QUICK GUIDANCE ON SIMPLIFIED APPROACHES FOR THE MANAGEMENT OF WASTING

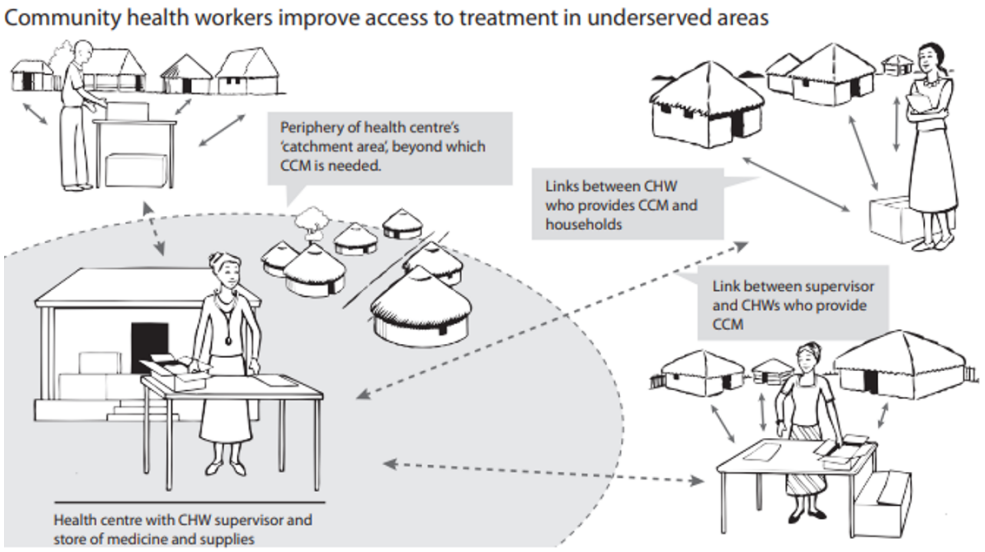
COMMUNITY HEALTH WORKER MANAGEMENT OF WASTING

INTRODUCTION

Currently, the management of wasting is mostly delivered at health facilities as part of child health services, provided by the national health force. The limited reach of these health facilities, particularly in rural areas can result in low coverage of routine services, particularly those which need repeat visits to the health facility, as is the case for wasting treatment. Decentralisation of wasting management to the community health platform provides an opportunity to increase access, utilisation and overall coverage of this life saving service. Furthermore, in the current COVID-19 context, this approach also helps limit movements and the potential transmission of COVID-19, as well as relieving pressure on health facilities.

The Integrated Community Case Management (iCCM) model was first published in 2012 by WHO and UNICEF as an evidence based model to improve child health outcomes by decentralising the management of common childhood illnessses to community level.[1] To date, this package has largely focussed on the treatment of malaria, diorhea and pneumonia at community level by community health workers. In recent years, wasting management has been integrated in to this platform given the opportunity this model provides to increase access to treatment demonstrating promising results.

FIGURE 1.
Justification for integrated Community Case Management[13]



OVERVIEW OF EVIDENCE & PRACTICE

15 studies, pilots or projects have tested the effectiveness of wasting management when delivered by Community Health Workers dating from 2009 to 2020. Recovery rates recorded in these trials are consistently high,[2–4] indicating that this is a very promising service adaptation, which can be delivered by low-literate CHWs.[5,6] Furthermore, defaulter rates across these studies are consistently low which is likely due to the fact that this model of service delivery brings treatment closer to the household[2]. What is more, where treatment is available closer to the household, care seeking can happen in a more timely manner leading to early detection and admission, improving overall service quality.[7] Importantly, this modification also reduces costs for families to access the service by over a half and is also less costly for the health system.[8,9]

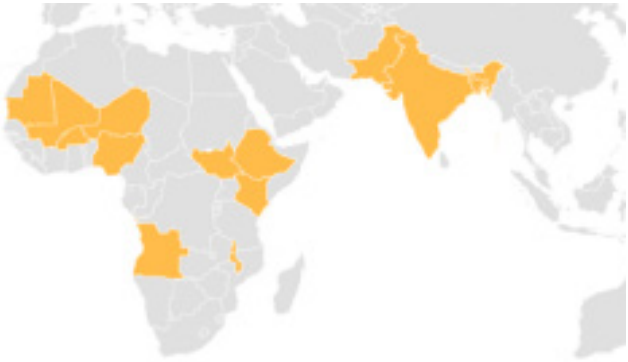


FIGURE 2: **Countries where CHW trials have taken place**

Finally, decentralised services have also proven to increase access and coverage of treatment services.[9]

In addition to these small-scale interventions, the management of wasting by CHWs is also delivered at a larger scale in a few countries, such as Togo and Mali. In Togo, CHWs in the northern regions of the country have been engaged in the treatment of wasting since 2009. CHWs in villages further than 7km from health facilities were trained to treat wasting and equipped with necessary tools and supplies. Since this initial training, the approach has been scaled-up to more regions and CHW admissions contribute to almost a third of all admissions. In Mali, following research trials demonstrating the effectiveness of CHW treatment, national policy for community health was formally adapted to include wasting treatment. Since this policy change, wasting treatment has been scaled up through the community health platform.

In the context of COVID-19, the decentralisation of treatment services was on modification proposed by UNICEF and WHO[10,11] to reduce crowding at health facility level. This was accompanied by specific tools developed to facilitate implementation co-created by a global level technical working group.[12]

CONSIDERATIONS FOR IMPLEMENTATION

Given the robust evidence base regarding the quality of care when wasting treatment services are decentralised to the community health platform, this modification is now being considered for scale across multiple contexts. Systematically scaling up the treatment of wasting through the community health platform may allow for a more integrated service which is more accessible to families, particularly in rural contexts. Furthermore, coupling CHW treatment with the Family MUAC approach could help improve both supply and demand for the service, enhancing overall effectiveness and reach.

Community health platforms vary in scale and maturity country by country impacting upon the capacity and readiness of this platform to integrate wasting treatment services. As such, where wasting treatment is to be added to the community health platform, this should be accompanied by a strengthening of the system to provide this additional service, to ensure that the platform does not become overburdened. Where possible, wasting treatment should be integrated into existing workplans and curriculums. Job aids and tools should be modified to incorporate wasting treatment rather than the creation of stand-alone documents and tools.

Additional supervision to support these community health workers is also key. Important consideration must be paid to the supply chain, given the operational implications of decentralising treatment. Local solutions ensuring delivery to the last mile will be necessary and close end user monitoring should be considered to ensure supplies are being appropriately used. Finally, appropriate renumeration of these community workers in accordance with national health system guidelines and mechanisms for payment should be clearly determined by local or regional health authorities.

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