According to the World Health Organization (WHO), nearly 20 million children under five suffer from severe acute malnutrition (SAM). Traditionally, all children suffering from SAM (with and without complications) are admitted to inpatient therapeutic feeding centers (TFCs), where they are treated using WHO protocols. Few TFCs are available, making accessibility and coverage of programs highly limited. Children have to stay in the TFC facilities with their mothers for several weeks, which often leaves other children at home with poor care.

Community-based therapeutic care (CTC), a new model for treating malnourished children in their communities and homes, was first developed in the northeastern state of Bihar, ADRA is providing emergency food aid for displaced flood survivors after monsoon rains inundated the state this fall, affecting nearly 5 million people. The three-month project is primarily addressing the nutritional needs of those most affected by the disaster, providing medical services for those in need and reducing their risk to illness and other dangers caused by the winter cold and unfavorable weather conditions.

ADRA is currently providing emergency kits for more than 2,400 internally displaced persons in Tbilisi after deadly fighting between Georgia and Russia drove nearly 200,000 from their homes. ADRA distributed food, hygiene items, and kitchen and laundry sets for more than 3,000 survivors at the outbreak of the fighting and is planning to conduct future assessments in the Gori region, in addition to its continued response in the Georgian capital.

INFO BRIEFS

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program BEST PRACTICES

Community Management of Acute Malnutrition: A Way Forward for Child Survival

Dr. Bridget Aidam, Technical Adviser for Health and Nutrition, ADRA International

According to the World Health Organization (WHO), nearly 20 million children under five suffer from severe acute malnutrition (SAM). Traditionally, all children suffering from SAM (with and without complications) are admitted to inpatient therapeutic feeding centers (TFCs), where they are treated using WHO protocols. Few TFCs are available, making accessibility and coverage of programs highly limited. Children have to stay in the TFC facilities with their mothers for several weeks, which often leaves other children at home with poor care.

Community-based therapeutic care (CTC), a new model for treating malnourished children in their communities and homes, was first developed.
in 2004 by Valid International. This model, now referred to as community-based management of acute malnutrition (CMAM), was jointly endorsed in 2007 by WHO, WFP, UNSCN, and UNICEF for treatment of SAM. It has been proven to be 95 percent effective in addressing acute malnutrition and has since reduced under-five mortality significantly. A majority of SAM patients are now treated at home, and program coverage and impact are greatly enhanced.

Innovations making this possible include:

- Development of ready-to-use therapeutic food (RUTF), specifically Plumpy’nut, a peanut paste with milk powder, which is supplemented with the right combinations and amounts of vitamins and minerals.
- New classification of acute malnutrition (see chart) and separation of children without complications* for treatment with RUTF in outpatient therapeutic centers.
- Screening using mid-upper-arm circumference (MUAC), an easy measurement using color-coded or numbered tapes.

ADRA Ethiopia, with technical support from Valid International, started implementing a CTC project in 2006. ADRA was the first organization to implement a simplified version of this approach in which MUAC measurements are used both for screening and treatment. All three components of the model—supplementary feeding centers, outpatient therapeutic centers, and a stabilization center—are implemented by ADRA Ethiopia, in addition to health and nutrition education for the community. To date, more than 9,000 children under five have been treated by ADRA, with a 92 percent recovery rate in the Kelafo district of Ethiopia.

Although highly effective, the CMAM approach has been slow to scale up, and investments are comparably low. Implementation has been limited to emergency and post-emergency situations and nutrition hot spots. Integration into other programs, such as food security, is necessary to prevent numerous children from dying in silence.

*Complications include infection, edema, lack of appetite, and severe anemia, among others.

References:

Know Your Terms: Nutrition 101

Often, nutrition terms are used without a full understanding of their meaning. Below are definitions of some commonly used nutritional terms. These are limited to indices for children under five years.

