ADAPTATIONS IN THE MANAGEMENT OF CHILD WASTING IN THE CONTEXT OF COVID-19

Case Study
Organization: ACTION AGAINST HUNGER
Location: SOMALIA
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CONTEXT OVERVIEW

Following guidelines provided by WHO, the Somalia Ministry of Health, and the Nutrition Cluster, Action Against Hunger USA implemented adaptations to its nutrition programs in March and April 2020. These adaptations aimed to minimize the risk of COVID-19 transmission while continuing services for the management of child wasting. CMAM protocol adaptations, in addition to IPC measures, included:

(1) Modified frequency of follow-up appointments during acute malnutrition treatment; and
(2) Suspension of screening and outreach by Community Health Workers and scale-up of Family MUAC for early case identification.

ADAPTATION IMPLEMENTATION

(1) Modified Frequency of Follow-Up Appointments

To reduce overcrowding at clinics, Action Against Hunger reduced the frequency of scheduled follow-up visits for children in the program. Follow-up visits for children with SAM enrolled in outpatient treatment changed from weekly to bi-weekly visits, and follow-up for children with MAM was shifted from bi-weekly to monthly appointments.

When this adaptation was first implemented, some caregivers were confused about the scheduling changes. Program staff increased messaging and sensitization at the clinics and in the community to resolve this confusion. Staff also suggested that increased time between visits might result in sharing of nutrition supplies among other children in the household. Healthcare workers were therefore concerned that children may regress or lose weight as a result of the adaptation. Staff recommended that increased follow-up of children at the community level could promote adherence and minimize missed visits and non-response.

Logistically, the increased demand for nutrition supplies combined with movement restrictions related to COVID-19 and the rainy season challenged the prepositioning of sufficient supplies. Staff workload also increased due to two factors. First, clinic hours were extended to adapt to the revised scheduling, increasing staff's working hours. Second, staff spent additional time with each patient at the site to ensure implementation of IPC measures and that caregivers and patients are aware of and adhere to the revised scheduling.

(2) Scale Up of Family MUAC

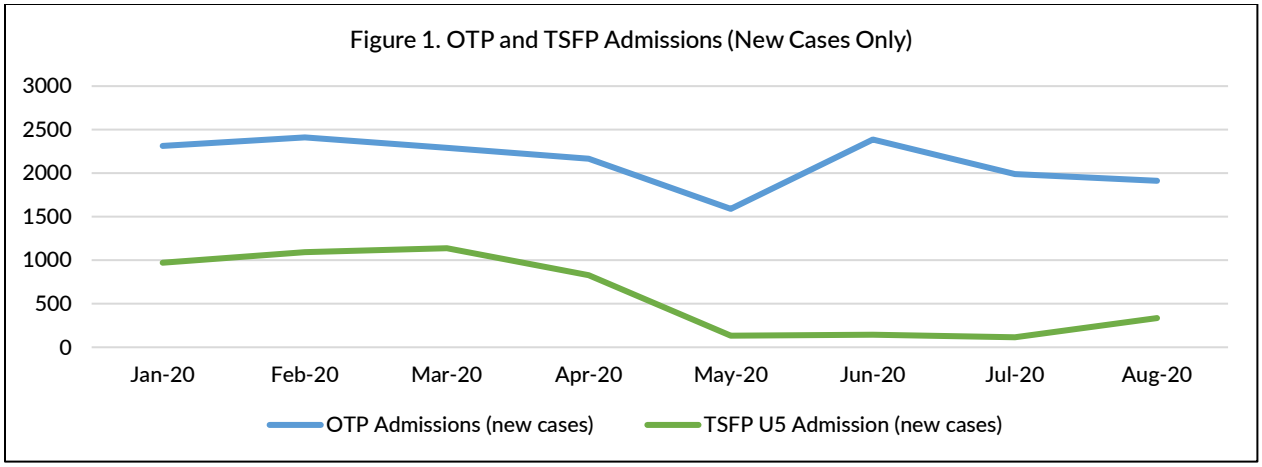
As in many other contexts, mass screening and surveillance were severely restricted in Somalia under COVID-19 guidance. Furthermore, while children are usually screened for malnutrition as part of routine health services, staff reported that the number of children coming for visits reduced due to fear of contracting COVID-19 at the clinics. Therefore, to promote continued early identification of cases, Action Against Hunger implemented Family MUAC

in line with official guidance. Mothers and caregivers received training both at clinics and within the community in small groups of 5-10 individuals.

Overall, the Family MUAC approach has been well received by staff and caregivers. It has reportedly reduced the workload of community health workers (CHWs) within the community, as it is intended to shift primary ownership of screening over to caregivers. Furthermore, one staff noted that this might ultimately lower the severity of acute malnutrition and complications, as mothers may identify signs of malnutrition and bring their children for treatment earlier, before they deteriorate. The primary challenge in implementing this adaptation was reported to be a limited supply of MUAC tapes, therefore restricting participation in this approach.

