Getting the Knack of NACS

Highlights from the State of the Art (SOTA) Meeting on Nutrition Assessment, Counseling and Support (NACS)

22-23 February 2012

Written by Kara Greenblott, Nzinga International

USAID FROM THE AMERICAN PEOPLE
TOPS Promoting excellence in food security programming
coregroup Advancing community health worldwide.
CRS CATHOLIC RELIEF SERVICES
Save the Children
PCI CELEBRATING 50 YEARS OF POSITIVE COMMUNITY IMPACT

Acknowledgements:

The SOTA meeting and this report were made possible with a grant from Technical and Operational Performance Support (TOPS), a project of USAID's Office of Food for Peace.

Additional support was provided by CORE Group, and USAID's Food and Nutrition Technical Assistance Project (FANTA-2) and the Livelihood and Food Security Technical Assistance Project (LIFT), both managed by FHI 360.

Special thanks is extended to Catholic Relief Services (CRS), PCI, Save the Children, World Vision and USAID's Office of HIV/AIDS, who contributed significant staff time and energy to organizing this SOTA meeting.

The TOPS Micro Grants Program was made possible by the generous support and contribution of the American people through the United States Agency for International Development (USAID). The contents of the materials produced through the TOPS Micro Grants Program do not necessarily reflect the views of TOPS, USAID or the United States Government.

This report was written by Kara Greenblott, Nzinga International, on behalf of CORE Group.

Published March 2012

Recommended Citation:

CORE Group. *Getting the Knack of NACS: SOTA Meeting on Nutrition, Assessment, Counseling and Support (NACS), 22-23 February 2012, Washington D.C. Meeting Report.* Washington, D.C.: CORE Group, 2012.

Contact Information:

Kate Greenaway at kate.greenaway@crs.org

Ronnie Lovich at rlovich@savechildren.org

Janine Schooley at jschooley@pciglobal.org

Kathryn Reider at kreider@worldvision.org

Foreword

Over the past decade, the integration of HIV and nutrition programming has been increasingly recognized as *imperative* to successful HIV treatment outcomes. As the evidence accumulated for 'integrated' programming, Food by Prescription (FBP) emerged as a way to treat SAM and MAM for PLHIV on ART, *and* to bolster adherence to these life-saving drugs.

In the past several years, however, a shift has occurred. While nutrition support in the form of therapeutic and supplementary foods continues to be an important aspect of integrated programming, stakeholders have recognized the importance of balancing emphasis among nutrition *assessment, counseling* and *support* (including food and nutritional supplements when necessary), as well as intervening earlier before malnutrition occurs. Hence, the framework has evolved into an aspiration to deliver adequate nutritional care and prevention for all.

Importantly, this shift is relevant and compelling not only in an HIV context, but to nutrition programming more broadly. As noted throughout this report, while NACS has initially emerged from nutrition programming within an HIV context, today NACS is for *everyone*, and contributes to achieving the goals that the nutrition community has long been promoting! Yet, there is still important work to be done to ensure that our workstreams merge to ensure the best possible outcomes for all those living with HIV and others who are vulnerable to malnutrition.

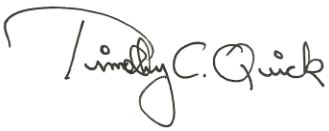
This report not only records the proceedings from this landmark meeting – *Getting the Knack of NACS* – but just as importantly, it documents and advances our thinking around these questions:

- *What is NACS?*
- *What are costs and benefits of NACS?*
- *What are some promising examples of how NACS programming has worked?*
- *And how can we apply NACS in our own, country-specific contexts?*

We hope that you will share this report with your staff, your nutrition colleagues and stakeholders from other sectors in your country. It is our desire that, through the coordinated investment by a wide range of donors, the benefits of the NACS framework become available to people in all countries, and that we each fully participate in its ongoing development.

Karen LeBan
Executive Director
CORE Group

Judy Canahuati
MCH, Nutrition & HIV Advisor
USAID Office of Food for Peace



Tim Quick
Senior Technical Advisor for HIV/AIDS & Nutrition
USAID Office of HIV/AIDS

Laura Birx
Food Security / Nutrition Specialist
Acting Nutrition Division Chief
USAID Office of Health, Infectious Diseases & Nutrition

Table of Contents

Abbreviations and Acronyms 4
1. Executive Summary 5
2. Introduction and Background to NACS 6
3. Objectives 7
4. Participants 7
5. Meeting Process 8
6. Proceedings from Day One – Framing NACS and the Science of Delivery 8
   Opening Remarks 8
   Framing FBP and NACS 9
   What Does the Evidence Tell Us? 10
   Building the NACS: The View from 60,000 Feet 11
   Delivering Quality: Experience from Uganda and Kenya 12
   How are we Measuring Up? 13
7. Proceedings from Day Two -- Advancing our Collective Work 14
   Reflections from Day One 14
   Working for Change: CORE and FANSHA 15
   Aid Architecture, Program Streams and Policy Context 15
   Promising Practices #1: Lessons from the Zambia and Malawi 17
   Promising Practices #2: Lessons from the Namibia, Ethiopia and Mozambique 18
   Advancing the SOTA – Working Group Sessions 19
      Design Challenges I – Building Systems 19
      Design Challenges II - Service Delivery 20
      Establishing a Research Agenda 20
      Guidance for NACS Implementation: Community Component 21
      Overcoming Policy Barriers and Aid Constraints 21
      The Future of Food: Innovation in Food Commodities and Partnering with the Private Sector 22
   The Facts about NACS 23
   Closing Remarks 24
8. What's Next with NACS? 24
Annex 1 – Meeting Agenda 26
Annex 2 – Meeting Participants 29

Abbreviations and Acronyms

ANC	antenatal care
ART	antiretroviral therapy
BCC	behavior change communication
BMI	body mass index
CDC	US Centers for Disease Control and Prevention
CHW	community health workers
CMAM	community-based management of acute malnutrition
CMCI	community management of childhood illnesses
CRS	Catholic Relief Services
ES	economic strengthening
FANTA	Food and Nutrition Technical Assistance project
FBF	fortified blended food
FtF	Feed the Future - USG Global Food Security and Hunger Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHC	Global Health Council
GHI	Global Health Initiative
GMO	genetically modified organisms
GMP	growth monitoring and promotion
HBC	home-based care
HCI	Health Care Improvement
IMAM	Integrated Management of Acute Malnutrition
LIFT	Livelihoods and Food Security Technical Assistance
LNS	lipid-based nutrient supplements
M&E	monitoring and evaluation
MAM	moderate acute malnutrition
MCHN	Mother Child Health and Nutrition
MUAC	mid-upper arm circumference
NACS	nutrition assessment, counseling, and support
NGO	non-governmental organization
OHA	US Office of Humanitarian Affairs
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
QI	quality improvement
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
SII	strategic information for impact (a new term for M&E)
TOPS	Technical and Operational Support Program
UN	United Nations
URC	University Research Corporation, LLC
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

1. Executive Summary

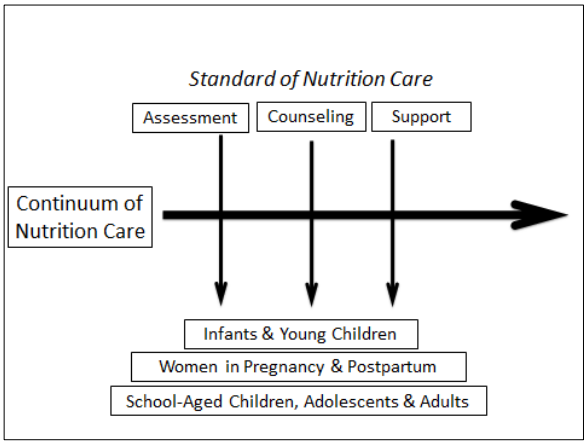
Getting the Knack of NACS was a two-day SOTA meeting aimed at taking stock of progress since the NACS meeting in Jinja, Uganda in 2010; examining the evidence base to date; and further advancing the state-of-the-art on NACS in the context of HIV, and health care more broadly. While a wide range of issues emerged, some of the key ones appear below:

Defining NACS: NACS is an organizing framework that is client-centered and emphasizes nutrition assessment, counseling and support. NACS brings together existing nutritional services, protocols and actors along the continuum of care, with referrals and effective coordination for optimal quality and impact.

NACS is doable: The NACS framework is successfully being implemented in variety of contexts, with each country adapting the framework to their existing structures, mandates, protocols and programs.

Partnerships are critical: One agency can't do NACS alone. The framework relies on a range of partners to contribute resources and expertise along a country-specific continuum of care.

NACS is for everyone: While NACS was born from an HIV context; the framework has evolved into an aspiration to deliver adequate nutrition care and prevention for all, regardless of age, gender and HIV status (see box at right). This approach comes with challenges, since donors that have historically contributed to FBP and NACS had specific, HIV-related objectives in mind. Coordinated investment by a wide range of donors and partners will be necessary for NACS to achieve broader applicability.



Let's do it well: Quality improvement (QI) is a critical aspect of NACS and should be done on a continuous basis to ensuring ongoing improvement. A range of QI tools have been tried in Uganda, Kenya and other 'early adopting' countries, and these tools need to be more broadly disseminated. Likewise, a platform for shared learning on NACS is much needed.

Evidence: Programming without evidence can be irresponsible, but waiting can be disastrous and unethical. In retrospect, we can now demonstrate that targeted supplementary feeding for underweight people living with HIV (PLHIV) improves their nutritional status more quickly (than without food), but only during the time that they are underweight, which is the highest risk period.

NACS is not just curative: NACS implementers from several countries noted the importance of emphasizing *prevention* of malnutrition within the NACS continuum of care. Nutrition 'assessment' guides nutrition 'counseling', and in addition to treatment of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM), comprehensive counseling should advocate for use of locally available foods, and point individuals to appropriate 'support', including food security and economic strengthening (ES) to grow incomes. Some participants advocated for extending 'support' beyond the individual, to addressing the needs of the family as well.

Creating demand for nutrition services: NACS requires that we expand our focus outward from the clinics, and work with community health workers (CHWs) and volunteers to conduct assessment and counseling (where appropriate), and *create demand* for nutrition services at the community level. The CORE constituency should use its existing community-based platforms to strengthen prevention, promote earlier access and support for adherence and follow up.

