ACKNOWLEDGEMENTS

The No Wasted Lives Coalition would like to thank its partners; Action Against Hunger, the Children’s Investment Fund Foundation, the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO), the UK Department for International Development (DFID), UNICEF and the United Nations World Food Program (WFP) for their support in the design, planning and implementation of the conference. NWL would also like to thank ECHO and UNICEF for their financial support.

FOREWARD

Acute malnutrition results in 5 million preventable child deaths each year and affects children’s prospects of surviving and thriving in all areas of their lives. Acutely malnourished children are up to 9 times more likely to die from common infection than their better-nourished peers.

Treatment for this form of malnutrition is simple and effective, but less than 20% of children affected are able to access the treatment they need. It does not have to be this way: the world has the knowledge, the ability and the resources to help.

The No Wasted Lives Coalition will help accelerate a child survival revolution by building knowledge about prevention and treatment of acute malnutrition, catalysing investment, and doubling the proportion of children annually receiving treatment by 2020. By investing more resources and working better together, we could save millions of lives, and build a brighter, more productive future for all.

Throughout 2017, No Wasted Lives has invested in a range of activities in order to further the objectives of the Coalition in the West and Central Africa Region, including the following;

- No Wasted Lives Regional Advisor to support in collaboration and coordination of NWL members.
- Support in Information Management concerning operational research on AM, including facilitation of Regional technical group
- Regional analysis of SAM management, and subsequent research in to key evidence gaps concerning policy and financing.
- Systematic Review in line with global research prioritisation.

In addition to these activities, UNICEF also conducted a regional workshop entitled; “Accelerating Effective and Sustainable Management of SAM. What more and what else needs to be done?” The outputs of this meeting have provided key indications on the priorities and notably next steps for UNICEF concerning the integration of SAM within the Health System.

With these key regional orientations in mind, the No Wasted Lives Coalition called a technical meeting in October 2017. The objective of the meeting was to consult with partners working in nutrition and health, as well as donors from the humanitarian and development sectors, in order to propose next steps for the scale-up and integration of innovations in CMAM protocols in to services across the region.

The technical day focussed on the contents of the upcoming update of the 2007 Joint Statement on CMAM, taking each thematic area referenced, matching these areas with existing or ongoing research with time for panel discussions at the end of each session. Forty-Six participants attended the meeting, representing 25 different agencies, ranging from the UN, NGOs, Research Institutions, National Government and Donors. A detailed list can be found in ANNEX 1. National and international journalists also covered the event.
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<td>Discussion</td>
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<td>Health System Strengthening</td>
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UPDATES ON MANAGEMENT OF ACUTE MALNUTRITION

REGIONAL OVERVIEW OF SAM
MANAGEMENT: EUNICE ICHIMWE

UNICEF shared the key trends in SAM across the region since 2012, highlighting a persistently high prevalence and burden of SAM. In 2016, the burden peaked at over 6 million cases, with Nigeria and DRC accounting for over 75% of the regional burden. Admissions have seen a steady rise since 2012, gradually increasing from 1.2 million children to 1.7 million in 2015. Currently 50% of global admissions come from the WCA region. However, trends in admissions show a plateau since 2015, with a slight decrease between 2015 and 2016.

Many countries, particularly those across the Sahel have very high geographic availability of services, with normative guidelines at national level for the management of acute malnutrition. Whilst there have been many enabling factors to ensure service availability, such as donor commitment, systems strengthening and the development of normative guidance at global level, there are multiple barriers that affect the sustainable scale-up of services. The most critical barriers identified were the following:

1. Positioning of SAM at national level
2. Sustainable financing
3. Community Management of SAM

In order to overcome these issues, UNICEF WCA have developed the following vision:

“Systematic management of severe acute malnutrition* is considered as a priority intervention for child survival and is fully appropriated and integrated by governments at all levels of the Health System to reduce mortality and morbidity.”

In order to arrive at this vision, UNICEF is committed to working on the following areas; advocacy and communication, programme design, resource mobilisation, partnerships, and knowledge generation. In line with the global target of treating 6 million children, UNICEF WCA has committed to scaling up services to reach 3.6 million children by 2021.

