

# **SAM2020**

**AN AGENDA FOR SCALING UP THE MANAGEMENT OF SEVERE ACUTE MALNUTRITION (2016-2020)**

ACF International Network

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## CONTRIBUTORS

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## ABOUT THIS AGENDA

To have a long term, sustainable and significant impact on undernutrition two things are needed; a multi-sectoral preventative approach and an effective curative service at scale. **We believe in effective prevention and effective management of undernutrition as two inseparable parts of an effective global effort towards nutrition security.**

Yet we know that in spite of collective efforts millions of families remain nutritionally insecure. For many, this nutritional insecurity creates the conditions in which acute malnutrition continues to occur. **There is an urgent need to make lifesaving services available to children suffering from its most severe forms today.**

Acute malnutrition, and severe acute malnutrition in particular, can no longer be addressed in isolation. The efforts to address SAM at a global level are today inseparable from the wider efforts to strengthen and improve the health systems necessary to deliver SAM management. **Making health systems stronger and more accessible is the only viable way to deliver SAM management at scale.**

The need to scale up SAM management services is increasingly recognised by leading nutrition stakeholders – from national governments and UN agencies to international donors – who are developing their own strategies to support SAM management. For the past three decades Action Against Hunger (ACF) has accumulated unparalleled experience and expertise in addressing SAM. We have led the development of products and protocols for its management and continue to support their delivery in more countries than ever. This experience gives authority to our voice and substance to our messages. **ACF must be increasingly proactive in using this voice to shape emerging initiatives to scale-up SAM management services.**

But ACF, nor any other actor, could do this alone. We need a collective effort driven by a common purpose. We need a set of clear, concrete and ambitious changes achievable through collective action. A plan that focuses not only on more but also on better SAM management, a macro-level vision for global level efforts that can influence and guide context-specific action at national level. **Everyone committed to scaling up SAM management needs an agenda to guide these efforts.**

**The SAM2020 Agenda is that guide.**

The agenda focuses on six critical changes necessary for more children suffering from SAM to access effective treatment. Building on lessons from the last decade, and the experiences of other successful health initiatives, the agenda addresses issues ranging from the creation of a more enabling environment to stronger mechanisms for tracking progress. It provides a diagnosis of the key challenges in each of these areas to-date and the specific solutions needed to turn things around over the next five years. These solutions require a collective effort at global, regional and national levels. The Agenda lays out ACF's commitments and contributions to these joint efforts.

## ABOUT SEVERE ACUTE MALNUTRITION

Severe acute malnutrition (SAM) is a condition affecting mostly children under five years of age who are suffering from severe wasting and/or oedema. An estimated 17 million children suffer from SAM in the world today, but evidence suggests the number of cases could be far higher<sup>1</sup>.

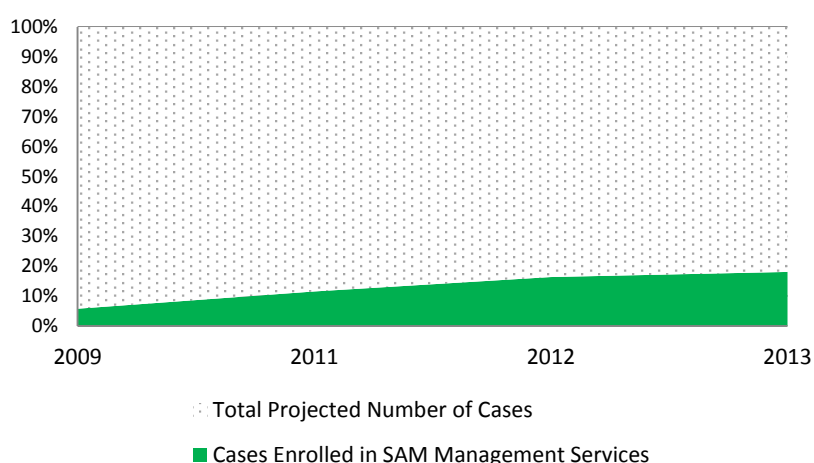
**SAM is lethal.** A child suffering from SAM is nine times more likely to die from common infections<sup>2</sup> and the condition is responsible for at least one million child deaths every year<sup>3</sup>.

