# GNC Side Session A1: Wasting

# OVERVIEW OF SESSION

- Welcome and Overview (Iris Bollemeijer)
- Increasing coverage of SAM treatment with CHWs using a combined protocol, in the emergency context of Gao, Mali (Pilar Charle Cuéllar)
- Integrating SAM Treatment into iCCM (Naomi Mwikali Ndung')
- Programming in the absence of product (Diane Ashley)
- Question and Answer

# Increasing coverage of SAM treatment with CHWs using a combined protocol, in the emergency context of Gao, Mali

Pilar Charle Cuéllar PhD

Action against Hunger Spain

# BACKGROUND

- More than 5.0 million of Children under 5 year (U5Y) die in 2021, preventive with: birth care, nutrition, vaccination, and water interventions*
- Number of children suffering from malnutrition is immense, intolerable and unjustifiable. More than 90% of children who receive treatment are cured.

HIGH PREVALENCE: GAM (16.1%) and SAM ( 3.3%)
LOW COVERAGE of acute malnutrition treatment

Stock out of RUTF and RUSF

Armed conflict and violence

Economical barriers to health service delivery

Geographical access to health facilities

Periodic droughts

* UNICEF. Levels and trends in child mortality. United Nations Inter-Agency Group for Child Mortality Estimation. Report 2022 link

# OBJECTIVE

Main objective: To assess the effectiveness, cost-effectiveness, and coverage of adding SAM treatment delivered by CHWs into the iCCM protocol in an emergency setting in Mali

Specific objectives:

- To determine if CHWs can treat SAM children and respect the SPHERE standards in an emergency setting;
- To assess whether coverage increases by including SAM treatment within iCCM package delivered by CHWs in an emergency setting;
- To assess whether CHWs can effectively use a combined/simplified protocol to treat SAM children in an emergency setting;
- To analyze the cost and cost-effectiveness of three different models of SAM treatment.

# METHODS

A cluster Randomized Control Trial (cRCT) with a non-inferiority design to compare three different protocols for SAM treatment without complications https://doi.org/10.1186/ISRCTN60973756

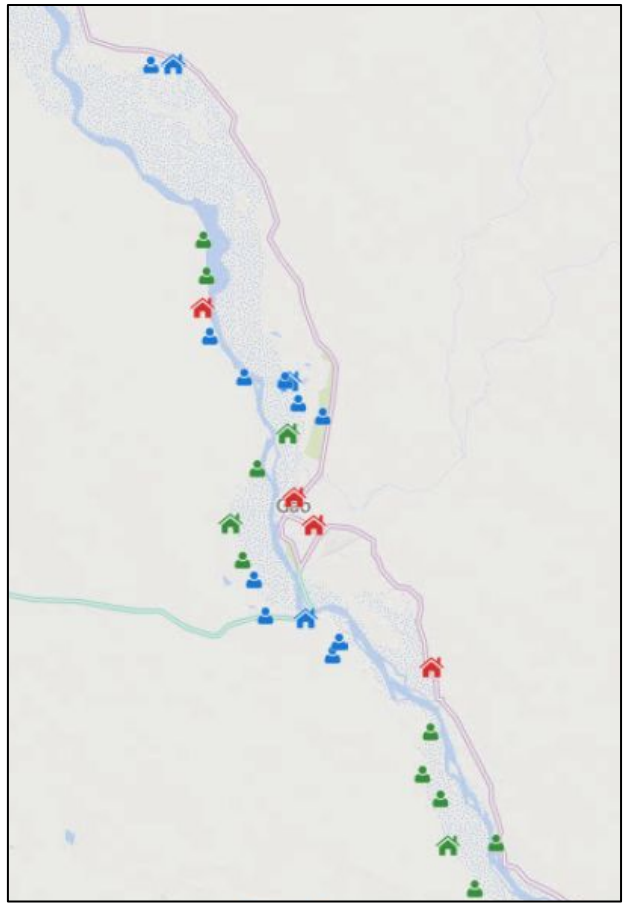
| CONTROL ARM<br>Health facilities | INTERVENTION ARM 1<br>Health facilities + CHWs | INTERVENTION ARM 2<br>Health facilities+ CHWs |
|---|---|---|
| • **Protocol CMAM**<br>• **Admission: WHZ<-3 or MUAC<115mm, or oedema**<br>• **Treatment: RUTF/weight**<br>• **Discharged: WHZ>-1.5 or MUAC> 125mm** | • **Protocol CMAM**<br>• **Admission: WHZ<-3 or MUAC<115mm or oedema**<br>• **Treatment: RUTF/weight**<br>• **Discharged: WHZ>-1.5 or MUAC> 125mm** | • **Protocol combined**<br>• **Admission: MUAC<115mm or oedema**<br>• **Treatment: 2 RUTF**<br>• **Discharged: MUAC> 125mm** |

