

*International Workshop on the  
Integration of CMAM  
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**Recent National Scale Up Experience  
of CMAM in  
Moçambique  
2006 -2008**

Bernadette Feeney  
CTC Advisor  
SC US/Valid International.

# Objectives

To discuss:

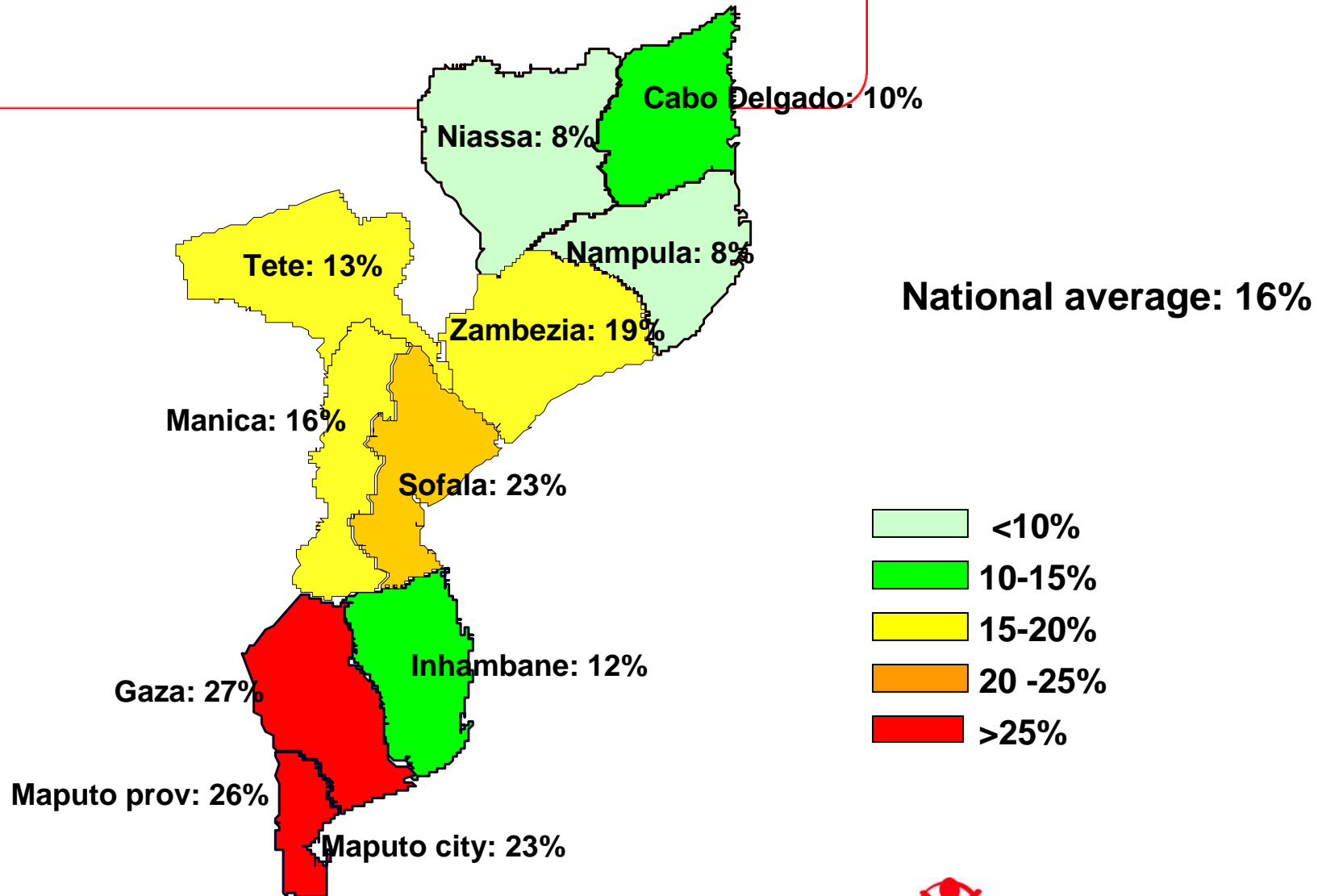
- Background and context
- Delivery of CMAM and national expansion
- Policy environment
- Results to-date
- Limiting factors and possible solutions

