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Strengthening the Prevention and Treatment of Malnutrition in Niger

OFDA-G- 14-00090

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Child with severe acute malnutrition and medical complications referred for treatment at the maternal child care center in Diffa hospital

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Introduction and overview

Niger is a landlocked nation, whose economy centers on subsistence agriculture, livestock and uranium. Drought, desertification and strong population growth have undercut the economy and since 2005, acute malnutrition in children under five has consistently been above the alert threshold. The Diffa region is one of the most underserved regions of the country due to its remote location, insecurity and climactic challenges. The most recent estimates of prevalence among children under five included 12.3% global acute malnutrition (GAM), 3.9% severe acute malnutrition (SAM), 42.3% chronic malnutrition (2013 National Nutrition Survey) and anemia at 88% (2012 NDHS). This project targets 80 villages in Diffa district.

The program works at departmental, facility, community and household levels to strengthen linkages between the health system and communities, and to improve prevention and management of acute malnutrition. Ultimately the goal is to reduce all forms of undernutrition in target zones. Using the newly revised Essential Nutrition Actions and Essential Hygiene Actions (ENA-EHA) framework¹ at both health center and community levels, the project promotes appropriate preventive practices, regular screening activities (monthly in villages that do not have health center; daily in health centers), referral of acutely malnourished pregnant and lactating women and children under age 5 to health centers for treatment, and follow up to recovery. ENA-EHA training helps health and community agents work effectively with individual mothers and build social support for behavior change. At the community level, volunteers organize group discussions, community events and home visits to reinforce positive practices. The EHA component of the new toolkit emphasizes the promotion of optimal water, sanitation and hygiene (WASH) practices in coordination with government and other local sanitation strategies. The official government protocol for the Community-based Management of Acute Malnutrition (CMAM) is the basis for training the health and community agents in their respective roles in identifying, treating and supporting children and mothers with acute malnutrition. Finally, UNFPA's "*Ecole de Maris*" approach will engage fathers in support of healthy practices while leader mothers' clubs reach out to mothers in the critical first 1,000 days. Active monitoring and supportive supervision of health workers and community volunteers will further help build capacity for quality health services and preventive actions.

The security situation in Diffa region deteriorated greatly in the beginning of February 2015, causing significant internal displacement of the population, and limiting project activities to secure areas (pastoral and central zones). The government declared a state of emergency, imposed a curfew from 6:00 p.m. to 6:00 a.m. and banned the use of motorcycles, further limiting field supervision to where staff can visit via one four-wheel vehicle. In November, 2015 it was possible to resume many activities and recruit replacement field staff.

¹ See <http://www.coregroup.org/our-technical-work/working-groups/nutrition>

Table 1: Project monitoring indicators

Sector 1: Nutrition																
Objective: Strengthen the capacity of health workers and communities in the prevention and treatment of acute malnutrition through the community and behavior change in essential nutrition and hygiene actions in the departments of Bosso and Diffa in Diffa District																
National Nutrition Survey (May/June) 2013 data on crude mortality and wasting in Diffa region: Wasting (WH<-2 SD 2006 WHO standards) urban: 14.2 (CI 9.6-20.6); rural: 10.9 (7.7-15.4); total 12.3 (9.7-15.4) Crude mortality rate: 1.47 per 10,000 persons/day; 0.92 per 10,000 children <5y/day																
Sub-sector 1: Management of Moderate Acute Malnutrition (MAM)																
	Indicator	Target ²	Year 1		Year 2		Year 3 – NCE+ Anticipated cost amendment								Cumulative To Date	
			Quarter 1	Quarter 2	Quarter 3	Quarter 4	M	F	M	F	M	F	M	F		
1	Number of sites managing MAM	74	74		39 ³		55								N /A	
2	Number of beneficiaries admitted to MAM services ⁴ :	414,152	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 6-23 months ⁵		3,059	3,200	3,015	3,353	990	1,030							7,064	7,583
	Children 24-59 months		1,368	1,155	1,460	1,293	447	372							3,275	2,820
	Total		4,427	4,355	4,475	4,646	1,437	1,402							10,339	10,403
3	Number of beneficiaries admitted to MAM services: Women 15-49 years	10,454	7,186		4,115		2,211								13,512	
4	Number of health care providers and volunteers trained in prevention and management of MAM	382	M: 92		M: 89		M:0		M	M	M	M	M	M	M: 181	
			F: 107		F: 126		F:0		F	F	F	F	F	F	F: 233	
			Total: 199		Total: 215		Total:0		Total	Total: 414						
5	Number of referrals made by traditional healers	TBD	0		54		62								116	
6	Cure/Recovery rate of children <5 treated for MAM	>75%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 6-23 months		92.3	92.5	23.4	27.7	28.5	34.5							27.1	31.1
	Children 24-59 months				11.9	12.9	12.6	12.1							11.4	12.7
	Total		92.45		76.2 ⁶		87.6								82.3	