Children SAM CMAM protocol RUTF / weight: 175Kcal/kg/day

Children SAM combined protocol 2 sacs RUTF fixed 1000 kcal/day

Children SAM < 5kg combined protocol 1 sac RUTF fixed 500 kcal/day

# INTERVENTION AREA

**Control group**
6 health facilities
(CMAM protocol)

**Intervention group 1:**
3 health facilities, 10 CHWs
(CMAM protocol)

**Intervention group 2:**
3 health facilities, 11 CHWs (
combined protocol )

# FINDINGS

## The proportion of cured children

| | Control CMAM (HF) | Interv 1 CMAM (HF+CHW) | Interv 2 Combined (HF+CHW) | p-value Control – Interv 1 | p-value Control – Interv 2 | p-value Interv 1. – Interv 2 |
|---|---|---|---|---|---|---|
| SAM | % (N) | % (N) | % (N) | | | |
| | 100 (386) | 100 (492) | 100 (365) | | | |
| Cured | 96.89 (374) | 95.12 (468) | 96.98 (354) | 0.254 | 0.999 | 0.234 |
| Defaulted | 1.03 (4) | 3.86 (19) | 0.27 (1) | 0.016* | 0.403 | 0.001** |
| Non-response | 0 (0) | 0 (0) | 1.37 (5) | -- | 0.063 | 0.031* |
| Referred | 2.07 (8) | 0.81 (4) | 0.82 (3) | 0.192 | 0.261 | 0.999 |
| Transfer | 0 (0) | 0 (0) | 0.55 (2) | -- | 0.454 | 0.353 |
| Death | 0 (0) | 0.20 (1) | 0 (0) | 0.999 | -- | 0.999 |

