Community-based Management of Acute Malnutrition (CMAM) Programme in Niger - Management of severe acute malnutrition - Preschool-age children (Pre-SAC)

Programme: Community-based Management of Acute Malnutrition (CMAM) Programme in Niger

Programme Data

Programme Description

The Community-Based Management of Acute Malnutrition (CMAM) is one of World Vision's core project models in nutrition. The CMAM approach enables community volunteers to identify and initiate treatment by referring children with acute malnutrition before they become seriously ill. Caregivers provide treatment for the majority of children with severe acute malnutrition (SAM) in the home using Ready-to-Use-Therapeutic Foods (RUTF) and receiving routine medical care at a local health facility. When necessary, severely malnourished children who have medical complications or lack an appetite are referred to in-patient facilities for more intensive treatment. CMAM programs also work to integrate treatment with a variety of other longer-term interventions such as Nutrition Education, Infant and Young Child Feeding and Food Security. These interventions are designed to reduce the incidence of malnutrition and improve public health and food security in a sustainable manner.

There are four key components to the CMAM approach: Community Mobilisation, Supplementary Feeding Program (SFP), Outpatient Therapeutic Program (OTP), and Stabilisation Centre/In-patient Care (SC). On the most part, World Vision does not set up Stabilisation Centres but instead works closely with existing local health institutions or medical NGOs to provide these services.

World Vision has been operational in Niger for almost two decades – implementing a wide range of long-term development activities across the country. Their work is structured alongside the model of comprehensive area development programs (known internally as ADPs). Each ADP has a Health & Nutrition component which seeks to deliver support through (while simultaneously strengthening) local health structures. In July 2005 and as a result of the 2005 food crisis in Niger that year, World Vision launched a community-based management of acute malnutrition (CMAM) program based on the National Protocol for the Management of Acute Malnutrition. At that time, contacts were made with Valid International – aimed at establishing a partnership for an effective and quality delivery of the CMAM program. An institutional agreement between World Vision and Valid International was reached in July 2006, thus paving the way for the provision of technical support to the Niger CTC (now called CMAM) program.

As a part of the national nutrition strategy, WV is currently implementing CMAM in many decentralized government health centers throughout the country, with the support of partner NGOs (ex. Medecins Sans Frontieres). From the onset of CMAM program implementation, It has been integrated within the Ministry of Health structures such as the CSIs (Integrated Health Centers) with regular trainings of MOH health staff at national, regional and CSI levels based on the most revised version of the National Protocol, ultimately leading to the final version (i.e. Protocole Nationale de prise en Charge de la Malnutrition. MOH Publique/UNICEF/OMS. Juin 2009).

Program type

National

Cost

Currency: US Dollars (USD)Purposes: Salaries & Benefits; Supplies & Materials; Travel & Transportation; Training & Consulting; Monitoring & Evaluation; Occupancy; Communications; Equipment.Action: Covers all actions

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Community-based Management of Acute Malnutrition Model: http://www.wvi.org/nutrition/project-models/cmam

Implementing organisations

- Government
  - Health
  - Details:
    more
    Gouvernement du Niger et la Direction Departementale de la Sante Publique et la Direction de la Nutrition (DN/MSP)

Funding sources

- Government
  - Health
  - Details:
    more
    Gouvernement du Niger et la Direction Departementale de la Sante Publique et la Direction de la Nutrition (DN/MSP)

Action data

Start date	July 2005
Country(ies):	Niger
Status:	On-going
Area:	Urban Rural
Place:	5 regions (Zinder, Maradi, Niamey, Tillabéri, Tahoua)
Topic:	Management of severe acute malnutrition
Target group:	Preschool-age children (Pre-SAC) SAM child
Age group:	6-59 months
Delivery:	Community-based
Implementation details :	World Vision works with communities through Area Development Programs (ADPs) that have been identified and implemented based on a series of development criteria. The ADPs serve as the basic intervention unit of the WV's multi-sectoral programs/projects (e.g. in education, water and sanitation, health, income-generating activities and sponsorship of children etc.), but the geographical areas of the ADPs do not necessarily align with administrative boundaries of the country. The whole ADP and program management structure is geared toward long-term development programming, into which the nutritional activities/programs such as Community-based Management of Acute Malnutrition (CMAM) are integrated. Since July/August 2005, WV Niger has been implementing and supporting the following four components of a CMAM program: 1. Community Mobilization 2. Outpatient Therapeutic Program (OTP) for children U5 suffering from Severe Acute Malnutrition (SAM) without medical complications 3. Stabilization Centre (SC) for children U5 suffering from SAM and Moderate Acute Malnutrition (MAM) with medical complications (in partnership with other NGOs)

