Program Packages for Frontline Nutrition Services

How to Choose Them and How to Use Them

July 23, 2020

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Introduction to the Program Package Review
Introduction to the Program Package Review
Introduction to the Program
Package Review

Essential Nutrition Actions and Essential Hygiene Actions

Training Guide: Health Workers and Nutrition Managers
April 2015
Introduction to the Program
Package Review
Introduction to the Program Package Review
Introduction to the Program Package Review
# Packages and Systems Building Blocks

Dark blue = covered, Light blue = covered but with limited explanation, Clear/white = not covered/mentioned

<table>
<thead>
<tr>
<th>Building Blocks</th>
<th>C-IYCF</th>
<th>ENA</th>
<th>CMAM</th>
<th>NACS</th>
<th>IMCI</th>
<th>CNCC</th>
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<td>Service delivery</td>
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<td>Equipment and supplies</td>
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<td>Financing</td>
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<td>Leadership and governance</td>
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</table>
Trainees are Taught to Promote

Dark blue = covered, Light blue = covered but with limited explanation, Clear/white = not covered/mentioned

<table>
<thead>
<tr>
<th>Practices</th>
<th>C-IYCF</th>
<th>ENA</th>
<th>CMAM</th>
<th>NACS</th>
<th>IMCI</th>
<th>CNCC</th>
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<tr>
<td>Breastfeeding practices</td>
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<td>Complementary feeding practices</td>
<td></td>
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<tr>
<td>Health care and supplementation for infants and young children</td>
<td></td>
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<tr>
<td>Practices for the social, emotional, and cognitive development of infants and young children</td>
<td></td>
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<tr>
<td>Practices for a healthy environment</td>
<td></td>
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</table>
USAID Advancing Nutrition is the Agency's flagship multi-sectoral nutrition project, addressing the root causes of malnutrition to save lives and enhance long-term health and development.

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Uganda Experiences in Adapting and Implementing Nutrition Program Packages

USAID ADVANCING NUTRITION WEBINAR

23RD JULY 2020
EZEKIEL MUPERE MBChB, MMed, MS., PhD
1. Background

2. Overview Addressing Malnutrition in Uganda under Uganda Nutrition Action Plan

3. Addressing Acute Malnutrition Packages in Uganda
Background

• Malnutrition is a major public health problem in Uganda with huge burden and poor outcomes in children <5 years
• Alarming high absolute numbers of stunted children ~2 million because of high population growth rate
• 4% of children <5 have acute malnutrition (combines moderate (MAM) and severe (SAM) acute malnutrition)
• Mortality in children with SAM ranges from 10% to 22% because of access, coverage, quality of care, and other issues
• Anaemia prevalence of 51%
Addressing Malnutrition in Uganda

- Uganda Government recognizes the important role of nutrition in the health of children and other age groups:
  - Food security and nutrition included in constitution, 1995
  - Food and Nutrition Policy recognizes food for all as a human right – FANTA 2010
  - Signatory to the Millennium Declaration to alleviate immediate, underlying and basic causes of malnutrition
  - Uganda joined the Scaling Up Nutrition (SUN) movement (2011), to promote a multi-sectoral approach

- Recognize optimal nutrition is closely intertwined with health, agriculture, gender, education, and other sectors, and is essential to the country’s social and economic development
  - Roll-out of the Uganda Nutrition Action Plan 2011–2016 (UNAP I) - specific and sensitive interventions
### UNAP I – 2011 – 2016/18 Achievements

