SEVERE ACUTE MALNUTRITION MANAGEMENT IN NIGERIA

ACF INTERNATIONAL

CHALLENGES, LESSONS & THE ROAD AHEAD
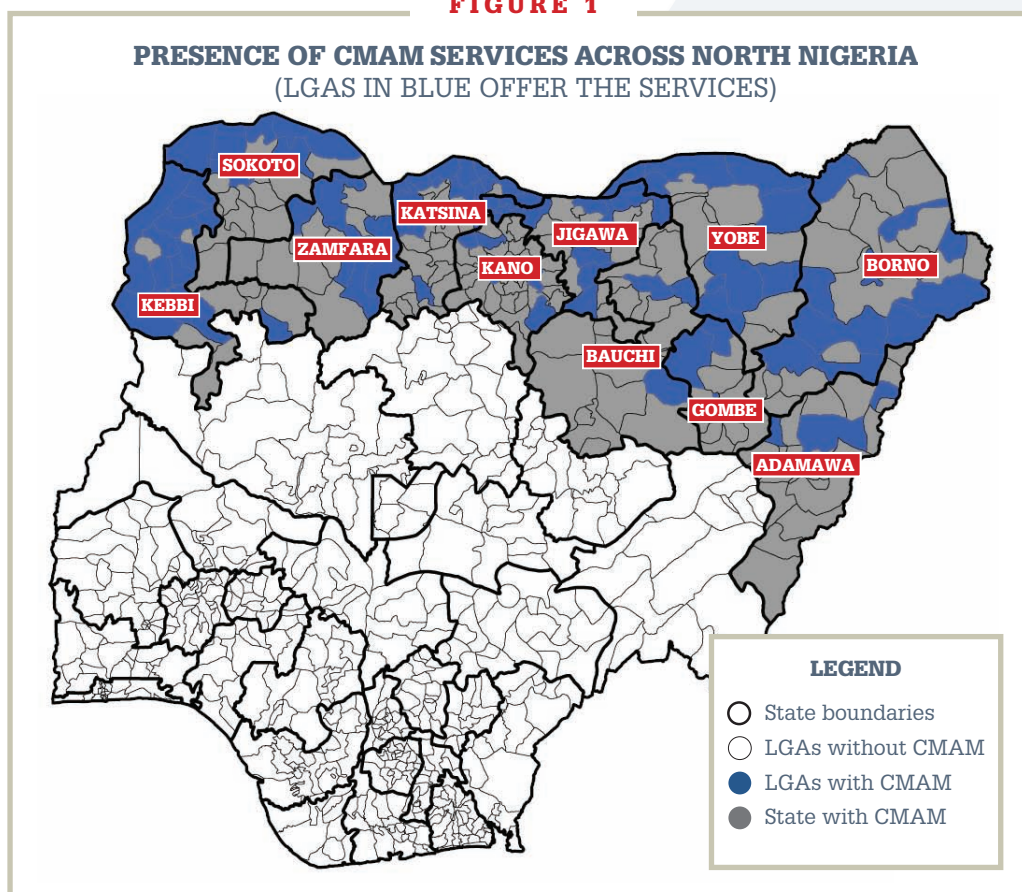

Severe Acute Malnutrition (SAM) is a critical problem in Nigeria. It has been estimated that 10% of the global SAM population is found in Nigeria (approximately 2 million children), with 60 to 80% of them living in the Northern part of the country. According to the National Demographic and Health Survey (NDHS), between 2003 and 2008 all regions of the country experienced an increase in SAM prevalence and the absolute number of cases. In 2009, a pilot programme in Gombe and Kebbi states introduced Community-based Management of Acute Malnutrition (CMAM), an approach that has delivered positive results worldwide in the provision of services to malnourished children from a communitarian perspective.

Today, Nigeria is entering a key stage in its fight against SAM. It has scaled-up the availability of CMAM to eleven states of the North, and has admitted over 800,000 kids under 5 years of age between 2009 and mid-2014. As of March 2015, more than 640 Health Facilities in 91 Local Government Areas (LGA) offer CMAM services free of charge. In 2014, the reported cure rate for children enrolled in the programme was above 75%, a threshold of high performance that is internationally acknowledged.

Nevertheless, there is still work to be done. Recent assessments of CMAM coverage in the region, coupled with analysis of available data, have contributed to the identification of key intervention

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FIGURE 1

PRESENCE OF CMAM SERVICES ACROSS NORTH NIGERIA
(LGAS IN BLUE OFFER THE SERVICES)

LEGEND

○ State boundaries
○ LGAs without CMAM
● LGAs with CMAM
● State with CMAM

areas upon which strategic action can and needs to be planned and implemented. In 2014, Action Against Hunger produced "SAM in Nigeria: Challenges, Lessons and the Road Ahead".

