Most of the funding for CMAM programming goes into the out-patient component (rightly so, given that 95% of SAM cases can be successfully treated in the community), and WHO is sometimes told by donors to request funds for in-patient care from UNICEF. However, where WHO cannot secure these it cannot build capacity at country level. If

there is not adequate capacity, it is difficult to engage adequately. Hence, WHO ends up not having a presence and then fails to secure funds. A vicious cycle ensues. However, it is not only an issue of financing. In some countries, such as Ethiopia, WHO lacks presence and capacity and UNICEF has no option but to fill the gaps in in-patient care. In Kenya, WHO struggles to secure funding for in-patient care outside of an emergency appeal, in which case it draws on health-related appeals for funding. Outside of emergencies, WHO is not a significant player in the IMAM Kenya programme.

Reports from UNICEF staff in West Africa also highlight WHO's lack of capacity to support in-patient care. In Somalia, WHO has minimal presence and input into the scaling up of stabilisation centres, and has not been involved in the nutrition cluster meetings in Nairobi where programming in Somalia is planned.

It is clear that, until very recently, there was little strategic work at global level regarding how SAM and MAM treatment and prevention fit together within coherent programming. The separation of acute malnutrition treatment between UNICEF, WFP and WHO can create a lack of continuum of care. What also appears to be happening is that the three UN agencies are securing different resources from different sources, and may have to compete with each other for financing. They also use different criteria for determining the geographical target areas in which they work. These factors may make it more difficult for them to coordinate with each other and with governments to ensure programme coherence and alignment with government priorities. Recent meetings amongst the UN agencies to examine mandates and ways of working in relation to acute malnutrition and stunting are a step towards resolving some of these challenges.

Chapter 6

Conclusion

The lessons drawn from this review are specific to current efforts towards achieving CMAM programming at scale. However, they may also have relevance to scaling up nutrition programming in general, and may be of relevance to other sectors. For example, the disjuncture between humanitarian and development financing and the extent to which humanitarian and development financing bypasses government have been highlighted, and it is hoped that this review will encourage an examination of the extent to which these and other challenges limit effectiveness within the nutrition sector and more widely. The following section highlights lessons specifically relevant to CMAM.

Lessons from this review

There is an urgent need to prioritise prevention and treatment programmes as part of integrated and long-term high-impact direct nutrition intervention packages (for example with IMCI and IYCF). In order to encourage a broader conceptualisation of the problems facing governments and other actors, advocacy needs to emphasise how acute malnutrition reduces the window of opportunity for addressing stunting. Furthermore, when the two conditions exist in the same individual there is a significant cumulative risk of mortality.²² Advocacy to promote the development of costed plans for scale up of CMAM need to emphasise that these are not fixed costs, since other preventive activities should lead to a reduction in the acute malnutrition caseload; as a result, costs should diminish over time as treatment programmes are scaled down. Countries prone to emergencies should however be aware of the need to retain capacity and resources to scale up if the prevalence of acute malnutrition increases.

Current funding arrangements, whereby financing comes from multiple sources and through multiple supporting and implementing partners, inevitably pose challenges for governments in terms of coordination, making resource allocation decisions and aligning programmes with national policies. Exceptionally, the World Bank is increasingly providing significant loans directly to governments for CMAM programming, including RUTF purchase (e.g. in Nepal and Kenya). In general, though, donor funding for CMAM (and nutrition more generally) largely flows through multilateral agencies and NGOs. As a result, national treasuries tend to view CMAM programmes as external to their financial considerations.

Governments may need support to develop and implement well-costed national nutrition plans. At the same time, a number of countries can and should allocate significant domestic resources to cover scale up costs, e.g. those with growing economies and/or middle-income countries.

²² McDonald et al., 'The Effect of Multiple Anthropometric Deficits on Child Mortality'.

Clarity and agreement are needed on the realistic split between domestic and external resource requirements and how this should change over time. Cost-sharing by donors and governments should, where possible, set a precedent and start a process that promotes greater investment in nutrition (and CMAM) from domestic budgets than has been the case to date.

