

Draft 10/30/98

No distribution or
quotation. Final
version should be
out soon - DP

Checklist for Reviewing Nutrition Interventions in District Health Services

Tina Sanghvi
Serigne Diene
John Murray
Rae Galloway

BASICS/USAID

CONTENTS

Introduction

1. Nature and Magnitude of the Problem
2. Priority Nutrition Activities in Health Facilities
3. Priority Nutrition Activities at Community-Level
4. Nutrition in District Health Services
5. Using the Information for Planning

ANNEXES

- A. Essential Actions for Health Services
- B. Ten Steps for Breastfeeding Support in
Baby Friendly Hospitals
- C. Nutrition Job Aids for Health Contacts
- D. Guide for Assessing a Counseling Session

INTRODUCTION

Periodic reviews of district health programs can help managers find critical gaps and focus their resources on priority needs. This is a checklist for collecting information about priority nutrition activities. It is designed for district health teams that want to strengthen the nutrition components of their primary health care programs. It can be used by government staff, non-governmental organizations, donors and others interested in integrating nutrition interventions in maternal and child health. References given at the end of the checklist provide background information that may be useful for understanding or interpreting the information collected.

Strengthening nutrition components of district health services is as high a priority as maintaining immunization coverage or improving the quality of sick child care. This is because malnutrition is associated with over half of all childhood deaths in the age group 6-59 months in developing countries. Moreover, health workers have many opportunities to provide nutrition services to women and children through routine health activities.

The most cost-effective nutrition interventions should be provided by all health workers, and these have been termed the “Minimum Package” of nutrition interventions (BASICS, 1997). The interventions are:

- Promotion of exclusive breastfeeding for about six months
- Promotion of adequate complementary feeding from about six to 24 months with continued breastfeeding
- Adequate nutritional care of sick and malnourished children
- Assuring adequate intake of vitamin A
- Assuring adequate intake of iron
- Promotion of iodized salt intake

Lessons learned from past efforts show that these six priority interventions need to be included in an integrated package with health services in order to improve key nutrition practices and reduce childhood under-nutrition.

Six categories of health contacts commonly occur in communities and clinics:

- Prenatal contacts
- Delivery and immediate postpartum contacts
- Postnatal contacts
- Immunization contacts
- Sick child visits
- Well-child visits

These contacts have been identified as the initial targets for building improved nutrition content in district health programs. Based on national household surveys in developing countries in Africa, Asia and Latin America, WHO estimates that each year about 75 million pregnant women receive at least one prenatal visit [ref]. Forty-five million births are

attended by trained health providers at health facilities. Another 25 million are attended by trained health workers at home. About 70 million infants or their caretakers come in contact with health workers within the first two months after birth [refs]. Building in proven nutrition interventions in each of these existing contacts can provide important benefits. The actions necessary at these contacts for improving nutrition services are summarized in **Annexes A and B**.

This checklist is designed to be used to review the current status of nutrition programs through routine health contacts and to identify areas that need to be strengthened. This information can be used by program managers to plan activities, advocate for resources and monitor changes over time. The checklist is designed to be used for rapid program reviews by using existing data, collecting information from health staff and visiting a limited number of health facilities and communities. It is not designed to replace quantitative surveys or studies which are required to collect high quality quantitative data on health worker knowledge and practices, or in-depth qualitative research necessary to develop feeding recommendations.

1. NATURE. AND MAGNITUDE OF THE PROBLEM

Key Questions

Are stunting and wasting a problem in this district?
Are micronutrient deficiencies a problem in this district?
What are the child feeding problems in this district?
Are there gaps in the available information?
Is the information current?

Determine the prevalence and severity of malnutrition

Existing surveys or other quantitative studies

What proportion of young children are stunted (low height-for-age)? ¹
What proportion of young children are underweight (low weight-for-age)? ¹
What proportion of young children are wasted (low weight-for-height)? ¹
What proportion of children have a significant vitamin A deficiency (VAD) problem according to WHO standards? ²
What proportion of women or pregnant women have anemia? Do pregnant women exhibit conjunctival pallor? What proportion of infants and young children are anemic? Do infants and children show signs of palmar pallor? ³
What proportion of adults and children show signs of iodine deficiency?
What is the evidence that any of these nutrition problems is improving or becoming worse?

Interviews with health workers or other key informants

Do health facilities' staff see a number of very thin or emaciated children?
Is VAD a clinical or subclinical **problem** (e.g., is there a local term for night blindness, and is there evidence of night blindness being commonly reported among pregnant women or school children)? ²
Are there cases of visible goiter in the area ⁴
What is the evidence that any of these nutrition problems is improving or becoming worse?

Identify areas, seasons or ethnic, age and gender groups that are more likely to have nutrition problems

Existing surveys or quantitative studies and interviews with health workers or key informants

Where/when/among whom is underweight/stunting/wasting most common?
Where/when/among whom is VAD most common?
Where/when/among whom is anemia most common?
Where/among whom is iodine deficiency most common?

Identify priority maternal, infant and child feeding problems

Existing surveys or quantitative studies

What proportion of infants under 4 months are exclusively breastfed? ⁵

What proportion of infants 6-9 months of age are fed adequate complementary foods? ⁵

What proportion of children are breastfed to at least 24 months?

What proportion of children who were sick in the previous 2 weeks were given food and fluids correctly?

Interviews with health workers or key informants

Are young children fed adequate diets (i.e., do types of food given, **feeding** methods, and frequency of feeding meet minimum requirements for energy, protein, vitamins and minerals)

Do women consume adequate diets (i.e. meet their requirements for energy, protein, vitamins and minerals)?

2. STATUS OF PRIORITY NUTRITION ACTIVITIES IN HEALTH FACILITIES

Key Questions

What services are offered by health facilities (including hospitals, health centers and clinics, health posts, health huts, rural maternities)?

Do health staff include key nutrition tasks in their routine practices?

What is the quality of nutrition services provided by health workers?

NOTE: The Nutrition *Job Aids* in Annex C and Counseling *Guide* in Annex D can be used to guide data gathering at facilities.

Which of the following services are provided by the different health facilities in the district?

- Prenatal care
- Assisted deliveries and postpartum care
- Postnatal care
- Immunizations
- Sick-child care
- Well-child care

Describe the nutrition components in each type of service identified above.