**SAM is widespread.** The condition is found worldwide, from failed states to emerging economies. The majority of SAM cases can be found in Sub-Saharan Africa, South and Southeast Asia.

**SAM is curable.** Most children who access services are successfully cured of the condition. The last decade has proven that SAM management can be effectively delivered at scale.

**SAM remains a problem.** During the last decade the number of children receiving treatment has increased from around one million children a year in 2009 to just under three million children in 2013<sup>4</sup>. This is the result of significant developments in services<sup>5</sup> and the incremental integration of SAM management into national health systems in more than 75 countries. Despite these successes, it is estimated that only 15 per cent of SAM children are accessing treatment today.

Estimated Proportion of SAM Children Covered by Services Worldwide (2009-2013)



We believe that this picture can change. We believe that taking immediate, concerted action can accelerate the scale-up of SAM management and provide services to more children.

<sup>1</sup> The UNICEF/WHO/World Bank Joint Estimates estimate the number of children suffering from Severe Acute Malnutrition (SAM) worldwide to be 17 million. Other UN estimates (e.g. UNICEF Global SAM Management Update 2012) suggest that the number could be as high as 32 million. Neither estimate, however, adequately accounts for children below 6 months of age suffering from SAM and children suffering from kwashiorkor, a specific form of the condition.

<sup>2</sup> Black, R.E. et al. (2013) "Maternal and child undernutrition and overweight in low-income and middle-income countries". The Lancet, (London, 382, pp.427–451.)

<sup>3</sup> UNICEF/WHO/WFP/SCN Joint Statement

<sup>4</sup> Covered cases extracted from UNICEF (2014) "Nutridash 2013: Global Report on the Pilot Year" (UNICEF, New York, p. 17.). Number of uncovered cases is based on a fixed annual average of 17 million cases, based on WHO/UNICEF/World Bank Joint Estimates 2012.

<sup>5</sup> According to WHO recommendations, effective services for SAM children, i.e. services allowing for a significant reduction in SAM-associated morbidity and mortality, are inpatient treatment for children with complicated SAM, with stabilization and appropriate treatment of infections, fluid management, and dietary therapy, and community-based care for uncomplicated SAM. Community-based care includes, in addition to the provision of RUTF, a short course of basic oral medication to treat infections and a follow-up which should be done weekly or every two weeks by a skilled health worker in a nearby clinic or in the community.

We believe that by 2020, the number of SAM cases will have decreased from 17 million to 13 million a year through stronger, nutrition-sensitive and nutrition-specific interventions<sup>6</sup>. SAM management services will effectively decrease morbidity and mortality, and prove more cost-effective, better integrated and more widely available. SAM management will not be delivered through a single model or approach, but will be integrated into health systems in different ways depending on the opportunities and challenges of each context. Stronger health services managing SAM will improve the proportion of cases accessing services to more than 20%, leading to an additional one million children with SAM being admitted and effectively cured each year.

That is our vision, and here's how we're going to make it happen ...

## 1. SAM MUST BE REDEFINED AS A PUBLIC HEALTH PRIORITY AND NOT SIMPLY AN EMERGENCY PROBLEM

### The Challenges

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SAM can be found in a range of contexts, from South Asia and Sub-Saharan Africa to the Caribbean. Yet, **SAM is often perceived by donors, governments and policy-makers as a condition that only affects children in humanitarian emergencies and crises.**

Part of this reflects the evolution of SAM management services; until the early 2000s, existing protocols and products used for SAM management could only be delivered vertically by international humanitarian NGOs outside of local health systems. As SAM children were most often treated in these contexts and in this manner, the wider need in non-emergency settings (and the capacity of health systems to address it) was underestimated.