REGIONAL UPDATE ON MAM
MANAGEMENT: ANNA HORNER

In WFP’s area of implementation across the Sahel, the estimated burden of MAM in 2016 was approximately 2.7 million cases. In 2016, WFP were able to reach 34% of the MAM burden through their treatment programmes, leaving a burden of 1.7 million children unreached. When looking at the trends in MAM admissions, WFP also noted a decreasing rate since 2015. Similarly to UNICEF, WFP have identified a series of barriers to the availability of services, notably:

- High costs and caseloads
- Weak governance
- Limited HR capacity
- Parallel information systems with poor quality data
- Complicated supply chain resulting in stock outs

Based on these limitations, and the existing evidence base, WFP stated that alternative treatment approaches could be helpful to ensure adaptability and flexibility. Whilst the focus should be centred around prevention, it is important to continue research on cost-effective interventions for treatment and ensure sufficient capacity and resources are allocated to manage the high caseload of MAM.

OVERVIEW OF JOINT STATEMENT:
NOËL ZAGRE

The previous joint statement, released a decade ago, clearly sited the importance of prevention first, but highlighted the urgent need for treatment of children suffering from acute malnutrition. This document formally endorsed the community based care model, and outlined the UN agency support. Since then, the sector has seen an increasing evidence base and normative guidance to address acute malnutrition, which has resulted in more children accessing care than ever before. However, more must be done.

The new statement, convened by UNSCN, aims to adopt and adapt new knowledge to nutrition programmes, including the integration of prevention and treatment into routine care and services. The new statement will focus on healthy growth of children, early identification, alignment of the care model with the context and needs. There is formal acknowledgement that identifying and addressing the needs of children with MAM is an important component of the continuum of care. There is a heavy focus on the importance of the community and community platforms in order to reach more children in a timely manner.

An update to this original statement, convened by UNSCN, aims to adopt and adapt new knowledge to nutrition programmes, including the integration of prevention and treatment into routine care and services. This updated statement will focus on healthy growth of children, early identification, alignment of the care model with the context and needs. There is formal acknowledgement that identifying and addressing the needs of children with MAM is an important component of the continuum of care. There is a strong focus on the importance of the community and community platforms in order to reach more children in a timely manner.

The update to the Joint Statement will be released in 2018, accompanied by a roll-out and communications plan. This roll out will require concerted effort from all partners to ensure uptake at national level.

*(Detection, referencing, treatment, monitoring)*
INCREASING ACCESS AND UTILISATION OF SERVICES

One of the key axes of AM treatment programmes is community engagement component, in order to ensure uptake and utilisation of services. Direct coverage rates for SAM treatment programmes fall short of SPHERE standards across most context, particularly when assessing national level coverage. Key barriers are related to limited awareness of treatment services and distance to treatment sites. More effort needs to be made in order to increase availability and accessibility of treatment programmes. Community detection and treating SAM in the community are two approaches that have proven to improve programme quality in the contexts in which they were implemented.

HOUSEHOLD DETECTION: KEVIN P.Q. PHELAN

In 2011, ALIMA launched the idea of training mothers to use MUAC tapes in order to assess the nutritional status of their children. The intention was to respond to two key issues; late admissions and low programme coverage. The first pilot, in 2012, helped as a proof of concept for the approach. A second study took the proof of concept to scale, concluding that mothers are indeed able to safely detect malnutrition in children U5, resulting in a more timely admission and fewer complicated cases.

One major issue faced during the implementation of the study was the height restriction (<67cm) in order to use MUAC. The key recommendation is that this restriction should be removed from protocols, as has been the case in Niger. Another limitation of the effective roll-out of this approach is the availability of MAM treatment programming. A direct response to this common operational challenge is to harmonise the protocol for treatment of SAM and MAM, as ALIMA are doing in the OPTIMA study in Yako, Burkina Faso.

ALIMA has changed its internal policy to ensure that MUAC training in the community is part of all programming. Since the pilot, ALIMA has trained over 500,000 mothers in 7 countries. Highly positive outcomes have been identified in Niger, where this strategy has been employed continuously since 2014, including an increased median MUAC at admission and a reduction of nearly 35% of hospitalisations.

"Externally, family MUAC has been very well received by the nutrition community. Already, over a dozen NGOs have integrated some form of this approach in their own programming."

ALIMA has been developed a range of operational tools, which are available on the organisation's website: http://alima-ngo.org/empowering-mothers-prevent-malnutrition

ICCM AND SAM TREATMENT: PILAR CHARLE

Integrating the treatment of SAM in to the icCM platform is a key opportunity to increase access and coverage, by bringing treatment services even closer to the community. Globally, over 30 countries have an established icCM platform. However, SAM management is not currently a standard service offered, as part of this community platform.