Visits to health facilities and direct observation of health worker practice (observe the management of 1 or 2 women or children)

Do health workers practice key nutrition activities as a component of routine practice? (the job-aid checklists presented in annex C can be used as a guide to the key elements that need to be observed). Key measures of the quality of nutrition practices could include:

- Sick children that have their weight checked against a growth chart
- Sick children who have their nutrition status assessed [plot on a growth chart, look for pallor, look for visible wasting, look for edema]
- Caretakers of children under 2 years of age who are asked about breastfeeding and complementary foods
- Pregnant women who receive prophylactic iron correctly
- Children receiving immunization services who are given vitamin A correctly
- Women and children with anemia who are prescribed treatment correctly

What is the quality of nutrition counseling given (the job-aids presented in annexes C and D can be used as a guide to key elements of counseling)? Key measures could include:

- Children with very low weight who are correctly assessed and counseled for feeding problems
- Caretakers of sick children who are advised to give extra fluids and to continue feeding
- Pregnant women who are given correct antenatal counseling messages

Visits to health facilities with health worker interviews and direct inspection of supplies and equipment

Are all essential **drugs/micronutrients** available on the day of the visit?

- Facilities with vitamin A capsules, **iron/folate**, mebendazole and chloroquine available on the day of the visit
- Number of stock-outs of vitamin A capsules, **iron/folate**, mebendazole or chloroquine in the 30 days before the visit

Is essential equipment available on the day of the visit?

- Facilities that have weighing scales and other essential supplies required for the provision of nutrition services available

What proportion of health workers providing services have received primary health care training which **includes** key nutrition elements?

- Facilities where at least 60% of health workers in each service category have been trained in methods that include key nutrition components in the previous 3 years

Are supervisory visits being made to the facility?

- Facilities that have received at least 1 supervisory visit during the previous 4 months

What is the quality of supervision provided (are practices observed, and is feedback and problem solving conducted in the facility)?

- Facilities that have received at least 1 supervisory visit which involved observation of clinical practice and immediate feedback ~~in the~~ last 4 months

Are **IE&C** materials for nutrition available and used (counseling cards, flip charts, posters etc.)?

- Facilities with key **IE&C** materials available

Do monthly reporting forms for each clinical service include information on cases of , malnutrition, vitamin A deficiency, anemia; counseling on feeding; and doses of vitamin A and iron administered?

- Facilities with all essential monthly reporting forms available and up to date

Are health workers aware of the vitamin A supplementation schedule for postpartum women, well children 6-59 months and sick children 6-59 months?

- Health workers with correct knowledge of vitamin A dosing schedules

Do health workers have access to key nutrition guidelines and protocols?

- Facilities with national vitamin A, and iron supplementation guidelines available
- Hospitals with 1 O-steps to Baby Friendly Hospitals guidelines available

3. STATUS OF PRIORITY NUTRITION ACTIVITIES IN COMMUNITIES¹

Key Questions

What services are offered in communities?

Do community workers include key nutrition tasks in their routine practices?

What is the quality of nutrition services provided by community workers?

NOTE: An important component of improved nutrition practices is building linkages with community leaders and community-based health providers and promoters. Supporting community level activities can help district health teams reach their program objectives faster and is more likely to result in long-lasting impact

Identify the sources of health care, diet/health counseling and health/nutrition commodities available at the community-level for women and children in the area:

- During pregnancy
- At deliveries and after
- When infants and children are sick
- ▶ For maintaining good health in infants and children (e.g. guidance on feeding, immunizations and other)

Describe the nutrition components of care, counseling and commodities

Visits to community health posts or home visits and direct observation of community health worker practice (observe the management of 1 or 2 women or children). If direct observation is not possible, discuss nutrition activities provided during each contact with community provider and caretakers.

Prenatal care

- Is there community-based distribution of iron/folate tablets?
- Is counseling done on mothers' diets, breastfeeding and taking iron/folate?

Deliveries and Postpartum Care

- Is breastfeeding initiated immediately after delivery?
- Is counseling done on mothers' diets, breastfeeding?
- Do mothers receive postpartum vitamin A?

¹

Potential providers of nutrition counseling and products may include, community health workers, outreach posts from facilities, NGOs, birth attendants, private practitioners, traditional healers, drug vendors, pharmacies, agricultural extension workers, school teachers, mothers/women's groups, health committees, cooperatives in which women participate, and others.

Well-baby Care

- ▶ Are the breastfeeding **and** complementary feeding practices of children assessed, and is counseling given?
- Are the protocols/content of counseling consistent with locally adapted guidelines?
- Is there community-based distribution of vitamin A?
- Is the status of vitamin A supplementation checked when immunizations are given?
- Are children regularly weighed in the community? Is vitamin A supplementation linked to weighing sessions? Are results of weighing reported to community leaders regularly? Are actions taken to reduce the number of children who **are not** growing well?

Sick Child Care

- Are breastfeeding and complementary feeding practices assessed and appropriate counseling given?
- Are supplementation protocols and the content of counseling consistent with district guidelines?
- ▶ Are sick children weighed and plotted on growth charts? How is this information used?
- Are sick children routinely screened for malnutrition, ARI, diarrhea, malaria, and measles, referred appropriately, and given follow-up care according to district guidelines?
- Have community health workers received training in integrated primary health care which includes key nutrition tasks?

*Visits to communities, interviews with **community** health workers and direct inspection of supplies and equipment*

- Are the protocols/content of counseling consistent with local guidelines?
- Are essential supplies (e.g., vitamin A and iron) available every time they are needed?
- Have community workers received training which includes key nutrition components?
- Have community workers received at least 1 supervisory visit in the last 4 months?
- Is there any recording of services given?
- Are IEC materials used, are they adequate for effective counseling? Do counseling guidelines for all contacts include messages on the consumption of iodized salt?

To what extent are community leaders (e.g., social/political leaders, teachers, priests, health workers, etc.) aware of the importance of nutrition and priority nutrition actions?

Do they know that?

Nutrition problems may be widespread in **their** area;

About half of all child deaths are associated with malnutrition;

The foundation for nutrition is laid down before birth,

Malnutrition is caused by a combination of inadequate diet, frequent illnesses, and insufficient care given to mothers and children;

Malnutrition increases the severity of common illnesses, increases the chances of becoming disabled or blind, lowers intelligence, and reduces **the** ability to work?

Is there?