Multi-sectoral linkages: Drivers of malnutrition are multiple and varied. Often the health of the individual is more of a driver than anything related to food consumption (or 'food access' more generally). It is important that nutrition interventions are linked to water, sanitation and hygiene (WASH), de-worming, TB treatment, family planning, and other health-related services, in order for NACS to result in improved nutrition outcomes. Similarly, a dynamic and responsive agricultural sector is critical to sustainable nutrition outcomes.

The SOTA participants concluded that if we are to advance the NACS framework and realize its potential, NACS must be marketed to a wider audience; i.e. not just to USG partners, but to the international development community more generally. With this in mind, some of the selling points below must be clearly articulated, packaged and disseminated. See the sections of this report entitled 'The Facts about NACS' and 'What's Next with NACS' for more detail.

- NACS offers a unifying framework to help health facilities work in synergy with their community towards better health outcomes. It bridges the gap between facility- and community-based care, treatment and support.
- NACS addresses nutrition on a continuum of care across the lifecycle, beginning with woman and infants, getting them into antenatal care and prevention of mother to child transmission (PMTCT).
- NACS provides a platform for nutritional health system strengthening, with strong linkages to other services. The state of the art will have arrived when this work is effectively coordinated and integrated to serve the needs of the general population, and not just those affected by HIV.
- A holistic NACS approach can create a continuum of care in which to invest resources from a variety of players. It creates a platform on which stakeholders can dedicate resources and create synergies for more effective use of resources.
- NACS offers an opportunity to overcome the challenge of interagency coordination and collaboration within the USG; within the UN; and among international development partners in a given country.

Finally, it was agreed that NACS is *not* a methodology or tool, nor is it a project or program. It's a way of framing or organizing health and nutrition services along a continuum of nutrition care, and in a way that is flexible and adaptable to the structures, protocols and stakeholders in each country-specific context.

2. Introduction and Background to NACS

As the HIV pandemic enters its fourth decade of existence, the drive for 'integrated', HIV and nutrition programming continues to gain momentum. Over the past decade, the integration agenda has been a priority for NGOs, host-governments, and bi-lateral and multi-lateral donors alike. This global conversation began (at scale) with the landmark, April 2005 WHO consultation on Nutrition and HIV/AIDS, held in Durban, South Africa, with participation from all of the major UN agencies, the World Bank, and NGOs, HIV networks, regional groups and donors from 20 countries across southern and east Africa. The Durban consultation reviewed the evidence and declared the urgent need for the integration of nutrition into essential package of care, treatment and support for people living with HIV and AIDS.

Less than a year later, the NGO community moved the integration agenda forward with the Africa Forum, held in Zambia in 2006, and again in Malawi in 2009. These two Forums brought together 170 HIV, food security and nutrition practitioners from 17 sub-Saharan African countries, both to share promising practices in integrated HIV, food security and nutrition programming; and, as importantly, to make recommendations to donors and policymakers about the importance of integration.

In September 2006, the US government responded to these calls with the release of PEPFAR Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs. The Guidance was approved by OGAC and disseminated to country PEPFAR teams to guide food security and nutrition programming. Finally, in the FY2008 Authorization Bill, Congress stipulated that OGAC "is directed to provide not less than $100,000,000 for programs that address short-term and long-term approaches to food security as components of a comprehensive approach to fighting HIV/AIDS, and is encouraged to support programs that address the development and implementation of nutrition support, guidelines, and care services for people living with HIV/AIDS."

This small, but significant step towards 'mandating integration' contributed to the proliferation of Food by Prescription (FBP) programming in southern and east Africa. At the time, FBP programming claimed its place as a critical component of nutrition assessment, education and counseling (NAEC), highlighting the need to view food as medicine in the context of HIV and acute malnutrition.

With the expansion of FBP programming underway, concern soon arose that food was being overly prioritized within the care and treatment package, and that a more nuanced, balanced approach was required. NACS emerged in this context,

with 'assessment' and 'counseling' placed at the forefront, and with food representing only one aspect of the 'support' component.

Different countries are currently at different stages of NACS programming. Kenya, Malawi, and Uganda were early adopters and have implemented NACS for several years. Ethiopia and Tanzania began in 2010, and today, a total of 15 countries are using the NACS framework. While the core set of NACS services are similar across countries, different approaches to the model are being tried, with variations in government ownership, community linkages, and implementing partner configurations.

In September of 2010, the first international conversation around NACS programming took place in the form of a four-day meeting entitled 'Nutrition Assessment, Counseling, and Support in HIV Services: Strategies, Tools, and Progress'. Held in Jinja, Uganda, the meeting brought together 98 participants from a variety of government ministries and agencies, UN agencies, and implementing and technical assistance partners. The meeting was organized by FANTA-2, and funded by USAID's Office of HIV/AIDS, Bureau for Global Health.

Just over a year later, this two-day SOTA meeting – *Getting the Knack of NACS* -- represents an effort to take stock of progress, examine evidence to date, and to further advance the state-of-the-art on NACS in the context of HIV, and beyond. The theme of integration has been high on the agenda for CORE Group for some time, and this meeting represents an effort by CORE Group's HIV Technical Working Group (TWG) and Nutrition TWG to demonstrate that integration should not only occur programmatically, but likewise through the creation of collaborative processes for discussion, debate and learning.

Finally, the involvement of TOPS and the Food Security and Nutrition (FSN) Network underscores the interest of the US NGO community in deconstructing the funding and operating silos that have built up around HIV, health and nutrition over time, and replacing them with mechanisms that reach *across* sectoral boundaries. In this vein, participants of this SOTA meeting include CORE Group members and the TOPS FSN Network, along with other key nutrition and HIV audiences.

3. Objectives

The SOTA meeting aimed to provide an overview of current thinking and predominant issues surrounding the design, implementation and evaluation of NACS programming. Tapping into a carefully selected team of academic and programmatic experts, the event covered a range of emerging science, technical content and program experience, as well as providing a venue for in-depth information exchange.

The specific objectives of the SOTA meeting were to:

1. Review emerging science informing the NACS approach
2. Provide an overview of the technical content of NACS delivery
3. Share promising practice and field experience for NACS implementation
4. Explore ideas for strengthening linkages and integration with other programming.
5. Contribute to advancing the NACS State of the Art (SOTA) through working group discussions

4. Participants

103 participants from 48 organizations attended the SOTA meeting. Participants included CORE Group members and the TOPS FSN Nutrition Network, along with other key nutrition and HIV audiences, including representatives from US government agencies, UN agencies, HIV and nutrition implementing agencies, and agencies providing technical assistance to implementers. The vast majority of participants were US-based technical staff in the areas of nutrition and/or HIV. Some of the country programs where NACS is being implemented were also represented, including Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Uganda and Zambia.

5. Meeting Process

The SOTA meeting took place over a two-day period and applied a range of formats, including plenary discussions, power point presentations, panel discussions, interviews with experts using a talk-show format, and working group sessions in smaller group. Rapporteurs were used to document all of the proceedings, in addition to audio and video recording managed by FHI 360. On the final afternoon, rapporteurs and facilitators from all six groups presented back to plenary with brief summaries of their sessions, followed by a short Q&A and discussion. Finally, the two-day event ended with some general conclusions and clarifying statements regarding what NACS is and how it fits into the big picture of health and nutrition programming on a global basis. See Annex 1 for the detailed agenda.

6. Proceedings from Day One – Framing NACS and the Science of Delivery

Opening Remarks

Welcome and Opening Remarks
Karen LeBan, CORE Group
Kathryn Reider, World Vision, TWG
Shannon Senefeld, Catholic Relief Services (CRS), HIV TWG

Video from this session

Karen LeBan opened the meeting acknowledging the lead organizers: CORE Group's Nutrition TWG and HIV TWG. The meeting is collaborative effort between CORE Group and US government partners including the Office of HIV/AIDS, Food for Peace and the Bureau for Food Security. Gratitude was expressed to the Technical and Operational Support Program (TOPS) for providing the funding for this meeting and making it free of charge to all participants.

As co-chair of the nutrition working group, Kathryn Reider acknowledged this meeting as an excellent opportunity for collaboration between stakeholders in the areas of nutrition and HIV, and recognized the efforts of the USAID participants for their support to make it happen. Gratitude was also expressed to the FANTA project, which helped with some of the organization of the meeting. Finally, Shannon Senefeld, co-chair of the HIV working group, noted that with the move from FBP to NACS this is the perfect opportunity to have this meeting. Shannon also expressed gratitude, on behalf of the organizing committee, to Kate Greenaway of CRS for her exhaustive efforts in bringing this meeting to fruition.

Ronnie Lovich launched the proceedings with a description of the paradigm shift currently taking place with regards to HIV and nutrition programming. Whereas FBP was the predominant language several years ago, we have evolved into the development of the NACS framework. Ronnie noted the importance of the 'Jinja' meeting in 2010 (see 'Introduction and Background' section), and cited today's unique opportunity within the CORE community to further advance this shift in our collective thinking. Meeting objectives; the agenda (see Annex 1); and logistics were then reviewed.

Framing FBP and NACS

Moderator: *Tim Quick, USAID*
Presenters: *Janet Paz Castillo, USAID and Robert Mwadime, FHI 360*

Video from this session

Session Quote

The Durban Declaration: "We call for the integration of nutrition into the essential package of care, treatment and support for PLHIV…"

Session Objectives:

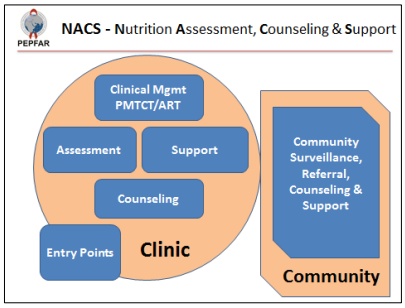
- Provide an overview of how Food by Prescription (FBP) programming began and evolved to the current approach that we refer to as NACS.
- Introduce the NACS framework and explain what it means within the 'big picture' context.

Session description:

Tim Quick began with the historical context of HIV and nutrition integration, including explaining the cyclical nature of malnutrition and HIV, the 2003 WHO guidelines, the 2005 Durban consultation and the start of FBP in Kenya.