The introduction of community-based management of acute malnutrition (CMAM) fundamentally changed that. The capacity of health systems to deliver SAM management at scale using the CMAM model has taken these services out of humanitarian crises and to a range of settings from Indonesia to Zambia. **While direct action by NGOs remains critical in a number of humanitarian contexts, a child suffering from SAM today is more likely to be treated by national health staff in a government health facility than by any other service provider.**

Changing perceptions about the critical impact of SAM on child survival also remains a challenge. The relationship between SAM (and undernutrition as a whole) on other critical childhood illnesses like malaria, diarrhoea and pneumonia is not always understood<sup>7</sup>. **The result is that while the SAM community has embraced a broader and more holistic health agenda, the health community has rarely incorporated SAM into their own agendas with equal resolve.**

**Accelerating and scaling-up SAM management demands a redefinition of the condition as a major childhood killer responsible for millions of deaths every year** and one that can be managed if systematically included in health services of all high burden countries. **We must turn evidence into action, and action into global commitments.**

### The Solutions

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1. **SAM must be recognised as a major childhood disease.** To do so we must successfully demonstrate and communicate the scale of the SAM problem. We must generate more accurate estimates of the SAM burden and its mortality, taking into account all forms of SAM (including kwashiorkor), all age groups affected (i.e. from 0 to 59 months) and its geographical

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<sup>6</sup> Based on ACF projections, which stipulate that the number of children suffering from acute malnutrition (severe and moderate) must drop from 51 to 40 million by 2020 in order to meet WHA wasting targets for 2025.

<sup>7</sup> Partly, because efforts to position acute malnutrition have been fragmented; in the UN system, for instance, up to four different agencies are mandated to support efforts against acute malnutrition

spread across multiple emergency/non-emergency contexts. We must continue to demonstrate the impact of SAM and other forms of undernutrition on other childhood illnesses (e.g. malaria, diarrhoea and pneumonia) and the effects of managing it on child survival as a whole.

2. **SAM must systematically be part of the Basic Package of Health Services.** That the fully integrated delivery of SAM management as part of national health system services is a fundamental solution in addressing SAM at scale (along with other critical child development and child survival initiatives) must be highlighted. Greater evidence of large-scale, integrated programming as part of national health systems, and funded by them, is essential.
3. **SAM must be part of global health and development commitments and this should be reflected in national targets and plans.** Successfully integrating SAM into the implementation of the Sustainable Development Goals (SDGs) and World Health Assembly (WHA) objectives and targets, and ensuring that SAM-specific targets and indicators are included and respected, is essential. To succeed, we must ensure greater representation in both nutrition and health platforms/forums/spaces and stronger leadership and coordination from SAM stakeholders, including (but not limited to) NGOs, UN agencies, multi-agency initiatives (e.g. Scaling Up Nutrition), donors, academics and national health ministries.

## **Our Contribution**

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1. **ACF will help demonstrate the scale of the SAM problem.**
  - We will support efforts to generate more accurate estimations of the aetiology, prevalence and incidence of SAM, taking into account all forms of SAM (including kwashiorkor), all anthropometric case definitions of marasmus (MUAC<115mm and/or WHZ<-3 according to the World Health Organization {WHO|}) and all age groups affected (i.e. from 0 to 59 months).
  - We will describe key biological markers to better identify children suffering from SAM and others forms of undernutrition.
  - We will map the distribution of SAM across emergency and non-emergency contexts
  - We will support efforts to improve the recording of SAM-related deaths, by reviewing the WHO disease and mortality index ahead of the 2017 revisions.
2. **ACF will continue to contribute to health system strengthening in the countries and areas where we operate**
  - We will support national governments in identifying critical measures to strengthen health systems across the six critical building blocks. In doing so, we will share learning and good practices on successful integration and the process leading up to it.
3. **ACF will continue to raise the profile of SAM as a major health issue, as a direct cause of death and as a disease.**
  - With others, we will advocate the World Health Assembly to adopt a new 2030 target on wasting by 2016 of less than 4 per cent global prevalence (in keeping with WHO recommendation) as a minimum level of ambition.
  - We will continue to advocate the inclusion of SAM into the WHO's classification of diseases.
  - We will push for effective implementation by high-burden countries of the SDGs' Target 2.2. on acute malnutrition and the role of addressing SAM, in order to achieve Target 3.2 – ending preventable deaths of newborns and children under five by 2030.
  - We will support the Scaling-Up Nutrition (SUN) movement and Civil Society Organisation (CSO) platforms at national level to strengthen alignment of CSO on multi-sectoral plans to address malnutrition and to improve accountability.

