

Lessons and Considerations from the Integrated Community Case Management 'Plus' (ICCM+) Pilot

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Delivery System
for Scale

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Overview

This case study is part of a compendium of country-level case studies produced by the Delivery System for Scale¹ project that explore promising, context-specific approaches to scale the management of wasting treatment for children under five. In Somalia, Save the Children, in partnership with DesignHealth and the Somaliland Ministry of Health and Development piloted the integrated community case management “plus” (ICCM+) approach - representing the first-known operational implementation of ICCM+ model in the Horn of Africa region and in Somalia, in particular. The pilot provided for community-level treatment of acute malnutrition via female health

workers (FHWs), with the expectation that the approach would increase screening and earlier admissions, leading to both improved nutrition outcomes and coverage in hard-to-reach areas. Learning from the pilot is timely, in light of new recommendations in the World Health Organization’s (WHO) guidelines on the prevention and management of wasting and nutritional oedema in infants and children under 5 years². This case study, therefore, outlines the ICCM+ pilot in Somalia, highlights key lessons learned, and details those considerations that should be kept in mind when considering adopting the approach moving forward.

Introduction

Child nutrition in Somalia remains a critical concern. According to the Integrated Phase Classification (IPC) August to December 2023 Snapshot³, an estimated 1.5 million children under the age of five will become acutely malnourished between August 2023 and July 2024, including over 330,000 children who are expected to experience life-threatening severe acute malnutrition (SAM). Despite prioritization of nutrition outcomes, the prevalence of acute malnutrition across the country remains high, with global acute malnutrition (GAM) rates exceeding 15% in many areas. Humanitarian assistance has and continues to play a critical role in treating these children, but coverage of integrated management of acute malnutrition (IMAM) services remains low due to limited: integration (with the national health system), resources (both human and financial), access (both from insecurity and between health facilities and the last mile of service delivery, particularly for hard-to-reach areas).

The Federal Ministry of Health in Somalia, in collaboration partners such as UNICEF, the World Health Organization, Save the Children, Trocaire, International Medical Corps, and World Vision, has actively engaged in the implementation of the Integrated Community Case Management (ICCM) approach for some time. Although originally focused on treatment for malaria, pneumonia, and diarrhea, provision of care at the community-level through community health workers (CHWs) under the ICCM approach has allowed these services to overcome similar challenges to those observed in the nutrition sector. As a result, from 2022-2023, Save the Children together with DesignHealth and in partnership with the Somaliland Ministry of Health and Development piloted the ICCM “plus” (ICCM+) approach, a nutrition-specific expansion of the existing model. In Somaliland, the pilot followed the essential package of health services (EPHS) guidelines (i.e., guiding how anti-emetic, anti-diarrhea medications, and anti-pyretic

medications are administered) with the addition of community-based treatment of uncomplicated SAM cases in children 6-59 months via trained Female Health Workers (FHWs). Implementation of the new approach in Somalia was expected to improve nutrition outcomes and treatment coverage by:

- ▶ Providing a wider outreach for and screening of malnourished children (than would have been achieved through the standard, facility-based care);
- ▶ Promoting a higher recovery rate (through earlier detection and frequent follow-up);
- ▶ Encouraging improved health seeking behavior by caregivers and the community (facilitated by their familiarity with and the acceptability of FHWs); and,
- ▶ Increasing adherence to treatment protocols (by decreasing the amount of effort and cost a caregiver incurs in accessing care and following care requirements).

ICCM+ Pilot

The ICCM+ pilot was implemented in the Gabiley region of Somaliland and targeted 5 communities (Yelda, Xushaley, Xidhinta, Maygaata, and Magalo Muumin) over a period of 5 months from 2022-2023. The first two months of the pilot were dedicated to training and enrollment. DesignHealth developed a FHW training curriculum and training aids. Training followed a training-of-trainers model and was conducted over 4 days across 17 student trainers from the Ministry of Health and Development, Save the Children Somalia and University College London. Given lower literacy rates among FHWs as compared to their facility-based health worker counterparts, the visual design of training and treatment tools was a critical priority. Upon training, FHWs were equipped with treatment registers containing visual patient history information and guiding treatment protocols.

