

Mother-led MUAC Webinar (4 April 2017) presented by ALIMA and World Vision

Acronyms

CMAM – Community-based management of acute malnutrition

MUAC – Mid-upper arm circumference, measured by a coloured MUAC tape/band/bracelet

OTP – Outpatient Therapeutic Program

SAM – Severe Acute Malnutrition

Q&A Notes

1. When are the families trained on MUAC and when they are provided with the MUAC tapes? At the time of discharge from the nursery? At a vaccine clinic visit?

There are many opportunities to train mothers on MUAC – it goes back to your organizational strategy. For ALIMA, the strategy was to train all mothers with children 3 to 59 years of age, so a mass training campaign was necessary. This happened in different ways in different countries. Mali started by first training mothers who came into the OTP, and then implemented a mass training campaign in 2017.

2. What is recommended on how often mothers/caregivers should screen their children?

About every two weeks or whenever they feel like it (for example, if their child is sick).

3. Do the MUAC tapes need to be replenished frequently or do mothers hold on to their "original" tape?

In coverage surveys in Burkina Faso and Niger, ALIMA found that mothers take very good care of the MUAC tapes and between 80-90% of MUAC tapes are in good condition, but they are replenished as needed. World Vision also found that the MUAC tapes were very well maintained by the mothers. The UNICEF tapes are coated with plastic and are fairly durable.

4. Where do you procure MUAC tapes?

For World Vision's Mauritania project, all tapes were supplied by UNICEF. ALIMA has obtained from UNICEF and also from UNICEF-validated manufacturer.

5. What is the cost of MUAC tapes?

ALIMA purchased 100,000 MUAC tapes through a UNICEF-validated manufacturer for \$5,000 (\$0.05 per tape) and they come in bundles of 50. The UNICEF warehouse in Copenhagen stores more than 1 million MUAC tapes.

6. With regards to sustainability of the action, how often do you need to go back and train the mothers again? Also are there more issues with sensitivity rather than specificity?

ALIMA's approach has been a mass campaign followed by trainings for mothers who arrive at the hospital/clinic and who have not been trained yet. They have not done follow-up mass campaigns. You should only need to do another mass training, if you are seeing problems i.e. self-referrals based on incorrect measurements.

7. Would you recommend the Mother-led MUAC approach during an emergency situation? Any experience/reference in this setting that you could share would be appreciated

This is a key issue. MUAC is easy to learn and quick to teach – skills can be passed along in a short period of time. For example, in North-East Nigeria, in areas with minimum access, ALIMA recommended finding a teacher in the community, provide him or her a quick briefing and ask them to train others in their village. If they are being asked to do paid work, then pay them.

8. During the presentation, Kevin referred to the approach as 'Family MUAC'. What has been ALIMA's experience with engagement of other family members - e.g. fathers, grandparents?

ALIMA has decided to use the term Family MUAC, even though mothers have the predominant role. Training other family members is very important. Older children in the households have taken this up and find it fun. Training fathers is also a good way to show that this is a family responsibility. Often grandparents are the caretakers for the child.

9. What do you think is the potential for remote data collection using mobile methodologies (such as operator phone calls, SMS) to monitor MUAC measurements collected by mothers – training mother to use MUAC and then calling up every month or so to collect MUAC measurements from the mothers.

There is great opportunity for use of mobile technology, especially for monitoring during care of child on mobile devices.

10. What motivates these mothers lead/conduct the MUAC-screening? Are they volunteers or being paid an incentive (non-monetary or monetary)?

No incentives were necessary in either ALIMA's or World Vision's program – mothers were empowered and were happy to have more knowledge about the nutrition and health status of their own children. If you ask mothers to go further and supervise or train other mothers, than that could be considered paid work.

11. Finding that almost one-half of cases are identified by mothers is significant; were you able to determine if there was an increased identification and therefore treatment of children using mother-led MUAC compared to conventional methods? maybe using historical comparisons? or comparison between communities with and without training?

World Vision's intervention in Mauritania was in a zone with no NGO intervention prior to this project. There was some state-level CMAM intervention, but it not well-followed up. Cases increased significantly, but we can't compare to a conventional approach there since there was not a good CHW approach operating in these zones prior.

12. Have barriers to adoption of this method been identified?

There are zero barriers in terms of mothers adopting and taking up this approach. Political barrier in how the approach is explained to CHWs and even health centre staff. There is often a worry as to whether people will lose their jobs. Needs to be explained well, and stressed that the knowledge and skills of CHWs and health centre staff is put to better use by training the mothers.

13. 46% of cases identified through the mothers is very good. Is there evidence or do you think the mother's screening leads to early identification of SAM, that is, with less complications?

In Mauritania, the endline results are not yet available, but we believe that this will be the case – that mothers screening their children will lead to early identification of SAM.

Thanks everyone!

For further questions/conversation, please contact kevin.phelan@alima.ngo; nutrition@wvi.org; judith_haase@wvi.org; or colleen_emary@worldvision.ca