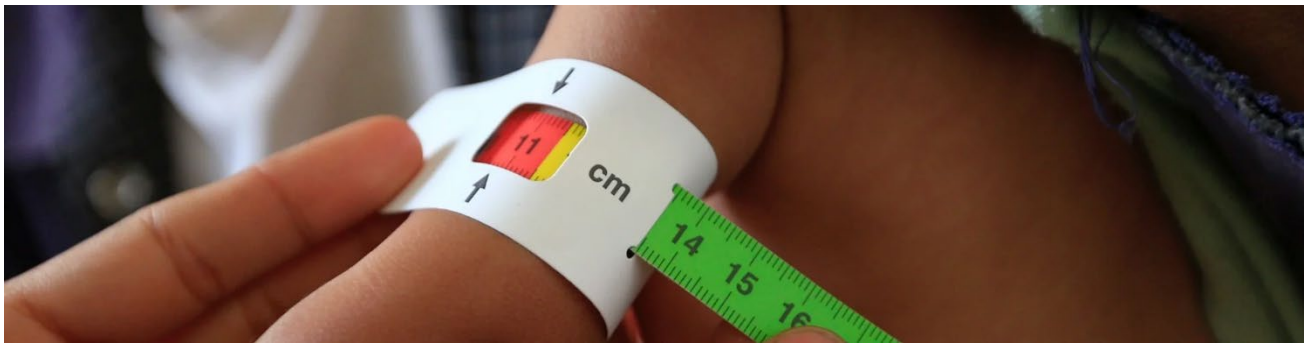
NE Nigeria NUTRITION SECTOR

GLOBAL NUTRITION CLUSTER Technical Alliance



Treatment of Acute Malnutrition Using Simplified Approaches

Standard Operating Procedures[1]

November 2022

1. Background

Northeast Nigeria states of Borno, Adamawa and Yobe (BAY states) experience a seasonal trend of acute malnutrition with a peak during the lean season. The state-level prevalence of acute malnutrition has remained static over the past 5 years – Borno (12.3%), Adamawa (7.2%) and Yobe (10.6%). However, the nutrition situation is classified as critical in several hotspot Local Government Areas (LGAs). It was projected that 1.74 million children under 5 years would be acutely malnourished in 2022, including 614,000 severe acute malnutrition (SAM) cases[2]. Trend analysis of admission data from nutrition facilities across the BAY states indicates that the number of SAM children admitted during January to September of 2022 in health facilities for the treatment of SAM with and without complications has on average increased by 54% and 15% respectively compared to the same period in 2021. Similarly, moderate acute malnutrition (MAM) admissions increased more than threefold compared to the same period in 2021. Borno state has the worst trends of SAM admissions among the BAY states, with an increase of 21% compared to the same period in 2021. In Maiduguri and Bama, Borno state for example, admissions of SAM

[1] Developed with technical support from the Global Nutrition Cluster technical support team whose work is made possible by the generous support of the American people through the United States Agency for International Development's (USAID) Bureau of Humanitarian Assistance (BHA),

[2] IPC_Nigeria_Acute_Malnutrition_2021Sept2022Aug_Report.pdf (ipcinfo.org)

with medical complications increased more than fourfold during the period of January to September of 2022[3].

The spikes in acute malnutrition have been exacerbated by synergistic drivers including, a) disruptions of humanitarian assistance due to the protracted conflict, delayed funding and/or funding cuts, b) outbreaks of communicable diseases (measles and cholera), c) food shortages and spikes in food prices, d) Internally Displaced Persons (IDPs) relocations to areas with limited humanitarian assistance, e) inaccessibility, f) low coverage of preventive services, etc. It is estimated that 128,522 acutely malnourished children under 5 years (9%) of 2022 acute malnutrition burden) live in hard-to-reach areas, of which 28,290 are severely malnourished. During January to August of 2022, sector partners scaled up the treatment of SAM through integration into health facilities and outreach/mobile services reaching 100% of the sector target in accessible areas. However, only 26% of MAM caseload were reached thus contributing to increased incidence of SAM, additional strain on health facilities and increased risk of mortality.