# FINDINGS

## Length of stay

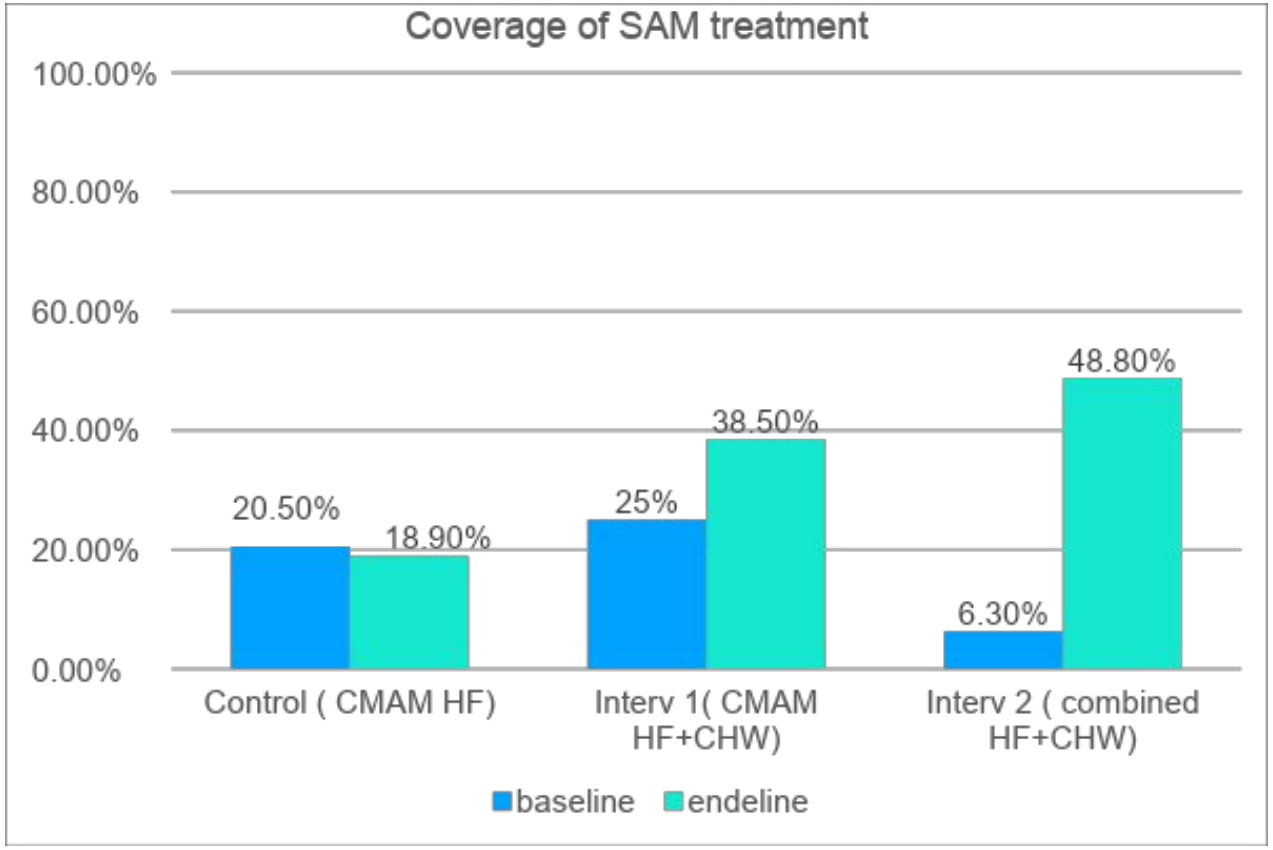
| | Control<br>CMAM (HF) | Interv 1<br>CMAM (HF+CHW) | Interv 2<br>Combined (HF+CHW) | p-value<br>Control–Int1 | p-value<br>Control–Int2 | p-value<br>Int1–Int2 |
|---|---|---|---|---|---|---|
| | Médiane et IQR | Médiane et IQR | Médiane et IQR | | | |
| MAS | N=368 | N=463 | N=342 | | | |
| N days treatment | 42.00<br>(34.00; 50.00) | 42.00<br>(32.50; 63.00) | 42.00<br>(35.00; 62.00) | $0.099^{NS}$ | 0.047 | $0.590^{NS}$ |

# FINDINGS

## Use of RUTF

| | Control CMAM (HF) | Interv 1 CMAM (HF+CHW) | Interv 2 Combined (HF+CHW) | p-valeur Control–Int1 | p-valeur Control–Int2 | p-valeur Int1–Int2 |
|---|---|---|---|---|---|---|
| | Médiane et IQR | Médiane et IQR | Médiane et IQR | | | |
| MAS | N=366 | N=459 | N=287 | | | |
| Sachets ATPE | 115.00 (90.00; 140.00) | 95.00 (75.00; 120.00) | 77.00 (70.00; 91.00) | <0.001 | <0.001 | <0.001 |

# FINDINGS




## Children reached

Increasing coverage of SAM treatment with CHW using a combined protocol, in the emergency context of Gao, Mali

**31.01.2023**

# CONCLUSION

1. The proportion of cured, defaulted and dead children is not lower in intervention group 1 ( CHWs+ CMAM protocol) and intervention group 2 (CHWs+ combined protocol) compared with the control group (CMAM protocol health facilities)
2. There is an increase in coverage in the two intervention groups that deal with CHWs
3. The intervention group 2 of the CHWs that uses the combined protocol, uses a lower number of RUTF bags, 77 bags per child, versus 115 in the control group, and 95 bags in the intervention group with the CHWs and CMAM protocol.

