Save the Children

Guidance

FAMILY MUAC APPROACH IN THE TIME OF COVID-19 – IMPLEMENTATION CONSIDERATIONS FOR PROGRAMME MANAGER

Guidance

COVID-19: HOW-TO GUIDE

Family MUAC Approach in the Time of COVID 19 - Implementation Considerations for Programme Managers

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This document aims to provide step by step guidance for implementing the Family Muac Approach, in both Covid-19 and non Covid-19 contexts, to increase community Management of Acute Malnutrition (CMAM) coverage while minimizing the risk of exposure of personnel, partners and beneficiaries.

This guidance can also be used inline with simplified treatment protocols during a Covid-19 pandemic where routine CMAM approaches may not be feasible.

The guidance pulls heavily from partner agency guidance – including ALIMA, ACF, World Vision, Concern – and from the following specific sources:
https://www.acutemalnutrition.org/en/Family-MUAC

CONTENTS

Section One: Why implement/scale-up Family MUAC in the time of COVID19? 2

Section two: What set up? 2

Section Three: How to adapt Family MUAC approaches to the Covid context? 7

Data Collection for community MUAC Training 7

Guidance

Section One: Why implement/scale-up Family MUAC in the time of COVID19?

The COVID 19 pandemic is expected to impact on nutrition security status, resulting in increased rates of malnutrition. Coverage of services to screen, refer and treat acute malnutrition has been impacted with constraints on outreach activities due to national lockdowns, social distancing and lack of Personal Protective Equipment (PPE) to adequately protect frontline workers.

Prior to the pandemic, and to drive up utilization and coverage of nutrition services, nutrition actors have been training members of the community, namely mothers and caregivers, to detect and refer children suffering from acute malnutrition to treatment services, both within their homes and within their communities; known as Family MUAC (Mid Upper Arm Circumference, previously mother-led MUAC). Task shifting from health workers to community members has been shown to be a viable and effective approach in resource limited settings and has shown its success in terms of accountability and quality across a vast array of sectors.

Family MUAC fits within existing normative guidance on how to manage acute malnutrition as recommended by WHO guidelines, therefore training community members how to screen using MUAC and assess for oedema does not require additional endorsement. The results of this approach have been evidenced in peer-reviewed articles, which have effectively demonstrated that family members are able to screen their children to the same sensitivity as Community Health Workers (CHWs).

With the spread of the COVID 19 pandemic, health services are likely to be strongly negatively impacted as the health workforce will be overloaded with the additional burden. COVID 19 control measures are also likely to temporarily suspend mass screening campaigns, with guidance to avoid physical contacts and/or to use Infection Prevention and Control (IPC) measures after each contact, which can have heavy resource demands. These factors will have a negative impact on the early and life-saving detection of children with acute malnutrition. Family MUAC offers a solution and has been recommended by UNICEF, the Global Nutrition Cluster and the GTAM in the brief on: Management of child wasting in the context of COVID-19 to overcome these barriers. The Family MUAC approach was also scaled-up in the Ebola outbreak in Western Africa to address this physical distancing recommendation, with caregivers measuring nutritional status of their own child. Finally, in a period where caretakers might have limited access to information, the approach aims at empowering caretakers to identify malnutrition and seek treatment and enabling them with the monitoring of their children's nutrition status

Section two: What set up?

Pre COVID 19, there were a variety of approaches that are being used by nutrition actors for Family MUAC[1], these approaches have been documented here. Whilst one standardized approach may help coordination, a singular approach may be too restrictive given different ways of working of partners, and the different community platforms that exist. It is recommended that a minimum set of criteria could be a useful approach to ensure an appropriate approach and coordination happens at a country level. These minimum standards should include the following considerations:

- **Desired outcomes / objectives**
- **Consideration of cost-effectiveness**[2]
- **Communications and messaging**
- **Integration into existing platforms and systems**

