

Tech RRT IYCF-E/CMAM Adviser: Experiences from Niger, Haiti and Nigeria

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The findings, interpretations and conclusions in this article are those of the authors and do not necessarily represent the views of USAID/OFDA, UNICEF or others.



Niger

What we know: IYCF-E and assessment

Location: Diffa, Niger

Period: 28 July to 7 October 2016

Requesting agency: Nutrition Cluster/Save the Children

Host agency (in-country): UNICEF

A security crisis in 2016 in Diffa, Niger, led to massive population movements and significant deterioration in an already precarious humanitarian situation. This area had previously been weakened by recurrent food crises, malnutrition in all its forms, floods, epidemics and limited access to basic social services. Both the local population and refugees from Nigeria and Chad were affected, with women and children particularly at risk. The Nutrition Cluster in Niger and Save the Children requested the Technical Rapid Response Team (Tech RRT) to conduct a Rapid SMART assessment and an infant and young child feeding (IYCF) assessment and to use the results to develop an IYCF in emergencies (IYCF-E) strategy and action plan for host communities, refugees and people living in sites for internally displaced persons (IDPs).

A Tech RRT adviser was deployed to conduct a Rapid SMART assessment in the IDP sites on the border with Nigeria to evaluate the nutrition status of children under 59 months of age (anthropometric data was collected for children aged 6-59 months and health data for children aged 0-59 months). A national SMART survey was in progress but did not include the IDP sites, hence the need for the Tech RRT-led assessment. The Rapid SMART survey was conducted jointly with the National Institute of Statistics (INS Niger) and UNICEF and the results were validated by the district health team and nutrition partners in Diffa and nationally in Niamey by the country cluster coordination team (involving public health ministry staff, INS and nutrition partners). The Rapid SMART assessment found the prevalence of acute and chronic malnutrition 'serious' based on World Health Organization (WHO) evaluation thresholds, as follows: global acute malnutrition (GAM): 13.6 per cent (9.1 to 20.0 95 per cent CI); severe acute

malnutrition (SAM): 2.4 per cent (1.1 to 5.2 95 per cent CI); stunting: 36.2 per cent (30.3 to 42.5, 95 per cent C.I.); underweight: 30.4 per cent; severe underweight: 10.2 per cent.) Results of the Rapid SMART survey were validated alongside those of the national SMART survey; there was consistency between the results of both.

Several recommendations were issued as a result:

- Increase the frequency and regularity of active screening at all displaced sites in Diffa;
- Activate enhanced surveillance of the food security situation in the region;
- Ensure that the most vulnerable people receive food distributions, including appropriate complementary foods for children;
- Promote IYCF-E best practices to ensure health workers and community members understand how to counsel pregnant and lactating women (PLW) and children under 24 months of age;
- Strengthen vitamin A supplementation and deworming in children aged 6 to 59 months; and
- Improve linkages with water, sanitation and hygiene (WASH) programmes.

The same Tech RRT adviser conducted an IYCF assessment in the IDP sites to understand priority programme needs and develop a response strategy and action plan. This was conducted jointly with the District Health Team in Diffa and implementing partners from other international non-governmental organisations (INGOs). Both also participated in the strategy planning workshop. The assessment revealed many concerns caregivers had in feeding their children. Challenges varied from perceived reduced breastmilk supply resulting from maternal malnutrition and stress, to lack of access to ap-

propriate complementary foods. With this information, the Tech RRT adviser worked with the district nutritionist and implementing partners to determine IYCF programme bottlenecks and develop an effective IYCF action plan to address the issues illuminated by the assessment. IYCF assessment results were validated and presented by the Tech RRT adviser at both district and national levels. Identified areas for action were: interventions to increase exclusive breastfeeding rates, especially after two months of age; support to mothers reporting stress, breastmilk insufficiency and inadequate food intake (as their main difficulties when breastfeeding); inclusion of PLW and families with children aged 6-24 months to receive emergency food rations and complementary food rations to help improve dietary diversity scores; and improved awareness among mothers of available health services and IYCF activities (support groups, counselling) in the IDP sites (many mothers were not aware of existing services).

Following the assessments, a two-day workshop led by the Tech RRT adviser was held for district health workers and implementing partners (totalling 30 participants) to develop an action plan to address priority needs and strengthen existing IYCF programming. Interventions included in the plan were mother-to-mother support groups and inclusion of PLW and children under two years of age as target groups in multi-sector interventions. Once this was completed, IYCF-E training was delivered to over 30 participants, including field workers currently implementing IYCF and nutrition programmes. This focused on the key IYCF-E elements of the action plan and aimed to increase technical capacity of field workers on IYCF practices and counselling. An abridged training curriculum, using standard resources and case studies adapted to the Diffa context, was used. Participants largely comprised Save the Children staff and district nutrition team members. The training was well received by field workers, who reported improved understanding of the key elements of IYCF-E and improved skills to respond to problems faced by mothers and caregivers. On departure of the Tech RRT adviser, the district nutritionist and Save the Children assumed leadership of the programme.

