

# 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**

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## Foreword

Over the past decade, the integration of HIV and nutrition programming has been increasingly recognized as *imperative* for 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 life-saving ARVs.

In the past several years, however, a shift has occurred. While nutrition treatment 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 nutrition supplements when necessary), as well as intervening before malnutrition occurs. Hence, the framework has evolved into an aspiration to deliver adequate prevention and treatment of malnutrition 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 work streams 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.



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## Table of Contents

Abbreviations and Acronyms .....	4
1. Executive Summary .....	5
2. Introduction and Background to NACS.....	6
3. Objectives.....	7
4. Participants.....	8
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 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.....	16
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.....	20
The Facts about NACS.....	24
Closing Remarks .....	25
8. What’s Next with NACS?.....	26
Annex 1 – Meeting Agenda.....	27
Annex 2 – Meeting Participants.....	30

## Abbreviations and Acronyms

ANC	antenatal care
ART	antiretroviral therapy
BMI	body mass index
CDC	U.S. Centers for Disease Control and Prevention
CHW	community health worker
CMAM	community-based management of acute malnutrition
CMCI	community management of childhood illnesses
CRS	Catholic Relief Services
ES	economic strengthening
ESLFS	economic strengthening, livelihoods and food security
FANTA	Food and Nutrition Technical Assistance III Project
FANSHA	Food and Nutrition Security and HIV/AIDS Advocacy
FBF	fortified-blended food
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 Project
IMAM	Integrated management of acute malnutrition
LIFT	Livelihoods and Food Security Technical Assistance Project
LNS	lipid-based nutrient supplement
M&E	monitoring and evaluation
MAM	moderate acute malnutrition
MCHN	Maternal and Child Health and Nutrition
MUAC	mid-upper arm circumference
NACS	nutrition assessment, counseling, and support
NGO	non-governmental organization
OHA	U.S. Office of Humanitarian Affairs
OVC	orphan(s) and vulnerable child(ren)
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	person or people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PSS	psychosocial Support
QI	quality improvement
RUTF	ready-to-use therapeutic food
SAM	severe acute malnutrition
SBCC	social and behavior change communication
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 state-of-the-art (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 SOTA 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 nutrition services, protocols and actors along the continuum of care, with referrals and effective coordination critical for optimal quality and impact.

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

**Partnerships are critical.** Neither nutrition assessment, nutrition counseling nor nutrition support alone is sufficient to achieve desired nutrition outcomes; the three must be combined. One agency may not be able to provide the entire range of NACS services on its own and should rely on a network of partners to contribute resources and expertise along a country-specific continuum of care.

**NACS is for everyone.** While NACS was born in the HIV context, the framework has evolved into a diverse range of nutrition-related services 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. Coordinated investment by a wide range of donors and partners will be necessary for NACS to achieve broader applicability.

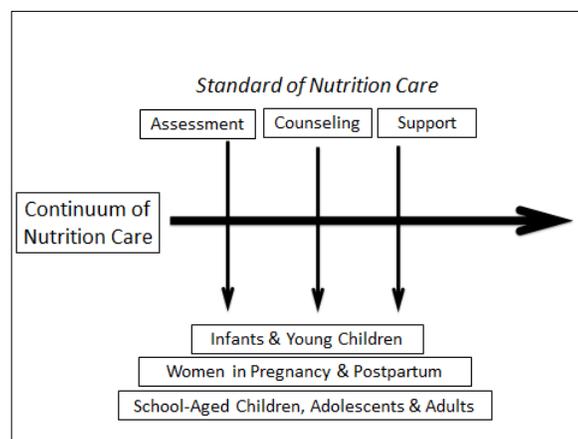
**Let's do it well.** Quality improvement (QI) is a critical aspect of NACS and should be done on a continuous basis to ensure ongoing improvement. A range of QI tools have been tried in Uganda, Kenya and other 'early adopting' countries, and these tools need to be more broadly disseminated. Likewise,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

**What is the evidence?** Programming without evidence can be irresponsible, but waiting for evidence to provide lifesaving interventions can be disastrous and unethical. In retrospect, we can now demonstrate that targeted therapeutic and 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 improved diet through consumption of locally available foods where available and connect individuals to appropriate support, including food security and economic strengthening (ES) to maintain improved nutritional status and avoid relapsing into malnutrition. Some participants advocated for extending support beyond the individual to address the food security needs of households as well.

**Demand needs to be created for nutrition services.** NACS requires that we expand our focus outward from clinics and work with community health workers (CHWs) and volunteers to build their capacity to conduct nutrition screening, assessment and counseling 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 treatment access and support ART adherence and follow up.