The State Primary Health Care Development Agency (SPHCDA), Nutrition Sector partners, UNICEF and WFP have therefore proposed a context-specific activation of Simplified Approaches (SAs) in exceptional circumstances to deliver lifesaving treatment services in hard-to-reach areas and mitigate the effects of the delayed scale-up of services. These will contribute to increase in nutrition services coverage and mitigate implementation challenges faced such as pipeline breaks, limited supervision, unavailability of health personnel, limited capacity, and limited accessibility to existing health facilities and other exceptional circumstances as agreed upon by the nutrition sector. Simplified Approaches are a set of modifications to the existing national and global protocols for the treatment of acute malnutrition designed to improve effectiveness, quality, coverage and reduce the cost of caring for children with uncomplicated acute malnutrition in exceptional circumstances.

2. Purpose

a) To improve coverage and access to lifesaving treatment services for uncomplicated wasting among children 6-59 months through existing and newly established service centers at health facility and community level

b) To provide a continuum of care for children 6-59 months with wasting in hard-to-reach areas.

3. Proposed simplified approaches

Insecurity in NE Nigeria has affected service delivery including nutrition prevention and treatment services. The number of functional OTPs and TSFPs stands at 593 and 165 respectively compared to the expected 929sites (50% OTPs and 50% TSFPs for effective continuum) in the BAY States with

[3] Northeast Nigeria Nutrition Sector 5W

support being provided largely by community health workers at the existing health facilities, as they are severely understaffed in addition to low technical capacity in nutrition programming. Other challenges include supply chain challenges including failure to deliver products due to insecurity, stockouts and leakage of nutrition therapeutic products (RUTF, RUSF or both), limited support supervision. Within this context several simplified approaches are proposed as indicated in the table below and one or more adaptations can be implemented depending on the operational capacity on ground. These adaptations, operational considerations and recommendations are based on the simplified approaches decision making guidance[4] The proposed simplified approaches are the use of one product to treat both SAM and MAM (focusing on areas where MAM treatment coverage is poor or non-existent), expanded MUAC admission criteria, Community health worker-led treatment of uncomplicated wasting, reduced visits and family MUAC. More than one of the simplified approaches can be implemented on a case-by-case basis depending on the exceptional circumstances in a specific context, resources and overall strategy of the implementer.

Table 1: Simplified approaches proposed for implementation in NE Nigeria.

Potential simplified approaches	Key considerations
1. Expanded MUAC admission criteria: Systematic expansions of MUAC to include more children (e.g., 120mm or 125mm)	• Community awareness and engagement • Communication and/or training/orientation of health workers • Consideration of pipeline needs • Documentation of lessons learned
2. Use of a single treatment product**[5]: Use of ready-to-use therapeutic food (RUTF) for the treatment of all wasted children in need of treatment.(1 sachet for MAM and 2 sachets for SAM <11.5cm and 1 for SAM>11.5cm[6])	• Community awareness and engagement • Communication and/or training/orientation of health workers • Consideration of pipeline needs. • Cohesion of approach in neighboring locations. • Knowledge base/capacity of health workers and volunteers (for optimized dosage)

[4] https://www.simplifiedapproaches.org/_files/ugd/2bbe40_8c181c7c429e47b69fb51da399473e20.pdf

[5] ** The simplified approaches do not focus on the treatment of SAM with RUSF. However in the event that the context changes and RUTF supplies are severely compromised, refer to MAM: A decision tool for emergencies. and Programming- in the absence of nutritional products for additional information on what products to use to guide in decision making.

