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

Case Study
Organization: CONCERN WORLDWIDE
Location: SOUTH SUDAN
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CONTEXT OVERVIEW

In South Sudan, Concern Worldwide runs an integrated program to treat children with severe and moderate acute malnutrition in Central Equatoria, Unity and Northern Bahr el Ghazal States. Four of the 72 nutrition sites are based in Protection of Civilian (PoC) sites for internally displaced persons (IDPs) in Juba and Bentiu.

In April and May 2020, following the South Sudan Nutrition Cluster's COVID-19 guidance, Concern Worldwide implemented adaptations to its nutrition programs aimed at minimizing the risk of COVID-19 transmission while continuing services for the management of child wasting. At facility level, hand washing facilities were established at the entrance and in the compound, staff used hand sanitizer after each contact with beneficiaries, physical distance of two meters was maintained, and temperatures were screened at the entrance, among other measures. In addition to these IPC measures, protocol adaptations included:

1. (1) Modified admission criteria in CMAM programs;
2. (2) Modified dosage of therapeutic foods during AM treatment;
3. (3) Modified frequency of follow-up appointments during AM treatment; and
4. (4) Scale-up of Family MUAC and suspension of mass screenings.

ADAPTATION IMPLEMENTATION

(1) Modified Admission Criteria

The standard national CMAM protocol in South Sudan includes three independent admission criteria: bilateral pitting edema, mid-upper arm circumference (MUAC), and/or weight-for-height Z-score (WHZ). COVID-19 guidance suspends the use of weight and height measurements in admissions, follow-up, and discharge to reduce contact between children, caregivers, and health workers. Therefore, only MUAC and edema are used as admission criteria under the revised protocol.

This modification enabled staff to continue providing treatment while reducing contact; however, program staff reported a significant drop in OTP and TSFP admissions, for example in Juba PoC in May and June (see Figure 1 in "Programmatic Data" section below). Positively, suspending weight and height measurements at the sites minimized contact between staff and enrolled children. Staff also train caregivers to take their own children's MUAC at the sites to reduce contact further. Shifting to MUAC and edema as sole admissions

criteria also reduced the time that caregivers spent at the sites, once they had been trained and became confident in taking the MUAC measurements.

(2) Modified Dosage of Therapeutic Foods

With the suspension of weight and height measurements, RUTF dosage for children enrolled in OTP is no longer calculated based on a child's weight; instead, using the simplified protocol, all beneficiaries receive two sachets a day regardless of their weight. The new dosage is based on the combined protocol for acute malnutrition study (ComPAS) that was conducted earlier in South Sudan, indicating that such simplified protocol does not affect performance indicators.

The modified dosage has reduced demand on the nutrition commodity supply at site level, enables easier stock management, and allows staff to calculate the rations much more quickly. To date, cure rates of discharged children continue to be above Sphere standards, and most enrolled children's MUAC continues to increase. However, staff report concerns that a reduced dosage may be influencing children's length of stay in the program.

(3) Modified Frequency of Follow-Up Appointments

Based on the national guidance, Concern Worldwide also 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 fortnightly visits while follow-up for MAM children changed from fortnightly to monthly visits. Caregivers made appointments to return to the clinics on specific days for follow-ups. Nutrition sites also expanded the number of days for OTP and TSFP consultations, which has successfully reduced crowding.

Caregivers have generally responded positively to this change since they need to travel to the facilities less frequently. This has also reduced crowding at the sites. However, staff reported concerns about the decreased frequency of visits: a delay in follow up visits could lead to delayed discharge and potential increases in lengths of stay. Some suspect that the increased rations given at each visit are shared among the children in the household or may be sold.

(4) Scale Up of Family MUAC

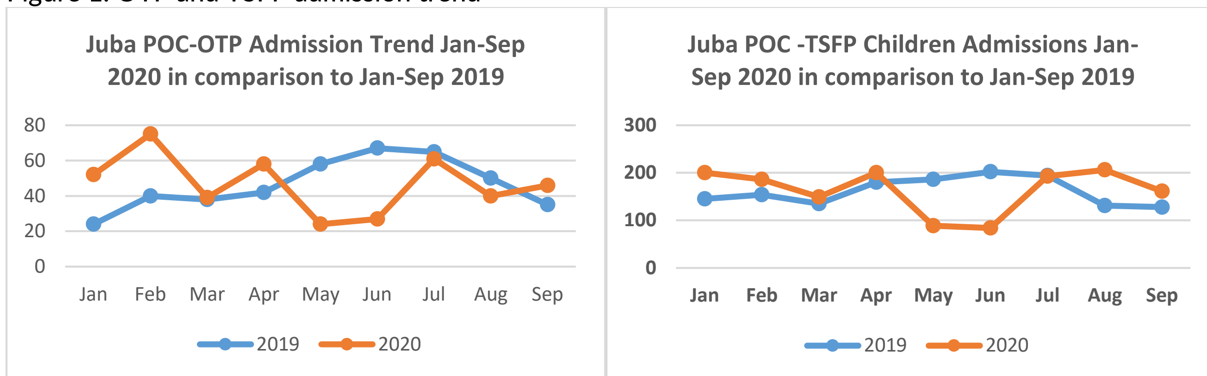
Community-level mass MUAC screenings and mother-to-mother support group meetings were suspended across South Sudan due to COVID-19 restrictions, and community nutrition volunteers' mobility was extremely limited. Therefore, as per the guidance, Concern introduced Family MUAC into its programming, an approach that trains caregivers to measure their own child's MUAC to screen for malnutrition and to monitor progress during follow up visits. The approach aims to strengthen health-seeking behavior, as caregivers then know how to assess their children's nutritional progress and note changes in their health status.

