Malnutrition response: Decision-making flow chart for emergency contexts where there is food insecurity and/or malnutrition and the National Society plans to integrate an element of malnutrition response into emergency response or long-term health programming (Last updated on: January 2022)

Using available data about the incidence and distribution of SAM, and prior to deciding on a malnutrition intervention, consider the following two steps when developing an EA/EPoA: (1) understand the components of CMAM and (2) determine the level (clinical and/or community-based) and components of the intervention based on the existing capacities of the National Society. NB. This is not technical guidance on CMAM programming, but instead guidance for decision-making on the modalities of a malnutrition response in emergencies for RCRC National Societies.

1. Understand the components of Community-Based Management of Acute Malnutrition (CMAM)

CMAM has the following four components (see Figure 1), which are linked to health systems delivery platforms. However, such platforms are different in each country.

(1) **Community mobilization** – Volunteers screen for malnutrition using mid-upper arm circumference (MUAC) tapes and refer those identified with severe or moderate acute malnutrition (SAM or MAM) to the nearest health facility.

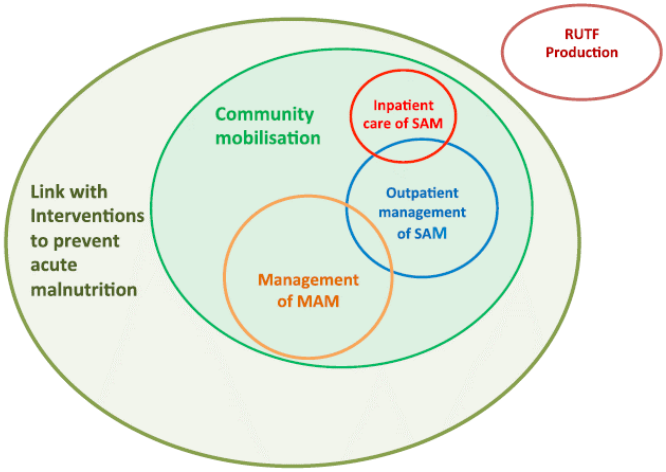


Figure 1 The four components of CMAM (UNICEF, 2020)

If a child is identified as acutely malnourished, the caretaker takes the child to the health facility. A health worker performs screening and diagnosis as per established protocols (checking for nutrition oedema, appetite, and other medical complications). Based on the outcome:

(2) **Outpatient management of SAM -** If the child has SAM without medical complications, and has an appetite, the child is treated at the outpatient unit with ready-to-use therapeutic food (RUTF).

(3) **Inpatient management of SAM -** If the child has SAM and medical complications or no appetite, the child is admitted to an inpatient unit using therapeutic milks until the child is stabilized and s/he can be transitioned to outpatient care.

(4) **Management of MAM -** If the child has MAM, s/he might receive ready-to-use supplementary foods (RUSF) or fortified blended foods (FBF). Not all CMAM programmes include this component, largely due to the absence of evidence and global guidance for MAM management (compared to SAM).