A committee or group of community members that is responsible for **health** and nutrition issues. Do they take action when a problem is detected?

At least one person in each community trained in priority nutrition actions for maternal/reproductive health, and child health. Is this person(s) adequately supported by staff of district health teams?

Ownership of the nutrition and primary health care activities by the community? **Is** there substantial, broad-based involvement by the community in decision-making ? Are resources provided by the community to support health and nutrition?

4. NUTRITION IN DISTRICT HEALTH SERVICES

Key questions

Are there district staff allocated to manage nutrition activities?

Are district nutrition policies and guidelines available and consistent with national guidelines?

Are key nutrition activities integrated into all services?

What is the estimated service coverage?

Have health staff been trained using protocols that include nutrition?

What is the status of the system supports (drug supply, supervision)?

Have nutrition targets been established and are they monitored?

Have resources been allocated for nutrition and integrated primary health care activities?

NOTE: District staff play a key role in planning for priority nutrition actions. Setting reasonable targets and allocating enough resources in health plans to reach them, are important steps for achieving the integration of nutrition with health.

Identify key staff who have responsibility for priority nutrition actions in the district health services

Interview district health staff

At what level and by whom are decisions made about policies and technical content of protocols?

Who is responsible for managing and coordinating primary health care and nutrition activities?

Is there adequate leadership and coordination?

Review nutrition-related maternal/reproductive and child health policies and guidelines

Interview district health staff and review of guidelines: determine whether they are consistent with national and international standards

What are the policies for the use of vitamin A and iron for infants and children?

What is the policy for iron/folate supplementation of pregnant women?

What is the policy for postpartum vitamin A supplementation of women?

What is the policy on duration of exclusive breastfeeding?

Is exclusive breastfeeding a choice offered for family planning in the first few months postpartum?

Is there a policy on breastfeeding and HIV-AIDS?

Is there a policy to train staff and revise maternity procedures according to the Baby Friendly Hospital Initiative (BFHI) "Ten Steps" (see Annex B)?

What are the policies and guidelines for complementary feeding and nutritional counseling guidelines?

What is the policy on the promotion of iodized salt?

Identify facilities that have integrated nutrition activities into routine services

*Interview district health **staff** and review district records. Make a table showing facilities by **category** and indicate the types of services they provide (maternal/reproductive health services, child health services or both).*

What proportion of **facilities** provide all essential services? What proportion of all services have incorporated key nutrition activities? Are facilities governmental, non-governmental or private? How can services be expanded or introduced to incorporate key nutrition activities? How can services at non-governmental sites can be expanded or improved?

Note the coverage of maternal and child health services

Review district records

What proportion of all deliveries are assisted, at clinics/posts, and in the community by trained birth attendants? What proportion of pregnant women make at least 2 antenatal visits? What is the immunization coverage for all immunizations including measles? What are the trends over time? What proportion of the population lives within 1 hour of a health facility? What proportion of the population lives in communities visited by health center staff at least three times per year? How does coverage vary by geographic area, ethnic groups, and seasons? How can coverage be improved?

Review the training and allocation of health staff

*Interviews with district health **staff** and review of records and materials*

Are records on staff placement and training available? Are there adequate numbers of staff at facilities to provide essential primary health care services? Is there a training plan? What proportion of staff have received integrated primary health care training that includes key nutrition activities? Is there a system for providing support to health workers in place? Are training materials and methods consistent with national and international standards? Has there been an evaluation of the quality of health worker practice? How can training materials and methods be improved? How can support to health workers be improved to sustain practice?

Determine whether the priority nutrition activities are integrated in routine health systems at the district level

Interviews with district health staff and review of records

Are supplies of iron/folate supplements, vitamin A supplements, and iodized salt testing kits routinely procured with other essential drugs?
Does routine supervision in maternal/reproductive health and child health services include supervision of the priority nutrition actions?
Do health education messages, materials and activities include priority nutrition themes?
Do all facilities have functional adult, child and baby weighing scales, and are stocks of growth charts and other essential recording cards available?
Are data on services provided and micronutrients distributed by facilities routinely collected?
Are data on the number of cases of malnutrition, including micronutrient deficiencies collected?
How are routine data used for program planning?

Determine whether the district has nutrition targets and whether the targets are reasonable

Interviews with district health staff and review of records

What is the current and expected reduction in prevalence of :

- ▶ low birth weight,
- underweight/stunting/wasting,
- vitamin A deficiency,
- anemia,
- ▶ iodine deficiency?

What are the targets for:

- improving women's diets,
- ▶ breastfeeding practices,
- complementary feeding practices,
- improving quality of nutritional care for sick and malnourished children
- vitamin A supplementation
- iron/folate supplementation for women
- iodized salt intake?

Are targets understood and attainable?

How is progress towards targets being measured?

Determine the level of staff and budgetary resources that have been allocated for priority nutrition actions and whether steps are being taken to implement the plans

How are nutrition activities budgeted?

Are resources adequate to allow **all** priority actions to be taken?

How have program priorities been set? **Were** the views of community representatives considered in priority-setting?

How are nutrition activities prioritized? Are data used?

How well are nutrition activities linked or integrated with other activities to maximize efficiency?

Is there a plan of nutrition activities linked with other primary health care planning?

Do donors or other organizations contribute to budgets or plans?

Are donor contributions coordinated to meet district needs and avoid duplication?

Have district teams been implementing plans?

What are the barriers to nutrition planning and budgeting?

5. USING THE INFORMATION FOR PLANNING

Key Questions

What gaps have been identified in nutrition programming?
What activities are needed in order to improve nutrition programming?
Who will be responsible for implementing activities?
What is the timetable for implementing activities?
What resources are required and are they available?

Determine what actions need to be taken for district planning

What actions are needed to ensure effective coordination, planning and budgeting of nutrition activities at the district level? Has a coordinator been identified? What is the coordination mechanism with other sectors? Are nutrition priorities based on data regarding the nutrition problem, behaviors of households, and community needs? How are nutrition activities incorporated into other, on-going, district health (and other sector) activities? How can planning be improved?

Determine what actions need to be taken to support priority nutrition actions at health facilities

What changes are needed in maternal/reproductive health and child health policies and technical protocols or procedures for:

- breastfeeding
- micronutrients (vitamin A, iron and iodized salt)
- ▶ management of sick and malnourished children?

