

Adapting Community-based Management of Acute Malnutrition in the context of COVID-19

Purpose of the Guide

This guide is designed to assist Concern's health and nutrition staff responsible for the management and coordination of Community-based Management of Acute Malnutrition (CMAM) operations to adapt and modify programme modalities in the context of COVID-19. The guide attempts to provide practical steps based on the current international guidelines and recommendations to ensure essential treatment services for acute malnutrition continue as much as possible while minimising the risk of COVID-19 transmission. The primary focus of this guide is the management of the outpatient component of CMAM. It focuses on health facility level decisions and planning and has a stronger focus on severe acute malnutrition (SAM). The recommendations must be adapted to each context. This guide can also help to build the capacity of the Ministry of Health (MoH) staff and/or to help them develop guidelines of their own if they do not yet exist.

Structure of the guide

This guide is divided into four sections. Section 1 and 2 summarise the main assumptions underpinning the guidance and the main adaptations to CMAM we are aiming for during COVID-19. Section 3 outlines some preparatory activities that need to be initiated as soon as possible. Section 4 provides a modified CMAM site layout and steps to carry out SAM (and MAM) services in a health facility under the current pandemic. Section 5 outlines other key considerations including community outreach. Links to reference materials are provided throughout.

Important Note

Always follow the guidance of the national ministries of health and/or the humanitarian cluster system where they exist.

Please adapt the below recommendations to your specific programming context and/ or contact your HQ advisers to discuss how.

Section 1: Main assumptions

- 1. COVID19 is already or may very soon be present in the communities we serve.** Testing levels will remain low in most communities, so we may never know the actual prevalence. We must, nonetheless, assume that COVID19 can increase the risk of mortality among children and pregnant women with acute malnutrition in a variety of ways throughout at least 2020.

2. **Countries are already or will soon be in some form of lockdown, affecting movement and access to health services.** The length, extent and enforcement of these lockdowns will vary a lot between contexts so interpret the guidance in light of your area's own restrictions.
3. **COVID19 is only one of many serious risks to the survival and health of children and their parents in developing countries.** All the relevant risk factors, including the risk of dying of acute malnutrition in the absence of COVID19, must be weighed into all decisions.
4. **SAM services Concern supports are being delivered at health facilities managed by the government whereas other services are provided for people of all ages.** (Staff supporting stand-alone nutrition centres can also benefit from this guidance but should keep that in mind).

Section 2: Four aims in adapting CMAM programmes for COVID-19

1. **Practice social distancing to reduce physical contact** between a) staff and beneficiaries and b) among beneficiaries as much as possible. This can be best achieved by the following:
 - Keep all individuals separated by at least 1 metre and, if possible, 2 metres. This means all staff and health service users/ beneficiaries. Only carers and their own children should be the exception.
 - Segment areas for different services and control the flow from one area to the next based on maximum occupancy and specific criteria.
 - Create a comfortable isolation area for suspected COVID-19 cases that is separate from the other areas, likely outside in a covered shelter. Refer to these areas discretely and sensitively to reduce stigma.
 - Extend the number of working days/ hours and/ or assign specific appointments/ time windows for communities to avoid crowding and mixing.
 - Promote no/ low touch assessment options by employing caregivers to carry out as many MUAC / oedema/ medical assessments on his/ her child as far as possible.
2. **Reduce the frequency of follow-up visits.** The objective is to minimise crowding in health facilities and unnecessary interactions while transiting to/ from the centre. This can be achieved by the following:
 - Outpatient Therapeutic Programme (OTP) - double RUTF rations and increase the time between appointments if the child is in stable condition. In most cases, this will mean moving to 4-week rations for all children who are on the road to recovery. **Any child who displays danger signs may need to return sooner.** Health staff will need to review each SAM case and decide the date of the next appointment after weighing a) the risk to the child's health and survival from SAM or other illnesses b) the risk of spreading COVID-19 to the family and wider community and c) any expected interruptions to service/ movement due to government lockdown measures.
 - Supplementary Feeding Programme (SFP) - move to 4-week rations/ visits. MAM children are generally less at risk than SAM children, but, as above, any child who shows danger signs should be asked to return sooner.
 - Explore the possibility to communicate and follow-up at the community level in a way that respects physical distancing and all other infection and prevention control measures (see below).
 - We do *not* recommend moving to 8-week OTP rations except in extreme conditions, for example, if clinic closure or a widely enforced travel ban is expected to last for eight weeks. Do so very

cautiously, however, and identify and invite any child who needs to return sooner to do so if possible.¹

3. **Reduce waiting time as much as possible.** This can be achieved by the following:
 - Simplify registration/ documentation steps and, where appropriate, reduce the frequency of weight/ height measurements
 - Follow the simplified protocols outlined below.
4. **Introduce simplified treatment protocols for SAM and, where relevant, MAM.** These evidence-based simplified protocols can help achieve all of the above and allow less qualified staff to administer rations if nurses are absent or overstretched due to illness. The main simplified protocols are:
 - *MUAC / oedema only for admission and discharge.* This means suspending weight-for-height if being used.
 - *Simplified RUTF dosage (based on MUAC):* This means two sachets/ day for uncomplicated severe wasting and one sachet/ day for uncomplicated moderate wasting. (See table below)
 - *Partially simplified RUTF dosage (based on simplified weight categories).* Simplified weight categories means packing RUTF can be done more quickly, but it still requires taking weight which introduces transmission risk and takes time. Many countries have already moved to this.² (See table below)

Section 3: Preparatory Activities

1. Compiling guidance and confirming COVID-19 referral pathways/ protocol

- i) Gather/ make copies of all existing guidance and job aids from the government/ UN and in-country clusters (or other NGOs as a last resort) on delivering health and nutrition services in the context of COVID-19 or other outbreaks. Establish strong coordination links so you can receive additional guidance as soon as they are created (including even in draft form). If they do not exist, advocate for very simple ones to be developed quickly and shared via official channels. (See Advocacy box at end)
- ii) Identify and familiarise staff with referral pathways for COVID-19 isolation/ treatment wards in the country/ area/ camps/ Protection of Civilian (PoC) sites. If referral pathways are not clear, advocacy and push for better coordination and communication at MoH/ Cluster level (see Advocacy box).