**Docteur Salimata Samaké**
Point Focal Technique du Programme "Integrated Community Case Management" (iCCM) pour ACF Mali.

Lire la suite >

**Docteur Mamadou Traoré**
Médecin-Nutritionniste à la Direction Générale de la Santé et de l'Hygiène Publique du Mali.

Lire la suite >

**Abdou Rahmane**

Agent de Santé Communautaire (ASC) du village de Tandagary, Mali

Lire la vidéo >

[Newsletter 1](), [Newsletter 2]()

[Newsletter 3](), [Newsletter 4]()

# RECOMMENDATIONS

## ACTIONS TO TAKE

- Implementation of CHW acute malnutrition treatment in the humanitarian context
- Under exceptional circumstances use of a combined protocol together with CHW

## RESOURCES

- Ministry of Health, stakeholders, donors, and NGOs who are ready to work with CHW.
- Funding to: 1) ensure recognition and inclusion of CHWs within the health system; 2) ensure supply of RUTF to the community

## ENABLING ENVIRONMENT

- Review by the WHO of management of acute malnutrition guidelines, expecting a favorable recommendation to treat acute malnutrition with CHWs
- Review of management of acute malnutrition protocol in several Sahelian countries.

Noemí Lopez Ejeda PhD (PI)
Saul Guerrero ( co-PI)

Ministry of Health, Nutrition Direction Bamako (Aliou Bagayogo), doctor head of district, 12 nurses' health facilities, 21 CHWs

ELRHA humanitarian innovation funds

Action against Hunger: Mali ( Salimata Samake, Magloire Bunkembo); ROWCA (Abdias Ogobara Dougnon, Fanta Touré); Spain ( Pilar Charle PhD, Antonio Vargas), UK ( Bernardette Chichon)

EPINUT Research Group Complutense University of Madrid, Spain

Increasing coverage of SAM treatment with CHW using a combined protocol, in the emergency context of Gao, Mali

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# Integrating SAM Treatment into iCCM

International Medical Corps - Somalia

International Medical Corp

# BACKGROUND

Somalia is currently experiencing a historic dry spell with a fifth failed rainy season, a situation not witnessed in more than four decades.

Pilot done in 3 villages in Jowhar District, Middle Shebelle Region, Somalia. The Livelihood Zone is Riverine with a critical GAM rate of 15%.

Jowhar district often experience acute food insecurity driven by localized floods, shocks, insecurity/Conflicts, weak health system and natural disasters.

# Rationale

- This idea was conceived during COVID-19 program adaptations in Somalia, such as reducing crowding and congestion in service delivery points.
- Caregivers travel long distances to the nearest facility.
- Waiting times at facilities are long.
- Competing priorities for the caregivers, means that as many as 2 out of 3 caretakers with children affected by SAM do not seek care or ‘default’ after only a few visits

# Approaches Used

- Integration of SAM treatment with ICCM: “ICCM Plus”
- IMC ICCM staff (CHWs) provided management of non-complicated SAM among children 6-59 months using RUTF on weekly basis alongside treatment for malaria, pneumonia, and diarrhea.
- MUAC only for admission and subsequent monitoring during treatment, same as our regular CMAM program per recommendation from the MOH and Nutrition cluster following COVID-19 containment measures.
- IMC was able to store one week supply in the PHUs and have the CHWs **collect supplies weekly** from the PHUs. CHW supervisor would review data weekly and provide supplies as per case loads.
- ICCM staff utilized the same referral pathways as for the CMAM program.


