Panel 5.1

Improving the Measurement of the Coverage of Programs to Treat Severe Acute Malnutrition

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The capacity to identify, rehabilitate, and cure severe acute malnutrition (SAM) among children has undergone dramatic transformations in recent years, resulting in robust, cost-effective models of care (Bhutta et al 2013) that if implemented at scale could make a significant contribution to child survival and child development (Collins et al 2006). These developments have led not only to consistently high cure rates but also to dramatic increases in the number of SAM cases receiving treatment. According to the United Nations Children's Fund's (UNICEF's) latest figures, more than 2.6 million SAM cases were treated in 2012 worldwide (UNICEF 2012)

In spite of the evident gains made, contextualizing these figures and establishing the coverage, or proportion of cases that are receiving treatment, remains difficult. Joint estimates from UNICEF, Action Against Hunger, and the Coverage Monitoring Network suggest that less than 15 percent of the global SAM population is currently receiving treatment (UNICEF, Coverage Monitoring Network, and ACF International, 2013). At the national level, estimates are also scarce, with only a handful of countries able to report reliable, direct estimations of coverage. Why is this happening?

Part of the challenge in generating the necessary coverage estimations relates to the methodologies involved. The recent development of comprehensive and innovative coverage monitoring tools (including SQUEAC, SLEAC, and S3M methods)[1] has provided the means by which to monitor program coverage practically, regularly, and easily (Myatt et al, 2012). These methods not only provide direct coverage estimations but also produce valuable insights into spatial distribution of coverage and the barriers preventing beneficiaries from accessing services. This information has improved the capacity of SAM treatment services to adapt and provide national authorities with guidelines to develop targeted efforts for scaling up SAM treatment. But these methods do require time and technical capacity at a national level (to design, implement, and analyze coverage surveys), which remains in short supply. Collaborative platforms such as the international Coverage Monitoring Network (CMN)[2] are helping to address these gaps and have begun a global effort to generate more SAM treatment coverage data and to build the capacity of national stakeholders.

Part of the challenge is also about resources and the comparative importance of coverage data. Coverage data is one of the many elements of routine program data that national authorities and nutrition stakeholders require. But unlike other crucial datasets, coverage data are generated through stand-alone surveys that are not directly linked to formal and periodic surveys including Demographic and Health Surveys and/or Multiple Indicator Cluster Surveys. This is in part due to target populations for these surveys being different from those required for coverage assessment—the population eligible for treatment. The new coverage methodologies noted above are less resource intensive and can therefore be implemented frequently and be used as a monitoring tool, even for monitoring short-term impact. But at the same time, coverage surveys must also compete for attention and resources

[1] SQUEAC=Semi-Quantitative Evaluation of Access and Coverage; SLEAC=Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage; S3M=Simple Spatial Survey Method

[2] The Coverage Monitoring Network is a multi-agency initiative co-funded by the European Commission's Office for Humanitarian Aid and Civil Protection (ECHO) and the Office of Foreign Development Assistance (OFDA) of the United States Agency for International Development (USAID) to improve nutrition programs through the promotion of quality coverage assessment tools, capacity building and information sharing. Visit www.coverage-monitoring.org to find out more about the CMN project.

with better established, multi-indicator surveys rather than exploring the opportunities for piggybacking or integrating (in one form or another) into these formal processes.

Successfully integrating coverage into these systems will take time, but there is plenty that can be done at present to start bridging and linking these datasets. UNICEF, Action against Hunger, the Food and Nutrition Technical Assistance (FANTA), and the Coverage Monitoring Network (CMN) are currently working together on developing ways of using existing routine data (admissions and exits, stock accounts, screening data, program staff, and so forth) to identify determinants of coverage and bottlenecks affecting coverage. Such an approach would not substitute for coverage surveys altogether, but it would enable nutrition services worldwide to better use existing information to generate concrete strategies for improving access to and coverage of SAM management services.

Strengthening the availability and reliability of coverage information is only part of the equation. UNICEF has developed a four-step approach focusing on reaching the unreached through identification and resolution of determinant of coverage bottlenecks. The analysis is based on Tanahashi's Health Service Coverage Evaluation Methodology (Tanahashi, 1978), which examines supply, demand, and quality determinants that contribute to effective intervention coverage. These determinants include (1) availability of essential commodities, (2) availability of trained human resources, (3) geographic access, (4) initial utilization, (5) continuous utilization, and (6) effective coverage. Removing the bottlenecks is therefore an important first step toward universal coverage, and monitoring the reduction of bottlenecks on a regular basis is an important step that could provide a robust baseline to define the context-specific challenges preventing SAM treatment services from reaching optimal levels of coverage.

The type of coverage data results shown in this report can be used to influence decisionmaking processes at different levels so that we can achieve universal treatment of SAM (Guerrero and Rogers, 2013). Universal coverage of SAM cases as a key part of a bundle of direct and indirect health and nutrition interventions will prevent child deaths[3] and have an impact on reducing childhood illness and stunting.

References

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[3] WHO is currently estimating the global number of severely acutely malnourished children and the global number of deaths associated with severe acute malnutrition

United Nations Children's Fund. 2012. Global SAM Management Update. New York, NY: UNICEF.