

Technical Issue Paper – June 2017

Increasing opportunities for treatment of acute undernutrition in complex crisis: Promoting the use of the simplified protocol

Rationale

DG ECHO has traditionally been a major donor of the treatment of acute undernutrition, supporting the implementation of programs on the field, and playing a crucial role in the evolution of the nutrition sector, contributing to the development of tools and their use at scale, to the coordination of nutrition in emergencies, and to the implementation of innovative approaches, always with the objective to make nutrition programming more accessible to the ones in need, and more performant.

The development and wide adoption of the CMAM (Community-based Management of Malnutrition) protocol in the last decade has allowed humanitarian assistance to save more lives than ever before. Yet, in complex crisis, CMAM cannot be implemented due to insecurity, lack of access or collapse of the health system.

For this reason, DG ECHO encourages the use of the *simplified protocol* for programming in exceptional emergency contexts. This protocol is intentionally flexible in order to allow for context-specific adjustments, and is meant to be adapted at country level. The main principles are:

- Every opportunity to screen and treat children under 5 years old should be used. Coordination among agencies is key to ensure that these activities are integrated in every point of contact with the target communities: registration, survey, vaccination campaign, Global Food Distribution, etc.
- In contexts with high morbidity and/or food insecurity, treating MAM children provides for earlier identification of cases, thereby reducing the occurrence of medical complications and mortality associated with acute malnutrition, and potentially reducing the SAM caseload.
- The protocol is simple, and its implementation is not limited to medical personnel. It can be applied by staff of all backgrounds, and does not require more than a basic training. It.

This guidance is part of a « no-regret approach »: it aims at promoting action over inaction, by reducing mortality linked to undernutrition despite limitations preventing the operationalization of a nutrition programming complying with WHO guidance.

The application of the simplified protocol is meant to be temporary, and is not intended to undermine national guidelines.

The principle of interchangeability of SAM and MAM programs has been endorsed by their respective lead agencies, UNICEF and WFP, as per the updated MoU in 2011¹. The use of simplified protocol as also been globally endorsed by the Global Nutrition Cluster, and can be found in annex 4 of 2017 update of the “MAM decision tool”.

The implementation of the simplified protocol can be used as an opportunity to trigger or reinforce the application of a minimum intervention package, based on identified needs of the target population.

Guidance for implementation

What is the simplified protocol?

- MUAC, as the best proxy of the risk of mortality², becomes the unique anthropometric measurement for admission, follow-up and discharge of cases to and from the nutrition program. All children under 5 with

¹ “Areas of technical collaboration between the WFP and UNICEF, April 2011”:
<http://documents.wfp.org/stellent/groups/public/documents/reports/wfp262576.pdf>

² “Low mid-upper arm circumference identifies children with a high risk of death who should be the priority target for treatment”:
<https://bmcnutr.biomedcentral.com/articles/10.1186/s40795-016-0101-7>

a MUAC < 125mm are eligible to treatment. Nutrition screening and follow up can be performed by caretakers or program personnel after basic training³.

- A unique product is used, RUFT (preferably) or RUSF, for the treatment of both Severe and Moderate Acute Undernutrition. The management of the pipeline and the distribution becomes simpler, and the impact of potential shortages is reduced.
- Systematic screening and provision of nutrition treatment are done during every contact to affected communities, alongside other activities (i.e. registration exercise, food distribution)
- The frequency of follow up visits can be reduced if frequent or regular contact with beneficiaries is impaired due to insecurity or long distances between the affected communities' location and the point of contact.
- The involvement of medical personnel in the program is preferred. But the absence of health staff should not jeopardize the implementation of nutrition treatment, as nutrition products alone, even in the absence of systematic treatment, has proven to significantly reduce the morbidity and the mortality of cases of acute undernutrition.
- When possible the setup of a referral system for the management of complicated cases in link with available health services is encouraged.

Where does it apply?

The simplified protocol should only be applied in very specific contexts:

- ✓ Access to the nutrition treatment for the beneficiaries, or for specialized partner to the treatment site, is compromised due to insecurity or long distances, and
- ✓ Global and Severe Acute Malnutrition prevalence are high (beyond the 15% emergency threshold) or increasing rapidly, with reported associated mortality, and
- ✓ Food insecurity is prevalent (disrupted food availability or access or utilization).

What can ECHO do at country/ regional level for contexts with exceptional emergencies conditions?

1. Monitor the nutrition situation at country level and assess if the simplified protocol would improve sensibly the delivering nutrition services in otherwise inaccessible areas. Promote this protocol if need be. Do not hesitate to contact the regional experts for support.
2. Review with implementing partners and other stakeholders the need, feasibility and risks of simplified protocol. The Nutrition Cluster, the MoH, UNICEF and WFP are key actors for the implementation of the simplified protocol.
3. The existing coordination mechanism (nutrition cluster or other ad hoc platform) is in charge of the development and application of the simplified protocol, and the items required for its application: training and roll out material, reporting modalities.
4. In agreement with the key stakeholders, draft and validate the simplified protocol and ensure it is adhered to. This can include minimum reporting requirements:
 - ✓ **Supplies provision:** the application of the simplified protocol will induce 2 changes: the shift of use of some commodities (RUFT or RUSF can be used to treat both MAM and SAM cases as identified by MUAC), and the need for additional quantities of RUF (all children from 6 to 59 months with a MUAC < 125mm are eligible to treatment). Modification requests and cost extensions are to be expected in consequence of the application of this protocol.

