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**Operational and Technical Guidance**

**On**

**Piloting the SMART MUAC Screening Assessment Tool in Myanmar**

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**December 2021**

**Pilot Implementing Partners:**

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# Abbreviations and Acronyms

ACF Action Contre la Faim | Action Against Hunger

AIM-TWG Assessment and Information Management Technical Working Group

BHS Basic Health Staff (health staffs of MOHS such as midwife, public health supervisor)

CDC Center for Disease Control and Prevention, USA

CHW Community health worker (also known as a volunteer)

COVID-19 Corona Virus Disease-2019

DHS Demography Health Survey

EPI Expanded Programme on Immunization

HF Health Facility

IMAM Integrated Management of Acute Malnutrition

INC Integrated Nutrition Center

IYCF Infant and young child feeding

MAM Moderate acute malnutrition

MEAL Monitoring, Evaluation, Accountability and Learning Department

MHAA Myanmar Health Assistant Association (NGO)

MHNT Mobile health and nutrition team

MN Micronutrients

MOHS Ministry of Health and Sport

MUAC Mid Upper Arm Circumference

OTP Out-patient Therapeutic Program

PLW Pregnant and Lactating Woman

RHC Rural Health Center

SAM Severe Acute Malnutrition

SFP Supplementary Feeding Program

SMART Standardized Monitoring and Assessment for Relief and Transitions

TFP Therapeutic Feeding Program

THD Township Health Department

UNICEF United National Children Organization

WHO World Health Organization

WHZ Weigh for Height-Z Score

WV World Vision

# Introduction and Background:

Data is quite scarce in Myanmar. The most recent national level Demographic and Health Survey (DHS) was conducted in 2015-16 and the National Micronutrient & Food Consumption survey was conducted in 2017-18. Since then, no population level surveys or assessments have been conducted in the country. Previously NGOs and the UN had supported and implemented different small scale nutrition surveys such as SMART, Barrier Analysis, IYCF KAP etc. at township and camp level but after 2016, there have been no SMART nutrition surveys conducted in Myanmar that can provide key nutrition information like GAM, MAM or SAM rates.

Humanitarian partners in Myanmar faced several challenges in conducting nutrition assessments due to sensitivities around population level surveys as well as the long and bureaucratic approval process from the respective government agencies. Even the 2020 national level planned Myanmar DHS survey has not yet been started which is considered the most important health and nutrition survey for country.

Due to lack of most recent and population representative assessment data in Myanmar, the Nutrition Cluster and other nutrition programme implementing partners (e.g. NGOs) are still basing their programme planning and implementation based on the old data and it’s projections. However, cluster and humanitarian partners are still collecting limited routine programme data like monthly children U5 MUAC/Oedema screening and the number of admission and discharges in OTP/TSFP wherever active IMAM nutrition programmes are ongoing. To capitalize this opportunity and further improve the quality of routine programme MUAC/ Oedema screening, the nutrition cluster is keen to pilot the CDC/SMART MUAC screening assessment tool in the selected locations of Myanmar with a few nutrition implementing partners.

The MUAC Screening Tool was initially developed under the guidance of CDC and then branded under The SMART Initiative. It was developed for the Tigray emergency response during August 2021 in Ethiopia to assist partners conducting active and passive screening amid the challenges of not being able to implement any population representative nutrition surveys. The SMART Initiative hosted by Action Against Hunger Canada later on expanded the scope of MUAC Screening Tool and start assisting partners in other similar contexts to improve the quality of community screening data as well as a better representation of nutrition situation monitored through routine IMAM programming.

The mass screening of targeted age groups of children between 6-59 months old and pregnant and lactating women is organized periodically, usually every month to every quarter. Mass screenings may be combined with the delivery of other health and nutrition interventions, such as vitamin A supplementation, deworming programmes, or the distribution of micronutrient powders for home fortification. Measurements are done in the households, either in small groups or by door-to-door visits. Due to the workload and operational complexity, case detection using MUAC and checking the presence of bilateral pitting oedema are common in the field, while other anthropometric measurements such as height and weight are not systematically collected.

