CMAM 2021

22-25 March

VIRTUAL CONFERENCE

CASE STUDY 3

SOMALIA

Scaling Up Management of Wasting in Somalia: A Case Study

CONCERN worldwide

Irish Aid
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1.

Context

Wasting burden

Somalia continues to experience a high burden of wasting due to political instability, prolonged conflict, and livelihoods vulnerability related to climactic variability, access issues and variable coverage of basic services.

An intensive series of SMART surveys are conducted twice a year in Somalia producing an overall global acute malnutrition (GAM) prevalence following the two main rainy seasons. GAM remains persistently above WHO-UNICEF's "high" threshold[1] for nutrition emergencies (1,2), see Figure 1.

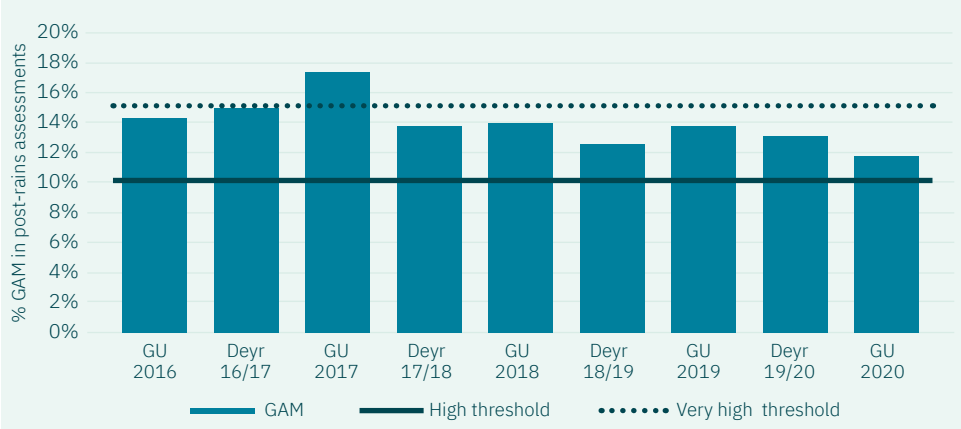

Figure 1. Prevalence of GAM in the post-rainy seasons assessments in Somalia, contrasted with WHO-UNICEF emergency nutrition thresholds (1,2).

Wasting policies and frameworks

The Somalia Nutrition Strategy (2020-2025) seeks to position wasting within a primary health care approach and aligns with Health Sector policy documents and the National Development Plan for Somalia (3,4,5). The Basic Nutrition Services Package (BNSP) guides which nutrition actions (curative and preventative/promotive) are critical in the Somali context. While the protocol for the Integrated Management of Acute Malnutrition (IMAM) 2019 provides guidance on nutritional and medical rehabilitation.

1 The prevalence of global acute malnutrition of 10-14.9% is considered "High, and a GAM of 15% or over is considered "Very High"(2).

Service quality and coverage

Due to security constraints, coverage surveys are difficult to conduct in most areas of Somalia. Instead the Nutrition Cluster gauges coverage as the proportion of the yearly target reached for new admissions. Concerning the coverage of programmes for severe wasting, they typically exceed over 100% of the target[2] (6). Coverage of moderate wasting services for both children and pregnant and lactating women is normally lower. For example in 2020 the coverage of moderate wasting services for children was 79% (6). Coverage of services for wasting is compromised by a lack of nutritional rehabilitation products. Performance indicators consistently remain above SPHERE standards in Somalia, recovery rates in 2020 were 95.5% for severe and 91.9% for moderate wasting (6).

2 The calculation of coverage for severe wasting in Somalia has consistently shown proportions of greater than 100. Nutrition Cluster members belief that this is not an issue of all children in need accessing services, but is more a reflection of the incorrect application of incidence or issues with individual reporting.

2.

Key successes

Despite a prolonged civil war and continued political and security constraints, services for the management of wasting have remained a key feature of humanitarian response in the country.

The federal Ministry of Health has demonstrated their commitment to scaling up and improving service delivery through various strategic frameworks. At national, regional and district level there are now health sector structures responsible for disseminating normative guidance and supervising implementing partners. Joint supervision experiences between implementing partners and district health management teams are increasingly frequent and offer a concrete way to build capacity and accountability. While the strength of these governance structures can vary and they are still fairly dependent on external support, only ten years ago they were essentially non-existent. These structures mark an important step for government ownership and oversight of nutrition services.

An additional success is the migration of coordination structures from Nairobi, Kenya to Mogadishu, Somalia. This has allowed key partners such as the Nutrition Cluster, UN agencies, donors and implementing partners to support the government to develop its vision for wasting as well as its oversight and accountability mechanisms.

