A conversation with Alliance for International Medical Action (ALIMA), March 5, 2021

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Note: These notes were compiled by GiveWell and give an overview of the major points made by staff at ALIMA.

Summary

GiveWell spoke with several staff members from the Alliance for International Medical Action (ALIMA) as part of its investigation into 2021 funding opportunities in the treatment of malnutrition. Conversation topics included ALIMA's adaptation to local contexts, its support of existing health systems, the implementation of simplified nutrition protocols, stock management, and program expansion.

Overview

Children in many countries experience malnutrition. The World Health Organization benchmarks used by humanitarian organizations consider greater than 10% acute malnutrition to be a severe problem and greater than 15% to be an emergency.

The Alliance for International Medical Action (ALIMA) identifies unmet nutrition needs and addresses them by supporting existing health systems in treating malnutrition in 11 countries in West and Central Africa. It uses national protocols for treating malnutrition that have been approved by each country's Ministry of Health; these treatment protocols are adapted by each country based on the standard protocol for West and Central Africa.

At a national level, ALIMA participates in the UN-organized nutrition cluster that coordinates nutrition programs and engages in joint needs assessment. ALIMA encourages ministries of health to see childhood malnutrition as a public health problem and to devote additional resources to nutrition programs. Progress toward this goal has been made over the past 20 years, but efforts are ongoing.

Adapting to the local context

In order to ensure that children have access to treatment, ALIMA adapts its strategy to the local context based on the needs of the population, the role of the Ministry of Health, and the presence of other NGOs. In addition to directly treating malnourished children, ALIMA engages in some or all of the following activities, depending on the context:

- Conducting training and coaching for Ministry of Health staff
- Hiring and training new staff
- Training caregivers in identifying malnutrition by measuring children's mid-upper arm circumference (MUAC)
- Determining the level of acute malnutrition, especially among displaced populations
- Supporting the referral system
- Supporting screening at the community level by community health workers
- Improving water and sanitation as well as infection prevention and control
- Raising awareness about malnutrition and feeding practices among caregivers

Nigeria

ALIMA began work in Monguno, in Borno State in northeast Nigeria, in 2016. It first treated the most severely malnourished children at a functional inpatient therapeutic feeding center (ITFC), which provides inpatient treatment for malnourished children with other medical complications. Over time, ALIMA expanded its work to include treatment at outpatient therapeutic feeding programs (OTPs). One year after beginning work in Monguno, ALIMA was operating the ITFC and nine OTPs. It then reduced services once it had treated the influx of malnourished children that followed the humanitarian emergency there.

Effects of insecurity

Insecurity in Nigeria makes it difficult to treat malnutrition, and many people have been internally displaced. For example, about 60% of the population of 200,000 in Monguno are internally displaced people. The threat of violence from Boko Haram, or being mistaken by the military as part of Boko Haram, prevents people from going to the fields to farm, so the population is completely dependent on humanitarian aid. ALIMA's initial nutritional assessment showed more than 6% of children were experiencing severe acute malnutrition (SAM).

Coordinating with other NGOs

Boko Haram's targeting of health workers made it more difficult for NGOs to carry out programs in the area; UNICEF and the Ministry of Health were the only groups present until ALIMA began its work there. ALIMA initially provided services directly using only ALIMA staff. After other NGOs, such as Save the Children and

International Rescue Committee (IRC), began work at OPTs there, ALIMA focused its work on managing malnutrition cases with complications, such as infection, at the inpatient stabilization center. As it coordinates with other NGOs, ALIMA attempts to avoid duplication of services.

Chad

ALIMA has been working for seven years in N'Djamena, Chad. The number of children treated varies from year to year based on need. In 2020, ALIMA supported the treatment of 25,000 to 30,000 children in four or five OTPs and one stabilization center; in previous years, it treated 30,000 to 35,000 children in six to eight OTPs.

Mali

Southern Mali has a high rate of malaria. The Ministry of Health does not have sufficient capacity in the area and had not previously been treating malnutrition cases. In addition to supporting care, ALIMA set up a 50-bed ITFC training center to teach Ministry of Health staff from the entire district, with a population of one million, how best to treat children with SAM who also have infections. Ministry of Health staff now carry out the treatment themselves.