# RATIONALE OF PILOTING:

Below here are some key rationales of piloting the SMART MUAC Screening tool-

* Conventional surveys and assessments that provide population representative and more reliable data are currently not possible to implement in Myanmar
* Active and passive nutrition screening (mostly MUAC and Oedema) are ongoing by nutrition partners implementing CMAM programme
* Heterogeneity exists among partners in terms of conducting screening that includes screening cycle, area coverage, children age groups, data collection and reporting methods etc. Hence, implementing a harmonized and standardize nutritional screening method and tool will improve the comparability of data as well as aggregation across the areas.
* Starting with a few selected partners for piloting will provide an opportunity to document key lessons learned and operational experiences through close monitoring and supervision. This will also allow further tailoring and contextualization of the global tool for a local context.
* Moreover, The SMART MUAC Screening tool will allow calculating proxy GAM, MAM and SAM rates in a more systematic and reliable way compared to current heterogenous practices.
* Global level technical support and backstopping are available to help partners build their capacity including advanced analysis of screening data in a systematic way that will inform further improvement and capacity building of the outreach staff and volunteers.
* Where the necessary level of quality is met, the screening data will provide a proxy indication of the wasting situation in the selected pilot areas that can be used by nutrition clusters, partners, donors and other stakeholders. Hence, this can contribute to annual HNO and HRP exercise for better targeting and planning.
* Good quality and representative monthly MUAC and Oedema screening data will serve as nutrition surveillance system with possible indication of seasonality and peak of malnutrition. This will help cluster and partners to effectively monitor the nutrition situation including necessary contingency planning and supply provision.

# Pilot location and timeline

Three organizations namely Action Against Hunger Myanmar, MHAA and World Vision Myanmar will be taking part in the pilot project starting from December 2021 while the actual screening process will start form 1st January 2022. Below here are the geographic locations by partners where the MUAC screening tool will be operationalize –

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **State** | **Region** | **Township** | **Village** | **Respective Partner** |
| NRS |  | Kyauktaw | 11 villages | ACF |
|  | Minbya | 14 villages |
|  | Mruak-U | 15 villages |
|  | RTD | 12 villages |
|  |  |  |  |  |
|  |  |  |  |  |

Timeline

The initial piloting of the CDC/SMART MUAC screening tool will be carried out over a period of four months. After all the preparatory work in December, actual data collection and reporting will be done from January to April 2022. After this four month of implementation with 3 selected partners, an evaluation and comparison will be carried out (towards May-June 2022) to see whether there are any improvements in the data as well as nutrition situation monitoring in the pilot location.

# Objectives

The primary purpose of MUAC screening is to find and refer the children (as well as PLWs) eligible for nutrition treatment. The secondary purpose is to use screening data to better understand nutrition situation in the area.

Specific Objectives are:

**SO1:** To detect early cases of acute malnutrition and to refer for early treatment, and therefore diminish the potential negative consequences of undernutrition

**SO2:** To know better the undernutrition situation (e.g. proxy GAM rate) in the program coverage area and adapt our program and advocacy axes accordingly

**SO3**: To increase awareness of the population in communities with regards to undernutrition and available services

# Key definitions

## Acute undernutrition

Acute undernutrition is a form of malnutrition caused by an inadequate food intake (quantity, quality and utilization) and/or illness that results in sudden weight loss or oedema (fluid retention), coupled with other underlying and primary causes.

Acute undernutrition is classified into Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) according to the presence or absence of bilateral pitting oedema, Mid Upper Arm Circumference (MUAC) thresholds and Weight for Height Z Score. See Table below.

|  |  |  |
| --- | --- | --- |
| **Indicators** | **Moderate acute malnutrition** | **Severe acute malnutrition** |
| Bilateral pitting oedema | Absent | Present |
| Mid Upper Arm Circumference (MUAC) for children 6 to 59 months old | ≥ 115 and < 125 mm | < 115 mm |
| Weight for Height-Z score/Weight for Length (W/H) for children under five | ≥-3 Z score and <-2 Z score | < -3 Z score |
| Mid Upper Arm Circumference (MUAC) for PLW | <210 mm |  |

\* MUAC cut-off point for PLW is according to Myanmar IMAM guidelines.

