Enhanced Responses to Nutrition Emergencies

JUNE 2020 – MAY 2023

Concern worldwide

Funded by the European Union

PILOT PROGRAMMATIC PARTNERSHIP

THE CMAM SURGE APPROACH IN NIGER: LESSONS LEARNED FROM SEVEN YEARS OF IMPLEMENTATION

FEBRUARY 2022

PHOTO 1: Mohammed Roufai, CMAM Surge specialist (Concern), explaining to the team at Yama Integrated Health Centre how to monitor thresholds, step 6 of the CMAM Surge approach (Tahoua, may 2021).

Photo: Apsatou Bagaya/Concern Worldwide.

PHOTO 2: Ibrahim GARBA, Head of Yama Integrated Health Centre and Mohammed Roufai, CMAM Surge Specialist (Concern Worldwide) during a Surge supervision (Tahoua, May 2022).

Photo: *Apsatou Bagaya/Concern Worldwide*

1. Introduction

The CMAM Surge approach was introduced in Niger in 2014 by Concern Worldwide in 11 Integrated Health Centres and the Stabilisation Centre of the Regional Hospital of Tahoua. The Tahoua region was chosen for the initial pilot project because of the high prevalence of global acute malnutrition (15% in 2014[1]) and the known problems in the health system, including insufficient human resources and inadequacies in stock management and in the management of acute malnutrition (CMAM) relative to the general functioning of health facilities. Since 2018, the CMAM Surge approach has been expanded throughout most of the country by the Nutrition Alliance partners (funded by ECHO, OFDA and the Common Fund) in collaboration with the District Health Management Teams (DHMTs). To date, the approach covers five regions (Tahoua, Tillabéri, Maradi, Zinder and Diffa), covering 25 Health Districts (HD) and approximately 434 health facilities, including 22 Stabilisation Centres (Figure 1).

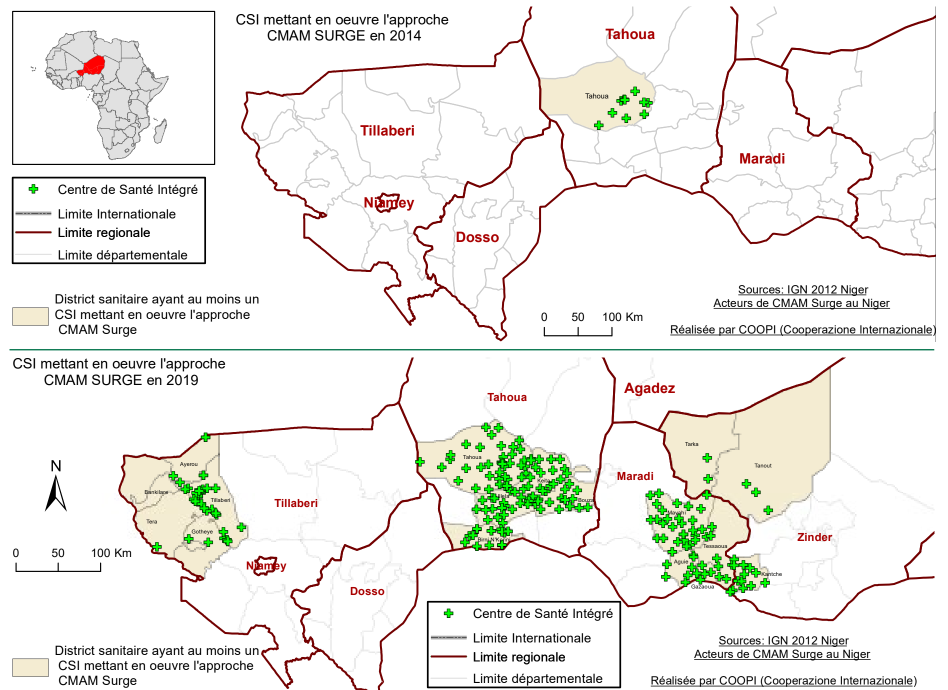
In 2019, Concern Worldwide received funding from ECHO to lead a consortium (in collaboration with Action Against Hunger – ACF and Cooperazione Internazionale – COOPI) to support capacity building of health structures and the National Directorate for the Prevention and Management of Disasters and Food Crises for the scaling up of the CMAM Surge approach and support to the national Early Warning and Response Mechanism (SAOURI/WASSI Programme). In 2020, this project was absorbed by the Enhanced Responses to Nutrition Emergencies (ERNE) programme, a 3-year multi-country programme that aims to increase the scale, efficiency and effectiveness of responses to nutrition emergencies by working with local services and communities to link approved and innovative solutions in fragile, conflict-affected and disaster-prone countries. As part of result 3 (*"shocks in supported districts are anticipated and prepared for"*) of the programme, the consortium is supporting the implementation of the CMAM Surge approach in the regions of Tahoua, Maradi and Tillabéri, as well as supporting national coordination and scaling up of the Surge approach by the Nutrition Directorate.