## **2. RESOURCE MOBILISATION FOR SAM GLOBALLY AND NATIONALLY MUST BE INCREASED**

## The Challenges

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In November 2014, the second International Conference on Nutrition (ICBN2) formally acknowledged that improved coverage of SAM management will require additional allocation of resources at a global and national level<sup>8</sup>. **The World Bank estimates that the delivery of SAM management to 80 per cent of all children affected would cost an estimated US\$2.6 billion per year**<sup>9</sup>.

Some estimates suggest that between \$300-400 million a year is currently going to SAM management. These estimates, however, are based largely on the amounts invested in therapeutic products and does not account for funding allocated to service delivery.

What is clear is that most of the funding currently going to SAM management is covered by bilateral donors, with only limited funding coming from national health budgets. There are a number of reasons for this. Firstly, there are few national SAM management costing plans available in high burden countries. Most countries lack projections of how much, and what, resources should be allocated to enable effective SAM treatment at scale. Secondly, plans and projections that do exist are generally perceived as expensive. Countries that have made fiscal pledges have struggled to meet those pledges. Thirdly, there are few efforts currently ongoing to advocate and lobby for adequate resource mobilisation at national level.

The resources invested in SAM and SAM management today might be higher than before, but they remain largely insufficient to meet even the most basic of global needs. **National governments are yet to incorporate SAM management systematically and in a meaningful scale into their budgets and international donors continue to underfund it and channel their contribution through short-term humanitarian streams.**

## The Solutions

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1. **SAM management scale-up must be costed at national level.** These costed plans must be based on reaching a significant proportion of all SAM cases through integrated management services, delivered as part of basic health package. They should reflect proven ways of optimising the integration and cost-effectiveness of SAM management. This would help to shift the focus from the financial needs of SAM management services to the need for health systems that include SAM management.
2. **SAM management commitments must be formalised.** Generating stronger costing plans will need to be followed by resource mobilisation and associated national level advocacy to see their gradual incorporation into health budgets.
3. **SAM management commitments must be tracked.** In order to contribute to costing, resource allocation and to ensure greater accountability to stakeholders, commitments must be transparent and expenditure effectively tracked.

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<sup>8</sup> Under Recommendation 34, the ICBN2 recommended that the world “adopt policies and actions, and mobilize funding, to improve coverage of treatment for wasting, using the community-based management of acute malnutrition approach and improve the integrated management of childhood illnesses”. WHO (2015) “Outcome of the Second International Conference on Nutrition” Report by the Director-General (WHO, 24 April 2015, [http://apps.who.int/gb/ebwha/pdf\\_files/WHA68/A68\\_8-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_8-en.pdf), accessed on July 6<sup>th</sup>, 2015)

<sup>9</sup> Horton et.al. (2010) “Scaling Up Nutrition: What will it cost?” (World Bank, Washington DC). These estimates are based on the following analysis: “The prevalence of severe acute malnutrition is 4.8 percent across the 36 countries in the 6–59 months age group (implying an incidence of 9.6 percent, using the incidence: prevalence ratio of 2:1). We assume that if all the other interventions are funded, that prevalence of severe acute malnutrition will fall to 50 percent of present levels (Isanaka et al. 2009, reporting on the effect of an intensive complementary feeding program). Unlike other interventions (where we aim for 100 percent coverage) we aim for 80 percent coverage, since there are no existing programs at scale achieving higher coverage, and we cost the intervention accordingly” (pp.63).