# Training and Capacity Building

Modified modules extracted from Somali ICCM Guidelines and IMAM guidelines.

CHWs (main implementers) & CHW supervisor & Health and Nutrition Officers (supervisors).

- Initial training of 5 days
- Refresher done once per months
- Close supervision and OJT on bi-weekly basis

# How were CHW's motivated or Incentivized?

- Bi-weekly on job and mentoring sessions
- Monetary incentives.
- To mitigate against increased CHW workload and the related effect on quality of care, and frequent turn over – assigned fewer households to cover (50 instead of 180)
- Motorbikes (Bajaj) for ease of movement for the CHWs from house to house
- Daily supervision visits by the Health and Nutrition Officer

# Results: Treatment Outcomes

ICCM plus contributed 19.87% (460) of all admissions analyzed from IMC Jowhar district CMAM routine data (1871).

| Sites | Outcome of acute malnutrition treatment (December 2021 to June 2022) | | | | |
|---|---|---|---|---|---|
| | Cure rate | Defaulter rate | Non-response rate | Death rate | Average length of stay |
| 3 ICCM Villages data | 100% | 0% | 0% | 0% | 37 |
| Other Fixed and Mobile OTPs data | 97.0% | 1.9% | 1.0% | 0.1% | 49 |

# Results Continued

- CHWs to **take correct MUAC** and check for Oedema correctly. This has improved significantly over the reporting period compared to the baseline.
    - Correct MUAC endline: 96.8% compared to 33.3% at baseline
    - Correct oedema endline: 68.7% compared to 6.7% at baseline
- Close supportive supervision and quality control measurers by CHW supervisor and the Health and Nutrition Officer at least three and two times a week respectively, greatly **improved the capacity of the CHWs** to manage acute malnutrition correctly.
- Per week of treatment, households receiving CHW-delivered care **spent only half as much time receiving treatment and less money** compared with those receiving treatment at an outpatient facility.
- **80%** of the patients/caregivers in the project areas reported that they **knew the presence and role of their CHWs** reported.

# Lessons Learned

- This approach can definitely work in Somalia. However, the management of supplies in areas where there is no proper storage and control, have the risk of being misused and high chances of leakages.
- This strategy works well, where monitoring and frequent OJT and supervision is done especially in areas with low literacy levels.
- The CHWs in this pilot supported all other community based interventions because there were no other CHWs in those Villages.
- CHWs need to be remunerated because they dedicate 100% of their time on this. This cannot work on voluntary basis.

# Lessons Learned

- Rather than having CHWs cover 170-180 H/H per month (Somali CH Strategy), this pilot had only 50 H/H per CHW per month.
- Importance of working closely with the health team to ensure full integration (training, tools, implementation)
- Importance to work closely with MOH to receive required approval or endorsement
- Inception of pilot requires a lot of time with designing protocol and tools (3+ months) - allow enough time for preparation phase

# THANK YOU

# Programming in the absence of product January 31st

## Wasting GTWG sub-group

# PRESENTATION OVERVIEW

- Background, purpose and applicability of the Note

- Overview of the Information Note
  - Preparedness
  - Mitigation of shortages of products
  - Managing treatment in the absence of products (outpatient, inpatient, complementary measures)

- Recap of key points on Note purpose and suggested measures

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# Management of wasting during a shortage or absence of specialised nutritious food products

| Category: Products and Supply Chain Challenges |
| --- |
| **Challenge:**<br>How to temporarily manage programmes for the treatment of child wasting when ready-to-use therapeutic and supplementary food (RUTF/ RUSF) products are in short supply or absent |
| **Applicability**:<br>This Note applies predominantly to situations where specialised nutritious foods (SNF) have been used. It does not replace guidance already existing in national guidelines for the treatment of wasting or where the use of SNF is not indicated, accepted or established. There may be emergency situations where governments may want to consider SNFs where they have not previously been used.<br>*The suggestions included in this Note are not intended to be prescriptive and are only to be adopted if relevant to context and after consultation with Government/ Nutrition Cluster and/ or UN agencies* |