5 Moments for Hand Hygiene for Health Workers

All staff must wash hands :

- Before touching a caregiver
- Before any clean or aseptic procedure is performed
- After exposure to body fluid,
- After touching a caregiver and
- After touching a caregivers' surroundings.

¹ The Guidance from UNICEF, GNC and GTAM on Management of Wasting in the Context of COVID-19 (March 27th, 2020) suggests "If all services are temporarily suspended, distribute RUFs/ nutrition commodities for up to 8 weeks." We caution you to make that decision very carefully.

² Given some uncertainty regarding RUTF/ RUSF supply, we do not currently recommend moving to expanded admission criteria. We feel it is best to use the current RUF supplies to treat the SAM/ MAM cases we have now. We can review this once we are more confident in the RUF supply chain and if we see increasing caseloads.

- iii) Identify and familiarise staff with referral pathways to inpatient for children who are NOT a suspected COVID-19 case but have danger signs for complicated SAM. These may have changed in the context of COVID-19.
- iv) Identify and familiarise staff on any other key referral pathways, particularly to sexual and reproductive health or gender-based violence services for pregnant women and mothers, as there is already evidence that domestic abuse is already increasing under the COVID-19 circumstances.

2. Training and capacity building:

- i) Train volunteers and health facility staff on COVID-19 and encourage them to have a high level of COVID-19 awareness and knowledge.
- ii) Familiarise the staff working in the facilities with all relevant COVID-19 guidance on health facility protocols.

3. Pre-positioning essential supplies and increasing storage space

- i) Accurately plan for and pre-position RUTF and other nutrition supplies based on expected COVID-19 caseloads and potential transport challenges. We do not yet know how much COVID-19 may increase caseloads, if at all. The most important thing is that facilities have enough RUTF and storage space to distribute 4-week rations very soon. A basic plan might be to procure a 2-month buffer stock for the current caseload in each facility, but in country MoH/ Cluster planning will guide you on what is possible.
- ii) Procure sufficient MUAC tapes. Low/ no-touch MUAC assessments will essentially require every child to have their MUAC tape. If this is not possible, you will still need to order more than usual as the material will deteriorate quickly with repeated disinfecting. Plan to procure 1 MUAC for every child currently registered and expected new admissions for at least the next three months. If not possible, procure at least 30% more than usual to account for rapid deterioration.
- iii) Support the procurement of essential Personal Protective Equipment (PPE) for staff providing nutrition services via the government's District team and Ministry of Health channels and/or via the Health/ Nutrition Cluster. The process for procuring PPE and the availability will be determined by each country context. Concern cannot procure PPE for their staff due to global shortages and logistical constraints. We can, however, advocate and support the in-country procurement channels as much as possible (see Advocacy Box below). Refer all staff to in country PPE guidance or if not available to the WHO guideline on '[Rational use of personal protective equipment \(PPE\) for coronavirus disease \(COVID-19\)](#)'. The Concern Head Office Health Team will share some basic PPE guidance in April 2020, which we will share widely.
- iv) Procure up-to-date, localised posters on handwashing and COVID-19 infection and prevention control from the government/ UN/ Clusters and make them visible throughout the facility. If not available/ delayed, make your own with pictures. Some infographics from WHO can be found [here](#).

Essential Supply List

- Ready-to Use Therapeutic Food and/ or Ready-to-Use Supplementary Food
- Personal Protective Equipment (PPE) – as available in country
- MUAC tapes
- IEC materials: health/nutrition centre and for the community
- Soap, buckets and handwashing stations (2 bins with plastic bags and lids: one for non-medical waste/one for medical waste)
- Megaphones
- Chlorine solution (0.05%), sanitizers (if available)
- Alcohol wipes
- Doll/ dummy for demonstrating MUAC, etc.
- Infrared/non-invasive thermometer
- Marking tapes/ chalk/ paint

4. Modifying CMAM protocols and processes:

- i) Carry out an assessment of each facility with facility staff and District Health Office counterparts to identify areas/ spaces that can be modified to accommodate the recommendations given by the Ministry of Health, in the following points, and in Flow Chart 1, below.
- ii) Establish the COVID-19 case definition and relevant screening questions and steps. There should be an in-country case definition that is based on the WHO's – see box. Screening questions (like the ones presented below) may need to be adapted to reflect the in-country definition/ guidance.
- iii) Establish a handwashing and triage area at the entrance to the health facility and outside the OTP consultation room. This will include 1) handwashing station 2) COVID screening area/ temperature check and 3) normal waiting area for those who are NOT suspected COVID-19 cases.
- iv) Establish an Isolation Area separated from the OTP and SC for anyone with suspected COVID-19 while they wait for onward referral via the agreed pathway with MOH/ District Health Management Team or where they may be treated by staff using recommended precautions (see Flowchart 2).³
- v) Set up handwashing areas at the critical points with an adequate supply of soap. We suggest a minimum of three: 1) before entering the main health facility area, 2) before entering the OTP, 3) after exiting the facility. Annex 5 and the guideline on '[How to design handwashing facilities that change behaviour](#)' by Wash'Em will help you to design the best handwashing station for your context.
- vi) Develop additional storage capacity for RUTF and/or supplementary foods in the facility and/ or at the local level to pre-position enough 4-week rations for all.
- vii) Organise and clearly mark the area of 1-2 metres around the handwashing area, between seats in the waiting area, and for seats and queues inside the centre to keep a distance between the staff and between each beneficiary (carer-child pair).
- viii) Hang COVID-19 info posters, signs and other visual materials in waiting areas and prepare to make regular announcements - using megaphones if appropriate - informing people of the symptoms and how to prevent the spread of the virus.
- ix) Determine the maximum number of beneficiaries that can be accommodated in each of the areas, especially the waiting area, if respecting a 1-2 metre distance between all individuals. This will require measuring the room and 1-2 metre distances. Make this number clear to all staff and make someone responsible for monitoring and enforcing it for each room.