In 2014, a pilot study was launched in Mali by Action Against Hunger, to integrate SAM treatment in to the existing icCM platform. The key results demonstrated a much higher rate of admissions in the area of intervention, with a doubling of programme coverage from 43% to 87% coverage at the end of the trial. Defaulters were twice as high in the control group comparing with the intervention, and there were statistical difference in terms of cured rates, better in the intervention group. An additional qualitative study, assessing the quality of care, demonstrated very high rates of accuracy in detecting, diagnosing and treating SAM children as well as high levels of capacity to detect danger signs. Finally a cost-effectiveness study demonstrated this approach to be much more cost-effective than the standard facility based model ($442 per child treated in the control vs. $259 per child treated in the intervention). As a result of this pilot, the Ministry of Health in Mali has amended their icCM protocol to include SAM Treatment as a standard intervention.

This approach will be scaled up to three regions in southern Mali from 2017 onwards, with the support of Action Against Hunger. In addition, other trials are ongoing for Kenya, Niger and Mauritania.

5 Alvarez Moran JL, et al. The effectiveness of treatment for severe acute malnutrition delivered by Community Health Workers, compared to a traditional facility based model. Submitted February 2017 to BMC Health Services Research
7 Rogers E, et al. Cost-Effectiveness of the Treatment of Uncomplicated Severe Acute Malnutrition by Community Health Workers Compared to Treatment Provided at an Outpatient Facility. Submitted April 2017 to Public Health Nutrition
CMAM protocols are widely available across all countries in West and Central Africa (22 out of 24 countries).

These protocols are largely based on the 2008 Joint Statement, and are very similar across all contexts.

With new and complex contexts emerging, combined with overburdened health systems, it is important to simplify treatment protocols in order to ensure availability of services.

**EXPANDED CRITERIA:**

**MARIE ME DIAW**

In 2014, at the Inter-Agency Nutrition Meeting held in Washington D.C., it was recommended to expand admissions criteria (MUAC <125mm) to admit MAM children into OTP - or SAM into TSFP - as a temporary measure in emergency situations when no TSFP or OTP are not available.

The rationale for expanded criteria included:

- RUTF at a lower dose is nutritionally appropriate for MAM children.
- RUSF at similar dose to RUTF has potential to avert SAM deaths when RUTF is not available.
- Treating MAM children allows earlier case identification, thereby reducing mortality.
- In contexts with high morbidity, there is a high risk of relapse if children are sent home at 115 mm in the absence of a TSFP.

In 2017, operational guidance was developed entitled “Options for Exceptional CMAM Programming in Emergencies” in order to support the implementation of this guidance.

**CONTINUUM PROTOCOL (THE OPTIMA STUDY): MAHAMAN SALEY**

ALIMA began the OPTIMA study in 2017, an operational research into a simplified treatment protocol in 54 health facilities across Yako, Northern Burkina Faso. The modified protocol tries to optimise three aspects of current practice: 1. Training mothers to screen their children for early identification; 2. Treating SAM and MAM children with one protocol and one product (RUTF), using only MUAC <125 mm (and edema) as the admission criteria; and 3. Gradually reducing RUTF dosage based on MUAC status, according to the dosage table on the right (children with MUAC >=125 mm with a weight-for-height z score <-3 are treated per the current national protocol).

**EMERGENCY PACKAGE AND REDUCED CONTACT:**

**GEZA HARCZI**

MSF implemented a modified SAM treatment intervention in Banki, North Eastern Nigeria, in 2016. Due to the very complex emergency in this area, combined with very high rates of SAM (14.3%) and mortality (U5: 6.19/10,000/day), MSF implemented a comprehensive intervention package. This package included components of screening, treatment and prevention. Of most significance, a blanket feeding distribution of therapeutic nutritional products was implemented for all children U5 (children with MUAC <115 mm received 2 packets RUTF/day, while those with MUAC >=115 mm received 1 packet RUTF/day.) Approximately 6,000 children were treated. Over a period of 6 months, the mortality rate decreased significantly to under 1 death per 10,000 per day. As this was an operational response, the monitoring and evidence generated was sub-optimal. However the drastic reduction of mortality and malnutrition rates demonstrates that the strategy was high impact.