1. **ACF will support national fiscal planning efforts to ensure that SAM is costed and included in health budgets**
  - We will support national and local authorities in efforts to integrate SAM management costs into health budgets.
  - We will continue to provide technical support to civil society alliances to improve their capacity on budget tracking for nutrition.
2. **ACF will influence bilateral and private donors, through traditional and innovative funding mechanisms, to increase funding for health systems.**
  - We will campaign to secure new funding commitments from governments and at EU level for SAM management.
  - We will also continue to work on mobilizing innovative financing for nutrition, seeking to shape and influence new funding streams like Power of Nutrition and UNITLIFE.

### 3. THE EFFECTIVENESS AND COST-EFFECTIVENESS OF SAM MANAGEMENT MUST BE IMPROVED

#### The Challenges

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According to *The Lancet* series on Maternal and Child Health (2013), **the treatment of acute malnutrition at scale has the potential to be the most cost-effective of all essential nutrition packages**. At present, the potential cost-effectiveness of SAM management has not been fully realised.

The costs per child treated remain high. Available evidence suggests that the costs per child treated range between US\$150-200<sup>10</sup>. The elevated cost of treatment reflects a number of issues. The cost of Ready-to-Use Therapeutic Foods (RUTFs) remains high. While these have decreased over the last decade, production and delivery costs can still be optimised. The treatment protocol for SAM also remains largely unchanged for a decade. Research into optimising the protocol suggests that the amount of RUTF needed to rehabilitate SAM cases could be lower than proposed by current protocols<sup>11</sup>.

Although there is evidence to suggest that integrated SAM management services can be effective<sup>12</sup>, the quality of these services worldwide varies. In a number of contexts, SAM management protocols are not fully implemented, defaulting is high and the quality of both inpatient and outpatient care is suboptimal. In addition, the proportion of cases accessing treatment in virtually all contexts remains low. Those that do reach services often do so late, when the condition has deteriorated. Late presentation leads to complications that demand inpatient care and longer treatment cycles, which in turn lead to higher number of cases abandoning treatment before being discharged as cured. SAM management services must be made more effective, and this demands more accessible, higher quality services.

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<sup>10</sup> Horton, et.al. (2010)

<sup>11</sup> James, et.al. (2015) "Low-dose RUTF protocol and improved service delivery lead to good programme outcomes in the treatment of uncomplicated SAM: a programme report from Myanmar" *Maternal and Child Health* (April 2015, doi: 10.1111/mcn.12192)

<sup>12</sup> Rogers E. & Guerrero, S (2013) "Access for All, Volume 1: is community-based treatment of severe acute malnutrition (SAM) at scale capable of meeting global needs?" (Coverage Monitoring Network, London, June 2013). The authors reviewed over 97 public records from SAM treatment programmes (2000-2013).



1. **SAM management costs must be reduced.** The cost of producing and distributing RUTF need to be reduced. This can be best achieved by supporting local/national production, establishing viable quality assurance processes and more open certification procedures that truly and responsibly encourage competition and entrepreneurship. The RUTF amount needed per SAM child must also be fully evaluated to determine optimal dosage.
2. **SAM management must improve.** SAM management services must increase the number of cases enrolled early<sup>13</sup>. The earlier SAM is detected, the more likely it is that they will successfully recover and the less time it takes to do so. Early detection requires stronger referral systems, formal (e.g. via active case finding) or informal (e.g. via self-referrals) that ensure that all SAM cases can be identified irrespective of the context<sup>14</sup>. Once enrolled, SAM children must be treated using improved diagnosis and full treatment protocols, and they must continue to attend services until treatment is completed. Improving compliance with treatment protocols and strengthening community engagement must be prioritised in equal measure.