**Scaling up Nutrition in Uganda from 2011-2016 and beyond**

**Goal was to reduce malnutrition among women of reproductive age, infants and young children**

<table>
<thead>
<tr>
<th>Outcome indicator</th>
<th>Baseline UNAP target 2016</th>
<th>Baseline in 2011</th>
<th>UNAP I target 2016</th>
<th>UDHS 2016</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stunting: prevalence in children &lt;5, %</td>
<td>38</td>
<td>32</td>
<td>29</td>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td>2. Underweight: prevalence in children &lt;5, %</td>
<td>16</td>
<td>10</td>
<td>10.5</td>
<td></td>
<td>Not achieved</td>
</tr>
<tr>
<td>3. Underweight non-pregnant women 15–49 years old with BMI less than 18.5 kg/m², %</td>
<td>12</td>
<td>8</td>
<td>7.2</td>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td>4. Iron-deficiency anaemia: prevalence in &lt;5s, %</td>
<td>73</td>
<td>50</td>
<td>53</td>
<td></td>
<td>Not achieved</td>
</tr>
<tr>
<td>5. Iron-deficiency anaemia: prevalence in women 15–49 years old,</td>
<td>49</td>
<td>30</td>
<td>31.7</td>
<td></td>
<td>Not achieved</td>
</tr>
<tr>
<td>6. Vitamin A deficiency: prevalence in &lt;5s, %</td>
<td>33</td>
<td>13</td>
<td>9</td>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td>7. Vitamin A deficiency: prevalence in women 15–49 years old,</td>
<td>20</td>
<td>12</td>
<td></td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>8. Low birth weight: new borns weighing less than 2.5 kg, %</td>
<td>13</td>
<td>9</td>
<td>9.6</td>
<td></td>
<td>Not achieved</td>
</tr>
<tr>
<td>9. Infants aged under 6 months who were exclusively breastfed:</td>
<td>60</td>
<td>75</td>
<td>66</td>
<td></td>
<td>Not achieved</td>
</tr>
<tr>
<td>10. Dietary diversification index: % age of calories consumed from foods other than cereals and starchy roots</td>
<td>57</td>
<td>75</td>
<td></td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>11. Calorie consumption: average daily energy intake per capita, kcal</td>
<td>2,220</td>
<td>2,500</td>
<td>1,883</td>
<td></td>
<td>Not achieved</td>
</tr>
</tbody>
</table>
Addressing Acute Malnutrition in Uganda

• Attention was critical in 2003/04 to address high burden in Northern Uganda with support of UNICEF and Valid International – using a community therapeutic approach

• Two key nutrition services integrated within the Uganda health system
  ➢ Integrated management of acute malnutrition (IMAM)
  ➢ Nutrition assessment, counselling, and support (NACS)

• Both IMAM-NACS interventions seek to:
  ➢ Detect, treat, and prevent acute malnutrition in children, adolescents and adults, and inclusive of people living with HIV/AIDS (PLHIV)
  ➢ Utilize similar health service delivery points, health staff, and supplies

• Protocols and training packages for IMAM-NACS approaches have been in existence since 2010 and have undergone a series of revisions to address the management of acute malnutrition among all populations

• Process of integration, coverage and sustainability have been donor dependent
  ➢ Guideline and policy development well support at national level
  ➢ Coverage, scale-up and sustainability limited to vulnerable regions – refugee host districts/regions and regions with high burden
  ➢ In-service capacity building, commodity and logistics supplies has varied from district to district and by regions and dependent
IMAM and NACS Interventions

- Guidelines have four main program components:
  - Inpatient therapeutic care (ITC) and outpatient therapeutic care (OTC) for the treatment of SAM,
  - Treatment of MAM with supplementary feeding programs (SFPs) and without, and
  - Community outreach
  - Community outreach component involves early detection of SAM clients at the community level to enable early referral and increase the number of SAM cases accessing quality treatment

- IMAM uses nutritional products to treat clients, including Formula 75 (F-75), Formula 100 (F-100), and ready-to-use therapeutic food (RUTF)

- NACS approach targets HIV clients detailed in IMAM Guidelines
  - HIV clients undergo a nutritional assessment and are provided with nutritional counselling tailored to the outcome of their assessment
  - Clients are also provided with nutritional support, typically in the form of RUTF, to help stabilize and improve their nutritional condition