WHO definition of a suspected COVID-19 case
Always defer to the in-country case definition first

A. A patient with acute respiratory illness (fever and at least one sign/ symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.

OR

B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see definition of contact) in the last 14 days prior to symptom onset.

These are the 2 most relevant of 3 case definitions in interim guidance by WHO 20 March 2020 [here](#)

³ The layout of the areas will depend on the space available in the facility. If limited space, separate the waiting area with e.g. a screen or plastic sheeting to maintain physical distance between the beneficiaries.

5. Modifying and communicating the service schedule as agreed with MoH/ DHMT:

- i) Prepare written instructions for staff with modified/ simplified CMAM procedures (see RUTF ration chart below, for example) and stating the expected frequency of return visits.
- ii) Agree on measures to divide beneficiaries into smaller groups or shifts (e.g. morning, mid-day, afternoon) to minimise the number of people in the facility at any given time: allocate time slots to specific communities or enrol new cases in the morning only and returning cases in the afternoon. Make, put on the wall and communicate the revised schedules to all staff and patients and ask them to share the message back home safely (with physical distancing).
- iii) Utilise the existing outreach structure to inform the caregivers about the modified schedule and frequency of follow-up visits. Inform the caregivers not to visit the nutrition centre if s/he or anyone in the family is having symptoms related to COVID infection.

6. Staffing:

- i) Assess staffing needs based on the modifications of the activities. It is difficult to determine if patient load will increase or decrease as a result of COVID-19 and facilities may experience both as time passes.

Some key questions for Concern staff to discuss with facility staff when working out how to manage the adjusted patient flow in each facility:

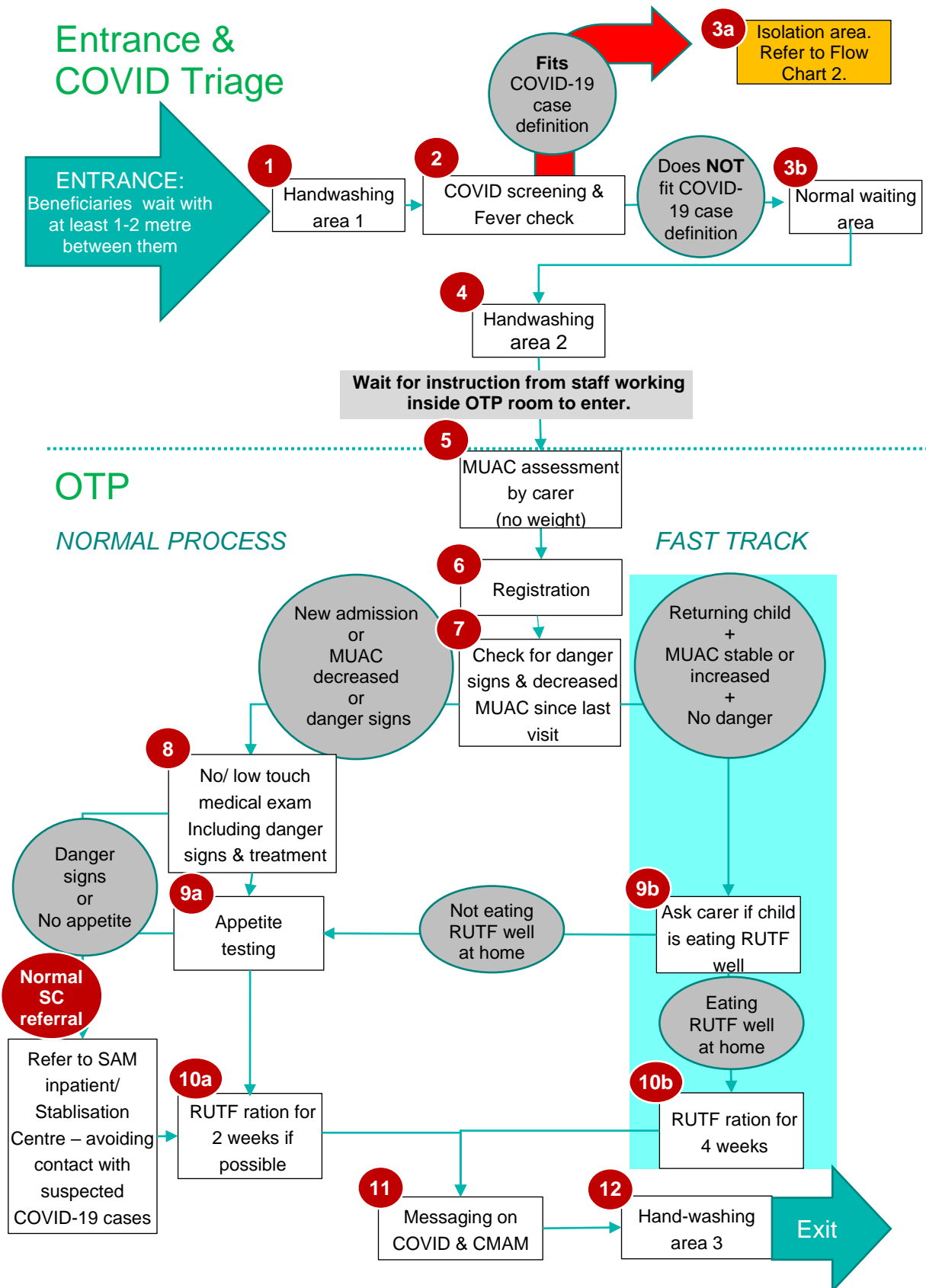
- How many staff do you have now to deliver the required services in each room?
- What tasks can be done by non-medical staff – this will hopefully have expanded with simplified protocols?
- Do you have the required PPE to provide basic treatment to high risk cases in the Isolation room? Who will be responsible for the Isolation room and referrals?
- How many nurses/ medical officers will you need for the OTP and for the other health consultations in the facility at one time?
- How will the set-up change if one staff got sick? Could you shift tasks and continue for 14 days or what services would you temporarily stop? What training is needed of other staff in case they need to cover those tasks in the future.
- What is the availability of personal protective equipment (PPE) (e.g. gloves, masks) for other health facility staff and other key personnel (e.g. cleaners)?