Haiti

What we know: IYCF-E

Location: Haiti

Period: 14 October to 11 November 2016

Requesting agency: International Medical Corps (IMC)

Host agency (in-country): IMC.

Tech RRT support was initiated by the Tech RRT Steering Committee after Hurricane Matthew devastated homes, harvests and infrastructure in five departments in Southern Haiti in 2016. The mission was to help design an IYCF-E response package by assessing priority needs and strengthening the capacity of nutrition stakeholders to include IYCF-E indicators in assessments and programme monitoring. IMC hosted the Tech RRT and UNICEF provided technical supervision. The Nutrition Cluster was not activated; in the south of the country, only a health cluster was activated and in Port au Prince nutrition coordination was just gaining momentum.

As an immediate action, a joint IYCF statement was drafted by the Tech RRT (this was an updated version of a statement issued in the 2010 earthquake response) and, led by UNICEF in coordination with the Ministry of Public Health and Population (MSPP), was disseminated to key partners.

A rapid IYCF assessment was conducted in eight of the worst hit sites in Southern Haiti to better understand the impact of the hurricane on IYCF practices. Sixteen focus group discussions were held with caregivers of children under 24 months of age (n=89) and 42 health workers. Results helped pinpoint priority needs for IYCF emergency interventions and identify the most effective measures to improve IYCF practices

for children under two years of age. Key findings included: low to zero dietary diversity due to limited availability of food; mothers believing that their breastmilk was finished or no good because they were hungry; and high rates of infant formula and bottle use (using infant formula purchased from markets). Other difficulties noted were fatigue and poor sleep of mothers; diarrhoea, cough and fever in infants; lack of potable water; unequal distribution of food items; and collapse of health systems, including existing IYCF and nutrition programming. There was a lack of interest in the community to continue IYCF/nutrition programmes as people were prioritising the reconstruction of homes, dealing with the lack of food and money and avoiding illness. Results of the assessment were presented to health officials and NGO partners for validation and discussion. An IYCF-E response plan was developed by the Tech RRT adviser, supported by a workshop attended by nutrition partners from the south of the country. In addition, a key IYCF message sheet was developed and shared with all partners to encourage inclusion of IYCF in multi-sector responses, such as including trained IYCF counsellors (who already existed in Haiti) in emergency mobile clinics and cholera clinics.

A number of challenges associated with the rapid-onset nature of the emergency hindered the completion of all objectives in the terms of reference (TOR) for the deployment. On the Tech RRT adviser's arrival, the nutrition emergency response received minimal support from the MSPP at central and departmental level; health issues, specifically the cholera response, mobile medical clinics and food distributions were priorities at that point rather than nutrition. In addition there was no IYCF technical working group or platform to discuss technical issues at departmental level. IYCF needs were identified in the assessments and a response plan developed, but responsibility to take this forward and the



View from outside of a health facility following Hurricane Matthew, Grande Anse, Haiti, 2016

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best modalities to deliver on activities could not be identified in the absence of engagement by the MSPP. At the time of Tech RRT deployment, national nutrition coordination was just evolving; a nutrition working group was set up at Port au Prince and UNICEF was recruiting to increase nutrition programme capacity. Finally, the TOR included IYCF-E and response plan trainings, however participants were not available for training within the deployment's short timeframe. After the Tech RRT deployment ended the nutrition working group followed up on outstanding TOR objectives.



Community mapping for rapid SMART assessment in Diffa, Niger, 2016

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North-eastern Nigeria

What we know: CMAM

Location: North-eastern Nigeria

Period: 23 June 2017-27 July 2017

Requesting agency: Nutrition Sector

Host agency (in-country): UNICEF

In Northern Nigeria the Tech RRT was deployed to help improve the quality of care in stabilisation centres (SCs) across Borno and Yobe states. Northern Nigeria has been in a state of violent conflict for the last few years, causing unprecedented movement of populations. The conflict has left a significant number of people with limited access to food. The onset of the lean season in June 2017 impacted the situation negatively, leading to increased rates of SAM. This created a need to improve reach and quality of community-based management

of acute malnutrition (CMAM) services, particularly services offering inpatient management of SAM with medical complications.

The Nutrition Cluster requested a Tech RRT adviser to undertake the following:

- Assess the capacity of health staff in the management of SAM with complications;
- Train a team of coaches to follow up on SC trainings conducted by WHO and the NGO ALIMA; and
- Development of a 'Stabilisation Centre Capacity Building Plan and Scale-up Strategy', including quality improvement, standardisation of service delivery and scale-up of inpatient services in Borno and Yobe States.