# Background, purpose and applicability of the Note

# BACKGROUND

## RATIONALE

Practical guidance requested on what to do when there are supply breaks of therapeutic and supplementary food products in child wasting treatment programmes, expanding beyond COVID-19 context

## PROCESS

- Review and obtain field practitioner feedback on *COVID-19 adaptions Information Note* that has guidance on this topic.
- Revise existing Information Note and release as a standalone piece applicable beyond COVID-19 context

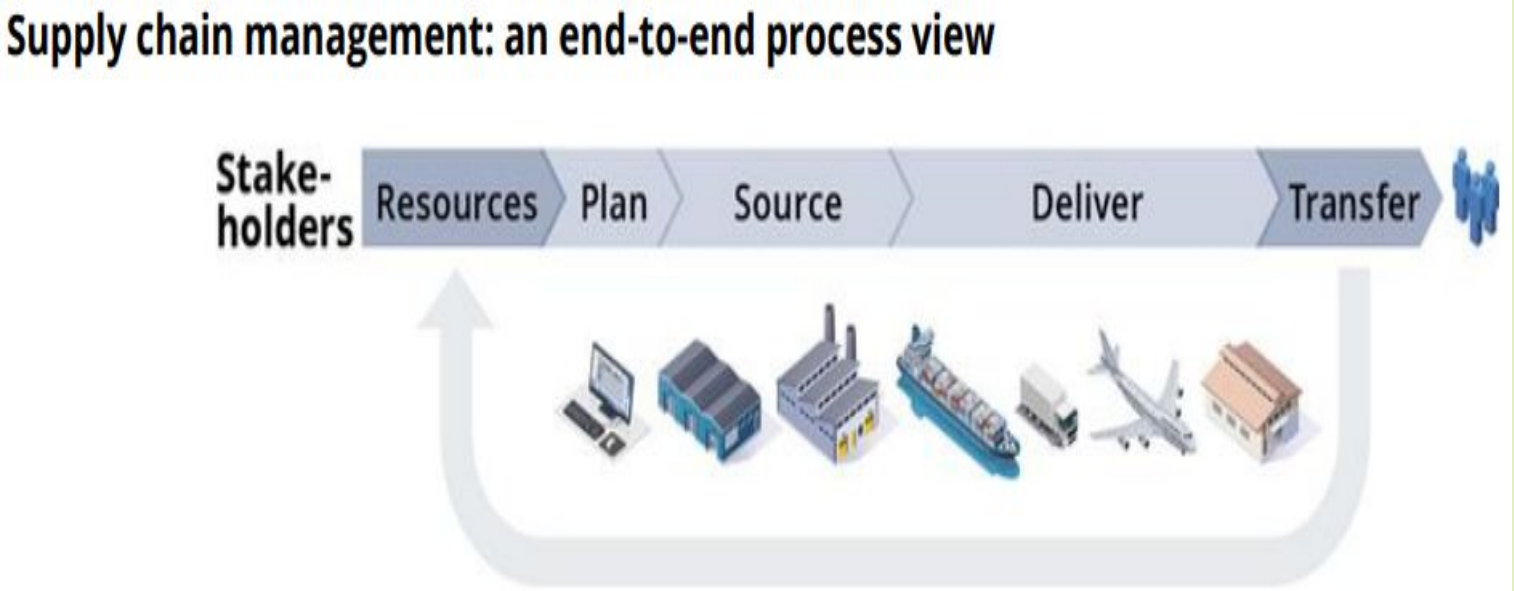
## PURPOSE

- Outline ***suggestive actions*** for the ***treatment of child wasting*** to be taken in ***preparedness*** to avoid or mitigate situations of shortage, as well as to ***manage the absence of therapeutic and supplementary food products when mitigation measures are unsuccessful***
- Guidance note circulated via GNC website https://www.nutritioncluster.net/resources/programming-absence-nutritional-products

