

# INVESTING IN SYSTEMS, SCALING-UP CARE

The expansion of Nigeria's integrated  
management of acute malnutrition programme



## FIELD REPORTS

Lessons from improving  
nutrition at scale

unicef  | for every child

Nigeria's integrated management of acute malnutrition (IMAM) programme is the largest in the world. From 2009 to 2020, the programme was scaled-up from less than 7,000 children treated to almost 400,000 children. The IMAM programme is part of a more comprehensive nutrition strategy that prioritizes the prevention of malnutrition first, while providing life-saving treatment and care when prevention falls short. Through investments in strengthening health systems and harnessing the support of partners and communities, Nigeria achieved a 50-fold expansion in the number of treatment sites over this time, building the foundations of a high-quality, sustainable programme. Nigeria's journey to integrate the care of children with acute malnutrition into health systems offers important lessons for improving programme quality and national ownership. It also demonstrates how investments in systems strengthening can build resilience and help countries sustain and scale-up life-saving nutrition services when emergencies strike.

#### **Malnutrition: A threat to survival and development for the most vulnerable**

Nigeria has the second highest number of stunted children in the world: 11 million children are being denied the opportunity to grow, develop, learn and reach their potential. This represents a national stunting prevalence rate of 37 per cent – with more than two out of five children under 5 affected.

There are also an estimated 2.1 million of children under 5 suffering from wasting and 538,405 from severe wasting in any point in time in Nigeria. Every year, an estimated 2 million (2020) children require treatment for severe acute malnutrition (SAM) – more children than in any other country in Africa.

While all malnourished children are at higher risk of disease and death, severe wasting is the most lethal form of malnutrition: children with severe wasting have weakened immunity and are up to 12 times more likely to die from common childhood illnesses such as diarrhoea, pneumonia and malaria.<sup>1</sup>

Although malnutrition is pervasive across Nigeria, disaggregated data show that children and women from states in the northern geopolitical zones (north west, north east and north central) are particularly

vulnerable. Rural areas, which have reduced access to health, education and water and sanitation services and are located further from markets, also face a disproportionate burden.

#### **Ensuring treatment when prevention fails**

In this challenging nutrition context, the Government of Nigeria, UNICEF and partners have stepped up efforts to prevent malnutrition through programmes to boost maternal nutrition, improve infant and young child feeding practices, and facilitate better access to healthcare and water and sanitation services.

Actions to prevent malnutrition in all its forms are paramount; but when prevention falls short, the early detection and treatment of children with acute malnutrition through facilities and community-based platforms are vital to saving lives and returning children to healthy growth.

In 2009, the Government of Nigeria set targets for reducing the prevalence of under-five mortality by 2015; and tackling acute malnutrition was prioritized as critical to achieving them. Driven by this policy commitment, the government, with the support of UNICEF, the European Commission Humanitarian



## BOX

### Nigeria's IMAM approach

In Nigeria, the IMAM approach calls for regular nutrition assessment and the early detection and treatment of children with severe acute malnutrition to be incorporated within existing health and community services. IMAM allows children requiring specialized hospital care (such as those suffering from medical complications or other illnesses) to be referred in a timely manner. The community component of the IMAM programme involves sensitizing health workers and training them to recognize the signs of malnutrition, allowing children at risk to be identified earlier and reached sooner with appropriate treatment and care, often within their own communities.

Aid (ECHO), and Valid International, aimed to more effectively reach the most vulnerable children with SAM. Informed by global and national guidance, Nigeria's IMAM programme sought to provide early detection and treatment for children in need, in accordance with the operational context and capacity. This Field Report tells the story of nationwide programme scale-up.

#### **A vision to integrate care for children with SAM and extend health services to communities**

Before 2009, most children with SAM were treated in hospitals and care was limited in terms of scale and service provision. UNICEF leveraged global evidence about the community-based management of SAM<sup>2</sup> to gain consensus among government and partners to pilot a new approach—the integrated management of acute malnutrition (IMAM)—which extended care closer to communities and integrated services within the primary health care system. This allowed for more routine and timely contact with trained community and health workers who were equipped to identify children

at risk as early as possible. The integration of these services into the community and primary health care system also offered the potential for rapid scale-up.