**Multi-sectoral linkages.** Drivers of malnutrition are multiple and varied. Health status is often more of a driver of nutritional status than food access or availability. It is important that nutrition interventions be linked to water, sanitation and hygiene (WASH), micronutrient supplementation, de-worming, TB treatment, family planning, other health-related services, and economic strengthening/livelihoods/food security (ESLFS) services in order for NACS to result in sustainable nutrition outcomes. Similarly, a dynamic and responsive agricultural sector is critical to 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 communities 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 antenatal care and prevention of mother-to-child transmission of HIV (PMTCT).
- NACS provides a platform for 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, 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 and UN and among international development partners in a given country.

Finally, SOTA participants 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 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 an 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 U.S. Government (USG) 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 nutrition assessment and counseling should be in place before specialized food products were rolled out. It was felt 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<sup>1</sup> are using the NACS approach. While the core set of NACS services is 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, in collaboration with URC/Nulife, the Regional Centre for Quality Health Care and the Uganda Ministry of Health and funded by USAID’s Office of HIV/AIDS, Bureau for Global Health.

Just over a year later, the two-day SOTA meeting in February 2012— *Getting the Knack of NACS*—represented an effort to take stock of progress, examine evidence to date and 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 was 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 the Technical and Operational Performance TOPS and the Food Security and Nutrition (FSN) Network underscored 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 included 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 programming using the NACS approach. 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

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<sup>1</sup> Cote d’Ivoire, DRC, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Tanzania, South Africa, Uganda, Viet Nam, Zambia

## 4. Participants

The SOTA meeting was attended by 103 participants from 48 organizations. Participants included CORE Group members and the TOPS FSN Nutrition Network, along with other key nutrition and HIV audiences, including representatives from USG 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 groups. 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

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### 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 was a collaborative effort between CORE Group and USG partners including the Office of HIV/AIDS, Food for Peace and the Bureau for Food Security. Gratitude was expressed to TOPS for providing the funding for the 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-2 Bridge Project, which helped with some of the organization of the meeting. Finally, Shannon Senefeld, co-chair of the HIV TWG, noted that with the move from FBP to NACS this was 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 (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 FBP programming began and evolved to the current approach that we refer to as NACS.
- Introduce the NACS approach and explain what it means within the ‘big picture’ context.

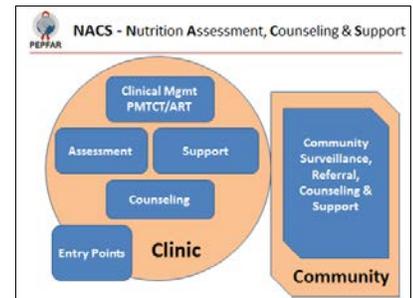
### Session description:



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 PEPFAR eligibility criteria for therapeutic feeding from body mass index (BMI) <16 to BMI <18.5.



### Key messages that emerged from the session:

- NACS is an 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 have 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 approach.

## What Does the Evidence Tell Us?

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

### Session Quote

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



### Video from this session

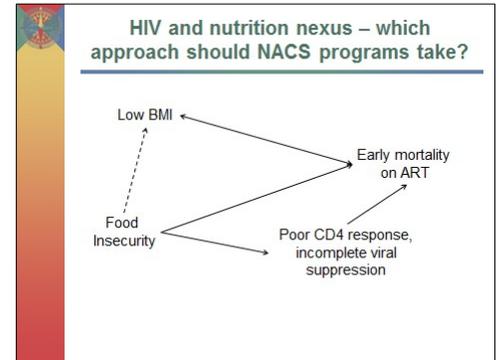
### Session Objectives:

- 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 therapeutic and supplementary feeding for PLHIV, core aspects of NACS programming.

### Key messages that emerged from the session:

- The relationship between evidence and programming is 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 among people not infected with HIV.
- What we *don't* know: 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 in some programs using the NACS approach.

### 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 is a barrier to ART uptake and adherence.
- There is an association between food insecurity and incomplete viral suppression, reduced CD4 and increased mortality.
- 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.

