The Community-Based Management of Acute Malnutrition (CMAM) program 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 (e.g., Médecins Sans Frontières). 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

Formation sur la Prise en charge Communautaire de la Malnutrition Aiguë (PCMA) ADP de Zinder & de Tillabéri (20 juin au 19 juillet, 2010); ADP de Maradi (20 Juin au 8 Juillet, 2010), Lionella Fieschi, Consultante PCMA et Bernadette Feeneey, Valid International.


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

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

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

### Action data

<table>
<thead>
<tr>
<th>Start date</th>
<th>July 2010</th>
</tr>
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<tbody>
<tr>
<td>Country(ies):</td>
<td>Niger</td>
</tr>
<tr>
<td>Status:</td>
<td>On-going</td>
</tr>
<tr>
<td>Area:</td>
<td>Urban, Rural</td>
</tr>
<tr>
<td>Place:</td>
<td>5 regions (Zinder, Maradi, Niamey, Tillabéri, Tahoua)</td>
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<tr>
<td>Topic:</td>
<td>Nutrition education and counselling</td>
</tr>
<tr>
<td>Target group:</td>
<td>Adolescents, Adult men and women, Elderly, Family (living in same household), Females, Lactating women (LW), Males, Non-pregnant women (NPW), Non-pregnant, non-lactating women (NPNLW), Pregnant women (PW), Pregnant/lactating women with HIV/AIDS, Women of reproductive age (WRA)</td>
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<tr>
<td>Delivery:</td>
<td>Community-based</td>
</tr>
<tr>
<td>Implementation details :</td>
<td>Once the main components of the CMAM programme (e.g. OTP and SFP) have been well implemented in the existing MOH and community structures, a focus was given to address the negative behavioural and adaptive issues around IYCF in order to prevent further malnutrition. Depending on the priorities and funding availability, some ADPs were able to integrate IYCF activities</td>
</tr>
</tbody>
</table>
in the CMAM. These included carrying out weekly health and nutrition session on CMAM days at the CSIs (Health Centers) and reactivating PD Hearth approach to develop menus using new types of locally available foods for complementary feeding promotion. Additional objectives of IYCF included strengthening existing nutrition systems and capacity building through training of health workers and community volunteers on IYCF and carrying out a baseline survey on IYCF and quarterly monitoring of changes in behaviour (e.g. EBF rates, diversity of food groups in complementary feeding).

However, apart from the weekly nutrition education sessions at the CSIs, some of the activities did not translate into action at the community level. For example, the training of national WV staff on IYCF did not cascade down to the community level with community volunteers and also did not translated into activities or development of monitoring tools at community level. Additionally, no baseline IYCF information was available and quarterly monitoring data had not been collected or was unavailable at community level.

NB: This program was funded for a year therefore continuation of the activities beyond the funding period is likely be sporadic as it will depend on various factors including staff and volunteer capacity and motivation.

**Target population size:** See outcome indicator section

**Coverage level (%):** NA

**Outcome indicator(s):** For Tillaberi and Niamey regions in July 2010-July 2011:

Nutrition education (incl. IYCF): Target 24,700; Achieved (by the 3rd quarter) 14,234

Number and percentage of infants 0-6 mos who are exclusively breastfed: Target 310 (10%);

Achieved N/A

Number and percentage of children aged 6-24 mos who receive foods daily from 4 or more food groups: Target 3045 (40%); Achieved N/A

**M&E system:**

Due to a lack of monitoring and reporting it was not possible to report on Infant and Young Child Feeding activities apart from nutrition education sessions at the health centers even if these activities had been occurring in an informal manner in the communities. But it appears that these activities had been strengthened and expanded towards the end of the programme cycle.

**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%

**Post-intervention:** Same as above

**Outcome reported by social determinants:** Vulnerable groups

**Other lessons learnt:** WV Niger?s implementation of IYCF activities into the ongoing CMAM program started late in the program period. Due to the high resource (human & financial) intensity of implementing a CMAM program, it was not feasible to introduce IYCF activities until the latter program stages. At the beginning of the program, the MOH staff were trained in providing nutrition education sessions at CSIs on OTP/SFP days which included IYCF messages. Later on, national WV staff were trained on IYCF with the aim that they would cascade this training to the ADP level and then to the community level. However, the training did not continue to the community level (with community volunteers) until near end of the program period.

To strengthen IYCF component of CMAM including monitoring activities, the following activities are recommended:

1. Recruit community mobilisers at ADP level who will work with district Community Focal Points, WV ADP and National Community Mobiliser. The lack of WV community mobilisers at ADP level to work alongside the Nutrition Coordinators has risked a delay in training community volunteers and may have also prevented the implementation of community mobilization activities including IYCF activities and monitoring of these activities.

2. Ensure women are represented in nutrition programs. During the IYCF investigation the 50/50 presence of women as interviewers for the IYCF investigation ensured better access to women and thus the provision of more rigorous information regarding IYCF practices.

3. Develop monitoring tools for IYCF. E.g. How many IYCF sessions held and how many participated?

4. Carry out a representative and statistically significant baseline and final IYCF survey for EBF
Typical problems

Management

Problem: Some of the IYCF activities were not carried out effectively and implemented late in the program period. Solution: From the beginning it was not clear who was responsible for rolling out the IYCF activities. At national level it appeared to have been the responsibility of the Nutrition Coordinator, Community Mobiliser and Health and Nutrition Manager, whereas at ADP level the responsibility lay with the ADP managers. This lack of coordination or agreement may have contributed to the non-achievements of some of the IYCF objectives. Therefore, it is suggested that point person to be designated at both national and ADP levels. Furthermore, as there are no community mobilisers at ADP levels, recruitment of community mobilisers is also suggested so that they can partly be responsible for IYCF activities in addition to providing support for other activities.

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 - Prevention or treatment of moderate malnutrition - MAM child

Links to policies in GINA

Plan National D'Action Pour La Nutrition