The effective integration of services for children with SAM within the health system is critical to scaling-up programmes sustainably, both within and beyond emergency contexts, and requires the commitment, resources and ownership of the national government (*see Lessons Learned*). Children with acute malnutrition often suffer concurrently from other illnesses, such as malaria, and successful treatment and care means putting the child at the centre of a broader system of routine health services, leading to better treatment outcomes. These were central tenets of the IMAM approach in Nigeria (*see Box*).

#### **Testing the feasibility of the IMAM approach**

Nigeria's IMAM approach was piloted in six local government areas (LGAs)<sup>3</sup> across two states (Kebbi and Gombe) in 2009, funded by external financial resources. The main objective of the pilot was to test

the feasibility of the IMAM model and determine its scalability and cost effectiveness.

Following the 4-month pilot period, a national workshop with key stakeholders was held to collectively review the findings, which showed that 7,000 children with SAM were reached, with treatment provided across 30 health facilities. The review also identified key success factors, including strong commitment by government authorities at the federal level that had cascaded down to the state level; functional health systems with an elaborate community structure; and the capacity to integrate IMAM.

### From pilot to scale-up

Based on the findings of the pilot programme, the government and partners committed to developing a national scale-up strategy. Northern Nigeria was prioritized given the high number of children affected by SAM and donor commitment was secured to further expand the reach of services. Specific LGAs were selected for scale-up based on several criteria: the commitment of local government authorities and the existence of a functional primary health care infrastructure, defined by having adequate staffing and human resource capacity; the accessibility of transport to facilities; and the availability of drugs to treat common childhood infections.

To guide implementation during scale-up, evidence-based IMAM guidelines were developed by the end of 2010 with technical support from UNICEF. Data collection tools were included in these national guidelines to harmonize them with the data collection system.<sup>4</sup>

Using existing health infrastructure and human resources, the IMAM programme was scaled-up to 5 additional states in 2011 and to 11 states by end of 2013 (*Figure 1*). The transportation of supplies to implementation sites and the provision of routine drugs to treat common infections was supported by the government. However, the bulk of the programme cost (more than 90 per cent), used to procure ready-to-use therapeutic food (RUTF),<sup>5</sup> was provided by the international community,<sup>6</sup> with a view for the government to take over procuring RUTF in the future.

Throughout the scale-up period, UNICEF and partners supported the Government of Nigeria in strengthening national policies and leadership to end malnutrition. In 2011, Nigeria joined the Scaling Up Nutrition movement, signaling its strong commitment to addressing nutrition as a development issue and coordinating the necessary multisectoral response with relevant ministries and partners; and in 2012, Nigeria held its first Nutrition Summit to create a roadmap to scaling-up nutrition in the country.

UNICEF provided technical support to shape the nutrition policy environment with the development of guidelines and policies that captured the importance of investing in prevention first, while embedding the early detection and treatment of SAM into health and community systems. Examples of such guiding frameworks include the 2010 National Policy on Infant and Young Child Feeding in Nigeria and the 2016 National Food and Nutrition policy.

