Where ‘Exceptional Circumstances’ Are Not So Exceptional

A strategic approach to adapting the management of child wasting in emergency-prone contexts, including through the use of simplified approaches

Webinar Briefing Note

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This analysis is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the International Rescue Committee, Action Against Hunger and Save the Children – and do not necessarily reflect the views of USAID or the United States Government.

Introduction

A growing number of country-level leaders have recognized the need to adopt a more strategic approach to the way they manage recurrent, yet exceptional circumstances in humanitarian emergencies – particularly in ways that outline which conditions would trigger the use of adaptations, which adaptations should be prioritized, and when to advise a return to the standard protocol for treatment of severe wasting in children 6-59 months old. With the release of the new WHO guidelines, WHO and UNICEF re-affirm that, "in exceptional circumstances, and as part of a response to a time-bound acute emergency, some adaptation of standard protocols may be needed" and that, "as emergencies become more and more protracted, a return to standard protocols is advisable as soon as feasible to deliver the best possible care to malnourished children and their families."[1] As a result, it is expected that adaptations will continue in emergency contexts, as agreed by local stakeholders – including the Ministries of Health, nutrition clusters, etc. – and therefore a more strategic approach to their management may prove useful in certain contexts moving forward.

The term 'simplified approaches' is an umbrella term referring to a range of different adaptations – which can be used in isolation or often, together as a package of interventions – to streamline the treatment of child wasting. These are modifications to the standard national and global treatment protocols for uncomplicated cases of child wasting that are designed to:

- Improve the effectiveness, quality, and coverage of treatment services,
- Reduce the cost per child treated,
- Improve the continuum of care, and
- Contribute to Universal Health Coverage goals.

Ultimately, the objective of simplified approaches is to "improve the provision of care for wasted children so that barriers to access and uptake of quality services can be effectively and sustainably addressed by health systems around the world". It is important to note that these approaches may be relevant in both development contexts, where they may respond to structural health system and cost barriers, and emergency contexts, where they may ensure continuity of care amid dramatic changes in the security or operational environment.

Over the past five years, implementation of simplified approaches has moved beyond the realm of research into direct operational implementation in emergency contexts, as exemplified by their widespread application during the COVID-19 pandemic. Such emergency contexts are often referred to as 'exceptional circumstances'. An exceptional circumstance in the management of child wasting is defined as a "complex and/or challenging context resulting in negative effects on treatment services or the target population". While there are a multitude of possible negative effects possible in emergency settings, examples of exceptional circumstances in the treatment of child wasting often include:

- Shortages or stock-outs in the product used to treat child wasting (i.e., either ready-to-use therapeutic food (RUTF) or ready-to-use supplementary food (RUSF));
- Closure or impeded access to health facilitates (e.g., due to insecurity, weather or other contextual challenge);
- Significant deterioration in the nutritional situation resulting in a sudden increase in the rate of child wasting (i.e., hot spots) and/or increases in defaulting or mortality; and,
- Unavailability of health facility staff (e.g., COVID-19 or strikes of health workers)

1 Briefing Note: 'Simplified Approaches' in relation to the new WHO Guideline on the Prevention and Management of Wasting and Nutritional Oedema (Acute Malnutrition)

In these contexts, adaptations to the standard protocol are often necessary to mitigate the impact of such negative effects. The word 'exceptional', however, seems to imply that these circumstances are atypical or unpredictable. Meanwhile, in many humanitarian emergency settings, they are often seasonal or otherwise fairly predictable and expected, following a pattern in certain context-specific conditions that fluctuate dynamically but often regularly.

The "Where Exceptional Circumstances Are Not So Exceptional" webinar highlighted the work of two countries – Somalia and Nigeria – which recently established a more strategic approach to adapt the management of child wasting in exceptional circumstances. By sharing experiences from Somalia and Nigeria, it is expected that other national, regional and global-level stakeholders can better understand, support and learn from their experience.

Opening Remarks

Grace Funnell, Nutrition Specialist in Child Wasting, UNICEF

Grace explained that efforts to ensure the early detection of children with wasting remain more critical than ever – the 2022 Global Report on Food Crises showed that 27 million children live in severe food insecurity across 15 countries and a total of 8 million are affected by severe wasting. The new WHO guideline on the prevention and management of wasting and nutritional oedema provides the 'gold standard' for wasting programming. However, some adaptation of such protocols may be needed as part of a time-bound response to an acute emergency.

Simplified approaches, as-is, are not part of the new WHO guidelines. They have been and continue to be instrumental, however, in testing new ways of delivering nutrition services and allowing for continued delivery of life-saving services during emergencies. Grace clarified that there is no specific set of criteria that define an exceptional circumstance across contexts, so identifying what may be unique and/or abnormal for a given context in terms of negative effects on treatment services or the target population is critical to determining the most appropriate emergency adaptations.

She emphasized that many countries adapted one or more of these protocol modifications over the past few years (e.g., in response to the COVID-19 pandemic) and a few have gone one step further to define when to introduce protocol adaptations in national emergency standard operating procedures (SOPs). Finally, Grace said that close coordination with the national Ministries of Health (MOH) and country-level stakeholders are essential to define if, when and how to activate adaptions to the standard protocol, noting excitement for the upcoming details about how this was done in Somalia and Nigeria.

