The Family MUAC Approach: Action Against Hunger India

The Challenge

The India National Family Health Survey found that childhood undernutrition accounts for 45 percent of under-five mortality in the country. 21 percent of children in India are wasted, accounting for around 25 million acutely malnourished children – over half the global burden.

In order to address the large number of children suffering from acute malnutrition in Rajasthan, Action Against Hunger initiated Community based Management of Acute Malnutrition in close collaboration with the government in Baran. However, even with the CMAM approach implemented, treatment coverage was still low. It was noticed that however well trained and motivated the frontline workers were, they had limitations following multiple cohort of malnourished children, who usually stayed in the outskirts of villages, and had limited access to the Anganwadi centres or sub-centres. In addition, competing health programmes and village administrative works are found to put lesser premium on home-visits by frontline workers, especially when the families stayed in settlements away from service units.

Mother support groups enabling early detection

In order to overcome the challenge of accessing treatment services, mothers' support groups were formed to empower them on several essential care practices, building maternal confidence and behavioural practices around the continuum of care of malnutrition. Depending upon the groups' perceived needs for knowledge on childcare, initial sessions focused on maintaining their interest to assemble together on a regular basis, and discussing common problems in caregiving, as simple as not finding time to rest, challenges spending quality time in babycare, breastfeeding difficulties, lack of family support, or inability to access quality healthcare or Anganwadi ration services. As the groups developed, complex interventions ritualising behaviour change were introduced. One among them is monitoring a child's MUAC.

The Pilot Programme: Baran district

There is no one-size-fits-all approach to community engagement in an integrated nutrition-care practices programme. It is therefore important to design interventions that align with cultural practices of the tribe, encourage participation, and build cohesive social networks, availing vulnerable families opportunities to engage, express and empower.

In the predominantly tribal population of Baran district, malnutrition is passed on from generation to generation, access to healthcare is poor, and diverse socio-cultural beliefs and child-rearing practices mean that programmes must be adapted to local customs to ensure uptake.

IMPLEMENTATION STEPS

1. Determining the Programme Area:

In this pilot programme to increase the coverage for early detection of children with acute malnutrition, 44 villages were selected, from among 283 where the integrated nutrition-care practices programme run by Action Against Hunger is operational, based on the following vulnerabilities and facilitating factors: ▪ Hamlets far away from Anganwadi centers, posing difficulties to access on regular basis and an inability of ASHA and Anganwadi workers to visit the hamlets periodically due to long distance ▪ Absence of caregivers during previous visits of healthcare workers ▪ Motivation of mothers to engage in participatory learning group ▪ Cordial working relationships between beneficiaries and local frontline workers

2. Training Mothers:

In selected villages community mobilisers were appointed and received a technical training on effectively engaging mothers to use MUAC. The community mobilisers were provided with: ▪ MUAC tapes ▪ Training aids and tools per trainer (e.g. IEC on malnutrition causes and consequences, audio-visual aids explaining use of MUAC and checking for oedema, terms of references outlining key messages, objective of the activity, and target group, monitoring sheet to maintain attendance records) were used. Community mobilisers then trained the mothers during participatory learning group session. During these sessions, which are approximately an hour long, mothers were exposed to a mix of presentations and practical demonstrations, with clear and simple messages delivered in the local language. A typical 40 – 60 minutes session included:

- Welcoming mothers and explaining objectives of Mother-MUAC
- Understanding malnutrition types, causes and consequences (through flip-charts, using audio-visual aids)
- Understanding difference between wasting and oedema presentations
- How to recognise early signs of malnutrition
- Cultural proximity between practice of tying thread band and using MUAC to monitor child growth
- Advantages of Mother-MUAC
- Practical demonstration on using MUAC colour codes to effectively identify acute malnutrition
- Frequency of use – when to use MUAC and check for oedema
- Information on 'What to do', 'Whom to contact' if a child is found acutely malnourished – referral procedures reinforced
- Ensuring periodic follow-up: initially once every week for first 4 weeks and later twice a month
- Thanking mothers for participation

3. Follow-up with Mothers:

Follow-up to track the uptake of training with mothers,and bridge additional support needs to arrive at accurate measurements are important steps to sustain mothers' motivation and ritualize the practice of growth monitoring at home. The community mobiliser, with the assistance of the local frontline worker, managed periodic follow-ups at village level. It involved: ▪ Motivating mothers to continue using MUAC and oedema checking procedures ▪ Repeat appropriate key messages for identification and referral to services, in case, when MUAC measurement indicate loss of body mass ▪ Apprising mothers of child's growth status and deciding appropriateness of education session on young child feeding, dietary diversity, etc. ▪ Encouraging mothers to keep up with good practice and support other mothers, young adolescents to regularly screen all children in the neighbourhood

4. Monitoring effectiveness:
The number of cases referred by mothers and if the identification is correct is monitored to ensure effectiveness of the training. What has worked well? Consistent engagement and periodic follow-up with mothers boosts their confidence and helps ritualise the practice of monitoring MUAC in the home environment. What challenges have been encountered? Initially there was some reservation from the community on measuring their child: they were concerned that MUAC measurement may harm the children or that it would lead to the child becoming weak as a result of an evil spirit. However, after observing recoveries of children who were identified by mothers and referred for treatment, the community was convinced of the benefits of monitoring MUAC.

Next steps:
The current project runs until 2019, although there are plans to extend it. The Action Against Hunger India team are planning to replicate this approach across their projects in other states.

The Case of Lehruni village

Foranti, our Community Mobiliser, is a young Sahariya girl who runs mothers' participatory learning groups in Lehruni village. In October 2015, in her regular screening drive, Foranti was shocked to find 6 children with SAM and 11 children with MAM. With continuous awareness programmes and innovative implementation of Mother-MUAC, Lehruni village, exactly two years after, has one child with SAM and one child with MAM. Foranti and mothers trained in her support group attribute this success to vigilante parenting a simple yet powerful tool like MUAC afforded. Mothers are able to diagnose acute malnutrition in children and seek appropriate treatment before the disease can cause further loss.