- HIV disease and malnutrition need to be treated simultaneously for good outcomes.
- 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 NACS: The View from 60,000 Feet

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



**Video from this session**

### 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 whom NACS targets.



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

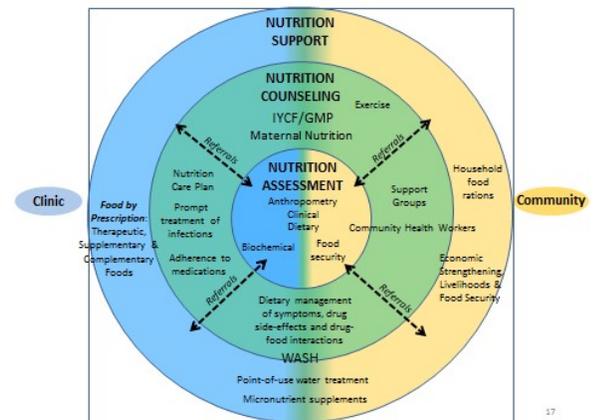
### Key messages that emerged from the session:

- While getting people on ART is our single most powerful nutrition intervention for HIV 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 women 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), micronutrient powders, safe water and food security interventions.
- Quality improvement (QI) is central to the NACS approach; we need the right people in the right jobs (and retained in those jobs) to make it work.
- If there isn’t enough emphasis on the community side, the facility side gets bottle necked. There has to be a healthy balance, with referrals upstream to clinics where necessary.
- Agriculture must be linked to NACS programming; a vibrant agriculture sector is critical to sustainable nutrition outcomes

### 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.”

The NACS Framework



## 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 the 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.

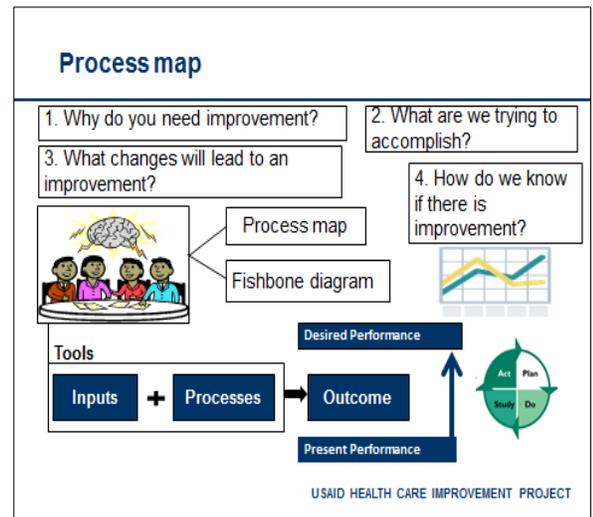


Ram Shrestha talked about how the QI method is applied in Kenya; the use of QI teams and coaches and benefits of the QI approach.

### 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 and (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 acted 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.



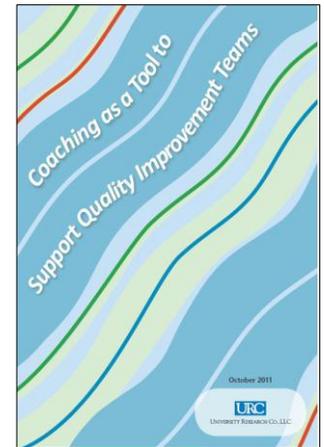
### Service delivery using the seven-step QI process:

1. Assessment using MUAC and task shifting;
2. Categorization of nutritional status;
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: a community coordinator selected to be part of the QI team at the facility and joint monthly meetings between volunteers and the community coordinator; and,
7. Education: support of implementing partners with materials for health and nutrition education and training of expert

clients to carry out health education messages.

Kenya:

- Kenya uses the same seven-step delivery process as Uganda.
- QI 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.” People are encouraged to always ask questions about whether desired change is actually happening.
- A key to the success of the QI approach is that it’s 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. NuLife staff said 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.

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## 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 Quotes**

“If you are not confused, you are not paying attention.”

“If the data is *useful* to health care staff, 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:**



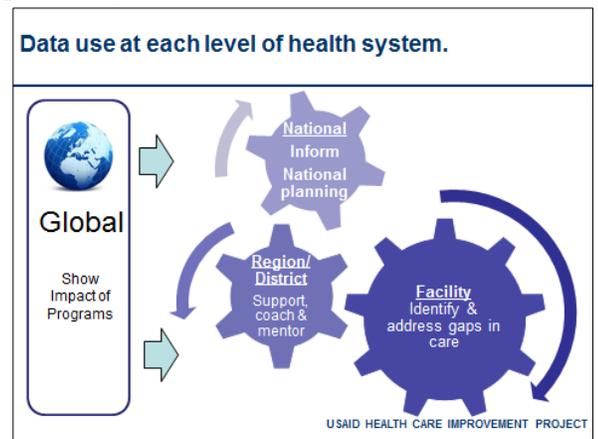
Amie Heap presented on 1) global indicators and tools for M&E of NACS programs, 2) steps for creating a relevant NACS M&E framework and 3) gaps and future directions for M&E of NACS.