## Targeted Supplementary Feeding Programme

The children with Moderate Acute Malnutrition are provided with Ready to Use Supplementary Food (RUSF) or Fortified Blended Food (FBF) until their MUAC reach 125 mm and above. This service is provided in the community by NGO run Integrated Nutrition Centers (INC), Basic Health Staff (BHS) as Fixed site service delivery in villages with Rural Health Centre (RHC)/Sub RHC and as Outreach service delivery in villages where there is no health centre. Every 2 weeks, follow up is required until the admitted cases reach criteria for discharge as ‘cured’.

## Out-patient therapeutic Programme

The children with Severe Acute Malnutrition are treated with Ready to Use Therapeutic Food (RUTF) if they do not have complications until their MUAC is equal to or less than 115 mm. This service is delivered as a Fixed-site service or Outreach service as mentioned above and may be delivered in the hospital as the Recovery Phase of the Inpatient Treatment Programme for complicated cases. Weekly follow up is required until the admitted cases reach criteria for discharge as ‘cured’.

## In-patient Treatment Programme

Severe Acute Malnutrition patients with a MUAC <115mm measurement, usually require in-patient care and often have a poor appetite. Also, with a combination of medical complications such as diarrhoea, dehydration, sepsis, pneumonia, severe anaemia, etc. Thus, the patients will often require treatment of both the complication and their routine dietary and medicine section. The management of the complications takes precedence over routine care and may change how the routine care is given; the two sections should be read in conjunction with each other.

## COVID-19

In the current pandemic context, acknowledging critical definitions related to COVID-19 is of importance. Fieldwork will be adapted to all measures put in place to limit the spread of the COVID-19 virus. Therefore, NGOs will have to adapt its mass screening methodology accordingly. (Source: WHO COVID-19: Case Definitions)

COVID-19 Confirmed cases

* A person with a positive Nucleic Acid Amplification Test (NAAT)
* A person with a positive SARS-CoV-2 Antigen-RDT AND meeting either the probable case definition or suspect criteria A or B
* An asymptomatic person with a positive SARS-CoV-2 Antigen-RDT who is a contact of a probable or confirmed case

COVID-19 Suspected cases

* A person who meets the clinical criteria

Clinical Criteria: Acute onset of fever AND cough; OR Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue1, headache, myalgia, sore throat, coryza, dyspnoea, anorexia/nausea/vomiting1, diarrhoea, altered mental status

* A patient with severe acute respiratory illness: (SARI: acute respiratory infection with history of fever or measured fever of ≥ 38 C°; and cough; with onset within the last 10 days; and requires hospitalization).
* A person who meets the clinical AND epidemiological criteria: Asymptomatic person not meeting epidemiologic criteria with a positive SARS-CoV-2 Antigen-RDT

COVID-19 Contact Cases

A COVID-19 contact case is any person who has contact with a positive COVID-19 patient within a timeframe of 48 hours before the onset of symptoms and 14 days after the onset of symptoms. ⇒ If the index case has no symptoms, a contact person is defined as someone who had contact with the patient within a timeframe ranging from 48 hours before the sample was collected, which led to confirmation to 14 days after the sample was taken.

## Screening for acute undernutrition among Children 6-59 months and PLW

The aim is to detect children U5 and PLW with acute undernutrition at the health facility and community levels. Medical and paramedical staff living under the coverage of the health post and the CHW should do this screening systematically for all children 6-59 months and PLWs visiting the health facilities. Screening is done using MUAC tape and checking for bilateral pitting oedema for children and PLWs by using MUAC. (Reference: Standard Operational Procedure Guideline for Nutrition in BPHS & EPHS). WHZ is also checked at INC/HF level. Screening can be done either:

* Passively, for all newcomers visiting a health structure
* Actively, at the community level

It is to be noted that, for the MUAC pilot in selected locations – active screening data will mainly be collected.