Robert Mwadime talked about the evolution of the role of food in the HIV care package, and the step-by-step process to integrating nutrition into HIV programming in a given country. He also gave a summary of lessons learned from NACS programming to date.

Janet Paz Castillo gave a personal history of her involvement in FBP/NACS programming; she talked about the USAID stakeholders that played a critical role in evolution of FBP programming, and the crucial shift in BMI criteria from <16 to <18.5.



Key messages that emerged from the session:

- NACS is a framework or approach to nutrition programming, not just in the context of HIV, but more generally to the broader population.
- The integration of nutrition into HIV programming required significant leadership at all levels, particularly within countries that are at the forefront (e.g. Kenya).
- Sometimes we need to save lives and collect evidence later. The learning process evolved, and as we've documented results we can apply that learning to ongoing programming.
- Collaboration between the public and private sector needs to happen and should be well thought out to avoid creating monopolies.
- Siloed funding sources contributed to 'AIDS exceptionalism'. Now we now have to deal with the consequences.
- 'Care' is not only food; it is much more comprehensive.
- The voice and advocacy of the NGO community was critical getting PEPFAR to embrace integrated programming.
- The name NACS deemphasizes food and is more focused on the continuum of nutrition care.
- Synergy between the clinic/facility and the community is an important aspect of the NACS model.

What Does the Evidence Tell Us?

Moderator: *Tony Castleman, George Washington University*
Presenters: *Alice Tang, Tufts University and Mark Manary, Washington University*

Video from this session

Session Objectives:

- Provide current evidence of the nutrition implications of HIV and of ART.
- Explain the effect of malnutrition on HIV outcomes.
- Provide the evidence base for therapeutic and supplementary feeding for PLHIV.
- Discuss the delivery mechanisms of program interventions and the evidence behind them.

Session description:

Tony Castleman reminded us that understanding the evidence is an important starting point to identifying programmatic objectives, and developing effective programs. It can help us to understand what types of interventions, and delivery mechanisms, work and in what context.

Alice Tang presented the evidence on the nutrition implications of HIV and of ART, as well as on the relationship between HIV and food security.

Mark Manary presented the evidence base for supplemental and therapeutic feeding for PLHIV, core aspects of NACS programming.

Key messages that emerged from the session:

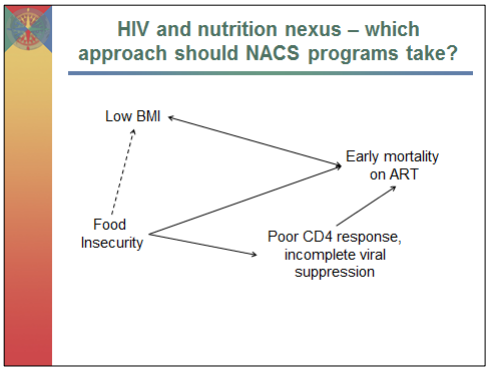
- It's helpful also to think about the relationship between evidence and programming as bi-directional – one must inform the other.
- In some circumstances, programming without evidence can be irresponsible. But at the other extreme, waiting can be disastrous and unethical.
- There is ample evidence to be drawn from non-HIV situations, i.e. the management of malnutrition in non-HIV+ clients.
- What we still ***don't*** know is: Will interventions to improve weight or BMI prior to or at ART initiation improve subsequent outcomes on ART? Or is baseline BMI and weight loss just a marker for disease severity?
- Another important question: Are PLHIV accessing ART early enough? Or are they already too malnourished once they show up at the clinic? And therefore, should nutrition support begin earlier (pre-ART) where possible, as some NACS programs do?
- HIV disease ***and*** malnutrition need to be treated simultaneously for good outcomes.
- Targeted supplementary feeding (macronutrients) for underweight PLHIV improves nutritional status more quickly, but only during the time that they are underweight (the highest risk period).
- For micronutrients, one study showed that supplementation leads to slower progression of HIV, but this finding has not been replicated.

Session Quote

"Programming without evidence can be irresponsible. Waiting for complete evidence to program can be a travesty."

Evidence Base:

- Low BMI at ART initiation is associated with increased mortality.
- ART initiation is associated with weight gain.
- Early weight gain on ART is associated with survival, particularly when baseline BMI is low.
- There is not good evidence that nutritional status is associated with CD4 count recovery.
- There is a high prevalence of food insecurity in HIV-infected populations.
- Inadequate access to food and safe water are a barrier to ART uptake and adherence.
- There **is** an association between food insecurity and incomplete viral suppression, reduced CD4 and increased mortality.



- NACS should take a two-pronged approach: 1) nutrition support to address the direct biological effects of nutrition status on disease progression (i.e. increase energy and protein intake, and replete micronutrients); and 2) address social determinants of food insecurity and barriers to adherence.

Building the NACS: The View from 60,000 Feet

Presenters: Tim Quick, USAID and Brian Njoroge, FHI 360

Video from this session

Session Quote

"The concept of NACS is one where we are bringing the community and clinic together, defining a standard of care and figuring out how all of this can be provided as a continuum of care over the life cycle."

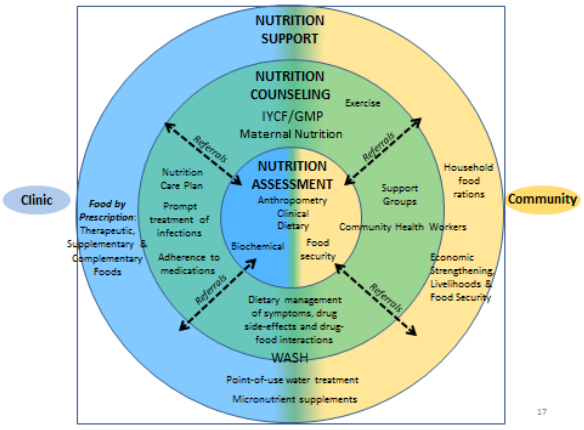
Session Objectives:

- Explain 'what NACS is' from the big picture perspective.
- Discuss NACS in the context of a continuum of care for individuals across the entire life cycle.
- Explain NACS as an approach to systems strengthening.
- Draw lessons from the Kenya experience and provide examples on how NACS evolved there.

Session description:

Tim Quick provided a summary of what NACS is; what it aims to achieve; the approach that NACS takes; and who NACS targets.

Brian Njoroge gave an overview of the history of NACS in Kenya, and shared lessons from implementation in that country.



Key messages that emerged from the session:

- While getting people on ART is our single most powerful nutrition intervention for AIDS patients, NACS services play a vital role throughout the entire health-illness continuum, helping people with HIV maintain health and delay disease progression, initiating HIV service referrals, and supporting ART adherence and retention in clinical care.
- NACS is a unifying framework. We know the (nutrition and HIV-related) pieces; NACS helps us to put it all together.
- NACS aims to help the health facility work in synergy with the community towards better health outcomes.
- NACS addresses nutrition on a continuum of care across the lifecycle, beginning with woman and infants, getting them into antenatal care and PMTCT.
- NACS is about health system strengthening; ultimately it's for the general population, not just for PLHIV.
- NACS is also opportunity to *prevent* malnutrition through a variety of interventions, lipid-based nutrient supplements (LNS), sprinkles, safe water, and food security interventions.
- QI is central to NACS; we need the right people in the right jobs (and retained in those jobs) to make it work.
- Kenya was the original model for NACS programming; others have since been emulating and growing that model. NACS began in Kenya as FBP in the context of NAEC.
- If there isn't enough emphasis on the community side, the facility side gets bottle necked. There has to be a healthy balance, with referring upstream to clinics where necessary.
- Agriculture must be linked to NACS programming; a vibrant agriculture sector is critical to sustainable nutrition outcomes.

Delivering Quality: Experience from Uganda and Kenya

Moderator: Ronnie Lovich, Save the Children
Presenters: Margaret Kyenkya, NuLife Uganda and Ram Shrestha, URC Kenya

Session Quote

"In a country like Uganda with very few nutritionists, establishing a 'nutrition program' was not an option. Instead, we had to make sure nutrition was *everybody's* business."

Video from this session

Session Objectives:

- To share an overview of NuLife project and the use of the NACS framework in that project.
- To describe the service delivery model used in Uganda, with a special emphasis on the health facility-community continuum.
- To describe the QI approach and tools related to coaching and mentoring.
- To draw lessons from the experiences in Kenya and Uganda in relation to QI.

Session description:

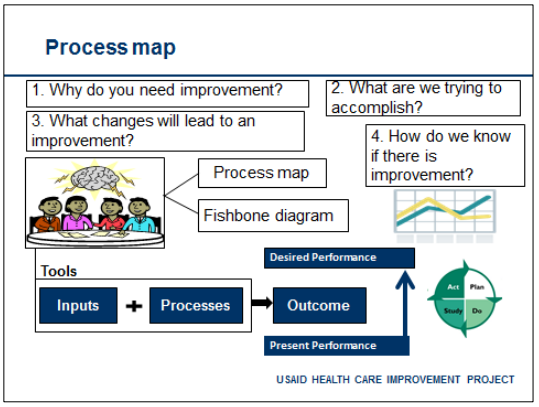
Margaret Kyenkya described NULIFE's holistic service delivery model, which we've come to refer to as NACS, and how they approached QI within that project.

Ram Shrestha talked about how the QI method is applied in Kenya; the use of QI teams and coaches; and benefits of the QI approach.

Key messages that emerged from the session:

Uganda:

- In a country like Uganda with very few nutritionists, establishing a 'nutrition program' was not an option. Instead, they had to make sure nutrition was *everybody's* business.' Priority was on developing guidelines and job aids.
- Nulife used three strategies: 1) policy -- partnerships and guidelines; 2) service delivery -- QI in clinics (3) production -- establishing local, ready to use therapeutic food (RUTF) production and linking to agricultural livelihoods.
- Nulife depended heavily on community volunteers to find the malnourished PLHIV (of all ages) in the communities. Successfully rehabilitated cases act as models / examples, showing people that assessment of malnutrition needs to happen not just at the clinic, but out in the community; and that it's for everyone, not just PLHIV.
- Service delivery using the seven step QI process:
    1. Assessment using MUAC tape and task shifting;
    2. Categorization into severity of malnutrition;
    3. Counseling, remembering that cultural issues often interfere with good nutrition and that there are many free/inexpensive locally available foods that provide good nutrition;
    4. FBP with RUTF presented as a medicine for people 'sick' with malnutrition;
    5. Follow-up: a) return appointments; but also b) follow-up at home to reduce default;
    6. Community links: select a community coordinator to be part of QI team at the facility, joint monthly meetings between volunteers and community coordinator; and,
    7. Education: support of implementing partners with materials for health and nutrition education, training of expert clients to carry out health education messages.

