BEHAVIOR PROFILE: CARE OF ACUTE MALNUTRITION

HEALTH GOAL

Improve maternal and child survival and reduce malnutrition

BEHAVIOR

Caregivers immediately seek and appropriately provide care for acute malnutrition (wasting)

1- Number of children under five who were admitted for treatment of severe acute malnutrition [Source: DHIS II/USAID reporting]
2- Number of children under five who are receiving treatment of moderate acute malnutrition. [Source:DHIS II/USAID reporting]

BEHAVIOR ANALYSIS

BEHAVIOR AND STEPS

What steps are needed to practice this behavior?

Behavior

Caregivers immediately seek and appropriately provide care for acute malnutrition (wasting)

Steps

1. Promptly take child for treatment upon diagnosis (Note: See Growth Tracking Behavior Profile)
2. Mobilize transport, resources, logistics to allow for initial screening, treatment, and follow-up appointments or to obtain additional therapeutic food
3. Continue age appropriate breastfeeding and complementary feeding, and ensure that the child drinks safe treated water throughout the day (Note: See Feeding During Illness Behavior Profile)
4. Adhere to recommended treatment including prescribed medicines, supplements, and therapeutic food
5. Continue to monitor child's nutritional status (Note: See Growth Tracking Behavior Profile)

FACTORS

What factors may prevent or support practice of this behavior?

STRUCTURAL

Accessibility: Caregivers do not take their children for treatment or follow-up visits due to competing responsibilities (household chores, caring for multiple children, work and lost wages, agricultural labor, etc.).

Accessibility: Caregivers do not take their children to a qualified provider at a facility for treatment because they cannot afford the associated costs, including transportation costs.

Accessibility: Caregivers do not take their children to a qualified provider at a health facilities for treatment because of the long distance, poor road quality, and safety and security issues

Service Provider Competencies: Caregivers do not seek treatment for their child because they lack confidence in the provider's ability to treat malnutrition.

Service Provider Competencies: Caregivers do not seek care from providers because they have been treated negatively during past visits (blamed for their child's condition, health beliefs not valued, questions not answered, scolded, etc.).

Service Experience: Caregivers are reluctant to seek treatment at health facilities because they perceive the quality of care to be poor, with frequent stock outs of therapeutic foods, medicines, and other supplies.

SOCIAL

Family and Community Support: Caregivers do not seek treatment or advice from qualified providers as they prefer or are pressured to seek treatment or advice from family and community members who share the same cultural values (local drug sellers, in-laws, elders, religious leaders, traditional healers).

Family and Community Support: Caregivers do not seek treatment for malnutrition because they have experienced or fear experiencing stigma or discrimination from community members for having a malnourished child.

SUPPORTING ACTORS AND ACTIONS

Who must support the practice of this behavior, and what actions must they take?

INSTITUTIONAL

Policymakers: Strengthen integration of therapeutic foods and commodities for supplemental rations into public and private supply chains for facilities, and ensure those supply chains are functioning safely and efficiently.

Policymakers: Ensure that national guidelines are up to date with recent evidence regarding cut-off points for defining acute malnutrition and that they are integrated into existing facility and community level protocols.

Managers: Ensure supportive supervision and quality assurance systems are in the place that support community and facility providers to give empathetic, effective, and client-centered care for acute malnutrition.

Managers: Engage with existing community groups to discuss sharing, selling, or trading therapeutic foods, and agree on actions to reduce pressure on caregivers to share or sell therapeutic foods.

Providers: Provide respectful, quality services to children with acute malnutrition and to caregivers, including diagnosis, referral, treatment, and follow up, according to national protocols.

Providers: Refer clients to specialized medical care to supplement and re-establish breastfeeding, and to manage cases of children who do not gain sufficient weight in the program. Where available, refer clients to psycho-social support in cases of trauma or family violence.

Health Program Manager: Ensure that those children who are referred for treatment at a hospital or facility are able to get to that facility; work with community leaders to secure reliable transport.

Logistics Personnel and Managers: Ensure timely and sufficient supply and quality of therapeutic foods.

Managers and Providers: Adhere to national guidelines and protocols for identifying and treating acute malnutrition.

COMMUNITY

Community Leaders: Ensure community identification, treatment, and follow up for acutely malnourished children and support nutrition programs in the community, including reducing stigma for families with children who have acute malnutrition.

Community Leaders: Support finding safe, efficient transport for malnourished children

STRATEGY

POSSIBLE PROGRAM STRATEGIES

What strategies will best focus our efforts based on this analysis?