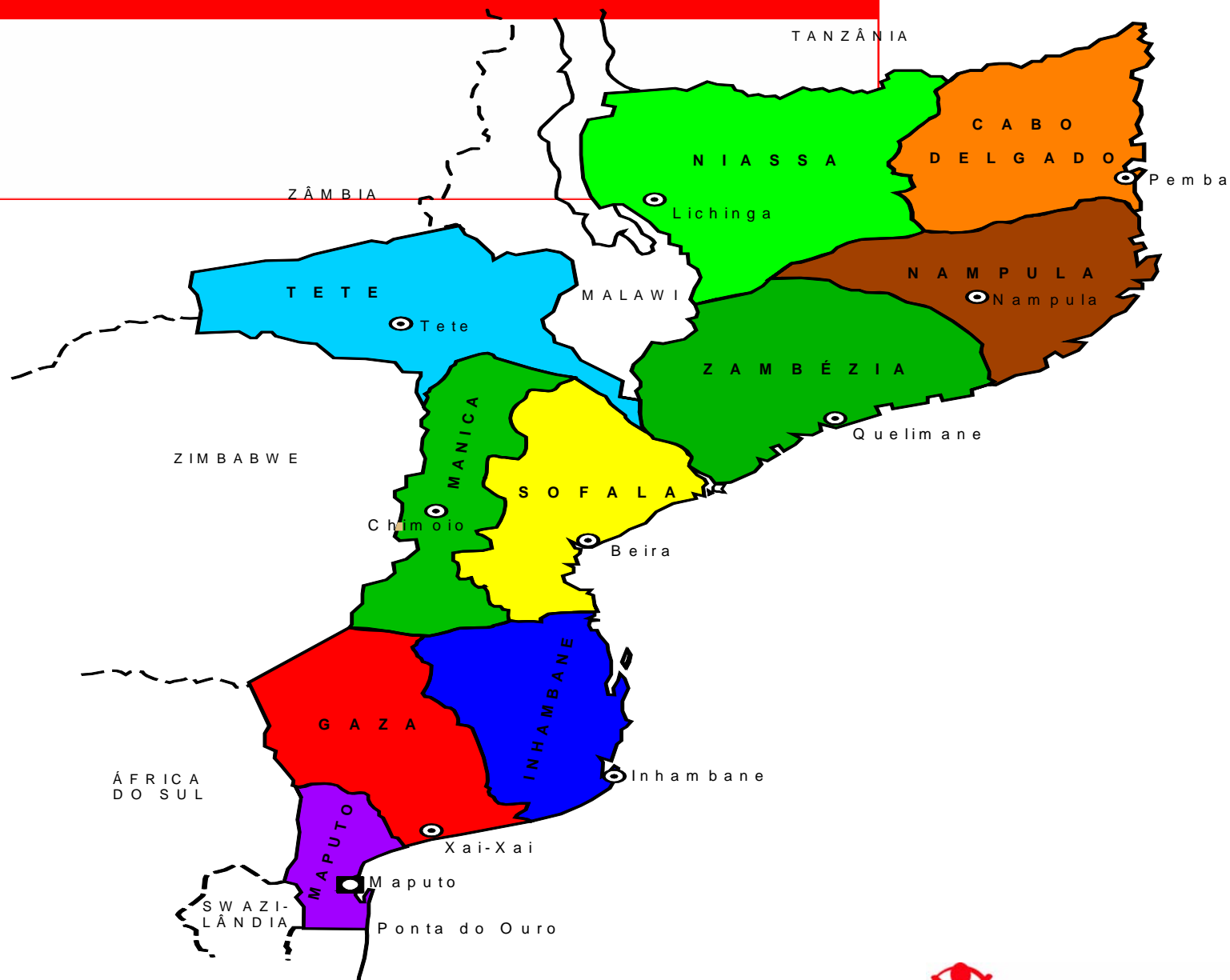


# Background

- Population 20.9 million (1 million in Maputo)
- Very large (801km<sup>2</sup>) and not very dense (23/km)
- GAM 4%
- SAM 0.9%
- HIV prevalence 16.2%
- 11 provinces & 144 districts (5 -25 districts/province)
- Reason for introduction of CMAM: the MOH wanted to link nutrition and HIV services. SAM in children increasingly associated with HIV in Southern Africa
- Low coverage of existing inpatient system (20%) and case fatality (4-35%)