Does any new information need to be collected or analyzed before making the necessary revisions?

What actions need to be taken to improve supplies of:

- iron/folate,
- vitamin A,
- salt testing kits,
- counseling cards,
- other IEC materials
- essential equipment such as weighing scales

What are staff training needs? Do materials need to be updated? Does a training plan need to be developed?

How can existing services be expanded to incorporate key nutrition activities?

What actions are needed to improve the quality of supervision provided to health workers? Are revisions in supervisory tools are needed?

What actions are needed to strengthen the routine monitoring of nutrition

activities? What tools and methods are required to conduct routine monitoring?

Determine what actions need to be taken to improve priority nutrition actions at community level.

Are district Staff and health workers aware of the importance of **sensitizing/mobilizing** community leaders to give **priority** to maternal and child nutrition? Do they need training in these methods?

How can the nutrition skills of existing community-based workers be improved? Is better training required? What other kinds of support are necessary?

Are there local groups or organizations working in communities who can promote key nutrition activities in collaboration with district and health facilities' **staff**? What can health staff do to support these groups and organizations?

Have market channels for improving access to iodized salt, **iron/folate** (and other) commodities been explored? Have private practitioners been engaged in planning for improved practices? What support can the district health team provide private retailers and service providers?

How can community links to **health** posts/clinics be improved? Can **additional/different** training, supplies, monitoring and supervision be provided?

How can various channels of communication (radio, print, traditional media etc) be used to reach communities and motivate families/communities?

ANNEXES

- 1. Essential Nutrition Actions in Health Services**
- 2. “Ten Steps” for Baby Friendly Hospitals**
- 3. Nutrition Job Aids for Health Contacts**
- 4. Guidelines on Counseling**

Essential Nutrition Actions in Health Services

<i>When You See Clients for. .</i>	<i>You Should Provide.</i>	<i>The Content Should be. . .</i>
Prenatal Care	Breastfeeding counseling	Breastfeeding (BF) immediately after delivery; the importance of colostrum and exclusive breastfeeding (EBF); solving problems that prevent establishing breastfeeding; mother's diet.
	Iron/folate supplements and counseling	One daily tablet (60 mg iron) throughout pregnancy for 6 months (180 tablets); counsel on side-effects and compliance; and when and how to get more tablets.
Delivery and Postpartum Care	Breastfeeding assistance & counseling (all maternities should follow the "10 Baby Friendly steps")	Initiation of BF immediately, check for position & attachment, management of common problems, duration of EBF up to about 6 months, dangers of giving water or liquids, how to express breastmilk.
	Vitamin A supplement for mothers	One dose of 200,000 IU administered to the mother after delivery (within the first 8 weeks)
Postnatal Checks	Exclusive breastfeeding check, and reinforce good diet and rest for mothers.	Assess and counsel on problems; teach prevention of "insufficient milk"; how to increase milk supply; manage problems. Mother's diet
Immunizations	With BCG contact, check mother's vitamin A supplement	Complete one dose of 200,000 IU for women within 8 weeks after delivery (within 6 weeks if not breastfeeding)
	With NIDs and community outreach for immunizations check and complete children's vitamin A	One dose of 100,000 IU for infants from 6-11 months; and one dose of 200,000 IU for children 12 to 59 months of age every 4 to 6 months
	With OPV-3, and measles immunization check infant's vitamin A	One dose of 100,000 IU for infants 6-11 months; and one dose of 200,000 IU for children 12 to 59 months should be given every 4-6 months (for infants below 6 months use 50,000 IU per dose)
Well-Baby Visits	Assess and counsel on breastfeeding; assess and counsel on adequate complementary feeding (use locally adapted recommendations)	Counseling and support for EBF in the first 6 months; counseling and support for adequate complementary feeding from 6-24 months; continuation of BF to 24 months. Use iodized salt for all family meals.
	Check and complete vitamin A protocol	See protocols under immunizations above
Sick Child Visits	Screen, treat and refer severe malnutrition, vitamin A deficiency, and anemia	IMCI and WHO (1997) protocols for severe malnutrition, vitamin A deficiency, and anemia
	Check and complete vitamin A protocol	See protocols under immunizations above. Also provide vitamin A supplements for measles, diarrhea and malnutrition according to WHO/UNICEF/IVACG.
	Assess and counsel on breastfeeding; assess and counsel on adequate complementary feeding (use locally adapted recommendations) .	Increase breastfeeding while child is sick. Counseling and support for EBF in the first 6 months; counseling and support for adequate complementary feeding from 6-24 months; continuation of BF to 24 months. Continued and recuperative feeding for sick children.

ANNEX B

Recommended Practices Wherever Births Take Place, or The “Ten Steps” for BFHI (Based on UNICEF/WHO, Baby Friendly Hospital Initiative 1992)

1. BF Policy Routinely communicated to All Health **Staff**: a) explicit written lo-steps policy, b) prohibit all promotion and group instruction on substitutes, bottles, teats, c) give policy to **all** maternal and child health staff, d) post and display policy in all areas, e) put in place a mechanism for evaluating program effectiveness.
2. Train all health staff in skills needed: a) all staff must be aware of benefits and policy, b) train all new staff within 6 months of joining staff, c) training should cover at least **8/10** steps, d) train should be at least 18 hours with 3 hours of supervised clinical experience, e) provide more specialized training for 40 hours for some staff.
3. Inform all pregnant women: pregnant women attending antenatal clinic, outreach or in-patient informed about benefits and management of BF.
4. Help mothers breastfeed immediately after birth: a) for normal deliveries mothers placed in physical contact with infants within $\frac{1}{2}$ hour after birth, including for C-sections.
5. Show mothers how to breastfed and maintain BF even if separated **from** infants: a) mothers in postpartum wards should be given help within 6 hours after delivery and shown how to express milk, b) mothers with babies in special care should be given help to initiate and express breastmilk, c) staff should be able to demonstrate manual expression
6. Give newborns no water, food or fluids unless **medically** indicated: a) no mothers permitted to give food or fluids, b) no promotion of infant foods, drinks and related apparatus displayed or promoted, c) staff should know acceptable medical reasons for giving other fluids, milk or foods.
7. Practice rooming-in - keep mothers and infants together 24 hours a day: a) mothers and newborns should remain together after leaving the delivery room, day and night except for up to 1 hour for special procedures.
8. Encourage breastfeeding on demand: a) mothers should know that no restrictions should be placed on frequency or duration of each breastfeed, b) health staff should place no restrictions.
9. No artificial teats, pacifiers (dummies or soothers): staff and mothers should know not to give these objects.
10. Foster establishment of support groups and refer mothers on discharge: staff should discuss mothers' plans after discharge, tell mothers about support groups in the local area, and encourage mothers to return for checkups.