² Targets have been revised to reflect more current data.

³ Due to elevated insecurity, the project limits support to 39 health centers treating MAM.

⁴ Our reporting follows the government protocol, which does not treat infants <6 months of age for MAM.

⁵ The Nigerian government HMIS for CMAM reports categories of children as 6-23 months and 24-59 months as opposed to the categories used by OFDA.

⁶ The number of children defaulting greatly increased in the month of June (2015) due to the high insecurity that reduced mothers' mobility

Sub-sector 1: Management of Moderate Acute Malnutrition (MAM) (cont.)																
Indicator		Target	Year 1		Year 2		Year 3 – NCE+ Anticipated cost amendment								Cumulative To Date	
			Quarter 1	Quarter 2	Quarter 3	Quarter 4	M	F	M	F	M	F	M	F		
7	Default rate among children <5 treated for MAM	<15%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 6-23 months		5.0	4.8	2.3	3.0	3.9	4.3							2.4	2.7
	Children 24-59 months				1.0	0.7	1.2	1.6							0.9	0.8
	Total		4.9	7.0	11.1					6.6						
8	Mortality rate in children <5 treated for MAM	<5%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 6-23 months		0	0	0	0	0	0							0	0
	Children 24-59 months		0	0	0	0	0	0							0	0
	Total		0	0	0				0							
9	Strengthened supervision ⁷ : - # of formative supervision visits to health centers by field supervisors conducted (annually)	592	160	265	39									464		
	-# of formative supervision visits to community structures by field agents (annually)	2,160	160	1,224	409									1,793		
	-# of joint formative supervision visits by district health team and HKI staff (annually)	144	0	60	0									60		
10	#MAM cases deteriorating to SAM	N/A	M: 67	M: 157	M:6	M:	M:	M:	M:	M: 230						
	F: 58		F: 111	F:15	F:	F:	F:	F: 184								
	Total: 125		Total: 268	Total:21	Total:	Total:	Total:	Total: 414								

⁷ Supervision visits began during Quarter 3 as the baseline was delayed and only completed at the end of Quarter 2. Supervision visits were temporarily stopped during Quarter 4 due to insecurity and violence, and only recommenced in secure regions during Quarter 5 (Year 2, Quarter 1).