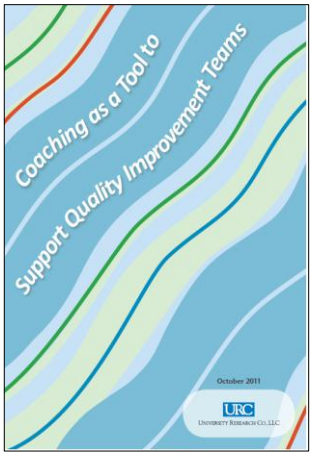


Kenya:

- Kenya uses the same seven-step delivery process as Uganda.
- QI process is a process of improving the quality of services. It consists of: identifying problems/gaps, analyzing problems, developing change ideas, testing change ideas and measuring improvements.
- The focus of this process is on "systems thinking." Always ask questions

about whether the change you desire is actually happening.

- A key to the success of the QI approach is that its done by the implementers, i.e. health care staff and community health workers (CHWs)) themselves, not outsiders.
- It's true that QI is very time consuming. But once the staff adopt it, they see that it really helps them improve their work. They say that it 'really is opening our eyes'.
- There has to be a balance between 1) bringing promising practices from other countries, and 2) letting people experiment and find their own solutions.
- Bringing the client perspective to the QI process (e.g. via expert clients) is a key benefit of the QI approach.



Interactive Session:
A 20-minute interactive session was conducted on using the QI approach. The exercise was designed to help people gain clarity on how the QI approach can assist in the NACS process, and give them practice in using the approach. Participants applied the QI process to a situation in a district hospital in Uganda, and addressed a series of questions using guidance from the document entitled 'Coaching as a Tool to Support Quality Improvement Teams', URC, October 2011.

How are we Measuring Up?

Moderator: *Amie Heap, USAID*
Presenter: *Amy Stern, URC*

Panel members:
Robert Mwadime, FHI 360; Margaret Kyenkya, Africare; Ram Shrestha, URC; Tony Castleman, George Washington University; Brian Njoroge, FHI 360;and Amy Stern, URC

Video from this session

Session Quote

"If you are not confused, you are not paying attention."

"If data is *useful* to health care workers, they will become invested in collecting it."

Session Objectives:

- Understand the development of M&E for NACS programming in the global context.
- Discuss the integration of M&E for NACS at the clinic level.

Session description:

Amie Heap presented on 1) global indicators and tools for M&E of NACS programs; 2) steps for creating a relevant NACS M&E framework; and, 3) Gaps and future directions for M&E of NACS.

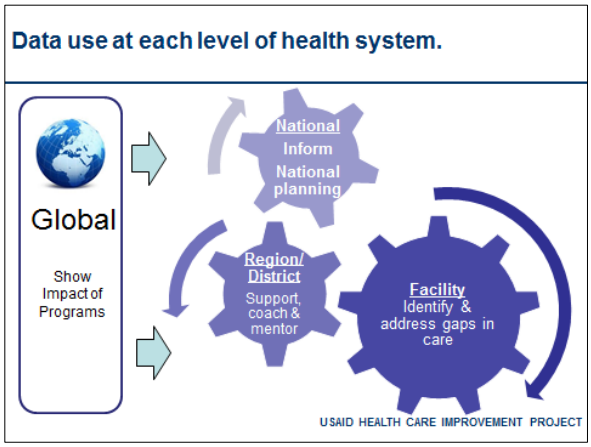
Amy Stern discussed the integration of M&E for NACS at the clinic level, including 1) establishing data collection as part of the clinic workflow; and 2) Making data relevant at the clinic level.

Key messages that emerged from the session:

- There was a growing need to harmonize across stakeholders and develop a set of core NACS indicators that would be available for program implementers, donors, host-countries, etc… We now have that draft set of indicators.
- The three core categories of NACS indicators are: Nutrition Care and HIV, PMTCT and Infant Feeding, and Food Security and HIV. All three can be stripped of HIV specificity and used in any context.
- The indicators within the Nutrition Care set are considered to be the central cascade for M&E of NACS programs. This indicator cascade includes monitoring: 1) how many clients receiving services receive a nutrition assessment, 2) determining how many of those assessed are undernourished, 3) determining how many undernourished clients

were counseled, 4) and then determining how many of those that are malnourished receive supplementary and therapeutic feeding.

- There are 14 NACS indicators. They are not mandated by anyone; somewhere along the continuum countries can choose to select and implement indicators that are best suited to their programming needs. Indicators are meant to be flexible; they can be adapted as needed.
- Children are not just small adults; they have their own nutrition treatment protocols. For the NACS indicators, nutrition information is disaggregated by age, but thus far indicators specifically related to children (over 12 months) have not *yet* been incorporated.
- The nutrition indicators can be broken out by gender. In the future, the group may consider adding indicators that look at intra household sharing.
- Three key lessons: 1) use metrics relevant to the clinic; 2) make data collection part of the daily routine 3) use data to improve clinic performance.
- If data is *useful* to health care workers, they will become invested in collecting it, especially when they see how it can help them do their job better.
- Remember that countries must create a critical mass of NACS/nutrition advocates; once nutrition is positioned as part of broader care, it will be more easily accepted nationally.



7. Proceedings from Day Two -- Advancing our Collective Work

Reflections from Day One

Moderator: Janine Schooley, PCI

Video from this session

Reflections on Day One:

- We discussed evidence: if we need it, when we need it, the quality of evidence; how to apply it and how to inform it.
- The importance of making the data useful; we see that people are more committed to collecting data if they value it.
- At PCI, the term M&E has been changed to 'strategic information for impact' (SII), representing a shift in mindset to viewing M&E as useful for improving programs, not just for donor reporting.
- The issue of community as separate from facility or a part of it, what about PLHIV and the broader community?
- Should we be focused on PLHIV? Or should we focus on people with the greatest need (lowest BMI)? Or should NACS be focused in a broader, public health kind of way?
- Why haven't we gone to scale with NACS already? Why isn't it getting more play with the other global partners?
- Yesterday we talked about evidence and looked a lot at the facility level. But we haven't explored how this works at the community level. This will be a theme for day two.
- What is the role of men in NACS? When looking at household decision making around resources, how do we help involve men in NACS programming? Can we apply the lessons from maternal child health and nutrition (MCHN) and child survival to NACS?
- There are practical challenges when we have NACS in an HIV context (AIDS exceptionalism, stigma, etc…). Also, ministries might be more excited about NACS, and even see it as the next generation of growth monitoring and promotion (GMP)! But unfortunately, NACS still has an HIV hat on. We need to look at the broader implications of that HIV history (of NACS), and find ways to bring it out of that box.

Working for Change: CORE and FANSHA

Presenter: Janine Schooley, PCI

Video from this session

> ***Session Quote***
> "When spiders unite they can tie down a lion'. We couldn't wait for evidence; we had to address these dual epidemics right away, with practical, 'how to' guidance from one practitioner to another."

Session Objectives:

- Provide the historical context on integrated HIV, food security and nutrition programming.
- Describe that context from the viewpoint of CORE Group members and the Links for Life/FANSHA process.

Session description:

Janine Schooley summarized the general themes that emerged on day one; outlined the day ahead; and then described the events leading to NACS from the viewpoint of the NGOs involved.

Key messages that emerged from the session:

- We all have a different view of 'the elephant' (NACS history) depending on the part of the elephant we are holding at the time. This talk is about one viewpoint: that of the NGO/CORE community.
- Links for Life (a project of PCI) convened Africa Forum 06 and 09 with a host of NGO partners.
- A declaration and call to action emerged on the dual epidemics of HIV & AIDS and food & nutrition insecurity.
- When spiders unite they can tie down a lion'. We couldn't wait for evidence; we had to address these epidemics right away, with practical, 'how to' guidance from one practitioner to another, and by making recommendations to donors and policy makers on the importance of integration.
- The Food and Nutrition Security and HIV/AIDS Advocacy Group (FANSHA) came out of the declaration as well. This was an intention to stay coordinated, and maintain momentum around advocacy for integrated programming.
- Links for Life used Communities of Practice (CoPs) as a learning platform to share promising practices. They helped address the question: 'How can we better integrate HIV programming with food, nutrition and livelihoods security, given the heavy siloing of funding streams to each of these areas?
- Remember that 'integration' was happening far before the evidence, policies and guidance came out. It was happening because it made sense; not because of any instruction or mandate from donors.
- UNGASS was a real opportunity to talk about integration within the *global* community, not just as a USG initiative. There were lots of stakeholders outside of this room who were involved in what ultimately led to NACS. We need to find a way to continue the momentum to date.

Aid Architecture, Program Streams and Policy Context

Moderator: Janine Schooley, PCI
Case study presenters: Jim Hazen, USAID and Amie Heap, USAID
Panel members: Tin Tin Sint, UNICEF, Judy Canahuati, USAID FFP, Brenda Pearson, WFP, and Laura Birx, USAID Feed the Future

> ***Session Quote***
>
> "For many, NACS language is brand new. Our challenge is to 'sell' its many benefits. It offers a solution to the many challenges of multi-sectoral and multi-agency collaboration."

Video (Part I) from this session (Panel Discussion)

Video (Part II) from this session (Mozambique Case Study)

Session Objectives:

- Discuss NACS as it relates to the donor community, funding, global collaboration and advocacy.
- Draw from experiences from Mozambique with regards to fostering collaboration and integration of NACS into existing country mechanisms.

Session description:

Janine Schooley facilitated a 'conversation' among the panel members listed above. Questions were posed by the moderator, Oprah Winfrey-style, with the inclusion of audience participation. The conversation focused on the 'aidscape': donors and policy makers that have made and continue to make a difference in moving NACS forward.