This summary highlights the main findings and recommendations of that review. **Two out of every three SAM cases in Nigeria are not accessing treatment.** CMAM services across the 11 northern states are reaching an estimated 36.6% of SAM cases. Combined with a cure rate that averages below 80%, this means that only a fraction of SAM children in the region is receiving effective treatment. Any scaling-up initiative should consider the capacity of absorption of current health facilities offering SAM treatment, as well as the feasibility to deploy more resources across other health facilities.

SAM treatment services are located in states with the greatest need, but the spread of services within those states remains limited. Most states only offer SAM treatment services in less than half their Local Government Areas (LGAs) and in an average
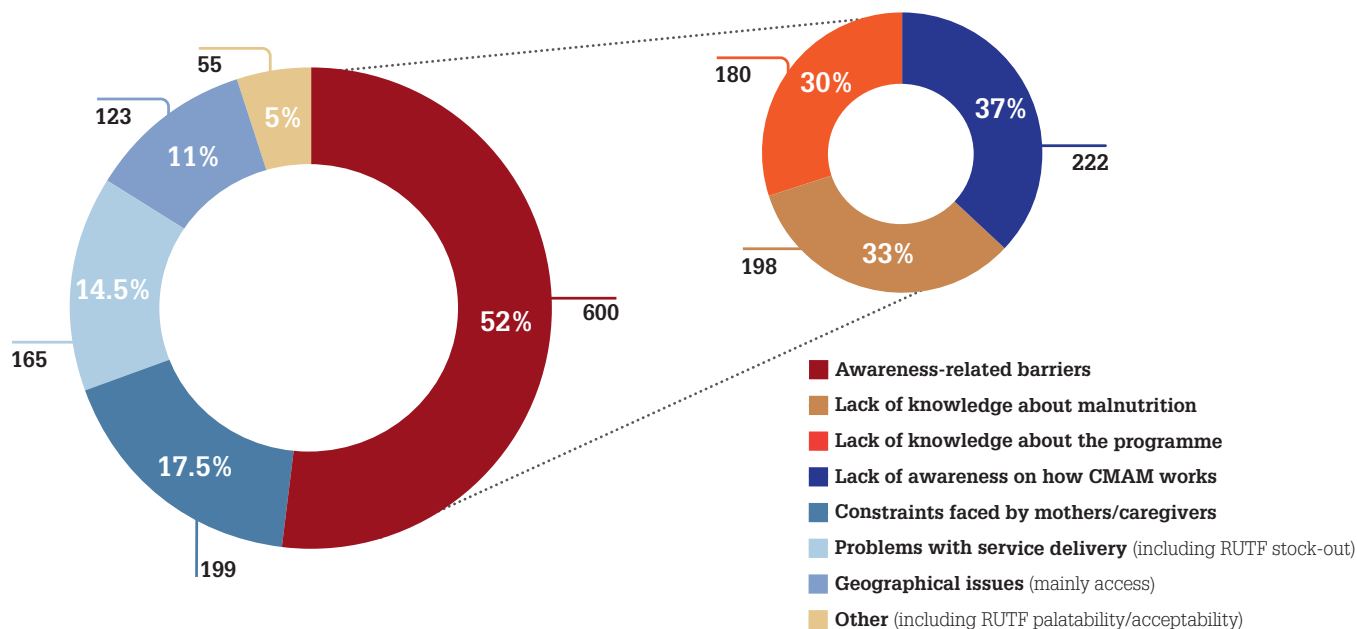
of six health facilities in these LGAs due to important resource constraints. Moreover, the performance is not homogeneous, and both state-to state and intra-state disparities suggest that additional efforts should be made to optimise service-delivery.

Expanding CMAM services to more facilities is important, but availability is not the same as accessibility. An accurate mapping of current needs in combination with short-term actions represents the basis of a scale-up strategy that could genuinely improve service quality in the region. Supportive actions need to be matched to expansive measures so that both coverage and quality of service delivery are improved.

Awareness about SAM and CMAM services can and must be improved. Lack of awareness was found to be the most important barrier preventing access to treatment across all states and is one of the leading causes of defaulting. It currently limits the options of caregivers when seeking care and it creates confusion regarding eligibility and functioning of CMAM services.

FIGURE 2

**WEIGHT OF BARRIERS TO ACCESS TO CMAM SERVICES AS
IDENTIFIED BY THE SQUEAC ASSESSMENTS**
(10 SQUEACS COMBINED)

Legend:
- Awareness-related barriers
- Lack of knowledge about malnutrition
- Lack of knowledge about the programme
- Lack of awareness on how CMAM works
- Constraints faced by mothers/caregivers
- Problems with service delivery (including RUTF stock-out)
- Geographical issues (mainly access)
- Other (including RUTF palatability/acceptability)

Community Mobilisation has a positive impact on CMAM coverage. Evidence suggests that awareness and defaulting are directly related, and both in turn have a direct effect on coverage and the delivery of SAM treatment. Levels of awareness must be improved if coverage of services is to be improved.