The remit of development actors has generally not included the treatment of acute malnutrition. However, the persistence of chronically high levels of acute malnutrition should be recognised as both a development *and* a humanitarian issue, and needs to become a key concern of development actors (implementing partners and donors alike). The onset of emergencies in a context where governments allocate regular domestic resources for treatment could dictate that humanitarian financing be deployed to deal with surges in cases of acute malnutrition, thereby guaranteeing that these resources align with existing government arrangements.

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

The transaction costs associated with the involvement of multiple UN agencies and implementing partners in the treatment and prevention of acute malnutrition are considerable, and costs could be reduced by streamlining responsibilities. The process for setting roles and responsibilities needs to be reviewed and clarified with respect to how the response to a condition like acute malnutrition is allocated to multiple agencies, without full consideration as to how their respective programmes are to be coordinated.

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

Strengthening the management of undernutrition

Clarify the links between acute malnutrition and stunting

With the mandate to provide normative guidance on nutrition issues, WHO is well placed to compile a briefing note on the relationship between acute malnutrition and stunting based on the published literature. This note should be contextualised by providing an overview of the evidence for persistent high levels of acute malnutrition in many countries, and the high burden of stunting in others. Based on this, the note should seek to clarify that ‘acute malnutrition’ is not simply a result of emergency events, and should challenge misconceptions about its ‘emergency’ nature. Furthermore, the note should underscore the need for coherent approaches to the treatment and prevention of acute malnutrition over the long term. Key areas for research could usefully be highlighted, such as prospective studies using existing treatment programmes to show the impact of acute malnutrition on growth and cognitive development. The SUN Secretariat, along with others such as REACH, are encouraged to continue to clarify to governments the programmatic advantages of linking acute malnutrition and stunting and the theoretical underpinning of this.

Clarify and streamline donor policies and financing arrangements

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

In recurrent or chronic emergency contexts and in fragile states, where humanitarian funding predominates, donors can explore ways of instigating multi-year funding or combining humanitarian and development funding to achieve greater CMAM scale and thus nutrition resilience. Each donor will face different institutional and political challenges in achieving this, so good practice examples might be shared between donors to generate ideas. If this ambition is underpinned by clearly articulated nutrition policies which explicitly acknowledge that the persistently high prevalence or high burden of acute malnutrition in many countries is a development concern rather than a problem to be addressed through emergency response, then advocates of this type of financing arrangement will have greater leverage within their organisations to effect change.

Strengthen nutrition governance

In the interests of strengthening nutrition governance, donors could explore opportunities to fund CMAM (and nutrition programming in general) through direct support to governments (e.g. pooled or earmarked funds or direct

budget support), rather than through UN and international NGO implementing partners. For this to occur national CMAM plans need to be embedded in the pooled fund agreement so that nutrition managers have explicit access to these resources.

Where donors continue to fund through multilateral or international NGO partners, it would be advisable to consider the increased transaction costs of this approach, and to develop a clear exit strategy. Where the impediments to funding governments are directly concerned with accountability, transparency and corruption concerns efforts could be made over a realistic timeframe to address these through an audit system.

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

In general, it is in the interests of all stakeholders that there is greater transparency around donor financing of nutrition, including prevention and treatment programmes for acute malnutrition. Existing mechanisms could help make donors more accountable. Such mechanisms include the annual report submitted by the SUN Movement to the UN Secretary-General; the annual reports to the G8 and African Union on the New Alliance on Food Security and Nutrition;²³ reports submitted to the World Health Assembly as part of the monitoring of the global target to reduce stunting by 40% by 2025; and specific analyses of funding trends by specialist agencies such as Development Initiatives. There may also be scope to incorporate donor accountability in the post-2015 Development Agenda,²⁴ either in association with a specific nutrition target or as part of a wider priority around child mortality, aid effectiveness or good governance.

Donor accountability could also be strengthened under the auspices of the EC; following the same process that is being prepared currently within the SUN Movement, the EC could track and report on nutrition spending by all EU member states (many of whom are not members of the SUN Movement), thereby broadening the reach of such accountability systems.

