

STRIDES for Family Health Nutrition Implementation Strategy

Management Sciences for Health

2011

Development Objective(s)

- The primary objective of these nutrition activities is to scale up sustainable, cost effective child survival nutrition interventions in all STRIDES supported districts in Uganda

Key word(s): STRIDES Nutrition Strategy

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**[STRIDES for Family Health
Implementation Plan**

For

**Nutrition Interventions (IMAM and
Positive Deviance/Hearth model)**

Pilot Project

2011

Include a page of acronyms.

**STRIDES for Family Health NUTRITION INTERVENTIONS:
IMPLEMENTATION PLAN**

Introduction

1.1 About STRIDES(This can come earlier in the document)

MSH-STRIDES for Family Health a USAID funded project is working with the Government of Uganda (GoU) in its objective to increase the use of quality RH/FP and CS services at the facility and community levels in 15 districts namely; Bugiri, Kumi, Kamuli, Kaliro, Mayuge, Kayunga, Luwero, Nakasongola, Mityana, Sembabule, Kalangala, Kasese, Kyenjojo and Kamwenge. In order to strengthen the capacity of the health system in the selected districts to deliver quality, integrated reproductive health and child survival services to the most vulnerable, the project supplements Government's efforts to improve the health of families and communities, reduce fertility rates and lower the maternal and child morbidity and mortality over the period 2009-2014.. STRIDES also supports private sector partners to complement the public sector in its service delivery task and helps in the extension of the Government health system to the community level through strengthening of village health teams and other community networks.

STRIDES for Family Health recognizes that, improving the nutrition status of women and children is a key benefit to stakeholders and should be prioritized for investment. Improved maternal nutrition leads to better child survival, and healthier newborns. Improved nutrition for children in turn leads to better mental and physical health in adulthood, thus a stronger and productive workforce. It is against this background that STRIDES intends to use the Fully Functional Service Delivery System (FFSDS) approach as one of its strategies to achieve rapid expansion of an integrated essential package consistent with the GOU policies for its child survival component.

Implementation will adapt both the IMAM and PD/H approaches to contribute to national efforts to reduce acute malnutrition in children under five. The IMAM and PD/H roll out will be implemented in six STRIDES supported districts to begin with and later scaled up to cover other districts

This document specifies the implementation process for the pilot six districts of Mityana, Kamwenge, Kasese, Kamuli , Kayunga and Mayuge. Implementation is subject to further discussion on modality and resources available. Close monitoring and evaluation of the implementation, in combination with specific assessments will be further discussed, decided and designed, to synthesize lessons learned that will form the input for decision making on and design of up-scaling of the approach in all 15 STRIDES supported districts. STRIDES will support and expand capacity to implement, evaluate and scale up PD/Hearth initiatives in the 15 districts in Uganda. PD/Hearth activities will begin April 2011 in one of the selected districts. Currently there are no organizations implementing PD/Hearth in Uganda. STRIDES would like to use this program as a model based on experiences in order to share lessons learnt with both government and non-governmental organizations/stakeholders seeking to reduce child malnutrition. Efforts will also made through the existing health system structures to complement the ongoing IMAM strategy within the implementing districts.

1.2 Problem statement

Malnutrition has detrimental impact on health, physical development, brain development, and intellect especially during pregnancy and the first two years of life. The consequences of malnutrition are higher child morbidity and mortality and hence higher burden to the health system; lower cognitive development, hence lower returns from investments in education; and lower productivity. As calculated in a recent World Bank report, malnutrition accounts for an economic loss of about 3 percent of Gross Domestic Product in developing countries¹. Malnutrition is a major cause of under-five mortality, accounting for up to 60% of the mortality.

A significant proportion of Uganda's children under the age of five years still suffer from acute and chronic under nutrition, despite decades of the MOH and USAID investment in

¹ Repositioning Nutrition as Central to Development, as strategy for large scale action, The World Bank, March 2006

Uganda's basic health services (cite the source). Acute Malnutrition in children is a life-threatening condition and undermines their health and development (UDHS, 2006). The resulting mortality, morbidity and loss of productivity impede social and economic development. According to the UDHS (2006), 38% of under-fives are stunted, with 6% wasted; and 16% underweight, 73% anemic and 20% VAD. In Uganda, regional variations exist (Table 1). The east central districts rank highest in underweight and wasting, followed by western, central 1, eastern and lastly central 2 (Table 1). Based on acute malnutrition alone still east central ranks highest, followed by central 1 and western. Eastern and central 2 share the same position. There is no district specific data for nutritional status because most of the nutrition indicators such as: extent and magnitude of malnutrition (wasting, stunting and underweight) among children aged 6-59 months, current perceived causes, challenges and constraints, common practices specific for the selected districts are not regularly collected. However, clinical based data from most hospitals offering pediatric services indicate that the figures may be higher than what are documented by the UDHS.