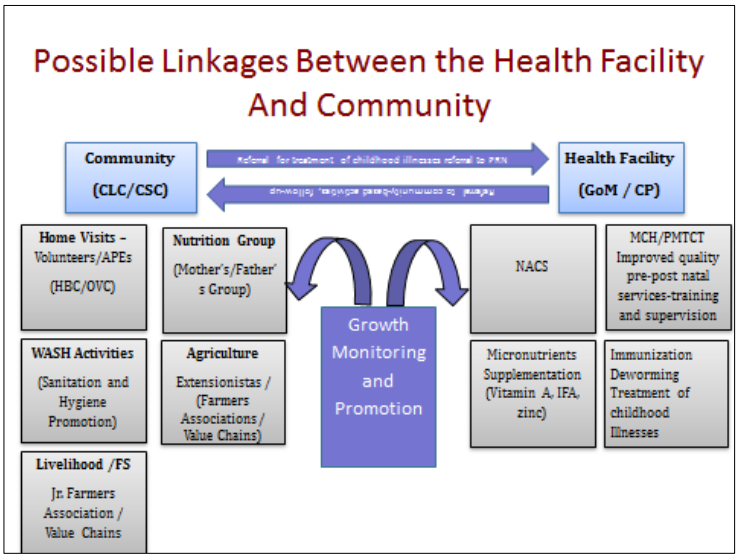
Jim Hazen and Amie Heap discussed the experience of Mozambique around creating synergy among different funding streams, investment platforms and mandates.

Key messages that emerged from the panel discussion:

- Panelists shared their hope that NACS could be scaled up and that links/referrals between the communities and clinics could be strengthened. Nutrition is a critical issue around which to initiate multi-sectoral collaboration.
- There is a tremendous amount of momentum right now around using comprehensive approaches towards nutrition programming. We need to take advantage of this to promote NACS and move the NACS agenda forward.
- What are the "low hanging fruit" for scale-up, integration, or collaboration that can be done in the next 6-12 months?
  - UN agencies are moving toward a joint partnership to tackle multi-sectoral issues of this type. This is an opportunity for NACS.
  - Similarly, the US Government, through Feed the Future, is tackling 'multi-sectoral collaboration' by working across 26 agencies doing international development work. Here is another opportunity for NACS.
  - Designing of RFAs/programs/sub-awards to include NACS programming.
  - Conducting operations research (refer to list from the research working group).
  - Incorporating NACS issues into global HIV and nutrition indicator sets.
  - Participating in the Scaling Up Nutrition (SUN) movement.
  - TOPS is about to launch an RFA for operations research and perhaps a CORE member could apply for this on the topic of how to scale up NACS.
  - NACS fits in well with global interest of using a 'life cycle' approach – this should be plugged!
- For many, NACS language is brand new; the UNICEF representative first heard it only a month ago. We need to market it better.
- UNICEF 'challenged' the audience to come up with a sexy, ear-catching, three-point message to sell NACS to non-USG entities. The need to get non-USG stakeholders on board was emphasized.
- UNICEF suggests using numbers to make the NACS pitch. Also using visuals, like the ARV message made in two photos – before and after ART.

Key messages that emerged from the Mozambique Case Study—Making Aid Work for NACS

- Mozambique had the advantage of having community-based management of acute malnutrition (CMAM) already being in place, covering children and HIV+ /HIV- adults. This provided a strong foundation for NACS. In Mozambique, the term NACS isn't used – its CMAM/PRN.
- An inclusive design process (a broad base of stakeholders) provides a better chance for integrated programming.
- One selling point of NACS is that it creates a continuum of care in which to invest resources (and leverage *additional* resources) from a variety of players.
- It is important to listen to partners, understand the gaps and identify practical ways to address them.
- Integration should not be done for integration's sake alone. There will be a trade-off (benefits *and costs*) of integration, and both have to be measured and considered.



- As we move forward, we need to provide evidence, including potential positive and negative consequences of integrated vs. non-integrated platforms.

Promising Practices #1: Lessons from the Zambia and Malawi

Session Quote

"Our experience shows how NACS ***is*** doable, and not just for PLHIV, but for the community at large."

Presenters: *Elizabeth Jere,CRS Zambia and Samson Njolomole, Partners in Health (PIH), Malawi*

Video from this session

CRS Zambia: Integrating NACS into clinical and community HIV Care.

PIH Malawi: Integrating nutrition care for an HIV-affected population, *and* the broader population.

Key lessons that emerged from this session:

CRS-Zambia:

- At facility level especially, buy-in and involvement of senior managers and administrators is critical to smooth, sustained integration of NACS into existing service delivery systems, protocols and work roles.
- NACS should place more emphasis on prevention, and less on treatment of malnutrition.
- Similarly, priority should be placed routine-izing nutrition assessment and counseling, and then secondarily on food.
- Advocate for nutrition indicators to be integrated into ART M&E systems.
- Community involvement and engagement should be a top priority.
- Explore opportunities for systematizing NACS skills, including: 1) Integration into national policies, guidelines and curricula: infant and young child nutrition (IYCN), ART, PMTCT; 2) Pre-service education for (clinical) staff; 3) Integration into HBC and OVC minimum standards, and care curricula; 4) Incorporate into continuing medical education (stagger topics over weeks); and, 5) Distance learning certification and self-study.
- Because the NACS target populations are highly vulnerable to infection and illness, programs need a system to routinely test and monitor the quality of the food commodities to detect and avoid contamination.
- Supply chain systems can be integrated into the national system, but should ensure access to food commodities by community-based HIV programs and hospices, which play an important role in identification, assessment and counseling.

PIH-Malawi:

- Village health workers are the key to success: they are responsible for assessment and monitoring of the entire community, adults and children, determining severity using MUAC and clinical indications.
- Monthly meetings to review data with staff ensures that the program meets emerging needs. PIH meets with district health officers to analyze data, identify red flags, and then follow-up with community members/households.
- A food security/livelihoods component is critical towards reducing recidivism. Program on Social and Economic Rights (POSER) serves those discharged from the food program with follow-up and assistance, and cash transfers if they meet the criteria. It helps them set up micro businesses like restaurants.
- Private sectors partnerships provide food commodities – for every chocolate bar sold by Two Degrees, money is donated to PIH for RUTF.
- Household charts are used to assess every single member of the community, taking NACS *beyond* PLHIV. This project shows how NACS is doable now, and can be brought to the wider community, not just PLHIV.

Promising Practices #2: Lessons from the Namibia, Ethiopia and Mozambique

Presenters: *Gareth Evans and Mandy Swann, LIFT*
Tina Lloren and Habtamu Fekadu, Save the Children

Session Quote

"A goat owned by many, dies of starvation. Someone needs to own and manage the referral system or it won't survive."

Video from this session

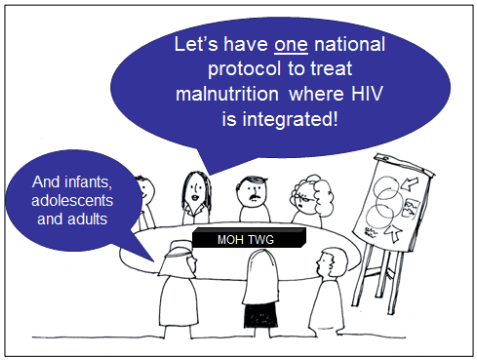
Save the Children Ethiopia and Mozambique: Integration beyond HIV -- Building on CMAM and maternal, neonatal child health (MNCH).

LIFT Ethiopia and Namibia: Linking NACS with economic strengthening and safety nets.

Key lessons that emerged from this session:

Save - Ethiopia

- NACS is scalable and demand is high.
- Screening and support scale-up was faster than the counseling.
- Harmonize guidelines from the outset.
- NACS should have a strong community component.
- Economic strengthening should be a part of NACS to graduate clients from RUTF as a longer-term strategy.
- Simplify and limit the information to be collected by busy health providers; integrate recording formats of NACS with MNCH and CMAM services, and make NACS part of CMAM/MNCH joint supportive supervision and HIV mentoring.
- Avoid the name FBP as it is food biased.
- Find alternative, cheaper and manageable treatment of MAM.



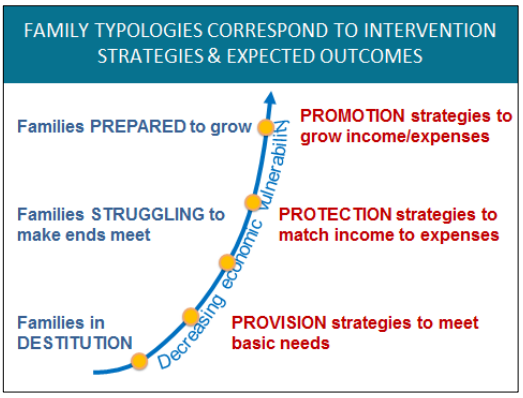
Save the Children - Mozambique

- In Mozambique, treatment of SAM using RUTF (such as Plumpy'nut) began in pediatric HIV clinics, and was expanded quickly to include all children under five under the CMAM program. The next version of the CMAM protocols (volume one) covered all children from birth to 15 years with SAM and MAM, and incorporated issues of HIV. The Ministry of Health has now drafted the second volume of the protocols for treatment of SAM and MAM in adults, incorporating issues of HIV.
- Increased collaboration among partners, donors, and funds are under one national protocol.
- There is no stigma associated with RUTF and NACS; "it is for everyone".
- HIV testing became a standard part of CMAM package, in which caretakers can opt out if they choose.
- HIV nutrition is included as a topic for community cadres.
- Challenges of the integrated approach included: 1) referral systems need to be set up; 2) HIV focus is more diluted when subsumed under broader malnutrition, as opposed to the stand alone approach; and, 3) adding HIV to CMAM reporting forms makes them more complicated.

LIFT – General

- Referrals from NACS sites to ES programs are essential to the continuum of care.
- For those NACS clients that are destitute (bottom left of box on next page), basic needs should be met first. ES in these cases should be short-term and should aim to build assets to decrease household vulnerability.
- Know your families and their vulnerabilities. Build on natural household behaviors and assets. When in doubt, strengthen money management – especially through savings.