Section 4: Example of a modified patient flow for a SAM treatment site

General Objectives:

- Maintain full infection prevention and control measures through the health facility, including the OTP area. For more on infection prevention and control, refer to the WHO guideline [here](#).
- Recognise, isolate and refer, as appropriate, suspected COVID-19 cases in order to protect the facility staff and health services users and limit the spread of infection.
- Treat as many SAM (MAM) children as possible with minimal contact and in the shortest time possible while reducing the spread of infection. This includes safe referral to SAM inpatient services (Stabilisation Centre) for children with dangers signs but no specific signs of COVID-19 (many of the symptoms of COVID-19 would be considered SAM complications).

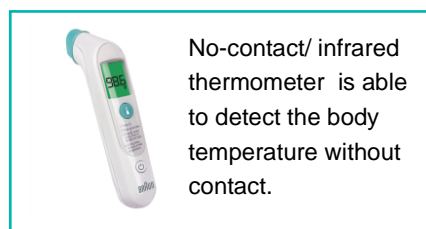
Flowchart 1: Sample layout of outpatient SAM services at a health/ nutrition facility adapted for COVID-19



ENTRANCE & COVID-19 TRIAGE AREA

Step 1 Handwashing station 1. Before entering the health triage area, ask the beneficiaries to wash their and their children's hands and to maintain 1-2 metre distance from each other throughout the process.

Step 2 COVID-19 screening and temperature check.
Check the temperature of both carer and the child using a non-invasive thermometer. If a non-invasive thermometer is not available, disinfect the normal thermometer after each use (with alcohol solution if available and with soap and cold water otherwise – see Box below under Step 8).



Ask the following screening questions:

COVID-19 screening questions

1. Have you or anyone in your household been asked by the public health or medical staff to self-monitor or self-isolate?
2. Have you or anyone in your household travelled to an area where there are suspected cases of COVID-19 during the last 14 days?
3. Have you or your child had close contact with or cared for someone suspected or diagnosed with COVID-19 within the last 14 days?
4. During the last 14 days, have you or your child had any of the following?
 - 4.1. Fever or sense of having a fever?
 - 4.2. A new cough that you cannot attribute to another health condition?
 - 4.3. Shortness of breath?
 - 4.4. Sore throat?
 - 4.5. Muscle ache that is not attributed to a specific activity?

Step 3a 3b Refer to Isolation Area or normal waiting area based on COVID screening results

Actions:

- a. Direct the carer to the appropriate waiting area:
 - If *FEVER* in carer or child and YES was the answer to any of the above screening questions, refer to the Isolation Area (3a). Refer to Flowchart 2 for what to do next with these patients.
 - If *NO FEVER* in carer or child invite them to enter the normal waiting area (3b).
- b. For Isolation Area referrals: Explain to the carer why they are being sent there, the next steps for referral (based on national protocol in your country) and encourage her/ him to prepare by sending message back to her family by another carer if possible. Ease their concerns, encourage them to comply, but ultimately it is the individual's decision. You cannot force them to be referred.
- c. For those in normal waiting area: Explain that the steps may be slightly different than before due to new precautions against the spread of infection. If possible, provide basic COVID-19 messaging here.

Step 4 Handwashing area 2 and entering OTP

Actions:

- a. Ensure each child and carer washes their hands before entering the OTP area.
- b. Maintain 1-2 meter distance inside the OTP as well. Even though suspected COVID cases have been screened out, there is still a risk that those without symptoms may transmit, including the health staff.

Step 5 No/ low touch MUAC assessment.

Actions:

- a. Ask the carer to sit in the designated chair that is 1-2 metres away from the staff and explain the procedure.
- b. Hand the MUAC tape to the carer and assure her that you are going to guide her through the procedure.
- c. Explain what the different colours on the tape mean
- d. Use a doll/ dummy to demonstrate how to take MUAC, repeat if necessary
- e. Ask the carer to now take the MUAC of her child by following the instructions; guide her throughout the entire procedure by using the doll/ dummy.
- f. Repeat step d and e until you are confident that the carer is taking the MUAC correctly. Read the measurement from a distance. Together with the carer, interpret and discuss the result before you record the result.
- g. Explain how to detect if the child has oedema, use a dummy/ doll. Ask the carer to now assess the child for oedema by following the instructions; guide her throughout the entire procedure by using the doll/ dummy. Together with the carer, interpret and discuss the result before you record the result.
- h. Record the findings and thank the carer.
- i. If sufficient MUAC tapes, hand the MUAC tape to the carer for her/him to take MUAC measurements at home to practice and monitor the child's condition. See Annex on Training Carers on Taking MUAC at home. Ask her to bring the tape with her next time she/ he comes for a follow-up visit.

Step 6 Registration

Actions:

- a. Consider having the staff carrying out the medical examination doing registration as well to reduce the number of staff needed at the facility.
- b. Simplify the information needed in the registration – for example, MUAC mm/ oedema check may be enough. Consider writing information only in the register and not on beneficiary cards to avoid touching surfaces and speed up process.
- c. Later you might note down the locations of any suspected COVID cases and use this information to inform further COVID-19 responses how you plan beneficiary shifts in the coming weeks.

Step 7 Check for decreased MUAC & danger signs – refer child to FAST TRACK or NORMAL OTP

Actions:

- a. A nurse or other medical staff must assess all children (new admissions or returning cases) from a distance of 1-2 metres for:
 - MUAC that has gone down since the last visit
 - Check for danger signs for referral to SAM inpatient services/ stabilisation centre (see Box on Danger Signs below)

The FAST TRACK is for children who:

- Are returning cases (not new admissions) *and*
- Have stable/ increased MUAC since last visit *and*
- Have no danger signs.