# HIV Prevalence in Mozambique, 2007

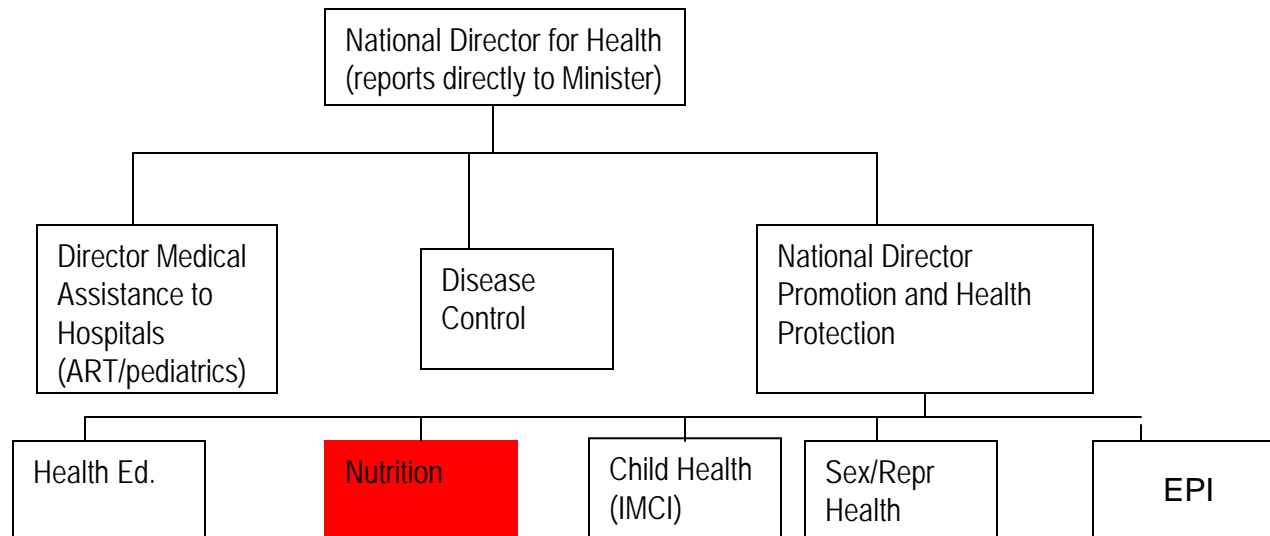




# Structure of the National Nutritional Rehabilitation Program

- SAM Inpatient F75/F100
- SAM outpatient with RUTF (200kcal/kf/d)
- MAM HIV- with CSB (SFP)
- MAM HIV + with RUTF (1pkt/day)
- Nutrition education/food demonstrations
- Community mobilization strategy: just beginning implementation
- Several algorithms/manuals have been integrated into 1 manual/algorithm

# Management Chart: MOH



## Coordination and Planning

- One nutrition meeting in Nov 07; No MOH presence.
- Ad hoc meetings with nutrition department.
- No formal central link with other departments such as Child Health
- Planning for community mobilization December 2007
- Good coordination. UNICEF- NGOs

# Capacity Building/ Training

## INPATIENT

- Mike Golden 2004 in Maputo
- HW training in all provinces, 2005-2007

## SFP

- WFP/UNICEF – 23 districts
- Emergency response to floods – on the job training



UNICEF provided technical & material support to nutrition response during floods Jan 2008



Nutrition technician in flood affected area in Zambezia province providing training to Red Cross CHW carrying out SFP

# Capacity Building/Training

## OTP/AMBULATORY

- Series of presentations at central level by UNICEF
- Training focusing on RUTF for HW in health facilities with HIV services in all provinces (2007)

## COMMUNITY MOBILISATION

- Nil at central level (delayed due to floods)
- Started in some districts in Nampula province supported by SC US