- The approach presented here assumes that there are already ES services in place. If ES services are *not* already established in a given context, then the model will not thrive. In this scenario, LIFT's focus is to help set up these services and strengthen them where necessary.
- We still need research on what ES activities (if any) actually contribute to improved health and nutrition outcomes.



LIFT - Ethiopia

- When imbedded in clinics, case managers and community volunteers can help to reduce burden (on clinics) of tracking and reporting.
- Volunteers can also provide essential PSS to PLHIV, and can follow-up on referrals.
- It's helpful to establish a coordinating committee among clinics, private sector, PLHIV groups, ES providers, etc… Committees should meet regularly, follow-up on issues and share data.
- Increased collaboration among partners, donors, and funds under one national protocol is essential to success.
- ES should be a part of NACS to graduate clients from RUTF as a longer-term strategy
- There is a need to strengthen community linkages and provider knowledge of existing community resources

LIFT Namibia:

Formalized referral networks (NACS/ES) are just beginning to emerge. Key components of NACS/ES referral systems are:

- Community ownership of the referral process is critical.
- Mapping and Evaluation of available services.
- Assess individual patient needs and capacity.
- Identify referral points of contact—community intermediaries, government agencies, PLHIV support group, etc... These points of contact follow up on referrals and own of the process.
- Engage a 'lead organization' to conduct assessment and make referrals to community resources. Many strong NGOs and CBOs, or HIV support groups are well positioned to lead referral coordination.

Advancing the SOTA – Working Group Sessions

Moderator: *Kara Greenblott, Nzinga International*

Video of the commercials for each working group

Video of the presentations from each working group

Design Challenges I – Building Systems

Facilitator: Robert Mwadime, FHI 360

Working Group Objectives:

- To discuss challenges with the NACS framework.
- To clarify misunderstandings with regards to NACS.

Key messages that emerged:

- We need agreement among USG agencies (Global Health Initiative (GHI), Feed the Future (FtF), Office of Humanitarian Affairs (OHA), etc…) and other key donors (UNICEF, Global Fund, WHO, etc...) on what NACS is, and how it fits into various development strategies. In particular, it needs to be clear that NACS is not just for PLHIV, and not just a curative paradigm. Effort should be made to remove the current confusion. If we are confused, then outsiders will be even more confused.

- Need to bring in other kinds of assessments in addition to that of nutritional status, e.g. anemia levels, presence of non-communicable diseases, cholesterol levels, etc…
- We still need to establish: What's the goal of NACS? Is it improved nutritional status? Reduced mortality and morbidity?
- For many it's still unclear: We need communicate that NACS is an 'organizing principle' or an implementation framework. NACS is not a stand-alone project or program. We also need to clarify 'how' it goes beyond HIV.
- The group made a call for clarity, e.g. a results framework, a brief, talking points, presentations, that are consistently giving the same message defining NACS.
- On the policy side, there is a need to get NACS on the global policy agenda, as well as incorporated it into country-level nutrition strategies.
- There are ethical and practical challenges of HIV ('AIDS exceptionalism'). There is still the question of how to treat malnourished adults with PEPFAR funds if those adults are NOT HIV+. Will PEPFAR guidelines be harmonized with other guidelines? Or will they stay HIV-focused?
- We need tools: what kinds of assessments will NACS promote? Are there screening mechanisms at community level? What kinds of nutrition 'support' qualifies under NACS? Is it broader than food?
- A 'Frequently Asked Questions' on NACS would be helpful.

Design Challenges II - Service Delivery

Facilitator: Elizabeth Jere, CRS

Working Group Objectives:

- To discuss implementation issues related to NACS, based on topics raised over the past two days.
- To answer the question: How can we apply the NACS framework to our own programs?

Key messages that emerged:

- The specific roles and responsibilities of the community and clinic need to be well defined in order to avoid duplication, gaps, and double counting.
- Community health management information systems are weak and data needs to go both ways (aggregated up to national level, as well as brought back out to the community).
- NACS can help lead to more emphasis on prevention, instead of focusing on just treatment.
- Some organizations have modified the PD Hearth Model, using it for adults, not just women and infants.
- Local Determinants of Malnutrition (Tom Davis) is another model we can promote. This is about finding people with good nutrition and capturing what they do in the local behavior change communication (BCC) strategy.
- There is a lack of equipment in the clinics (e.g. scales, MUAC tapes, etc…) for full implementation of NACS.
- There is an overall challenge of using NACS without having the commodities/RUTF to give patients. We need to adapt counseling messages and promote use of locally available foods, especially where there is no RUTF.
- Along the same lines (as above), we also need to promote kitchen gardens, fruit trees, and interventions that are available immediately and link to economic strengthening.
- There are already a lot of job aids and tools for NACS (e.g. Nulife). We need a repository, website or other means of sharing them.

Establishing a Research Agenda

Facilitator: Shannon Senefeld, CRS and Ronnie Lovich, Save the Children

Working Group Objectives:

- Explore research interest and brainstorm key operations research needs.

Key research topics that emerged:

- What does it take to deliver effective counseling interventions (given practical realities) and prevention interventions? What are the most effective counseling strategies?
- Understanding the community as part of the continuum of NACS. CHWs vs. other community volunteers – effective mechanisms for delivery and support; what are feasible responsibilities?
- Linkages with other programming – what fosters effective linkages and care coordination?

- What are the longer-term outcomes of specialized components of NACS (e.g., CMAM, treatment of SAM, MAM, etc…) on targeted populations? What is the recidivism rate?
- How does the NACS framework apply throughout the lifecycle? Are there different NACS components for different life periods that should be elaborated and examined in terms of efficacy?
- How can technology help to relieve burden of health workers and what can we learn from pilots with CHWs?
- There is a need for a dedicated platform for sharing lessons learned from implementers in this area.
- What are the nutritional outcomes for PLHIV (from both a prevention point of view as well as once recovered from SAM/MAM) from linkages with food security/ES?
- How can the NACS framework be applied to MNCH programming in countries where other populations are not covered by nutrition responses? Does the degree of underlying malnutrition in the general population influence how NACS/MNCH is applied?

Guidance for NACS Implementation: Community Component

Facilitator: Phil Moses, FHI 360

Working Group Objectives:

- To gather input for the NACS Guidance, soon to be developed by FANTA.

Key messages that emerged:

Members of the two sessions broke into thematic groups (disciplines), including food security, MCHN, OVC, HIV, etc… and were asked to name one community-based activity from that group's discipline. They were then asked to explain why it would be advantageous to integrate this activity into the NACS framework; what challenges integration might pose; and what might be some solutions to those challenges. Findings were as follows:

- Of the activities selected, each *already had* a piece of NACS somewhere within the activity. Usually the 'S' (support) was there already; but also some cursory assessment or counseling existed as well.
- The advantages groups cited of NACS integration was to add more detail, rigor and quality to the existing activity, e.g. if food supplementation to pregnant and lactating women was the activity, then adding assessment and counseling could improve quality.
- Examples from OVC programming were also used: one group noted how linking children to OVC services (under the Ministry of Social Welfare) was a clear advantage of NACS integration.
- Counseling is the Achilles heel of a lot of our programming. This is also true with NACS, just as it is with GMP. Maybe the term counseling is too restrictive; it might be important to look at not only one-on-one counseling, but at counseling to groups, such PLHIV or mothers' groups. Clarification was provided: USAID considers 'counseling' be an umbrella concept, which includes 'nutrition education'. The 'counseling' component of NACS includes both one-on-one *and* group counseling.
- The issue of revisiting 'support' was raised, so that we aren't only looking at the individual, but also the family when we talk about support.

Overcoming Policy Barriers and Aid Constraints

Facilitator: Janine Schooley, PCI

Working Group Objectives:

- Explore the opportunities and constraints to advancing NACS with regards to policies and funding.
- To identify next steps to advancing the NACS agenda.

Key messages that emerged:

The group discussed a two-pronged approach:

1) Develop a two-page document and power point (as well as other necessary marketing materials) to refine our NACS message, raise awareness, minimize confusion and advocate for the NACS framework. This would be reviewed by a technical advisory group to test it out before disseminating to a larger audience.

2) Approach the Global Health Council (GHC) and Interaction to get the NACS message in front of Congress. The group felt that given the complicated structures within the USG and our various organizations, it would require pressure from Congress to push interagency collaboration towards building NACS. Ultimately, we want to get in front of people like Lois Quam at the GHI and show her that NACS can solve the problem of inter-agency collaboration.

Finally, there is a need for an ongoing coordinating mechanism at the level of our organizations. Ideas include the CORE nutrition TWG; a group led by TOPS; and other ideas are welcome. It's critical that NACS has a home as we move forward.

The Future of Food: Innovation in Food Commodities and Partnering with the Private Sector

Facilitator: Lauren Ruth, Land O'Lakes

Working Group Objectives:

- Identify betters ways to integrate NACS with commodity reporting and requisition.
- Review the current trends and innovations in local food commodity production and alternative food formats.
- Explore and brainstorm options for engaging the private sector.

This working group used a power point as an introduction to the discussion.

Key messages that emerged:

- There is currently a trend towards local procurement of food commodities, including specialized foods like corn soya blend (like HEPS) and RUTFs. Why procure locally? Some reasons include: 1) wanting to invest in the local economy, 2) sourcing from small holder farmers as an ES strategy; 3) promoting sustainability; 4) GMO is prohibited so can't import; 5) national pride.
- We need to be able to get the right food to the right people at the right time: the supply chain is often a constraint. Where the supply chain is inefficient, there can be too much supply (leading to waste or encouraging practitioners to over-prescribe), or not enough supply (not meeting demand and causing drop-out).
- It takes a long time to set up supply chains, and this needs to be taken into account in project targeting. Year one might just be assessment and counseling, with commodities starting in year two.
- Need to have data on monthly needs/use to be able to procure the right amount. In understaffed facilities, even very basic reports/requisitions can be a burden. What is the potential for task-shifting?
- Consider vouchers to buy food on the local market instead of dealing with the supply chain component?
- We can't underestimate the complexity of food programming (food formulation experts, dealing with local processing, etc...). Zambia has a somewhat competitive market, but in many countries (e.g. Kenya) the market is not competitive, and food safety is a real issue.
- When engaging in local procurement, there is often a need for capacity building to local producers and supply chain managers. This means money and training for quality control, good manufacturing practices, laboratory services, and a long list of other requirements.