4. Supplementary Feeding Program (SFP) for children U5 suffering from MAM without medical complications and for moderately malnourished Pregnant and Lactating Women (PLWs)

All programmatic activities are implemented through the local health structures and systems and their respective catchment areas. The majority of the OTP and SFP activities are implemented in the Integrated Health Centers (CSI) but in order to achieve greater coverage and to bring supplementary facilities closer to communities, WV has also implemented the programs in Health Posts (CS) which are satellites of CSI. Most OTP take place together with SFP in CSI but few are located in CS as well. The OTP activities, including the provision of Ready-to-Use Therapeutic Food (Plumpy Nut) and the systematic treatments are conducted on a weekly basis, whereas the SFP activities, including the distribution of Fortified Blended Food (Premix with CSB (Corn Soya Based), oil, sugar) for MAM children and moderately malnourished PLWs are carried out bi-monthly basis. The numbers of OTP and SFP sites and staff per ADP differ depending on the target population size and needs.
The technical (nutrition related) and managerial structure of WV in Niger (WVN) includes two nutrition coordinators (East and West) and six regional nutrition supervisor mangers (one per region) who coordinate and harmonize nutritional activities through the different locations. All of them are supported by a relief-nutrition country manager based in Niamey. In each ADP, there is also a health-nutrition manager who is responsible for overseeing ADP related health and nutrition programs and staff. As the national health system is WV's principle partner, WVN staff always work in partnership/collaboration with Ministry of Health (MOH) staff. Currently, WVN staff mainly act as technical facilitators and help with the general management of the program activities such as site organization, training of the community volunteers who help during distributions, channeling food and medical supplies coming from UNICEF and WFP, and program monitoring. Depending on the ADP, there is also either one or two nurses who provides support to the MOH staff in the field.

Target population size : ADP Name Total Population; 6-59 months Kornaka West 68,165; 15,261 Gobir Yamma 56,032; 12,934 Ouallam 572,377; 188,745 Simiri 186,528; 76,805

Coverage level (%): Zinder: April-May 2007, point coverage = 21.4% and period coverage = 36.1%.

Outcome indicator(s):

OTP Outcome
Cured % (#)
> 75%
Died % (#)
< 10%
Defaulted % (#)
< 15%
Non-recovered % (#)
Regions

Reporting Period: 2010

Maradi (June-Dec)
74.5 (1540)
0.7 (14)
6.9 (143)
17.9 (371)
Niamey (Aug-Dec)
83.3 (445)
0.4 (2)
3.6 (19)
12.7 (68)
Tahoua (Aug-Dec)
86.6 (453)
1.0 (5)
10.3 (54)
2.1 (11)
Tillaberi (Jan-Dec)
86.4 (912)
1.5 (16)
11.0 (116)
1.1 (12)
Zinder (Jan-Dec)
83.6 (799)
4.3 (41)
10.0 (96)
2.1 (20)

Reporting Period: Jan - Dec, 2011

Maradi
93.5 (4510)
0.3 (16)
4.9 (235)
1.3 (62)

Niamey
NA
NA
NA
NA
Tahoua
84.2 (1054)
0.8 (10)
5.8 (72)
9.3 (116)
Tillaberi
85.5 (1484)
1.6 (27)
10.8 (187)
2.1 (37)
Zinder
94.8 (1803)
0.5 (9)
3.2 (61)
1.5 (29)

Reporting Period: Jan - Dec, 2012

Maradi
97.7 (2651)
0.1 (3)
1.5 (41)
0.7 (18)
Niamey
86.9 (839)
0.3 (3)
5.4 (52)
7.5 (72)
Tahoua
84.7 (762)
1.6 (14)
10.4 (94)
3.3 (30)
Tillaberi
89.1 (886)
1.7 (17)
8.4 (83)
0.8 (8)
Zinder
98.8 (4200)
0.3 (12)
0.1 (6)
0.8 (32)

Reporting Period: 2013

Maradi (Jan-Apr)
94.6 (546)
0.5 (3)
3.3 (19)
1.6 (9)
Niamey (Jan-May)
70.1 (129)
0.0 (0)
18.5 (34)
11.4 (21)
Tahoua (Jan-May)
92.7 (281)
0.0 (0)
4.6 (14)
2.6 (8)
Tillaberi (Jan-Mar)
95.8 (46)
0.0 (0)
4.2 (2)
0.0 (0)
Zinder (Jan-May)
99.6 (1254)
0.2 (3)