The NORMAL OTP PROCESS is for all other children:

- New admissions *or*
- MUAC has decreased since last visit *or*
- Danger signs are present

Step 8 Medical examination (Normal OTP only):

Actions:

- Ask the carer and child to sit in the designated area and explain the procedure.
- Use a non-invasive thermometer to measure the temperature. If not available, hand over the thermometer to the carer and ask her to follow your instruction.
- If using a normal (invasive) digital thermometer, ensure it is disinfected from the previous use and when finished, disinfect again using methods outlined in the Box to the right.
- Use the stethoscope to measure breathing and sanitise it (with alcohol solution if available and with soap and cold water if no alcohol solution available) as soon as the measurement is done.
- Record the outcome of the medical examination on the OTP card as much as possible, but if some info must be skipped due to patient overload, this may be acceptable.
- Thank the carer for helping you and direct her to appetite testing area

Step 9a Appetite testing (Normal OTP Only)

Actions:

- If handwashing station is available in the OTP room, ask the carer and the child to wash their hands with water and soap. Check if they are following standard handwashing procedure.
- Observe the child as his/her carer feeds them the RUTF 1-2 metres away from you. If the carer does not bring her/ his own cup, provide a disposable cup. If disposable cups are not available, ask the carer to clean the cup after use and dip it in a bowl containing chlorine water before placing it on a dishrag for drying.

Danger signs of complicated SAM

General

- Unable to feed
- Vomits everything
- Had fit (convulsions)
- Movement only when stimulated (lethargic)
- Fitting now (convulsions)
- No movement (unconscious)

Difficulty breathing

- Fast breathing/ severe cough
 - infant 0-1 months: ≥ 60 breaths/ min
 - infant 2-5 months: ≥ 50 breaths/ min
- Lower chest wall in-drawing
- Grunting

Diarrhoea

- Has diarrhoea
- Sunken eyes

Source: FANTA CMAM Training Guide 2018

Disinfecting digital invasive thermometers

- **If alcohol/ sanitizing solution is available:** Use alcohol wipes or soak a soft, disposable pad or cotton ball in alcohol. For small crevices, use a cotton swab soaked in alcohol. Let the alcohol dry completely.
- **If NO alcohol/sanitizing solution is available:** Wash the thermometer with water and soap. Never submerge a digital thermometer entirely in water. Avoid wetting the digital components, such as the display. If you want to clean these parts, wipe them with a damp cloth.

Note: Let the thermometer air dry before putting away. Wiping with a towel could reintroduce bacteria.

**Normal
SC
referral**

Refer all children with signs of complicated SAM or no appetite to normal inpatient SAM services (Stabilisation Centre)

Actions:

- a. Arrange referral for child to inpatient SAM services that does NOT mix with the COVID-19 referral pathway
- b. Explain to the carer that the child is being referred to normal inpatient SAM services because the child's malnutrition / health has declined but they are not being referred for COVID-19. Allow the mother time to inform her family.

Step 9b Asking carer history of appetite (Fast Track Only)

Actions:

- a. Ask the carer if the child has been eating the RUTF well. This is in place of a full appetite test for children who have met the criteria for the Fast Track option: they are a returning SAM case, they have a stable or increased MUAC since their last visit and there are no danger signs.
 - *If the answer is NO* (child has NOT been eating RUTF well) then refer to a full appetite test (9a).
 - *If the answer is YES* (child has been eating RUTF well at home) then send to RUTF ration distribution area (10b).

Step 10a 10b Distribution of RUTF

Actions:

- a. Prepare the rations ahead of time in bundles as much as possible with minimal touching.
- b. For all children, we suggest the following Simplified RUTF ration dosage protocols. If the simplified RUTF dosage protocol cannot be used for some reason, use the following Partially Simplified RUTF dosage, which generalises the number of sachets by weight. See more on Simplified Protocols above in Section 2.
 - **Simplified RUTF dosage** based on MUAC (not weight) wherever possible

MUAC	Total sachets of RUTF			
	Per day	Per week	Per 2 weeks	Per 4 weeks
MUAC <115mm	2	14	28	56
MUAC 115 mm to <125mm	1	7	14	28

- **Partially simplified RUTF dosage** based on simplified weight categories

Child's Weight (kg)	Simplified weight category (kg)	Total sachets of RUTF			
		Per day	Per week	Per 2 weeks	Per 4 weeks
3.5 – 4.4	3.5 – 5.9	2	14	28	56
4.5 – 4.9					
5.0 – 5.9					
6.0 – 6.9	6.0 - 7.9	3	21	42	84
7.0 – 7.9					
8.0 – 8.9	8.0 – 11.9	4	28	56	112
9.0 – 9.9					
10.0 – 11.9					
≥12.0	≥12.0	5	35	70	140

Step 11 Messaging

Actions:

- a. Disseminate appropriate IYCF messages in the context of COVID-19. Instead of group sessions or home visits consider announcements using megaphones, text messages, radio, TV.
- b. Focus on key messages on COVID-19 symptoms, and Infection, Prevention and Control (IPC) measures.
- c. Communicate the COVID referral pathway.

Step 12 Handwashing station 3

Actions:

