SIMPLIFIED **APPROACHES**

Implementing Simplified Approaches

DECISION MAKING GUIDANCE

WHAT INDICATES AN EXCEPTIONAL CIRCUMSTANCE?

Exceptional circumstances refer to a complex and/or challenging context resulting in negative effects on treatment services or the target population. These negative effects may be mitigated by adapting treatment services to include one or a combination of several simplified approaches. Whilst there is no specific set of criteria to determine an exceptional circumstance, the following questions may help to decide whether it is necessary to make adaptations to services to ensure continued availability and access.

1. Have health facilities recently closed (e.g. due to insecurity) or become inaccessible (e.g., due to a shock such as flooding or other contextual changes)?
2. Has the nutritional situation significantly deteriorated, leading to a sudden increase in rates of child wasting?
3. Are there foreseen or current pipeline breaks for essential treatment products?
4. Have there been gaps across the continuum of care for wasting?
5. Have health facility staff become unavailable (e.g., due to other health emergencies like COVID-19)?
6. Has coverage recently decreased in the area of intervention and/or is coverage considered to be excessively low?
7. Have there been sudden increases in defaulting or mortality rates?
8. Have community activities, particularly screening, decreased as a result of a change in context?

GENERAL CONSIDERATIONS FOR IMPLEMENTING SIMPLIFIED APPROACHES

Prior to implementing any simplification, it is important that certain factors are considered.

Relevance

- Are the simplifications responding to issues or barriers identified at local level?
- Are the simplifications appropriate for the context?
- Have all relevant local stakeholders been consulted, and their inputs integrated?

Feasibility

- Are national and local health authorities engaged?
- Are there sufficient resources (financial and human resources) to implement these simplifications for the desired timeframe?
- Is there the operational and technical capacity within the health system to implement these simplifications? If not, can support be provided by partner NGOs to build capacity?
- Are essential supplies (i.e., RUTF, RUSF, MUAC tapes etc) available and is the supply chain adapted for any changes?
- Are these changes temporary or long-term?
- Is enough product available for an expanded admissions criteria and can teams forecast for the anticipated caseload? If not, what alternatives can be offered for nutritionally vulnerable children?
- Are the necessary data collection mechanisms available or can they be put in place to ensure outcomes are accurately recorded?

WHICH SIMPLIFICATIONS SHOULD I CONSIDER FOR MY CONTEXT?

When implementing simplified approaches for the early detection and treatment of child wasting, it is important that *the context plays a key role in determining the simplifications* to be implemented.

Common supply and demand barriers result in low coverage and poor performing services. Linking contextual barriers to simplifications can improve treatment outcomes.

In addition, communication and support from community leaders and members will be essential to the success of any combination of the simplified approaches.

SIMPLIFIED **APPROACHES**

SUPPLY BARRIERS → **SIMPLIFICATIONS** ← **DEMAND BARRIERS**

STOCK AND PIPELINE ISSUES

- Shortages of RUTF and/or RUSF
- Pipeline breaks for treatment products
- Limited or inconsistent management of wasting across the continuum

COMBINED NUTRITION PROTOCOL

- Reduced & simplified dosage
- MUAC admissions
- Expanded MUAC
- One treatment product

Reduced Visits

Community Health Worker-led Treatment

Family MUAC

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SUPPLY BARRIERS → **SIMPLIFICATIONS** ← **DEMAND BARRIERS**

HEALTH STAFF AVAILABILITY & CAPACITY

- Complexity of multiple admissions criteria and interpretation of WHZ scores
- Health facilities over-burdened and health workers not able to cope with the caseload
- Seasonal spikes in malnutrition mean health facilities are unable to cope with demand / caseload
- Community health worker / outreach screening for malnutrition is sub-optimal

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ACCESS TO HEALTH FACILITIES

- Increased insecurity means population cannot access services
- Closure of health facilities due to contextual factors
- Significant proportions of the population live far away from health facilities
- Health facility hours of care are not compatible with caregivers working patterns
- Certain areas are hard to reach and inaccessible to health facilities (e.g., mountaineous regions, floods, etc.)

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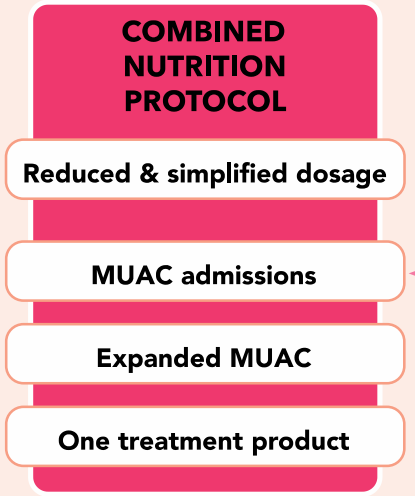

Reduced Visits

Community Health Worker-led Treatment

Family MUAC

USE OF THE SERVICE

- Limited awareness of malnutrition at the caregiver and community level
- Limited coverage of health facilities, i.e., remote communities not reached by sensitisation or community outreach
- Caregiver does not have decision making capacity and therefore cannot travel to use the service
- Indirect costs pose too great a barrier to access
- Defaulting from treatment due to perceived improvement of child or distance to health facility
- Non-adherence to treatment protocols at the household

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REDUCED AND SIMPLIFIED DOSAGE

Treatment dosage of RUTF product reduced over course of recovery and dosage regimen simplified for low-literate providers. For details on the different dosage regimens please consult this summary.

