IMAM programme scale-up plan

Emergency Nutrition response to the drought-affected districts with support from UNICEF-Zambia

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Introduction

Child undernutrition has major implications for a child's physical and mental development and health outcomes, in addition to a country's economic productivity as adults. The 2018 UNICEF/WHO/World Bank estimates indicate that 149 million under-five children (21.9%) are stunted and 49 million children (7.3%) are wasted[1]. Children suffering from severe acute malnutrition (SAM) are nine times more at risk of death compared to well-nourished children.[2] SAM exacerbates child morbidity and increases the risk of mortality, with an estimated 45% of deaths attributable to undernutrition.[3]

Following the drought that affected several provinces in Zambia, there arose a need to support the scaling up of the Integrated Management of Acute Malnutrition (IMAM) program to treat and prevent acute malnutrition. UNICEF managed to secure funding from United Kingdom Government with the objective of enabling the healthcare system to respond to prevention of and treatment for children with SAM. Under the leadership of the Ministry of Health (MoH)and National Food and Nutrition Commission, UNICEF is supporting the Government of Republic of Zambia (GRZ) in implementation of IMAM Programme as part of the Nutrition Response plan in the health sector. The proposed scale-up plan is intended to provide a clear framework to hasten the process of implementing the IMAM program in the 58 affected districts.

Context analysis

Zambia has taken a lot of strides to reduce undernutrition. Stunting among under-five children improved from 40% in 2013 to 35 % and wasting (acute malnutrition) at 4.6% (ZDHS 2018). This translates to an estimated 487,000 children with acute malnutrition of which more than 130,000 are suffering from severe acute malnutrition.

Infant and young child feeding practices (IYCF) show 70% of infants 0-6 months exclusively breastfed, continued breastfeeding at age 12 months as high as 63%. Timely introduction of complementary feeding is high (90.9%) for children aged 6-8 months but the proportion of children 6-23 who consumed a minimum acceptable diet (at least four food groups) is very low at 12%.

Zambia as all southern African subregion has been faced with pockets of drought. Fifty-eight districts were prioritised by the Vulnerability Assessment Committee as the most affected by the drought resulting in negative food and assert -based coping strategies. This has a direct impact on poor infant feeding practices and a surge in cases of acute malnutrition. The onset of this emergency has most-likely further compromised IYCF practices in food insecure districts and therefore exposed many children to an increased risk of morbidity and malnutrition.

The Global acute malnutrition (GAM) rate in the drought-affected provinces of the country is 8.7% (Zambia Vulnerability Assessment Committee 2019). While this result needs to be further validated, it is possible that the situation could have further deteriorated from the baseline of 4.6% GAM rate before the drought. A mass MUAC screening that was done in 4 priority districts indicates a high

[1] United Nations Children's Fund (UNICEF), World Health Organization, International Bank for Reconstruction and Development/The World Bank. Levels and trends in child malnutrition: key findings of the 2019 Edition of the Joint Child Malnutrition Estimates – UNICEF Regions.

[2] Black, Robert E., et al., 'Maternal and Child Undernutrition: Global and regional exposures and health consequences', *Lancet*, vol. 371, no. 9608, 19 January 2008, pp. 243–260. See especially Table 2.

[3] The State of the World's Children 2016. A fair chance for every child. New York, UNICEF: June 2016.

number of acute malnourished children. This is indicative of the problem on the ground and the need for support.

The exploratory field visits showed the facilities as lacking the capacity to implement IMAM program. In all the facilities, following the protocols (due to limited technical capacity), registration and reporting and IYCF counseling were the areas found to be very critical. The main concerns reported by the healthworkers were the distances, lack of supplies pipeline challenges, lack of motivation for the volunteers, limited awareness about the program, lack of job aids and fear that the program will not be sustained after the project ends.