In Niger, MSF and Epicentre implemented a study to test the safety and feasibility of a monthly distribution of RUTF for uncomplicated SAM cases. The study concluded that the treatment response was adequate and RUTF use in the outpatient treatment of SAM was maintained over 4 weeks of follow-up with a monthly schedule of RUTF distribution.

**MUAC AT ADMISSION**

<table>
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<tr>
<th>RUTF DOSAGE (KCAL/KG/D)</th>
<th>EXPECTED LENGTH OF STAY (D)</th>
<th>EXPECTED % OF CHILDREN</th>
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<td>&lt; 115 mm</td>
<td>175</td>
<td>42</td>
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<tr>
<td>115-119 mm</td>
<td>125</td>
<td>35</td>
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<tr>
<td>120-124 mm</td>
<td>75</td>
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The objective of the study is to increase coverage, impact and efficacy of treatment. The advantages of this protocol are considered to be early treatment initiation of children with AM, which in turn reduces the risk of complications and therefore hospitalisations. The protocol also enables more children to be treated without any additional cost. The simplification is believed to drive towards an increased coverage, and a lightened workload for health care workers. In addition, harmonising the supply chain could significantly improve issues with stockouts, and subsequently improve adherence to treatment.

The preliminary findings show that there has been a reduction in children with SAM being admitted, confirming the hypothesis of earlier detection and treatment as a result of this model. Despite the gradual reduction of RUTF, the recovery rate remains high, demonstrating that an optimised dosage to fit the nutritional status of the child is able to achieve better programme outcomes.
HEALTH SYSTEM STRENGTHENING

As highlighted by UNICEF and WFP, it is now very important to work towards integrating AM treatment services into the basic minimum package for child health. The current service delivery model is only partially integrated, and many components remain parallel to the existing health system. Whilst it is important to look at simplifying the management protocols, it is also important to strengthen the health systems, which supply the services. Coordination with health partners is essential in order to achieve this aim.

CMAM SURGE: DIANE MOYER

The objective of the CMAM surge model is to improve the resilience of the health system, with a focus on periods of high caseloads of malnutrition, which risk overwhelming the health system.

Save the Children conducted an analysis, using the tools developed by Concern Worldwide, in Mopti, Mali. This analysis, across 13 different health facilities between 2013 and 2017, demonstrated only a few instances of “serious” and no “emergency” situations. This analysis was helpful to demonstrate that the health structures in this region were indeed capable of responding to the caseload. Save the Children highlighted the importance of the threshold setting as part of the analysis process, which weights health facilities differently according to their context. The action plan setting is arguably the most important part of the process, and should be a collaborative and participatory process with local health staff. In addition, the real-time monitoring component is essential to ensure that the surge actions are relevant and effective.

In terms of lessons learned, Save the Children expressed the importance of early planning and comprehensive communication in order to improve coordination challenges. Furthermore, in order to ensure sustainability of the approach, it is important to advocate at sub-national and national levels in order to obtain financial commitments.

HEALTH SYSTEM STRENGTHENING: SUSIE VILLENEUVE

Acute malnutrition suffers from a lack of appropriation and prioritisation within child health, and as such, there are issues with financing, resources and capacity to manage the condition. UNICEF has a 7-step approach to better position health interventions, which focuses on the identification of bottlenecks and proposed solutions. This approach has had proven success, particularly with regards to resource mobilisation.

In order to ensure domestic resource allocation to nutrition, it is essential for activities to be costed and for these activities to feature in national strategic plans. A good example of this is the National Development Plan (2016-2020) in Ivory Coast, where nutrition activities were successfully integrated. Some key tools are the Equist and OneHealth Costing tool.

Finally, advocacy is a key component of this process, and linkages should be made to existing national and international commitments. Innovative financing mechanisms should also be considered, in order to diversify financial sources.

HEALTH SYSTEM DIAGNOSTICS: FANTA TOURE

Since 2012, Action Against Hunger has been refining its Health System Diagnosis methodology. The latest version focusses on identifying the peaks of malnutrition in line with other impacting pathologies, as well as mapping of stakeholders and a focus on community participation. The methodology uses a mixture of quantitative and qualitative methods, including reviewing epidemiological data and focus-group discussions.