Operational Considerations

- Recalculate the stock needs based on revised dosage regimen
- Ensure a harmonised approach with local actors to ensure parity of services being delivered
- Train health staff on new dosage and support with revised job aids
- Consider coupling with CHW treatment
- Engage with service users on the revised dosage
- Consider food security in the area and any consequences a reduction in dosage may have at the household level
- Monitor clinical outcomes to ensure reduced dosage does not affect recovery rates

Inputs Needed

- Training of health staff
- Communication with health providers
- New job aids
- Informing of service users and sensitisation of family members
- Enhanced Monitoring of clinical outcomes

Level of Effort for Implementer

Moderate

MUAC & OEDEMA ADMISSIONS

Admission, treatment, discharge based on MUAC and/or oedema only. This simplification should be considered in combination with an expanded MUAC admission criteria

Operational Considerations

- Analyse prevalence data to understand local characteristics of wasting
- Consider coupling with prevention intervention for enhanced protection
- Ensure availability of MUAC tapes
- Consider linking with Family MUAC approach
- Consider expanding MUAC threshold
- Revise admissions and discharge process

Inputs Needed

- Communication with health providers
- Informing service users
- Enhanced monitoring of clinical outcomes

Level of Effort for Implementer

Low

EXPANDED MUAC ADMISSIONS

Systematic expansions of MUAC to include all children <125mm

Operational Considerations

- Calculate revised pipeline needs
- Consider adaptations to health facility admissions circuits to account for additional caseload
- Consider whether HR capacity at health facility is sufficient to deal with additional caseload
- Consider coupling with Family MUAC
- Consider coupling with reduced dosage
- Ensure availability of stock and capacity of pipeline to deliver based on revised needs

Inputs Needed

- Communication with health providers
- Informing of service users (i.e., family members)

Level of Effort for Implementer

Low

ONE TREATMENT PRODUCT

Use of RUTF for the treatment of all wasted children in need of treatment

Operational Considerations

- Ensure availability of additional RUTF given increased caseload
- Calculate revised pipeline needs
- Communicate with local authorities particularly in neighbouring districts to ensure coherent approach

Inputs Needed

- Communication with health providers
- Informing of service users

Level of Effort for Implementer

Low

REDUCED VISITS

Reduced frequency of follow-up visits during the course of treatment, from weekly to biweekly

Operational Considerations

- Consider contextual factors and status of children to determine if it is appropriate to reduce visits, e.g. it may be safe for children ≥ 110 mm but all children below should continue to attend weekly
- Conduct sensitization to caregivers during visits on how to monitor child's status between visits (e.g., complications, weight loss, appetite. See box above) and consider combining with Family MUAC of caregivers of malnourished children
- Prepare sufficient stock to cope with greater distribution as reducing visits means distributing double quantities
- This approach may lead to longer LoS if still applying discharge upon 2 consecutive visits (meaning 1 month and not 2 weeks)
- Consider increased monitoring at community level in collaboration with community health workers/volunteers

WARNING SIGNS AND WHEN TO REFER CHILDREN

One risks of this approach is that a child's condition may deteriorate or they may develop complications which are not picked up at the weekly visit. It is very important that family members and health staff are thoroughly informed of these warning signs each visit.

Inputs Needed

- Communication with health providers
- Informing service users
- Revised stock planning and supply.

Level of Effort for Implementer

Low

CHW TREATMENT

Management of wasting by Community Health Workers at village level

Operational Considerations

- Identify existing community health platform and develop contextualised training approach
- Align with national or local remuneration policy for CHWs
- Asses availability of health posts and their capacity to adequately stock, store and monitor RUTF and other essential supplies
- Ensure appropriateness of tools for service providers (e.g. low-literacy & simple)
- Develop appropriate supervision approach between health facility and community level
- Ensure availability of referral services for children with complications or danger signs

Inputs Needed

- Revised job aids & data collection tools for CHWs
- Training of staff – health workers and community health workers
- Remuneration of CHWs
- Informing service users
- Communication with health providers
- Monitoring and supervision mechanism at community level
- Enhanced supply chain to community outposts and supply monitoring systems

Level of Effort for Implementer

High

FAMILY MUAC

Engaging family members to screen and refer their children

Operational Considerations

- Ensure availability of MUAC tapes
- Develop a contextualised training approach
- Engagement & sensitization of local health authority and frontline health workers
- Conduct refresher trainings to remind family members of this new practice

Inputs Needed

- Training of family members
- Communications with health providers (including CHWs)
- Enhanced monitoring and supervision

Level of Effort for Implementer

Moderate