[6] Based on the ComPas study

	● Monitoring of clinical outcomes (recovery rates, length of stay… ● Application of the CHW-led treatment. ● Ensuring supplies availability. ● Potential to couple with Family MUAC and optimized dosage adaptations. ● Consideration of pipeline needs. ● Prioritization criteria ● Documentation of lessons learned
3. CHW-led treatment of wasting: Management of wasting by Community Health Workers (CHWs)	● Community awareness and engagement ● Existence of an active platform of CHWs in the community ● Literacy levels of the CHWS ● Communication and/or training/orientation of health workers and the community workers/volunteers. ● Motivation/ incentivization of the community workers/volunteers (available and uniform). ● Supervision approach ● Effective referral pathways ● Access to health facilities ● Safety and storage of supplies, tools and materials ● Documentation of lessons learned
4. Reduced Frequency of Follow-up Visits (this operationally implies follow up every 2 weeks for SAM cases and 4 weeks for MAM).	● Community awareness and engagement ● Communication and orientation of health workers ● Pipeline and HR considerations to cater for increased numbers on distribution days. ● Monitoring of clinical outcomes ● Increased involvement of community worker/volunteers ● Considerations of severity of wasting (e.g., children below 110 should be monitored every week) ● Documentation of lessons learned
5. MUAC and oedema only: Admission, treatment, discharge based on Mid-upper arm circumference (MUAC) and/or oedema	● Community awareness and engagement ● Communication and/or training/orientation of health workers ● The MUAC Vs WFH discordance ● Potential to link with Family MUAC and expanded MUAC threshold. ● Prevention programs to enhance protection.

	• Documentation of lessons learned
6. Family MUAC: Engaging family members to screen and refer their children	• Community awareness and engagement • Communication and orientation of health workers and volunteers • MUAC tapes availability • Training and refreshers • Effective referral mechanisms. • Considerations to include critical signs for Under 6 months children • Strong referral mechanisms • Involvement of males • Involvement of males • Documentation of lessons learned

4. Simplified Approaches Decision Tree[7,8]

Prior to implementing the simplified approaches, the nutrition sector coordination desk together with SMOH, SPHCDA, UNICEF, WFP and CMAM TWG will ensure that:

- All partners, health and local authorities and community are aware of the simplified approaches. This can include information on what the simplified approaches are, why they are to be implemented in the area, the specific adaptations to be implemented, the target population, implications, and duration.
- There is operational technical capacity to implement the chosen adaptations and a support system in place to ensure capacity strengthening prior to and during implementation.
- The supplies necessary are available (RUTF, MUAC tapes, RUSF, routine medications, data collection and reporting etc.) and sufficient and there is a buffer stock to cater for any changes in caseloads.
- There is a proper data collection, monitoring, and reporting system in place to ensure effective reporting on implementation, and documentation of lessons learned.

[7] GNC. 2017. Moderate Acute Malnutrition: A Decision Tool For Emergencies, MAM Task Force. https://www.nutritioncluster.net/sites/nutritioncluster.com/files/2021-01/DECISION-TOOL-FOR-MAM_w-exceptional-cicumstances_-May-2017-update-final1.pdf

[8] Rapid Response Mechanism (RRM) will prioritize hard-to-reach areas without OTP and TSFP services.

Exceptional circumstances/ Scenarios	Pipeline Breaks (stockouts, delays, period is to be locally determined)	Hard-to-reach areas (poor accessibility for partners, no SFP.)	Human resources challenges	Poor services[9] utilization
Potential adaptation	• Expanded admission for MUAC • Single product for treatment (RUTF) • MUAC and oedema only • Family MUAC	• CHW-lead treatment • Reduced visits frequency • MUAC and oedema only • Family MUAC • Single product for treatment (RUTF) •	• MUAC and oedema only • CHW-lead treatment • Reduced visits frequency • Family MUAC • Single product for treatment (RUTF) (RUTF) (1 sachet for MAM and 2 sachets for SAM <11.5cm and 1 for SAM>11.5cm) • Optimized dosage • Expanded admission for MUAC.	• CHW-lead treatment • Reduced visits frequency • Family MUAC

[9] The TWG reported that poor services utilization in the BAY region is as result of several factors including: poor service coverage, proximity of beneficiaries to treatment facilities, limited community awareness of service availability, caregivers not having decision-making rights, non-adherence to treatment protocol at households, poor attitude of service providers towards beneficiaries.

