

ORIE Research Summary

Nutrition Research in Northern Nigeria

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How to strengthen a Community-Based Management of Acute Malnutrition programme in northern Nigeria

This summary highlights findings and recommendations from operation research on a Community-Based Management of Acute Malnutrition (CMAM) programme in northern Nigeria.

The treatment and prevention of severe acute malnutrition via the CMAM programme is one of four outputs of the UK Department for International Development funded *Working to Improve Nutrition in Northern Nigeria* (WINNN) programme. This output aims to deliver effective treatment for severe acute malnutrition through local health systems in collaboration with communities.

WINNN is implemented by UNICEF, Action Against Hunger (ACF) and Save the Children International (SCI), in partnership with the Federal Government of Nigeria and the state governments of Jigawa, Katsina, Kebbi,

Yobe and Zamfara. SCI is responsible for its implementation in Zamfara, Kebbi and Katsina states, and ACF is responsible for its implementation in Jigawa and Yobe states.

Each of the five WINNN states implements the CMAM programme in three Local Government Areas (LGAs). The CMAM services are currently provided in 79 Outpatient Therapeutic (OPT) centres and 15 Inpatient Therapeutic (IPT) centres, across the five states. As of April 2014, the WINNN CMAM programme had admitted 58,515 children aged 6-59 months, which exceeded their cumulative target levels by 46%.

Despite the high level of acceptance of CMAM services within communities, WINNN has identified several key challenges for the sustainability and effective delivery of the CMAM programme. There are currently relatively high programme default rates. Additionally, there are implementation challenges at the community, LGA and state levels that might impact on the long-term sustainability of the CMAM programme and its integration into the primary health care system.

Research objectives

Operations research was carried out to:

- determine opinions and perceived benefits of the WINNN CMAM programme amongst mothers and fathers of CMAM beneficiaries and programme staff; →

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The WINNN CMAM service includes:

1. Community outreach, for the early identification and referral of severe acute malnutrition (SAM) and later follow-up;
2. Outpatient care for children with SAM without medical complications at health facilities and at home (Outpatient Therapeutic, OPT);
3. Inpatient care for children with SAM, and medical complications or no appetite (Inpatient Therapeutic, IPT);
4. Treatment of SAM with ready-to-use-therapeutic-food (RUTF).

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- identify the common reasons for beneficiaries defaulting from the programme, and the challenges they face in accessing CMAM services;
- understand what is required to ensure workloads of Health Workers (HW) and Community Volunteers (CVs) are manageable and their motivation and long-term commitment to the CMAM programme remains high;
- understand what is required to successfully integrate CMAM into the primary health system.

Research approach

The CMAM operations research was conducted in two LGAs in two of the five WINNN states: Jigawa and Zamfara. Data were collected through 24 focus group discussions (FGDs) and 44 in-depth interviews. FGDs were conducted with mothers of CMAM beneficiaries – both those who had and had not defaulted from the CMAM programme. FGDs were also conducted with CMAM community volunteers (male and female). In-depth interviews were facilitated with State and LGA level officials, health workers (management and front line positions in the CMAM programme), and fathers of CMAM beneficiaries (defaulters and non-defaulters). The community level FGDs and interviews were facilitated with four interviewee strata: (1) urban high/moderate defaulter areas; (2) rural high/moderate defaulter areas; (3) urban low defaulter areas; and (4) rural low defaulter areas.

Perceptions of the programme

Overall, beneficiary opinions of the CMAM programme were highly positive across all interview strata and across both states, for which the Government was given credit. It was felt to contribute to community progress and to save children's lives.

Other perceived benefits of the CMAM programme at the community and health systems levels were that it brought people into the health care system; reduced care-seeking from herbalists and traditional healers; increased the status of health care workers and community volunteers in the community;

and mothers of CMAM beneficiaries were educated on general health issues and the causes of malnutrition.

There was a perception that CMAM is well integrated with other programmes in the health care system, and particularly with childhood immunisation. Respondents were positive about this integration because other interventions are delivered on CMAM days along with the ready-to-use-therapeutic-food (RUTF) and treatment drugs. This includes health education and advice on specific preventive behaviours such as antenatal advice for mothers, hygiene education, infant and young child feeding (IYCF), family planning and HIV counselling. These interventions were perceived to contribute to an overall improvement in maternal and child health status in the communities through the prevention, detection and treatment of other illnesses as well as SAM.

Barriers to attendance and causes of defaulting

The key barriers to attendance identified by all interview strata were distance to a CMAM facility, drug or RUTF stock-outs, lack of transport, and a lack of support from husbands (some of whom forbid their wives from attending or did not/could not provide transport money). Women often had to travel long distances to attend CMAM clinics, in some cases incurring transportation costs they could not afford. These barriers, when compounded by long waiting times at the health facility, made women disinclined to make a return visit. They were especially disinclined to make a return visit if they had experienced, or had heard rumours of, stock-outs of RUTFs or medicines, or their child's health had improved.

Reasons specific for defaulting included the perception that a child is healthy after few weeks of treatment and no longer needed RUTF, distance from the health facilities or lack of transportation, and the death of a registered CMAM beneficiary (child) or poor maternal health, maternal death or the birth of another child.