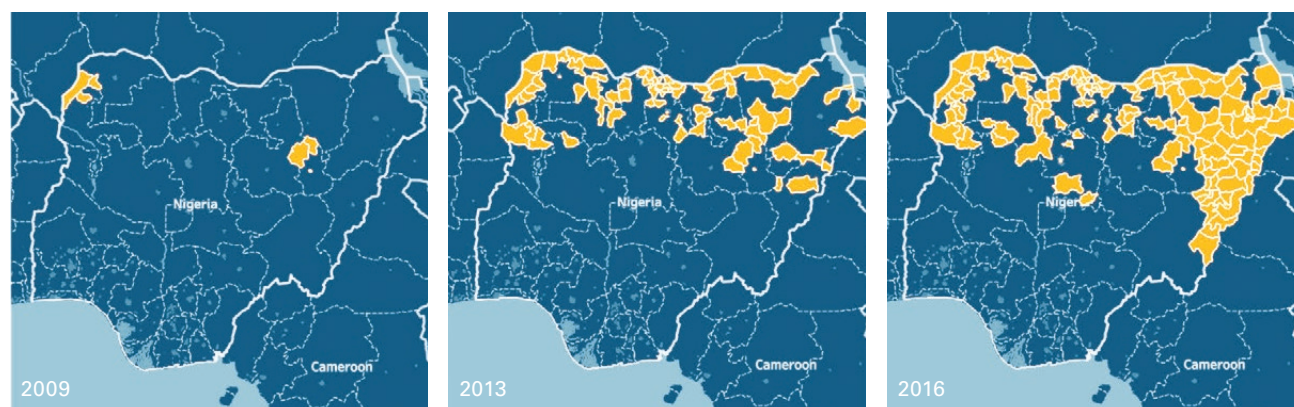
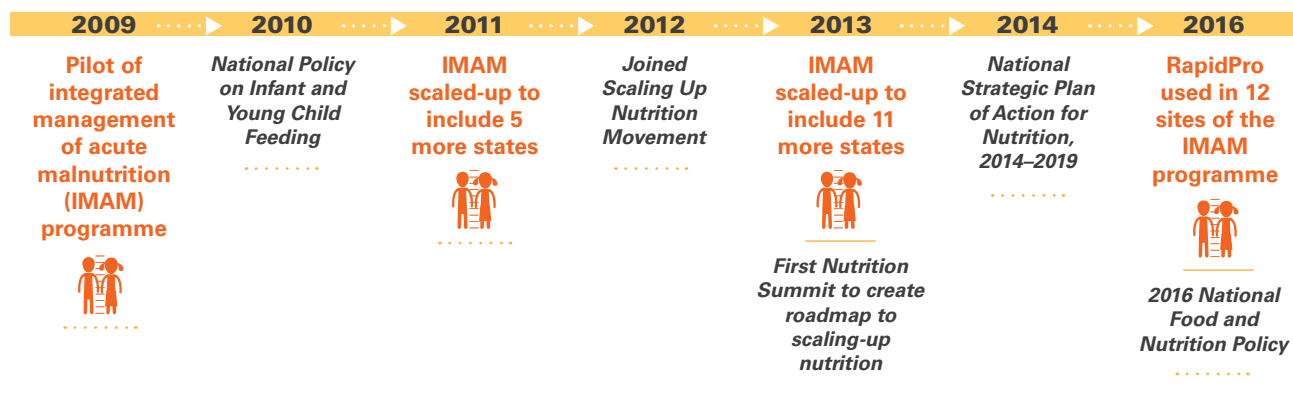


Figure 1: Scaling-up services in a high-burden context: Local Government Areas implementing the IMAM programme by year

## Timeline of nutrition-focused scale-up in Nigeria



More recently, the government adopted a costed National Strategic Plan of Action for Nutrition, 2014–2019, which highlighted that the treatment of SAM in children under 5 can be efficiently managed at the community level in a cost-effective manner. As part of the Action Plan, three delivery platforms – the health system, community structures, and national campaigns and outreach activities – were identified as the most relevant and cost-effective to reach the most vulnerable groups. Among these, there was recognition of the need to focus on strengthening primary health care service delivery points to provide both preventative and curative services.

### Tracking progress to improve quality

Various measures and innovations supported by UNICEF were put in place to ensure the quality of the scale-up and response. This included working with the states to build capacity through training and on-the-job coaching and mentoring and using data and innovative tools to inform decision-making.

