IRC experience implementing a simplified & combined treatment protocol :

Results from RCT & programmatic experience





Simplified, combined protocol (ComPAS)

A simplified, combined protocol is intended to simplify and unify the treatment of uncomplicated severe and moderate acute malnutrition for children ages 6 - 59 months into one protocol.

It does this by:

- Treating SAM and MAM in one program, as a continuum condition
- Simplifying the diagnostic criteria edema + MUAC only
- Treating MAM and SAM with a single therapeutic food product, used in different doses (2 RUTF sachets/day for MUAC
 <115mm, one RUTF sachet/day for MUAC 115-
 <125mm)

In resource-constrained settings, this is intended to:

- Improve coverage, quality, continuity of care
- Improve cost-effectiveness of treatment



ComPAS RCT in Kenya and South Sudan (n=4,110)

Non-inferior recovery:

- 76.3% of children treated with the combined protocol recovered vs 73.5% recovery with standard treatment protocol in per-protocol analysis.
- 23 (1.8%) deaths in the combined protocol arm and 21 (1.8%) deaths in the standard protocol arm.
- Median time to recovery under both simplified and standard protocol was approximately 10 weeks.

Cost-effective:

- Amount of ready-to-use food required for a SAM child to reach full recovery was less in the ComPAS protocol (122 vs. 193 sachets)
- ComPAS protocol was \$123 less per child recovered (\$918 vs \$1,041)

Generating evidence in high-burden countries: IRC experience



Kenya and South Sudan: RCT and cost effectiveness analysis

Enrolled 4,000+ children in Nairobi Kenya and Aweil East, South Sudan (2016-2018)

Kenya: Operational pilot

Treating 6,000 children in Dadaab camp

Somalia: Past study of combined protocol

Enrolled 727 SAM children without complications

Somalia: Ongoing operational pilot

Treating 4,000 children

Mali: Ongoing operational pilot

- Treating >18,000 children
- Working with health facilities and CHWs
- Analyzing relapse data from Mali
- Collecting extensive cost data
- Will conduct behavioral mapping study of Family MUAC to target where improvements are needed

Chad: Past operational pilot

- Treated > 18,000 children
- Currently analyzing evidence from pilot

CAR: Exploring pilots here

UNICEF. WFP and MOH collaboration

Preliminary findings from operational pilots treating >20,000 children in multiple countries



- High recovery (85-95%), low mortality and low defaulting
- Length of stay is acceptable (8 weeks for MUAC <115 mm, 5-6 weeks for MUAC 115-<125mm)
- Average daily weight gains of 5-6 g/kg/day
- High recovery (>80%) in vulnerable sub-groups (SAM and over 8kg; MAM and WHZ<-3; SAM and WHZ<-3; MUAC<100mm)

Ideal contexts for the adaptation – Mali case study

- Existing community mobilization
- Reliance on MUAC for screening (No effective Growth Monitoring)
- CHW treatment policy in place
- Low MAM treatment coverage & availability of inputs



What has been achieved – Mali case study

- + 19 000 admissions:
 - 38% w/ MUAC <115 mm
- 96% recovery rate:
 - 93% w/ MUAC <115 mm
- Length of stay:
 - 56d w/ MUAC <115 mm
 - 32d w/ MUAC 115-124 mm
- RUTF consumption
 - 88 sachets w/ MUAC <115 mm
 - 38 sachets w/ MUAC 115-124 mm



Barriers and boosters for going to scale – Mali case study

Potential barriers:

- Recent protocol revision
- Lack of clear cost data
- Lack of experience from urban context
- Several adaptations being tested in the same context
- RUTF availability & pipeline

Boosters:

- High acceptance from health care staff
- UNICEF & MoH engagement
- Other adaptations & pilots on-going in the same context
- Coordination between UNICEF & WFP
- Alignment of major RUTF funders on the new approach

What are the practical implications for governments? – Mali case study



If ComPAS protocol adopted at national level:

- \rightarrow Inputs: calculate the needs
- \rightarrow Training: who? How?
- \rightarrow HR: possible re-organisation of the CMAM days



What next: priority actions to address barriers – Mali case study

Potential barriers:

- Recent protocol revision → keep sharing new evidence & follow WHO guideline review
- Lack of clear cost data \rightarrow produce rigorous costing data
- Lack of experience from urban context → OptiMA pilot producing results on this
- Several adaptations being tested in the same context → engage the simplified approaches steering committee in more policy debate
- RUTF availability & pipeline → developing a resource estimation tool

Thank you

For more information, please visit www.example.net



VIRTUAL CONFERENCE



ComPAS publications with more information

- Stage 1 analysis [PLOS ONE, June 2020]
- Trial protocol [Trials, April 2018]
- Cost-effectiveness analyses methods [Trials, 2018]
- RCT Trial results from Kenya and South Sudan [PLOS Medicine, July 2020]
- Follow-up study on relapse and body composition in Kenya [PLOS One, February 2021]
- Analysis of children with severe underweight and/or severe MUAC [Accepted by Nutrients]