Amongst some mothers, there was a mistrust of the safety of RUTF or its true purpose (for example, some believed that it might reduce

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fertility in the child receiving it). Competing demands for the woman's time, such as other household chores, ceremonies and travels, were also cited as reasons for defaulting. Some mothers who had defaulted from the programme also stated they did not know that it was important to complete the treatment regime.

Implementation challenges

Community volunteers

Community volunteers (CVs) were perceived by all interview strata to be vital for the success of the CMAM programme. The CVs however face constraints in undertaking their role. As volunteers, they do not receive remuneration for their work, and many had to leave their income generating activities to carry out CMAM duties, while at the same time incurring transportation costs. CVs, especially male CVs in both states, wanted to be given more responsibility in the CMAM programme than their current role allowed. Some CVs also felt that some of the tasks they had been asked to do were culturally inappropriate, such as a man measuring the mid-arm circumference of a child – of a woman he did not know.

Although the CVs in Zamfara appreciated efforts made to motivate them, including occasional monetary tokens, many CVs felt that more could be done.

Concerns were raised by some CVs and community leaders that the de-motivating factors may create a reluctance to take on the role of CV by other community members; because a reputation is growing that it involves hard work without monetary rewards. CVs who continued to faithfully carry out their responsibilities did so because of their religious convictions, a desire to contribute to community development, and to save the lives of children.

Health workers

Government officials and health workers in both study states were concerned about the insufficient number of trained health workers in CMAM health facilities. To meet the high demand for CMAM, it is often necessary to recruit health workers from other facilities on CMAM days to manage the heavy workload. However, health workers from other facilities



Jane Miller/DFID

did not always turn up as assigned, or were not always trained in CMAM activities. Frequent health worker redeployment also puts additional pressure on the CMAM programme, especially when CMAM trained health workers are replaced by those who are untrained. At the time of the research, the focus of training was primarily on health workers in health facilities currently delivering CMAM services.

Sustainability and integration

At the time of the research, Zamfara was the only WINNN state in which LGAs had committed monthly counterpart funds for CMAM. In late 2014, the WINNN focal LGAs in Jigawa and Katsina made similar commitments for LGA counterpart funding for CMAM. These earmarked funds are to secure adequate resources and establish mechanisms for financial sustainability in the absence of partners. →

A child is checked for signs of malnutrition in Katsina State, Nigeria, March 2011

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«Develop and implement plans for capacity and systems strengthening, especially at the LGA level, to ensure a constant supply of RUTF and essential drugs through effective forecasting, timely delivery of sufficient supplies and safe storage.»

In Zamfara, government respondents also reported some additional factors that may have contributed to sustainability. This includes funds donated by some members of the community; a meeting convened in Abuja by UNICEF for LGA and state level government officials; the awareness raised with both the LGA Chairmen and Emir; the visible impact of CMAM on children with SAM; and a desire at the state level to own and sustain the programme.

As mentioned above CMAM was perceived as well integrated into the primary health care system, because other programmes are delivered along with CMAM. There were few mentions, however, of wider health systems integration beyond this service delivery. CMAM was perceived to be a programme not required by everyone and therefore the current model of having dedicated CMAM days, as with antenatal care days, was seen as appropriate.

Recommendations for WINNN

1. Improve access to the CMAM programme by encouraging communities to identify ways of providing transport for children needing CMAM treatment; and increase coverage of CVs in rural areas for early identification of SAM cases.
2. Develop and implement plans for capacity and systems strengthening, especially at the LGA level, to ensure a constant supply of RUTF and essential drugs through effective forecasting, timely delivery of sufficient supplies and safe storage.
3. Design and test strategies of material and non-material incentives for CVs, including providing means of transportation for them to reach remote areas or facilitating indirect mechanisms that would serve to improve livelihoods or reduce their losses.
4. Review strategies for health worker training. This may include more frequent CMAM-specific trainings, or integration of CMAM training into a standard health worker training syllabus and/or other trainings.
5. Consider the feasibility of supporting or advocating for the establishment of mechanisms that would ensure financial sustainability of CMAM across the WINNN states.

ORIE and WINNN

ORIE is an independent component of the UK Government's Department for International Development (DFID) funded Working to Improve Nutrition in Northern Nigeria (WINNN) programme. WINNN is working to improve the nutritional status of 6.2 million children under five years of age in five states of northern Nigeria. ORIE is carrying out research to determine the impact of WINNN and generate important research on key evidence gaps regarding solutions to undernutrition in northern Nigeria.

Credits

This ORIE Research Summary is based on the CMAM operations research report by Olutayo Adeyemi, Wasiu A. Afolabi, Isaac Akinyele (late), Elaine Ferguson, Jenna Hoyt, Hussiani Lawal, Rasheed A. Okunola, Jayne Webster, and Cynthia Yohanna-Dzingina. Readers are encouraged to quote and reproduce material from ORIE Research Summaries in their own publication. In return, ORIE requests due acknowledgement and quotes to be referenced as above.

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