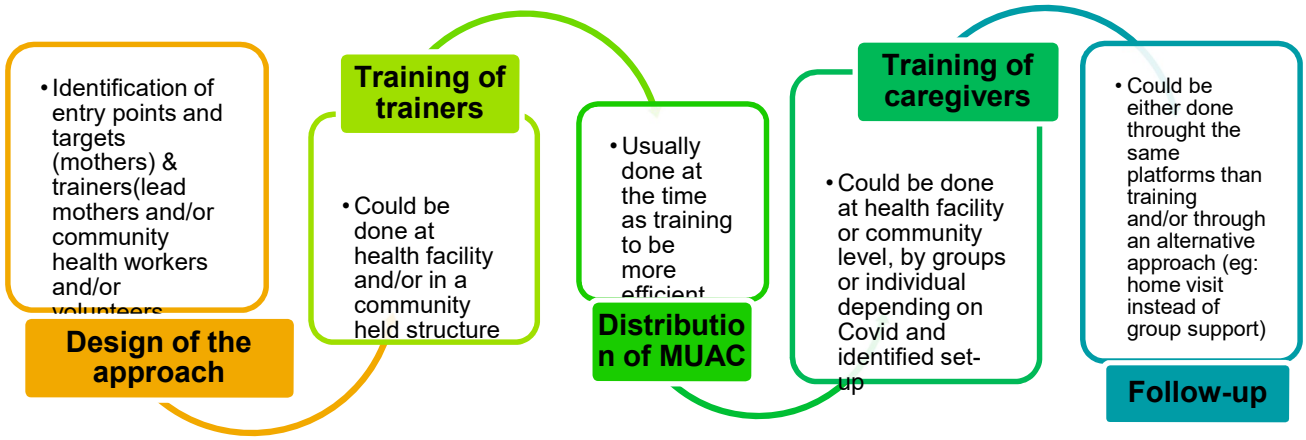
[1] Guidelines and resources available on: https://www.acutemalnutrition.org/en/Family-MUAC
[2] Resources (human, logistic, supplies) required

Guidance

- **Data collection**

The minimum standards should be based on lessons learned from existing implementation in country, where available, and developed in a collaborative manner amongst all implementing partners under the guidance of the Ministry of Health or relevant lead / coordination mechanisms for nutrition. Furthermore, consideration should be given to existing community health platforms and community groups. Priority should be given to identifying and reinforcing the capacity of these existing community mechanisms, and to integrate Family MUAC and oedema assessment training using these entry points rather than creating new parallel groups specifically for this activity. The approach basically includes 5 steps as described below:

1. **Design**
2. **Training of trainers**
3. **Distribution of MUAC**
4. **Training of caregivers**
5. **Follow-up.**



The design of the approach will depend on the context and existing platforms. Several entry points could be considered, each with its pros and cons. The table below provided a list with expected operational requirements, expected targeted and operational details.

At community level

Entry point & Platform	Why use this entry point?	Who will be reached	How: Implementation process			What: Prerequisites (resources, protocols)
Mother Baby Areas (MBAs)	Accessing mothers of children under 2, in a quiet, safe area	Mother of children under 2 (depending on the set-up of the MBA)	Training could be done at community level to avoid travels, gathering the different trainers (CFS lead, MBA staff, CHW...), and facilitated by experienced CHW and/or NGO workers	Training will be done by groups in the meeting place (MBA/CFS), allowing enough time for questions and trial	If caretakers tend to comeback frequently, follow-up could be done during visits or during	Spaces are functioning and staff are trained and equipped to provide orientation and follow-up
Child friendly space (CFS)		Caretakers of children under 5 (depending on the set up of the CFS)				
Integrated Community Case Management (CCM) /ICCM with Management of Malnutrition	Prioritizing children at risk of developing malnutrition or relapsing and emphasizing the need for early detection and referral. Using caretakers of former malnourished children as agents of change.	Mother of children 6-59 months old attending ICCM services		Training could be done individually during ICCM visit if the patient fit the criteria (child between 6 and 59 months)	Follow-up should be done at home visit if available staff, or the trainee could be asked to come back for monitoring	- ICCM is functioning with motivated and trained, equipped and supervised CHWs - Sufficient supply of MUAC tapes that can be distributed to caregivers - Health staff are trained and equipped to mitigated the risk of COVID 19 transmission
Community health worker package of activities	CHW sit in the community and have close access and trust of communities. They can ensure a regular, local follow-up and have access to communities not attending health facilities Family MUAC coaching could be coupled with other activities such as home visits	PLW up to reproductive age women depending on the CHW capacities/abilities	CHW/lead mothers are trained at community site by health staff/ NGO workers	CHW should identify a list of potential targets depending on capacities and available resources and provide training during home visit, integrating it within existing services (counselling, case follow-up etc..)	If trainees are attending platform (support groups, CFS etc..), follow-up should be during these meetings, otherwise, follow-up should be done at home depending on the CHW availability	-Strong community health system - Good Community health coverage/networking - Community health workers are trained and motivated
Support groups (Mother to mothers supports groups, Care Groups - MtMSGs, Positive Deviance Groups - PDI)	Cost effective approach through a cascade training multiplying targets exponentially (health staff to lead mothers to mothers), Opportunities to link sensitization (IYCF/Hygiene	PLW (depend on the support group set-up) (could be enlarged to mother of U5)		Training will be done during the MtMSG including session on why early detection is important, use of MUAC and demonstration	Follow-up could be done at each follow-up meeting, for recently discharged mothers, follow-up could be done at home	- Functional support groups - Trained and equipped CHWs and lead mothers