³ "MUAC= Mother Understand And Can do it", <https://www.ncbi.nlm.nih.gov/pubmed/25992287>

✓ **Results and activities:**

- For Actions including nutrition results and activities: the target numbers of children might be amended, and the shift of protocol should be notified;
- For Actions with no initial results or activities in nutrition: partners who are keen to include nutrition screening in treatment in the frame of their outreach activities (i.e. GFP, vaccination, campaigns) should notify ECHO. The relevance of a modification request and potential cost extension must be discussed case by case.
- It is understood that this guidance will be applied in contexts where monitoring of activities is difficult, and consequently, the reporting requirements are not expected to meet the ones of more stable contexts. In order to optimize the use of resources for field operations, no parallel reporting should be required; when possible, reporting should be done through existing channels and modalities. Outputs indicators will be favoured (number of children screened and provided with treatment), and outcomes indicators (i.e. proportion of children cured) are not expected to be reported on. A follow up will be done by ECHO technical experts with partners implementing this approach directly with their counterparts at Headquarter levels, and to ensure that lessons learnt and evidence are captured to feed global evidence and potential use/ adaptation of this approach in various contexts.

5. Define the exit criteria and monitor the situation, so that as soon as the situation returns to normality the standard protocols can be reinstated.

What changes compared to a classical nutrition program?

	CMAM (Regular protocol)	Impact of acute crisis on CMAM implementation	Simplified protocol	Impact of application of the Simplified protocol
Screening	Done by health staff at facility level during medical visit, community health workers (variable frequency), surveyors, trained caretakers.	Not effective if collapse of the health system or if no prior nutrition program for training of Community workers or caretakers	Done by trained multisectoral team during every contact opportunity	Coverage of nutrition screening is increased
Admission for treatment and monitoring visits	Mostly done at health structure Weekly or biweekly monitoring.	Program coverage affected by reduced access for beneficiaries or supporting partners (delivery of supplies) Not effective if collapse of the health system.	Treatment can be provided in the same place than screening, and not necessarily at health facility level	Coverage of treatment is increased Reduced proportion of lost to reference, greater chances of treatment completion Reduces workload of existing medical staff/ facilities Number of visits and quantity of supplies provided function to the planning of field visit. Supplies could be provided for up to 4 weeks at once.
Moderate acute malnutrition	Products supplied by WFP (RUSF, CSB++, fortified flour) Admission using Weight for height or MUAC.	MAM treatment not always available due to resources or capacity constraints => MAM children often not identified or treated, high risk of deterioration into SAM (high food insecurity, poor health conditions) and/ or medical pathologies	Admission, monitoring and discharge using MUAC single criteria Systematic and specific medical treatment can be provided only if medical capacities are available in the team.	<ul style="list-style-type: none"> • One product => one supply chain, simpler management • Early inclusion in treatment => quicker catch up on nutrition status, and reduced proportion of medical complications • High proportion of children cured or with significant

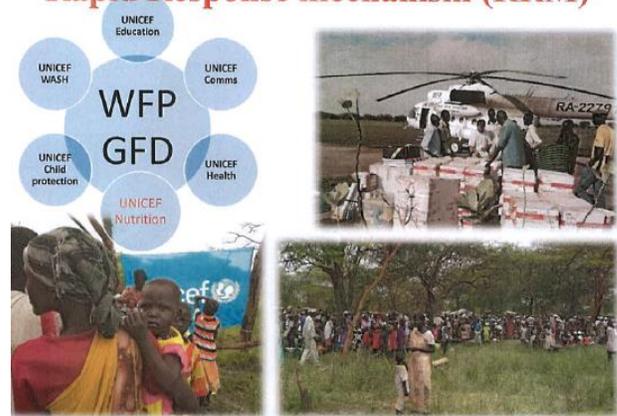
		Irregular supply and access by supporting partners		weight gain => reduced morbidity and mortality associated with acute undernutrition
Severe acute malnutrition	Products supplied by UNICEF (RUTF), admission using Weight for height or MUAC. Systematic medical treatment to all cases admitted Specific treatment and referral to secondary health care structure on medical recommendations	Irregular supply and access by supporting partners Insecurity and distance compromising the compliance to treatment, and chances of recovery		

What would this application look like, concretely?

Example of the Rapid Response Mechanism, South Sudan 2014: due to conflict and massive displacement, affected populations are scattered on a vast zone, mostly accessible by air. They are moving frequently due to volatile security situation.

At coordination level, a planning is established on a monthly basis to program day trips to identified locations. A multisector response is provided: nutrition screening are performed on children queuing for General Food assistance, and cases with MUAC < 125mm are provided up to 4 weeks supply of RUF.

Rapid Response mechanism (RRM)



Preconditions and limitations

- ✓ The simplified protocol is not meant to be used in locations where CMAM programming can be implemented as per standard protocols: CMAM remains the only globally accepted protocol for the treatment of acute malnutrition⁴. The simplified protocol provides temporary options for early treatment of acute malnutrition, and is meant for **acute crises only** (rapid onset or protracted crisis with a significant unexpected spike in caseload).
- ✓ It is resource-dependent, to be used **only when the pipeline or buffer stock of specialized nutrition products is sufficient, to ensure that treatment of Severe Acute Malnutrition is not compromised.**

Perspectives

The protocol proposed has been applied in several instances on the field⁵⁶, and although it has demonstrated a great efficacy, there is not enough evidence available at the moment for adoption by WHO as a normative guidance. Several studies are underway to build this evidence, and allow for a systematic use in complex emergencies.

⁴ Community-based management of severe acute malnutrition: A Joint Statement:

<http://www.who.int/nutrition/publications/severemalnutrition/9789280641479/en/>

⁵ Severe and Moderate Acute Malnutrition Can Be Successfully Managed with an Integrated Protocol in Sierra Leone:

<https://www.ncbi.nlm.nih.gov/pubmed/26423737>

⁶ ComPAS study in Kenya and South Sudan: <http://www.enonline.net/fex/53/thecompasstudy#>,