MANAGEMENT OF CHILD WASTING IN THE CONTEXT OF COVID-19

Brief No.1
(March 27th, 2020)

To support implementers on how to prepare and respond to the COVID-19 pandemic, a series of guidance briefs will be produced and updated every ten (10) days as new information and evidence emerges. **This Brief is meant to provide information specific to services and programmes for the management of child wasting in the context of COVID-19**, and it contains information that is not already available elsewhere. This Brief does not cover wider mitigation and response measures available in other guidance. As a nutrition community, we will continue to develop our understanding on practical solutions to deliver programming in the context of COVID-19.

Documenting and disseminating this guidance and emerging evidence and lessons will be key to implementing the most appropriate and effective responses in the face of this pandemic. Please share your questions and programmatic adaptations with us:

English : https://www.en-net.org/forum/31.aspx **French**: https://fr.en-net.org/forum/31.aspx

KEY MESSAGES & PRIORITY ACTIONS
1. Intensify the public awareness[i], protection, promotion and support of appropriate and safe feeding for all breastfed and non-breastfed children and use all opportunities to include hygiene messages, key messages on COVID-19 symptoms, and Infection, Prevention and Control (IPC) measures[ii].
2. Intensify pre-positioning (with a minimum buffer stock of 2 months) of essential commodities for nutrition programming (e.g. F100/75, Ready to Use Foods, Fortified Blended Food, Lipid-based Nutrient Supplements, Multiple Micronutrient Powders) and routine medicinal supplies at national, health facility and community level in anticipation of supply chain disruptions[iii].
3. In food insecure contexts where communities have limited access to an adequate diet, scale-up preventive distribution of Specialized Nutritious Foods (e.g. fortified flours and Medium Quantity-LNS) for all households with children under the age of 2.
4. Intensify efforts to strengthen the capacity of mothers and caregivers to detect and monitor their children's nutritional status using low-literacy/numeracy tools including Mid-Upper Arm Circumference (MUAC) tapes[iv,v].
5. Initiate necessary discussion with Ministries of Health and national coordination platforms/nutrition clusters on context-specific simplifications of treatment protocols for child wasting[vi], including simplifying anthropometric criteria, dosage and distribution schedules of Ready to Use Foods (RUFs) and other specialized nutrition foods, as well as potential adaptations to inpatient management for complicated cases in the context of COVID-19.
6. Initiate efforts to build capacity of community health workers (CHWs) to provide treatment for uncomplicated wasting at the community level[vii], including training on low/no-touch assessment, simplified treatment protocols, remote supervision and key messages on COVID-19[viii].
7. Strengthen real-time monitoring and surveillance systems for child wasting with the use of mobile technologies to inform response options and allocation of resources.

POTENTIAL ADAPTATIONS TO CHILD WASTING PROGRAMMING IN THE CONTEXT OF COVID-19

Where there are no mobility restrictions in place, preparatory measures for child wasting programming should be considered. Additional measures should be considered when partial or full mobility restrictions are in place.

<table>
<tr><th></th><th>No Population Mobility Restriction</th><th>Partial or Full Population Mobility Restrictions</th></tr>
<tr><td>Inpatient Services</td><td colspan="2">Ensure strict adherence to recommended hygiene and safety measures in Stabilization Centres/Wards, including enforcing strict staff sickness policy, screening and triage procedures, identification of isolation areas, limiting contact with multiple healthcare workers, and strict cleaning protocols (e.g. disinfecting scales between measurements).
Emphasize strong hygiene standards of mothers, all those handling infants under six months, and of feeding equipment, while actively supporting skin to skin contact and breastfeeding.
Increase physical space to at least two (2) metres between beds in Stabilization Centres.
Reduce family member visits to primary caregiver only.
Whenever possible, separate patient areas for suspected/confirmed COVID-19 cases from non-cases and apply recommended IPC measures.</td></tr>
<tr><td>Outpatient & Community-based Services</td><td>Minimize the risk of infection for staff working in In-patient/Outpatient nutrition centers and CHWs as per WHO guidance.
Where services are available, maintain provision of treatment for moderate wasting applying recommended IPC measures and reducing the frequency of follow-up visits to 1 every 4 weeks for children by increasing the take home ration of specialized nutrition foods (e.g. RUFs, Super Cereal+).
Reduce overcrowding through more frequent provision of services (e.g. from 1 to 3 outpatient days per week) applying recommended IPC measures or through delocalization of services to the community.
Reduce exposure by shifting to MUAC only for anthropometric measurements in children and encouraging caregivers to carry out MUAC and oedema assessments under the supervision of a health practitioner.
Initiate on-the- job training for Community Health Workers (CHWs) to treat uncomplicated wasting including introduction to simplified treatment protocols and approaches, if feasible.
Initiate/intensify trainings for caregivers and community members on the use of MUAC, and the provision of MUAC tapes to all caregivers.
Continue provision of preventive food supplementation and hygiene kits to children and pregnant and lactating women (PLW) applying recommended IPC measures, avoiding any mass gatherings.
Continue provision of preventive food supplementation to children and PLW applying recommended hygiene and safety measures.</td><td>Whenever possible, deliver all treatment for uncomplicated wasting in the community via Community Health Workers (CHWs)[ix] or other community-based platforms[x] using a limited/no touch simplified treatment approach. Programmatic modifications should consider:
Using simplified admission criteria (e.g. MUAC and oedema only)[xi]
Using expanded admission criteria (<120mm or <125mm MUAC and/or oedema)[xii]
Adopt simplified RUF dosage (e.g. 1 sachet/day for uncomplicated moderate wasting, and 2 sachets/day for uncomplicated severe wasting)[xiii]
Appropriate remuneration of CHWs
Reduce the frequency of follow-up visits to once per month for children with uncomplicated severe or moderate wasting by increasing the take-home ration of RUFs and other nutrition commodities[xiv]. If all services are temporarily suspended, distribute RUFs/nutrition commodities for up-to 8 weeks. Whenever possible, establish links between these households and existing social protection systems.
Maintain frequency of provision of specialised nutrition foods or other preventative supplementation to children and PLW to 1 per month adhering to recommended hygiene and safety measures, avoiding any mass groupings of people.</td></tr>
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OUTANDING PROGRAMMATIC QUESTIONS TO BE ADDRESSED AS EVIDENCE EMERGES
• In the absence of widespread COVID-19 testing, and as standardization of case-definition emerges, is triage to isolate these cases at nutrition service delivery points required / feasible/ recommended? • In the context of severe disruption to services/insufficient commodities, how should the allocation of treatment services for child wasting be prioritized and/or combined with other public health interventions? • What criteria can be used for early transition from inpatient to outpatient treatment of wasting in the event of widespread community transmission and/or increased demand on inpatient facilities? • How can access to nutrition rations/commodities be ensured at a community level in the event of widespread closures of health facilities and other service delivery infrastructure? • How should nutrition protocols and services be adapted in the absence of essential commodities and medicines, including (but not limited to) RUFs? • How is COVID-19 expected to impact on the incidence of wasting, and how should programmes reflect these changes? • How is COVID-19 expected to impact on morbidity, mortality and treatment response in children with wasting and how should programmes accommodate this? • What digital solutions are available to continue training/supervising/monitoring/reporting on the nutrition situation and performance of programmes for the management of child wasting remotely?