The capacity assessment was conducted in seven SCs in Borno and Yobe States and involved interviews with 43 SC staff. Estimating that 10 per cent of outpatient therapeutic programme (OTP) cases require inpatient treatment, an analysis of admissions revealed that only 22 per

Coaching and scale-up strategy planning in Yobe State, Nigeria, 2017



cent of estimated complicated SAM cases were admitted to an SC at the time of analysis. Fifty technical questions were asked during the assessment. These were based on admissions; nutrition and medical protocols; follow-up; discharge; reporting; stock management; nutrition education and play; and hygiene and overall SC set-up. The results revealed an overall SC capacity score of 75 per cent and noted individual scores for each SC included in the assessment. Some were supported by NGO partners and operating at very high levels, while others were struggling to operate and meet standards. The areas that scored the lowest were execution of national nutrition and medical protocols, overall hygiene and SC set-up. Borno state ranked higher on following nutrition and medical protocols and lower on reporting; Yobe state showed the converse, with higher marks in reporting and lower marks on the nutrition and medical protocols. Other challenges revealed were weak referral systems with limited linkages between OTPs and SCs, limited training and post-training follow-up, and challenges regarding accessibility of services due to insecurity.

As a result, a capacity development plan was developed with the overall goal of contributing to a reduction of under-five mortality by increasing access to high-quality treatment of SAM with complications; WHO is taking the responsibility to carry this plan forward. Part of the capacity development plan was to train teams of coaches to conduct on-the-job coaching in all SCs to improve quality of treatment. Two three-day coaching workshops were held with a total of 23 (nine from Borno; 14 from Yobe) state health/NGO staff participants. A four-step coaching process was presented that involved observing the work in the SCs, noting strengths and areas for improvement then working with the SC team to improve capacity.

Following this a scale-up plan was developed jointly with the State Nutrition Officer and the Health Management Board. This analysed the areas that lacked SC coverage and presented a three-phase plan to open an SC in each local government area in every state. The Nutrition Cluster and WHO took the lead in executing these plans on departure of the Tech RRT adviser.

A challenge in the initial stages was the time taken to develop the TOR. The deployment was

clearly needed but it took a long time (five months) to get buy-in and sign-off from UNICEF as it was necessary to ensure that the TOR was in line with the long-term work already underway with the government in supporting SCs. A positive effect of this long lead in time was that all involved were well prepared and 'on board' when the deployment finally happened.

Reflections from all deployments

Typical deliverables across deployments are IYCF assessments in the wake of insecurity and natural disasters; development of IYCF-E response/implementation/action plans; facilitation of workshops to analyse and validate assessment results; and IYCF-E orientation and trainings. CMAM deployments for this adviser followed the same type of deliverables, such as assessing capacity and developing response plans and trainings.

Across all the deployments, key partners had challenges distinguishing between IYCF and IYCF-E programming, likely reflecting the weak capacity for IYCF programming pre-crisis, which in turn means limited knowledge and programmes to build upon when the crisis hits. The focus of IYCF-E programmes is on immediately saving lives by protecting, promoting and supporting the needs of lactating women and infants under 24 months of age in the context of an emergency. Different levels of intervention will be necessary, depending on the context. IYCF programmes take more time to establish and provide more

intricate IYCF technical support with (usually) a large behaviour-change component. This involves strengthening the policy environment for the International Code of Marketing of Breastmilk Substitutes, strengthening capacity of health workers at both facility and community levels, and improving the quality of the diet of young children. When these activities are taking place pre-crisis, the building blocks are there for an effective emergency response. Other common findings are: lack of inclusion of planning on IYCF-E in national nutrition plans and emergency response plans; limited awareness of IYCF indicators to use in multi-sector assessments; difficulty in monitoring violations of the International Code of Marketing of Breastmilk Substitutes; and limited knowledge of IYCF-E programme monitoring and evaluation. Follow-up requests post-deployment have been for more IYCF-E monitoring tools.

In the wake of the hurricane response in Haiti the rapid IYCF assessment, development of a joint statement and an IYCF response plan were crucial; however low prioritisation of IYCF by government and partners and lack of programming platforms to integrate IYCF limited putting plans into practice in the immediate term. In the context of an acute emergency, including training is more challenging within the Tech RRT deployment timeframe as staff are much less available due to acute project priorities.

The Nigeria deployment provides an ideal example of how the Tech RRT can contribute and improve emergency nutrition responses. In this case, partner organisations were available to contribute to assessments and trainings and provide inputs into national strategies. The need for the request was clear. Since the completion of the deployment, Nigeria has received additional funding for SC scale-up activities. This shows the dedication of the team on the ground and how Tech RRT support can feed into longer-term response plans.

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The group on completion of training on the IYCF-E response plan in Mogadishu, Somalia, 2017