The Facts about NACS

Presenters: Janine Schooley, PCI and Robert Mwadime, FHI 360

The Facts about NACS

Throughout the two-day SOTA meeting, individuals expressed confusion around what exactly NACS is, and where it fits in to existing health and nutrition structures, mandates, protocols and programs.

In an effort to clarify, Janine Schooley responded to these questions using the series of graphics at right. The first graphic is a slide from Tim Quick's second presentation. It's a good reminder of the different elements of NACS, and how NACS helps the clinic and community to work together through the use of referrals, and other formal linkages.

The subsequent three images complement the first, and establish NACS as an 'organizing framework' or a 'health systems strengthening approach', in addition to a way of linking clinic and community.

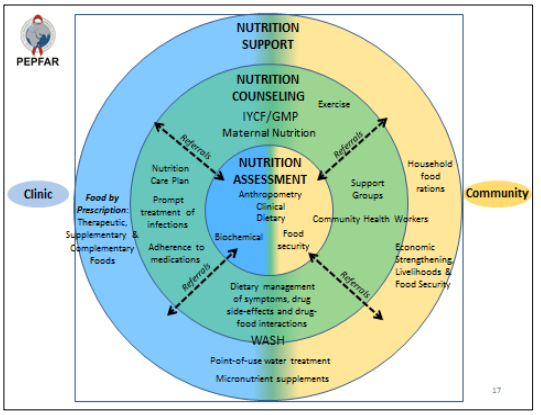
The contrast between the second and third images depicts the benefits of applying the NACS framework. In the second image, pre-NACS, the clinic co-exists within the community, along with the various programs, interventions, models, protocols (CMAM, community management of childhood illnesses (CMCI), etc…) with some cross-over activities and possible coordination, but with most actors operating independently, for the most part.

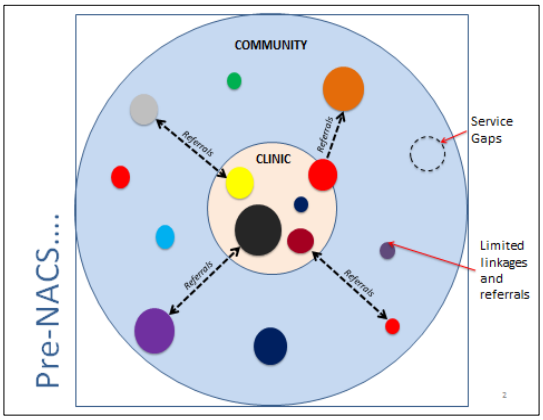
As we know, this scenario can create a burden on health care workers since they are often overwhelmed with various protocols, guidelines, M&E systems, etc., which have been imposed by various stakeholders. Pre-NACS there is potential for duplication, as well as gaps in programming. And frequently, referral mechanisms, bridging mechanisms and coordination are lacking.

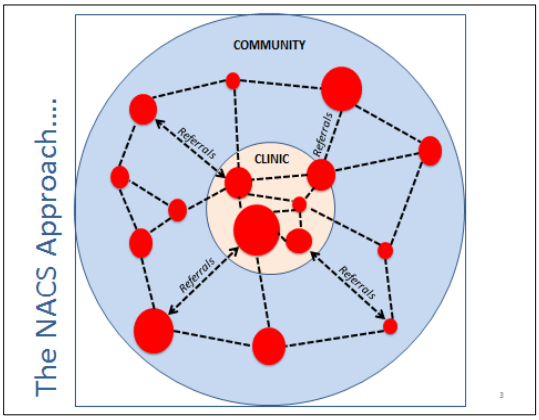
The third image represents a functioning NACS framework. NACS links all of the elements together, fills gaps, and strengthens linkages via referral mechanisms. It also ensures that not only *treatment* of malnutrition is addressed, but as importantly, NACS includes *prevention* of malnutrition.

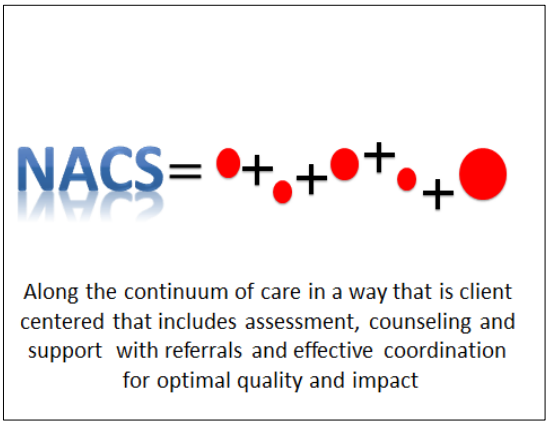
NACS does *not* add protocols; it does *not* replace existing frameworks (e.g. CMAM); and it does *not* require major changes to existing programs and interventions.

Instead, as depicted in image four, NACS adds together what is already there and helps it to function in a seamless and more comprehensive manner. NACS sums the elements "along the continuum of care in a way that is client centered, and that includes assessment, counseling and support, with referrals and effective coordination for optimal quality and impact". NACS is for all individuals: infants, children, adolescents, adults, PLHIV and non-PLHIV.









This narrative, and series of images, represents an effort to define and clarify the concept of NACS, and to convey the message that NACS, as an organizing framework, can improve our ability to create better nutrition outcomes for all.

Closing Remarks

Video of this session

Closing remarks were made by Robert Mwadime of FHI 360. Robert noted that while some partners work at the community level, and others work in the clinic, we are all working towards better nutrition for our clients. In the end; what's important is that at a minimum, we have Nutrition, Assessment, Counseling and Support served over a continuum of nutrition care. Some of the key points he mentioned were:

- **Partnerships are critical in NACS:** One agency can't do NACS alone; we rely on one another and the wide range of stakeholders to contribute their resources and expertise along the continuum.
- **NACS is for everyone:** Some participants may have come to this meeting thinking that NACS is for PLHIV. But we hope it's now clear that NACS is for everyone. With this, there will be challenges, since many of the major donors that have contributed to NACS had HIV-related objectives in mind, and sometimes used funding that was specific to HIV programming.
- **Let's do it well:** QI is a critical aspect of NACS. We need to stay open to making changes and constantly improving on quality.
- **NACS means coordination:** Robert gave the example of flooding the Kenyan market with specialized food commodities due to poor planning and coordination between Global Fund and PEPFAR players, resulting in spoilage, depressed prices, etc… A NACS framework aims to facilitate coordination and the efficient use of resources.
- **NACS is not just curative programming:** Prevention of malnutrition is a critical aspect of NACS. Nutrition assessment guides nutrition counseling, and these pieces must act facilitate the prevention of malnutrition, in addition to treating SAM and MAM.
- **Creating a demand for nutrition services:** NACS requires that we expand our focus outward from the clinics, and work with CHWs and volunteers to *create demand* for nutrition services. To date, not enough of our resources and thinking have focused outside of the clinic.
- **Linkages:** Nutrition cannot be addressed separately from health and food security. Drivers of malnutrition are multiple and varied. In many cases, the health of the individual may be more of a driver of malnutrition than anything food-related. Linkages must be made to WASH, de-worming, TB treatment, family planning, and other health related services.

Finally, NACS is *not* a methodology or tool, nor is it a project or program. It's a way of framing or organizing health and nutrition services in a manner that is flexible and adaptable to the needs of structures, protocols and mandates that exist in a given, country-specific context.

8. What's Next with NACS?

Over the course of the two-day meeting, participants cited a range of 'emerging opportunities' for advancing the NACS agenda in the coming months. Some of the key opportunities are listed below:

- **UN collaboration:** UN agencies are currently discussing how they might tackle challenges to multi-sectoral and inter-agency collaboration. Introducing NACS to them now could be timely.
- **Feed the Future:** Similarly, the US Government, through FtF, is tackling the issue of multi-sectoral collaboration by working across 26 agencies involved in international development work. Here is another opportunity for NACS.
- **FFP RFA's:** The FFP representative present at the SOTA meeting noted her desire to see NACS written into FFP RFA guidelines in the near future. She suggested that this could be a model to work on health system strengthening in nutrition. She also mentioned that if a NGO wrote NACS into a MYAP now, it would be looked upon favorably.
- **SUN Initiative:** The moment for nutrition is now! Globally, the SUN initiative offers an excellent opportunity for getting NACS on the global agenda.
- **Nutrition Profiles:** The use of Nutrition Country Profiles may be a way to get NACS message disseminated and provide a convincing argument for advancing NACS.
- **USG agencies:** The NACS SOTA included participation from representatives from PEPFAR, FFP, OHA, etc... This is a starting point for getting the USG agencies to come together around NACS.

- **NACS Guidance:** FANTA-3 will soon be developing guidance for NACS implementation. This offers an opportunity to further clarify, define NACS, as well as to educate stakeholders on its benefits.
- **Nutrition Mapping:** Bread for the World Institute is in the process of mapping out and analyzing both USG-funded and multi-lateral nutrition programs, including programs within key Feed the Future (FtF) and GHI countries, for positioning to scale up nutrition. This analysis may offer opportunities for promoting NACS as a way to scale up nutrition in targeted countries.
- **SPRING:** USAID's new five-year, $200 million nutrition program entitled Strengthening Partnerships, Results and Innovation in Nutrition Globally (SPRING) aims to promote appropriate policies and programs that enhance country nutrition programs to reach vulnerable populations, especially women, infants, and young children. SPRING has potential to be a key resource for promoting NACS to a broader audience.
- **TOPS micro grants:** TOPS is a new USAID/FFP program designed to build the capacity of FFP grantees and improve the quality of implementation by fostering collaboration, innovation, and knowledge sharing around food security and nutrition best practices. A TOPS micro grant was used to fund this SOTA meeting and there is a possibility for securing additional TOPS funding to build on the outcomes of this meeting.
- **CORE Spring Meeting:** The CORE Group spring meeting (April 30 – May 4) offers a platform for further discussion about NACS, and advancing the NACS agenda.