0.1 (1)
0.1 (1)

M&E system:	Ongoing monitoring and evaluation of CMAM programs is essential for ensuring program targets are being reached. As of Spring 2010, WV is using a consolidated online database management system for CMAM programs. The system is a positive transformation from the existing Excel spreadsheets (template provided by Valid International) that were used during the first few years of WV CMAM programming by National Offices. A simple and systematic data management system allows multi-level program managers to easily retrieve CMAM data and make quick and accurate decisions based on the data that is available to them. In the early days of WV CMAM implementation, prompt access the Excel database was limited to the field staff throughout the year. However, WV's online CMAM system aims to facilitate this overall data recovery process for WV Staff located in the National, Regional and Support Offices, and Global Health Centre, as well. The online system is carefully designed to be user friendly and applicable for WV staffs across partnership. Staff members are provided with password protected login identification and can access the different online pages that are relevant to their job responsibilities. In this way, they are able to input their monthly tally sheets, generate clear reports, predict future trends (including resources), provide timely input to all internal/external requests and access raw data sheets for further analysis. Furthermore, the quantitative indicators and data collection tools closely align themselves with what has been developed and used by different MOH, facilitating a simple integrating with existing administrative systems and standards in a particular country. All WV CMAM indicators and data collection tools have been standardized to complement the existing myriad of MOH and National Office requirements, as well as the International benchmarks (e.g. SPHERE). In addition to these standard indicators, the CMAM database also includes WV contextual data (e.g. # Registered Children, # Orphans & Vulnerable Children) that is mandatory with the Partnership's Integrated Program Management.
Baseline:	Sept - Oct, 2005: National GAM 15.3%, SAM 1.8%; Zinder GAM 16.1%, SAM 1.2%. Sept, 2006: Maradi GAM 8.2%, SAM 0.8%, U5M 1.3/10,000. Oct - Nov, 2006: National GAM 10.3%, SAM 1.4%, U5M 1.08/10,000, Exclusive breastfeeding 2.2%, Complementary feeding (6-9mos) 78.4%; Zinder GAM 9.7%, SAM 1.7%; Maradi GAM 6.8%, SAM 0.6%; Tahoua GAM 12.5%, SAM 1.1%; Tillaberi GAM 11.2%, SAM 1.9%; Niamey GAM 9.2%; SAM 0.5%. June, 2007: National GAM 11.2%, SAM 1%, U5M 0.71/10,000; Tillaberi GAM 11.2% Oct - Nov, 2007: National GAM 11.0%, SAM 0.8%, U5M 1.81/10,000, Exclusive breastfeeding 9.0%, Complementary feeding (6-9mos) 78.4%; Zinder GAM 11.7%, SAM 1.0%, U5M 3.55/10,000, EB 9.7%, CF 68.2%; Maradi GAM 10.7%, SAM 0.8%, U5M 0.83/10,000, EB 7.6%, CF 73.9%; Tahoua GAM 13.1%, SAM 0.4%, U5M 1.62/10,000, EB 15.7%, CF 89.7%; Tillaberi GAM 7.9%, SAM 1.0%, U5M 3.14/10,000, EB 1.6%, CF 63.5%; Niamey GAM 9.9%, SAM 0.9%, U5M 1.57/10,000, EB 17.1%, CF 40.6%. June-July, 2008: National GAM 10.7%, SAM 0.8%, U5M 1.53/10,000; Zinder GAM 15.7%, SAM 1.9%, U5M 2.13/10,000; Maradi GAM 9.9%, SAM 1.0%, U5M 1.79/10,000; Tahoua GAM 8.4%, SAM 0.6%, U5M 1.67/10,000; Tillaberi GAM 10.1%, SAM 0.1%, U5M 1.11/10,000; Niamey GAM 6.8%, SAM 0.9%, U5M 0.34/10,000. May-June, 2010: National GAM 16.7%, SAM 3.2%; Maradi GAM 19.7%, SAM 3.9%; Zinder GAM 17.8%, SAM 3.6%; Tillaberi GAM 14.8%, SAM 2.7%. June, 2009: National GAM 12.3%, SAM 2.3%. Oct, 2010: Maradi GAM 15.5%, SAM 4.3% MAY, 2013: TILLABERRI GAM 13.3%, SAM 3.1% ZINDER GAM 11.7%, SAM 2.3% MARADI GAM 16.3%, SAM 3.0% TAHOUA GAM 13.1%, SAM 2.3% NIAMEY GAM 11.0%, 1.6%
Post-intervention:	See above
Outcome reported by social determinants:	Vulnerable groups Sex
Personal story:	Zeinaba Abdoulahi lost her second child five years ago at the age of 4; his death is still a source of grief for this young Nigerien mother. Earlier this year, her fourth child, Tinoumoune, was close to death. The eight-month old girl was dehydrated and losing weight. After treating her with traditional herbal remedies, Tinoumoune continued to become physically weaker and weaker and had a fever for eight days. Zeinaba says "My child was between life and death. She was fading away. I had not a droplet of hope." Zeinaba bundled her daughter on her back and left early in the morning to walk the seven kilometres from her village to the closest health centre, which runs a community-based management of acute malnutrition (CMAM) programme supported by World Vision. Tinoumoune was diagnosed with severe acute malnutrition and admitted to the nutrition programme, where she was treated with ready-to-use therapeutic food. "In two weeks, she regained weight and became stronger and healthier. I'm very happy." explains Zeinaba. The family has been spared the grief of a second lost child.