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 is 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 initial set of 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 1) monitoring how many clients receiving services received nutrition assessment, 2) determining how many of those assessed were undernourished, 3) determining how many undernourished clients were counseled 4) and then determining how many of those that were malnourished received therapeutic and/or supplementary feeding.
- There are 14 NACS indicators. 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 and 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 adopted 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 focus on PLHIV? Or should we focus on people with the greatest need (with the 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.

- What is the role of men in NACS? When looking at household decision making around resources, how do we help involve men in NACS? 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 is still wearing an HIV hat. 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 Objectives:

- Provide the historical context for integrated HIV, food security and nutrition programming.
- Describe that context from the viewpoint of CORE Group members and the Links for Life/ [Food Nutrition Security and HIV/AIDS Advocacy](#) (FANSHA) group 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 and AIDS and food and 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 'siloeing' 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.

### 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."

“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.”

## 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*



**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:

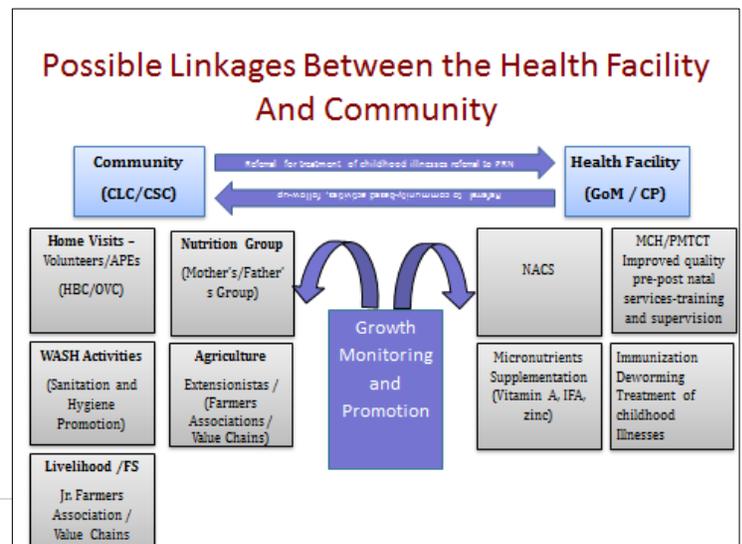
Janine Schooley facilitated a ‘conversation’ among the panel members listed above. Questions were posed by the moderator, Oprah Winfrey-style, with the inclusion of audience participation. The conversation focused on the ‘aidscape’: donors and policy makers that have made and continue to make a difference 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 the NACS approach 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 USG, through Feed the Future, is tackling ‘multi-sectoral collaboration’ by working across 26 agencies doing international development work, 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 in place, covering children and HIV+/HIV- adults. This provided a strong foundation for NACS. In Mozambique, the term NACS isn't used—it's CMAM/PRN (Nutrition Rehabilitation Program).
- 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

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



Video from this session

### Session Quote

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



**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 were critical to smooth, sustained integration of NACS elements 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 'routinizing' nutrition assessment and counseling, and then secondarily on food.
- It's very important that nutrition indicators to be integrated into ART M&E systems – this requires dedicated advocacy.
- Community involvement and engagement should be a top priority.
- Opportunities should be explored for systematizing NACS skills, including 1) integration into national policies, guidelines and curricula: infant and young child nutrition (IYCN), ART, PMTCT, 2) integration into pre-service education for (clinical) staff, 3) integration into HBC and OVC minimum standards and care curricula, 4) incorporation into continuing medical education (stagger topics over weeks) and 5) development of distance learning certification and self-study opportunities.
- Because the target populations for NACS programming 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 to reduce recidivism. The Program on Social and Economic Rights (POSER) serves those discharged from treatment of malnutrition 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 and neonatal child health (MNCH)