KEY MESSAGES

- A significant expansion has been observed over the past seven years of implementation, with strong commitment and leadership from the Nutrition Directorate (Ministry of Health) central to this expansion.
- Ensuring dynamic thresholds, based on the capacity of the health facility, is essential for the functionality of the CMAM Surge approach.
- Funding of Surge actions and ensuring a rapid response remains a challenge; strong commitment from the community from the outset is important to support this step.
- The leadership within the health facility to ensure that the approach is adapted is a key factor in the success of CMAM Surge.
- Accessible training resources are needed to help meet the challenge of high staff turnover.

1. Ministry of Health. "Stratégie Nationale de l'Approche CMAM Surge Appliquée à la Nutrition". August 2021.

FIGURE 1: Spatial and temporal evolution of the implementation of the CMAM Surge approach in the Integrated Health Centres from 2014 to 2019 in Niger (Map produced in June 2020).



2. Evaluating CMAM Surge in Niger

Given that the approach has been implemented for more than six years – with the support of several partners – and the planned nationwide expansion, there was a need to take stock of the lessons learned to date. Although the approach is particularly appreciated and supported by local health services, the functionality of certain steps remains a challenge and requires reflection and review by the implementing actors. Two evaluations were carried out in 2021. This document summarises the main lessons learned and recommendations from both evaluations.

The first evaluation focused on capturing the experiences of the CMAM Surge approach at a regional and national level[2]. The main objective was to document and share practical experiences of CMAM Surge implementation in the regions of Tahoua, Tillabéri and Maradi.

The evaluation involved:

- A document review, after which the steps of setting thresholds (step 3), defining and costing actions (step 4) and formalising commitments (step 5) were identified as a key focus for this evaluation given the challenges they face.
- Data collection in health facilities where CMAM Surge was classified either as "functional" or "non-functional" during a joint supervision in March 2021.
- Regional workshops held in Maradi, Tillabéri and Tahoua in collaboration with ACF, COOPI and members of the regional pools of CMAM Surge trainers. Based on the data collected in the field, these workshops served as an opportunity for discussions between all the key stakeholders to identify lessons learned and good practices and to formulate recommendations for improving the implementation of CMAM Surge.
- A national workshop was held in July 2021 to consolidate the results of the regional workshops and to highlight the nuances that exist between regions and health facilities. Under the leadership of the Nutrition Directorate, this workshop brought together regional actors, donors (e.g. ECHO) and UN agencies (UNICEF and WFP). The workshop resulted in the development of a national document summarising key learning generated on the Surge approach in Niger.

2. Concern Worldwide Niger. "Rapport de capitalisation des connaissances pratiques sur l'approche CMAM Surge au Niger". June 2021.