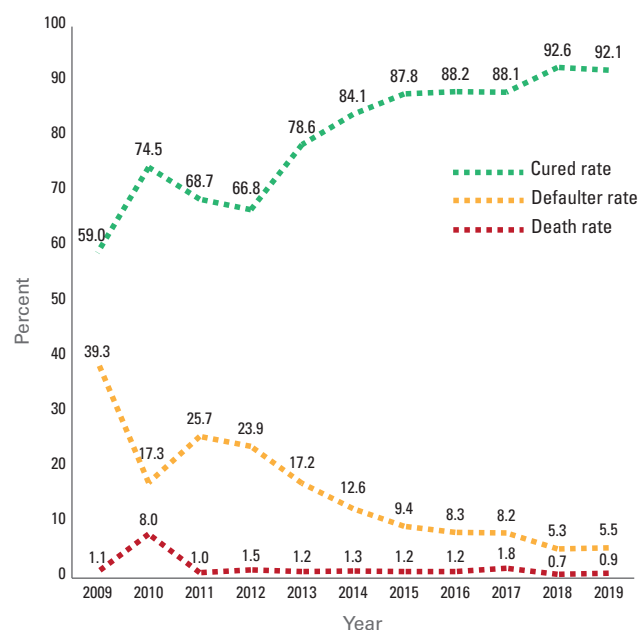
Performance at the various implementation sites was closely tracked using a colour-coded 'traffic light' system, with data aggregated monthly at state level. With this system, field staff were able to identify sites with the greatest need for supportive supervision and increase the frequency of field monitoring and supervision visits. Key performance indicators were measured at each site, in line with international standards of cure, defaulter and mortality rates.<sup>7</sup>

To improve the timeliness and quality of reporting on nutrition indicators, RapidPro (a mobile technology tool that allows real-time data collection) was

piloted, building on UNICEF's successful monitoring of vaccines and cold chain functionality. By 2016, all IMAM sites across 12 states were trained and using RapidPro to report nutrition supply stock-outs. These actions improved the overall quality of the programme: the percentage of children successfully recovering from SAM rose steadily to reach 88 per cent in 2016 (Figure 2).

Significant efforts were made to ensure the quality of the IMAM programme. These included closely monitoring the transition from inpatient to outpatient care, with the diligent follow-up of children as they moved between health facilities and communities;

Figure 2: Cure, defaulter and death rate by year, 2009–2019, Nigeria



**2009****30 sites**  
offering IMAM**30** majority  
inpatient**2020****1,313 sites**  
offering IMAM  
of which...**91** inpatient

+

**1,222** outpatient

Nearly

**400,000****children admitted for  
treatment in 2020**

the maintenance of an uninterrupted supply chain of drugs and therapeutic foods, led by UNICEF; and, the establishment of, and investment in, dedicated community workers, especially in the north-eastern part of the country in 2017. These community workers supported active case finding, early detection of children requiring care, and follow-up of defaulters.

### Leading the world in numbers treated

In only nine years, the IMAM programme expanded from providing care for 7,000 children with SAM in 2009 to reaching almost 400,000 children in 2020 – 90 times the number of children treated in the first year. To support this expansion in care, the number of sites offering IMAM services increased steadily from 30 facilities in two states to 1,313 (1,222 outpatient and 91 inpatient) in 12 states. Since 2009, more than 1.7 million cartons of RUTF (valued at approximately US\$85 million) have been imported and distributed to treatment sites to treat children with SAM.

Nigeria's IMAM programme is now the largest in the world, admitting more children with SAM for treatment and care each year than any other country (*Figure 3*). An earlier study estimated that between its inception and 2015, the IMAM programme provided life-saving treatment to an estimated 1.9 million children with SAM, averting approximately 360,000 deaths.<sup>8</sup> With the more recent expansion, the impact of this programme is even greater.

The exponential increase in the number of treatment sites and children reached demonstrates that systematic scale-up of care for children with SAM is possible across a large country with the commitment of the national government, partners and communities. At the same time, despite this success, too many children in Nigeria are still being left behind. In 2016, only about 20 per cent of children with SAM nationwide were reached with treatment. Geographic coverage of the programme within states remains low, particularly in the north western part of the country where most children with SAM live. Detecting these children early is a priority and when prevention and detection is not possible, reaching these children with domestic resources, including for RUTF, and improved integration of treatment within the health system, to ensure that all children in need are identified and reached before it is too late.

### Strengthening ownership and national supply systems

Using existing health and community systems as the delivery platform for IMAM has been critical for strengthening national ownership and sustainability. The skills of the existing health workforce, for example, were enhanced through knowledge transfer from the international community and long-term investments in capacity development.

As the programme evolved, the need for RUTF increased across treatment sites, providing an opportunity to explore local production. UNICEF provided technical support in 2017 to enhance local production of quality RUTF, ensuring it met specific nutrient and hygiene requirements in line with existing norms and standards. This encouraged the government to procure RUTF locally as they were injecting resources to the local economy.