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

### **Key lessons that emerged from this session:**

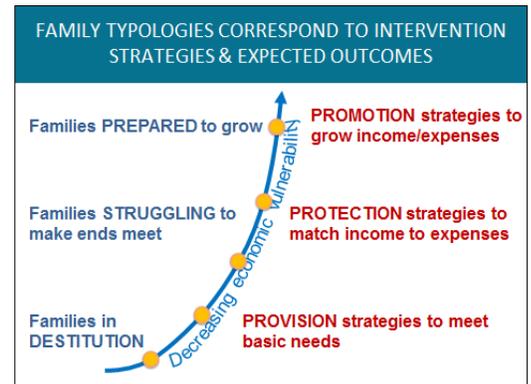
#### Save - Ethiopia

- NACS is scalable, and demand is high.
- Screening and support scale-up was faster than the counseling.
- Guidelines should be harmonized 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.
- Information to be collected by busy health providers should be simplified and limited; recording formats of NACS should be integrated with MCHN and CMAM services, and NACS should be made part of CMAM/MCHN joint supportive supervision and HIV mentoring.
- The name ‘FBP’ should be avoided because it focuses on food at the expense of the nutrition assessment and counseling that has to be in place before food is prescribed.
- Alternative, cheaper and manageable treatment of MAM is needed.



### 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 the 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) the need for referral systems, 2) a diluted HIV focus when subsumed under broader malnutrition, as opposed to the stand alone approach, and 3) the complication of adding HIV to CMAM reporting forms.



### LIFT – General

- Referrals from NACS sites to economic strengthening (ES) programs are essential to the continuum of care.
- For those NACS clients that are destitute (bottom left of box at right), basic needs should be met first. ES in these cases should be short-term and should aim to build assets to decrease household vulnerability.
- Recommendations: 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 embedded in clinics, case managers and community volunteers can help to reduce burden (on clinics) of tracking and reporting.
- Volunteers can also provide essential psychosocial support (PSS) to PLHIV and follow-up on referrals.
- It is 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.
- Mapping and evaluation of available services.
- Assessment of individual patient needs and capacity.
- Identification of referral points of contact—community intermediaries, government agencies, PLHIV support groups, etc... These points of contact follow up on referrals and own of the process.
- Engagement of 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.

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## 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, 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.
- Other kinds of assessments in addition to anthropometrics should be done for NACS clients, e.g., dietary intake, anemia levels, appetite test, presence of non-communicable diseases, cholesterol levels, food security.
- 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 to 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 to incorporate 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 does 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 need 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 social and behavior change communication (SBCC) strategy.
- There is a lack of equipment in the clinics (e.g., scales, MUAC tapes) 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 materials). We need a repository, website or other means of sharing them.

## Establishing a Research Agenda

*Facilitators: 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) 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 MCHN 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/MCHN is applied?

## **Guidance for NACS Implementation: Community Component**

*Facilitator: Phil Moses, FHI360/ FANTA*

### **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:**

- To explore 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 PowerPoint (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 better 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) prohibition on importation, and 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.
- We 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?
- Could we 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 (e.g., food formulation experts, dealing with local processing). 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 into 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.

