ADAPTATIONS IN THE MANAGEMENT OF CHILD WASTING IN THE CONTEXT OF COVID19

Case Study
Organization: ACTION AGAINST HUNGER
Location: SOUTH SUDAN
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CONTEXT OVERVIEW

In April 2020, following the South Sudan Nutrition Cluster's COVID-19 guidance, Action Against Hunger USA implemented adaptations to its nutrition programs aimed at minimizing 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 admission and discharge criteria in CMAM programs;
(2) Modified dosage of therapeutic foods during AM treatment;
(3) Modified frequency of follow-up appointments during AM treatment; and
(4) Scale-up of Family MUAC and suspension of mass screenings.

ADAPTATION IMPLEMENTATION

(1) Modified Admission and Discharge Criteria

The standard national CMAM protocol in South Sudan includes three independent admission and discharge criteria: bilateral pitting edema, mid-upper arm circumference (MUAC), and/or weight-for-height Z-score (WHZ), in line with the global WHO guidelines. New COVID guidance suspends the use of weight and height measurements in admissions, follow-up, and discharge to reduce contact between children, caregivers, and nutrition workers. Program staff report the suspension of weight and height, and thus WHZ as an admission criterion, has reduced clinic staff workload and streamlined procedures, monitoring and reporting. However, staff have expressed concern that the restricted admission criteria may exclude children from the program that would have otherwise received services. For example, of children newly admitted to OTP and TSFP in 2019, an average of 55% and 10% of children, respectively, were eligible for admission based on only WHZ. They also suggested that many children who would be admitted to OTP based on WHZ under standard protocols are now likely admitted to TSFP based on MUAC. Some staff and caregiver confusion was reported during the transition period of eliminating weight and height measurements. Over time, the use of MUAC and/or edema was embraced due to lessened staff workload and caregiver engagement and sensitization.

(2) Modified Dosage of Therapeutic Foods

With the suspension of weight and height measurements, therapeutic and supplemental rations for children are no longer calculated based on a child's weight; instead, children receive a set ration (either 1 or 2 sachets per day) according to the severity of their malnutrition status: severe or moderate. For most children, except for the smallest and youngest, this new regimen is less than what they would have

received previously. Program staff report reduced workload at clinics because the new dosing regimen is faster, requires simpler calculations, and is easier to explain to caregivers.

(3) Modified Frequency of Follow-Up Appointments

To reduce crowding at CMAM clinics, Action Against Hunger reduced the frequency of scheduled follow-up visits for admitted children to be monitored and receive their next ration: follow-up for SAM children changed from weekly to bi-weekly visits while follow-up for MAM children changed from bi-weekly to monthly visits.

Program staff have reported such schedule changes have successfully reduced crowding at the clinics, yet, other challenges have occurred. Staff report increased workload, due to time expended on planning schedules. Also, there are anecdotal reports that caregivers are confused on the revised schedule and bring their children to the sites on incorrect days. Because of the reduced frequency of scheduled visits, the ration size provided at each visit has doubled. Caregivers must therefore manage larger amounts of specialized food over a longer period of time. Reports have been made of increased sharing and selling of the increased rations. Pre-positioning larger amounts of RUTF and RUSF at the sites before the rainy season has also presented increased logistical challenges in terms of storage and transportation.

Sharing or selling of RUTF and RUSF may reduce the amount allocated to the malnourished child, prolonging the time to recovery. Less frequent visits also mean fewer health checks, leaving program staff concerned for SAM children whose weakened immune systems leave them vulnerable to illness and rapid deterioration.

(4) Scale Up of Family MUAC

The recent suspension of mass screenings and reduced community nutrition volunteer mobility accelerated the scale up of Family MUAC, an approach that trains caregivers to measure their own child's MUAC to screen for malnutrition. Family MUAC is now the primary way in which children are monitored and referred for treatment at the community level. Program staff reported that caregivers are actively engaged and interested in participating, and sensitization prior to the pandemic brought high levels of community acceptance. Challenges in scaling up Family MUAC include a lack of MUAC tapes and incorrect caregiver referrals to the clinics for treatment, with caregivers becoming frustrated if their children do not qualify for admission to treatment.