While the pilot represented the first-known implementation of ICCM+ model in the Horn of Africa region and in Somalia, in particular, it has important and timely implications in light of a number of new recommendations in the World Health Organization's (WHO) guidelines on the prevention and management of wasting and nutritional oedema in infants and children under 5 years⁴. These new global guidelines indicate that moderately wasted children can be managed by Community Health Workers (CHWs) in the community as long as adequate training and on-going supervision can be ensured. The WHO adds that this recommendation must be adapted to context, especially in terms of the management of severe wasting and the integration of wasting treatment within Integrated Community Case Management (ICCM+). As such, Save the Children's recent pilot of the ICCM+ approach in Somalia offers a critical point for learning as country-level stakeholders consider different options to revise the Somali national guidelines in alignment with the new WHO global guidelines.

The essence of treatment, as provided by FHWs under the pilot approach, differed slightly but not significantly from standard care:

1. During the FHW weekly household visit, all children under five were screened for acute malnutrition using a simplified mid-upper arm circumference (MUAC) tape.
2. If/when a child was identified as acutely malnourished, the caregiver was encouraged to ensure the child is present during at the FHW's home during the next distribution day (Thursdays). On that day, a SAM or moderate acute malnutrition (MAM) register was opened for the child and if no danger signs were present, the caregiver was provided with a 2-week allocation of ready-to-use therapeutic food (RUTF) along with counseling for how to

provide the food and any danger signs to look out for in terms of further deterioration. The caregiver was then instructed to return every two weeks (on Thursday, home distribution day) for continued monitoring and treatment.

3. Each child and caregiver continued this routine until the child was discharged as cured (or defaults, doesn't respond to treatment, or is transferred for this or other complications).

The later three months of the pilot were dedicated to monitoring both implementation by FHWs and the recovery of children in the treatment program. Remuneration for FHWs was determined by the Ministry of Health and Development and monthly supervision

was carried out by field managers from Save the Children Somalia in order to evaluate the screening, assessment, data in registers, stockkeeping, and to resolve any emergent issues encountered by FHWs. Over the 5-month implementation period, a total of 87 admissions were recorded, with 40 cases resulting in successful SAM treatment, 10 cases resulting in treatment default, and no reported deaths. According to staff, the elevated rate of default was likely linked to the migration of households from targeted villages to alternative locations in pursuit of economic opportunities, as well as the regular seasonal mobility of pastoralist households.

Lessons Learned

While there are a number of advantages, as an adaptation of the existing ICCM model, ICCM+ has new and additional requirements around supplies (specifically nutrition commodities and medications) and FHW time (with more time required per household visit to offer a wider range of services). In the pilot, efforts were made to ensure a consistent supply chain through the provisioning of contingency stocks (which could be used in the event of a disease outbreak or for a sudden surge in the number of displaced individuals, for example). Partners ensured a reserve inventory of treatment-related nutrition commodities, which guaranteed their availability to FHWs within a two-day window for uninterrupted service delivery. The stock management process did not follow that of the standard ICCM or IMAM approach, but rather involved the Save the Children nutrition team working in close collaboration with the ICCM project coordinator to manage nutrition supplies directly (e.g., tools, medication, RUTF and other materials) without integrating fully into the ICCM program.

In order to alleviate some of the additional time demands that follow from the inclusion of nutrition screening and treatment to the existing

ICCM model, the workload of FHWs was also streamlined – specifically, FHWs conducted home visits on specific days (between Saturdays and Wednesdays) and distribution of RUTF occurred on Thursdays at the FHW's residence. Therefore, while ICCM+ adds additional time to anticipated length of each household visit due to the additional screening protocols, patient documentation, and stock-keeping requirements, it also decreases the number of days per week that an FHW spends conducting laborious house-to-house visits (since distribution day is spent in their own residence). An evaluation of FHWs workload and scheduling indicated that on distribution days, caregivers most typically arrived to receive the nutrition commodities between the hours of 8am to noon, rather than throughout the full working day. As a result, future iterations of this approach could consider consolidation of distribution to the morning period, which would free availability for the afternoon period. Additional factors such as caseload demand, catchment characteristics, household allocations, community needs should all be taken into consideration when assessing FHW level of effort for potential use of the ICCM+ approach.