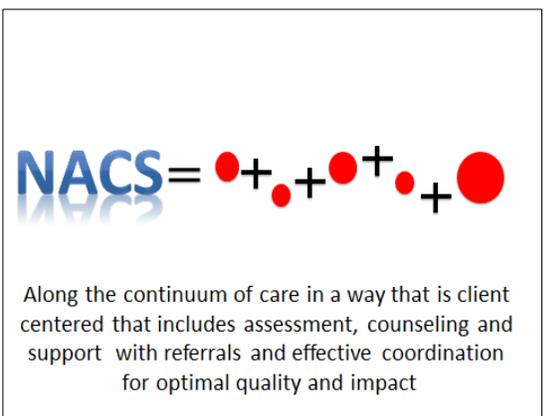
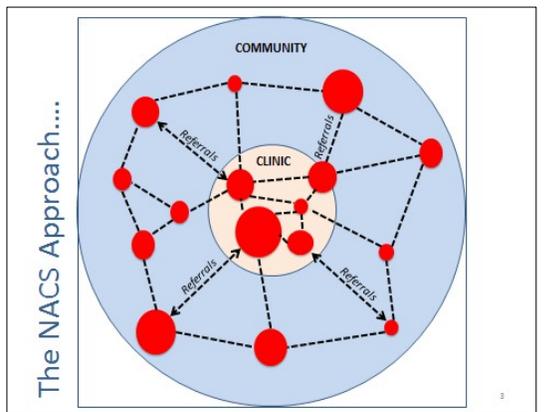
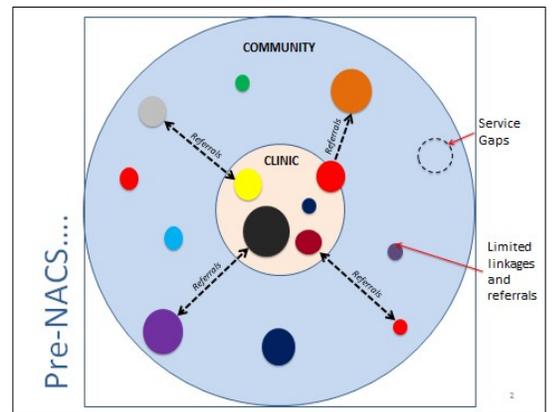
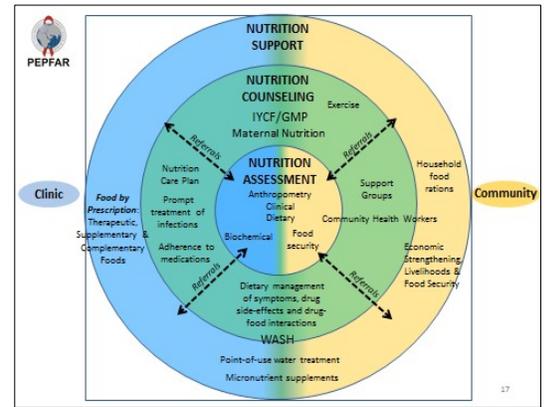
The contrast between the second and third images depicts the benefits of applying the NACS framework. In the second image, pre-NACS, the clinic co-exists within the community, along with the various programs, interventions, models, protocols (e.g., CMAM, community management of childhood illnesses [CMCI]) 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, works to identify and fills gaps and strengthens linkages via referral mechanisms. It also ensures that not only *treatment* of malnutrition is addressed, but equally important, 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 to 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 been 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 Feed the Future, 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 RFAs:** 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 an 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 and, 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 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	<b>Arrival</b>	
8.30	<b>Welcome and Opening Remarks</b>	<i>Karen LeBan, CORE Group Kathryn Reider, World Vision Shannon Senefeld, CRS</i>
9.00	<b>Framing FBP and NACS</b> <ul style="list-style-type: none"> <li>- From Intervention to Framework: Evolution of FBP to NACS</li> <li>- Introduction to the NACS framework: The big picture</li> </ul>	<i><u>Moderator:</u> Tim Quick, USAID Janet Paz Castillo, USAID Robert Mwadime, FHI 360</i>
9.45	<b>What does the evidence tell us?</b> <ul style="list-style-type: none"> <li>- Current evidence of the nutrition implications of HIV and of ART</li> <li>- The effect of malnutrition on HIV outcomes</li> <li>- The evidence base for therapeutic and supplementary feeding for PLHIV</li> </ul>	<i><u>Moderator:</u> Tony Castleman, George Washington University Alice Tang, Tufts University Mark Manary, Washington University</i>
10.30	Break	
11.00	<b>What does the evidence tell us? <i>Continued...</i></b>	<i>Continued</i>
11.30	<b>Building NACS: The view from 60,000 feet</b> <ul style="list-style-type: none"> <li>- Integrating Nutrition: Overcoming Liebig’s Law of the Minimum</li> <li>- Linking Communities and Clinics</li> <li>- A Continuum of Care for Individuals Across the Life Cycle</li> <li>- A Systems Approach</li> <li>- NACS Beyond HIV</li> </ul>	<i>Tim Quick, USAID Brian Njoroge, FHI 360</i>
12.30	<b>Lunch – Materials Display</b>	
1.30	<b>Delivering Quality: Experience from Uganda &amp; Kenya</b> <ul style="list-style-type: none"> <li>- QA along the community to facility continuum: community, clinic and inpatient services</li> <li>- Using a case management approach</li> <li>- Coaching and mentoring</li> <li>- QA / QI tools and process</li> </ul>	<i><u>Moderator:</u> Ronnie Lovich, Save the Children  Margaret Kyenkya, NuLife Uganda Ram Shrestha, URC Kenya</i>
2.30	<b>Interactive Session / Discussion</b>	
3.00	Break	
3.15	<b>How Are We Measuring Up? <i>Creating Relevant M&amp;E Frameworks for NACS</i></b> <ul style="list-style-type: none"> <li>- Global indicators and tools for monitoring and evaluation of NACS programs</li> <li>- Steps for creating a relevant NACS M&amp;E framework</li> <li>- Gaps and future directions for monitoring and evaluation of NACS</li> <li>- Establishing data collection as part of the clinic workflow</li> <li>- Making data relevant at the clinic level</li> </ul>	<i><u>Moderator:</u> Amie Heap, USAID <u>Presenter:</u> Amy Stern, URC  <u>Panel members:</u> Robert Mwadime, FHI 360 Margaret Kyenkya, Africare Ram Shrestha, URC Tony Castleman, George Washington University Brian Njoroge, FHI 360 Amy Stern, URC</i>
5.00	End of day	