The design of a Community Mobilisation Strategy for sensitisation and awareness is therefore encouraged, always empowering local communities and state authorities. Such strategy should aim to improve both awareness among local population and capacity for service-delivery among Community Volunteers and health staff.

However, sensitisation alone cannot improve access. Recent experiences in Sokoto state have suggested that developing a strong campaign for social communication and sensitisation succeeded in improving attendance and reducing the impact of awareness as a barrier to access. Yet their impact on coverage was not immediately evident, suggesting that such initiatives must be made part of holistic efforts to address other barriers and improve accessibility.

There is room to improve the quality of SAM management information and data. Whilst nationally aggregated data suggests high quality outcome indicators (recovery, defaulter, death) across most states, localised analysis of records as a part of the SQUEAC assessments suggests that these figures are often inaccurate. Data quality is fundamental to better understand the performance of CMAM service delivery. For instance, reliable data reflecting accurate recovery rates will improve our understanding of met need.

Once better data unveils the challenges of service quality, these need to be further addressed. For instance, the coverage assessments revealed that CMAM service delivery does not always correspond to CMAM national guidelines. Children are often discharged before they reach the official discharge criterion, leading to an increase in relapse and consequently undermining the positive outcome indicators reported by the services.

Improving data quality can be achieved with increased technical capacity and supervision. Strong and reliable data can boost the

FIGURE 3

RELATIONSHIP BETWEEN DEFAULT RATES AND THE RELEVANCE OF AWARENESS-RELATED BARRIERS AS MEASURED BY 10 SQUEACS
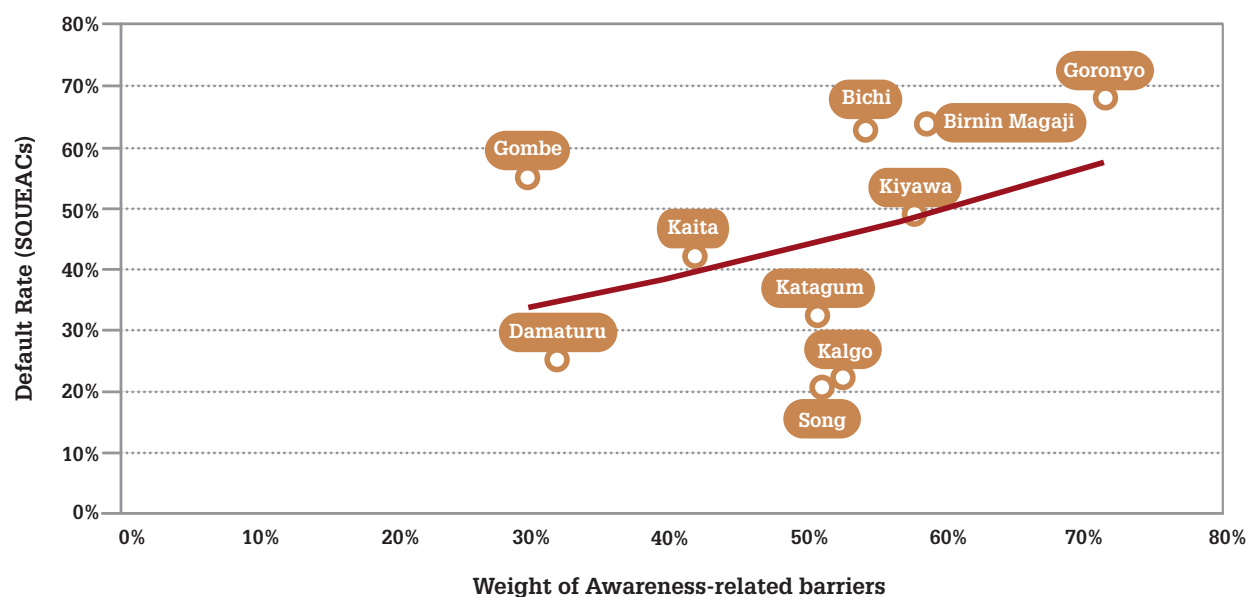
ability of nutrition stakeholders to make informed, strategic and tactical decisions about how best to strengthen scale-up efforts.

Important efforts need to be made to both tackle structural barriers limiting access to CMAM services, and challenges in ensuring the quality of such services. These efforts should include (but not limited to):

▶ Staff in the health facilities need to be more aware of the correct CMAM guidelines and implementation. Increased support from authorities and partners is required for training on community mobilisation, sensitisation and follow-up of individual cases.

▶ The quality of service delivery will also benefit from periodic training, in addition to a more dynamic monitoring data and information system, supported by partners and local authorities to ensure high quality data is being generated and used for programmatic decision-making.

▶ Delivery of commodities (RUTF and routine drugs) can be improved through stronger financial and logistic commitments from all partners at local, state and federal level.

▶ SAM management and other health interventions can be included in the long term, and complemented with programmes for economic activities to boost food security and strengthen local livelihoods.

In this context, scaling-up SAM treatment in Nigeria will require both increased availability and improved quality of existing services.