WORLD VISION INTERNATIONAL & COMMUNITY-BASED MANAGEMENT OF ACUTE MALNUTRITION (CMAM)

UNICEF Meetings,
Copenhagen, Denmark
October 2011
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WV CMAM History

• WV CMAM programming began in 2006 in 3 countries: Niger, Ethiopia and south Sudan

• From 2006 to 2011 increased to 12 countries: Sierra Leone, Niger, Mauritania, Kenya, Ethiopia, Burundi, South Sudan, Somalia, Zambia, Zimbabwe, DRC, Pakistan

• Currently active in 11 countries
WV continuum of CMAM

Emergency CMAM programming e.g. Somalia, Sudan, Niger

Integration focused CMAM programming e.g. Ethiopia, Kenya, DRC

Development gains-CMAM fully integrated e.g. Zambia, Zim

CMAM programme still required which can manage the emergency case load at the same time as build local government and partners capacities

Critical point where malnutrition doesn’t rise to emergency levels and can be managed by MOH/health Structures.

Little acute Malnutrition might still be present in any community.

TIME
WV’s Role: Technical & Financial assistance

Support MOH in Capacity Building:

- Baseline study/Assessment
- Design
- Community mobilization
- Implementation of OTP, SFP, SC including supply logistics
- Coverage survey
- Program performance monitoring
- Evaluation
WV CMAM Partnerships

With

- MOH
- UNICEF in country to support decentralized health center access to RUTF
- WFP for SFP component
- Valid for technical package delivery
- Other NGO involved in CMAM (e.g., MSF for SC)
WV CMAM: Building capacity

Number of trained CHW/volunteers: 5751

Number of government staff trained: 645

Number of WV staff trained: 240
WV CMAM: Other Key Activities

• Supervision

• Logistical support
  – In-country transportation,
  – donation of RUTF and
  – essential medicines supply.
**WV CMAM data base**

- CMAM Reporting system is **entered into an ELECTRONIC DATABASE since 2010**
  - Historically, we used Excel Spreadsheets

- **Standardized Reporting Sheets!**
  - These are very important so that service’s overall effectiveness can be precisely monitored (monthly) at
    - Site levels
    - Country levels
    - Regional levels
    - globally
  - Automatically generated from WVI CMAM Database
CMAM data base

- [https://cmam.wvncoe.org](https://cmam.wvncoe.org)
Generate summary report

**DISTRICT/STATE/REGIONAL or ADP/IPA REPORT FOR MANAGEMENT OF SAM (Outpatient Care)**

**REPORTING ON:**
- Province(s) or Region(s) or Woredas (City/Town(s) or Municipalities)
- District(s) or Territorial(s) or Counties (or Municipalities)
- Health Zone(s) or Division(s) of Community(s) in Payame
- SO(s)

**ADP(s) or IPA(s):**
- Year(s): 2010 - 2011
- No. of ADP(s) or IPA(s)
- No. of OTP Care Site(s)/Clusters: 300

**IMPLEMENTED BY:**
- Type of Market: Outpatient

**ESTIMATED MAXIMUM CAPACITY:**
(based on latest survey data and admission criteria)
- RUTF Consumption: Packets/pk or kg equivalent

**TOTAL CHILDREN BEGINNING OF REPORTING PERIOD:**
- Total RC Beginning of Reporting Period (U)
  - 4203

**TOTAL OVC BEGINNING OF REPORTING PERIOD:**
- Total OVC Beginning of Reporting Period (U)
  - 0

**NEW CASES (B):**
- 6-59m Bilateral Pitting Oedema (B1a)
- 6-59m W/FH (B1b)
- 6-59m MUAC (B1c)
- Other (adults, adolescent females, children >5 yrs, infants <6m) (B2)
- Referred from SC (C1a)
- Returned after Default (C1b)
- Referred from other sites (C1c)

**OLD CASES (C):**
- Total CHILDREN ADMISSIONS (D) (B + C + D)

**TOTAL CHILDREN ADMISSIONS (E):**
- Total RC ADMISSIONS (Z)
  - 433

**DISCHARGES (E):**
- CURED (E1)
  - 355
- DIED (E2)
  - 306
- Defaulted ID (E3)
  - 277
- Non-Recovered (E4)
  - 2125
- Total CHILDREN EXITS (G) (E + F + E4)

**TARGET (Sphere Standards):**
- >75% <100% <15%

**ADDITIONAL INFORMATION:**
- RELAPSE: 31
- HIV: 56
- MALE: 8156
- FEMALE: 11023

**AVERAGE WEIGHT GAIN and AVERAGE LENGTH OF STAY** (only for children 6-59)
- Average weight gain: Maasae 
  - g/kg/day
- Average length of stay: KuRukshorkor
  - Day

**Global Health & Nutrition**
**Nutrition Centre of Expertise**
Outcome for children

Number of children reached FY11:

- More than 27125 in 300 sites
- 17063 fully recovered
- Cure rate: 89%

(Data from 8 of 11 countries)
WV CMAM future plans

• Integration of Infant and Young Child Feeding (IYCF) with CMAM
• Extension to other countries (India, Cambodia..)
• Scale up within a country (as needed)
• Support integration in the MOH/Health routines services
• Monitoring of individual child in the DB using mobile technologies.
• Generate AWG and LoS
• Monitoring RUTF consumption
Thank you!!