

Wasting and COVID 19 Programme Adaptations Information Note 1

Category: Products and Supply Chain Challenges

Challenge: Protocols in absence of products
What do you do when RUTF and RUSF are unavailable?

Recommended adaptation: Ensuring good supply chain management; temporary use of different specialised products, use of local recipes, reduced dosage, reduced programme admission and discharge thresholds.

Background

At present, every effort is being made to ensure that there is an adequate pipeline for specialised nutritious foods and large-scale pipeline breaks are not yet projected. However, with systematic closure of borders and airports and much unknown about the likely duration of the crisis, there is a risk of disruptions.

This information note has been prepared to outline potential options if programmes are faced with this situation.

Any changes to normal protocols are an exceptional temporary measure to prevent negative consequences for child growth and development, deterioration into more severe undernutrition (for those at the moderate end of the spectrum), non-recovery from wasting, associated morbidity and mortality.

Process to compile this note

This note was produced through the Wasting and Risk workstream of the GTAM. Members of the workstream contributed to a discussion of relevant issues and adaptations to programming in the context of COVID 19.

Recommended Adaptations:

A. Efficient management of the supply chain

In the first instance, measures should be put in place to ensure minimal misuse/leakage of food products by:

- Ensuring all staff understand and are following admission and discharge criteria correctly;
- Strong supply chain management from caseload/supply calculation, ordering and delivery to site level stock management processes and fraud prevention.

B. Temporary use of different specialised products

In the event of supply breaks, the following substitutions can be considered:

1. Where RUTF is not available to treat uncomplicated severe wasting, the MAM Decision tool for emergencies (<https://reliefweb.int/report/world/moderate-acute-malnutrition-decision-tool-emergencies> GNC, 2017) recommends use of **RUSF** as a temporary, life saving measure in exceptional circumstances until standard treatment with RUTF can resume.
2. Where RUSF is not available to treat moderate wasting in children aged 6 to 59 months, substitutions or temporary replacement with the following SNF are recommended if they are available:
 - Fortified blended flour - **FBF** (e.g. Super Cereal Plus) which is a blend of ingredients such as milled cereals, soya beans, milk powder, fortified with vitamins and minerals. Note though that, unlike RUSF, FBF needs to be prepared into a porridge before consumption and therefore requires access to cooking facilities and safe water, which might be challenging in some emergency contexts or if people are on the move.
3. Where there is no RUSF or no FBF, a potential temporary option (as suggested in the GNC 2017, MAM Decision Tool in emergencies) is RUTF (if this can be made available by partners). This should only be considered if stocks to treat SAM children can be ensured.
4. Where there is no RUSF, FBF or RUTF, use of medium quantity lipid nutrient supplement (**MQ-LNS**) such as **plumpy doz** can be considered as RUSF and MQ-LNS formulations are the same. RUSF is provided in sachets of 100 g/d and LNS-MQ in 50 g/d, which means that 2 sachets of LNS-MQ can replace 1 of RUSF.
5. **High-energy, micronutrient fortified biscuits** such as BP5 are a ready-to-eat compact food often used during the first few days of an emergency, particularly when people are displaced with limited/ no access to local food or to a general ration. They can be eaten directly or crumbled into safe water and eaten as a porridge and can be given to children from age 6 months (Note that this product is not developed to treat child wasting and is not recommended for the treatment of severe acute malnutrition).

C. Where no specialised nutrition products are available

In situations where RUTF or RUSF are recommended but are not available and cannot be substituted with other specialised nutrition products as outlined above then it is suggested that next best local alternatives be considered. The option chosen should be that which gives the child the best chance to meet his/ her energy and nutrient requirements while also being

age-appropriate, safe and palatable so as to maximise recovery (or at least prevent deterioration) until standard treatment can be provided.

1. Seek to maximise the child's nutritional intake from **existing sources of local foods**. This option requires analysis of locally available age-appropriate, safe, nutritious foods (energy and nutrient dense with adequate essential fatty acids, protein and micronutrients and a low content of antinutrients) as well as any barriers to access, challenges with preparing food within the home (knowing how to cook, access to utensils, water, fuel) or consumption by the child (food preferences or intra-household sharing).

The Positive Deviance Hearth (PDH) model recommends the following (for treatment of underweight) in terms of nutrient requirements for a meal.

Calories:	600–800 (500–600*)
Protein:	25–27g (18–20g*)
Vitamin A:	300 µg RAE (RAE=retinol activity equivalent)
Iron:	8–10mg
Zinc:	3–5mg
Vitamin C:	15–25mg

Local menus are developed using food tables, to design a menu meeting these requirements.

<https://www.wvi.org/sites/default/files/PDH%20MTManual%20EnglishRound4Final1web.pdf>

2. Support could include **sensitisation** of the caregiver/ family on appropriate local nutritious complementary foods and on how to prepare them through cooking demonstrations/ recipes (note there is a paucity of studies evaluating the effectiveness of local recipes to improve the adequacy of the child's diet to aid recovery from wasting).
3. Where local, safe, age-appropriate, nutritious complementary foods are available on the market but unaffordable, **feasibility of using vouchers/ cash transfers** or similar context-specific strategies (coupled with SBCC/ MIYCN) to increase access could be considered to support nutritionally vulnerable children (note evidence demonstrating the effectiveness of such a strategy to manage child wasting is lacking)

D. Additional measures in the absence of products could be to:

- Prioritise the treatment of more severe cases of SAM (reducing lowering the admission threshold to MUAC >110;
- Reducing the dosage provided. Trials of simplified protocols have used 2 sachets per day for SAM and 1 sachet per day for MAM. There is currently mixed evidence on the

impact on treatment outcomes, but this could be used a temporary measure to make sure that stock last during a short stock-out

In all instances:

Support continued breastfeeding

With all options: infants and young children up to 24 months and beyond should continue to be breastfed and policies surrounding the Code on marketing and use of breastmilk substitutes and related items should be adhered to; all children should continue to receive systematic health care and regular follow-up (respecting national IPC measures in view of COVID-19).

All adapted programming should be accompanied by key messaging (MIYCN, good hygiene practices, safe food preparation).

Changes from standard protocol should be discussed and agreed

Any deviation from standard wasting treatment protocols should be discussed and agreed with national authorities.

Any changes should be discussed with local community leaders, and partners to ensure appropriate usage and consumption.

Deviations to national treatment protocols should be subject to close monitoring and standard treatment should start/ resume as soon as is feasibly possible

Resources

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