In collaboration with partners, UNICEF engaged in evidence-based advocacy with the government, emphasizing the number of lives saved through the IMAM programme to strengthen the policy environment and secure government ownership. This advocacy proved effective in mobilizing domestic resources for IMAM and transferring the procurement of RUTF and other supplies to the government – an important change from the pilot programme, which was funded entirely by external resources.

Between 2016 and 2017, the Government of Nigeria released US\$3.9 million to support the treatment of children with SAM in the country. The contribution was an important sign of national ownership and commitment to sustaining the programme over the long-term. However, it only represented a fraction (3 per cent) of the resources required for RUTF to reach all children with SAM in the country. Greater investment is still needed to improve geographical coverage of IMAM and ensure all children receive appropriate treatment and care.

### Testing the resilience of nutrition systems in crisis

Only one out of every five children with SAM was accessing treatment services in Nigeria in 2016 – and the needs continue to be pressing today. Indeed, the systems built in Nigeria as part of the IMAM programme scale-up were tested in 2017 when northern Nigeria faced a humanitarian crisis, including acute food insecurity and malnutrition driven by conflict and insecurity in the north east states. To some extent, earlier investments in scaling-up IMAM enabled a faster response to those children most in need. At the same time, greater investment in prevention, by both donor partners and government, could have reduced this large-scale burden of acute malnutrition and the need for such costly treatment—and built stronger, more resilient systems, able to respond in times of crisis.

### Exposing the challenges in reaching every child

Despite the exponential increase in treatment sites and the number of children with SAM being reached with life-saving treatment, important challenges remain:

**Integration between facility- and community-based platforms** – There is a need for local solutions to better identify children in need and manage transitions between community and primary health care platforms. Human resources are the lynchpin: providing integrated nutrition training and tools for community nutrition mobilizers and health workers can support better linkages between community and health systems platforms. The high attrition rates of community nutrition mobilizers continue to be a challenge; however, providing training and a stipend to cover expenses has helped strengthen the community component.

#### Democratic Republic of Congo

792,512

Ethiopia

482,295

Niger

426,119

Nigeria

397,055

Chad

311,509

Afghanistan

308,881

Yemen

282,900

Sudan

255,010

Pakistan

254,405

Somalia

251,078

Figure 3. Top ten countries with the highest number of children with SAM admitted to IMAM programmes (both inpatient and outpatient) in 2020



On 17th November 2016, UNICEF Nutrition Officer, Aishat Abdullahi, assesses seven-month-old Umara Bukar for malnutrition at a UNICEF supported health clinic at Muna Garage internally displaced persons camp, Maiduguri, Borno State, northeast Nigeria. Umara was malnourished and weighed just 4.2kg when he first arrived at the clinic, run in partnership with the Government of Nigeria. Three weeks later, he weighed 5.1kg. © UNICEF/ UN041140/Vittozzi

**Improving equity for those in need** – Limited access to treatment sites was a significant barrier to families, many of whom were poor, illiterate or lived far from health facilities and were unable to afford transport costs. Some state governments began providing transportation to and from treatment sites to improve access, boost adherence and address equity. However, such support is not yet provided uniformly across states and equitable access remains a challenge.

**Supply chain management and sustainability** – The delivery of RUTF to treatment sites faced delays, including a pipeline breakdown in 2013 due to congestion at the Lagos Port, and other heavy administrative issues. UNICEF continued to provide operational support for supply chain management and distribution; however, the challenge of securing sufficient RUTF requires greater resources for sustained procurement. As part of this solution, UNICEF began providing technical support to locally produce RUTF in 2017. Nigeria started producing RUTF locally and one manufacturer has been certified.

## Lessons learned through scale-up and beyond

The scale-up of IMAM in Nigeria offers important lessons on strengthening the health system's ability to deliver timely and quality treatment and care to children with SAM.

**Generate evidence to demonstrate proof of concept:** UNICEF and partners used global guidance to design and implement a pilot programme and subsequently demonstrate that IMAM could work in the Nigerian context. Establishing an inclusive process and creating a forum to discuss findings of the pilot helped build consensus between government and partners.