Given a limited supply of MUAC tapes, training was first targeted to mothers with children enrolled in OTP and TSFP. Staff conducted initial trainings with caregivers at the sites during follow-up visit, using dolls to demonstrate how to take the measurement while caregivers measured their own children's arms to practice. This temporarily increased caregivers' time at the sites while receiving the initial training. After seeing a noticeable decline in admissions when community-based screenings were suspended, Concern then expanded the program to other caregivers with children under 5 years old in the community. CNVs or nutrition workers trained caregivers on an individual basis during house-to-house visits, and instructed them to bring their children to the nearest health facility or nutrition center for further screening if they suspect their child is malnourished. Staff anticipate that Family MUAC will be cost effective, requiring fewer resources to conduct active case finding in the community.

PROGRAMMATIC DATA[1]

As shown in Figure 1 below, data from Juba PoC shows a decline in both OTP and TSFP admissions after COVID-19 adaptations were implemented in April 2020. This may be related to suspension of WHZ as an admission criterion as well as restrictions on active community screening by nutrition staff and volunteers. When the first case was confirmed, some caregivers were also afraid to bring their children to the sites for treatment due to perceived risk of contracting COVID-19. However, admissions in Juba PoC increased in July after the resumption of community-based screening.

Figure 1. OTP and TSFP admission trend



Programmatic data from Juba PoC also shows an increase in the length of stay in OTP, from 49 days pre-COVID (July to Sep 2019) to 57 days during COVID (July to Sep 2020). Similarly, there is an increase in average length of stay in TSFP, from 62 days pre-COVID (July to Sep 2019) to 73 days during COVID (July to Sep 2020). There are several possible reasons for this increase, including delays in seeking treatment, reduced dosage for OTP, the reduced frequency of follow-up visits, sharing the increased ration of nutrition supplies within the household, or sale of nutrition supplies to meet other needs.

LESSONS LEARNED

Successes

- In addition to the guidance from the Nutrition Cluster, Concern Worldwide had detailed guidance outlining how to implement these adaptations, including site set-up, family MUAC training which facilitated easier rollout of the modifications.
- Staff are routinely recruited internally from within the PoC sites or from the community. Therefore, when access was restricted, staff recruited from the sites were able to continue service provision to enrolled beneficiaries.
- Staff's workload at the site level decreased as a result of the fewer anthropometric measurements to be taken, simplified dosage, and reduced frequency of follow-up visits. Therefore, staff were able to spend more time in the community rolling out the Family MUAC approach, following up on absentees and defaulters, and conducting risk communication and community engagement (RCCE) activities.

[1] There are several possible factors that could contribute to changes in programmatic indicators, such as increased market prices, poor harvests in 2019, poor health seeking behavior for fear of COVID-19, increased transportation costs, travel restrictions, suspension of other health services, program protocol adaptations, etc. Therefore, any interpretation of these data should be made with caution as further complex analyses would be needed to attribute outcomes to potential driving factors.

- The Family MUAC approach has contributed to increased acceptance of the CMAM program as caregivers better understand how their children are assessed for admission into the program.
- Engaging lead mothers from mother-to-mother support groups and community nutrition volunteers to supervise Family MUAC implementation at the community level could expand coverage.

Challenges and Limitations

- Given the suspensions of community screenings and use of WHZ as an admission criterion, staff are concerned that some eligible children may not be captured and receiving treatment under the current protocol. The resumption of house-to-house community-based screening in July resulted in a dramatic increase in admissions, showing continued need for nutrition services.
- Some caregivers of children enrolled in OTP who used to receive more than two sachets per day were concerned that the reduced RUTF ration their children received under the new protocol would not be enough and expressed frustration at the smaller ration. Staff have addressed this by explaining that this reduction results from a temporary nationwide change in protocol.
- COVID-19 IPC measures have also made monitoring consumption challenging: typically, caregivers are asked to bring the empty sachets back to the site to be counted. In order to avoid touching the used sachets, this practice has been temporarily stopped. Therefore, under current circumstances it is more difficult to monitor how the nutrition supplies are being used.
- Limited supply of MUAC tapes inhibits scale-up of the Family MUAC approach. Conversations are underway to procure additional tapes.
- The Family MUAC approach has thus far been targeted at children under five, who are able to be measured using color-coded MUAC tapes. However, no color-coded tapes exist yet for adults; therefore the approach has not yet been used to screen adults, since many community members are illiterate.

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