Admission criteria	For Expanded admission criteria: MUAC < 12.5 cm and no distinction between SAM and MAM For MUAC and oedema only **SAM:** MUAC <11.5cm and/or grade +/++ without medical complications and good appetite. **MAM:** MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite For other **SAM:** WFH/L <-3 z-score or MUAC <11.5cm and/or grade +/++ oedema without medical complications and positive appetite test **MAM:** WFH/L ≥-3 - <-2, or MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite	For MUAC and oedema only **SAM:** MUAC <11.5cm and/or grade +/++ without medical complications and good appetite. **MAM:** MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite For Other **SAM:** WFH/L <-3 z-score or MUAC <11.5cm and/or grade +/++ oedema without medical complications and positive appetite test **MAM:** WFH/L ≥-3 - <-2, or MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite	Depends on the adaptations chosen **OR** national guidelines as below **SAM:** WFH/L <-3 z-score or MUAC <11.5cm and/or grade +/++ oedema without medical complications and positive appetite test **MAM:** WFH/L ≥-3 - <-2, or MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite	Depends on the adaptations chosen **OR** national guidelines as below **SAM:** WFH/L <-3 z-score or MUAC <11.5cm and/or grade +/++ oedema without medical complications and positive appetite test **MAM:** WFH/L ≥-3 - <-2, or MUAC ≥11.5cm - < 12.5cm, without medical complications and good appetite
Service delivery points	Health facility/hospital, Outreach/mobile	Health facility/hospital, Outreach/mobile	Health facility/hospital, Outreach/mobile clinic,	Health facility/hospital, Outreach/mobile clinic,

	clinic, community health post,	clinic, community health post	community health post, central location in the community	community health post, central location in the community
Systematic medical treatment	As per the CMAM guidelines for SAM and MAM cases	As per the CMAM guidelines for SAM and MAM cases	As per the CMAM guidelines for SAM and MAM cases	As per the CMAM guidelines for SAM and MAM cases
Monitoring/ performanc e indicators	As per the CMAM guidelines.	As per the CMAM guidelines.	As per the CMAM guidelines.	As per the CMAM guidelines.

5. Areas of implementation and duration of Intervention

The selected adaptations will be implemented in areas with exceptional circumstances as defined in the decision tree above. Priority will be given to areas with IDPS (including returnees and those relocated). Other factors to consider include hard-to-reach areas with aggravating factors such as limited access to WASH. The areas of implementation will be updated on a regular basis through joint consultation between UNICEF, WFP, Nutrition Sector Coordination Desk and CMAM technical working group (TWG). The Nutrition Sector will regularly conduct in-depth gap analysis of nutrition interventions, showing gaps at the ward level if possible.

The Simplified Approaches will be rolled out for a period of 3 to 6 months during which WFP, UNICEF, MoH, SPHCDA and Nutrition sector partners will work to scale up the nutrition response in line with the national CMAM guidelines. The implementation of the Simplified Approaches will be adjusted based on the changes and evolution of the exceptional circumstances upon consensus between SMOH, SPHCDA, UNICEF, WFP, Nutrition Sector Coordination Desk, CMAM TWG and implementing partner(s). In some locations where the simplified approaches are being implemented as part of the emergency response, the period will be 6 months during which steps will be taken to ensure transition to standard programming. The implementation of the Simplified Approaches is a temporary strategy to save lives in the specified areas as agreed by SMOH, SPHCDA, UNICEF, WFP, Nutrition Sector Coordination Desk and CMAM TWG in consultation with Sector implementing partners. The implementation of the Simplified Approach will be stopped immediately upon WFP, UNICEF, and partner's scale-up of OTP/TSFP and/or other malnutrition prevention and nutrition sensitive programmes leading to changes in the aggravating factors in the specified locations.