## Mass screening

This term is used to indicate the large-scale screening of targeted population groups. It refers to an inclusive screening conducted to all children between 6-59 months old and pregnant and lactating women from IDP camps and villages. (Reference: Principles and Practice of Screening for Disease, WHO)

## Mid Upper Arm Circumference (MUAC)

The mid-upper arm circumference measurement measures both the fat and the lean muscle mass of the upper arm. MUAC is considered a standalone indicator for acute undernutrition among children 6-59 months old and PLW. Therefore, besides screening, MUAC is also used for both admissions and discharge criteria for undernutrition treatment, both for MAM and SAM.

## Oedema

This refers to swelling caused by fluid accumulation in any body part, often accompanied by inflammation, most easily seen around the ankles (peripheral oedema). Nutritional oedema should be pitting (with shallow print), bilateral, and start from the feet, going progressively to the upper level as ankles and legs. For severe cases, oedema can be present in the whole body. Oedematous malnutrition is always an indication of severe acute malnutrition and corresponds to Kwashiorkor cases (although not so common in Myanmar).

# Taking anthropometric measurements

## Age determination

Accurate child age information is essential for measuring sessions. The age determinations can be determined using legal documents like birth certificates or Extended Programme of Immunization (EPI) cards. However, in the absence of a birth certificate, EPI card or any legal document, it is essential that the parents' memory, explanation of circumstances of childbirth, and developmental milestones can be accounted for as supportive information. Therefore, the CHW and Outreach workers will estimate the age in months for all children screened. In addition, the age of PLW will also be estimated and recorded as needed in years.

## Sex determination

The information of children sex is also essential for gender analysis. The measurer must note male or female under the sex column of children. The boys can be denoted as "m", and girl children can be denoted as "f" to ensure the sex variable is collected during the MUAC screening.

## Measuring MUAC

Here are the different steps to correctly take MUAC measurement:

1. MUAC is always measured on the left arm for children from 6-59 months of age. First, have the child bend his/her arm at a 90-degree angle. Next, find the top of the shoulder and the tip of the elbow. Next, hold one end of a piece of string at the top of the shoulder and hold the string where it meets the tip of the elbow (endpoint).
2. MUAC for PLW is measured using non-stretchable adult MUAC tape on the participants' relaxed left arms by searching mid-points between olecranon and acromion. The MUAC tape is longer than the ones used for children and has different colour coding for undernutrition classification.
3. Locate the tip of the shoulder and elbow. Mark the midpoint with a pen, then use the small string as well. If there is no string available, carefully use the MUAC tape. With the child’s arm relaxed and falling alongside his/her body, wrap the MUAC tape around the arm at the midpoint. There should not be any space between the skin and tape, but do not wrap the tape too tight. Slide the end of the tape through the small opening.
4. Read the measurement from the middle window exactly where two arrows point inward. For numbered tapes, the measurement should be recorded with a precision of 1 millimeter (mm). For three-color tapes (red, yellow, green), record the color that shows through the window at the point the two arrows indicate.



**Video on MUAC Measurement:** <https://drive.google.com/drive/folders/1FI4PmyB5tqUhq6uPaDoOHHdg0Az8zNvU>

## Checking Oedema

A picture containing person, indoor

Description automatically generatedBilateral pitting oedema is the sign of Kwashiorkor. Kwashiorkor is always a severe form of acute undernutrition. Children with bilateral oedema are directly identified to be acutely undernourished. These children are at high risk of mortality and need to be promptly treated in a therapeutic feeding program, under ambulatory treatment, or in-patient care for complicated cases.

In order to determine the presence of Oedema, normal thumb pressure is applied to both feet for three seconds. If a shallow print persists on both feet, then the child presents oedema. Only children with bilateral pitting oedema are recorded as having nutritional oedema. Nutritional oedemas are classified as follows:

|  |  |
| --- | --- |
| **Grade** | **Definition** |
| + | Mild: both feet/ankles |
| ++ | Moderate: both feet, plus a lower leg, hands or lower arms |
| +++ | Severe: generalised oedema including feet, legs, hands, arms and face |

# Instructions for data collection and reporting in SMART MUAC screenings TOOL

Please follow these simple instructions. If you do not follow these instructions and do not use included data collection and analysis tools in the attached Excel file your data **cannot** be used for the secondary objective.