- Clients suffering from or who are at risk of food insecurity are linked with food security and livelihoods programs within their communities
IMAM / NACS Assessment: Leadership and governance

• Knowledge about IMAM/NACS at the national level was strong among actors engaged in nutrition activities

• Limited roll-out of behavioral change communication and advocacy to sub-national level where key decision makers in local government, the DHOs, and facilities can be targeted

• District-level leadership and governance for nutrition were strong in select districts with nutrition problems – Karamoja and supported by implementing partners

• Inconsistency of work-plan alignment to UNAP among ministries, implementing partners, DHOs, and facilities highlighting the gap between national-level coordination efforts and actual coordinated implementation at the district and facility levels

Source: FHI360 FANTA III 2014
IMAM and NACS Assessment: Workforce

- Uganda health system has limited human resources

- Systems for building and strengthening workforce competencies need strengthening

- Nutrition content including in pre-service curriculums for health workers needs to be updated

- In-service training need to be accompanied by strong mentorship, coaching, and support supervision

Table 7. DHO Staffing Levels

<table>
<thead>
<tr>
<th>District</th>
<th>Total Norms</th>
<th>Filled</th>
<th>Vacant</th>
<th>Excess</th>
<th>% Filled</th>
<th>% Vacant</th>
<th>% Excess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keabong</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>45.45%</td>
<td>54.55%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Masindi</td>
<td>11</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>72.73%</td>
<td>27.27%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Namutumba</td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>27.27%</td>
<td>72.73%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nebbi</td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>27.27%</td>
<td>72.73%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Source: Oguliei 2012.

Figure 14. Percent of Total Facilities That Received Mentoring on IMAM/NACS

Source: FHI360 FANTA III 2014
IMAM / NACS Assessment: Financing

• Resources for health programs are limited

• Nutrition actors need to accurately plan and advocate for a share of these limited resources

• Nutrition does not have its own budget line item anywhere in the health system but considered part of PHC budgets

• Guidance need to be provided to both national-level and district actors on how to plan and budget for nutrition

• Work planning for nutrition should be encouraged at all levels so that it can inform the planning and budgeting process

Source: FHI360 FANTA III 2014
IMAM / NACS Assessment: Information Systems

- MOH does not systematically analyze and disseminate information from IMAM/NACS reporting
- Timeliness of reporting and the use of reporting data was low

Table 14. Timeliness and Completeness of Reporting

<table>
<thead>
<tr>
<th>District</th>
<th>% monthly reports sent on time</th>
<th>% completeness of monthly reports</th>
<th>% completeness of facility reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaabong</td>
<td>51.9</td>
<td>83</td>
<td>96</td>
</tr>
<tr>
<td>Masindi</td>
<td>87.0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Namutumba</td>
<td>66.4</td>
<td>75</td>
<td>93</td>
</tr>
<tr>
<td>Nebbi</td>
<td>82.4</td>
<td>83</td>
<td>94</td>
</tr>
<tr>
<td>National Average</td>
<td>80.0</td>
<td>79</td>
<td>94</td>
</tr>
</tbody>
</table>

Source: MOH n.d.
IMAM / NACS Assessment: Supplies and Equipment

• Procurement delays, poor estimation of orders, late orders from facilities, and poor record keeping all contribute to shortages and waste of medical and nutrition commodities products

• Gaps between implementing partners that procure RUTF products and the planning for supplies at the MOH and facility levels

• Limited involvement of the national authorities, NMS and NPA personnel, in management of RUTF supplies

Figure 20. Percent of Facilities That Reported Shortages of RUTF

Source: FHI360 FANTA III 2014
**IMAM / NACS Assessment: Service Delivery**

- Availability of IMAM/NACS is not reported as frequently at these lower levels.

- Low levels of NACS were found to occur at the lower-level health facilities reducing the success of other nutrition interventions.

- Level of input from community-level actors was limited at the national level limiting awareness and ownership of services, and contributing to higher service utilization rates.

