A New Approach to Optimizing Family MUAC in Mali

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We have a question for you

Do you feel you have sufficient evidence that Family MUAC is the best option to include in your program design for screening or early detection?
Our assumption is that Family MUAC will lead to:

- identification of more children with SAM
- earlier identification of SAM cases
- earlier entry of children into treatment
But has not met expectations in reality...

In Mali, ¼ mothers who’d been trained reported never screening their child, many more only used the tape only once.
We applied a user-centered design and behavioural science lens to understand the problem and arrive at possible solutions.
Caregiver Journey: Our target behaviors

**STEP 1**
Attend the training & get tape

**STEP 2**
Understand the training

**STEP 3**
Store tape safe, accessible place

**STEP 4**
Use tape correctly, every month

**STEP 5**
Read tape measurement correctly

**STEP 6**
Take timely action based on measurement (repeat monthly)
Why are families not completing each step?

Behavioral Barriers

**STEP 1**
Attend the training & get tape

**STEP 2**
Understand the training

**STEP 3**
Store tape safe, accessible place

**STEP 4**
Use tape correctly, every month

**STEP 5**
Read tape measurement correctly

**STEP 6**
Take timely action based on measurement (repeat monthly)

Insecurity and lack of access
Lacking decision making power
Information too complex
Literacy and language barriers
Store it somewhere too safe (not seen)
Lend it to others, lose it
Forget to use
Discouraged from past bad experiences
Never got to practice in the training
Long distance

Women are negligent of children

Lack of refresher training!
Validating assumptions and understanding clients’ preferences
What women said....

I have too many chores. I take care of the home, the children. I have too much to do.
What we learned the barriers are

**Stigma** of having a malnourished child.

Screen children correctly at least once per month, every month

“forgetting” → cognitive overload, too many things to do

Women don’t feel their efforts are seen or acknowledged by others for screening (but expectations high for other duties)

Consequences of action are uncertain, unmet expectations
Women ranked options and told us what characteristics informed their choices.
What we heard from testing

Women are interested in playing a supporting role in screening as "reminder".

Women would like to be acknowledged for efforts.

Women are part of tontines (saving groups) & leaders are interested in supporting.

Screen children correctly at least once per month, every month.

Women would like to be reminded: “Can IRC just come every month?”
Which is why we’re currently prototyping as a package...

- Screenings as a group during tontine
- Behaviorally informed training videos, delivered by tontine leaders
- Testimonials from local women like them who have overcome barriers to screening
- In-home visual reminder
- Engaging men in a “reminderer” role
- Engaging imams to support men
Dr Diarra, you used a lot of interactive activities to understand what clients and CHV value and want. How did clients react to these activities?

As a qualitative researcher, what was useful about the overall approach we used? What was difficult for you?
What we would like to test next

**Short term**
- Can we improve the design of the tape itself to encourage its uptake and use?
- How can we address feelings of discouragement (occurring at clinic level)?

**Longer term**
- Does this approach work better than standard Family MUAC? For what cost?
- Does it work better than other solutions, such as Community-Health Volunteer led screening or clinic-based screening?