## Data collection:

Use tally sheet included on the **2. Tally Sheet** tab of the Excel file.

Note, in this tally sheet - you do not need to establish the exact age of the child, only establish whether (1) the child is in the eligible age range (e.g., 6-59 months), and (2) whether the child is above or below 2 years of age. However during the piloting phase, this simplified tally sheet will be not be used.

Graphical user interface, application, table, Excel

Description automatically generated

**Optional**: Instead of **2. Tally Sheet** you will use **4. Tally sheet 2 Optional** for the pilot project

Using tally sheet 4 will be a bit complex, since it requires recording exact MUAC measurement of each child, and then entering these data into Excel using the same **4. Tally sheet 2 Optional** page

Graphical user interface, application, table, Excel

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However, using the **4. Tally sheet 2 Optional** is highly recommended, since recording MUAC measurements for each child allows for much more advanced analysis of data quality and increases confidence when using these data for decision making.

Using this option is especially useful if doing exhaustive door-to-door outreach screenings

If you are doing MUAC screening of pregnant and lactating women, use **5. Tally sheet PLW** sheet in attached Excel file for data collection in the field.

Graphical user interface, table, Excel

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## Data reporting:

For reporting you will only use attached excel file

1. First, fill out carefully all fields on the **1. Title Page**. Note, your report will not be accepted unless **1. Title Page** is filled out

Graphical user interface, application

Description automatically generated

1. If you used **2. Tally Sheet** for data collection in the field (not applicable for pilot project), enter the tallied numbers from your sheets into the table on page **3. Results** of the attached Excel file. Follow instructions provided under the table, they are very simple and self-explanatory. Stop here, you are ready to send your report.
2. If you used **4. Tally sheet 2 Optional** for data collection in the field, first enter the data from your tally sheets into Excel file attached, page **4. Tally sheet 2 Optional.** After entering the data, tally the numbers of children and enter them in the table on page **3. Results.** Stop here, now you are ready to send your report.

Graphical user interface, application, table, Excel

Description automatically generated

## Data interpretation

Interpretation of data collected in MUAC screenings is a very complex process, and depends on many factors – the setting, sample size, quality of data, representativeness by age and sex, coherence with other available data, etc. It will be conducted by nutrition technical staff at higher levels.

If you are doing MUAC screening of pregnant and lactating women, use **5. Tally sheet PLW** in attached Excel file for data collection in the field.

For reporting, you still must fill out **1. Title Page** information in full. Then report the number of PLW in two categories – below 230 mm and above or at 230 mm, that’s all.

# Data Management System from Mass Screening

According to IMAM guidelines, the Nutrition Surveillance Manager will create the data reporting system with the help of the MEAL Manager. The data reporting will be based on the KOBO data collection system. Respective Program Managers should verify the data from KOBO System with the support of the MEAL team and Surveillance Manager. For the process of data interpretation and reporting, the Surveillance Manager will be responsible. Organizations who do not use KOBO or other digital data collection platform, they can continue with usual paper based method.

## Internal data flow

Roles and responsibilities

|  |  |  |
| --- | --- | --- |
|  | **What** | **Who** |
| **Data collection** | CHW/ volunteers in each village collect information from beneficiaries and recording them in a safely stored paper form | Beneficiaries  CHW/ Volunteer |
| **Activity reporting on Kobo/ Excel DB** | At the end of each day, Team leaders collect information on activities from CHWs/ Volunteer to fill Kobo reporting form. Organizations that don’t use Kobo can enter data in an excel database | CHW/ Volunteer  Team leaders |
| **Case management on Kobo/ Excel DB** | Once the mass screening event is completed, the screening tally paper form is checked and sent to the nearest IP Office, where it is kept and computerized in Kobo (or in excel database) by a Data Entry Organizer. | CHW/ Volunteer  Checked by Team leaders  Data Entry Organiser |
| **Data cleaning** | Regularly all databases must be checked following the agreed database quality procedure. A list of checks to run regularly will be proposed by Programme and Surveillance Managers. | Checked Data Entry Organiser  MEAL Officer  Programme and Surveillance Managers |
| **Data analysis and verification** | After data cleaning is completed, the MEAL Officer sends to the Program Manager with Nutrition & Health HoD, MEAL HoD, MEAL Manager and Surveillance Manager (in copy). They can also access the Kobo server for data analysis and verification, including monitoring. | MEAL officer  Programme Manager  MEAL Manager  Nutrition Surveillance Manager  Nutrition & Health HOD, MEAL HoD, |
| **Sharing report with Cluster** | The final data and reports (in the excel result sheet) will be shared with nutrition cluster, AIM-TWG on a monthly basis | MEAL Manager  Nutrition Surveillance Manager  Nutrition & Health HOD, MEAL HoD, |