- **MALNUTRITION**: Refers to overnutrition or undernutrition; however, it is regularly used synonymously with undernutrition.
- **ANTHROPOMETRY**: The measurement of body dimensions to determine nutritional status.* This is a widely used way of assessing the health and survival potential of children.
Age, weight, and length/height measurement can be combined into indices. These indices, when compared to a reference or standard population, can be used to determine z-scores, a standardized measure of the degree of malnutrition. Children can be classified as normal, mild, moderate, or severely malnourished based on their z-score.

**Types of Malnutrition in Children as Measured by Anthropometric Indices**

- **STUNTING**: Low length/height-for-age (H/A) is an indicator of past growth failure and a measure of long-term or *chronic malnutrition*. This is appropriate for use in developmental projects to determine the impact of nutrition or food security interventions.

- **WASTING**: Low weight-for-height (W/H) is an indicator of current or *acute malnutrition* resulting from failure to gain weight or actually losing weight. This is normally used in emergency settings and reflects changes in food supply, disease state, infection, or a combination of these factors.

- **UNDERWEIGHT**: Low weight-for-age (W/A) reflects both past (chronic) and present (acute) malnutrition; however, it is not a specific indicator, as it is unable to distinguish between the two types of malnutrition. This is commonly used in growth monitoring because it is easy to train people to use.

Most food security, health, and nutrition programming targets moderate and severely malnourished children. Using the WHO cutoffs, moderate malnutrition is defined by H/A, W/A, or W/H z-score < -2, and severe malnutrition by z-score < -3.

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**ADRA INTERNATIONAL APPOINTMENTS**

Asamenew Alemu  
Senior Financial Compliance Administrator, Program Management

Rowena Boccheciam  
Director of Finance/Controller, Finance and Operations

Sandra Fletcher  
Assistant Director for Program Performance and Learning, Program Management

Carmen Saltos  
Accounting Clerk, Finance and Operations

Barbara Stuart  
New Business Planner, Planning

John Torres  
Senior Public Relations Manager, Marketing and Development

**ADRA NETWORK APPOINTMENTS**

Romain Kenfac  
Country Director, ADRA DRC Goma

Daniel dos Santos  
Regional Director, ADRA Asia Regional Office (former Country Director for ADRA Rwanda)

Edgar Castillo  
Country Director, ADRA Sri Lanka (former Country Director for ADRA Armenia and Georgia)

Stephen Cooper  
Regional Director, ADRA TED (former Country Director for ADRA Sri Lanka)

Munk Jargal  
Country Director, ADRA Georgia

Wenford Henry  
Country Director, ADRA West Indies

Vasyl Hanulich  
Country Director, ADRA Ukraine (former Finance Director for ADRA Ukraine)

Denis Baratov  
Country Director, ADRA Russia (former Project Director for ADRA Afghanistan and ADRA Azerbaijan)

Johnny Velasquez  
Country Director, ADRA Bolivia (former Program Director for ADRA Bolivia)

**Note:** The Bureau for Human Resources of ADRA International provides the information for the “Transitions and New Hires” section of First Monday.
USEFUL WEBSITES


CORE Group, the child survival and health programs nutrition working group site, provides various resources, including technical reference materials on nutrition: www.coregroup.org/working_groups/nutrition.cfm

Emergency Nutrition Network: www.ennonline.net/

FANTA (Food and Nutrition Technical Assistance) Project supports nutrition programming to improve the well-being of women and children: www.fantaproject.org/

LINKAGES, a USAID-funded project (1996-2006), has technical publications and training manuals on breastfeeding, complementary feeding, and maternal dietary practices: www.linkagesproject.org/

Measure DHS publishes nationally representative data on nutritional status and other health indices from most countries worldwide: www.measuredhs.com/start.cfm

Micronutrient Initiative: www.micronutrient.org/


SMART nutrition assessment tool: www.smartindicators.org/


UN Standing Committee on Nutrition: www.unsystem.org/scn/


WFP (World Food Programme): www.wfp.org/aboutwfp/introduction/index.asp?section=1&sub_section=1