Challenges to the implementation/gaps identified

The field visits, interaction with the teams at the Ministry of health and experiences gathered from the orientation workshop and training on CMAM presented the following gaps mentioned below. These were challenge were confirmed from the review of the bottleneck analysis

- Limited program coverage. There are very few facilities that have benefited from the IMAM program. These are mostly facilities in Lusaka and Copperbelt provinces. These were supported by various partners.
- Limited capacity contributing to poor service delivery. Most health workers have not had any training on IMAM both during pre-service training and during employment. Some health programs especially those on HIV have covered certain information on nutrition for some health workers. The mapping exercise revealed very limited knowledge about IMAM and IYCF among the health workers that had received training or orientation. In the stabilization centers and active Out-patient therapeutic programs (OTPs), protocols were not followed. In addition, community-based volunteers are not trained on IMAM.
- Human resources: There is a high staff turnover within the health workforce and limited number of health workers in most health facilities.
- Supplies: Challenges include insufficient quantitates purchased, regular stock-outs, priority given to therapeutic milks not RUTF, poor stock management and reporting system.
- Focus on prevention program. This has led to low advocacy, leadership support and prioritization of the treatment components and thus affects the implementation of the national scaleup plan as the resources allocated are not sufficient.
- Gaps in monitoring, reporting and evaluation: There is very limited resource persons to support the nutrition M&E at country, province and district level. Reporting is affected by inconsistency, incompleteness, timeliness challenges in addition to lack of reporting tools and limited use of the reports/information generated to inform program performance and quality.
- Parallel management structure for the in-patient therapeutic care program (under the Clinical care services department) and the other components of the IMAM program (under the Public Health department) which impacts on ensuring a continuum of care for children and provision of quality care for the children in the program.
- Limited community awareness

- Access: Most communities are long distances away from the nearest health facilities are long distances thus caretakers must spend a lot of time to reach the facilities. Other factors affecting access include stock out of supplies, seasonal movements, wild animal migrations (elephants) and natural barriers e.g. rivers, lakes and floods cutting off roads

The Scale-up approach

WHO defines scaling up as deliberate efforts to increase the impact of successfully tested health innovations to benefit more people and to foster policy and development on a lasting basis.[4] A scale-up plan should look at existing and/or potential complexities and how to overcome them. The hard and easy steps (quick wins) during the process must be known and ensuring respect for human rights, equity and gender must be at the forefront.

The proposed approach is a combination of both functional (based on available resources that can enable quick implementation) and horizontal (expansion) scaling up. The horizontal approach should be used in the 14 priority districts with the MoH and UNICEF availing all resources as soon as possible to enable services to start. In the 34 districts, implementation will be based on the prioritization made by the provincial and district nutritionists. To overcome the challenge of limited access to services due to long distances, OTP service as will be offered as part of the community outreach either as mobile facilities or stationed in hard-to-reach neighborhood committees- These are to be agreed upon by the district teams.
As there are existing structures, the program should have an integration lens right from the start to ensure effective utilization of resources and sustainability rather than having a parallel implementation structure within the health facilities.
On-job coaching during support visits will be key in ensuring technically sound and efficient implementation including respecting of the protocols, good documentation and reporting, supplies and materials management, community outreach and ensuring effective linkages between all the components of the IMAM program

Additional aspects to consider during the implementation of the approach:

- The need to have a large scale-up should not overshadow ensuring quality of services provided.
- Accountability: The nutrition department and partners share progress reports on performance, supplies, field visits and supervision reports.

[4] Nine steps for developing a scale up strategy-WHO and EXPANDNET 2010

Scale-up framework

Objective	activities	Indicators*	Recommendations
Improve the capacity of health workers to implement IMAM	Training of all health services providers and community-based volunteers on IMAM.	# of people trained categorized by level of training	Effective implementation of the IMAM program requires an understanding of all the components. In the current context where there is very little pre-service training and more so very limited training of health workers in IMAM it's important to ensure that they are trained on a full IMAM package. The trainings should be cascaded to all levels of health care managers, health workers and volunteers. To ensure that IMAM is rooted in health systems strengthening, district health managers, doctors and other stakeholders (who are key decision makers) should be included in the capacity development plan. Understanding the importance of the program (including the treatment component) is crucial for planning and overall support and success of the program
	Orientation of the healthworkers on the project and IMAM scale-up.	# of people oriented and districts	
	On-job supervision plan for all the health facilities.	# of districts with a project's supervision plan.	
	Update and validate the national IMAM guidelines to be the document base for implementation.	Validated national guidelines	
	Finalize the national training kit (modules for different levels of training)	Validated training kit in place.	
Improve community outreach and mobilisation	Mass MUAC screening	# of children and PLWs screened, Proxy prevalence and proxy program coverage figures.	Buy-in from the communities served, ability and vigilance to actively screen and referral of children for treatment and follow-up and effective linkages of all the other components to the community are the basis of a good IMAM program. Community outreach is key to the whole program. In the haste to open the OTPs in facilities, community outreach component is not usually given enough attention and resources. There is very limited awareness on IMAM, it is therefore imperative that focus is placed on strong community outreach by using and empowering existing community health structures.
	Mass awareness about the program	# of people reached with awareness messages.	
	Recruitment/reselection of CBVs and orientation of existing CBVs on the program and their roles.	# of volunteers oriented # of active volunteers	
	Selection of community champions for nutrition	# and cadre of community champions for nutrition	
	Active case finding, referral and follow-up	# of children screened routinely	