Sub-sector 2: Management of Severe Acute Malnutrition (SAM)																
	Indicator	Target	Year 1		Year 2		Year 3 – NCE+ Anticipated cost amendment								Cumulative To Date	
							Quarter 1		Quarter 2		Quarter 3		Quarter 4			
1	Number of health care providers and volunteers trained in prevention and management of SAM	382	M: 92		M: 101		M:0		M:		M:		M:		M: 193	
			F: 107		F: 114		F:0		F:		F:		F:		F: 221	
			Total: 199		Total: 215		Total:0		Total:		Total:		Total:		Total: 414	
2	Number of sites established/rehabilitated for inpatient and outpatient care	18	23 ⁸		18 ⁹		16								N/A	
3	Number of Children admitted for treatment of SAM with complications: Children 0-<6 months ¹⁰ Children 6-23 months ¹¹ Children 24-59 months Total	1,405	M	F	M	F	M	F	M	F	M	F	M	F	M	F
			39	35	93	86	24	17							156	138
			172	142	271	272	105	79							548	493
			88	60	163	163	57	64							308	287
			299	237	527	521	186	160							1,012	918
4	Number of Children <5 admitted for SAM treatment w/o complications: Children 0-<6 months Children 6-23 months Children 24-59 months Total	7,965	M	F	M	F	M	F	M	F	M	F	M	F	M	F
			0	0	0	0	0	0							0	0
			1,899	2,184	3,787	4,517	924	1,197							6,610	7,898
			537	553	1,353	1,738	378	455							2,268	2,746
			2,436	2,737	5,140	6,255	1,302	1,652							8,878	10,644
5	Number of referrals made by traditional healers	TBD	0		29		40								69	
6	Recovery/Cure rate among children <5 treated for SAM: Children 0-<6 months Children 6-23 months Children 24-59 months Total	>75%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
			0.7	0.6	0.7	0.6	0.9	0.8							0.8	0.7
			30.3	36.1	25.6	32.1	24.8	31.4							26.9	33.3
			7.5	8.7	10.8	11.8	10.7	13.7							9.4	11.1
			83.9		81.55		82.3								82.1	

⁸ There are five health posts (cases de santé) that are qualified to treat SAM.

⁹ Due to elevated insecurity, we were able to support only 16 health centers in Quarter 5 (Year 2, Quarter 1) for management of SAM.

¹⁰The government protocol treats all malnourished infants <6 months as inpatients.

¹¹The Nigerian government HMIS for CMAM reports categories of children as 6-23 months and 24-59 months as opposed to the categories used by OFDA.

Sub-sector 2: Management of Severe Acute Malnutrition (SAM) (cont.)																
Indicator		Target	Year 1		Year 2		Year 3 – NCE+ Anticipated cost amendment								Cumulative To Date	
							Quarter 1		Quarter 2		Quarter 3		Quarter 4			
7	Dropout rate among children <5 treated for SAM:	<15%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 0-<6 months		0.0	0.0	0.0	0.0	0.0	0.0							0.0	0.0
	Children 6-23 months		1.2	1.3	1.3	1.4	1.4	0.8							1.3	1.4
	Children 24-59months		0.3	0.2	0.4	0.3	0.4	0.2							0.4	0.3
	Total		3.0		3.4		2.8								3.4	
8	Mortality rate among children <5 treated for SAM:	<5%	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Children 0-<6 months		0.00	0.00	0.00	0.02	0.04	0.00							0.01	0.01
	Children 6-23 months		0.00	0.07	0.02	0.03	0.00	0.07							0.01	0.05
	Children 24-59 months		0.02	0.00	0.11	0.01	0.04	0.07							0.06	0.02
	Total		0.09		0.18		0.21								0.17	
9	Formative supervision systems strengthened: - #joint formative supervisions of health centers by field supervisors	51	0		160		39								199	
	-#joint supervision visits by district health team and HKI staff	12	0		24		0								24	

Sub-sector 3: Infant and Young Child Feeding and Behavior Change									
Indicator		Target	Year 1	Year 2	Year 3 – NCE+ Anticipated cost amendment				Cumulative To Date
					Quarter 1	Quarter 2	Quarter 3	Quarter 4	
1	Number of beneficiaries receiving nutritional education in communities - Through radios	76,810	M: 0	M: N/A	M:0	M:	M:	M:	M: N/A
			F: 0	F: N/A	F:0	F:	F:	F:	F: N/A
			Total: 0	Total: 658,814	Total:0 ¹²	Total:	Total:	Total:	Total: 658,814
	- Through group discussions and interpersonal counselling ¹³ Male Female	52,130	M:135	M: 8,366	M: 9,290	M:	M:	M:	M: 17,791
			F: 316	F: 17,913	F: 13,643	F:	F:	F:	F: 31,872
			Total: 451	Total: 26,279	Total: 22,933	Total:	Total:	Total:	Total: 49,663
2	Number of service providers trained in the promotion of nutrition education Male Female	942	M: 92	M: 504	M:0	M:	M:	M:	M: 596
			F: 107	F: 168	F:0	F:	F:	F:	F: 275
			Total: 199	Total: 672	Total:0	Total:	Total:	Total:	Total: 871
Indicator		Target	Baseline			Endline			
3	Percentage of children < 6 months exclusively breastfed in the previous 24 hours	+25%	55%						
4	Percentage of children 6-23 months receiving foods daily from 4 food	+25%	8%						
5	Percentage of mothers of children <24 months who know the correct age for the introduction of complementary foods	+25%	61%						
6	Percentage of mothers of children <24 months who know the minimum number of meals that a 9-23 month breast-fed child should have each day	+25%	38.7%						