# APPLICABILITY OF THE NOTE

- Settings where products used or emergency situations where product planned but not used previously
- Does not replace existing national wasting guidance
- Not prescriptive - adopt only if relevant to context and after Government/ Cluster/ UN consultation
- Measures to mitigate shortages or manage product absence are exceptional, temporary of last resort

- The Government with nutrition stakeholders must agree on:
  1) the circumstances that allow for activation of temporary measures
  2) the maximum timeframe during which any of these alternative measures are to be applied; and
  3) how the return to the national protocol will be ensured




# Overview of Note:
## *Preparedness*

# PREPAREDNESS

With Government/ Nutrition Cluster/ UN strengthen planning, coordination and supply chain to minimize risk of SNF supply breaks and ensure preparedness in case of shortfall.

Examples:

- Prepare or update management/ contingency plans with estimate of needs
- Pre-position SNF supplies, maintain buffer stock, review stock management processes to minimise stock losses
- Develop community engagement plan for rapid dissemination of information


# Overview of Note:

## *Mitigation of shortages of products*

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# MITIGATION OF SHORTAGES OF PRODUCTS

Context-specific, coordinated through Govt and/or cluster and implemented only as ***temporary measures*** after assessing contextual pros and cons

- Stock sharing - (contact in-country MoH/ Cluster/ UNICEF/ WFP)
- Prevention measures
- Early identification of children and enrolment in treatment
- Product substitution
- Revised targeting and programme design
- As last resort, implement protocol adaptation(s)

***Ensure strong monitoring, reporting, lessons learned***


# Overview of Note:

*Managing treatment in the absence of products*

- *inpatient*
- *outpatient*
- *complementary measures*

# MANAGING TREATMENT IN THE ABSENCE OF PRODUCTS

## Inpatient Case Management

- In absence of commercially prepared F75 / F100, use locally prepared F75 & F100 therapeutic milks (if CMV available https://supply.unicef.org/s0000238.html - see Annex 1)

## Outpatient Case Management

- Caregivers continue to attend wasting services (register child, anthropometric/ feeding assessment; follow IMNCI protocols where possible; systematic medication; MNP 1 RNI/ d after concurrent infections treated until SNF restored OR Iron tablets/syrups - see guidance in Annex)
- Refer SAM to inpatient care if available/ sufficient capacity (prioritise those most at risk)
- Counselling on age-appropriate breastfeeding and complementary feeding
- If capacity exists, increase community outreach activities (e.g. home visits, group meetings)
- Consider other complementary measures

# MANAGING TREATMENT IN THE ABSENCE OF PRODUCTS

**Complementary measures to consider:**

- Local, safe, age-appropriate alternatives providing energy/ nutrients for MAM or SAM (requires analysis of appropriate locally available foods)
- Encourage increased nutritious food intake > 6 m
  (e.g. +10% MAM; +30% SAM; Positive Deviance Hearth)
- Cash transfer / voucher + nutrition SBCC
- Link with food security programmes where available
- Ensure improved WaSH facilities / practices

For all measures:

- SBC/ MIYCN counselling (i.e. breastfeeding promotion. consider cooking demonstrations; reinforcing support groups)
- Strengthened inter-sectoral coordination

# Recap of key points

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# RECAP ON KEY POINTS – NOTE PURPOSE AND SUGGESTED MEASURES

**Purpose:**

- suggestions for treatment during product shortage/ absence where product used/ planned for emergency.
- Note does not replace existing national guidance

**Measures:**

- non-prescriptive i). preparedness to avoid/ mitigate shortage; ii) to manage product shortage/ absence when mitigation unsuccessful
- adapt to context in consultation with Govt, Cluster, UN agencies
- to mitigate shortages or manage product absence are exceptional, temporary of last resort

**Once SNF become available, revert back to standard programming, as per national protocol asap**

# THANK YOU

# Q & A