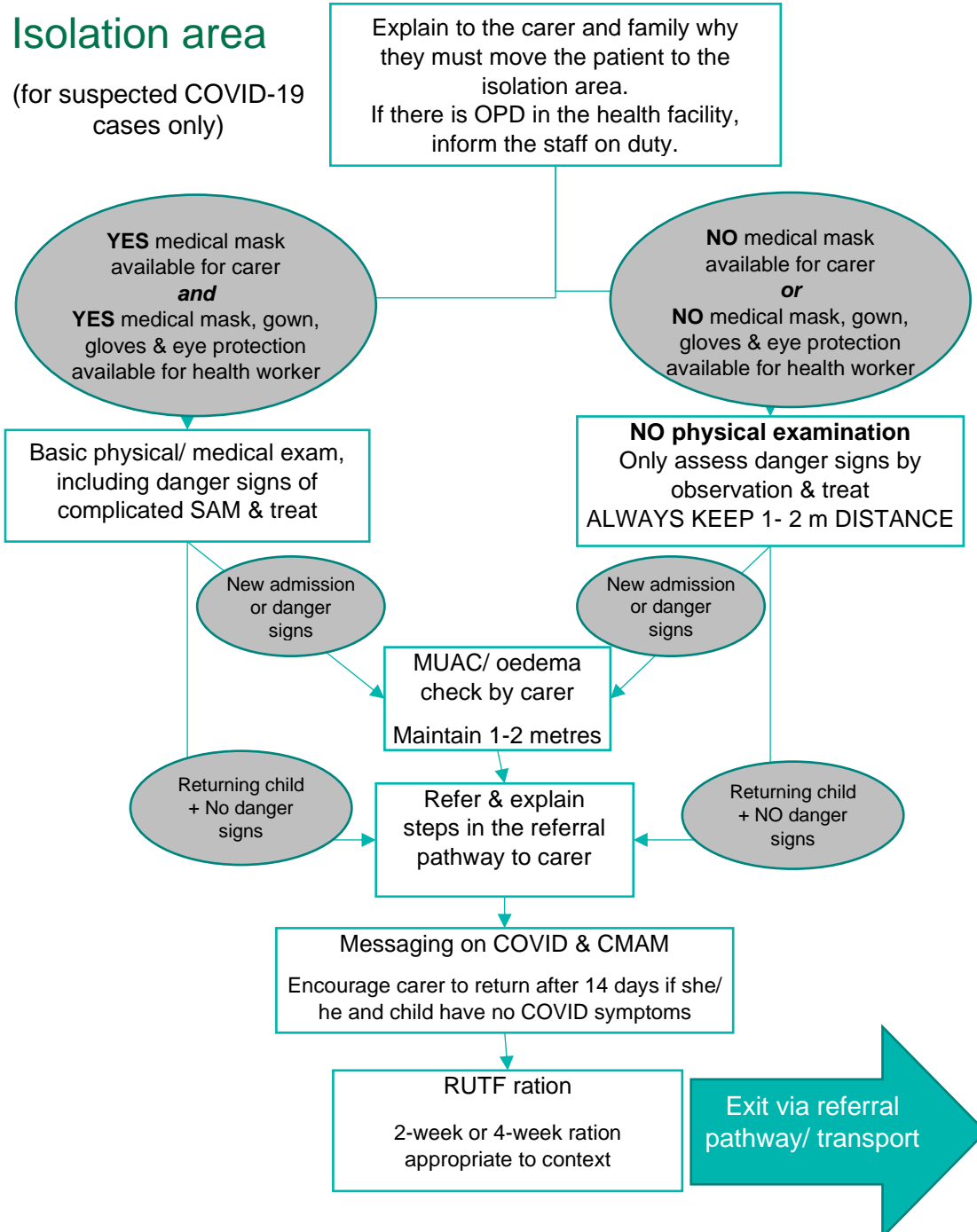
- a. Ensure all carers and children wash their hands before exiting the OTP site

Referral, ration and treatment for children/ carers with suspected COVID-19

This section provides an example of a detailed flow for carers and children who fit the case definition for COVID-19 and are referred to the Isolation Area (the orange box in Flowchart 1).

This section, in particular, *must* be adapted to national protocols for isolation and referral of suspected COVID-19 cases. If no protocols or referral pathways yet exist, you will need to determine the most appropriate protocols for your context.

Flowchart 2: Suggested flow for suspected COVID-19 cases referred to the Isolation Area



Section 5: Other essential considerations

Ending the CMAM session

1. Ensure that the distribution point (room/ area/ tarpaulin) is swept clean and sprayed with disinfectant (0.5% chlorine solution).
2. Clear handwashing station and remove/store handwashing solution.
3. Ensure safe waste disposal of medical and non-medical waste in line with Concern guidelines/WHO recommendations.
4. In addition to compiling your CMAM report follow national protocol for reporting the number of suspected COVID cases; it is recommended that health workers up-date their facility-specific COVID trend charts and analyse the data for the day.
5. Ensure all staff wash hands with clean water and soap, face, body and change into clean clothes before they go home.

Community Outreach

Scenario 1: No suspected COVID-19 cases

1. Train and encourage the carers to take MUAC of their children and in case of suspected acute malnutrition to come to the health facility.
2. Inform about any changes in opening time or shifts at the nutrition/ health centre
3. If Mother-to-Mother/ Carer-to-Carer Support Group (MtMSG), Care Group (CG) or any group activities is continuing, focus messaging only related to COVID-19 symptoms preventative measures (handwashing with soap; respiratory hygiene and social distancing).
4. Update the contact details of each community outreach workers, volunteers and lead carers. Set up a communication tree.

Scenario 2: Suspected COVID-19 cases in the community. In agreement with the MOH/ DHMT directives, consider the following indicative actions:

1. Suspend any activities that require mass gathering.
2. Use mobile phones to convey messages related to COVID.
3. If a home visit is necessary to provide nutrition supplies to suspected COVID caregivers, ensure the community volunteers are aware and following the basic preventative measures (adapted from Core Group CG checklist).
 - Do not conduct home visits if you or someone in your household feels unwell or the neighbour or someone in their household feels unwell.
 - Do not enter the house
 - Greet in a culturally appropriate manner, which does not include contact (putting a hand to heart, bowing the head, nodding, clasping hands, etc.)
 - Maintain a 1-metre distance between volunteers and the family visited (the family can be together; they don't have to maintain 1-metre apart).
 - Leave the ration outside of the house to be collected by the caregiver later.
 - Cough and sneeze into elbows or tissue and discard of it properly. Wash your hands after discarding the tissue.
 - Be sure to allow time for mutual emotional support, discussion of barriers to the behaviours being promoted, and to ask for a commitment to practice the behaviours.
 - Prioritise handwashing and provide support for handwashing (inexpensive soap options, etc.)