## Monitoring & Supervision

- Finalizing monitoring guidelines (individual/compilation reports)
- Finalizing supervision guidelines (checklists)
- Finalizing data base – use at central and provincial levels



## Resources

- **MOH nutrition dept staff:** recently expanded from 3 to 8
- **Provincial health office:** each has one Head of Nutrition Department and one assistant.
- **Nutrition technicians at district level:** shortage, is not possible to have one per district
- **SC US in Nampula has an advisory team** made up of CMAM coordinator, community mobilization, capacity building and M&E
- Shortage of staff to carry out growth monitoring/anthropometry – use CHWs (*activistas*).
- Ambulatory components of CMAM often carried by *activistas*



# Logistics

- **Central level:** Unclear how stock system works within MOH – difficult to track supply system process.
- **Provincial level:** relatively easy to supply
- **District level:** meant to be requesting RUTF using same system as requesting medical supplies
- F75/F100 is within CMAM system – **RUTF is not**



## Links with other structures

- **HIV/AIDS**: at present OTP is only in hospitals/health centers with HIV services
- **Child Health/IMCI/growth monitoring**
- **Consulta da Criança em Risco (CCR)**
- **At-risk child visits TB**: using some CHW trained in TB treatment and follow up for community involvement in PRN
- **Health and nutrition education**



# Policy Environment Challenges

- MOH 'buy in'
- Coherence in Nutritional Rehab Program (PRN)
- Monitoring: incomplete reporting of outcomes
- MOH objections to a pilot approach in selected provinces only
- Validating MUAC as admission criteria
- Facility-based treatment started before community mobilization



# Policy Challenges

# Solutions

1. MOH 'buy in'
2. Coherence in PRN
3. Monitoring: incomplete reporting of outcomes.
4. MOH objects to a pilot approach in selected provinces only.
5. Validating MUAC as admission criteria
6. Facility-based treatment started before community mobilization

1. Coordination forum/Local production
2. I manual & I algorithm
3. Standardize reporting system/outcomes
4. Use several provinces as a learning centre
5. Continue to present/discuss evidence base/WHO
6. Finalize and implement community mobilization strategy



## Logic of Expansion

- Already in all provinces in 87 out of 144 districts (5 -10 districts/province)
- Logic is according to number of nutrition technicians/province
- Also focused on health centers in district capitals where HIV services provided.
- Difficult to expand further into districts into smaller health centers/health posts (logistics, availability of HIV services)



## Results

- Trainings
  - Health workers trained in inpatient management of acute malnutrition: 1483
  - Health workers trained in management of acute malnutrition without complications using RUTF: 878
- 110 out of 148 sites that provide pediatric HIV/AIDS services using RUTF (87 districts covering all provinces)



## Results

- From Jan to Sep 2007: **4018** children treated with PlumpyNut
- From Jan to Sept 2007: **8845** children with acute malnutrition treated as inpatients
- Mortality: **993/11.2%** (6.4% -21.2%)
- Aim was to reduce mortality **<15%**.  
Achieved
- Still low coverage



# Operational Challenges

- Lack of staff
- Criteria for HIV+ moderates – 1 packet/day
- Floods in January 2008 – need for focus on emergency response
- Lack of acute nutrition experience: confusion over process; related to coherence
- Few cases of SAM appear. Relatively low population density. Acute nutrition not on health staff radar
- Vastness of country – difficult to expand – logistical constraints
- Perception around malnutrition



# Operational Challenges

# Solutions

1. Lack of staff.
2. Criteria for HIV + moderates – 1 packet/day
3. Floods in January 2008 – need for focus on emergency response.
4. Lack of acute nutrition experience- confusion over process –related to coherence
5. Vastness of country – difficult to expand – logistic constraints
6. Perception around malnutrition
7. Few cases of SAM appear

1. Advocate use of MUAC
2. HIV + moderates – treat as SAM.
3. Disaster preparedness
4. Clarify and endorse ambulatory treatment with RUTF with community involvement/Exchange exp
5. Mass treatment model/mobile teams/Child Health campaigns
6. Nutrition awareness/Community mobilization.
7. More on the job, less centralized training





**Children playing on a cannon on Ilha de Mozambique  
tiny mystical island off northeast coast.**