Supporting existing health care systems

ALIMA works within existing Ministry of Health systems, which include outpatient care as well as inpatient care with pediatric, surgical, and maternity wards. Malnutrition treatment is often a standard part of both outpatient and inpatient services.

In some projects, ALIMA staffs a stabilization center, which provides inpatient services to acutely malnourished children. Sometimes nutrition treatment and pediatric care both occur in the stabilization center. In cases in which pediatric wards are separate from stabilization centers, ALIMA may support the stabilization without supporting the pediatric ward.

Ensuring sufficient staffing

ALIMA seeks to maintain and support existing staffing systems by filling salary and personnel gaps. In some cases, ALIMA provides monetary incentives to increase the salary of Ministry of Health staff to compensate them for the fact that ALIMA's activities increase the number of patients treated, and thus increase the work load of Ministry of Health staff. This is more common in areas experiencing conflict, where it is more difficult to hire staff.

In other cases, ALIMA determines the appropriate ratio of health care providers to patients and then hires additional staff as needed to maintain that ratio. For example, the ratio of intensive care patients to nurses should be 10:1. In outpatient clinics, the desired ratio is 40 patients per day for each nurse because the return consultations following initial diagnosis are less time-consuming (a complete consultation may take 10 to 15 minutes; providing RUTF and checking height and weight may take only two or three minutes). In order to maintain these ratios during

times of the year with more patients, additional staff are sometimes hired seasonally. In stable contexts, ALIMA tries to recruit additional staff at the same salary as that paid to Ministry of Health staff in order to avoid disrupting the existing system.

Staffing levels in areas in which ALIMA works vary from country to country; many health centers and hospitals are significantly understaffed. In Burkina Faso, each health facility has at least two or three qualified staff. In Mali, in contrast, half of the facilities have no Ministry of Health staff. In locations where health facilities are not staffed, ALIMA works with the local community to recruit staff and provides salary support.

Mentoring and capacity building

ALIMA frequently works with Ministry of Health staff to manage malnutrition. Using a patient-focused approach, ALIMA mentors and coaches local supervisors, who understand the local context and can best supervise other staff at the health facility. In addition, ALIMA provides regular joint supervision along with Ministry of Health supervisors. ALIMA adjusts its role to the needs of the local context, building the capacity of local supervisors over time.

Each district has a focal point of nutrition employed by the Ministry of Health to ensure that the health centers have supplies and are collecting data. ALIMA mentors the focal point of nutrition, providing additional resources, troubleshooting when needed (as in the case of stockouts and personnel gaps), and ensuring proper data collection and reporting to the Ministry of Health data system.

The goal of these mentoring efforts is to ensure that the programs are effectively implementing national nutrition protocols and other national guidelines for treatment, and to ensure high-quality data collection, management, and analysis.

Transportation

Transportation is often a barrier to care, so when critically ill patients arrive at an outpatient center, ALIMA often transports those patients to an inpatient center by either using ALIMA's vehicles or providing reimbursement for the costs of other transport.

Implementing simplified nutrition protocols

Simplified nutrition protocols combine diagnosis, treatment, and dosage of ready-to-use therapeutic food (RUTF) for severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) into one protocol. Simplified treatment strategies, such as "Optimizing treatment for acute MAlnutrition" (OptiMA) and "Combined Protocol for Acute Malnutrition Study" (ComPAS), could provide treatment to a larger number of children using the same amount of RUTF. The simplified strategy can be transferred from one context to another and can be implemented without hiring additional clinical staff for outpatient treatment.

In Mali, Burkina Faso, and Chad, ALIMA has expanded existing health care services using a simplified nutrition protocol. In Bamako, Mali, ALIMA launched a malnutrition program without adding additional staff. The program, which used a simplified nutrition protocol, treated 2,000 children in one commune where there was no functional malnutrition program. (Bamako, the capital of Mali, is divided into eight communes, or administrative units.) ALIMA hopes to implement similar programs in other Bamako communes. In Yako, Burkina Faso, ALIMA's program treated 5,000 children; three or four supervisors were hired, but no additional clinic staff were needed.