Based on UNICEF Guidelines, March 1992

ANNEXC 1. Nutrition Job Aid For Prenatal Care Contacts

WHY? Poor nutrition in pregnant women endangers the lives of mothers and newborns.

WHAT? At each prenatal contact with mothers, check and complete the following schedule.

Who	How Much/Content	Duration
-----	------------------	----------

All pregnant women	-1 iron/folate tablet daily (60 mg iron + 400 ug folic acid) -Counsel on compliance, safety, side-effects	180 days starting at first prenatal visit and continuing until all 180 tablets are taken
Pregnant women with pallor (pale eyelids and palms)	2 iron/folate tablets daily (120 mg iron + 800 ug folic acid) until pallor disappears, followed by 1 tablet daily (60 mg iron + 400 ug folic acid) - Counsel on side-effects, compliance, safety	2 tablets daily until pallor is no longer seen or a minimum of 90 days. Then continue taking 1 tablet daily until a total of 180 days of iron supplementation is achieved; continue taking tablets postpartum.
All pregnant women	Assess and counsel for preparation for exclusive breastfeeding; counsel for BF immediately after baby is delivered	Counsel at every prenatal contact
All pregnant women	Counsel on adding one meal per day, more vitamin A and C rich foods, and taking extra rest	Starting as soon as pregnancy is detected and continuing during lactation

HOW?

1. Screen each mother for pallor (check eyes and **palms**).
2. Ask each mother when she can return for the next prenatal visit. Count how many tablets she needs until the next visit - use the protocol above. Give her or suggest that she should use old **film** containers or **plastic/poly** bags to store iron tablets to prevent their decay **from** moisture and air.
3. Give each mother enough **iron/folate** tablets until the next visit. Give her 60 or 90 (or more) tablets if she can only **return** after 2 months or 3 months (or later). She can continue to take tablets after delivery until she has taken 180 in all.
4. Counsel her on side-effects, compliance, safety (keeping tablets away from young children).
5. On the mothers' card, record the date and number of tablets given.
6. On the tally sheet/register, make one mark for each mother as she is given tablets. **Also** record the number of tablets given.
7. Screen each mother for flat and inverted nipples and counsel.
8. Counsel each mother and her accompanying family members on EBF for about 6 months, and on immediately breastfeeding after delivery.
9. Counsel each mother and her accompanying family members on taking extra food and rest, particularly in the last three months of pregnancy. Use a list of local, affordable foods and show her how much extra (volume) she needs to eat.
10. Record breastfeeding counseling given in the mothers' card.
11. Remind each mother to return for her next prenatal visit.

NOTE: Many women in your catchment area probably do not come for prenatal visits or come very late. To reach them work with community mid-wives (matrons) or **TBAs**; train, supply and supervise them.

2. Nutrition Job Aid for Delivery and Postpartum Contacts

WHY? Building a strong foundation for successful breast feeding and giving vitamin A to mothers and infants **increases** the ability to fight infections and prevents infant disease and deaths.

WHAT? At delivery and during the first few hours and days postpartum, check and complete the following activities.

Who	How Much/Content	Duration
All women	Put the baby to the breast immediately after delivery	Continue to keep the baby with the mother in the same bed or adjacent cot for unlimited breastfeeding
All women	Give no water, glucose water, teas or any fluids to the baby	From birth until about 6 months
All women	Teach mothers correct attachment: Baby should be turned completely toward mother. Chin should touch mother's breast, mouth wide open, lower lip turned outward. More areola visible above than below the mouth. Infant should take slow, deep sucks (these should be audible), sometimes pausing. Show mothers different breastfeeding positions.	Once or more until mother is confident
All women	Counsel mothers on taking an extra meal, and ingredients/snacks rich in energy, protein, vitamins	For the first four to six months after delivery
All women	Give one 200,000 IU dose of vitamin A as soon as possible after delivery but no later than 8 weeks (or 6 weeks if she is not lactating)	Once only

NOTE Women should continue taking iron/folate tablets after delivery until a total of 180 days.

HOW?

1. Place the newborn on the mother's breast/abdomen immediately after delivery immediately after delivery. Do not separate the baby and mother.
2. Place the baby in the mother's bed or an adjacent cot for easy access to breastfeeding throughout the day and night. Do not give any fluids. Only give medications that are prescribed by the doctor.
3. Observe position and attachment, show mother the correct ways.
4. Give each mother one vitamin A capsule of 200,000 IU (or two 100,000 IU capsules). Open the capsule and squeeze the contents in the mother's mouth or ask her to swallow it with water in your presence. Do not give her the capsule to take away. Do not give this dose if 8 weeks have passed since delivery; for non-lactating mothers do not give this dose if 6 weeks have passed.
5. Record the date of giving vitamin A on the mother's card. Also record breastfeeding and diet counseling given.
6. On the tally sheet/register place a mark for each woman given vitamin A. Also place a mark for each mother given counseling on diet and breastfeeding.
7. Counsel each mother and her accompanying family members on EBF for about 6 months, taking extra food and rest, particularly in the first four to six months after delivery.

NOTE: For women in your catchment area who do not come for deliveries, adapt this protocol for use by midwives (matrons) or TBAs, then train, supply and supervise them.

3. Nutrition Job Aid For Postnatal Contacts

WHY? Lack of follow-up to support women in exclusive breastfeeding during **the first week or two** will often lead to infants receiving other fluids. This in turn causes diarrhea, reduction in milk supply, and the danger of another pregnancy.

WHAT? In the first week or two after delivery, contact each mother to complete the following.