Data flow

Diagram

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Analysis of MUAC and Oedema Data in ENA for SMART Software

After data cleaning and verification, raw MUAC and Oedema data together with other variables (e.g. Age, Sex, location etc.) will be entered in the ENA for SMART software. The software will provide some advance automated analysis through the Plausibility check option. Each partner and respective area programme manager will be given feedback based on the plausibility check data quality analysis.

It is to be noted that, ENA for SMART provides plausibility check on 10 tests and among them 7 are based on the WHZ indicators (including weight and height variables). Hence, the analysis just based on MUAC data needs to be carefully scrutinized and should not be judged based on the overall score.

# Referral system of undernourished cases identified during the mass Screening

CHWs perform several activities at the community level, so case finding for undernutrition in the community should be integrated with these other community activities. As part of the community activities, the community health workers will periodically implement the mass screening based on the local authorities' conflict sensitivity and COVID-19 restrictions.

Screening with weight for height is a feasible option at the community level, most often through gathering (while it is more complex to organize it for door-to-door screening). However, it is important also to assess children aged less than 6 months for signs of oedema, visible severe wasting or where the carer reports the child is not well breastfed. Any children who show any of the following danger signs and symptoms should be referred immediately to the hospital. Signs requiring medical check can be as follow (not exhaustive list): diarrhoea and dehydration, hypothermia, hyperthermia, open skin lesions, severe vomiting, pneumonia, anaemia, convulsion, clinical vitamin A deficiency.

For complicated cases in screening areas, the CHWs must report immediately to the mass screening team leader. The team leader will coordinate with the CHW to refer to the nearest INC or government health facilities with a referral card. In the INC or health facilities, the doctor or nurse will check the complicated diseases and refer them to the hospital accordingly. For the referral cases, NGO will support the facilitation cost for hospitalization.

The CHW or screening team uses a referral card to identify the child in the community and the case registered in the screening book. When the referred cases go to health facilities/INC, the staff in centres keep the referral cards and register the referred cases. Admission of the referred case will be confirmed only after measurements at the health facility or INC levels of all anthropometric measurements and according to the IMAM admission criteria.

Then, NGO nutrition staff (assigned as screen team) will coordinate with CHWs and the Basic Health Staff (BHS) of Township Health Department to conduct a monthly meeting in government health facilities. The CHWs or screen teams will check with health facilities or INC teams to see if any cases did not attend after referral and how many cases came to the health facility or INC after referral but were not admitted after checking the anthropometric criteria. This will provide the rejection rate.

For the cases that do not attend after referral, the respective CHWs will follow up on these cases to know the reasons. Thus, the CHWs will report the detail of these cases to NGO staff (TFP or SFP agents in mass screening team) or BHS for better service or support.