**Use evidence-based advocacy to establish and sustain political support:** Using data from the programme and the annual national health and nutrition survey, UNICEF developed advocacy kits, held meetings with senior-level decision makers and arranged site visits for political leaders to observe the IMAM programme first-hand. These approaches strengthened political commitment,

TABLE 1

## INTEGRATING CARE AND MANAGEMENT OF ACUTE MALNUTRITION INTO HEALTH SYSTEMS

HEALTH SYSTEM	Actions to support integration of management of acute malnutrition into routine health systems	
	Support national governments to:	Factors affecting integration of IMAM into Nigeria's health system
	<b>Service delivery</b> <ul style="list-style-type: none"> <li>• Deliver quality services for the management of acute malnutrition as part of primary and community health care services.</li> <li>• Integrate RUTFs and other key commodities into national supply chains.</li> </ul>	<ul style="list-style-type: none"> <li>• Care for children with SAM is delivered through government-owned health facilities; however, the scale of service delivery remains limited.</li> <li>• RUTF and therapeutic milk are included in the essential medicines list, however routine procurement and distribution of RUTF remain limited.</li> </ul>
	<b>Health workforce</b> <ul style="list-style-type: none"> <li>• Include management of acute malnutrition into pre-service training.</li> <li>• Provide on-the-job, post-service training on management of acute malnutrition.</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-service training curriculum for health workers includes the treatment of acute malnutrition.</li> <li>• Training and tools are available to support community nutrition mobilizers, and on-the-job mentoring is provided to support nutrition staff.</li> <li>• Overall capacity of the health and nutrition workforce is still limited.</li> </ul>
	<b>Health information systems</b> <ul style="list-style-type: none"> <li>• Include acute malnutrition indicators in national health information systems.</li> </ul>	<ul style="list-style-type: none"> <li>• IMAM indicators are included in the new health information system.</li> </ul>
	<b>Access to essential medicines</b> <ul style="list-style-type: none"> <li>• Integrate RUTF and other key commodities for the management of acute malnutrition into national essential medicine/commodity lists.</li> </ul>	<ul style="list-style-type: none"> <li>• Although RUTF and therapeutic milk are included in the essential medicines list, domestic financing and supply chain integration are limited.</li> </ul>
	<b>Financing</b> <ul style="list-style-type: none"> <li>• Include and integrate management of acute malnutrition into national health budgets.</li> <li>• Leverage external resources to fill gaps and strengthen systems for the management of acute malnutrition.</li> </ul>	<ul style="list-style-type: none"> <li>• At national level, only 0.02 per cent of the budget is invested in nutrition and funds are rarely released from the federal Ministry of Health. However, many state governments have made significant investments in nutrition.</li> <li>• Allocation of funds is inefficient, with inadequate investment in prevention.</li> <li>• Donor partners continue to heavily support procurement of RUTF and a more sustainable solution is required.</li> </ul>
	<b>Leadership/ Governance</b> <ul style="list-style-type: none"> <li>• Support national governments to include the management of acute malnutrition in national health and nutrition strategies and plans.</li> <li>• Support national governments to adopt national coverage targets for the management of acute malnutrition.</li> </ul>	<ul style="list-style-type: none"> <li>• A National Council for Nutrition is led by the Vice President; and nutrition policy is overseen by the Ministry of Budget and National Planning. Yet, ministerial capacity in nutrition requires further support and health policies could better integrate nutrition.</li> <li>• The National Strategic Plan of Action for Nutrition has specific targets and indicators related to childhood wasting and the care and treatment of children with SAM.</li> </ul>

and resulted in the Government of Nigeria, both federal and states, agreeing to release US\$3.9 million in 2016 and 2017 for the procurement of RUTF to treat children with SAM. While these resources are small compared with the total Nigerian budget, they are nonetheless significant; indeed, few West African countries have made this level of investment.

**Integrate IMAM into a broader strategy for preventing malnutrition:** From the outset, it was clear that IMAM was one part of a comprehensive strategy to prevent and treat child malnutrition in all its forms in Nigeria. This approach was firmly established in guiding policy documents that aligned all stakeholders on the overall approach to improving child nutrition.

