

# Introduction to MUAC and Oedema Screening

[🕒 20 min]



# Acknowledgements

- Myanmar Nutrition Cluster and AIM-TWG Online Resources
- ACF Myanmar SOP on Mass Screening
- FSNWG guidance on MUAC Screening
- SMART Methodology

# What is MUAC and Oedema Screening?

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## DEFINITION OF SCREENING:

Search to detect un-diagnosed cases of moderate and severe acute malnutrition in the community using MUAC (and edema).

## OBJECTIVE OF SCREENING:

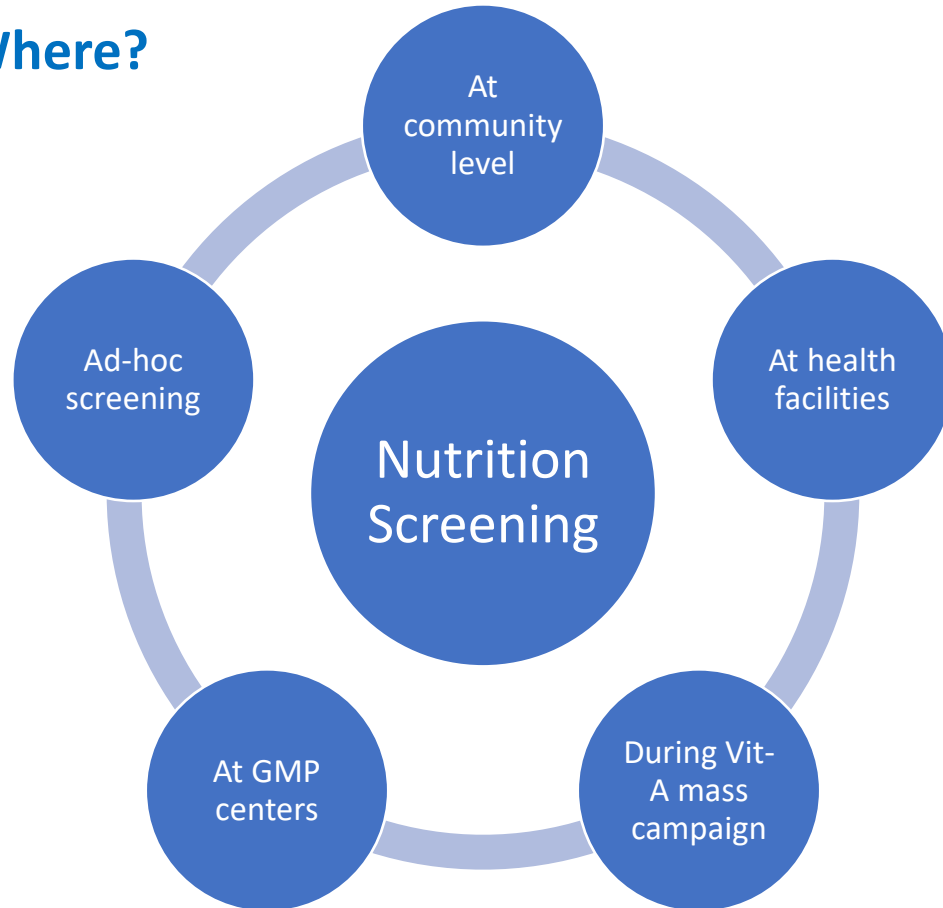
To identify undetected cases of acute malnutrition in the community and refer for treatment in order to improve program coverage.





# Where, what, when and by whom?

## Where?



## By Whom?

Usually the nutrition volunteers/ outreach workers, nutrition or health facility staff

## What screened?

MUAC and Oedema are the two most common measurements for children while only MUAC for PLWs

## When/ Frequency?

Most of the CMAM programme, GMP and HF screening happen monthly basis whereas Vit-A mass campaign or other ad-hoc screening happen quarterly/ bi-annually or annual basis

# Limitation of Screening Data

- ❑ **MUAC screening does not follow any particular methodology. It can be carried out:**
  - As part of child health days (e.g. Vit-A, Deworming campaign)
  - As part of routine services at health facility level (e.g. IMCI corner)
  - House-to-house as a community-based mass MUAC screening exercise for identification and referral of malnourished cases to OTP/TSFP centers
  - Mobilizing mothers / caretakers to bring their children to a central location for screening
- ❑ **There is no sampling methodology (to minimize bias) followed**
- ❑ **There is very limited training for MUAC measurement and no standardization testing of measurers**
- ❑ **There is often very limited to no supervision**

# Data cannot be used for estimation of prevalence or for calculating caseload **UNLESS:**

- ❑ **Screening data has been disaggregated by age (children above / below 2 years) and sex at collection. This is in order to control for the known age and sex bias of MUAC.**
- ❑ **Some information about the way the screening was carried out is provided:**
  - Some general information on the location and type of population screened (e.g. IDPs / Refugees / residents etc).
  - A brief description of the method used for the screening (house to house **exhaustive** / house to house with a skip pattern / screening at a fixed post, e.g. clinic or OTP / random or EPI sampling).
  - A brief description of the purpose of the screening (e.g. screening on arrival of IDPs or Refugees / as a part of child health days or immunization campaigns / dedicated acute malnutrition case- finding etc).
  - The estimated total population in the area screened is provided.

# Some technical points to understand and remember....

- 1) Screening at community vs facility level.
- 2) Usual community/ facility screening with skipping pattern vs the exhaustive screening of all the eligible children in a defined geographical area
- 3) Main objective of usual community screening (part of CMAM nutrition programme) is to detect and refer malnourished cases which also provide monthly/ quarterly trends of nutrition situation while nutrition survey is to identify the exact prevalence of malnutrition at a given point of time.
- 4) Monthly/ quarterly MUAC and Oedema screening can not replace the importance or need of population representative surveys (e.g. DHS, MICS, SMART etc.). Both are important and have different objectives.
- 5) Improving the quality of MUAC & Oedema measurement, skilled outreach staff/ volunteers, balance ratio of child age/ sex and a standardize data collection and reporting system can however increase the reliability and validity of proxy rates/ prevalence calculated from MUAC screening data.

# Key Messages

- 1) MUAC and Oedema screening is a valid program intervention to increase coverage of selective feeding programs and should continue as needed.
- 2) MUAC and Oedema screening data can only be used for program targeting, proxy GAM / proxy SAM estimation and/or caseload estimation if the mentioned quality criteria have been met.
- 3) If the results, meeting the criteria mentioned, are alarming then a survey (e.g. SMART,) should be considered.
- 4) If none exist, interventions should always be started to treat the children identified with acute malnutrition through screening. Survey results should not be awaited before treating children in need.
- 5) All children identified with acute malnutrition through screening should be referred for treatment (either for moderate or severe acute malnutrition) and followed up to ensure they are admitted.



Any Question?