- Minimal community level efforts to coordinate IMAM/NACS outreach.

- Minimal social mobilization and BCC for nutrition interventions.

- Availability of QI national trainers was less certain.

*Source: FHI360 FANTA III 2014*
Recommendations for Adaptations in Addressing Acute Malnutrition

- Strengthen stakeholder involvement in planning, coordination, and implementation to leverage on limited resources – sector departments and partners

- Organize and implement a comprehensive system for capacity development of personnel throughout their career

- Efforts should be made to streamline forecasting, purchase and distribution of nutrition commodities and supplies through the national supply chain to ensure that adequate, appropriate, and quality supplies are available to facilities

- Establish and strengthen nutrition information sharing platforms at different levels with various nutrition stakeholders

- Efforts should be made to develop harmonized behavioral change communication and social mobilization materials for nutrition aligned to the National Nutrition Advocacy and Communication Strategy and standardized for use by all nutrition partners
Acknowledgements

• Ministry Of Health Nutrition Division – Technical and Management Teams

• USAID FHI360 FANTA III Project Team

• USAID Advancing Nutrition Webinar Organizing Team

Thank You

Q & A
IYCF Counselling Cards in Kenya: Adopting, Adapting, Harmonizing and Institutionalizing

Presented by
Laura Kiige,
Nutrition Specialist, UNICEF KENYA
Nationally, very few children are getting the nutrition they need to survive, grow and develop – yet what needs to be done is clear. Exclusive Breastfeeding Rate – 61%, Minimum Acceptable Diet -22%
IYCF Cards: Why the adoption

How do we communicate a consistent/accurate message to mothers/care givers?

- From all health care workers irrespective of date/year trained?
- All media
- One on one

IYCF cards were already in use in some projects in Kenya
Adaptation: what and why

Culture sensitivity
Address harmful practices
More details and pictorials

• Address controlled feeding
• More context relevant

Front

Back

To combine IYCF Counselling Cards and key messages booklet – all in one, ease of Supply
Adaptation: Content added

This was guided by the findings of KABP surveys, to include essential hygiene actions, food production, child stimulation, developmental milestones.
By MIYCN steering committee

1. Consensus building
   - What are the gaps, what we want and why?

2. Content and evidence generation
   - Workshops, Multi meeting, expert consultation

3. Development of the illustrations with concurrent reviews
   - Engagement of graphic designers plus a technical team

4. Piloting

5. Content and illustrations adjustment
   - he feedback – while ng a utlook

6. Validation of content and the MIYCN counseling cards

- CN steering committee
- C) plus b) Nutrition cy coordination e for nutrition
- he 47 counties OR, b)protocol, y, d) in different context – an areas, ii) religion, literate iv) levels of sectors - education, ater and sanitation, Health

Done by the MIYCN TWG
Harmonizing and institutionalizing the card: Who contributed? - MIYCN TWG

All interests were addressed on the discussion/decision table.
Institutionalizing MIYCN Counselling Cards

BFCI Implementation Package

- BFCI implementation guidelines
- BFCI training packages for health care workers and CHVs
- BFCI advocacy and communication materials
- BFCI assessment and monitoring tools
Training institutions in curriculum for health care workers

Use of MIYCN counselling cards

In workplaces

Community level platforms - BFHI

Health facilities - BFHI

Group discussions

Interpersonal communication during home visitation
Challenges

1. Changes in guidelines and policy environment
   - Eg: IYCF in the context of HIV. It is hard to recall the old version of the cards
   - There is need to keep updating content

2. Unmet demand
   - Number of MIYCN counselling cards – 25,000 cards printed, more under print... Yet the demand is massive