A recent study in Mali closely linked the peaks of malnutrition with other pathologies, that recurrently took place during specific months of the year. Regardless of the year, the study was able to identify that for 7 months of the year, the health system was under increased pressure. This calls for a coordinated management of all childhood pathologies, coupled with prevention at community level.

Action Against Hunger will now be focussing on an analysis of coordination mechanisms in order to be able to better respond to health and nutritional emergencies, as well as attempting to harmonise tools which identify the level of integration of SAM treatment services within the health system.
OUTSTANDING THEMES

The upcoming Joint Statement refers to the following thematic areas;
• Early Childhood Development
• IYCF-E
• Treatment for Under 6 months

IYCF-E: DIANE MOYER

IYCF is one of the most effective preventative methods regarding under five mortality rates. Children who are non-breastfed have much higher risks of morbidity and mortality. The risks of artificial feeding are heightened in emergencies, with constraints on water and sanitation, fuel, preparation, storage and supplies. Emergencies tend to be characterized by extremely infectious environments. Considerable skilled and well resourced support is needed to minimise the risks of artificial feeding in this environment.

Infant and Young Child Feeding in Emergencies, collectively referred to as IFE or IYCF-E, concerns the protection and support of safe and appropriate feeding for infants and young children (ages 0~24 months of age) in emergencies, wherever they happen in the world. It refers to a range of nutrition and care techniques that improve child survival and growth. As such, IYCF-E is concerned with protecting and supporting breastfed and non-breastfed infants, complementary feeding, care practices, child development, child protection, pregnancy, general maternal, child nutrition, and health (mental and physical). IYCF-E is about feeding of infants and young children but in order to ensure this and appropriate care for the infant it requires cross-sectoral responsibility and engagement including WASH, camp management, security, shelter, health, food security and livelihoods, logistics, child protection, general coordination, etc. It also encompasses a range of activities at different levels, for policy development to building capacity for one-to-one support of mothers.

It is important to balance the reality of IYCF-E on the ground with the immediate focus of IYCF-E to do no harm and save the most lives in the shortest time. The immediate majority of efforts and resources may concentrate on large-scale public health communications to reach the most with the broadly most relevant IYCF messages with less focus on 1 to 1 technical individual support.
The No Wasted Lives initiative is focusing on three key pillars in order to accelerate the sustainable scale-up of treatment and prevention:

1. Advocacy: Position AM as a key health and nutrition intervention at global and national level
2. Technical Accelerator: Generate evidence on what works to improve the effectiveness and reduce the cost of SAM treatment and prevention.
3. Financing: Generate information on the cost of SAM treatment, improve donor coordination and increase global investments

Under the Technical Accelerator, a setting of priorities and driving the use of evidence for action is taking place, through The Council of Research & Technical Advice on Acute Malnutrition (CORTASAM). CORTASAM is an independent advisory group established in 2016 to guide the technical work of No Wasted Lives. The Council is comprised of 14 members, bringing a breadth of expertise in nutrition and health and global experience. The goal to drive the use of evidence for action, in order to ultimately reach more children with effective treatment and prevention programs, through influencing and driving the use of evidence in programmes and policies. Where time, capacity, and financial resources are limited, research priorities can ensure align focus and funding on the areas that will ultimately translate into meaningful action and impact.

In mid-2017, a global research prioritisation exercise took place. The goal of this exercise was to provide a robust and transparent framework to collect global, regional, and country-level stakeholder feedback on research priorities across the continuum of acute malnutrition in children 0-5 years of age.

The following 5 areas were subsequently identified as the most important research priorities concerning treatment of acute malnutrition, and will subsequently be driven by CORTASAM.

1. Diagnosis and treatment in the community
2. Causal factors of relapse and interventions to minimise
3. Optimal entry and discharge criteria
4. Effective treatment for children with diarrhoea
5. Cost-effective and safe dosage of RUTF for treatment

For up to date information on the prioritisation process and Research Agenda for Acute Malnutrition released in January 2018 visit https://www.nowastedlives.org/technical-accelerator/
# ANNEX 1

## MEETING PARTICIPANTS

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<tr>
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  Mamadou Diop  
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  Marieme Diaw  
  Saidou Magagi |
For more information and to find out how you can get involved in the work of the Coalition visit NoWastedLives.org.

For more information, global and country level data and resources on acute malnutrition visit AcuteMalnutrition.org.