The Simplified Approaches can only be implemented as long as the implementing partners, Rapid Response Mechanism (RRM) Teams and Government have physical access and/or appropriate remote access (telecommunications and technology such as WhatsApp, videocalls, short messaging services etc) to the specified locations and the risk of loss of resources and life is mitigated.

6. Expected caseload

Case load can be determined using the caseload and suppliers calculator. However, the overall caseload will be dependent on:

a) OTP/TSFP coverage
b) Overall nutritional situation and needs[10] e.g., the number of LGAs with GAM ≥15% based on SMART surveys, and proxy prevalence.
c) RUTF/RUSF pipeline capacity to support Simplified Approaches caseloads.
d) Type of adaptations selected.

7. Reporting of the treatment of acute malnutrition in children through Simplified Approaches

With the Simplified Approaches, all children with WFH/L <-3 z-score or MUAC <11.5cm and/or grade +/++ oedema without medical complications and good appetite will be registered as SAM cases. Children with WFH/L ≥-3 - <-2, or MUAC ≥11.5cm - < 12.5cm, without medical complications will be registered as MAM cases; even in cases where MUAC threshold is increased as it is important to maintain the distinction between SAM and MAM. The admissions card captures information in relation to the simplified approaches 1-6. It is important that in facilities where these approaches are being implemented; this information should be extracted and reported. In the case of family MUAC, the existing Family MUAC reporting tools should be used. All children should be provided with a treatment card with a note made of all the anthropometric indices, RUTF/RUSF, and other medication provided on admission and during the follow-up. Program performance will be assessed using the standard SAM and MAM indicators (cure rate, defaulter rate, death rate) used for monitoring OTP and TSFP performance. Additional variables will be included in the reporting tools to capture the simplified approaches in use in a given facility

8. Coordination

The Nutrition Sector Coordination Desk and CMAM TWG under the leadership of the government through the SPHCDA will provide the overall guidance on the activation and implementation of the Simplified Approaches. The Nutrition Sector Coordination Desk and CMAM TWG will convene regular meetings to review the implementation of the Simplified Approaches.

[10] Taking into consideration the incidence correction factor to estimate the burden

9. Simplified Approaches Implementation Framework

Activity	Timeline	Responsible
UNICEF, WFP, SMOH, SPHCDA, Nutrition Sector Coordination Desk and CMAM TWG conduct a mapping and gaps analysis.	Quarterly (to be done prior to implementation and just before the phase out)	CMAM TWG, UNICEF, WFP, SMOH & SPHCDA
Review of the Simplified Approaches SOP	On need basis	CMAM TWG
Submission of requests to activate Simplified Approaches to Nutrition Sector Coordination Desk	On need basis	Sector Partners
CMAM TWG convenes a meeting with SMOH, SPHCDA, WFP, UNICEF, and Implementing Partner to review the request submitted based on the agreed criteria and decision tree. - The action points of the above meeting/discussion should be documented.	Immediately upon receipt of the request	CMAM TWG, SMOH, SPHCDA, UNICEF, WFP, Sector Partner
Activation of Simplified Approaches indicating agreed duration, while regular modalities for management of acute malnutrition are put in place through UNICEF/WFP agreements with partners.	Immediately upon recommendation from CMAM TWG.	Nutrition Sector Coordination Desk
Conduct orientation on Simplified Approaches for the implementing partner.	Immediately upon activation	CMAM TWG
Partner submits supplies requests to UNICEF/WFP based on the agreed targets and locations.	On need basis	UNICEF, WFP, Sector Partner
Review of the implementation to inform action and documentation of results and lessons learnt to inform future implementation of SA.	Monthly	Implementing Partner