The majority of deaths in children under-five are due to a small number of common, preventable, and treatable conditions, occurring singly or often in combination with malnutrition. Improving nutrition status would not only eliminate deaths due to malnutrition but also avert a significant proportion of deaths due to diarrhea, measles, pneumonia, and other childhood diseases. Nutrition is foundational for health and development and only improving nutrition can contribute enormously to the achievement of the MDGs. It has been estimated that investing in nutrition can increase a country's GDP by at least 2-3 percent annually (cite source of information/data). Uganda Nutrition Profiles (2010). Improving maternal and young child nutrition supports the growth and development of the next generation that will drive a nation's growth. The key to making rapid progress towards attaining MDG 4 is to reach every newborn and every child in every district and village with a priority set of high impact interventions. With only 5 years remaining to achieve the MDG targets, what is needed now is not new science, but a new and serious commitment to prioritize, allocate resources to, and accelerate child survival efforts in Uganda.

Globally recognized cost-effective, proven approaches that have made key contribution to improving child health and nutrition such as, Community Based Growth Promotion (CBGP), PD/Hearth, IMAM and ENA among others exist, the routine use of nutrition interventions in health service delivery is still low. Health services in Uganda have not adequately delivered high quality nutrition interventions. More-over successful community based programmes piloted elsewhere (such as UPHOLD, GINA in South western Uganda,NECDP REF), have been difficult to scale up and sustain. Many interventions have not paid attention to the barriers to child care and infant feeding (breastfeeding and complementary feeding in infants), at community and household level.

1.3 Objectives

Overall Objective

The primary objective of these nutrition activities is to scale up sustainable, cost effective child survival nutrition interventions in all STRIDES supported districts in Uganda.

Specific objectives

- To pilot and evaluate the feasibility of the PD/H approach for prevention of childhood malnutrition in six STRIDES supported districts in Uganda.
- To build the capacity of local health system/structures, and local partners in the prevention and treatment of acute malnutrition through the implementation of Integrated Management of Acute Malnutrition (IMAM) in the STRIDES districts.

1.4 Expected Outputs

- Set up treatment including rehabilitation (and referral) capacity at HC II, HC III and HC IV for complicated SAM and MAM cases
- Set up timely screening and referral system for AM cases at community level by local volunteers, VHTs and other community groups (it is

expected that about 80% of the identified SAM cases can be treated at community level without referral to health centres).

- support the stabilization (and subsequent referral to community-based treatment) of SAM and MAM cases with complications.
- Support the remodeling of health centres.
- Document findings, lessons learned and recommendation to wider audiences

STRIDES in collaboration with the Nutrition Section of MOH will initiate and jointly conduct planning, coordination, monitoring and evaluation activities. Collaboration from the implementing partners will be essential for the outcome. The implementing facilities/communities in collaboration with DHMTs will be responsible for the actual implementation in their areas, with the understanding that activities will be conducted in line with the harmonised/standardised guidelines for the IMAM which will be agreed upon in the planning phase(I thought the MOH has developed these/ is finalizing these). Collaboration is proposed to develop IEC materials specifically related to IMAM, training materials,job aides, manual and guidelines. The available Ministry of Health National Training of Trainers curriculum in IMAM and IYCF will be used to support and build capacity of service providers.

The STRIDES National Nutrition Advisor in consultation with and assisted by the Regional nutrition advisors,and the DHMTs will initiate the development and implementation of the STRIDES facility and community based nutrition activities.

2.0 Health facility and community approaches

2.1 The Integrated Management of Acute Malnutrition (IMAM) Approach

In the past, management of severe acute malnutrition was principally concentrated in the in-patient health facilities that were not accessible to poor families and did not reach children early. Evidence built up since 2001 has shown that the management of severe acute malnutrition in the community with weekly visits to the nearest low level health

facility can offer effective, sustainable treatment of severe acute malnutrition which benefits the health systems by reducing the burden on inpatient care². The strategy known as the integrated Management of Acute Malnutrition (IMAM) has achieved sustainably higher treatment coverage due to the improved access to services. The approach combines early community-level identification of cases with simple outpatient treatment protocols using ready to use therapeutic foods and inpatient care only for the most complicated cases (usually less than 20% of the caseload). It also fits into a wider programming context that should include interventions and initiatives for the prevention of malnutrition.