Strategy requires Communication Support

ENABLING ENVIRONMENT

Financing: Establish or strengthen community funds to provide transportation and treatment costs for the most vulnerable families of children with acute malnutrition.

Partnerships and Networks: Establish or support regional and national public-private partnerships to integrate therapeutic foods and commodities for supplemental rations into existing private and public supply chains.

Partnerships and Networks: Establish or strengthen linkages with specialized care, such as psycho-social and lactation support, as well as context-appropriate complementary services and programs (e.g sanitation and hygiene, food security, HIV, livelihoods, social protection)

Policies and Governance: Support development and enforcement of policies mandating equitable geographic distribution of facilities covering an agreed minimum percent of the population.

Policies and Governance: Support development and enforcement of a policy providing free care for all children under 5 that includes treatment of acute malnutrition at multiple levels.

Policies and Governance: Support development and implementation of a community health package that includes preventative nutrition services and management of acute malnutrition.

SYSTEMS, PRODUCTS AND SERVICES

Supply Chain: Strengthen government supply chain system to reduce stock-outs.

Quality Improvement: Strengthen provider accountability and client satisfaction mechanisms within programs.

Quality Improvement: Strengthen identification, referral, and follow-up system ensuring patient continuity across inpatient and outpatient care for acute malnutrition.

Health Services: Modify and simplify existing protocols to increase coverage based on a contextual and operational analysis (e.g. family MUAC approach, standard simplified ration, ICCM for uncomplicated SAM).

DEMAND AND USE

Gender: Female caretakers do not always promptly take the child for treatment because they are sometimes forbidden from leaving the house if they are not accompanied by a male relative.

Gender: Female caretakers do not seek prompt treatment or attend follow-up visits for malnourished children because they lack decision-making autonomy.

Norms: Caregivers do not provide the recommended amount of therapeutic foods to the malnourished child because of norms to share food among all children and/or other family members in the household, especially in food insecure areas.

Norms: Caregivers do not provide the recommended amount of therapeutic foods to the malnourished child because they sell the therapeutic foods to earn money for basic household commodities and food for the entire family.

Norms: Caregivers sometimes send the same child to the health facility with a different caregiver and an alternate identity to receive multiple rations of therapeutic foods because these are valuable resources in food insecure areas.

INTERNAL

Attitudes and Beliefs: Caregivers do not appropriately manage recovery from acute malnutrition because they perceive these programs to be long-term sources of food assistance and thus expect their child will be readmitted.

Attitudes and Beliefs: Caregivers follow recommended treatment with therapeutic foods because they perceive these foods to be beneficial to their child's health.

Attitudes and Beliefs: Caregivers do not adhere to some recommendations, such as the importance of relactation or boosting sucking frequency, because they believe their child is likely to die.

Self-Efficacy: Caregivers do not carry out instructions received from the health provider because they do not feel confident in their ability to do so.

Knowledge: Caregivers do not appropriately manage care for acute malnutrition because they lack knowledge about care and treatment and are discouraged when the child does not rapidly gain weight.

Knowledge: Caregivers do not follow therapeutic food instructions because they are non-literate or the instructions on the package are unclear.

Skills: Caregivers do not feed adequate amounts of therapeutic foods because they lack the skills needed to encourage their children to eat them.

and their caregiver to health facilities for assistance

Religious Leaders: Encourage caregivers to seek treatment from health facilities when they seek guidance or counsel on malnutrition, including reducing stigma for families with children who have acute malnutrition.

Community and Religious Leaders: Work to address norms around sharing, selling, and trading therapeutic food.

HOUSEHOLD

Family Members: Encourage mother to seek treatment for the malnourished child and help her get the child to treatment or take on some of her tasks so she has time to seek treatment.

Male Partners: Provide caregivers with money needed for costs associated with seeking treatment or help get the child to treatment and following provider recommendations for home care and follow up.

Communication: Conduct outreach to fathers and grandmothers of children enrolled in treatment programs to build their motivation and self-efficacy to take on tasks for the caregiver.

Collective Engagement: Mobilize communities around acute malnutrition, including development of community-based strategies to support families with acutely malnourished children.

Skills Building: Establish or strengthen a "buddy system" where caregivers recruit someone to come with them to all appointments and support them to adhere to home care recommendations. Train "buddies" in communication skills and basic childcare skills so that they can support caregivers effectively.