PROGRAMATIC DATA[1]

(1) OTP and TSFP Admissions

Overall, OTP admissions for 2020 have been lower than the average, specifically with a drop in admissions in April and May after the implementation of CMAM protocol adaptations and the announcement of the first case in South Sudan (Fig 1a). When examining admission by MUAC only, the 2020 trend also diverges from the historical average, with lower overall admissions, but quickly increasing in April and May. This may be attributable to the fact that some children who would have been previously admitted on WHZ were also eligible for admission based on their MUAC. (Fig 1b). Other factor could be heavy flooding leading to inaccessibility.

Figure 1a. OTP Admissions, WHZ and MUAC

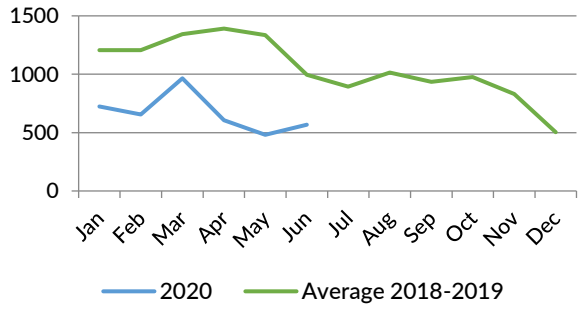
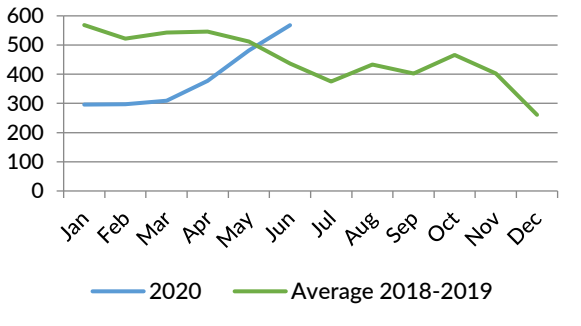
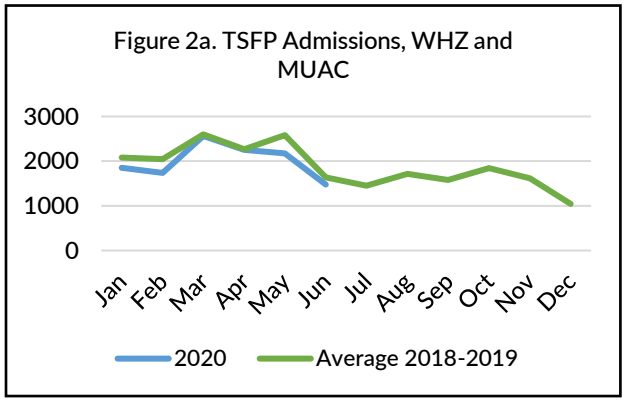
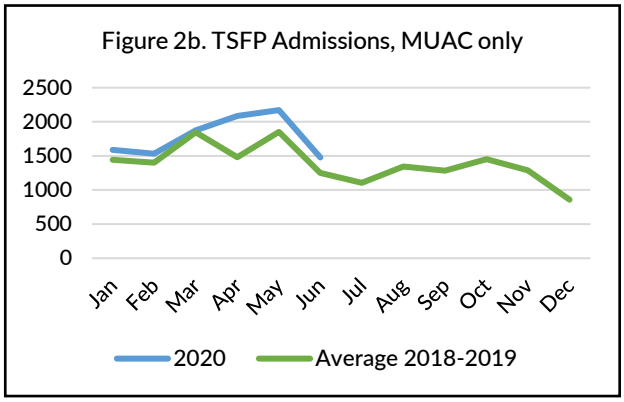