**Engage communities to build demand and strengthen community platforms:** Through community mobilization and sensitization, caregivers learned where and how to access free IMAM services. Community volunteers were trained on how to screen and refer children with SAM, and were provided with a stipend to incentivize ownership in the programme. Systematically identifying barriers and bottlenecks in the community component of IMAM and finding local solutions has and will increase the likelihood of continued success.<sup>9</sup>

**Deliver through national systems and strengthen platforms:** From the beginning, the IMAM programme was designed to use and strengthen existing community and health systems. This approach was critical to the effective integration and scale-up of IMAM. It also fostered national ownership and sustainability (see Table 1).

**Invest in capacity development and coordination between government and partners:** Monthly meetings with state personnel, LGA staff and UNICEF were coordinated at state level to review programme and supply data. These meetings served to strengthen programme planning and build government capacities to better assess programme performance, forecast treatment supply needs and address service gaps in a timely way.

**Find local solutions for RUTF supply and sustainability:** Collaborating with government, donors and the private sector, UNICEF advocated for RUTF to be produced locally, and provided technical support to companies interested in producing it, which will

enhance the sustainability of the IMAM programme. Continued efforts will be needed to ensure product quality and maintain interest in local RUTF production long-term.

## Sustainable and resilient systems for the future

Drawing from a decade of experience, UNICEF will continue to work with partners to support the Government of Nigeria in its quest to end malnutrition by generating evidence to address gaps; building the capacities of government in programme implementation and performance monitoring; strengthening partnerships to deliver cost-effective IMAM programmes; and providing technical support to locally procure RUTF. These systems-strengthening efforts will be critical to sustaining quality treatment services and ensuring that more children are identified and treated with life-saving care every year.

The journey to make Nigeria's IMAM programme accessible to all children in need will not be possible without greater government investments and long-term political commitment to ending malnutrition. Current estimates indicate that US\$132 million is required annually to sustain the IMAM programme; yet today, less than five per cent of funds for the IMAM programme come from government resources. In late 2017, Nigerian parliamentarians renewed the government's commitment to improving child nutrition throughout the country.<sup>10</sup> Investments in community and health systems and a 'prevention first' approach will be central to meeting this commitment and ensuring every child's right to survive and thrive.

## COVID-19 pandemic effects

The advent of the COVID-19 pandemic led to restriction of movement and global lockdown. The lockdown brought about major disruptions impacting negatively on program implementation and service delivery. The effects revamped realities to integrate nutrition into health and other service delivery platforms. To ensure programme delivery continuity, adjustments were made to the method of early SAM identification, frequency of visits to health facilities and follow up on children under treatment. Presently, there is a programmatic shift aimed at predominantly prevention and offering treatment when prevention fails.

## ● UNICEF's Role

In its support to the Government of Nigeria, UNICEF served as:

### ● Technical and policy advisor

Contributing to the development of the national IMAM guideline and offering technical leadership to implement the programme in line with international norms and standards.

### ● Knowledge leader

Generating evidence on the scale of the problem<sup>11</sup> and developing models to measure treatment impact, including estimates of the number of lives saved by the programme<sup>12</sup> and cost-effectiveness analyses.<sup>13</sup>

### ● Partner and convenor

Investing in collaborative partnerships to harmonize support to the government in coordinating the nutrition sector; and leveraging partnerships, such as the SUN movement, to influence the nutrition agenda in Nigeria.

### ● Trainer and capacity builder

Strengthening the capacities of government and partners to provide effective IMAM services; improving monitoring capacities by assessing key performance indicators; and training the first local producers of RUTF in Nigeria.

### ● Advocate

Engaging in consistent evidence-based advocacy, which has contributed to mobilizing domestic resources for nutrition and strengthening the sustainability of the IMAM programme.

