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

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

References


Rapport De La Mobilisation Sociale Dans Le Cadre Du Redémarrage des Activités Du Programme De World Vision de?Prise en charge Communautaire de la Malnutrition Aiguë Régions de Zinder, Maradi et Tillabéri, Niger (13 Juin au 8 Juillet, 2010), Allie Norris et Gabriele
<table>
<thead>
<tr>
<th>Implementing organisations</th>
<th>Funding sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bilateral and donor agencies and lenders</td>
</tr>
<tr>
<td></td>
<td>- Australian Agency for International Development (AUSAID)</td>
</tr>
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<td></td>
<td>- Canadian International Development Agency (CIDA)</td>
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<tr>
<td></td>
<td>- The Canadian International Development Agency (CIDA) is Canada's lead agency for development assistance. <a href="http://www.acdi-cida.gc.ca/home">http://www.acdi-cida.gc.ca/home</a></td>
</tr>
<tr>
<td></td>
<td>- Swedish International Development Cooperation Agency (SIDA)</td>
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<tr>
<td></td>
<td>- The Swedish International Development Cooperation Agency (Sida) is a government organization under the Swedish Foreign Ministry responsible for administering approximately half of Sweden's budget for development aid. <a href="http://www.sida.se/English/">http://www.sida.se/English/</a></td>
</tr>
<tr>
<td></td>
<td>- US Agency for International Development (USAID)</td>
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<tr>
<td></td>
<td>- The United States Agency for International Development (USAID) is the United States federal government agency primarily responsible for administering civilian foreign aid.</td>
</tr>
</tbody>
</table>

- International NGOs
  - World Vision International
    - World Vision is a global Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. http://www.wvi.org (WV Canada, WV US, WV Taiwan, WV UK, WV New Zealand, WV Germany, and WV Switzerland are support offices)

- UN
  - United Nations Children's Fund (UNICEF)
    - The United Nations Children's Fund (UNICEF) is the main UN organization defending, promoting and protecting children's rights. UNICEF works to improve the social and economic conditions of children by increasing children's access to health care, safe drinking water, food, and education; protecting children from violence and abuse; and providing emergency relief after disasters. http://www.unicef.org
  - World Food Programme (WFP)
    - The World Food Programme (WFP) is the United Nations' frontline agency in the fight against hunger. It responds to emergencies, saving lives by getting food to the hungry fast, and it also works to help prevent hunger in the future. http://www.wfp.org (The WFP provides WVN direct supply of food for SFP in different CSI).

**Action data**

<table>
<thead>
<tr>
<th>Start date</th>
<th>July 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country(ies)</td>
<td>Niger</td>
</tr>
<tr>
<td>Status</td>
<td>On-going</td>
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</tbody>
</table>
Area: Urban  
Rural

Place:  
5 regions (Zinder, Maradi, Niamey, Tillabéri, Tahoua)

Topic:  
Management of moderate malnutrition

Target group:  
MAM child  
Preschool-age children (Pre-SAC)

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 (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 = 28.5% and period coverage = 49.0%.

Outcome indicator(s):  
<table>
<thead>
<tr>
<th>SFP Outcome Regions</th>
<th>Cured % (#)</th>
<th>Died % (#)</th>
<th>Defaulted % (#)</th>
<th>Non-recovered % (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt; 75%</td>
<td>&lt; 3%</td>
<td>&lt; 15%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reporting Period: 2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maradi (Sept-Dec)</td>
<td>88.5 (491)</td>
<td>0.4 (2)</td>
<td>8.6 (48)</td>
<td>2.5 (14)</td>
</tr>
<tr>
<td>Niamye (Jan-Dec)</td>
<td>88.6 (194)</td>
<td>0.0 (0)</td>
<td>1.4 (3)</td>
<td>10.0 (22)</td>
</tr>
<tr>
<td>Tahoua (Aug-Dec)</td>
<td>86.4 (248)</td>
<td>0.0 (0)</td>
<td>13.6 (39)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Tillaberi (June-Dec)</td>
<td>88.4 (501)</td>
<td>0.7 (4)</td>
<td>10.2 (58)</td>
<td>0.7 (4)</td>
</tr>
<tr>
<td>Zinder (Jan-Dec)</td>
<td>90.8 (640)</td>
<td>2.6 (18)</td>
<td>5.4 (38)</td>
<td>1.3 (9)</td>
</tr>
</tbody>
</table>

Reporting Period: Jan - Dec, 2011

|                      | Reporting Period: Jan - Dec, 2012 |
| Maradi              | 97.0 (7069)   | 0.0 (3)    | 2.2 (162)       | 0.7 (51)             |
| Niamye              | 85.8 (1949)   | 0.2 (5)    | 7.7 (175)       | 6.3 (143)            |
| Tahoua              | 92.1 (1413)   | 0.0 (0)    | 6.3 (96)        | 1.6 (25)             |
| Tillaberi           | 93.7 (4413)   | 0.2 (9)    | 5.1 (242)       | 0.9 (44)             |
| Zinder              | 95.6 (4825)   | 0.4 (18)   | 2.4 (119)       | 1.7 (84)             |
### Maradi