Involvement of the community is a key feature in wasting programming in Somalia. The community is involved through several mechanisms i.e. Community Health Workers diagnosing and either referring or managing wasted children at community level; caregroups with support either the leaders and/or its members to use MUAC tapes to diagnosis and refer wasted children and pregnant/lactating women; and more recently Family MUAC where families are empowered to use MUAC tapes regularly for early detection. Community Health Committees provide oversight of the nutrition services being provided in the catchment. The CHCs also serve as a mechanism of obtaining feedback and accountability of the provided services and act as a linkage between the facilities, partners, MoH and community members

3.

Enablers and barriers to the scaling up of wasting treatment

Enablers

A key enabler which supports the planning of wasting services in Somalia are the information products produced by the Food Security and Nutrition Analysis Unit for Somaila (FSNAU) which is a body of FAO Somalia[3].

The FSNAU produces food security and nutrition assessments following the Gu and Deyr rainy seasons, this includes comprehensive SMART surveys. Nutrition Cluster partners are able to use this data to anticipate caseload, but also to plan for the pipeline of nutritional products. While there have been pipeline breaks for a variety of reasons, they are often not severe or prolonged. The timely information and forecasting of caseloads facilitated by the FSNAU assessments helps the pipeline partners anticipate supply demand. The pipeline system for nutritional rehabilitation products in Somalia is unique from other similar contexts. The pipeline is managed by a blend of partners including NGOs, UN agencies, and the Ministry of Health.

The fact that the coordination structures for nutrition and other sectors are now located in-country supports Somali ownership and oversight of the services. With the support of the Nutrition Cluster the MoH has ensured that all partners implementing wasting services in Somalia are using a common protocol, training tools, and a unique reporting and monitoring system. This has helped to bring coherence to what was previously a very vertical and NGO-led sector. In addition, this approach has support both the MoH and the Nutrition Cluster in their resource mobilization efforts. Finally, the MoH, through the National Nutrition Strategy, has demonstrated a renewed push to ensure wasting service providers are offering a minimum integrated nutrition and health package. This includes identification and management of wasting, deworming, vitamin A supplementation, immunizations, and behaviour change communication (3).

3 https://www.fsnau.org

Barriers

During the 2011 famine in Somalia, the nutrition sector managed to significantly scale up services for severe wasting, largely through local NGOs and the use of simplified tools. This scale up was complicated by the fact that the largest need for services was within the access-restricted areas of south central Somalia. Therefore, there was limited oversight over site location and relatively no supervision mechanism for these new wasting service points. Post-famine, the Nutrition Cluster engaged in a rationalization process to reduce the number of sites. However the political complexities of this process have meant that it has had a limited impact on total site number. At the same time, there remains areas and population groups in Somalia with poor access to wasting services due to the continued political and civil unrest, or limited financial means of service providers to reach these groups Therefore Somalia must both rationalize and scale-up services for wasting, with a more pronounced focus on an equitable distribution of service delivery points.

- **Governance and leadership.** The MoH supported by its partners has developed a variety of strategic frameworks which guide nutrition and health programming in Somalia. Operationalization of strategies and policies can be complex in Somalia as the MoH is not always the service provider. Furthermore, insufficient funding to fully roll out the Essential Package of Health Services for Somalia (EPHS) has led to a lack of coherence among services being provided. However, that is starting to change. Through large scale programmes such as SHINE[4], the Ministry of Health is empowered to both steward and implement health and nutrition programming. Frequent changes to the country leadership affects all ministries and the Ministry of Health is not immune. While staffing changes are communicated in a timely manner, with each change there is a loss of continuity in stakeholder relationships. This limits the ability of partners to help build capacity within the ministry and can compromise the progress of joint-planning.
- **Health workforce.** A standardized curriculum and protocol for the management of wasting is finally implemented across Somalia. However, from the community to the facility, there is limited standardization or clarity on the health worker cadres which delivery nutrition services. In most cases, training for the management of wasting is still a vertical, stand-alone process. Supervision of service delivery is complex in Somalia and in many places is significantly hampered by security and access issues.

4 Somali Health and Nutrition Programme (SHINE) 2016-2021, is funded by FCDO and supported by a variety of partners which work through the Ministry of Health.