¹² The radio contracts were completed in February 2016 but mobile caravans will be organized beginning in August.

¹³ Again, the problems of insecurity have limited the activities in this line.

Sector 2: Water, Sanitation and Hygiene - Sub-sector: Hygiene Promotion										
Objective: Strengthen the capacity of the community to make improvements in WASH practices and facilities (see footnote 13)										
Indicator		Target	Year 1	Year 2	Year 3 – NCE+ Anticipated cost amendment				Cumulative To Date	
					Quarter 1	Quarter 2	Quarter 3	Quarter 4		
1	Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double counting)	13,065	M: 0	M: 552	M: 1,815	M:	M:	M:	M: 2,367	
			F: 0	F: 483	F: 1,444	F:	F:	F:	F: 1,927	
2	Number of health brigades established (3 members each)	80	0	36	36				72	
3	Number of villages having implemented CLTS process	36	0	36	36				36	
4	Number of latrines built by community members	720	0	1,229	721				1,950	
5	Number of households with hand washing stations established and functional	1,600	0	53	454				507	
Indicator		Target	Baseline				Endline			
6	Percentage of caretakers reporting washing their hands at a minimum of 3/5 critical moments	+25%	17%							

Activity Summary

During this quarter, a total of 2,954 cases of SAM without complications and 346 with complications were treated, including 41 children <6 months of age. Nevertheless, a large proportion of detected cases of both SAM and MAM are still not reaching facilities for treatment; barriers include disruption of inputs as well as insecurity.

Training and Capacity Building

In April two training sessions were held on techniques of latrine construction, in the villages of Mallan gamari (Chétimari commune) and Boulanyaskou (Diffa). The objective is for masons to train others in the community to use these recommended construction techniques.

A visit from HKI's Senior Nutrition Advisor focused on reinforcing techniques of supportive supervision using quality improvement checklists. She provided training modules for use with field staff to help staff practice and build confidence in their use of these tools at both health center and community levels.



Practical training for masons of Malan Gamari (Chétimari)

Community mobilization and social and behavior change (SBC)

Table 2 below presents the number of participants in the various social and behavior change sessions organized during the quarter.

Table 2: SBC by community volunteers

Activities	Men	Women
Cooking demonstrations	2,390	4,964
Group discussions	9,290	9,787
Home visits	285	962
Breastfeeding support groups	N/A	3,856



Cooking demonstration, Chétimari

Screening and Referral

A total of 424 children were diagnosed as SAM through community screening; 402 (85 percent) were brought to health centers for treatment. A total of 1,381 children were found to be MAM, of whom 1,252 (91%) were brought for treatment. There are many reasons for failure to seek treatment, including workload in preparing fields and fear of mistreatment by

health agents; HKI is working to address these barriers. HKI was also able to provide transport to 95 children with complicated SAM from health centers to the hospital in Diffa for treatment.

Traditional practitioners screened a total of 323 children, detecting 24 cases of SAM including four with bilateral edema. Of these 19 (79%) arrived at health centers for treatment. The traditional healers also identified 68 cases of MAM, of whom 62 (91%) were brought for treatment. During the screening efforts 604 fathers and 646 mothers were counseled on optimal nutritional and hygiene practices and the importance of prompt treatment of acute malnutrition.

With HKI support, the health district conducted monthly mobile clinics to reach remote and disadvantaged communities with a package of preventive and curative care. Table 3 presents data from services provided during the months of April and May; it was not possible to obtain accurate data for the month of June. Health agents, community volunteers and HKI field agents participated in the events. All Integrated Health Centers (IHC) conducted at least one outreach visit. During these visits a total of 4,015 people (2,959 women; 1,056 men) participated in health education discussions. Topics included the importance of antenatal care and exclusive breastfeeding.

