WORKING GROUP CO-CHAIR
INTRODUCTIONS

Sarah Kellogg, HDTF Co-Chair
Susan Otchere, HDTF Co-Chair
Shelley Walton, Nutrition WG Co-Chair
CORE Group convenes global community health professionals to share knowledge, evidence, and best practices, and then translates these into the real world with a direct impact.

CORE Group’s Humanitarian-Development Health Task Force (HDTF) aims to drive improved coordination, communication and collaborative learning across global health programming in emergency response, recovery, and development.

CORE Group’s Nutrition Working Group underscores the critical role of nutrition in maternal and child survival and health through dissemination of state-of-the-art information and approaches essential for quality nutrition programming.
AGENDA

• Welcome
• Co-Chair Introductions
• Presentation on preliminary findings
• Brief Q&A
• Panel Discussion
• Participant Discussion
• Final Summary
Maria Wrabel, CMAM Adaptations Project Officer for Action Against Hunger USA
INNOVATIONS AND COVID-19 ADAPTATIONS IN THE MANAGEMENT OF CHILD WASTING

Maria Wrabel
CMAM Adaptations Project Officer
Action Against Hunger USA
GLOBAL RECOMMENDATIONS: ADAPTATIONS

Aim: Continue life-saving services, while reducing risk of transmission

March 2020

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 3-6 months to 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 other mitigation and response measures available in other guidance. As a nutrition community, we will continue to develop our understanding of practical solutions to deceive 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:


1. Intensify the public awareness, 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.

2. Intensely pre-positioning (with a minimum buffer stock of 2 months) of essential commodities for nutrition programming (e.g., F1000/75, Ready-to-Use Foods, Fortified Dried Foods, Egg-based Nutrient Supplements, Multiple Micronutrient Powders) and routine medical supplies at national, health facility and community level in anticipation of supply chain disruption.

3. In food insecure contexts where communication has limited access to an adequate diet, scale-up preventive distribution of Fortified Nutritious Foods (e.g., fortified flour and Medium Intensity-VMI) for all households with children under the age of 2.

4. Intensify efforts to mobilize the support of mothers and caregivers to detect and monitor their children’s nutritional status.
### Global Recommendations: Adaptations

<table>
<thead>
<tr>
<th>Adaptation</th>
<th>Moving From</th>
<th>Moving To</th>
<th>COVID-19 Aim</th>
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</thead>
<tbody>
<tr>
<td>1. Family MUAC</td>
<td>CHWs only</td>
<td>+ Caregivers</td>
<td>Continue detection of wasting; reduce physical contact</td>
</tr>
<tr>
<td>2. Simplified Admission Criteria</td>
<td>MUAC Edema Weight Height</td>
<td>MUAC Edema (Expanded MUAC thresholds)</td>
<td>Reduce physical contact</td>
</tr>
<tr>
<td>3. Simplified Dosage</td>
<td>Based on weight</td>
<td>2 sachets/day for SAM 1 sachet/day for MAM</td>
<td>Necessary if not collecting weight</td>
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<tr>
<td>4. Reduced Follow-up Visits</td>
<td>Weekly or bi-weekly</td>
<td>Bi-weekly or monthly</td>
<td>Reduce need to travel, Reduce crowd sizes at clinics</td>
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<tr>
<td>5. Treatment by CHWs</td>
<td>Health facility/clinic</td>
<td>CHWs in community</td>
<td>Reduce need to travel, Reduce crowd sizes at clinics</td>
</tr>
</tbody>
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MIXED METHODS STUDY

Study Aim:
To systematically document, analyze, and synthesize information related to adaptations for detection and treatment of child wasting

Methods:

1. Survey:
   • Track and map: Who? What? Where?

2. Interviews:
   • Document lessons learned on operational implications, strengths and challenges

3. Secondary Data Analysis:
   • Trends, impact on programmatic outcomes
DISSEMINATION

State of Acute Malnutrition Website

• COVID-19 adaptations tracker/mapping

• Collation and creation:
  • 10 country case studies
  • Relevant tools and guidance

www.acutemalnutrition.org
Case Studies:
• Using Family MUAC for continued screening and surveillance in Kenya: Action Against Hunger USA, Kenya Red Cross, National Drought Management Authority (NDMA)
• Modified frequency of follow-up appointments in Ethiopia: Action Against Hunger USA
• Modified admissions criteria to reduce risk of COVID-19 transmission in Uganda: Action Against Hunger USA
• Continuing treatment of acute malnutrition when facilities are inaccessible in Nepal and India: Action Contre la Faim (ACF), Action Against Hunger India
PRELIMINARY RESULTS

Data represents malnutrition treatment conducted by
18 organizations in 42 countries.
PRELIMINARY RESULTS

Qualitative Observations

Reported decrease in CMAM admissions
- Fear of visiting clinics
- Suspension of screenings and surveillance
- Travel restrictions

Most adaptations have been:
- Not complicated to implement
- Accepted well by communities

Protocol simplifications
- Reduced workload for staff
- Improved caregiver understanding of treatment procedures
Qualitative Data/Observations

Challenges:

- Lack of implementation guidance
- No standard M&E tools, indicators
- Insufficient MUAC tapes to scale up Family MUAC
- Concerns and confusion around admission eligibility criteria
  - Enables program continuity, reduces contact
  - Possible exclusion or miscategorization of at-risk children
- Reduced frequency of follow-up visits:
  - Anecdotal observations of selling and sharing RUTF
  - Decreased rate of weight gain, increased LOS (mixed evidence)
QUESTIONS?
MODERATOR AND PANELISTS

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