Figure 1b. OTP Admissions, MUAC only



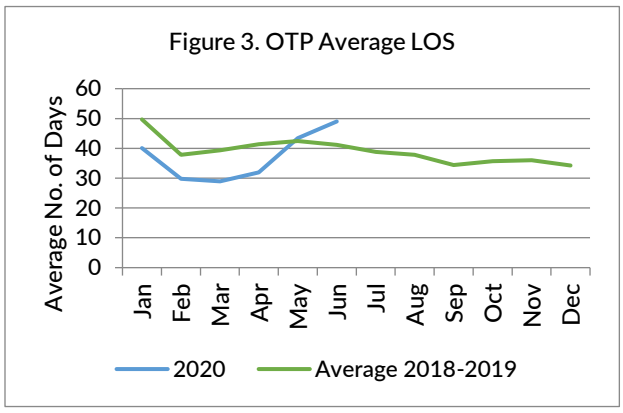
Overall admissions to TSFP in 2020 have been largely on trend with admissions from 2018-2019 (Fig 2b and 2b).

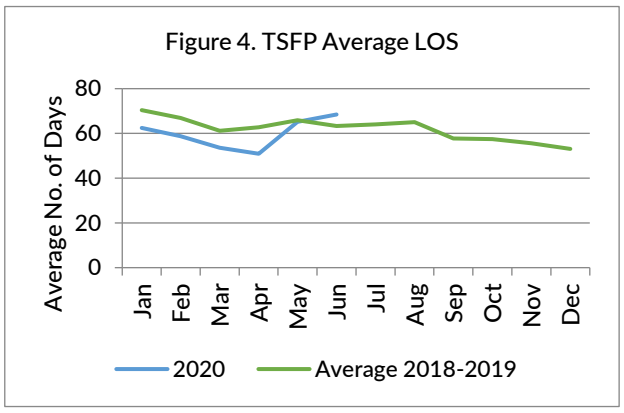




(2) Length of Stay

In 2020, the trend of average length of stay (LOS) for children discharged as "cured" in both OTP and TSFP has been steadily increasing since April, rising beyond the historical average (Fig 3 and 4).





(3) Program Outcomes

Program outcomes[2] (cured, default, death, and non-response) for both OTP and TSFP in 2020 have been relatively similar to average outcomes from 2018 and 2019 (Table 1). The percentage of children discharged as cured in OTP has remained between 1 and 7 percentage points higher in 2020 than the average of 2018 and 2019, and 3 to 11 percentage points higher for TSFP. Default and non-recovered rates are also similar in 2020 when compared to previous years (data not shown).

[2] 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. Also, there are many factors that may be impacting program outcomes beyond program adaptations and require further complex analyses to determine attribution.

(1) Data Summary

- Admissions based on MUAC have increased since April 2020, when COVID-19 was reported in South Sudan and program adaptations were put into place. However, overall admissions into OTP have remained lower than anticipated, possibly due to the inability to admit children by WHZ.
- Children's length of stay in the program has also increased in 2020 following programmatic adaptations. Staff expressed concern that this is not only a consequence of extended time between visits, but may be affected by reduced household-level follow-up and changes in household management of the increased rations of RUTF.
- With the exception of length of stay in the program, the CMAM program performance indicators remain consistent with previous years and continues to meet Sphere standards.

(2) Successes

- Reduced scheduling of follow-up appointments has successfully limited crowding at sites.
- Family MUAC is well accepted in the community and was widely agreed upon as a community mobilization method and a tool to enhance caregivers' monitoring of their children's health that should continue beyond COVID-19.
- Staff appreciate the reduced workload associated with the simplified dosing regimen and elimination of weight and height measurements as well as; however, scheduling appointments to manage crowds has increased workload.
- Open communication and continued sensitization at clinics and in the community has been critical to ensuring strong community acceptance of programmatic adaptations.

(3) Challenges and Limitations

- Accuracy of caregiver referrals through the Family MUAC approach varies widely. Program staff underscored the need for refined training and ongoing support to maximize the impact of the Family MUAC approach and improve accuracy of caregiver referrals.
- The reduced ability to conduct follow-up home visits due to movement restrictions has hindered community engagement and patient tracking. Staff called for innovative ways for continued follow-up visits.
- Some children remain excluded from the program due to suspended use of WHZ as an admission criterion.

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