The IMAM approach, endorsed by WHO, UNICEF and partners internationally³ has been adopted in Uganda as an integrated approach to the management of acute malnutrition. The national guidelines are currently in press and will soon (March 2011) be launched by the Ministry of Health (MOH). Nationally an IMAM scale-up action plan has been developed for the next 5 years to guide roll out of treatment programs in Uganda in a phased approach categorised based on districts caseloads by both absolute numbers of the malnourished and prevalence.

2.2 The Positive Deviance/ Hearth (PD/H) Model

The Positive Deviance/ Hearth Approach is a proven community based nutrition rehabilitation program that sustainably addresses childhood malnutrition in resource poor settings. The approach identifies and shares solutions (practices) already being used by community members with well nourished children who have no access to special resources (positive deviants). Through identifying and using demonstrably successful local practices and resources and promoting behavior change by doing, caregivers and communities are empowered to take responsibility for nutritionally rehabilitating and maintaining good growth and health in their children. The PD/Hearth Approach can be implemented as a standalone program but benefits greatly from established relationships

² Collins et al. Management of severe acute malnutrition in children. **Lancet 2006; Vol 368**

³ WHO/WFP/SCN and UNICEF Joint statement on Community-Based Management of Severe malnutrition

and strengthened community and health structures when integrated into ongoing child survival or multi-sectoral development initiatives. The PD/ Health Approach can be summed up by its three goals:

- To quickly rehabilitate malnourished children identified in the community.
- To enable families to sustain the rehabilitation of these children at home on their own.
- To prevent future malnutrition among all children born in the community by changing community norms in childcare, feeding and health-seeking practices.

3-0 .

3.0 Implementation arrangements

3.1 : Planning phase

In each pilot district, the project staff will work with the district health management team with the (DHMTs) to introduce the program, seek commitment, select the facilities for etc implementation and implications for their program. Support and cooperation will be sought and promoted with staff from the technical and political leadership of the district through the District Health Office (DHO), and representatives from the District Health Management Team (DHMT). The detailed district level implementation plan will be developed in a joint district planning exercise.

An understanding will be developed by STRIDES and the DHO to detail roles, responsibilities, provision of resources and working modalities during the pilot phase for each pilot district. Given the fact that MoU between partner organizations and will be signed for the purpose of coordination, supply and training support, and data sharing for monitoring and evaluation. Collaboration is proposed to develop IEC materials specifically related to IMAM, training materials, manual and guidelines.

An orientation meeting for all DHMT members will be organized to inform them about the pilot and applicable implications. The district implementation plan will be shared with them to facilitate project operation and cooperation at the district, health facility and community level.

A nutrition focal person will be identified. On a three-monthly basis the DHO and Nutrition Focal Person of the pilot districts will be invited to meetings to share progress reports and their experiences with a STRIDES management. **3.2 : Initial assessment**

An assessment of health facilities for readiness to provide nutrition care and support services for children in the six selected districts will be conducted. The objectives of the assessment will be to:

- Determine the readiness to implement IMAM
- Identify potential nutrition related focal persons
- Identify existing nutrition programmes (TFC, SFC, OTC) and partners
- Determine the staff available and their responsibilities
- Identify training needs and capacity building
- Verify the availability of reporting formats and record keeping
- Establish availability of essential drugs for treating acute malnutrition
- Availability of weighing and measuring equipment and IEC materials
- Determining the role, activities and linkage of the health facility with community

The baseline information will be used to monitor and evaluate the project and to ascertain project. At the end of an intervention, an evaluation will be carried out to assess the impact of the project based on the initial status..

3.3 : The Pilot Project and Activities

The IMAM and PD/H pilot is intended to be a first step towards scale up of the two approaches by STRIDES, in its effort to address malnutrition through the health services

system. The anticipated implementation period for the pilot will be from April till September 2011. If and when the approach is found to be efficacious and feasible STRIDES will be in a position to roll out the nutrition programme – particularly the PD/Hearth community component. The IMAM pilot will be implemented in collaboration with the regular health system. STRIDES will adopt harmonized standards with guidance from a consultant in collaboration with the Nutrition Section of MOH. During the pilot they will be working with the DHT to establish feasible modalities for integration of the IMAM into the Primary Health Services system, including the contribution of local organizations and partners.