World Bank’s recent publication Repositioning Nutrition as Central to Development is an excellent source that provides the background research and reports to support investments in nutrition: http://publications.worldbank.org/ecommerce/catalog/product?item_id=6699867
Coming Out of Retirement

How HIV/AIDS is Redefining Family Roles in Lesotho

Hearly Mayr, Director for Public Awareness

Standing at the doorway of her brick house, 13-year-old Anna watches her grandfather, Benedict, till the soil of the small family plot. Here is where he grows the chili, maize, squash, and beans that end up on the family kitchen table at dinnertime. Grandmother Maria Anna sits by the doorway enjoying the only bit of shade she can find.

Anna was born in this small house on a hillside outside Maseru. Some years ago, Anna’s mother, still in her 20s, was having a difficult life in so many ways that it seemed right at the time to leave Anna and her two siblings in the care of their grandparents. Benedict, now 63, knew full well the sacrifices that a working-class Basotho family like his had to make. After all, he had spent 17 years working at a gold-platinum mine in neighboring South Africa to earn enough to help raise his three children—two daughters (one of them Anna’s mother) and a son.

When Anna was about 10, her mother began to feel ill. She wasn’t sure what it was, since the symptoms were intermittent; some days she felt well, and then she’d have almost no energy to get out of bed. She started having episodes of severe sweating and diarrhea. Her joints got weak. She had very little appetite, and as a result began losing weight at an alarming rate. Maria Anna took care of her like a baby, bathing and feeding her. “It made me very much upset,” she says, “but I didn’t know what to do.”

Anna’s mother died at the local hospital. She was 32 years old. When Benedict and Maria Anna took their other grown daughter and son to the same hospital a couple of years later, the staff said there was really nothing they could do for them. When they died, they were 28 and 41, respectively. The family never received an official cause of death, but they suspect that they died of AIDS.

“We are extremely concerned about our grandchildren,” says Benedict. “People don’t live for long once they’re diagnosed with HIV.” The deaths of their children also thrust them into new roles.

In the evenings, Benedict and Maria Anna sit down at the kitchen table to help the children work on their math exercises and spelling, science, and grammar lessons. They never expected that one day they would be in this situation.

“The elderly are challenged by the age they face, by the pandemic. They’re becoming parents again,” says Evelyn Nkhethoa, a local community leader who recently started a club for the elderly in Maseru. This club helps them understand their newly redefined roles as grandparents, as well as learn about HIV and AIDS through ADRA’s Training of Trainers (TOT) program.

One of the goals of this new club, and of the TOT project at large, is to get the elderly in touch with younger people, who face one of the highest rates of HIV infection in the world. They discuss how the two generations can collaborate and make headway against the pandemic.

“Young people feel misunderstood, because we don’t think parents can relate to us. So we do things our way,” says Kefuoe Matete, ADRA TOT site coordinator in Lesotho.

This is why ADRA must help establish a dialogue and also help improve gender parity in education, alleviate poverty, and encourage a change of personal attitudes.

“As we’re busy fighting HIV,” adds Matete, “we must take some time to look inside ourselves to understand what things we’re still clinging to.”
Global Food Crisis and Undernutrition

This year, food prices reached their all-time high and threw the world into panic. The drivers include:

- The rapid increase in oil prices, which has caused an increase in fertilizer costs and other food production costs
- Global climate change and recent extreme weather incidents in major food-producing countries
- Increase in demand for food due to increasing world population and income levels
- Use of grains for production of biofuel
- Global economic crisis

Of 30 countries predicted to be worst hit by the high food prices, 22 are located in Africa, a continent already vulnerable to a myriad of economic, health, and developmental problems. It is predicted that supply and demand dynamics, climate change, natural resource degradation, and scarcity issues are expected to keep food prices high. These, together with the global economic crisis, will undoubtedly impact the achievement of the Millennium Development Goals, particularly those associated with poverty, hunger reduction, and maternal and child health.