Somalia

Simon Karanja, Nutrition Cluster Coordinator, UNICEF Somalia

Gabriel Ocom, Emergency Nutrition Specialist, UNICEF Somalia

Simon explained that the simplified approaches SOP in Somalia was developed to bridge gaps in moderate acute malnutrition (MAM) treatment (stemming from pipeline issues), to better extend treatment services to hard-to-reach and/or rural areas, to bolster the continuum of care and to scale-up early detection and referrals. The strategy is intended to provide clarity on when and where it should be activated, as well as the most appropriate that should be used. Additionally, it highlights relevant supply management implications, reporting channels and tools, and how to document evidence and lessons learned. Simon was the one who kick-started the strategy development process, seeking inputs from various stakeholders, including: UNICEF and WFP, UNICEF regional office, the Global Nutrition Cluster (GNC) Technical Alliance, the Somalia integrated management of acute malnutrition (IMAM) technical working group, the nutrition cluster and its strategic advisory group (SAG), and the Federal Ministry of Health (FMOH).

In terms of the strategy itself, Simon noted that there were two primary scenarios for activation of the SOP: 1) a pipeline break of MAM or severe acute malnutrition (SAM) treatment supplies lasting more than 2 months and a global acute malnutrition (GAM) rate above 10% and 2) hard-to-reach and inaccessible locations with a lack of either MAM or SAM treatment services, as well as a GAM above 15%. He briefly then explained that the SOP identifies which approaches should be adopted and specific deactivation criteria to return to normal programming before diving into consideration of the challenges and his subsequent learning and recommendations.

Among the top challenges in designing the simplified approaches SOP was data –in terms of a lack of timely and comprehensive nutritional data to better understand changes in context and unreliable district-level GAM data. He recommended various data-based improvements, including a comprehensive nutrition surveillance system, additional surveys to complement the Food Security and Nutrition Analysis Unit (FSNAU) assessments, respectively. Relatedly, he also noted a mismatch between projected, estimated and actual needs (especially for MAM) and suggested an in-depth analysis of program and projection data to refine caseload calculations. Data was also a challenge when it came to monitoring of supplies – both at site-level where there was lack of data on ready-to-use therapeutic food (RUTF) and ready-to-use supplementary food (RUSF) stock status to guide decision-making and at a systems-level, with concerns over the diversion of humanitarian resources. Here, he hopes to see improvements in monitoring that would increase granularity and reporting speed and also recommends that the information management system would also include the ability to report specifically on programming in exceptional circumstances (with indicators, tools, reporting channels, etc.).

On the political and operational sides, he noted a delay in the formal approval of the SOP by the FMOH and suggested that high-level advocacy might be beneficial, together with capacity building of MOH staff to fast-track formal endorsements in other contexts. For UN agencies, he cited UNICEF's lack of a clear commitment to promote a single product for combined treatment (i.e., of SAM and MAM) and recommended that this approach be considered in critical areas or those without WFP presence to reduce concerns about having enough resources to reach MAM targets. He also cited operational differences between UNICEF and WFP as complicating the treatment response, recommending one partner be responsible for both outpatient therapeutic programs (OTP) and targeted supplementary feeding programs (TSFP). Finally, he recommended capacity building for nutrition cluster partners on approaches for use in exceptional circumstances as well as the need to come to a clear contextually-drive definition of vulnerable (or "high-risk") MAM, in alignment with the new WHO guidelines.

As of the time of the webinar, the SOP received provisional approval from the FMOH, three districts formally activated the SOP in hard-to-reach areas (cluster endorsed and UNICEF supported), and Family MUAC was widely implemented, although not yet at-scale. Moving forward, the Somalia Nutrition Cluster plans to integrate this learning into critical upcoming initiatives, including: development of the IMAM scale-up framework, the revision of national guidelines, and improve subnational coordination, among others. He highlighted that buy-in was still critical to get to endorsement and there was an immediate need for capacity building of all cluster partners on the SOP and its adaptations. He emphasized the importance of continued learning and suggested benchmarking Somalia's experience alongside other contexts implementing similar approaches.

Nigeria

Solomon Atuman, Nutrition Coordinator, FHI 360 Nigeria

Solomon explained that in northeast (NE) Nigeria, the decision to pursue a simplified approaches SOP resulted from a number of consistent challenges, including: difficulty delivering treatment in hard-to-reach areas, pipeline breaks, limited capacity and human

resource availability, inaccessibility of health facilities, etc. He said that the SOP was developed to improve coverage and access to treatment for uncomplicated wasting, to provide a continuum of care in hard-to-reach areas, and to generate context-specific evidence and lessons learned on simplified approaches. In Nigeria, the SOP development process started at the level of the IMAM technical working group and then expanded into the NE Nigeria Nutrition Sector and the state primary healthcare development agencies (SPHCAs) and state-level MOH before progressing to UN Agencies (UNICEF and WFP), the GNC Technical Alliance and the FMOH.

