Carers' knowledge of treatment of severe acute malnutrition at Dadaab refugee complex, Kenya: A prospective cohort study

Research snapshot[1]

Research shows that carers' lack of understanding on the nature of treatment may contribute to poor adherence to treatment modalities. In response to the high prevalence of severe acute malnutrition (SAM) in emergency contexts and related mortality in children under the age of five years in refugee camps, this study was conducted to fill an evidence gap by describing carers' knowledge of treatment of SAM in a refugee setting.

A prospective cohort study of 128 children aged 6 to 59 months and their carers was carried out at the Ifo I and Hagadera refugee camps, two large camps (100,000 plus predominantly Somalian nationals) in Garissa County, Kenya. Over a three-month period, 22 child-carer pairs were selected from the stabilisation centre (SC) and 42 from the outpatient therapeutic feeding programme (OTFP) at each camp and followed up until the child met the discharge criteria. A carer's knowledge was assessed by the administration of a questionnaire in the early days of admission. None of the 128 children enrolled defaulted.

Dadaab refugee camp, Kenya

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More than 70% of carers participating in the SC programme in both camps and over one third of those whose children were treated at OTFP were unable to say how long their children's treatment would last. Few carers from the Hagadera OTFP (n=7; 16%) knew the correct frequency of prescribed therapeutic feeds while a majority from Ifo did (n=31; 72%). In both OTFPs, less than half of the carers fed their children strictly as per prescribed therapeutic feeds. There was a significant relationship between carers' level of education and their knowledge of the frequency of therapeutic feeds in both the SC programme and the OTFP at both refugee camps. The reasons given for keeping a malnourished child warm during cold weather were quite diverse among carers from the two camps in both programmes.

Carers have a critical role to play in managing acute malnutrition in community-based programmes; carers from refugee camps in Kenya showed room for improvement in their knowledge of SAM treatment.

[1] Jef L Leroy, Edward A Frongillo, Pragya Dewan, Maureen M Black, Robert A Waterland, (2020). Can Children Catch up from the Consequences of Undernourishment? Evidence from Child Linear Growth, Developmental Epigenetics, and Brain and Neurocognitive Development, Advances in Nutrition, Volume 11, Issue 4, July 2020, Pages 1032–1041, https://doi.org/10.1093/advances/nmaa020

Promoting ethnic parity in health, leaving behind "race": a challenge for the global community in 2020

Research snapshot[1]

Promoting parity is central to both medicine and public health, whether we refer to sex, age or population group. Beyond age and sex, it has long been recognised that nutritional status often differs on average between what are usually referred to as "racial" or "ethnic" groups. This article proposes that evaluating health and nutritional status relative to children of similar "race/ethnicity" increases the accuracy of the assessment, moving away from the idea that there is a single nutritional norm represented by any one population. In acknowledging such population differences, the language used to describe them profoundly affects how they are conceptualised. This is not simply a semantic issue but also influences how clinical and public health practices affect health outcomes.

The editors of the *American Journal of Clinical Nutrition* recognise the complexity of this issue and their current instructions aim to help authors to describe which aspect is under consideration: "use 'race' to describe racial categories based on physical appearance, 'ethnicity' to describe traditions, lifestyle, language, diet and values and 'ancestry' to describe ancestry informative markers based on genetic or genomic data." As soon as we try to apply these instructions, however, multiple problems manifest. If "race" refers to physical appearance, what characteristics should we look at and who is given the role of looking? When it comes to traditions, lifestyle and diet, are these selected by preference or are they imposed by socioeconomic constraints? At the level of genes, there are no discrete, objective racial groups.

Ethnicity is a very different concept from race and offers a much richer framework through which to explore and understand population variability. Ethnicity varies between countries due to historical circumstances, for example those who identify as "black" in the United Kingdom may differ in several ways from their African American counterparts in the United States. No such references adequately capture the full range of ethnic variability in contemporary societies and therefore any clinical benefits may be unequally distributed. Ethnic-specific reference data are to be welcomed but, if they are genuinely to promote parity in health, they must be used prudently.

[1] Wells, J. C. K. (2020). Promoting ethnic parity in health, leaving behind "race": a challenge for the global community in 2020. *The American Journal of Clinical Nutrition*, 112(3), 505-506. doi:10.1093/ajcn/nqaa189