		in the community # of referrals	
Starting IMAM activities	Orientation of the district health and administrative leadership on the program and the emergency support.	# of orientation meetings held # of participants in the meetings	The scale-up should build on the already existing health care system and not create a parallel structure. Given the limited capacity and limited experience, all functional OTP need to be supported with robust hands-on mentoring visits to learn on job and gain the experience and confidence to manage the program. In the medium and long term, there is need to recruit and allocate staff for nutrition programing at all levels of the health facilities.
	Preposition all the necessary supplies and materials (refer to the supplies and distribution kit for proposed details of the contents in the kit, forecasted supplies and distribution plan)	# of facilities with RUTF supplies to last for 3 months and a complete implementation kit	
	Opening new OTPs and replication of activities in other health facilities based on each district's prioritisation as per the implementation plans that were developed during the orientation workshop and training.	# of health facilities with functional OTPs	
	Integration of other programs with IMAM (WASH, EPI, HIV programming community health programs).	Specific indicators to each program e.g. # of health facilities with acceptable WASH facilities, # of children with updated vaccination.	
Improve reporting and monitoring of the program. **Note:** In the initial stages of the scale-up, indicators should focus more on the process (admissions, screening, supplies, actual facilities functional) Refer to project	Improving recording & documentation	# of health facilities with sending in complete reports in a timely manner	Monitoring should aim to ensuring that health workers provide quality treatment, carry out and support effective community outreach. It is recommended that each OTP receives at least one technical support visit in the first month of its opening. Engagement with ongoing health sector strategies, reforms and plans to increase visibility and advocacy for the IMAM program will be critical for the long-term implementation.
	Training on use of the tools, completeness of data collection, entry and reporting (data management)	# of people trained	
	Clear defined roles and responsibilities for health staff and volunteers supporting IMAM programme. on individual annual work plan	A monitoring and reporting frame work with clear roles and responsibilities	

documents for key performance indicators			
Improve the mentorship and on-job coaching to ensure effective and tailored support to implementation of the program	Create teams of trainers (trained on CMAM and a training of trainers on training and coaching skills) to provide hands-on support during the scale-up process	# of people trained as trainers.	The knowledge and information attained during trainings and orientations needs to be supported with on-job coaching to ensure effective learning. The focus of the mentorship visits should be on helping healthworkers have a hands-on understanding of the program and competences to implement the program independently.
	Create mentorship teams at national and provincial level to support various mentorship cohorts of during the scale-up.	# of teams created to support the scale-up.	
	Mentoring visits to ensure all OTPs have and respect the minimum standards of implementation.	# of visits by the mentorship teams	
	Strengthen supportive supervision	Indicators on improved performance and quality based on the quality assessment checklists	

*More indicators can be created depending on how detailed the activity is to be reported on and or need for information.

Conclusion

The IMAM program finds a health care system in the country on which it can be built and therefore activities should focus on utilizing and improving the existing resources. Potential challenges to look out for as the program evolves include the potential to create a parallel care/support system, RUTF pipeline challenges, environmental and hygiene implications related to the disposal of the empty sachets, poor community outreach, functionality of the stabilization centers and effective linkages between the components. The framework, activities and recommendations should serve as a guideline for the scale up of the IMAM program. This document should be shared will all partners in the nutrition sector and resource persons to review and finalize the plan in relation to the emergency support and existing district plans.

Annexes:

- Supplies forecast and distribution plan for the emergency support
- District implementation plans (to be shared directly by the provincial/district nutritionists)