Ensure that environmental cleaning and infection prevention and control measures, including disinfection procedures, are followed consistently and correctly

CMAM Surge

Countries implementing CMAM Surge should refer to the Interim Guidance on 'CMAM Surge Adaptations for COVID-19' in addition to following the recommendations outlined in this document.

Stabilisation centre

Countries implementing inpatient/ stabilisation centres should follow the standard national protocol and the WHO guideline on [Infection prevention and control during health care when COVID-19 is suspected](#). It is highly recommended that the staff responsible for the management of SC complete free online training for healthcare workers and public health professionals. The training covers on what facilities should be doing to be prepared to respond to a case of an emerging respiratory virus such as the novel coronavirus, how to identify a case once it occurs, and how to properly implement IPC measures to ensure there is no further transmission to Healthcare Workers (HCW) or to other patients and others in the healthcare facility. The WHO training can be accessed through this [link](#).

Advocacy priorities – what to push for at national/ district level

- Clear guidance from MOH or Clusters or other health coordination bodies on COVID-19 protocols at health facility level and referral pathways and protocols. If there is a gap, Concern might support mapping COVID-19 facilities at least in our working areas.
- Provision of essential personal protective equipment (PPE) via MoH, Cluster or other in-country channels and related guidance on their use.
- Production and dissemination of COVID-19 prevention and service information via as many appropriate channels as possible. Concern should be mainstreaming communication of these messages in all our activities.
- Shift to more simplified CMAM protocols and adaptations as suggested in this brief if others have not already been developed, including protocols for SAM inpatient/ Stabilisation Centre referrals for suspected and non-suspected COVID cases.
- A clear projection on RUTF availability / pipeline and planning for adequate preposition of stocks to accommodate larger rations and contingency planning.
- More MUACs or alternative MUAC designs from local materials that match the local cutoffs and are easy for carers to use and interpret.
- Continued/ increased support for and clear information on services and referral pathways for sexual and reproductive health and gender-based violence support given the expected increase under the COVID-19 situation.

Annexes

Annex 1. Training topics for health facility staff

A. General overview (check WHO Q&A page for details)

1. What is COVID-19?
2. Country specific COVID-19 situation
3. Signs and symptoms of COVID-19 (In-country case definition if available)
 - Mild
 - Moderate
 - Severe
 - Signs and symptoms in children
4. How can people get infected with COVID-19
 - Mode of transmission
 - Incubation period
5. Vulnerable/at-risk population
 - Age group
 - Underlying medical conditions
6. Protecting yourself and others (video link)
 - Protection measures for everyone
 - Protection measures for persons who are in or have recently visited (past 14 days) areas where COVID-19 is spreading
 - Protection measures at the health facility/OTP centre
7. What to do if you suspect you or someone in your household has COVID
 - When to consider going for testing (according to country protocol)
 - Where to get tested (country helpline, referral mechanism)
 - How to avoid being infected

B. CMAM continuity planning

8. Modification of CMAM protocol and process
 - Modified layout (discuss and agree on the layout to accommodate the changes necessary to minimise the risk of contamination)
 - Marking of the service area
 - Simplified protocol
 - No-touch anthropometric assessment
 - Disinfection of anthropometric and medical (MUAC tapes, weighing scale, thermometer, stethoscope) equipment's
 - Exercise: How to assist the carer to carry out MUAC and oedema assessment)
9. Modification of service schedule
 - General objective
Exercise: divide beneficiaries into smaller groups or shifts (e.g. morning, mid-day, afternoon) to minimise the number of people in the facility at any given time: allocate time slots to specific communities or enrol new cases in the morning only and returning cases in the afternoon. Finalise the schedule for each facility
10. Staffing:
 - Objective of the modification
 - Assess need based on the adjustments/modification
 - Identify at-risk staffs and adjust team composition, roles and responsibilities
11. Identification and isolation of cases suspected of having COVID-19
 - Rational and safe use of PPE
 - Case definition, triage and screening
 - Referral mechanism
 - Treatment flow
 - Precautionary measures
 - Exercise: Role play

12. OTP step-by-step
13. Community outreach activities
 - a) Essential HH visits
 - b) Household visits-Do's and Don'ts
 - c) Key messages
14. General messages related to COVID-19
 - a) COVID-19, pregnancy, childbirth and breastfeeding
 - b) Mass gathering and COVID-19
 - c) Addressing local perception and stigma
15. 9. How to cope with stress
16. Communication tree (OTP staffs, Community Health Workers, Volunteers, local leaders, Lead carers etc.)
17. Addressing the needs of women on the frontline of the pandemic: (explore referral pathways for psychosocial support through Ministry of Health, external specialists or qualified internal staff and consider their menstrual hygiene needs)
18. Referral pathways for GBV victims

Annex 2: How to train carers to assess MUAC and oedema at home

How to train carers to assess MUAC and oedema at home

Instructions: Hand each carer a MUAC tape so that they can follow along.

What is a MUAC tape?

- Explain there are measurements on the tape which measure the size of the child's arm.
- Insist that the carers keep the MUAC in a safe place in their house not bend the tape.
- Explain what the colours mean and what the carer should do **for each** colour of the MUAC

Green: Your child is properly nourished. Continue to feed him or her nutritious food like beans, carrots, fish, meat, and eggs. Check MUAC every two weeks.

Yellow: Your child may have moderate malnutrition. If there is no programme in the area to address this, tell the carer to feed her child nutritious food like beans, carrots, fish, meat, and eggs. Check MUAC every few days, and if your child becomes more malnourished **and becomes RED, do as instructed below.**

Red: Repeat the MUAC measure to be sure you are correct. If you measure Red twice, your child has severe malnutrition and can quickly become ill.

- **Within 48 hours, go to the community health worker/promoter (CNV in Sudan) for an additional assessment if you live far from the health facility.**
- **Within 48 hours, go straight to the closest health facility.**

What can carers expect when they go to the health facility?

- Health facility staff will ask them a few questions and will **supervise** the carer while she/ he re-assesses her child's MUAC and checks for the presence of oedema and possibly perform additional health checks.
- Based on the MUAC measurement and other clinical signs, the health facility staff will either provide appropriate care (outpatient or inpatient depending on the status of the child)
- Service is free.