The final SOP covers a total of four different scenarios of exceptional circumstances, including: pipeline breaks (e.g., stockouts or delays), hard-to-reach areas (e.g., those with poor access for nutrition implementing partners or no TSFP available), human resource challenges (e.g., limited availability of trained, skilled health workers), and poor service utilization (e.g., poor coverage or limited community awareness). Within each scenario, a different set of adaptations are recommended, drawing from the following simplified approaches: 1) expanded admissions criteria; 2) use of a single treatment product; 3) community health worker (CHW)-led treatment; 4) reduced frequency of follow-up; 5) MUAC and oedema only admission and discharge, and 6) Family MUAC. For implementation, priority is given to areas with displaced populations and/or hard-to-reach areas with additional aggravating factors (e.g., limited access to WASH). Finally, the SOP is emphasized as a temporary strategy, to be rolled out for a period of 3-6 months in order to save lives, with the intention of a return to the standard protocol at the end of that period (or sooner, if/as there are positive changes in the previously identified exceptional circumstances).

Prior to activation, it was agreed that all partners should be well-sensitized to and trained on the implicated simplified approaches so that they understand what they are, why they are to be implemented in the area, which adaptations are to be implemented and for how long, and the target population. Additionally, the necessary supplies (e.g., RUTF/RUSF, MUAC tapes, medications, etc.) must be available with sufficient buffer stock for changes in case loads and there must be an appropriate monitoring and evaluation system in place to ensure effective reporting and documentation of lessons learned.

As of the time of the webinar, the SOP has been validated by the FMOH and is available as a tool for use in NE Nigeria should the activation criteria be met and agreed by the nutrition cluster partners. To-date, however, the SOP has not been triggered in practice. Outside of the SOP and its use in exceptional circumstances, a number of simplified approaches are already being implemented in the region under 'normal' circumstances – notably Family MUAC. Use of a single treatment product is the exception as it is the only simplified approach that has yet to be implemented in the region to-date.

Digging into the Discussion: Q&A with Webinar Participants

After their presentations, Martha Nakakande (CMAM/IYCF-E Advisor, GNC Technical Alliance) facilitated a lively discussion among panellists to dig into the details of each of their experiences and lessons learned. Common emergent questions were around the availability (or lack thereof) of context-specific evidence on simplified approaches (including reporting for MAM cases treated with RUTF), community-level awareness of adaptations to the protocol, and plans to learn from implementation of these SOPs and approaches moving forward in each context. To this end:

- **Reporting**: In Somalia, Simon emphasized that the current reporting rules are very clear for the standard protocol, but new tools, developed ad hoc, were required for reporting against the adaptations because existing registers are not similarly adapted to capture this information. He said this is a key area to explore further as these approaches are

utilized more in practice. In Nigeria, Solomon mentioned that where activation is according to the SOP, there is a mechanism to annotate use of simplified approaches within the normal performance indicator reporting process in order to contextualize the adaptation within the standard analysis and reporting.

- **Community awareness**: With the increase in Family MUAC training in Somalia, one key area of confusion in Somalia is between RUTF and RUSF at community level, given how community members have been trained and understand the current process and procedures but are not aware of the adaptations. However, Gabriel noted that where they have done expanded admission criteria, awareness created by CHWs has helped to align understanding on where and how services are provided.
- **Continuous learning**: In Somalia, they are keen to look at the effectiveness of Family MUAC, in particular, as compared to other approaches like CHW screening and mass MUAC screening exercises. Simon also mentioned that while they haven't noticed any significant difference in outcomes that they have observed, quality of care and sub-national capacity are something they are keen to continue to monitor, especially in circumstances where there are rapid increases in caseload. Nigeria is also keen to look at how to ensure correct measurements among caregivers for Family MUAC and, like Somalia, look at comparing the economic value of this approach (especially in terms of supplies) as compared to others.

Finally, based on this experience, panellists were asked if they would do anything differently if they had the opportunity to repeat the process. Simon said that he would directly engage the government at the state and regional levels before engaging at the federal level. Additionally, he would consider the opportunity to build more localized scenarios – at lower levels than the district -level – for a more contextualized approach. Meanwhile, Solomon said that he would like to see UNICEF and WFP making commitment and buying into these scenarios before scaling up discussion with other stakeholders as he believes this would facilitate full implementation. He also said that bringing in support from the GNC Technical Alliance at an earlier stage in the process could have streamlined and expedited the process development.

Summary

This webinar gave its audience the opportunity to hear specific examples Somalia and Nigeria, both of which have recently established a more strategic approach to adapt the management of child wasting in exceptional circumstances. By sharing these experiences, it is expected that other national, regional and global-level stakeholders can better understand, support and learn from their experience. Panellists from UNICEF and FHI360 explained that the process to develop the simplified approaches SOP for use in exceptional circumstances was new in both countries; even though there were some delays and bumps in the road along the development process, as well as some refinement still expected, they were eager to continue learning as they are operationalized and excited to share more in-depth insights with stakeholders moving forward.

A recording of the full webinar, including translation into English, Spanish, French and Arabic is available on the GNC Technical Alliance website here.

Note: 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.