<table>
<thead>
<tr>
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<th>99.0 (9559)</th>
<th>0.0 (0)</th>
<th>0.4 (38)</th>
<th>0.6 (54)</th>
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<tr>
<td>Niamey</td>
<td>81.3 (1886)</td>
<td>0.0 (0)</td>
<td>10.0 (233)</td>
<td>8.7 (201)</td>
</tr>
<tr>
<td>Tahoua</td>
<td>90.1 (984)</td>
<td>0.2 (2)</td>
<td>7.7 (84)</td>
<td>2.0 (22)</td>
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<tr>
<td>Tillaberi</td>
<td>88.7 (2065)</td>
<td>0.2 (4)</td>
<td>9.7 (226)</td>
<td>1.4 (33)</td>
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<tr>
<td>Zinder</td>
<td>94.9 (5508)</td>
<td>0.1 (3)</td>
<td>2.6 (148)</td>
<td>2.5 (143)</td>
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**Reporting Period:** 2013

### Niamey (Jan-Apr)

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<th>97.1 (1501)</th>
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### Tahoua (Jan-May)

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<tr>
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<th>88.7 (344)</th>
<th>0.0 (0)</th>
<th>9.0 (35)</th>
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### Tillaberi

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<thead>
<tr>
<th></th>
<th>NA</th>
<th>NA</th>
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<th>NA</th>
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</thead>
</table>

### Zinder (Jan-May)

|              | 99.7 (2910) | 0.0 (0) | 0.2 (6)  | 0.1 (2) |

### 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 to 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 1.87/10,000; Tillaberi GAM 10.1%, SAM 0.1%, U5M 1.11/10,000; Niamey GAM 6.8%, SAM 0.9%, U5M 0.94/10,000. May-June, 2010: National GAM 16.7%, SAM 3.2%; Maradi GAM 19.7%, SAM 3.9%; Zinder GAM 17.8%, SAM 3.8%; 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%

### Post-intervention:

See above

### Outcome reported by social determinants:

Vulnerable groups

### Typical problems

**Solutions**

Problem: The lack of a consistent supply of nutritional commodities for SFP has put children suffering from MAM at an increased risk for relapse, non-response, deterioration in status (into SAM) and defaulting. This lack of consistency has also negatively affected the credibility of the SFP program within the community. In turn, this has reduced the overall number of caregivers accessing the SFP services and thus has become a barrier to access. Solution: Contingency planning by the Food Commodity Department and logistics within WV to avoid stock shortage. For example add an extra percentage onto projected estimations each month in order to always have stock in place.

### Supplies

**Typical problems**

**Solutions**

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**Typical problems**

**Communication**

Problem: The lack of clarity over the use of RUSF (Ready-to-Use Supplementary Food) and the target group has introduced increased risks for MAM cases in more vulnerable age groups. These cases were not being treated properly, thereby reducing effectiveness of the SFP program. Solution: Clarification with written protocols on the use of RUSF and other nutritional commodities for MAM and the target groups should be made available in the CSIs. It is also essential that there is community sensitization/awareness in the CSI catchment communities on the MAM aspect of CMAM.

**External factors**

Problem - Conflicting admission criteria: Community Volunteers (Femmes Relais) screen children for MAM in the communities using MUAC. However, upon arrival to the CSI/CS, the same children are admitted into the program on the basis of W/H criteria (outlined in National Protocol). Due to the discrepancies between W/H and MUAC screening, children are rejected from the program. This can reduce the effectiveness of community mobilization because of the problem of rejection. Solution: In order to increase coverage of the program a mass screening was carried out in the 5 regions covered by WV. Over 40,000 children were screened which resulted in a subsequent increase in the SFP admission.

**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 Institutional Agreement with Valid International to build their capacity in the overall management of acute malnutrition.

**Insufficient staff**

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.

**Solutions**

**External factors**

Problem: Distance as a barrier to access. Some of the CSI are located very far from the communities that they are serving. Solution: Expand MAM treatment (i.e. SFP) to Health Posts (CS) in order to reduce distance travelled for beneficiaries thus helping to improve the program accessibility as well as reducing the work load in CSIs (however the program capacity must be assured before decentralising these services to health posts).

**Staff retention**

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 - Management of severe acute malnutrition - Preschool-age children (Pre-SAC)


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

**Links to policies in GINA**

Plan National D'Action Pour La Nutrition
Supplementary feeding in community settings for promoting child growth

Food supplementation in children with moderate acute malnutrition