The second evaluation, carried out by an independent research group, LASDEL, aimed to draw lessons learned from the implementation and innovations of the CMAM Surge approach in Tahoua, Tillabéri and Maradi (ERNE programme area)[3]. The objective was to identify the key conditions (critical pathways, contexts, processes), main factors and obstacles to the success and sustainability of the implementation and ownership of the Surge approach by the health facilities and by the health system as a whole. Similar steps were followed by LASDEL, but with more detailed interviews with key informants and a different focus (described below), to gather information related to its main research questions:

- What is the perception of health workers and health authorities of the CMAM Surge approach (added value, challenges and usefulness)?
- In health facilities implementing the Surge approach, what adaptations or innovations have been made that can be learned from? What improvements/evolutions are relevant to CMAM Surge?

Following the document review, a preparatory meeting was held between LASDEL and Concern to discuss the evaluation methodology and the questionnaire to be used. The criteria for selecting the health facilities to be assessed were established: the context of implementation of Surge (emergency or development, urban or rural areas); the implementation partner; the duration of implementation; whether or not the Surge threshold had been crossed; and whether or not Surge actions had been triggered.

The approach chosen was essentially qualitative and broadly described by the ECRIS framework[4]. The data collection was carried out in two phases with CMAM Surge implementers and stakeholders, ranging from donors to supervisory authorities. The first phase focussed on Niamey, Maradi and Tahoua and the second on Tillabéri. Data was consolidated and additional information gathered remotely when necessary. The data was analysed and the evaluation report was drafted.

3. Common Observations

The two evaluations provided important information on lessons learned, good practices and challenges, some of which were common to both reports.

A number of **key best practices** were identified in the health facilities where CMAM Surge was functioning well:

- Strong commitment and understanding of the approach by a variety of stakeholders (e.g., health facility staff, DHMT, NGOs, community members);
- Dynamic thresholds that are reviewed regularly and reflect the capacity of the health care facility;
- The integration of Surge actions into annual investment plans;
- Having staff at the health facility who were considered as “reformers” who adapted, innovated or advanced the system to meet the needs of the health facility;
- Regular joint supervision by the DHMT and integration of CMAM Surge into the routine monitoring the management of acute malnutrition.

On the other hand, a number of common trends were observed in health facilities where CMAM Surge was not functioning:

- Insufficient ownership and low motivation by health facility staff to implement the approach. This was often compounded by high staff turnover resulting in few staff trained in the approach and loss of progress;
- CMAM Surge was perceived by some staff as an “NGO activity” and insufficiently integrated during the implementation phase. This poses the risk of the approach being dropped at the end of NGO-led projects;

3. LASDEL. “Le CMAM Surge au Niger – Une Capitalisation « par le bas »”, November 2021
4. Enquête Collective Rapide d’Identification des conflits et des groupes Stratégiques (ECRIS). Bierschenk et Olivier de Sardan 1994.

PHOTO 3: Example of a seasonal and events calendar in Founkoye Integrated Health Centre (Tahoua, May 2021).

Photo: *Apsatou Bagaya/Concern Worldwide.*

PHOTO 4: Training of health personnel on the Surge approach, Founkoye Integrated Health Centre (Tahoua, May 2021).

Photo: *Apsatou Bagaya/Concern Worldwide.*

- The rotation of staff trained on CMAM Surge between Health Districts impacts on the continuity and correct implementation of the approach, as new staff often have no knowledge of the approach (in other words, insufficient transfer of skills on the CMAM Surge approach during rotations of teams);
- Thresholds that do not reflect the workload and are not reviewed regularly, and Surge action plans with no confirmed source of funding.

A number of challenges were identified as requiring attention:

- The involvement of DHMTs in the monitoring of the CMAM Surge approach;
- The involvement of regional pools of trainers in the implementation and monitoring of the CMAM Surge approach;
- The interconnection and relationships between communities, diaspora, and health authorities.

For the three Surge steps which were specifically targeted (3, 4 and 5), a number of best practices and challenges were identified and are presented in Table 1 below.

TABLE 1: Summary of the best practices, innovations and challenges associated with the CMAM Surge steps: setting thresholds (Step 3), defining and costing Surge actions (Step 4) and formalising commitments (Step 5).

