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

Case Study
Organization: ACTION AGAINST HUNGER
Location: UGANDA
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CONTEXT OVERVIEW

Action Against Hunger USA, in alignment with the Ministry of Health and the World Food Programme (WFP), implemented adaptations to its nutrition programs in Uganda aimed at minimizing the risk of COVID-19 transmission while continuing services for the management of child wasting. In addition to infection prevention and control (IPC) measures, these adaptations included:

(1) Modified admission and discharge criteria in integrated management of acute malnutrition (IMAM) programs;
(2) Modified frequency of follow-up appointments during acute malnutrition treatment; and
(3) Scale-up of Family MUAC.

ADAPTATION IMPLEMENTATION

(1) Modified Admission and Discharge Criteria

National protocols in Uganda specify that children should be admitted to supplementary feeding programs (SFP) based on one of two criteria: mid-upper arm circumference (MUAC), or weight-for height Z-score (WHZ). To reduce contact between health workers or clinic staff and clients , clinics suspended the use of WHZ as a metric for newly admitted patents, though clients already admitted by WHZ continued to be monitored using their Z-scores. To capture children who might therefore be excluded, WFP conducted a rapid assessment at three facilities to determine a revised MUAC threshold, ultimately increasing the threshold from 12.5cm to 12.9cm. Children who fall within this range are considered “at risk” and enroll in SFP. Clinics continue to take weight and height measurements only to calculate dosage for certain prescription medicines.

Program staff estimate that this revised threshold has increased SFP admissions, increasing coverage to include additional children in the program. However, there is concern that the expanded MUAC range is not capturing more severely malnourished cases: staff report that children appearing to have SAM are admitted to SFP rather than outpatient therapeutic programs (OTP) based on their MUAC. They may therefore be delayed in receiving more intensive treatment until their MUAC deteriorates or may experience prolonged time to recovery. Finally, one reported challenge is changing the perception that children whose MUAC fall within the expanded range for admissions (e.g., 125-129mm) are in fact malnourished, because prior to the COVID-19 adaptations they would have been considered healthy. However, all children enrolled in the program, regardless of admission criteria used, are treated in accordance with program protocols on rations, health education, and counselling provided.

(2) Modified Frequency of Follow-Up Appointments

To reduce crowding at CMAM clinics, Action Against Hunger modified 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 for new enrollments, while follow-up for MAM children changed from bi-weekly to monthly visits. Program staff have reported that such schedule changes successfully reduced crowding at the clinics. They have been able to manage the changes in supply distribution, and no negative feedback from the communities was reported due to the change in scheduling.

Due to the longer time between visits, ration sizes provided at each visit has doubled. Caregivers have indicated no challenges related to storing additional supply. However, some were worried that the ration would not last between visits. Furthermore, when this adaptation was first implemented, program staff noticed an increase in nutrition supply sales in local markets. In particular, refugees were reported to purchase milk and meat with the money from the sales, due to limited alternative livelihoods options. Program staff have worked closely with the community to raise awareness of this issue, and the practice appears to have decreased.

The reduced frequency of follow-up visits has also left staff concerned about deterioration or prolonged time to recovery in program participants. Staff reported decreases in children's measurements between visits. This may be due to sharing or sale of the nutrition supplies, reducing the amount that the enrolled child receives. It is also possible that fewer health checks leave illnesses untreated, leading to deterioration among malnourished children with weakened immune systems.

(3) Scale Up of Family MUAC

The recent suspension of mass screenings accelerated Action Against Hunger's scale up of Family MUAC, an approach that trains caregivers to measure and monitor their child's MUAC at home. Training on this approach was conducted through village health teams (VHT) and existing care groups in Uganda through a cascade approach. Community-based facilitators train care group leaders, who then train the mothers in their groups on the approach as well as signs and symptoms of malnutrition. These mothers are linked back to VHTs. If a child is identified as malnourished, a village health worker (VHW) will confirm the child's status and refer him or her to a health facility. Records from Action Against Hunger's monitoring system, first implemented in June, show that more than half of referrals were accurate that month.

Program staff report that Family MUAC has thus far been most successful in identifying more severely malnourished children. Furthermore, Family MUAC participants are trained only on the traditional MUAC thresholds to align with the color-coded categories on the tapes. Therefore, this approach may not identify at-risk children as defined by the recent changes to MUAC thresholds described previously. Finally, since the approach is implemented through the care group model, communities or families who do not participate in care groups may be left out of the approach.

Family MUAC implementation has impacted dynamics between care group leaders, VHWs, and community workers. Staff reported tensions between care group leaders and VHWs. Under Family MUAC, care groups are performing a role that VHWs usually fill, which may intrude on the feelings of ownership that VHWs have over these activities. Action Against Hunger is mitigating this through continued sensitization and by ensuring that care group volunteers refer suspected malnourished children through the VHWs in adherence with the Ministry of Health's structure and guidelines. While community officers (who are usually in charge of mass screenings and oversee community-based facilitators) have seen a decreased workload, community-based facilitators' workload has increased with verifying Family MUAC referrals and providing increased support to care group leaders. Action Against Hunger hired additional community-based facilitators from within the areas of focus to meet this increased workload.

LESSONS LEARNED

(1) Successes

- Expanded MUAC admission thresholds has allowed the program to enroll at-risk children, despite the suspension of WHZ and height monitoring.
- Revised scheduling of follow-up appointments has successfully limited crowding, allowing programming to continue with reduced risk of COVID-19 spread from close interactions at the sites.
- Both staff and caregivers report being able to manage changes in nutrition supply distribution due to the increased rations given at each visit.
- Family MUAC is well accepted in the community. Staff perceive that this approach has identified more severely malnourished children in the absence of routine mass screenings. Staff perceive this as the best surveillance option in the current context.
- Use of the existing care group model has facilitated widespread training and easier scale-up of the approach.

(2) Challenges and Limitations

- The shift from use of MUAC and WHZ to only expanded MUAC as admission criteria may exclude more severely malnourished children from the program. Staff have sensitized caregivers on other signs and symptoms of malnutrition to encourage them to seek treatment early for their children; however, this does not fully compensate for the lesser sensitivity of MUAC as compared to WHZ in identifying more severe cases.
- Reports of increased sales of rations or therapeutic foods have emerged due to increased supply distributions at less frequent follow-up visits. This is likely due to families' livelihoods constraints and inability to meet needs through other means.
- Longer gaps between visits may result in the deterioration of children's nutritional status, either from nutrition supply mismanagement or reduced health checks.
- Tensions between VHWs and care group leaders with the implementation of Family MUAC have presented a challenge thus far. Action Against Hunger has aimed to minimize this by increased communication between groups and streamlining the role of care group volunteers to link potential clients to the village health teams.

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