Thank the carers for their participation and be available for individual follow-up questions.

Source: Adapted from Training guide on the family MUAC approach. GOAL [here](#)

Annex 3: Preventing and addressing social stigma

Do's and Don'ts on language when talking about COVID-19

Don't - attach locations or ethnicity to the disease, this is not a “Wuhan Virus”, “Chinese Virus” or “Asian Virus”

Don't - refer to people with the disease as “COVID-19 cases” or “victims”

Don't - talk about “COVID-19 suspects” or “suspected cases”

Don't talk about people “transmitting COVID-19” “infecting others” or “spreading the virus” as it implies intentional transmission and assigns blame.

Don't - repeat or share unconfirmed rumours, and avoid using hyperbolic language designed to generate fear like “plague”, “apocalypse” etc.

Don't - emphasise or dwell on the negative, or messages of threat. We need to work together to help keep those who are most vulnerable safe.

Source: Social Stigma associated with COVID-19. UNICEF, WHO, IFRC

Annex 4: Other resources by topic

Training

1. [WHO Q&A on coronaviruses \(COVID-19\)](#)
2. [Key tips and discussion points for community workers, volunteers and community networks.](#) IFRC, UNICEF, WHO.
3. [WHO Coronavirus disease \(COVID-19\) advice for the public: Videos](#)

General

1. [WHO COVID-19 resource page](#)
2. [Global Nutrition Cluster COVID-19 Resources](#)
3. [UNICEF COVID-19 resource page](#)

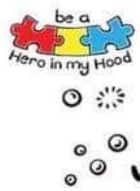
WASH (all internal Concern documents, available from Concern upon request)

1. [How to make chlorine bleach solution](#)
2. [Safe Hygiene practice-COVID-19](#)
3. [Social distancing in low income countries](#)
4. [WASH COVID-19 response - Concern Worldwide](#)

Gender and Equality

1. [Equality programming:COVID-19 - Concern Worldwide \(available from Concern upon request\)](#)
2. [IASC Interim guidance on gender alert for COVID-19](#)

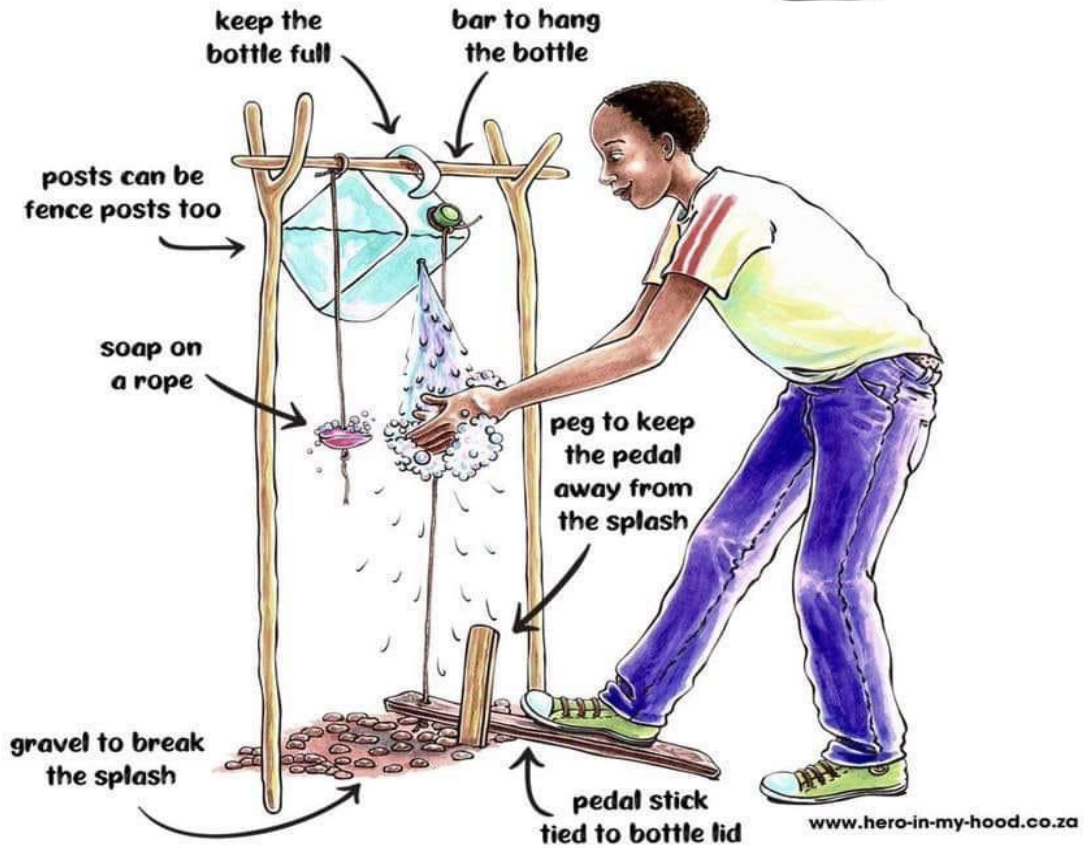
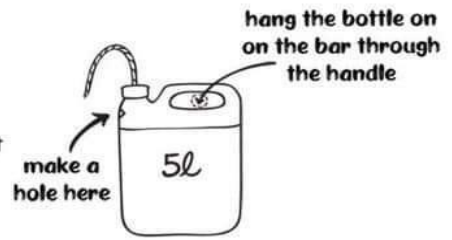
Annex 5. Example of a low/ no-touch handwashing facilities



TIPPY TAP

wash your hands with soap

you can thread the string through a hole in the lid and tie a knot



CONCERN
worldwide

**ENDING
EXTREME POVERTY
WHATEVER
IT TAKES**

For more information contact:

Kate Golden
Senior Nutrition Adviser , Concern Head Office
kate.golden@concern.net

Sajia Mehjabeen
Nutrition Adviser, Concern Head Office
Sajia.mehjabeen@concern.net