Table 3: Outreach services

Curative Activities	Number
Uncomplicated malaria	7,490
Simple pneumonia	11,250
Simple diarrhea	8,754
Other illnesses	7,022
Total	34,516
Preventive care	
Family planning	1,894
Vaccination	5,777
SBC activities	36,999
Antenatal care	2,656

Monitoring & Evaluation

Community level supervision

The security situation made community supervision easier this reporting period: a total of 409 visits were made reaching all 80 villages.

Joint formative supervision

In April staff of HKI, the Regional Health Directorate and the District Office as well as the regional directorates for planning and water resources conducted a joint supervision visit to 15 villages undertaking community-led total sanitation campaigns. The supervision noted progress in most villages, with the exception of the pastoral zone where the nomadic populations are less motivated to build permanent latrines. A total of 1,485 new latrines have been constructed in the 31 targeted villages.

Supervision visit from HKI's national office

In April, HKI/Niger's M&E Manager visited the project site to provide support to field officers in data collection. Overall he was impressed by the engagement of community structures in project implementation and observed job aids being used correctly by community health workers (relais) and Leader Mothers, Ecoles de Maris leading discussions in support of CLTS, and acceptable record keeping at the community level. Recommendations included reviewing the incentive structure for community volunteers, providing refresher training to hygiene brigades on their roles and responsibilities within the community, and reinforcing the importance of establishing tippy taps next to newly constructed latrines.

SQUEAC

A semi-quantitative evaluation of access and coverage (SQUEAC) survey was conducted over 16 days in collaboration with local MOH and NGO partners. HKI's regional CMAM advisor provided technical support and the survey covered all IHC in the Diffa district except

for Bosso, where insecurity remains a problem. The survey calculated coverage using the SLEAC methodology, and found it to be unexpectedly low: 7.2% (CI 4.9 – 10.3%).

Planning – Coordination – Advocacy

HKI supported the health district to organize a workshop to begin working on the health development plan for the period 2016-2020. The two-day workshop included administrative, health and traditional leaders as well as development partners. In response to the security situation, the plan will include mobile clinics to improve access for both refugee and host communities. HKI described experience in support of this strategy. The discussion focused on the content of the service package to be provided and the frequency of outreach.

Table 4: Villages certified open-defecation free

Communes	IHC	Villages
Chétimari	Chétimari	Kalgounam
	Bagara	Abakouradi
	Bagara	Madouri
Gueskerou	Déwa	Blabrime
Diffa	Diffa	Mataou



Gifts for leaders of Kalgounam for achieving ODF

In June HKI organized a ceremony to certify and congratulate five villages achieving open-defecation-free (ODF) status. The ceremony included residents of neighboring villages in hopes of motivating their efforts in achieving ODF. HKI is also encouraging residents of certified villages to spread the word of their achievement and encourage others to follow suit. Before the CLTS triggering there was a total of 489 latrines in these five villages; by certification an additional 1,529 had been built together with 362 tippy taps. Field agents are reinforcing efforts to motivate construction of a tippy tap at both latrines and cooking areas.



Speech by the Prefect of Chétimari



From left to right: DRSP, HKI, Gueskerou Mayor

Challenges/Difficulties encountered

Insecurity remains a significant problem. Use of motorcycles is still forbidden by the government security forces, and the project does not have enough cars to support field agents in their supervision. It also causes population displacement.

The presence of more than 30 NGOs in the region also means that staff are often resigning for more attractive opportunities.

Program Adjustments

HKI has provided support for ambulances to transport children to the hospital. HKI has also added to the training curriculum modules on infant feeding in emergencies.

Success Story



During the ODF certification ceremony the chief of Kalgounam village expressed his appreciation, “Since we began the CLTS strategy in our village we have noticed a great reduction in the cases of malnutrition and diarrhea. We now understand that poor hygiene was the cause of these illnesses. Thanks go to everyone, but especially to HKI.”