To capitalize on these opportunities, there is an urgent need for marketing materials that help define NACS for a global audience, and educate all stakeholders on the benefits of the NACS framework. See outcomes from the working group entitled 'Overcoming Policy Barriers and Aid Constraints' earlier in this document for more details.

Annex 1 – Meeting Agenda

Day 1: Framing NACS and the Science of Delivery		
8.00	**Arrival**	
8.30	**Welcome and Opening Remarks**	*Karen LeBan, CORE Group* *Kathryn Reider, World Vision* *Shannon Senefeld, CRS*
9.00	**Framing FBP and NACS** - From Intervention to Framework: Evolution of FBP to NACS - Introduction to the NACS framework: The big picture	*Moderator: Tim Quick, USAID* *Janet Paz Castillo, USAID* *Robert Mwadime, FHI 360*
9.45	**What does the evidence tell us?** - Current evidence of the nutrition implications of HIV and of ART - The effect of malnutrition on HIV outcomes - The evidence base for therapeutic and supplementary feeding for PLHIV	*Moderator: Tony Castleman, George Washington University* *Alice Tang, Tufts University* *Mark Manary, Washington University*
10.30	Break	
11.00	**What does the evidence tell us? *Continued…***	*Continued*
11.30	**Building NACS: The view from 60,000 feet** - Integrating Nutrition: Overcoming Liebig's Law of the Minimum - Linking Communities and Clinics - A Continuum of Care for Individuals Across the Life Cycle - A Systems Approach - NACS Beyond HIV	*Tim Quick, USAID* *Brian Njoroge, FHI 360*
12.30	**Lunch – Materials Display**	
1.30	**Delivering Quality: Experience from Uganda & Kenya** - QA along the community to facility continuum: community, clinic and inpatient services - Using a case management approach - Coaching and mentoring - QA / QI tools and process	*Moderator: Ronnie Lovich, Save the Children* *Margaret Kyenkya, NuLife Uganda* *Ram Shrestha, URC Kenya*
2.30	**Interactive Session / Discussion**	
3.00	Break	
3.15	**How Are We Measuring Up? *Creating Relevant M&E Frameworks for NACS*** - Global indicators and tools for monitoring and evaluation of NACS programs - Steps for creating a relevant NACS M&E framework - Gaps and future directions for monitoring and evaluation of NACS - Establishing data collection as part of the clinic workflow - Making data relevant at the clinic level	*Moderator:* *Amie Heap, USAID* *Presenter: Amy Stern, URC* *Panel members:* *Robert Mwadime, FHI 360* *Margaret Kyenkya, Africare* *Ram Shrestha, URC* *Tony Castleman, George Washington University* *Brian Njoroge, FHI 360* *Amy Stern, URC*
5.00	End of day	

Day 2: Advancing our Collective Work

8.00	Arrival	
8.30	**Working for Change: CORE and FANSHA** - Ice Breaker and Brief Overview of Historical Context on Integrated Programming - Historical perspective from CORE Group members and Links for Life/FANSHA Process	*Moderator:* *Janine Schooley, PCI*
8:45	**Aid Architecture, Program Streams and Policy Context** - Panel Discussion - Mozambique Case Study**:** Making Aid work for NACS - A Study in Effective Integrated Programming - Panel Discussion	*Case study presenters:* *Jim Hazen, USAID* *Amie Heap, USAID* *Panel members:* *Tin Tin Sint, UNICEF* *Judy Canahuati, USAID-FFP* *Brenda Pearson, WFP* *Laura Birx, USAID Feed the Future*
10.00	**Promising Practices: Lessons from the Field** - Introducing NACS into Clinical and Community HIV Care - Integrated nutrition care for PLHIV	*Moderator: Kara Greenblott, Nzinga International* *Elizabeth Jere, CRS Zambia* *Samson Njolomole, Partners in Health, Malawi*
10.45	Break	
11.15	**Promising Practice: Lessons from the Field** - Linking NACS with economic strengthening and safety nets *Lessons from Namibia and Ethiopia* - Integration beyond HIV: Building on CMAM and MNCH *Lessons from Mozambique and Ethiopia*	*Moderator: Ronnie Lovich, Save the Children* *Gareth Evans and Mandy Swann, LIFT* *Tina Lloren and Habtamu Fekadu, Save the Children*
12.30	Lunch -- Materials Display	
1.30	**Advancing the SOTA Block A:** Concurrent working group themes, repeated below so that each participant can select two themes to attend. **A. Design Challenges I: Building systems** (‘clinic’ style session) **B. Design Challenges II: Service delivery** (‘clinic’ style session) **C. Establishing a Research Agenda** **D. Guidance for NACS Implementation: Community Component** **E. Overcoming Policy barriers and Aid constraints** **F. The Future of Food: Innovation in food commodities and partnering with the private sector**	*Moderator:* *Kara Greenblott, Nzinga International* *Robert Mwadime, FHI 360* *Elizabeth Jere, CRS* *Shannon Senefeld, CRS and Ronnie Lovich, Save the Children* *Phil Moses, FHI 360* *Janine Schooley, PCI and Judy Canahuati, USAID* *Lauren Ruth, Land O’Lakes*
2.30	**Advancing the SOTA Block B:** A. Design Challenges I: Building systems (‘clinic’ style session)	*Same as above*

	B. Design Challenges II: Service delivery ('clinic' style session) C. Establishing a Research Agenda D. Guidance for NACS Implementation: Community Component E. Overcoming Policy barriers and Aid constraints F. The Future of Food: Innovation in food commodities and partnering with the private sector (TBD)	
3.30	Break	
3.45	Plenary report back from Working Groups (key takeaways and recommendations) and final discussion	*Facilitators and Rapporteurs*
4.45	**Summary and closing**	*Robert Mwadime, FHI 360* *Janine Schooley, PCI*

Annex 2 – Meeting Participants

First Name	Last Name	Organization
Ashley	Aakesson	PATH
Rose	Amolo	CEDPA
Nicky	Bassford	Future Generations
Sophie	Becker	Partners In Health
Hana	Bekele	JSI
Gilles	Bergeron	FHI 360
Heather	Bergmann	Social & Scientific Systems, Inc
Laura	Birx	USAID
Kendra	Blackett-Dibinga	Save the Children
Holly	Blanchard	MCHIP/Jhpiego
Charlotte	Block	Project HOPE
Ashley	Blocker	FHI360
Bart	Burkhalter	
Kimberly	Buttonow	Food for the Hungry
Judy	Canahuati	USAID
Jean	Capps	Independent Consultant
Kristen	Cashin	FHI 360
Tony	Castleman	George Washington University
Kudakwashe	Chimanya	American Dietetic Association
Alyssa	Christenson	CORE Group
Adele	Clark	CRS
Tonja	Cullen Balogun	URC
Clint	Curtis	FHI 360
Diane	De Bernardo	IMC
NENE	DIALLO	AFRICARE
Joanna	Diallo	URC
Serigne	Diene	FHI 360
Rebecca	Egan	usaid
Kali	Erickson	CARE USA
Gareth	Evans	Save the Children
Leigh Ann	Evanson	Winrock Internatonal
Habtamu	Fekadu	Save the Children USA
Mary Lou	Fisher	Samaritan's Purse
Ciro	Franco	MSH
Suzanne	Gaudreault	URC
Jill	Gay	consultant, Futures Group
Lilia	Gerberg	USAID
Kathryn	Goldman	Chemonics International
Kara	Greenblott	Nzinga International Consulting
Wendy	Hammond	FHI 360
James	Hazen	USAID

First Name	Last Name	Organization
Amie	Heap	USAID
Nicole	Henretty	Edesia
Abel	Irena	PSI
Joan	Jennings	TOPS Program
Elizabeth	Jere	Catholic Relief Services
Ann	Jimerson	Alive and Thrive, FHI 360
Maria	Kasparian	Edesia: Global Nutrition Solutions
Sonya	Kibler	Save the Children
Peggy	Koniz-Booher	JSI Research & Training Institute
Carolyn	Kruger	Project Concern International
Margaret	Kyenkya	Africare
KD	Ladd	ACDI/VOCA
Marni	Laverentz	University Research Co., LLC
Karen	LeBan	CORE Group
Judy	Lewis	Haitian Health Foundation
Tina	Lloren	Save the Children
Ronnie	Lovich	Save the Children
Carol	Makoane	PCI
Mark	Manary	Washington University
Stephanie	Martin	PATH
Corinne	Mazzeo	Consultant
Carrie	Miller	CRS
Barbara	Monahan	FHI 360
Melanie	Morrow	World Relief
Phil	Moses	FANTA-2 FHI360
Noreen	Mucha	Bread for the World Institute
Meghan	Murphy	
Haron	Muthee	USAID
Rebecca	Nerima	CORE Group
Natalie	Neumann	CORE Group
Samson	Njolomole	Partners in Health
BRIAN	NJOROGE	USAID Nutrition and HIV Program (Kenya)
Jennifer	Pearson	WFP
Anne M	Peniston	USAID
Cindy	Pfitzenmaier	PCI
Ketty	Philogene	AME-SADA
Tim	Quick	USAID
Bridget	Ralph	FHI 360
Kathryn	Reider	World Vision US
Nicole	Richardson	Save the Children
Jennie	Riley	Partners In Health
Dahal	Rojan	Blandeis
Julia	Rosenbaum	FHI360 WashPlus Project

First Name	Last Name	Organization
Lauren	Ruth	Land O'Lakes
Simon	Sadler	FHI 360
Janine	Schooley	PCI
Roseanne	Schuster	Cornell University, Division of Nutritional Sciences
Shannon	Senefeld	CRS
Ram Kumar	Shrestha	URC
Tin Tin	Sint	UNICEF
Matthew	Smith	Land O'Lakes
Meredith	Stakem	Catholic Relief Services
Angela	Stene	ABT ASSOCIATES
Amy	Stern	University Research Co., LLC
Mandy	Swann	FHI 360
Alice	Tang	Tufts School of Medicine
Manisha	Tharaney	HKI
Usha	Vatsia	Global Health Consultant
Susan	Vorkoper	Meds & Food for Kids
Monica	Woldt	FHI360
Kwaku	Yeboah	PCI
Sera	Young	Cornell University
Jennifer	Yourkavitch	MCHIP