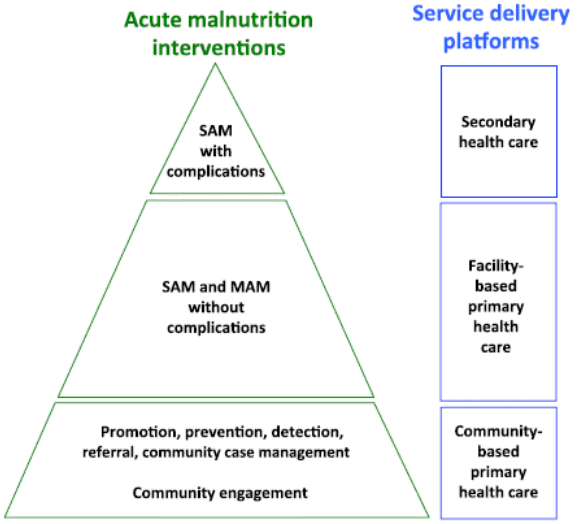
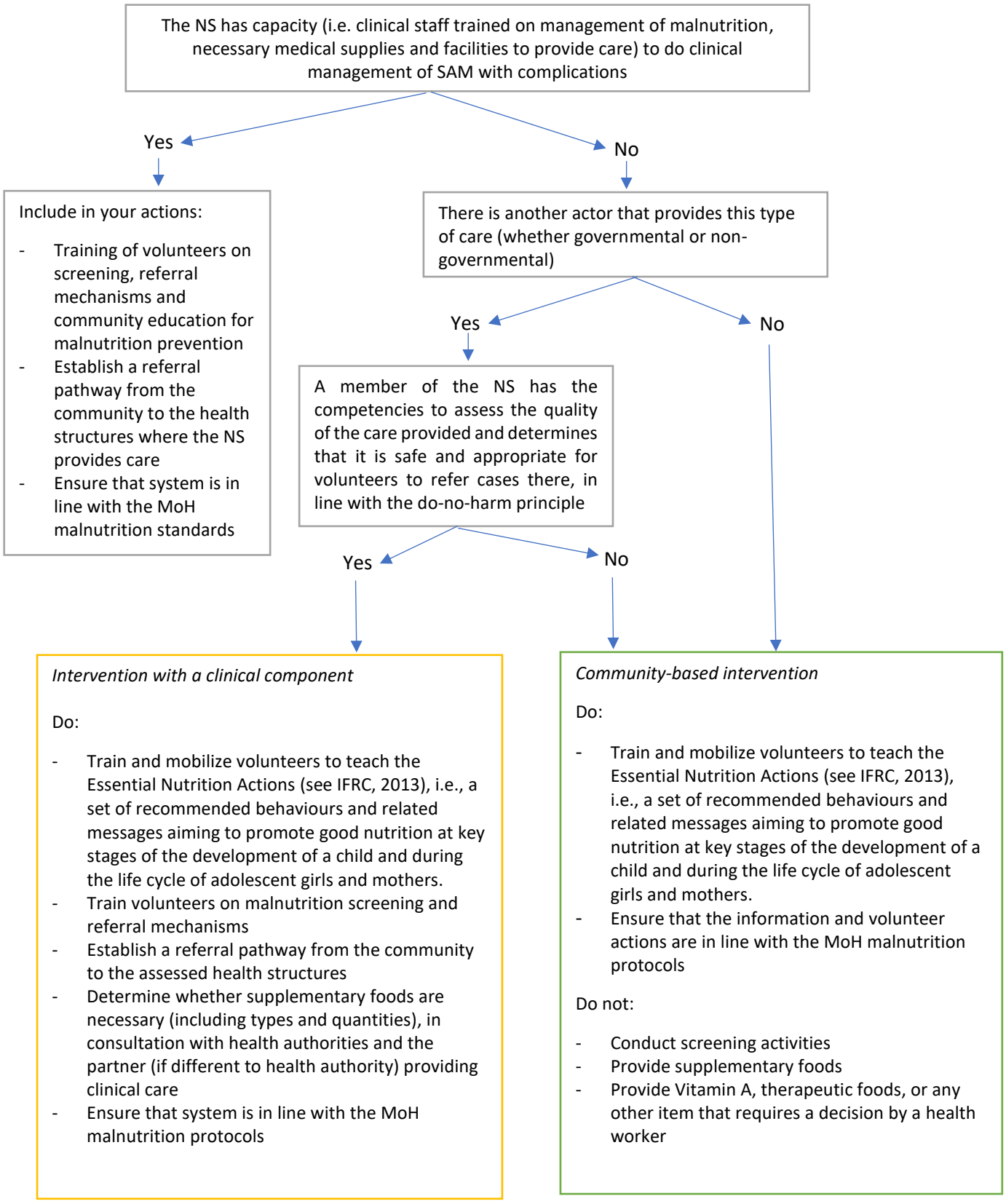


Figure 2 Levels of SAM treatment and service delivery platforms (UNICEF, 2020)

Components are delivered at the community level and in health facilities staffed with trained personnel (See Figure 2). The components constitute a continuum of care in CMAM and as such, they are interconnected and cannot be delivered as stand-alone components. Note that screening for malnutrition is only appropriate if there is an existing CMAM program that provides outpatient care for SAM without complications and/or inpatient care for SAM with complications, or if another partner is scaling up this service as part of the response. This can be run by the MoH or by an NGO. If volunteers find cases of SAM, they must be able to refer such cases to an effective program that meets minimum quality standards[1]. Similarly, supplementary feeding is only one of the elements of CMAM and, like screening, it cannot be a 'stand-alone' activity that volunteers do in the absence of referral mechanisms and facilities to receive and treat more severe cases. Supplementary feeding addresses MAM and should 'supplement' the regular diet with rations that are energy dense, high in protein, and rich in micronutrients, culturally appropriate, easily digestible and palatable. Importantly, RUTFs should not be considered as food products, but instead as medicines that are administered by health professionals. In the absence of a complete CMAM programme offering health care, NS staff and volunteers can provide community education through high quality Infant and Young Child Feeding (IYCF) counselling and disease prevention programmes.

[1] Global Nutrition Cluster. 2013. Nutrition Cluster Handbook: A practical guide for country-level action

2. Decide the level (clinical and/or community-based) and components of the intervention based on the existing capacities of the National Society and the availability of other services that the NS does not provide, in order to deliver assistance that adds value and that respects the do-no-harm principle.



Useful resources:

Global Nutrition Cluster. 2013. *Nutrition Cluster Handbook: A practical guide for country-level action*. Available at: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/NUTRITION%20CLUSTER%20HANDBOOK%20First%20edition%20January%202013.pdf

IFRC. 2013. *Nutrition guidelines*. Available at: https://www.ifrc.org/PageFiles/113913/1255500_Nutrition_Guidelines_EN-FINAL_LR.pdf

IFRC. 2020. *Epidemic Control for Volunteers: Toolkit*. Available at: https://ifrcgo.org/ecv-toolkit/ -

UNICEF. 2015. *Management of acute malnutrition: Working towards results at scale*. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/unicef_2015_management_of_severe_acute_malnutrition.pdf

UNICEF. 2020. *Community based management of severe acute malnutrition*. Available at: https://ta.nutritioncluster.net/sites/gtamcluster.com/files/2020-10/Community_Based_Management_of_Sever_Acute__Malnutirtion%20%281%29.pdf