	BEST PRACTICES AND INNOVATIONS	CHALLENGES
STEP 3	• Setting dual thresholds for severe acute malnutrition (SAM) considering service demands on the basis of seasonal patterns of other morbidities (e.g. normal period from January to June and period of high demand for services from July to December); • Progressive alerts – daily or weekly comparison of caseloads against thresholds, rather than waiting until the end of the month; • Threshold monitoring through dashboards (example: digitised Surge database, use of IT tool for more efficient monitoring and presentation of data); • Analysis of data and Surge information on a regular basis (for example: capacity changes, precursor events of high service demands) to make decisions to revise thresholds; • Use of graph paper for monitoring thresholds and morbidity curves.	• Health facility staff are overly focused on the theoretical threshold calculations (Tool 8) and have little understanding of why and on what basis thresholds are set and revised; • Thresholds do not take into account increases in workload or changes in capacity; • The same thresholds kept for 2 to 3 years with no evidence of revisions; • Thresholds are not confirmed or validated by the DHMT or Regional Health Management Team; • Other actors, such as community stakeholders are not involved in the process of setting and monitoring thresholds; • Data is poorly archived or support tools are incorrectly used/completed.
STEP 4	• Surge actions included in the micro-plans of certain facilities (for example: the stabilisation centres in the Mother and Infant Health Centre and Regional Hospital in Tahoua); • A link has been established between other services (e.g. RRM[5]) and Surge action plans (for example: mobile clinics triggered in response to exceeding Surge thresholds); • Surge actions are triggered on time because they are predefined and well understood by the team; • Existing means are mobilised for the execution of certain actions locally; • Preparation and anticipation of shocks or high service demands based on the seasonal calendar and past events; • Regular analysis and exploitation of data and Surge information to re-plan, re-adapt or review Surge actions.	• Surge actions are not detailed and not clearly defined (not SMART[6]); • Internal resources and reorganisation of resources not sufficiently explored or detailed in the Surge action plan; • There is confusion between routine actions (in normal phase), preparatory actions (in normal phase) and Surge response actions; • Non-reporting of Surge alerts; • Surge actions are sometimes not triggered when thresholds are exceeded; • Planning of high budget actions, which are not feasible; • The centralisation of Surge actions at a HD level is not completed

5. RRM: Rapid Response Mechanism
6. SMART: Specific Measurable Achievable Realistic and Measurable

STEP 5	• Model donors or local agreements (e.g. management committees, diaspora) and internal to the health facility (internal teams within the health centre); • Surge actions planned in the annual action plan and financed by the Common Fund (e.g. in the Mother and Infant Health Centre, Tahoua health facility staff were trained on CMAM and CMAM Surge at the same time); • Advocacy workshops at the level of the communes for the integration of Surge actions in the Annual Communal Investment Plan ; • Awareness-raising of communities and the diaspora on the CMAM Surge approach to encourage the funding/formalisation of commitments ; • Establishment of a committee to monitor commitments ; • Creation of WhatsApp group for sharing information related to the Surge approach and presentation of Surge actions in selected groups of the diaspora for funding.	• Failure to establish a timetable of activities; • Communal health committees are not functional; • Commitments made by certain communes are not respected; • Community actors are not involved from the set-up of CMAM Surge; • Meetings are not organised to formalise commitments to finance Surge actions; • Commitments are made on behalf of others without their approval; • Micro-plans are underfunded which does not facilitate the funding of Surge actions; • Standard budget frameworks limits the consideration of other actions; • Insufficient participation of health facility staff in the elaboration of Annual Communal Investment Plan/ Communal Development Plan.

4. Recommendations

A number of trends were observed in both evaluations, which echo the findings from other documentation from the region and at a global level. A summary of the key recommendations and innovation perspectives for implementating and scaling up the CMAM Surge approach are presented below.

Setting thresholds (step 3). Threshold setting should consider the elements outlined in the threshold setting job aid, developed following a workshop in September 2020 organised by the Niger CMAM Surge Taskforce, which focused on the challenges and harmonisation of the threshold setting process. Thresholds must be set correctly for the Surge approach to function. It is essential that threshold setting is a multi-stakeholder process, and that the capacity of the health facility is considered. It is necessary to consider how the DHIS2 can be better used, and strengthened, by the Surge approach. Reflexions were also encouraged around the calculations of thresholds and plotting of monitoring curves via an application (i.e. automated).