<i>Who</i>	<i>Assess</i>	<i>Diagnose problems</i>	<i>Counsel</i>
All women	Ask is there any difficulty breastfeeding? How many times in the past 24 hours was infant breastfed? Did the infant receive any other fluids or foods after birth to now?	Less than 10 breastfeeds in the past 24 hours or receives other fluids or foods.	Increase frequency of feeds. Reduce and gradually stop all other fluids and foods and at the same time increase frequency and duration of each breastfeed. Remind mothers of the importance of no other fluids/foods for about 6 months.
All women	Observe a breastfeed, listen and look at the infants	Infant should take slow, deep sucks (these should be audible), sometimes pausing	Check position and attachment. Clear blocked nose if it interferes with breastfeeding
All women	Check position and attachment, observe the infant	Baby should be turned completely toward mother. Chin should touch mother's breast, mouth wide open, lower lip turned outward. More areola visible above than below the mouth.	Teach correct position and attachment to mother.
All women	Counsel on preventing "insufficient milk", sore/cracked nipples, engorgement, manual expression and storage.	Confirm need to increase milk production, increase frequency and duration of each feed, correct attachment and position	Teach correct position and attachment to mother.
All women	Counsel mothers on taking an extra meal, and on ingredients/snacks rich in energy, protein, vitamins	Ask about affordable foods, timing of preparing/storing and consuming the foods.	Use a list of local, affordable foods and show her how much extra (volume) she needs to eat.

HOW?

1. Ask each mother about breastfeeding; observe a breastfeed; listen to and look at the infant; observe position and attachment, show mothers the correct ways.
2. Counsel each mother on the importance of continuing BF without fluids or foods for about 6 months and how to solve common difficulties (insufficient milk, separations etc. according to the above).
3. Counsel on mother's diet and work.
4. Counsel women and accompanying family members on EBF for about 6 months.
5. Record the date of counseling on the mothers' card, and any problems and solutions advised.
6. Record the number of women given postnatal counseling on the daily tally sheet/register.

NOTE: Most women do not come for postnatal visits to clinics or come only for problems. Find out who can follow-up each postpartum mother to provide the counseling. Work with community agents such as women's groups, social workers or midwives (matrons) or **TBA**s. Then train, supply and supervise them.

4. Job Aid For Giving Vitamin A With Routine Immunizations

WHY? Lack of vitamin A damages the ability to fight infections and causes blindness.

WHAT? At each immunization contact with mothers and children, check and complete the following.

*NOTE: Children who are not sick or malnourished should get preventive doses of vitamin A. These are: 2 doses during approximately 6-12 months of age, spaced about 4 to 6 months **apart**. Then they should continue to get doses spaced about 4 to 6 months **apart** until they are 5 years (60 months) of age. Use the **chart** below to **determine** how much vitamin A to give.*

Possible Immunization Contact	Age Group/Timing	Amount of Vitamin A	
		If using 100,000 IU capsules	If using 200,000 IU capsules
BCG contact up to 8 weeks	Mothers up to 8 weeks postpartum	2 capsules	1 capsule
DPT-3*, OPV-3 contact from about 6 months	Infants below 6 months	½ drops in a capsule	1/4 drops in a capsule
	Infants 6-11 months	drops in 1 capsule	½ drops in a capsule
	Children 12 months or older	drops in 2 capsules	drops in 1 capsule
Measles vaccination contact	Infants 6-11 months	drops in 1 capsule	½ drops. in a capsule
	Children 12 months or older	drops in 2 capsules	drops in 1 capsule
Booster doses, special campaigns, delayed primary immunization doses, immunization strategies for high risk areas or groups.	Infants 6-11 months	drops in 1 capsule [every 4 to 6 months Until 59 months of age]	½ drops in a capsule [every 4 to 6 months until 59 months of age]
	Children 12 months or older	drops in 2 capsules [every 4 to 6 months until 59 months of age]	drops in 1 capsule [every 4 to 6 months until 59 months of age]

* Pending confirmation on lack of interference with DPT seroconversion.

HOW?

1. Check the dose in the capsules, the child's age (for mothers, the date of delivery), and- when the **last** dose of vitamin A was received.
2. Cut the narrow end of each capsule with scissors or a **naileutter**, and squeeze out the drops into the child's mouth. Ask mothers to swallow the capsule in your presence. Do **NOT** ask a child to swallow the capsule. Do **NOT** give the capsule to the mother to take away.
3. To give less than 1 capsule to a child, count the number of drops in a sample capsule when a new batch of capsules is **first** opened. Give half or a quarter the number of drops from the capsule.
4. Record the date of the dose on the child's card, and the mothers' dose on the mother's card.
5. On the tally sheet/register place a mark for each mother dosed, and another mark for each child dosed. Make a monthly/quarterly/annual chart of VA-O, VA-1, VA-2 the same way as immunization coverage is charted. Report coverage of mothers' dose (VA-O), first dose for **infants** (VA-1), and second dose for infants (VA-2) routinely with immunization coverage.
6. Advise the mother when to return for the next doses of vitamin A, and encourage completion of immunization protocols.

5. Job Aid For Nutrition Services for' Sick Children

WHY? Illnesses drain the **child's** nutrition reserves, interfere with feeding, and make children more susceptible to getting sick in the future. The duration and severity of diseases can be increased, along with an increased risk of death and disability.

WHAT? At each contact with a sick child health workers should assess; classify and treat sick children using IMCI guidelines as shown below (also see complete IMCI protocols, WHO/UNICEF). For treating severely malnourished children use WHO's "Management of Severe Malnutrition", 1997.

Classification	Age in months	Management	Follow-up
Any sick child without a severe classification	≤ 24	<p>Assess the child's feeding and counsel the caretaker according to the IMCI food box from the Counsel the Mother chart</p> <p>Check and complete the preventive vitamin A dose: 1 age-appropriate dose every 4-6 months.</p>	<p>If there is a feeding problem, follow up in 5 days.</p> <p>Advise the caretaker about danger signs for when to return immediately</p>
Measles (severe complicated measles, measles with eye and mouth complications, or uncomplicated measles)	Age-appropriate dosage		<p>Give single dose and refer immediately if severe complicated measles</p> <p>For other classifications: treat conjunctivitis with tetracycline eye ointment and mouth ulcers with gentian violet. Follow-up in 2 days if complications are present</p>
	0-5	Vitamin A 50,000 IU per dose	
	6-11	Vitamin A 100,000 IU per dose	
	12 +	Vitamin A 200,000 IU per dose	
Severe malnutrition or severe anemia	0-59	Give single dose of vitamin A according to dosage schedule shown above	Refer urgently to hospital* * *
Anemia or very low weight	0-59	<p>Assess the child's feeding and counsel the caretaker according to the attached IMCI food box on the counsel the mother chart</p> <p>If pallor: give iron [Give % tablet of iron (30 mg iron)* daily to children > 12 months for 2 months or until pallor disappears. For younger infants give 20 mg elemental iron**.]</p> <p>Give antimalarial if high malaria risk</p> <p>Give mebendazole if child is 2 years or older and has not had a dose in the previous 6 months</p>	<p>Advise mother about danger signs for when to return immediately</p> <p>If pallor, follow-up in 14 days</p> <p>If very low weight for age, follow-up in 30 days</p>