²³ The New Alliance has agreed five objectives, including one on nutrition and one on accountability. See <http://www.whitehouse.gov/the-press-office/2012/05/18/fact-sheet-g-8-action-food-security-and-nutrition>.

²⁴ The current Millennium Development Goals expire at the end of 2015. Although much will have been achieved over their 15-year lifespan, many of the targets set for each of the eight goals will not have been reached. A process is underway to consider whether new global goals should be set for 2016 onwards, and if so what they should cover.



A Health Extension Worker provides health and nutrition education during a household visit, Menkere health post, Tigray region, Ethiopia

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

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

Inform country-level strategies for funding CMAM scale up

Given the recent surge in costing exercises for scaling up national nutrition programming, including CMAM, it is very important that such calculations are based on the integration of CMAM programmes into existing health services, and take account of the decline in acute malnutrition as prevention efforts achieve impact. Good examples of this type of costing should be captured and disseminated for replication in other countries, with donors supporting governments in undertaking these exercises. The World Bank is well placed to offer such support, having led the international costing efforts to date and because of its instrumental role in

supporting the development of national costed plans in specific countries. The SUN Movement has catalysed a great deal of the country costing work undertaken in the last two years. Members of the SUN Donor Network will play a key role in furthering such efforts.

Based on these costing exercises, donors will increasingly have an opportunity to work together to agree a strategy and vision for financing of CMAM within efforts to scale up nutrition generally. Donor coordination forums at country level could provide the impetus for this. At the global level, donors could explore different strategies for how to support governments in scaling up programmes for the prevention and treatment of acute malnutrition. These strategies will need to account for different elements of and contexts for programming, such as supplies versus human resources, relative national wealth and increasing domestic expenditure by governments. These

Clarify UN roles and responsibilities

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

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

strategies can then be clearly articulated in donor policy documents.

Enable better technical coordination between donors

There may be added value in greater technical coordination between donor organisations at global level, and we recommend that a regular technical forum for donor organisations working in the nutrition sector be convened. While the SUN Donor Network meets via teleconference on a regular basis, it is not clear whether this mechanism allows donors to properly review nutrition policies and financing arrangements as a group. A global forum for technical discussion would also allow donors to collectively prioritise key research areas and institutional arrangements for the delivery of nutrition programmes at country level. The SUN Secretariat would be well-suited to take a lead on this global forum, given the need to span development- and emergency-focused donors. The process could start with a small group of interested donors, perhaps involved in the SUN Movement, with the UN Standing Committee on Nutrition (UNSCN) brought in as a partner to the process.

Priorities for donor research and study

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

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

There needs to be a review of lessons learnt from the roll-out and scale-up of anti-retroviral therapy (ART) and malaria programmes globally, which have been underpinned by

innovative financing arrangements. Lessons may help inform efforts to scale up CMAM programming. One lesson has been identified already:

In the past decade, the great majority of additional funding for health has been through new vertical funds focused principally on specific diseases or interventions, such as vaccination. Important as these are, the record shows that their unintended consequences have included a neglect of broader health objectives and systems. In addition, because the arrival of the new vertical funds was not accompanied by mergers, closures or acquisitions of existing organizations, they also contributed to a greater fragmentation of an already highly fragmented organisational framework.²⁵

The outcome document of the Fourth High Level Meeting on Aid Effectiveness (the 'Busan Partnership Agreement') seeks to address this, stating: 'We will make effective use of existing multilateral channels, focusing on those that are performing well. We will work to reduce the proliferation of these channels and will, by the end of 2012, agree on principles and guidelines to guide our joint efforts'.²⁶

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

²⁵ Keith A. Bezanson and Paul Isenman, *Governance of New Global Partnerships: Challenges, Weaknesses, and Lessons*, CGD Policy Paper 014. Washington DC: Center for Global Development, 2012, <http://www.cgdev.org/content/publications/detail/1426627>.

²⁶ 'Busan Partnership Agreement', Fourth High Level Meeting on Aid Effectiveness, 2011.

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