## Endnotes

- 1 Olofin, Ibrinke, Christine M. McDonald, Majid Ezzati, Seth Flaxman, Robert E. Black, Wafaie W. Fawzi, Laura E. Caulfield, Goodarz Danaei, and Nutrition Impact Model Study (anthropometry cohort pooling). "Associations of suboptimal growth with all-cause and cause-specific mortality in children under five years: a pooled analysis of ten prospective studies." *PloS one* 8, no. 5 (2013): e64636.
- 2 WHO, UNICEF, WFP, UNSCN. Community-based management of severe acute malnutrition: A joint statement, 2007. < [http://www.who.int/maternal\\_child\\_adolescent/documents/a91065/en/](http://www.who.int/maternal_child_adolescent/documents/a91065/en/), accessed 22 August, 2018.
- 3 Nigeria is divided into thirty-six states and one Federal Capital Territory, which are further subdivided into 774 Local Government Areas (LGAs).
- 4 All IMAM sites record programme data in an IMAM registry, on registration cards, individual child cards and summary forms, which are stored locally at facility. Data collected as part of IMAM activities are aggregated into summary reports at the end of the week. These summary forms from each health facility are compiled on paper every month and sent to LGA-level authorities, which send it to state authorities, where it is transferred to an electronic excel-based database and then to the national level. Key performance indicators were measured in line with international standards of cure (>75%), defaulter (<15%) and mortality (<10%) rates.
- 5 RUTF is a key element of the programme. An energy-packed paste made from peanuts, oil, sugar, milk powder and vitamin and mineral supplements, RUTF is an effective tool for treating SAM. Easy to ship and administer, it requires no refrigeration and stays fresh for up to two years. No mixing with potentially contaminated water is required.
- 6 Resource partners included the United Kingdom's Department for International Development (DFID), the Children's Investment Fund Foundation (CIFF), Food for Peace (FFP), Action Against Hunger (ACF), and Save the Children International (SCI).
- 7 According to the SPHERE standard, cure rates (proportion of children who recover) should be greater than 75 per cent; defaulter rates (proportion of children who do not complete the programme) should be less than 15 per cent; and mortality rates (proportion of children who die during the programme) should be less than 10 per cent.
- 8 Assaye Bulti (UNICEF), Stanley Chitekwe (UNICEF), Chloe Puett (ACF), and Mark Myatt (Brixton Health) (2015). How many lives do our CMAM programmes save? A sampling-based approach to estimating the number of deaths averted by the Nigerian CMAM programme. *Field Exchange* 50, August 2015. p38. [www.ennonline.net/fex/50/deathsavertedcmamnigeria](http://www.ennonline.net/fex/50/deathsavertedcmamnigeria)
- 9 Action Against Hunger. Severe Acute Malnutrition Management in Nigeria. March 2015. <<https://www.actionagainsthunger.org.uk/publication/severe-acute-malnutrition-management-nigeria>> Accessed 30 October 2019.
- 10 Bulti, Assaye, André Briend, Nancy M. Dale, Arjan De Wagt, Faraja Chiwile, Stanley Chitekwe, Chris Isokpunwu, and Mark Myatt. Improving estimates of the burden of severe acute malnutrition and predictions of caseload for programs treating severe acute malnutrition: experiences from Nigeria. *Archive of Public Health* 75, no. 1 (2017): 66.
- 11 Assaye, André Briend, Nancy M. Dale, Arjan De Wagt, Faraja Chiwile, Stanley Chitekwe, Chris Isokpunwu and Mark Myatt; Improving estimates of the burden of severe acute malnutrition and predictions of caseload for programs treating severe acute malnutrition: experiences from Nigeria, *Archive of Public Health* November 2017
- 12 *Ibid.*
- 13 Sasha Frankel, Mark Roland, Marty Makinen. Costs, Cost-Effectiveness, and Financial Sustainability of Community-based Management of Acute Malnutrition in Northern Nigeria: Results for Development Institute, June 2015.

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### PHOTO CREDITS

Front cover: © UNICEF/UN0119095/Sokhin; Page 3: © UNICEF/UN055937/Gilbertson VII Photo; Page 7: © UNICEF/UN041140/Vittozzi

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January 2020

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Suggested citation: United Nations Children's Fund (UNICEF). *Investing in systems, scaling-up care: The expansion of Nigeria's integrated management of acute malnutrition programme*, New York: UNICEF; 2020