* Ferrous sulfate 200mg = 60 mg elemental iron. ** Give in the form of drops if possible, or powder ferrous sulfate tablets (2 tablets containing 10 mg iron each) and give by spoon, mixed with a liquid (WHO, IMCI guidelines).*** Referral hospitals or clinics treating severe malnutrition should follow WHO guidelines in "Management of Severe Malnutrition", 1997.

HOW?

1. Give each sick child the recommended vitamin A doses as noted above. For children who do not have the condition listed above, check and complete their preventive dose (see job aids for well-baby contacts and immunization contacts).
2. Vitamin A dosing. Cut open the narrow end of each capsule with scissors or a nailcutter and squeeze the drops into the child's mouth. Do **NOT** ask a child to swallow the capsule. To give less than 1 capsule, count the number of drops in a capsule from each new batch of capsules when they first arrive. Give half or a quarter the total number of drops counted.

3. Assess, **classify** and treat all sick children according to IMCI guidelines [see checklist on next page]. Assess child's feeding, and give nutritional counseling according to attached IMCI guidelines.
5. Record the classification **and treatment** given on the child's card. Place a mark on **the** tally sheet for each child assessed, dosed, counseled, referred.

MANAGEMENT OF THE SICK CHILD AGE 2 MONTHS UP TO 5 YEARS OBSERVATION CHECKLIST

Child's Name: _____ Age: _____ Weight: _____ kg
Temperature: _____ °C

ASK: What are the child's **problems**? _____ Initial visit? _ Follow-up visit? _

ASSESS (Circle all signs present)

CLASSIFY

<p>CHECK FOR GENERAL DANGER SIGNS</p> <p>NOT ABLE TO DRINK OR BREASTFEED VOMITS EVERYTHING CONVULSIONS</p> <p>LETHARGIC OR UNCONSCIOUS</p>	<p>General danger sign present? Yes ___ No ___ Remember to use danger signs when selecting classifications</p>
<p>DOES THE CHILD HAVE COUGH OR DIFFICULT BREATHING? Yes ___ No ___</p> <ul style="list-style-type: none"> • For how long? ___ Days • Count the breaths in one minute. breaths per minute. Fast breathing? • Look for chest indrawing. • Look and listen for stridor. 	
<p>DOES THE CHILD HAVE DIARRHOEA? Yes ___ No ___</p> <ul style="list-style-type: none"> • For how long? ___ Days • is there blood in the stool? • Look at the child's general condition. Is the child: Lethargic or unconscious? Restless and irritable? • Look for sunken eyes. • Offer the child fluid. Is the child: Not able to drink or drinking poorly? Drinking eagerly, thirsty? • Pinch the skin of the abdomen. Does it go back: Very slowly (longer than 2 seconds)? Slowly? 	
<p>DOES THE CHILD HAVE FEVER? (by history/feels hot/temperature 37.5°C or above) Yes ___ No ___</p> <p>Decide MALARIA risk: High Low</p> <ul style="list-style-type: none"> • For how long? ___ Days • If more than 7 days, has fever been present every day? • Has child had measles within the last 3 months? • Look or feel for stiff neck. • Look for runny nose • Look for signs of MEASLES: Generalized rash and One of these: cough, runny nose or red eyes. 	
<p>If the child has measles now or within the last 3 months:</p> <ul style="list-style-type: none"> • Look for mouth ulcers If Yes, are they deep and extensive? • Look for pus draining from the eye. • Look for clouding of the cornea. 	
<p>DOES THE CHILD HAVE AN EAR PROBLEM? Yes ___ No ___</p> <ul style="list-style-type: none"> • Is there ear pain? • Is there ear discharge? If Yes, for how long? ___ Days • Look for pus draining from the ear. • Feel for tender swelling behind the ear. 	
<p>THEN CHECK FOR MALNUTRITION AND ANAEMIA</p> <ul style="list-style-type: none"> • Look for visible severe wasting. • Determine weight for age. Very low Not Very low • Look for palmar pallor Severe palmar pallor? Some palmar pallor? • Look for oedema of both feet. 	
<p>CHECK THE CHILD'S IMMUNIZATION STATUS Circle immunizations needed today.</p> <p>BCG _____ DPT 1 _____ DPT 2 _____ DPT 3 _____</p> <p>OPV 0 OPV 1 _____ OPV 2 _____ OPV 3 _____ Measles _____</p>	<p>Return for next immunization on: _____</p> <p>(Date)</p>
<p>ASSESS CHILD'S FEEDING if child has ANAEMIA / VERY LOW WEIGHT or is less than 2 years old.</p> <ul style="list-style-type: none"> • Do you breastfeed your child? Yes ___ No ___ If Yes, how many times in 24 hours? t i m e s . Do you breastfeed during the night? Yes ___ No ___ • Does the child take any other foods or fluids? Yes ___ No ___ If Yes, what foods or fluids? _____ • How many times per day? times. What do you use to feed the child? _____ • If very low weight for age: How large are servings? _____ • Does the child receive his own serving? _____ Who feeds the child and how? _____ • During this illness, has the child's feeding changed? Yes ___ No ___ If Yes, how? _____ 	<p>Feeding Problems:</p>

6. Nutrition Job Aid For Well-Baby Contacts

WHY?

Preventing nutrition and feeding problems costs less than treating severe **malnutrition**. Every contact with a well child is an opportunity to prevent **severe** problems before they occur.

WHAT?

At each contact with a well child follow this **protocol**.

