# ADAPTATIONS IN THE MANAGEMENT OF CHILD WASTING IN THE CONTEXT OF COVID19

## CALL FOR DATA

Action Against Hunger, in a coordinated effort with USAID, UNICEF and the US Centers for Disease Control, seeks to systematically document, analyze, and synthesize information related to innovations and adaptations for outpatient & community-based management of child wasting. As part of this project, Action Against Hunger and the US Centers for Disease Control (CDC) are requesting the submission of data to inform an analysis of the adaptations made to outpatient and community-based programs treating child wasting in the context of the COVID-19 pandemic. The analysis aims to examine programmatic outcomes and effects in order to inform future program implementation.

INTRODUCTION. The COVID-19 pandemic presents an unprecedented challenge in the provision of life-saving services as disruptions to health systems are required to stem the transmission of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The impacts of such disruptions are especially deadly for young children. One projection estimates that as a result of the COVID-19 pandemic, an estimated 30 million children are at risk of death from secondary health impacts, including a 40% increase in children suffering from malnutrition.[1] A second projection estimates 506,900 to 2,313,900 additional child deaths will occur over the next 12 months, given an assumed increase in wasting of 10% to 50% respectively.[2]

In light of the COVID-19 pandemic, UNICEF, the Global Nutrition Cluster, and the Global Technical Assistance Mechanism for Nutrition (GTAM) developed a guidance document Management of child wasting in the context of COVID-19[3]. The purpose of the guidance is to support implementers on how to prepare and respond to the COVID-19 pandemic, to provide information specific to services and programs for the management of child wasting in the context of COVID-19. Various adaptions were included in the guidance document including expansion of admission criteria for treatment, altered dosage of therapeutic foods, increased time between treatment visits, and administration of mid-upper arm circumference (MUAC). Through informal discussions, it is apparent that various adaptions are being applied across partners and at national and subnational levels.
To capture current information on the adaptation and implementation of the management of child wasting in the context of COVID-19 at the national and subnational level, we propose conducting a real-time analysis of programs in collaboration with UNICEF, GTAM, and the Office of Foreign Disaster Assistance/USAID. This information will form the basis of a review of adaptations, sharing of practices, and potential revision of the current guidance.

OBJECTIVE. Action Against Hunger US and the CDC aim to conduct a secondary analysis of existing datasets to better understand programmatic outcomes when implementing adapted management of acute malnutrition programs. We aim to conduct a meta-analysis using existing data:

- To examine changes in routine program outcomes corresponding with operational adaptations to the management of acute malnutrition programming in low- and middle-income countries prior to and during COVID-19

[1] World Vision. COVID-19 Aftershocks: Secondary Impacts Threaten More Children's Lives then the Disease Itself. https://www.wvi.org/publications/covid-19-aftershocks-secondary-impacts-threaten-more-childrens-lives-disease-itself

[2] Roberton, T, Carter E, Chou V, Stegmuller A, Jackson B, Tam Y, Sawadogo-Lewis T, & Walker N. The Lancet Global Health. Manuscript Draft currently under review.

[3] **UNICEF, Global Nutrition Cluster, Global Technical Assistance Mechanism for Nutrition (GTAM). 2020. Management of child wasting in the context of COVID-19.** https://www.ennonline.net/covid19wastingbrief

- To identify and document adaptations of treatment programs for management of wasting in the contexts of COVID-19 implemented in low- and middle-income countries globally and lessons learned regarding the various adaptations as they relate to operational implementation

DATA REQUEST. We are requesting data from operational out-patient and community-based programs and/or research treating child wasting. Conversely, we are not interested in coverage data, surveillance surveys, or any datasets that may include only non-treatment or point-prevalence information.

Datasets must include:

- Data from programs or studies implemented in low- and middle-income countries, areas with limited resources, and/or context of conflict or extreme crisis
- Outpatient and/or community-based management of acute malnutrition
- Programmatic data regarding children 6-59 months diagnosed with acute malnutrition, admitted, and treated in an outpatient or community-based program
- Programmatic treatment outcomes rates (cured, defaulted, died, non-response, transfers, etc.)
- Data from programs with or without specific treatment protocol adaptations implemented in light of COVID19
- Data from programs implemented for at least 5 months during 2020 (if program include new or adapted protocols, the data must include at least 5 months of implementation using the new or adapted protocol)
- Geographic location of implementation
- Dates of treatment/program implementation

Highly desired information:

- Programmatic outcomes data from previous years (e.g. 2018-2019) to serve as an historical comparison
- Individualized, child-level data
  - Variables including age, gender, height/length, weight, and MUAC upon admission to treatment for SAM or MAM in an OTP or TSFP and at each follow-up visit during treatment until discharge from the program
- Therapeutic and supplementary product stock consumption for corresponding caseloads
- Type of treatment provided (e.g. food dosage, medications provided, non-food items distributed)
- Contextual information regarding type of programming/situation in which the treatment was provided

DATA SHARING AGREEMENTS AND PROTECTION. If an organization or researcher is willing to share their datasets with Action Against Hunger US and the CDC, we will provide a Data Sharing Agreement for all parties to outline appropriate uses of data and sign prior to the sharing of any data.

Raw data shared will be checked and cleaned, as well as verified to ensure there is no duplication with other or existing datasets. Data provided will not be used for any other use than that stated and it will not be shared with any third parties. Access to data will be limited to those directly involved in the project. Data will be maintained on a secure, password protected server.

Only de-identified (e.g. anonymous) data without personal identifiers will be accepted to minimize the risk of identification of individuals. Individuals implementing partners will not be linked to their data in the shared analysis.

DATA REQUEST PROCESS. Once the data sharing agreement has been signed, ACF/CDC will provide instructions for sharing the data via a secure portal.

DATA ANALYSIS. Descriptive statistics (frequencies, percentages, means, and stand deviations) will be calculated and visualized for the routine indicators by site. If multiple sites are available by country, country level statistics may be calculated. Further aggregation may occur at the urban-rural level, by type of population served, and type of program adaptations and mitigation measures adopted, pending data.

Interrupted time series analysis will be used to evaluate changes corresponding to implementation of program adaptations, using longitudinal data. This approach was chosen as it deals with time series data where there are multiple observations for the same unit over time. These models look at the effect of an intervention (adaptation of

treatment protocols), on a health outcome (one of the various programmatic indicators), adjusting for contextual factors (e.g., country, type of setting, stage of the outbreak, national/local mitigation measures).

Multiple regression models may be created to assess the various changes in protocols measured in the survey to be disseminated by ACF (e.g., admission criteria, dosage of ready to use therapeutic foods, interval between visits, and by measurer, family or staff). Specific models will be determined based on the data provided by implementing partners.

COLLABORATION Jointly, Action Against Hunger US and CDC will conduct the secondary analysis of data and will have access to all datasets submitted. Action Against Hunger US and the CDC will also collaborate closely with the Principal Investigators of the original studies that collected the primary data. For those organizations submitting routine program data, the organization will identify an individual for Action Against Hunger US to collaborate with. In return for the data shared, we will acknowledge your organization in any reports, materials, and/or manuscripts produced.

TIMELINE The call for data runs from July 30, 2020 through December 1, 2020. It is important to note this timeline is tentative and may be adjusted to reflect ongoing developments.

For additional information please contact us at cmamadaptations@actionagainsthunger.org or wzu0@cdc.gov

*This study is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Action Against Hunger and do not necessarily reflect the views of USAID, UNICEF, or the United States Government.*