	IEC) and practices (screening malnutrition) thus strengthening behaviour change					
Community meetings/ Community dialogues	Reaching community influencers to support the adoption of family MUAC and good nutrition/COVID 19 control practices Should be done in addition to other approaches	Community leaders & influencers	Demonstration during meeting of the use of MUAC, distribution to the key stakeholders and emphasis on why early detection and referral is important		Follow-up is unrequired as the	- Functional community network - Access and Involvement of stakeholders
Distribution (NFI/BSFP/ Blanket)	Optimizing contact opportunities to reach a large target in a limited number of times	Beneficiaries of the distribution, could be PLW up to the whole population depending on resources	Trainers (CHW, distributors) are trained at community site by health staff/ NGO workers	During waiting time, to identify and organize in small groups targets, distribute and coach on the use of Family MUAC and, if possible, link them with local CHW for follow-up	Follow-up could be done through existing platform if caretakers attend or at home visit, but might be difficult resource wise	# Distribution is well organised, allowing enough time and space to train/orientate caregivers # Trainers trained and equipped appropriately

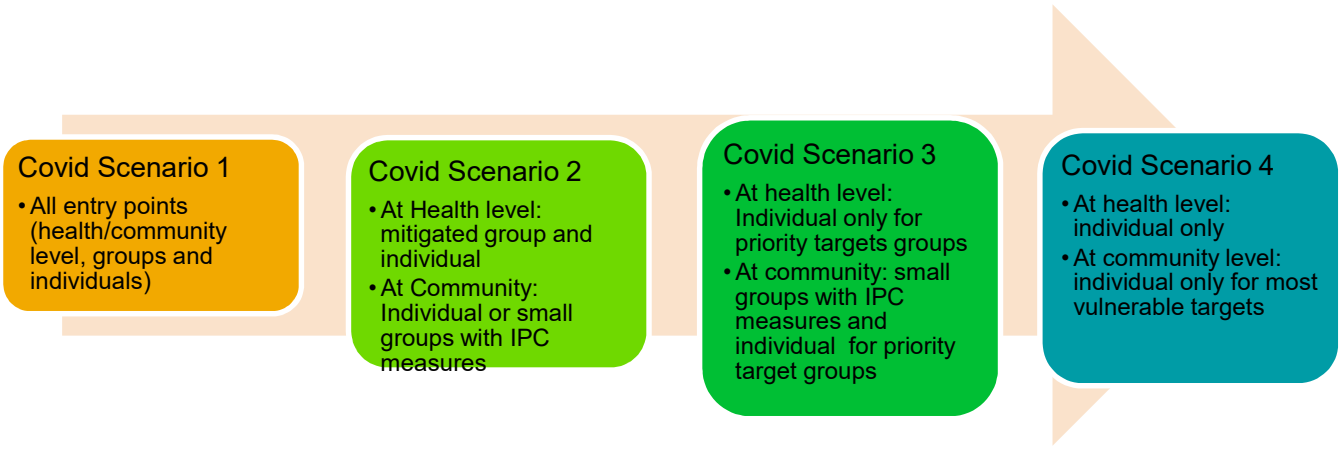
At Health Facility

Entry point & Platform	Why use this entry point?	Who will be reached	How: Implementation process			What: Prerequisites (resources, protocols)
SC/OTP/TSFP (CMAM)	Prioritizing children at risk of relapsing and emphasising the need for early detection and referral. Using caretakers of former malnourished children as agents of change.	Caretakers of SAM/MAM children under 5 years old	Done at the health facility and/or in appropriate structure by either Health staff and/or NGO staff	Could be done by group or through individual counselling at first visit	Should be done at each visit until full discharge	- Health facility staff are trained on family MUAC (including oedema s including appropriate training aids

Child & Mother health monitoring (Growth monitoring, Integrated Management of Childhood Illness, Infant follow-up & immunization, Antenatal / Postnatal Care ANC/PNC)	Optimizing opportunities for interaction between caretakers and health worker	Caretakers of children under 5		Usually done during individual interaction between health worker and caregiver; if conditions allow (enough women, time and appropriate space), training could be done by group	Should be done at home by CHW	- Sufficient supply of MUAC tapes that can be distributed to caregivers - The patients flow allows for extra time for training - Dedicated space for training (small groups or individual training) - Health staff are trained and equipped to mitigated the risk of COVID 19 transmission

Section Three: How to adapt Family MUAC approaches to the Covid context?

Based on the Covid Scenario, and the context, some entry points might be preferable to others as highlighted in the graph below.



IPC measures will have to be taken during distribution, training and monitoring depending on the set-up selected (group or individual) and the place (community, home, health facility).

Distribution of MUAC

Distribution should be integrated within training to reduce frequency of contact.