Needs assessments

Before launching a program in Bandiagara, Mali, in late 2020, ALIMA conducted several needs assessments. In Ngouri, Chad, where ALIMA treated tens of thousands of children over the past years but had recently ended its nutrition and pediatric activities, ALIMA is not conducting a new needs assessment.

Stock supply and management

Effective nutrition programs require an adequate stock of commodities to meet fluctuating needs. In some places, such as Niger, the Ministry of Health, supported by UNICEF, manages stock levels effectively. There are supply chain problems in Chad, so ALIMA maintains a buffer stock there to avoid stockouts.

In some cases, stock availability differs from one part of a country to another. In northeast Nigeria, for example, RUTF is available from UNICEF and donors are interested in funding nutrition programs. However, in northwest Nigeria, which is facing a security crisis, there are insufficient supplies of RUTF, and ALIMA does not have sufficient funding to meet the need there.

Stockouts

RUTF and therapeutic milk are the two commodities most likely to experience stockouts. RUTF is a necessary treatment for severe malnutrition. It is expensive (more than $40 for the amount typically budgeted for a SAM child) and bulky to transport.

In some cases RUTF is being sold for consumption by adults and others in the community, which increases the shortage. RUTF shortages have also been exacerbated by the COVID-19 pandemic. Ministries of health and UNICEF work together to ensure a sufficient supply of RUTF. In addition, ALIMA works with the focal point of nutrition to address stockouts.

ALIMA has experienced some stockouts with malaria rapid tests and malaria artemisinin-based combination therapy (ACT) treatments, especially during the rainy season. Deworming medications are less frequently out of stock.

Insufficient funding for treatment of MAM

MAM programs are also experiencing a funding shortfall. Less than 15% of the requested funds for MAM programs were provided in northeast Nigeria and Niger. In

Mali, funds for MAM programs were reduced to 30% to 50% of their original amount. No funding was provided for MAM programs in southern Mali. Donor interest in funding RUTF is low.

Family MUAC training

MUAC tapes allow parents to detect the first signs of malnutrition in their children by measuring their mid-upper arm circumference (MUAC), using a simple, tri-colored bracelet.

Community mobilizers, who have been trained to explain how to use MUAC tapes, work in health centers and in the community to teach caregivers and conduct mass screenings. Both men and women are trained as community mobilizers so that all homes can be visited.

Malaria screening

Community health workers, who provide monthly malnutrition screening, may also screen for other illnesses, such as malaria, in difficult-to-reach areas.

ALIMA treats a large number of malaria cases. Children who seek treatment for malnutrition are automatically given a malaria rapid test. Half of the children admitted for malnutrition in ALIMA's program in Kamwesha, DRC had a positive test. Some of those children were asymptomatic, and parents would not have known to seek treatment without the screening.

In contexts with a peak malaria season, children receive seasonal malaria chemoprevention through a separate program.

Program expansion

ALIMA's decisions about program expansion are based on unmet humanitarian and medical needs in a region. ALIMA typically engages in joint programs connected to the existing health care system. It is unlikely to launch a program in an area without existing medical care.

Urban areas

Malnutrition treatment programs had focused on rural areas, so eight years ago ALIMA launched an urban program in N'Djamena, Chad, that has now treated hundreds of thousands of children. Two years ago ALIMA created an urban program in Bamako, Mali.

Burkina Faso

In Burkina Faso, ALIMA launched programs in areas experiencing insecurity. For example, after security concerns led some government health centers to close and the government created an emergency protocol, ALIMA launched a malnutrition program there. ALIMA carried out an operational study in Barsalogho and was interested in expanding to Tougouri, which also faces insecurity, because of high malnutrition rates and staff interested in participating. However, the Ministry of

Health decided against using a simplified protocol in Tougouri because it is not located in the emergency area. ALIMA still plans to support standard CMAM treatment in Tougouri.

Nigeria

Katsina, Nigeria, has high malnutrition rates, experiences insecurity, and has a significant population of internally displaced people. In addition, few NGOs are present there. ALIMA sent a team to assess needs and gaps in services; it is now seeking funding to launch a program there, though there is little donor interest.

All GiveWell conversations are available at
http://www.givewell.org/research/conversations