3. MIYCN community level programming in the context of COVID-19
   - Need to address the lapse in reaching caregivers with key messages based on lessons learnt
What I see, even the health of children has started to change. Since these teachings started coming in, when the mothers were trained, some started to adhere to the teachings; how to take care of the baby from when you give birth up to 6 months and continue. And I can see the health condition of children has really changed as a result of these trainings.” Village Elder, KII
Management of at-risk mothers & infants <6 months (MAMI): from tools to integrated care pathways

July 23, 2020
Key messages

1. Entire ‘systems’ of care rather than isolated parts (beyond tools to integrated care pathways).

2. Importance of integrated care pathways for translating guidelines into straightforward protocols for frontline users.

3. Importance of user testing and feedback to ensure that programme packages facilitate patient care without increasing health worker burden.
What is MAMI?

**Management of At-risk Mothers and Infants under six months**

**VISION:**

Every infant <6m, at every community/health service contact, is nutritionally assessed & appropriately supported to survive and thrive.
What is MAMI?

A holistic community-based approach that aims to support infant feeding and maternal well-being in order to reduce risk of adverse outcomes among infants <6m.
**Clinical/inpatient care:**
- **3° prevention:** managing disease post-diagnosis to slow or stop disease progression
- Targeted → Only carers-infants w/ complications
- Many:1 contact
- HIGHER RISK

**MAMI:**
- **2° prevention AND/OR treatment:** *early detection* of disease, followed by *appropriate intervention*
- Targeted → Only carers-infants w/ risk but no complications
- 1:1 contact
- MOSTLY LOW RISK

**IYCF:**
- **1° prevention:** intervening before health effects occur
- Blanket → All carers-infants
- 1:many contact
- VERY LOW RISK
Background on MAMI

• ~2007: Frontline workers lack guidance on managing nutritionally at-risk infants<6m
• 2011: Research shows large burden of wasting among infants<6m (Kerac et al. 2011)
  • National guidelines focus on inpatient care only → poor compliance with referrals
• 2013: Infants <6m included in WHO SAM guidelines for 1st time
  • Recognition that uncomplicated cases of infant malnutrition can be treated as outpatients
  • Need to translate guidelines into tools for frontline practitioners...
• 2015: MAMI Tool V1 developed by MAMI-SIG
• 2017: Review of national CMAM guidelines: little uptake of outpatient care for <6m
• 2017/2018: Evals of MAMI Tool V1 in Bangladesh and Ethiopia: need for simpler too
• 2018: C-MAMI Tool V2 released → still perceived as too extensive for routine use
• 2020: MAMI-SIG adapting MAMI Tool V2 → MAMI Care Pathway
MAMI Tool V2, guiding principles:

- Lessons from CMAM...
- ‘CHECKLIST’ manifesto
- ICCM/IMCI & latest WHO (2013) guidance
- Includes support for mother (+ family) as well as infants
- Individualised/tailored support
Rationale for MAMI Tool → MAMI Care Pathway

Key findings of scoping review of patient management tools:

• Although many tools appear to be logical, intuitive means of translating guidelines into practice, there is often little evidence of their effectiveness.

• Reasonably strong evidence of effectiveness for use of integrated care pathways (ICPs) → “improvements in service quality and service efficiency without adverse consequences for patients” (Allen et al, 2009)

• Qualitative findings on multiple tools indicated that tool use added to health worker burden rather than facilitating patient care.
Integrated care pathways (ICPs)

“Task-orientated care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient’s expected clinical course” (Campbell, 1998)

<table>
<thead>
<tr>
<th>AIMS</th>
<th>KEY FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Facilitate introduction of guidelines &amp; systematic audit into clinical practice</td>
<td>· Multidisciplinary plan for / record of care</td>
</tr>
<tr>
<td>· ↑ multidisciplinary communication &amp; care planning</td>
<td>· Efficient, structured format for recording key clinical data (checklist of actions)</td>
</tr>
<tr>
<td>· ↑ quality standards in care</td>
<td>· Paper-based, requires minimal free text</td>
</tr>
<tr>
<td>· ↓ unwanted practice variation</td>
<td>· Freely available to patient</td>
</tr>
<tr>
<td>· ↑ clinician-patient communication &amp; patient satisfaction</td>
<td>· Variances from planned care noted &amp; analysed</td>
</tr>
<tr>
<td>· Identify R&amp;D questions</td>
<td>· Plan &amp; practice adjusted following audit</td>
</tr>
</tbody>
</table>
Integrated care pathways (ICPs)