Until recently, investments in nutrition have been limited, although nutritional interventions are among the most cost-effective public health strategies. Before the food crisis, 854 million people worldwide were estimated to be undernourished, and another 100 million are expected to be driven into poverty and hunger. With one in five in critical crisis, it therefore becomes crucial for food assistance to be treated not as charity but as a moral right issue.

If not addressed, the long-term consequences of undernutrition—stunted physical and mental development, poor health status, reduced resilience to disease, and shocks affecting productivity and a country’s economy—are bound to continue into future generations. Malnutrition prevention depends on not only the quantity but also the quality of foods consumed. Breaking the generational cycle of malnutrition requires well-targeted and focused food security and nutrition interventions.

In the short term, emergency food assistance, scale-up of nutritional support to vulnerable groups (including micronutrient supplementation), and support for therapeutic feeding are required. Long-term solutions need to increase food production and social/livelihood protection, in addition to stabilizing the international and local food markets.

References
2. UN-OCHA High-Level Task Force on the Global Food Crisis, Comprehensive Framework for Action (Draft), June 2008
Small “kitchen” gardens near the home offer an immense contribution to family nutrition. They are often a vital source of minerals, vitamins and even medicines that strengthen the body against disease. They seldom have the neat rows of commercial production but are rather a jumble of plants that develop synergies that will outperform the long, straight rows of commercial mono cropping!

Farmers face many pressures to grow cash crops, neglecting the crops vital to family use and nutrition. Traditional vegetables, wild leaves, roots and berries are often increasingly unavailable and even shunned. Working with women is usually the key to successful kitchen gardening, to preservation of the crops, as well as preparation.

Gleaning knowledge from the elderly will give insights into “native” plants that may have been eaten in the past but are now ignored and neglected.

Success is also enhanced if the crop promoted has a link to a particular nutritional challenge. The solution may not entail greater production but rather a variation in the food preparation or cooking process, the eating habits/customs of the family or even the quality of the water.

If iron or vitamin A deficiency is common, promote the growth and consumption of crops high in iron and vitamin A. If protein shortages exist, encourage planting beans and other edible legumes.

When introducing new crops, do it slowly and link them to a specific health concern. Choose crops that are popular, have a desired flavor, are easy to grow, have some pest and disease resistance, and are adapted to the local soil and climate. Sun, soil fertility and water are vital. When water is in short supply conserve this natural resource by shading young plants as well as clearing weeds, and adding manure for soil fertility. Also retain moisture for the roots, by covering the soil around plants with leaves or grass clippings. Keep in mind, if maintaining the crop is exhaustive work the program will deteriorate over time.

Landless and urban poor will face unique challenges but herbs or higher value vegetables can be grown, utilizing wastewater, in the smallest of areas such as a small corner, a window or even a doorway.
INFO BRIEFS, CONT.

➢ HONDURAS: ADRA recently distributed backpacks filled with school supplies for 90 children from low-income farming families in El Edén, in western Honduras. In this region, children are often forced to drop out of school in order to work with their parents as farmhands to earn additional income. The distribution was a result of donations given for the Honduran schoolchildren project showcased in the 2007 ADRA gift catalog, as well as funding provided by ADRA Honduras and the Honduras Department of Education.

➢ MID-UPPER-ARM-CIRCUMFERENCE (MUAC): This indicator is a good predictor of immediate risk of death. This can be measured relatively easily using numbered or color-coded tapes. It is commonly used in emergencies for screening and determination of acute malnutrition.

➢ EDEMA: The presence of excessive amounts of fluid in the intercellular tissue. This is a key clinical sign of a severe form of protein energy malnutrition. a

a. Most of these definitions were adapted from FANTA’s Anthropometric Indicators Measurement Guide, FANTA Publications, by Bruce Cogill, 2003.