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Mma Halima is a CMAM community volunteer in Niger. She started in this role after caring for her own malnourished son until he graduated from World Vision's CMAM programme. Mma Halima screens and refers malnourished children in her nomadic community and provides health and nutrition education. She describes the ripple effect of her son's rehabilitation through CMAM: "Now in my community all the mothers are using mosquito nets and our children are not getting sick as before. Now I have only two malnourished children in my community. It is impressive."

Typical problems	Solutions
Supplies	Problem: There had been some difficulties in ensuring a consistent supply of RUTF. The nutritional commodities for the treatment of SAM are supplied via UNICEF through the MOH supply structure. But there were some challenges due to logistical and organisational issues, including the local/global availability of RUTF. Solution: WV established a buffer stock to resolve the issue.
Supplies	Problem: A lack of consistent supply of medicines to the CSIs risks the increase in morbidity and mortality from illnesses such as pneumonia and malaria which are major causes of mortality in malnourished children. The care of children under the age of five are free in Niger. However, there are frequent shortage in medicinal supply. Because of the exemption of the fee and the system of cost recovery are in place, in principle UNICEF does not provide for the medicines for activities related to CMAM program although some spot supplies are available they are often inadequate. Solution: WVN is, already involved in the provision of medicines through the activities of ADP and, in case of need, the support will be intensified during this period of crisis. In addition to the routine medicines used for the treatment of the children admitted in the OTP, it would be important that WVN also considers to provide, in the event of rupture, the medicines needed to treat the pathologies associated with malnutrition.
Staff skills/training	Problem: When CTC/CMAM was launched in Niger in 2005/2006, the national/international capacity available for CTC/CMAM implementation was very limited, resulting in a low quality program. Solution: WV developed an Instituational Agreement with Valid International to build their capacity in the overall management of acute malnutrition.
Staff retention	Problem: Due to the erratic funding cycles associated with CMAM programming, it was very difficult to retain staff (Community Mobilization volunteers, MOH staff and WV Staff) when funding cycles terminate. Furthermore, there are difficulties retaining volunteers and keeping them motivated to continue their activities. Solution: WVN established permanent positions, embedded within their ADP and National management structures, for ongoing CMAM program support, including during funding disruptions. Furthermore, WVN can help improve sustainability of the self governing of CSIs and management of volunteers by building capacity of the village health committees (COGES) as an ongoing development commitment.

Typical problems	Solutions
Insufficient staff	Problem: In order to respond to the increased case load of SAM, the capacity of MOH (e.g. staff at CSIs) had to be increased. Solution: Rather than placing WV staff to manage the increased caseload, WV provided training and on-going support to strengthen volunteer capacity to manage SFP which will reduce workload of the health staff in the CSI thereby enabling them to address the more severe cases of malnutrition. This strategy appeared to be very effective in helping the MOH to cope with the case load. For Example: In three of the four CSIs sampled, it was found that the volunteers managed SFP completely thus relieving the existing CSI staff to manage SAM cases.

Other actions from same programme

Community-based Management of Acute Malnutrition (CMAM) Programme in Niger - Prevention or treatment of moderate malnutrition - MAM child

Community-based Management of Acute Malnutrition (CMAM) Programme in Niger - Food distribution/supplementation - Lactating women (LW)|Pregnant women (PW)|Pregnant/lactating women with HIV/AIDS (PLWHA)

Community-based Management of Acute Malnutrition (CMAM) Programme in Niger - Nutrition education - Adolescents

eLENA Link

Treatment of dehydration in children with severe acute malnutrition