PROGRAMMATIC DATA

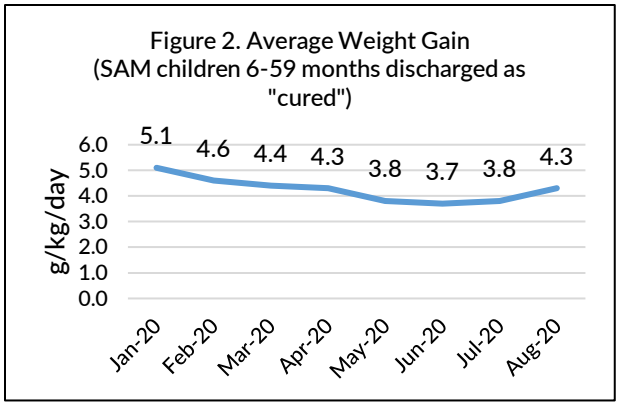
As indicated in Figure 1, OTP admissions declined slightly in April and May, with an uptick in June. This mirrors staff's perceptions of decreased admissions due to movement restrictions and other factors earlier in the year. TSFP admissions have also decreased, potentially ascribed to the suspension of community-level screenings, changes in follow-up appointments, and fear of contracting COVID-19 from health facilities.

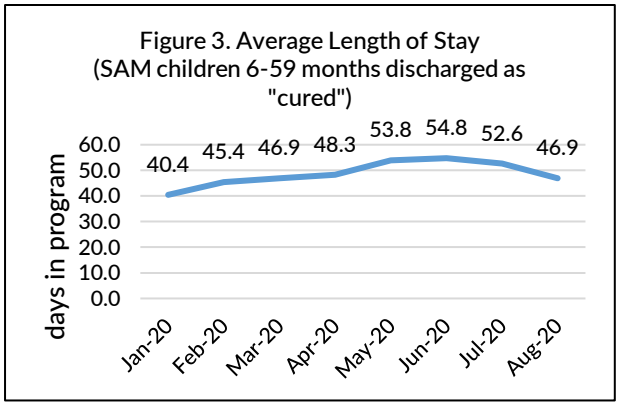


Program outcomes[1] (% cured, % defaulter, % deaths, and % non-respondents) for both OTP and TSFP have remained relatively steady through the year and there was no discernable difference between pre-COVID rates and those during the pandemic. The program's performance remains well within the Sphere standards.

Average weight gain for children discharged as cured from OTP declined steadily since the beginning of the year, only ticking back up in July and August (Figure 2). Conversely, the average length of stay has generally increased since January, though programmatic data shows a decrease starting again in July (Figure 3).

[1] It should be noted that any impact of the adaptations on program outcomes may be lagged, particularly given the increased spacing between appointments and, as noted above, a general increase in children's LOS in the programs.





LESSONS LEARNED

(1) Successes

- The adaptations reduced staff and beneficiaries' potential for exposure to the COVID-19 virus while ensuring continuity of services.
- Close collaboration between government authorities, NGOs, and other stakeholders is critical to ensuring widespread awareness and acceptance of program adaptations and guidelines adherence.
- Enhanced and strengthened community response and community-based interventions promotes continued access to services despite fear of coming to facilities.
- Interview participants were in favor of continued implementation of Family MUAC even after COVID-19 to enhance community-based screening, support caregivers in monitoring their children's health and nutrition status, and identify and enroll malnutrition cases early.
- In the absence of physical training sessions, staff were oriented through online webinars on the new adaptations and new ways of working, thereby enhancing their capacity to deal with the pandemic.

(2) Challenges and Limitations

- Adequate essential supplies must be prepositioned to avoid stockouts. International lockdowns also led to disruptions in the supply pipeline.
- Staff recommended developing surge capacity to enable service continuity if clinic staff fall ill or need to be quarantined after suspected exposure to COVID-19.
- Reduced frequency of follow-up visits may have impacted program quality. Given the noted increases in lengths of stay and reduced rate of weight gain, programs operating with increased durations between follow-up visits must be closely monitored in order to ensure that children are receiving optimal care.
- While there has thus far been positive feedback on the reduction of CHW workload and increased family ownership over monitoring their children's nutrition status through the Family MUAC approach, there may be other consequences to this shift. There may be future tensions if CHWs, operating under an incentives model, no longer have the same workload.
- Discussions also took place around suspending the use of WHZ as an admission criterion. However, this adaptation was not implemented due to staff concerns about missing malnourished children who would be ineligible for admission based on their MUAC.

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