Definition and costing of Surge actions (step 4). The Surge actions must be SMART. In practice this means ensuring that all Surge actions (with or without financial implications) are clearly defined, achievable and regularly reviewed, including a timetable for time-sensitive activities (e.g. the topic covered by the community awareness campaign). Surge action plans should include preparedness and prevention actions in the normal phase. These plans are not intended to replace routine planning processes in normal times. It is important to ensure that the elaboration of Surge action plans are carried out with community actors and that the action plan is shared with them once finalised. More detailed information is needed on Surge responses to know who in practice is funding Surge actions, and what proportion of funds are managed independently by the health facility (and/or with support from the HD).

Formalisation of commitments (step 5). Promote and advocate for the inclusion of Surge actions in annual investment plans and district action plans. Hold a workshop to formalise the commitments ahead of these processes at the district and communal level and ensure greater involvement of community organisations (e.g. health facility management committees, representatives of the diaspora, etc.). Strengthen inter-sectoral collaboration. Ensure that informal commitments are documented. Another suggestion to support the formalisation of commitments was to broaden the spectrum of actors engaged at a field level and who could mobilise resources for Surge responses. *A mapping of relevant actors/strategic groups in the health zone/area could be completed* as a starting point.

Invest in training and implementation of the Surge approach, ensuring strong involvement of the DHMT and regional pools of trainers during implementation to ensure ownership of the approach. Find sustainable solutions for the training of health facility staff on the CMAM Surge approach, for example by creating audio-visual training materials, pocket guides, tutoring etc. In addition the importance of ensuring interactivity of trainings was raised and ensuring a process to *keep a record of trainings and identified needs for refresher training.*

Establish and strengthen the capacity of national and regional CMAM Surge trainers to promote government ownership of the approach and sustainability after the project ends. It was suggested that this could be further explored, for example by exploiting the network of 'reformers' who are from the area and could *act as ambassadors* for the Surge approach, easily supporting its geographic extension.

Joint supervision is an important opportunity to build capacity and ensure technical quality of the Surge approach. Health facility staff who are not trained in the approach should be encouraged to participate in supervision sessions to orient them. If supervisions are completed jointly with the state and community actors it could help to strengthen the role and involvement of these structures in the implementation and monitoring of CMAM Surge activities. Similarly, the integration of CMAM Surge into the routine monitoring processes of CMAM is time efficient and avoids duplication of processes.

Encourage the engagement of community actors in the process. Closer links should be established with community focal points to organise and prioritise community activities based on the analysis of seasonal trends and thresholds. A suggestion was made regarding the name of the approach "CMAM Surge", which does not make much sense in French. It could be replaced with a name in the local language that could perhaps help to engage community actors. For example: "*hanguié*" (in Hausa) which means to see far ahead, to see what will come and refers to preparation/planning, or "*dogoney*" (in Zarma) which refers to overcoming/needing support.

Other **avenues of development** were mentioned, some of which were already underway, including the extension of Surge to other morbidities ('Health Surge'), to avoid health facilities being overwhelmed without thresholds being crossed (for example, with a spike in malaria). Secondly, to explore and strengthen the links with early warning and rapid action mechanisms.

The **process of building government ownership of CMAM Surge**, led by the Nutrition Directorate was supported by Concern and resulted in the development and validation of a "National Strategy for the Scaling up of the Surge Approach" which was produced in 2021. Key technical recommendations from the CMAM Surge learning processes were included in this strategy. It was recommended that the next step would be to advocate for the integration of the Surge approach into the national CMAM protocol.

Concern, through the ERNE programme, will continue to support the Nutrition Directorate to address the challenges outlined above and further explore the proposed innovations and implement the recommendation in the coming years.

For more information, please contact: *cmamsurge@concern.net* or visit our *website*.

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