## Our Contribution

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1. **ACF will continue supporting efforts to decentralise RUTF production**
  - We will work with local governments, donors, businesses and UN agencies to ensure that the RUTF market remains competitive and able to produce context-appropriate, high quality products in a timely manner.
2. **ACF will generate concrete evidence on ways to improve the effectiveness and cost-effectiveness of SAM management services.**
  - **We will generate evidence on how to optimise RUTF dosage.** Through our *Modelling an Alternative Nutrition Protocol Generalizable to Outpatient* (MANGO) project, we will work with others to measure the effectiveness & cost effectiveness of an optimised RUTF dose for the management of uncomplicated SAM. If successful, we will advocate a revision of nutrition guidelines and protocols.
  - **We will pilot the use of a new protocol for the treatment of acute malnutrition (SAM and MAM) as a continuum.** Through our *Combined Protocol for Acute Malnutrition Study* (CompAS), we will work with partners to explore the effectiveness of single protocol to address acute malnutrition in a more holistic manner.
  - **We will pilot and, if successful, roll out alternative service delivery approaches including (but not limited to) delivering SAM management through community health workers (CHWs) as part of the integrated Community Case Management (iCCM) package for the treatment of malaria, pneumonia and diarrhoea.** If successful, we will advocate the formal inclusion of SAM management into the WHO's iCCM global policy and its implementation in countries already delivering iCCM.
  - **We will develop and support the implementation of integrated mechanisms for improving community engagement.** Building on our experiences in different countries (e.g. Nigeria) and through initiatives like the Coverage Monitoring Network (CMN) we will develop and support efforts to improve community engagement in resource-limited settings, including mechanisms for improving awareness of SAM and SAM management services, and great involvement of caregivers and others in case-finding and referral of children with SAM.

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<sup>13</sup> Sadler K, Puett C, Mothabbir G, Myatt M. (2011). "Community case management of severe acute malnutrition in southern Bangladesh" (Tufts University, Boston, 2011).

<sup>14</sup> There is a growing body of evidence suggesting that MUAC-only referrals and admission can exclude some SAM cases (based on Weight for High Z-scores) in particular contexts, most notably South and South East Asia. For SAM management services to be accessible to all who need it, referral and admission criteria need to reflect and adapt to these variations.



## 4. AVAILABILITY AND ACCESSIBILITY OF SAM MANAGEMENT SERVICES MUST BE INCREASED

### The Challenges

It is estimated that less than 15 per cent of all SAM cases worldwide are currently accessing treatment<sup>15</sup>. This is lower than other essential health service, including immunisation<sup>16</sup> (84%), TB treatment (55%) and malaria (43%).

This is the result of a number of factors, but three of them are of particular importance. Firstly, **key high burden countries in South Asia are yet to commit to launching community-based SAM management services at scale**. The absence of a policy framework that recognises the importance of SAM, and provides a clear national protocol for SAM management that enables community-based treatment hinders the scalability and availability of services where they are most needed. **Secondly, geographical coverage (or the proportion of health facilities offering SAM treatment) remains low in many high burden countries**. Lack of national leadership to develop ambitious scale-up plans, limited technical and financial support, challenges in integrating a single SAM management service model to different health systems (a one size fits all approach), poor infrastructure and overall weak health systems, all contribute to limited geographical coverage. **Thirdly, treatment coverage (or the proportion of SAM cases accessing treatment) remains low in many high burden countries**. Low awareness of SAM and SAM management services, high opportunity costs (payment), distance and supply chain problems<sup>17</sup> create bottlenecks and barriers to access.

### The Solutions

1. **Community-based SAM management must be formally introduced in all high burden countries.** In countries currently lacking a policy framework (e.g. India, Bangladesh) the first priority must be to demonstrate that SAM is a condition that can be successfully managed at scale in the community through a combination of outpatient and inpatient approaches. This recognition must be followed by renewed efforts to create an appropriate national policy framework centred on community-based management of SAM, using locally appropriate products that meet WHO specifications. Increased recognition of SAM management and the introduction of an appropriate policy framework should pave the way for the introduction of SAM management services at scale, but these will need to be adequately supported to ensure that they are effectively implemented.
2. **SAM treatment coverage targets must be included in multi-annual health plans to steer and galvanise scale-up efforts.** Setting and meeting these targets will require strategic planning support from key nutrition stakeholders including UN agencies and NGOs. Clear plans for mainstreaming it as part of basic health packages must be developed, and a strategic framework for its scale-up designed and resourced.
3. **SAM management services must address critical bottlenecks and barriers to access.** In particular:
  - **Awareness of SAM and SAM management services must be improved.** To do so, sensitisation initiatives for resource limited settings must be developed, resourced and implemented. Whenever possible, these efforts must be integrated into health awareness campaigns and other mechanisms already in place.