Distributor should handle MUAC with gloves, wear a mask:

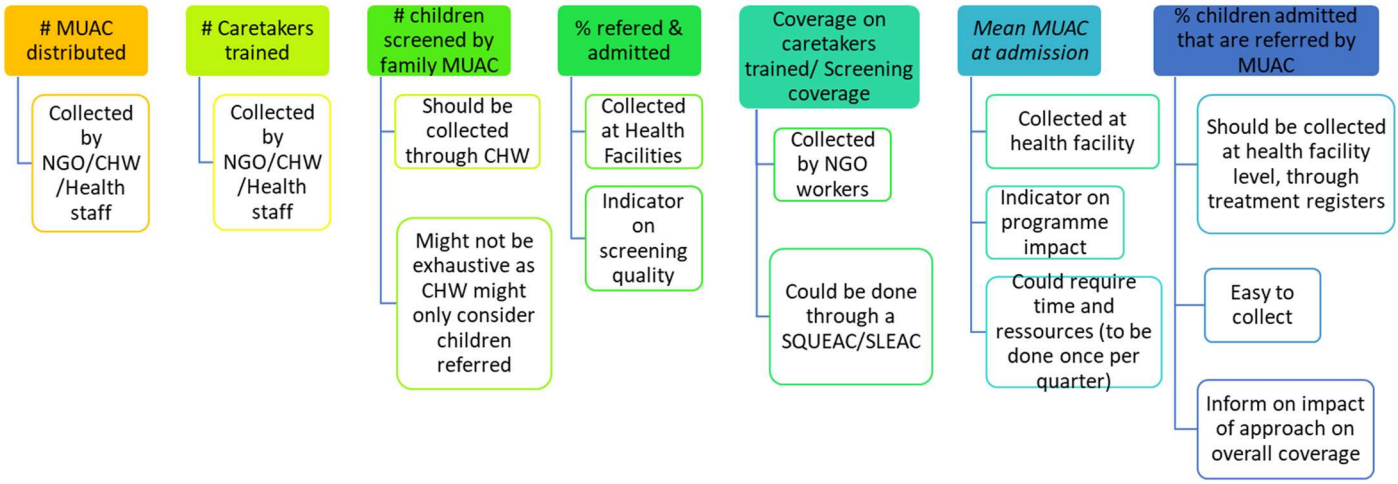
1 MUAC/Caretakers, MUAC should be kept within the household / cleaned with water and soap or gel after each use

Training and monitoring

Health Facility		Community	
Group	**Individual**	Home visit	Groups (support groups, CFS, MBA)
Identify an appropriate place (well ventilated, access to water and soap, enough space to implement physical distancing), ensure implementation of IPC measures and keep it small (5-10 persons max)	Identify an appropriate place: quiet, well ventilated, ask the caregiver to wash hands with soap and practice physical distancing, wear mask during the training	Hold the meeting (training/follow-up) outside , wear masks and wash hands before and after the visit, practice physical distancing	Keep the group small (less than 10 people), apply IPC measures (physical distancing, hand washing), provide PPE material if required and available, install hand washing station nearby meetings points

Data Collection for community MUAC Training

Whilst there are common indicators that many NGOs use to measure the inputs of community MUAC training, there is no standardized set of indicators. Organizations use different tools and measure activities in a variety of different ways, which tend to be linked to internal monitoring and evaluation systems as well as donor reporting requirements. The inconsistencies in data collection between partners results in limited monitoring capacity from a national perspective. Key indicators already exist in existing reporting mechanisms e.g. treatment I registers, such as "source of referral" and in areas where NGOs support, this data should continue to be monitored, particularly over time to gain a better understanding of whether seasonality and time since last trainings influence screening, referral and admission. With the outbreak of COVID 19, data collection might be impaired by reduced access and should be kept to the minimum information that is required and available. Partners should optimize existing/remaining points of contacts to ensure the proper use and adoption of the family MUAC approach but not add another layer of work with additional data collection. Below a list of indicators with the point of collection and additional information on the added value and resources required.


MUAC distributed
Collected by NGO/CHW /Health staff
Caretakers trained
Collected by NGO/CHW /Health staff
children screened by family MUAC
Should be collected through CHW
Might not be exhaustive as CHW might only consider children referred
% refered & admitted
Collected at Health Facilities
Indicator on screening quality
Coverage on caretakers trained/ Screening coverage
Collected by NGO workers
Could be done through a SQUEAC/SLEAC
Mean MUAC at admission
Collected at health facility
Indicator on programme impact
Could require time and ressources (to be done once per quarter)
% children admitted that are referred by MUAC
Should be collected at health facility level, through treatment registers
Easy to collect
Inform on impact of approach on overall coverage