# Empowering communities to tackle malnutrition

**By Steve Collins | Valid Nutrition**

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**Severe acute malnutrition (SAM) is a life-threatening condition that in 2007 alone affected more than 20 million children under five worldwide and was responsible for approximately 1 million avoidable childhood deaths.**

When I first became involved in humanitarian work in the 1980s, children with SAM were treated as inpatients in hospitals or specially designated 'Nutritional Rehabilitation Units'. Treatment took several weeks and mortality rates were high, often between 20–30 per cent.

Because of the high opportunity costs for those accessing care, the inpatient model was unpopular with families, and the high level of specialized resources required meant that only a tiny fraction of those affected ever received treatment. As a result, impact was low and access to care was inequitably spread, concentrated in or around major centres, leaving the vast majority of those affected with no access to specialized assistance.

Community-based management of acute malnutrition (CMAM) has changed that, and today most children treated for SAM receive the care they need exclusively as outpatients, while inpatient care is reserved for the few suffering from SAM with complications. Removing the need for intensive inpatient treatment has allowed access points to be spread more widely and equitably, increasing access and decreasing opportunity costs to those seeking care. More accessible care and fewer opportunity costs have made the new model much more popular with malnourished people. As a result, they present for treatment earlier, when SAM is easier to treat. Mortality rates have dropped and coverage rates have increased. This new approach is saving thousands of children each year.

"The shift to demand-driven programming has huge implications across the development sector."

The core innovation within CMAM is a change from the traditional 'supply-driven' approach to aid and development to a 'demand-driven', client-centred, model. The old approach treated malnourished children and their communities as passive victims who needed cures to be administered to them. In the new interactive approach, programmes are designed in consultation with target populations. An essential prerequisite for impact is to maximize understanding and minimize barriers, making programmes fit better with the constraints and opportunities of those requiring assistance.

This is a profound change – giving 'access and participation' the same level of importance as 'clinical efficacy', and 'coverage rates' the same level of importance as 'cure rates'. In practice, well-designed and well-run CMAM programmes not only vastly increase coverage and compliance, but they also achieve mortality rates lower than even the best run inpatient treatment centres – because they encourage early presentation and easy access.

The shift to demand-driven programming has huge implications across the development sector. The success of CMAM and other similar demand-driven approaches, such as Community-Led Total Sanitation, are just the start. Development agencies will become less involved in actual implementation and more engaged in facilitation, supporting other actors, from the public or private sector, to achieve impact.

Preventing chronic malnutrition, a problem that damages the lives of hundreds of millions of children every year, is one area that desperately requires a shift to demand-driven approaches. The old supply-led distribution of food commodities has achieved little impact or coverage and needs to be replaced by a customer-focused approach that empowers low-income consumers to demand and gain access to affordable, healthier food for their children.

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The development of innovative approaches requires strong evidence, combined with openness and transparency, to highlight and analyze problems with existing models.

During the establishment of CMAM, the shift from care administered by health professionals to care by mothers provoked opposition from many on technical and ethical grounds. Fears that mothers would not be able to identify or manage the commonly seen complications of SAM confused many as they sought to reconcile the ethics behind a clinician's duty to provide the best possible care to her or his patients with the 'public health' imperative to provide the greatest possible benefit to the largest number of people.

Only when large quantities of operational data demonstrated increased impact, lower mortality and lower costs, could such opposition be overcome. The same is likely to be true for any future innovations in development, all of which are by their nature risky and disruptive to the status quo. Ultimately, innovations can only be judged on their outcomes – and this requires evidence.

In my experience, an openness towards confronting problems and admitting failure is also vital in provoking change. In the case of CMAM, my published analysis of a cholera outbreak in an inpatient treatment programme that I had managed in Liberia was a major driver to develop a better model. In Liberia, the congregation of people, a direct result of the inpatient model, greatly increased vulnerability to diseases. When a staff member contracted cholera, the crowded conditions meant that the infection spread rapidly, exposing everybody in the centre in a very short span of time. The collection, analysis and publication of data on what went wrong provided the impetus behind the development of an outpatient model that minimized congregation. That analysis made me acutely aware of the dangers of the inpatient model and was a major motivation towards trying alternative approaches to decentralize care and prevent dangerous congregations of vulnerable people.

Initially, however, the narrow medical paradigm governing the therapeutic care of SAM and the focus on case fatality rates as the sole criteria of impact, blocked change. There was at the time no hard data on the low coverage or minimal population level 'public health' impacts of inpatient treatment programmes to counterbalance the focus on case fatality rates and the prevailing view that more intensive treatment was required. By contrast, the new models decentralize treatment, taking it into the community, which of necessity dictated less intensive individual level intervention.

(http://unicef-sowc-2015.s3.amazonaws.com/wp-content/uploads/2014/10/28211808/Collins.jpg)

At first, in the absence of this critical public health data, I was only able to tinker around the edges of the medical paradigm, improving outreach, decentralizing inpatient treatment centres and promoting early presentation. However, in 2000, the Ethiopian Government's decision to ban non-governmental organizations from setting up inpatient treatment centres gave me a 'window of opportunity' to try treating SAM using an outpatient, community-based approach.

Working with Kate Sadler and Concern Worldwide (http://www.concernusa.org), we designed and implemented a small community-based programme in Bedawacho woreda, later publishing the concept in 2001 and the data in 2002. Although this programme was small, the high-recovery and low-mortality rates provided sufficient data to persuade other governments – initially Ethiopia, Malawi, the Niger and the Sudan – to try out the new community-based approach at greater scale. It also gave the Irish Government (Irish Aid (https://www.irishaid.ie)) sufficient confidence to invest in research to collect the

data necessary to change policy. This core programmatic funding was vital in allowing Valid International (http://www.validinternational.org/demo/index.php) to draw together a team of experts to refine and develop the model and collect outcome data required to provoke policy change. Critically, it also enabled us to invest in the development of new and spatial surveying tools that allowed us to directly estimate programme coverage and impact – a necessary element to allow us to change the clinical paradigm of care into one of public health.

Over the next five years, the 'Community-based Therapeutic Care Research and Development' programme collected data on nearly 25,000 cases of SAM treated with this new approach, attracting additional investment from USAID (http://www.usaid.gov) and DFID (https://www.gov.uk/government/organisations/department-for-international-development) along the way to expand the range of programmes and partners. In 2005, this evidence, combined with data from other groups, who by this stage had also started working on the new models, was presented at a joint United Nations meeting where the decision was taken to adopt the CMAM model.

The central role of evidence and transparency in the process of innovation raises issues for a development system wherein many of the revenue sources are dependent on public perception. In such an environment, it is tempting to see transparency in relation to mistakes as a threat to income rather than as an opportunity to improve and innovate. Fostering an environment that promotes the use of evidence and transparency to provoke change is an important challenge to which we must all rise.

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