<sup>15</sup> UNICEF/CMN/ACF (2013) "The State of Global SAM Treatment Coverage 2012" (New York & London, 2013).

<sup>16</sup> Data taken from WHO/World Bank (2015) "Tracking Universal Health Coverage: First Global Monitoring Report" (WHO, Geneva, 2015). Immunisation here is defined 3 doses DTP-containing vaccine and malaria as the population (all ages) sleeping under an insecticide treated bed net.

<sup>17</sup> Puett C and Guerrero S. (2014) "Barriers to access for severe acute malnutrition treatment services in Pakistan and Ethiopia: a comparative qualitative analysis" *Public Health Nutrition* (Advance online publication. doi: 10.1017/S1368980014002444).

- **Supply chain for RUTF and other essential drugs must be improved.** RUTF must be classified as a critical product to be included in global food and/or medical supply systems. Timelier anticipation and reporting of stock needs is also needed across all levels of the health system (international, regional, national and local).
- **Distance and opportunity costs for caretakers must be reduced.** To do so, a wider range of service delivery options (including mobile clinics, child health weeks/days and linkages with integrated Community Case Management) must be further developed and implemented according to the opportunities and challenges of each context. Viable models for the removal of user fees, and approaches for incentivising attendance, must also be explored.

## Our Contribution

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1. **ACF will continue supporting efforts to introduce SAM management in India.**
  - We will work with others to ensure that nutrition policy and guidance enables the delivery of SAM management at scale by advocating the adoption of community-based models and a sustainable resolution to the challenges of therapeutic food production and use in a country.
  - We will undertake similar efforts in other countries where national policy remains a critical barrier to the scale up of SAM management services.
2. **ACF will help identify and address bottlenecks affecting SAM management in high burden countries.**
  - We will work with UNICEF and other partners<sup>18</sup> to develop and mainstream monitoring tools to identify critical bottlenecks affecting health systems delivering SAM management services and guide remedial action.
3. **ACF will generate and support efforts to improve awareness of SAM and SAM management services.**
  - We will work with other partners and donors to ensure that community engagement plans are developed, levels of awareness evaluated and indicators of success made part of nutrition programme performance targets.
4. **ACF will identify critical global procedures and mechanisms to improve availability of RUTF and other essential medicines for SAM treatment.**
  - We will explore the potential benefits and the practical implications of including RUTF into the WHO Essential Medicine List (EML).

## 5. THE CAPACITY OF HEALTH STAFF TO MANAGE SAM MUST BE IMPROVED

### The Challenges

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SAM management, like many public health services, faces significant human resource and capacity challenges. From nurses in paediatric wards to community health workers in health posts, there is a widespread shortage of staff in most countries where SAM is found. As a result, **existing human resources are generally responsible for delivering a wide range of health packages, which can affect workload and motivation.** Staff turnover is high, and relocations are common. Many remote health facility positions, critical to extend services in hard to reach areas, remain vacant for extended periods of time.

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<sup>18</sup> The bottleneck analysis initiative is a collaboration between ACF UK, UNICEF, FANTA, Coverage Monitoring Network (CMN) and David Doledec.

In addition, SAM management has not been integrated into the curricula of health staff in most of the countries in which it is available. Instead, SAM management training is provided after staff arrive at their post. The source of training varies: NGOs play an important capacity building role, but different UN agencies are also tasked with support health staff with different parts of the training<sup>19</sup>. Training is generally provided to some, not all, staff in a health facility, limiting the capacity to detect the condition among children that attend other services. **Once training is provided, follow-up is often limited which coupled with high staff turnover makes it difficult to determine whether health facilities have the capacity to manage SAM even within weeks of a training.**

More training initiatives may be necessary to support scale up efforts, but **for SAM to be managed at scale a lasting solution that addresses the underlying and systemic issues is needed.**

## The Solutions

1. **SAM management must be added to the curricula of frontline health staff.** SAM management must be incorporated into the training modules provided to different health staff (e.g. doctors, nurses, community health workers) prior to deployment. Training toolkits must be developed, adapted and translated to facilitate adoption across multiple contexts. This will mean that all health staff, irrespective of their location in a country or the availability of on-the-job training, will be able to support SAM management services.