“Facilitate the introduction of local protocols based on research evidence into clinical practice” (Campbell, 1998)

12 STEPS IN ICP DEVELOPMENT (from Campbell et al. 1998)

... 7. Develop an ICP which specifies elements of care detailed in local protocol, the sequence of events, and expected patient progress over time.
8. Prepare documentation for the ICP.
9. Educate staff in the use of the ICP.
10. Pilot then implement the ICP.

...
Guided by the AGREE instrument

• Appraisal of Guidelines for REsearch & Evaluation (AGREE)

• Purpose of AGREE framework:
  1. Assess the quality of guidelines;
  2. Provide a methodological strategy for the development of guidelines;
  3. And inform what information and how information ought to be reported in guidelines.

• 23-item tool, 6 quality domains:
  1. Scope and purpose
  2. Stakeholder involvement
  3. Rigour of development
  4. Clarity of presentation
  5. Applicability
  6. Editorial independence
MAMI Care Pathway (draft)

MAMI ASSESSMENT
Conduct MAMI assessment to determine eligibility for enrolment

MAMI ASSESSMENT TOOL

LOW RISK INFANT AND MOTHER

MODERATE RISK INFANT AND/OR MOTHER

STABILISATION

DETERIORATION

MAMI OUTPATIENT CARE
Ongoing support for infant feeding & maternal well-being up to 6 months of age.

Refer to specialist services if needed & available (e.g. B/TSFP, MHPSS, ECD, social safety net).

MAMI ENROLMENT AND MANAGEMENT CARD
MAMI COUNSELLING CARDS
MAMI SUPPORT ACTIONS BOOKLET

DETERIORATION
MAMI Rapid Screening Tool (draft)

1) IMNCI danger signs
   - No danger signs → 2) Infant anthropometry

CHECK FOR GENERAL DANGER SIGNS:
- Unable to drink or breastfeed
- Vomits everything
- Convulsions
- Lethargic or unconscious
- Difficulty breathing

CHECK FOR MAMI-SPECIFIC DANGER SIGNS:
- Bilateral oedema (+, ++, or +++)

ASK:
- Has infant recently lost weight or failed to gain weight? (reported or documented)

CHECK:
- MUAC and/or WAZ

URGENT REFERRAL REQUIRED

PROVIDE pre-referral treatment as appropriate

INPATIENT CARE
- Treatment of acute problem(s)
- MAMI-specific support as appropriate (see national guidelines on inpatient care for infants <6m)

INPATIENT CARE

2) Infant anthropometry

3) Infant feeding

ASK:
- Does infant have feeding problem(s)? (breastfed or non breastfed or mixed feeding)
- Does mother have feeding concern(s) or breast problem(s)? (reported or observed)

CHECK:
- MUAC < 19cm
- Bilateral oedema (not pregnant)
- Severe pallor (anaemia)

4) Maternal health

ASK & LOOK:
- Does mother have illness that requires inpatient care? (reported or observed)

CHECK:
- MUAC
- Bilateral oedema
- Severe pallor (anaemia)

Problems feeding infant
- AND/OR
- Breast problems

Refer at-risk mother-infant pairs to nearest MAMI service point for triage & assessment (see MAMI Triage Tool)
1. Entire ‘systems’ of care rather than isolated parts (beyond tools to ICPs)

2. Importance of ICPs for translating guidelines into straightforward protocols for frontline users.

3. Importance of user testing and feedback to ensure that ICPs / programme packages facilitate patient care without increasing health worker burden.