## Day 2: Advancing our Collective Work

8.00	Arrival	
8.30	<p><b>Working for Change: CORE and FANSHA</b></p> <ul style="list-style-type: none"> <li>- Ice Breaker and Brief Overview of Historical Context on Integrated Programming</li> <li>- Historical perspective from CORE Group members and Links for Life/FANSHA Process</li> </ul>	<p><u>Moderator:</u> Janine Schooley, PCI</p>
8:45	<p><b>Aid Architecture, Program Streams and Policy Context</b></p> <ul style="list-style-type: none"> <li>- Panel Discussion</li> <li>- Mozambique Case Study: Making Aid work for NACS - A Study in Effective Integrated Programming</li> <li>- Panel Discussion</li> </ul>	<p><u>Case study presenters:</u> Jim Hazen, USAID Amie Heap, USAID</p> <p><u>Panel members:</u> Tin Tin Sint, UNICEF Judy Canahuati, USAID-FFP Brenda Pearson, WFP Laura Birx, USAID Feed the Future</p>
10.00	<p><b>Promising Practices: Lessons from the Field</b></p> <ul style="list-style-type: none"> <li>- Introducing NACS into Clinical and Community HIV Care</li> <li>- Integrated nutrition care for PLHIV</li> </ul>	<p><u>Moderator:</u> Kara Greenblott, Nzinga International Elizabeth Jere, CRS Zambia</p> <p>Samson Njolomole, Partners in Health, Malawi</p>
10.45	Break	
11.15	<p><b>Promising Practice: Lessons from the Field</b></p> <ul style="list-style-type: none"> <li>- Linking NACS with economic strengthening and safety nets <i>Lessons from Namibia and Ethiopia</i></li> <li>- Integration beyond HIV: Building on CMAM and MNCH <i>Lessons from Mozambique and Ethiopia</i></li> </ul>	<p><u>Moderator:</u> Ronnie Lovich, Save the Children Gareth Evans and Mandy Swann, LIFT</p> <p>Tina Lloren and Habtamu Fekadu, Save the Children</p>
12.30	Lunch -- Materials Display	
1.30	<p><b>Advancing the SOTA Block A:</b> Concurrent working group themes, repeated below so that each participant can select two themes to attend.</p> <p><b>A. Design Challenges I: Building systems</b> ('clinic' style session)</p> <p><b>B. Design Challenges II: Service delivery</b> ('clinic' style session)</p> <p><b>C. Establishing a Research Agenda</b></p> <p><b>D. Guidance for NACS Implementation: Community Component</b></p>	<p><u>Moderator:</u> Kara Greenblott, Nzinga International</p> <p>Robert Mwadime, FHI 360</p> <p>Elizabeth Jere, CRS</p> <p>Shannon Senefeld, CRS and Ronnie Lovich, Save the Children</p> <p>Phil Moses, FHI 360</p>

	<p><b>E. Overcoming Policy barriers and Aid constraints</b></p> <p><b>F. The Future of Food: Innovation in food commodities and partnering with the private sector</b></p>	<p><i>Janine Schooley, PCI and Judy Canahuati, USAID</i></p> <p><i>Lauren Ruth, Land O'Lakes</i></p>
2.30	<p><b>Advancing the SOTA <u>Block B:</u></b></p> <p>A. Design Challenges I: Building systems ('clinic' style session)</p> <p>B. Design Challenges II: Service delivery ('clinic' style session)</p> <p>C. Establishing a Research Agenda</p> <p>D. Guidance for NACS Implementation: Community Component</p> <p>E. Overcoming Policy barriers and Aid constraints</p> <p>F. The Future of Food: Innovation in food commodities and partnering with the private sector (TBD)</p>	<p><i>Same as above</i></p>
3.30	Break	
3.45	Plenary report back from Working Groups (key takeaways and recommendations) and final discussion	<i>Facilitators and Rapporteurs</i>
4.45	<b>Summary and closing</b>	<i>Robert Mwadime, FHI 360 Janine Schooley, PCI</i>