REFERENCES & NOTES

[i] See https://translatorswithoutborders.org/assessment-effective-ebola-communication-requires-respect-and-transparency/

[ii] https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected

[iii] Evidence from past epidemics suggests that outbreaks (e.g. the experience from Ebola), that supply chain shortages and declines in essential health service occur, and that these need to be circumvented. See: 1) Decroo T, Fitzpatrick G, Amone J. What was the effect of the West African Ebola outbreak on health programme performance, and did programmes recover?. *Public Health Action*. 2017;7(Suppl 1):S1–S2. doi:10.5588/pha.17.0029. 2)

[iv] Recommendation based on lessons learned from the Ebola response. See: Kamara MH, Najjemba R, van Griensven J, et al. Increase in acute mal Sesay T, Denisiuk O, Shringarpure KK, et al. Paediatric care in relation to the 2014-2015 Ebola outbreak and general reporting of deaths in Sierra Leone. *Public Health Action*. 2017;7(Suppl 1):S34–S39. doi:10.5588/pha.16.0088 nutrition in children following the 2014-2015 Ebola outbreak in rural Sierra Leone. *Public Health Action*. 2017;7(Suppl 1):S27–S33. doi:10.5588/pha.16.0084

[v] Blackwell, N. et.al. (2015) Mothers Understand And Can do it (MUAC): a comparison of mothers and community health workers determining mid-upper arm circumference in 103 children aged from 6 months to 5 years. (Arch Public Health. 2015 May 18;73(1):26. https://pubmed.ncbi.nlm.nih.gov/25992287/

[vi] See examples https://acutemalnutrition.org/en/Simplified-Approaches and https://www.ncbi.nlm.nih.gov/pubmed/29690916

[vii] See https://www.ennonline.net/fex/52/communityhealthworkerssam and https://www.ennonline.net/fex/59/samtoolssudan

[viii] In line with national recommendations on continuation of essential health service delivery in the context of COVID-19

[ix] Lopez-Ejeda N, Charle-Cuellar P, G. B. Ale´F, Alvarez JL, Vargas A, Guerrero S (2020) Bringing severe acute malnutrition treatment close to households through community health workers can lead to early admissions and improved discharge outcomes. PLoS ONE 15(2): e0227939. https://doi.org/10.1371/journal.pone.0227939

[x] If routine medicines including antibiotics can only be provided at health facilities, introduce single-visit attendance on admission and transition to full community-based follow-up via CHWs or other community-based platforms for all subsequent visits.

[xi] Chitekwe, S., Biadgilign, S., Tolla, A. et al. Mid-upper-arm circumference based case-detection, admission, and discharging of under five children in a large-scale community-based management of acute malnutrition program in Nigeria. Arch Public Health 76, 19 (2018). https://doi.org/10.1186/s13690-018-0266-4

[xii] Burrell, A., Kerac, M., & Nabwera, H. (2017). Monitoring and discharging children being treated for severe acute malnutrition using mid-upper arm circumference: Secondary data analysis from rural Gambia. (International Health, 9(4). https://doi.org/10.1093/inthealth/ihx022

[xiii] Maust, A. et.a. (2015) Severe and Moderate Acute Malnutrition Can Be Successfully Managed with an Integrated Protocol in Sierra Leone (J Nutr. 2015 Nov;145(11):2604-9. doi: 10.3945/jn.115.214957. Epub 2015 Sep 30.)

[xiv] Isanaka, S. et.al. (2017) Outpatient treatment of severe acute malnutrition: response to treatment with a reduced schedule of therapeutic food distribution (Am J Clin Nutr. 2017 May;105(5):1191-1197. doi: 10.3945/ajcn.116.148064. Epub 2017 Apr 12.) https://www.ncbi.nlm.nih.gov/pubmed/28404577