## Referral Monitoring data flow

Roles and responsibilities

|  |  |  |
| --- | --- | --- |
|  | **What** | **Who** |
| **Data collection** | CHW/ volunteer in each village is taking information of beneficiaries in need to be referred to nearest INC/HF, in referral card and fill in screening book and mass screening report template | Beneficiaries  CHW/ Volunteer |
| **Activity reporting on Kobo** | At the end of each day, Team leaders collect information on activities from CHWs/ volunteer to fill Kobo reporting form. Otherwise in excel form | CHW/ Volunteer  Team leaders |
| **Ground Data checking** | CHW or mass screening team will check the referral data with teams in INC or HF in a monthly meeting in INC or HF, and if the referred beneficiary by CHW is not in data of INC/HF, CHW will follow-up this beneficiary for reason | CHWs/ Volunteer  Team Leader  TFP or SFP agents  Staff in INC or HF |
| **Data entry on EPI Info/Excel** | Once the mass screening event is completed, the paper from CHW's screening report template (referral data included) is checked by the Team Leaders and sent to the nearest NGO Office, where a Data Entry Organizer keeps it. | CHW/ Volunteer  Checked by Team leaders  Data Entry Organiser |
| **Data cleaning** | Regularly all databases must be checked following the NGO database quality procedure. A list of checks to run regularly will be proposed by Programme and Surveillance Managers. | Checked Data Entry Organiser  MEAL Officer |
| **Data analysis and verification** | After data cleaning is completed, the MEAL Officer sends to the Program Manager with Nutrition & Health HoD, MEAL HoD, MEAL Manager and Surveillance Manager (in copy). They can also access the KOBO server for data analysis and verification, including monitoring. | MEAL officer  Programme Manager  MEAL Manager  Nutrition Surveillance manager  Nutrition & Health, MEAL HoD |

# Principal Consideration to prevent Covid-19

## Before launching the Mass Screening

Review the epidemiological situation of COVID-19 in the local administrative region, if feasible, during the last 4 weeks. Specifically, the following points should be considered.

* The current incidence of COVID-19 in the screening areas;
* Worsening trends in incidence of COVID-19 in the screening areas;
* Percentage of positive cases among those tested in the screening areas;

The epidemiological situation of COVID-19 should be reviewed in consultation with the State Health Director or Township Medical Officer from the Ministry of Health and Sport. Implementation of mass screening can likely be justified in contexts where there are no clusters of cases of COVID-19. Areas where no cases or sporadic cases are reported could be considered regarding actual needs and feasibility to ensure the safety of the staff and the population we serve.

* Consider and review national and regional guidance and/or guidelines regarding mass screening and data collection at the household level during the COVID-19 epidemic.
* Consider existing national guidelines regarding restrictions on movements within and between the communities that may impact the feasibility of the teams reaching screening sites.
* Consider the availability of qualified staff or CHW to conduct the screening when deciding to start the mass screening.
* In the case of unavailable locally trained CHW, plans should be put in place for remote technical support from a qualified team leader or staff.
* If a team member develops symptoms consistent with the local suspect case of COVID-19, the supervisors should withdraw the entire team from the field until it can be confirmed that all team members are negative for COVID-19 or they can be replaced them with another team.
* Consider the availability of personal protective equipment and supplies to ensure appropriate infection prevention and control as outlined in this guidance and whether the local supply is sufficient for the survey without diverting from health facilities.

## By Staff and CHW/ Volunteer during Mass Screening

The CHW or outreach volunteers should be provided with at least three masks per day to be changed after lunch and whenever damaged or soiled.

* Hand washing points or personal handwashing gel must be provided. The CHW will make sure to sanitize their hands between each beneficiary by using soap and water or an alcohol-based hand sanitizer with at least 60% alcohol. If surgical gloves are used during anthropometric measurements, the new gloves are replaced between each household.
* The beneficiaries and caretakers must be limited in screening points and respecting the social distance between beneficiaries, and not more than 30 people will stay at the same time in one screening point (According to MoHS guidance at the State level).
* Temperature screening must be at the entrance of screening points with an infrared thermometer and provide a surgical mask to the beneficiaries coming without masks. Exclude and refer those with signs and symptoms related to COVID-19 to the nearest health centres.
* Any person who will be measured/screened, and any other household or community members will practice physical distancing and avoid unnecessary gathering
* NGO staff, CHW and beneficiaries must follow social distancing at 2 meters (6 ft) between each other in an inevitable gathering session.
* Measurement should be done outside in an open shaded area, with enough space for proper social distancing while still respecting a person's privacy whenever possible. The largest ventilated room should be used if the outside setting is unavailable or if the weather is not good enough to perform this work outside.