Check and complete vitamin A protocols	Age mths	Amount of Vitamin A		Number of doses
		If 100,000 IU capsules are used	If 200,000 IU capsules are used	
	6-11	drops in 1 capsule	½ drops in a capsule	One dose every 4-6 months from about 6 months of age to 59 months
	12 or more	drops in 2 capsules	drops in 1 capsule	
Assess and counsel for feeding difficulties	Age mths	Assess and Classify		Counsel/Treat
	0-5	Assess breastfeeding	Identify difficulties	Exclusive BF until about six months. Correct attachment , position, other difficulties; encourage longer duration and more frequent feeds
	6 or more	Assess complementary feeding	Identify difficulties: poor appetite, frequency, amount per feed, density, hygiene, feeding style	Strategies to correct problems in food content and feeding style. Increase amount and enrichment, after illness. Continue breastfeeding for at least 24 months.
Screen for severe anemia	Screen for pallor			Give ½ tablet of iron (30 mg iron)* daily to children >12 months for 2 months or until pallor disappears. For younger infants give 20 mg elemental iron**.
Screen for severe malnutrition	Screen for severe wasting, edema of both feet; if possible, weigh children.			Give vitamin A and refer to hospital immediately

* Ferrous sulfate 200mg (60 mg elemental iron). ** Give in the form of drops if possible, or powder ferrous sulfate tablets (2 tablets containing 10 mg iron each) and give by spoon, mixed with a liquid. Ref. IMCI (WHO/UNICEF).

HOW?

1. Check and complete the recommended vitamin A dose
2. Cut open the narrow end of each capsule with scissors or a nailcutter and squeeze the drops into the child's mouth. Do **NOT** ask a child to swallow the capsule. Do **NOT** give the capsule to the mother to be given later. To give less than 1 capsule, count the number of drops in a capsule **from** each new batch when it **first** arrives. Give half the number of drops counted.
3. Assess, classify and counsel on feeding.
4. Assess, refer or treat/counsel for severe malnutrition (visible severe wasting, edema); anemia (pallor)
5. Record the date of the vitamin A dose on the child's vaccination card; record feeding assessment, counseling on the child's card
6. Record treatment for severe malnutrition and anemia on the child's card.
7. Mark the daily tally sheet for vitamin A, feeding assessment/counseling, treatment.

ANNEX D

COUNSELING GUIDE

Stages	Good	Needs Improvement	Stages	Good	Needs Improvement
1. Entry/climate setting			4. Explain connection between desired outcome and behavior		
Kind and reassuring			Uses simple language		
Makes client feel comfortable			Makes suggestions not commands.		
Uses gestures and responses that show interest in the client			Gives only that amount of information or advice that can be remembered and followed.		
2. Agenda setting			5. Ask the client how she can achieve this behavior		
Announces the subject			Recognizes and praises what the client is doing correctly before suggesting changes.		
Asks consent of client			Checks what is practical and possible for the client to do.		
Assures it is a subject of interest			6. Verify clients comprehension and intention to try it		
3. Find out what client knows and believes			7. Plan for next appointment		
Asks open ended questions.			OVERALL LISTENING SKILLS		
Repeats/reflects back what the client says.			Uses encouraging non-verbal communication (e.g. facial expression, body language).		
Accepts or validates feelings of the client. Not challenging what the client feels.			Empathizes - show that he/she understands how the client feels.		
Avoids words that sound as if the client is being judged.					

REFERENCES

General nutrition

Sanghvi T and Murray J. 1997 Improving Child Health Through Nutrition: The Nutrition Minimum Package. Technical Report. Arlington, VA: Basic Support for Institutionalizing Child Survival (BASICS) for **USAID**.

Foster, S. 1997. Draft Revised EPI Essentials. Monograph. Arlington, VA: Basic Support for Institutionalizing Child Survival (BASICS) for **USAID**.

Yip Ft. And K. Scanlon, 1994. The burden of malnutrition: a population perspective. In: The Relationship Between Child Anthropometry and Mortality in Developing Countries. J.Nutrition **124:2043S-2046S**.

MACRO International. Demographic and Health Surveys (DHS). Series of country reports, Macro International. Calverton, Maryland.

UNICEF. Multiple Indicator Cluster Surveys (MICS). Series of country surveys. UNICEF, New York.

Iron

Stoltzfus R. J. And M. Dreyfuss, 1998. Guidelines for the Use of Iron Supplements to Prevent and Treat Iron Deficiency Anemia. **INACG/WHO/UNICEF**.

Iodine

WHO/UNICEF/ICCIDD, 1994. Indicators for Assessing Iodine Deficiency Disorders and Their Control Through Salt Iodization. **WHO/NUT/94.6**

Vitamin A

WHO/UNICEF/IVACG, 1997. Vitamin A Supplements: a Guide to Their Use in the Treatment and Prevention of Vitamin a Deficiency and Xerophthalmia. Second edition. WHO, Geneva.

WHO, 1997. Safe Vitamin A Dosage During Pregnancy and Lactation. Recommendations and report of a consultation. Preliminary version. **WHO/NUT/96.14**

Vitamin A and EPI. Statement from a Consultation held at UNICEF January 19-20, 1998. New York.

WHO, 1996. Indicators for Assessing Vitamin A Deficiency and Their Application in Monitoring and Evaluating Intervention Programmes. **WHO/NUT/96.10**

Infant and child feeding

WHO/UNICEF Statement, 1989. Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services. WHO, Geneva.

Institute for Reproductive Health, Georgetown University, 1996. Lactational Amenorrhea Method (LAM). Monograph. **USAID/Linkages**, Washington D.C.

UNAIDS, 1998. Statement on HIV-AIDS and Infant Feeding. UNAIDS, Geneva.

Brown K.H., K.G.Dewey and **L.H.Allen**, 1997. Complementary Feeding of Young Children in Developing Countries: A Review of Current Scientific Knowledge. UNICEF paper.

WHO/UNICEF, 1995. Integrated Management of Childhood Illnesses (IMCI). Chart Book. -Sections on Assessing Breastfeeding, Feeding Recommendations, Counsel the Mother.

Management of sick children

WHO/UNICEF, 1995 Management of Childhood Illness Chart booklets. Child Health and Development Division: WHO, Geneva.

WHO/UNICEF. Integrated Management of Childhood Illness: A WHO/UNICEF Initiative. *WHO Bulletin*. Vol 75, **Suppl.1**, 1997.

WHO, 1997. Management of Severe Malnutrition: A manual for physicians and other senior health workers. Final draft. February, 1997. Also see "*Malnourished Children: Ten Steps to Recovery*" in Child Health Dialogue, 1996. London.