Finally, while this pilot was not a research study, anecdotal evidence from program staff points towards a reduction in the burden of treatment on caregivers by reducing their transportation cost to access treatment and opportunity cost in terms of the time they are required to be away from home and performing other daily duties. Given the promise of the approach as observed through the initial pilot, Save the Children and

UCL have partnered to conduct a more rigorous research study on the approach in the regions of Gabiley and Hiiran. At the time of writing, ethical approval is pending with implementation expected towards the end of the year. Additionally, moving into 2024, there is interest to expand the pilot to the Bay, Bakool Lower Shabelle, Nugaal, and Awdal regions of Somalia.

Considerations for Adoption

The ICCM+ approach is most relevant for areas with established track-record successfully delivering ICCM, which could be leveraged to the benefit of nutrition treatment; this would increase cost-efficiency by streamlining expenses associated with the procurement and management of supplies, remuneration of FHWs/CHWs, training and transportation costs, etc. The approach is also well suited for areas with a high caseload of acute malnutrition in hard-to-reach areas, where access to facility-based treatment is limited, and for areas with a strong nutrition commodity supply chain, given the volume of product that treatment demands.

Based on the pilot experience in Somaliland, a number of operational challenges can also be expected when implementing the ICCM+ approach and these risks should be mitigated for when considering further adoption. First, as previously mentioned, ICCM+ places new responsibilities and liabilities on FHWs (or in other locations CHWs). In Somaliland, FHWs were expected to learn new skills in new technical areas (i.e., nutrition treatment), advance funds for potable water, and take responsibility for nutrition commodity management and patient care delivery from their homes. It is therefore not surprising that the retention and motivation FHWs was a challenge, especially given inadequate compensation and a potentially excessive workload. Future efforts must therefore:

- ▶ Carefully review the remuneration package to ensure it is sufficient to incentivize and motivate quality implementation among FHW/CHWs involved,
- ▶ Ensure continuous support and supervision, especially of the FHW/CHW workload to ensure any additional tasks from treatment-related responsibilities are off-set,
- ▶ Provide subsidies for FHW/CHW water purchases from local water truck vendors, and,
- ▶ Consider enabling the FHW/CHWs to facilitate care and distribution outside of their homes by providing small areas for assessment and treatment in centralized locations within each catchment region.

Second, program quality is achieved and maintained through dedication of a full-time staff to regularly monitor, supervise and continuously build the capacity of FHWs/CHWs. Future efforts should ensure consistently dedicated, full-time roles to oversee service delivery and data reporting, field managers for supervising FHWs/CHWs (with a recommended allocation of 5 FHWs/CHWs per field manager), and liaison officers at health facilities to serve as contact points between the ICCM+ approach and the health system (e.g., for referrals). And finally, as with all SAM treatment, there is a potential for misappropriation of RUTF (including sharing and re-sale). Efforts should be made to ensure proper community and household-level sensitization on RUTF and end-user monitoring should be considered where there are indications of misuse to ensure timely program adjustments.

Summary

ICCM+ is a promising approach for the provision of community-level treatment of acute malnutrition via FHWs in Somalia. The approach has the potential to increase screening and earlier admissions, leading to both improved nutrition outcomes and coverage in hard-to-reach areas. Learning from the Save the Children pilot is timely, in light of new recommendations in the World Health Organization's (WHO) guidelines on the prevention and management of wasting and nutritional oedema in infants and children under 5 years⁵ relating to the management of child wasting by CHWs. Still, further work is needed to adapt the approach to the context of Somalia and specific subnational regions where it may prove most useful. In this adaptation, it will be important to keep a keen eye towards FHW training, workload and incentives, as well as mechanisms to ensure appropriate monitoring and supervision of FHWs and strong RUTF supply management.

Endnotes

- 1 The Delivery System for Scale project was implemented from 2022-2023 by the International Rescue Committee, Action Against Hunger and Save the Children, with the support of UNICEF. The project provided technical and operational support to UNICEF country offices in high-burden countries, aiming to accelerate efforts to bring child wasting treatment to scale.
- 2 World Health Organization (2023): [Guideline on the prevention and management of wasting and nutritional oedema \(acute malnutrition\) in infants and children under 5 years](#).
- 3 [Somalia: IPC Acute Food Insecurity and Malnutrition Snapshot \(August – December 2023\)](#).
- 4 World Health Organization (2023): [Guideline on the prevention and management of wasting and nutritional oedema \(acute malnutrition\) in infants and children under 5 years](#).
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