## Annex 2 – Meeting Participants

First Name	Last Name	Organization
Angela	Stene	Abt Associates
KD	Ladd	ACDI/VOCA
Nene	Diallo	AFRICARE
Margaret	Kyenkya	Africare
Ann	Jimerson	Alive and Thrive/FHI 360
Kudakwashe	Chimanya	American Dietetic Association
Ketty	Philogene	AME-SADA
Noreen	Mucha	Bread for the World Institute
Kali	Erickson	CARE USA
Elizabeth	Jere	Catholic Relief Services (CRS)
Meredith	Stakem	CRS
Rose	Amolo	CEDPA
Kathryn	Goldman	Chemonics International
Corinne	Mazzeo	Consultant
Jill	Gay	Consultant, Futures Group
Alyssa	Christenson	CORE Group
Karen	LeBan	CORE Group
Rebecca	Nerima	CORE Group
Natalie	Neumann	CORE Group
Sera	Young	Cornell University
Roseanne	Schuster	Cornell University, Division of Nutritional Sciences
Adele	Clark	CRS
Carrie	Miller	CRS
Shannon	Senefeld	CRS
Nicole	Henretty	Edesia
Maria	Kasparian	Edesia: Global Nutrition Solutions
Meghan	Murphy	Face To Face
Phil	Moses	FANTA/FHI360
Gilles	Bergeron	FANTA/FHI 360
Kristen	Cashin	FANTA/FHI 360
Clint	Curtis	LIFT/FHI 360
Serigne	Diene	FANTA/FHI 360
Wendy	Hammond	FANTA/FHI 360
Barbara	Monahan	LIFT/FHI 360
Bridget	Ralph	FANTA/FHI 360
Simon	Sadler	FANTA/FHI 360
Mandy	Swann	LIFT/FHI 360
Ashley	Blocker	FANTA/FHI360
Monica	Woldt	FANTA/FHI360
Brian	Njoroge	FHI 360 (Kenya)

<b>First Name</b>	<b>Last Name</b>	<b>Organization</b>
Julia	Rosenbaum	WashPlus Project/FHI360
Kimberly	Buttonow	Food for the Hungry
Nicky	Bassford	Future Generations
Tony	Castleman	George Washington University
Usha	Vatsia	Global Health Consultant
Judy	Lewis	Haitian Health Foundation
Manisha	Tharaney	Helen Keller International (HKI)
Diane	De Bernardo	International Medical Corps (IMC)
Jean	Capps	Independent Consultant
Hana	Bekele	JSI
Peggy	Koniz-Booher	JSI Research & Training Institute
Matthew	Smith	Land O'Lakes
Lauren	Ruth	Land O'Lakes
Jennifer	Yourkavitch	MCHIP
Holly	Blanchard	MCHIP/Jhpiego
Susan	Vorkoper	Meds & Food for Kids
Ciro	Franco	Management Sciences for Health (MSH)
Kara	Greenblott	Nzinga International Consulting
Sophie	Becker	Partners In Health
Samson	Njolomole	Partners in Health
Jennie	Riley	Partners In Health
Ashley	Aakesson	PATH
Stephanie	Martin	PATH
Carol	Makoane	PCI
Cindy	Pfitzenmaier	PCI
Janine	Schooley	PCI
Kwaku	Yeboah	PCI
Carolyn	Kruger	Project Concern International
Charlotte	Block	Project HOPE
Abel	Irena	PSI
Mary Lou	Fisher	Samaritan's Purse
Kendra	Blackett-Dibinga	Save the Children
Gareth	Evans	Save the Children
Sonya	Kibler	Save the Children
Tina	Lloren	Save the Children
Ronnie	Lovich	Save the Children
Nicole	Richardson	Save the Children
Habtamu	Fekadu	Save the Children USA
Heather	Bergmann	Social & Scientific Systems, Inc
Joan	Jennings	TOPS Program
Alice	Tang	Tufts School of Medicine
Tin Tin	Sint	UNICEF
Bart	Burkhalter	University of North Carolina
Marni	Laverentz	URC

<b>First Name</b>	<b>Last Name</b>	<b>Organization</b>
Tonja	Cullen Balogun	URC
Joanna	Diallo	URC
Suzanne	Gaudreault	URC
Ram Kumar	Shrestha	URC
Amie	Heap	USAID
Laura	Birx	USAID
Judy	Canahuati	USAID
Rebecca	Egan	USAID
Lilia	Gerberg	USAID
James	Hazen	USAID
Haron	Muthee	USAID
Anne M.	Peniston	USAID
Tim	Quick	USAID
Mark	Manary	Washington University
Jennifer	Pearson	WFP
Leigh Ann	Evanson	Winrock Internatonal
Melanie	Morrow	World Relief
Kathryn	Reider	World Vision US
Amy	Stern	URC