- **Service Delivery.** The IMAM 2019 protocol calls for the integration of service sites for severe and moderate wasting to ensure a continuum of care and to help prevent relapse. However, in practice the management of moderate wasting is limited in some areas of Somalia due to a lack of nutritional products. Integration of nutrition and health services is still limited but changing slowly. It is constrained by the interest and ability of the NGOs to integrate these two services.
- **Supplies and equipment.** As mentioned, there are a variety of partners involved in the supply chain for nutritional commodities in Somalia. While pipeline breaks are not frequent, the supply chain is still handled largely vertical to the ministry of health's systems. Increased involvement of the MoH would increase capacity and promote sustainability.
- **Information.** Currently the ONA information systems is being used, managed by the MoH with support from the Nutrition Cluster. However, the MoH is interested to integrate the nutrition information system into the official MoH DHIS system in order to enhance decentralization and integration with health. However, this action is still incomplete pending buy-in from all stakeholders. Some partners and consortia still maintain parallel information platforms in order to satisfy their institutional or donor requirements.
- **Finance.** Insecurity and displacement are still significant constraints in Somalia, impacting on service access and continuity as well as supervision and accountability mechanisms. Despite continued high caseloads, funding opportunities continue to shrink for Somalia while global attention is pulled into other more acute emergencies and donors grow increasingly frustrated with the tumultuous political space in Somalia.
- **Community**. The Community Health Strategy for Somalia (2014) was never operationalized which has led to a lack of standardization across the different community health and nutrition worker cadres leaves some confusion within this space (4). However, the MoH is actively pushing for partners to adhere to a standardization of community health workers.

Recent adaptations to wasting services

While some adaptations had started prior to the global Covid-19 crisis, the pandemic did push forward other adaptions as the sector sought to ensure service continuity while reducing or modifying patient contact.

Family MUAC

Family MUAC has started prior to the global pandemic and grew out of a desire to improve early detection, referral and community ownership of wasting services. This approach has been well received in Somalia, with families appreciating a tool which supports them to monitor their child's nutritional status at home.

Modified admission criteria

While weight-for-height z-scores have always been an important feature for the admission of children to wasting services in Somalia, the Covid-19 pandemic has necessitated a change in order to limit patient contact and reduce the time that families spent at service sites. Currently admission to wasting services is based on MUAC and/or nutritionally oedema.

Modified dosage of therapeutic foods

As weight and height were removed from admission criteria, there could no longer be weight-based dosing of RUTF. Instead children presenting with severe wasting were advised to have 2 sachets of RUTF/day until cured. This simplified dosing removes the need for ration calculation, simplified stock management at site level and reduced stock-demand due to the reduced dosages. However, even prior to the Covid-19 pandemic a modified dosing protocol was being explored in Somalia by the NGO International Medical Corps, using 2 sachets of RUTF/day for children presenting with severe wasting and 1 sachet/day for children presenting with moderate wasting. The result of the prospective cohort study assessing effectiveness of this approach was released in July 2019 (7). It showed high adherence and excellent outcomes for children under the simplified dosage protocol, with a recovery rate of 98% and a defaulter rate of 1%. However, national protocol guidance has not yet changed, outside of the Covid-19 adaptations. It remains to be seen if the adaptation will remain when the pandemic is concluded.

Integration of treatment for severe wasting into ICCM

The integration of treatment for severe wasting into an ICCM approach has been piloted in Somalia since 2017 by Save the Children and Action Against Hunger. The policy environment in Somalia is conducive for the management of wasting at community level, however the practicalities of safely supplying, storing and accounting for nutritional commodities at community level are still extremely challenging.

CMAM Surge

The CMAM Surge approach supports the development of shock-responsive nutrition services at the health facility level. CMAM Surge is intended to support the health system, and empower health workers, to better anticipate, prepare for, and bounce back from fluctuations in the demand for services for the management of wasting. CMAM Surge is unique in that it empowers health facility staff to use their own data and understanding of health facility capacity to identify and address workload overwhelm in order to protect service quality. CMAM Surge has been successfully implemented in a number of countries, although none of them in contexts where NGOs are the service providers. In 2021, Concern Worldwide has proposed to lead a pilot of the CMAM Surge approach through the DG ECHO funded Caafimmad Plus consortium. This pilot will explore the relevance and acceptability of CMAM Surge to the Somali context.

4.

Moving forward

While Somali is still subject to environmental and political fragility, there are key steps to take in order to further scale up equitable access to services for wasting.

As the governance structures for health and nutrition in Somalia continue to strengthening, it is critical for implementing partners to support the MoH. Services for health and nutrition should be integrated and aligned the EPHS package with the MoH as the steward, and increasingly the service provider. Community health and nutrition structures should be standardized and empowered to offer a range of health and nutrition services, both curative and preventive/promotive. Decentralizing curative services to community structures can increase access, utilization and client-satisfaction of services. And finally, piloting the CMAM Surge model can ensure that services for wasting are shock-responsive, able to expand and contract in line with service demand and quality standards.

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