## Our Contribution

1. **ACF will contribute to developing national training plans**
  - We will continue to collaborate with ministries of health, UN agencies and other NGOs in the development of training plans and their integration into national training curricula in high burden countries.
2. **ACF will continue supporting on-the-job training and mentoring**
  - We will support ministry of health frontline workers with practical trainings at health facility level across all high burden countries in which we operate.
3. **ACF will continue to build skills in SAM management in emergencies**
  - We will continue to work with Bioforce and others in the delivery of Master level training for health staff in West Africa.

## 6. QUALITY, AVAILABILITY AND UTILISATION OF SAM INFORMATION MUST BE IMPROVED

### The Challenges

Today, critical information and data on SAM and SAM management is unavailable, scattered or unreliable. **It is unavailable because regular nutrition information systems collect little or no data on SAM.** Even when data is collected, much of it (in particular data on burden and programme admissions/exits) is closely managed by governments and UN agencies. **Scattered because whatever data can be found is generally located in many different databases and platforms.** These databases and resources libraries are seldom connected or linked, preventing systematic data mining and analysis on any meaningful scale. **It is unreliable because audit exercises have consistently revealed that SAM data is of poor quality** and often fails to adequately reflect the actual state of SAM and SAM management services.

As a result, the **magnitude of the SAM problem is often ignored or underestimated, the performance and effectiveness of SAM management services remains difficult to monitor, and the use of the SAM**

<sup>19</sup> WHO is mandated to train health staff to manage SAM children with complications who must enrol on an inpatient basis, whilst UNICEF is mandated to train health staff in facilities to manage SAM children without complications and can be treated on an outpatient basis.

information and intelligence by policy makers and practitioners (at national, regional and global level) remains limited.

## The Solutions

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1. **SAM data must be made more available and accessible.** To do so:
  - **A reduced set of key SAM indicators and standards must be agreed.** This should include core indicators on burden (e.g. SAM prevalence and incidence), service delivery (e.g. admissions) and performance (e.g. cure, default and coverage). The SPHERE minimum standards should continue to be used in emergency situations, but comparable indicators for non-emergency contexts must be developed.
  - **Minimum standards of quality and standardised data collection systems for nutrition information must be established** at a global level and implemented across high burden countries. Innovative means of improving timeliness and quality assurance, including mhealth platforms, should continue to be explored and scaled-up.
  - **Greater transparency and accessibility to nutrition information is needed.** National authorities (in high burden countries in particular) and UN agencies must commit to share SAM management service information on a more systematic and accessible basis. This data must then be made more accessible by aggregating, in a simplified, anonymised, open, global database that can be used by practitioners and policy makers.

## Our Contribution

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1. **ACF will collaborate with key global partners to identify and agree on a set of core SAM management service indicators.**
  - We will also support the identification, creation and/or adaptation of data collection systems in order to generate high quality information.
2. **ACF will support key stakeholders in creating a centralised, global platform to consolidate existing SAM information.**
  - We will collaborate with partners including UN agencies, national health authorities, NGOs and academic bodies, to ensure SAM data is made publicly available on a regular basis.
  - We will support inter-agency efforts to analyse and package available data to make it more accessible and easier to use to generate clear policy and programmatic changes.
  - We will support ministries of health in high burden countries to produce and report SAM information through their national health information systems.
3. **ACF will ensure that SAM information is adequately represented and utilised**
  - We will lead efforts to ensure that SAM information is reflected and used in key fora and spaces (e.g. SUN) and publications (e.g. Global Nutrition Report) in order to inform policy making, service planning and programme implementation, as well as advocacy.