# Human resources

## Personnel in charge

The NGO’s nutrition field teams (working in the INC), the community health workers and trained outreach volunteers in the Emergency Program and Development Program will conduct the mass screening campaign periodically with the technical support of the Access to Health Program.

The Nutrition Surveillance Manager and MEAL team will check the quality of data from mass screening. They will also verify, combine and interpret data to report to the Health and Nutrition Head of Department.

The health and nutrition Head of the Department will finalize the report, and he/she will act as a focal point for data sharing to external stakeholders if there is any request.

The SMART Regional advisor will oversee the process and validate any mass screening report, especially before external dissemination.

## Recruitment and Capacity Building

The respective health and nutrition program managers will determine the need for human resources such as staff or community health workers in the proposed intervention areas.

The Technical Managers and Officers of the Access to Health Program will train the newcomers who need the mass screening methodology. The training topics should focus on IMAM guidelines for community mobilization, active case finding, anthropometric measurements and reporting templates. In addition, the following topics will also be tackled: types of acute malnutrition and diagnosis; techniques for measurements; techniques to involve CHW; Technique for door to door or gathering; Techniques to report and analyze the data; Referral system for identified undernourished cases, where info about IMAM should be provided.

The training will be taken for three days, including the practical session for anthropometric measurements. In addition, the daily recap or pre-test/post-test and action planning will be conducted to evaluate the participants' knowledge. The training materials will be composed of PowerPoint presentations, hand-outs, and practical sessions.

## Management of community health workers and outreach Volunteers

The nutrition team leaders will coordinate with the respective essential health staff (BHS) of the Township Health Department (THD) to recruit CHW. The THD trains the recruited CHWs/ Volunteers for the remote villages with no health facilities and will be selected as implementing partners.

The mass screening will be conducted quarterly, and the NGO team will support the CHWs/ Volunteer with Per Diem and Transportation allowances as needed daily in the period of the mass screening. The payment amount is not fixed, and it will depend on actual costs and financial feasibility (as per allocated grant for conducting such activities).

Monitoring and Supervision will be carried out by the team leads and TFP or SFP agents in an assigned mass screening team.

To note that CHW are also known as volunteers because the MOHS of Myanmar trained the CHW (community health workers) in most remote villages, and the organizations are not allowed to recruit volunteers, but they can use the available CHWs.

## ConductiNG mass screening campaign at field level

The teams selected the targeted villages based on the Program coverage area and must include camps and remote villages, part of the program coverage area. Screening would involve both door-to-door and small gatherings. MUAC mass screening would be conducted by door-to-door visit, while the Weight for Height/Length screening would be done in small gatherings organised by the support of village leaders. In addition, oedema checks will be done on all sites.

The team leader is responsible for coordinating and involving all village leaders or authorities in the mass screening event, keeping them abreast of relevant information.

Approval from the State Coordinator is required to conduct mass screening. The Liason Manager will support getting approval by adding this mass screening activity in the regular monthly application of Travel Authorization on a quarterly basis.

# Logistic and Financial Flow

The health and nutrition Head of Department or Program Managers will purchase the required items such as MUAC tapes and PPE items (to prevent the transmission of COVID 19). For this flow, the Logistic and Finance Departments will support.

The program manager or respective team leader will send the transportation plan to the Logistics department once per week before mass screening. Then, the Logistics department will arrange the cars or motorbikes accordingly for NGO staff to participate and monitor the fieldwork. If there is a shortage of cars or any other challenges, the Program Manager should report to the Field Coordinator for better coordination or support.

The Program Manager will purchase the necessary anthropometric supplies with the coordination team and the Logistics department's support. During the mass screening, the field teams will carry the measuring scales and boards with the cars to respective villages. If the field teams go with motorbikes, the Program Manager will send these items by car after coordination with the Logistic Department. After the event, the teams will keep the items back in office stores or warehouses.

The team leader has to prepare all stationeries and reporting forms at least one week before the event for the stationaries and reporting forms. For the CHW, the team leader will provide the necessary items during the meeting or supervision/monitoring visit.

# Annexes

ANNEXE 1 – Referral/Transfer Card