A common understanding about the objectives and expected outcomes of the pilot project will be developed with the STRIDES team. This implementation framework will be discussed and a more detailed district level implementation plan will be developed during a planning workshop at district level. Technical experts and management staff from the implementing partners and the DHMT in the workshop will need to agree upon the comprehensive pilot project's design, project guidelines, logistical organization, training and monitoring and evaluation arrangements.

Operation of the STRIDES nutrition programme is proposed to function through the existing health care system, and supported by community outreach activities. During the implementation phase four major tasks need to be addressed:

1. Initial assessment and review of secondary data
2. Orientation of District Health Team on IMAM and the PD/H approaches and establish active district level participation in programme implementation
3. Establishment of In Patient care (ITC) and Out-patient Care (OTC) treatment capacity at the health Facility level;
4. Logistical arrangements to ensure continuous supplies of therapeutic foods, drugs and medical supplies to the health facilities;
5. Community sensitization on malnutrition and IMAM/PD/H programmes, including screening activities, counseling and follow-up.
6. Strengthening ITC capacity at the district hospital and HC IVs.

7. Development of TOT capacity, training materials and Information Education and Communication materials for nutrition
8. National and district level coordination

High prevalence of malnutrition (>30%) and current infection of children suggesting poor immune function as a result of inadequate nutrition have been recorded in the district³.

A remote hard to reach health sub-district/sub-county with high rates of child malnutrition will be selected in agreement with the district team and partners. In order to benefit complementarily, both the IMAM and PD/Hearth approaches will run alongside each other. 5 Health facilities (1 HC IV/hospital, 1 HC III and 3 HC IIs) within the health sub-district will be identified and equipped to run the ITC/OTC component of IMAM.

About twenty villages in the catchment area of the health units selected will be mobilized for the PD/Hearth initiative in the same sub-county as where IMAM is taking place in a phased manner . Two PD families/mothers will be identified per village for conducting the hearth sessions. Initially, one village per health ncenter cathment area will be targeted for the first 12 hearth sessions. In addition, two schools within the pilot sub-county will be identified and contacted for a possibility of carrying out screening of acute malnutrition in the respective villages. PD families will also be encouraged to establish their own backyard gardens.

.4 : Monitoring and Evaluation

Since this is a pilot project to learn about the PD/H and IMAM scale up and integration in the health system, intensive monitoring is an important aspect to address issues affecting the feasibility and sustainability in the long term. Monitoring is equally important for final evaluation of project's outcomes. STRIDES will perform project monitoring in their respective districts in collaboration with the district team. Indicators definition and registration will be harmonized by the M&E section to facilitate comparisons of across pilot districts. Monitoring reports will be shared on a regular basis across the regional offices. The following areas will be explored for indicators that will be used to determine whether pilot programme objectives are met and to measure programme performance.

- Coverage
- Barriers to accessing out-patient and in-patient care (referral effectiveness)
- Staff and volunteer capacity:
- Integration of nutrition intervention in health system
- Effectiveness of treatment:
- Nutritional status
- Behavior Change indicators

4.1 : Supportive supervision

Supportive supervision and monitoring will be done at least once every two months by district staff. STRIDES will occasionally join the supervision visits to gain understanding of the project implementation on-the ground.

4.2 : Evaluation

A thorough evaluation of the effectiveness, efficiency, and impact of the pilot projects will be conducted after conclusion of the pilot activities in each district. A joint evaluation will be undertaken between STRIDES, MOH/DHT and USAID after one year, to extract lessons learned and challenges for scaling-up of the IMAM and PD/H approaches. The evaluation will focus particularly on:

- Cost effectiveness
- Suitability of MUAC for screening children with malnutrition
- Integration into health services (staff, supply chain, protocols)
- Barriers to access of nutrition services

Specific assessments

For better understanding of the context and the challenges identified in the feasibility assessment report, a number of in-depth assessments will be designed and conducted.

H: Budget (refer to STRIDES work plan)

Annexes

Table 1: Prevalence of macro and micronutrient under nutrition among children aged less than five years in the selected districts supported by STRIDES in Uganda.

Region	Macronutrient Under nutrition			Micronutrient Under nutrition	
	Stunting	Underweight	Wasting	Vitamin A Deficiency	Iron Deficiency Anemia
Central 1					
Kalangala, Sembabule Mpigi,	39%	23%	5%	23%	80%
Central 2					
Mityana Luwero Nakasongola Kayunga	30%	8	3	24	72
East Central					
Mayuge Kamuli Kaliro	38	23	10	32	80
Bugiri					
Eastern					
Kumi	36	11	3	24	80
Western					
Kasese Kamwenge Kyenjojo	38	15	5	15	64
National	38	16	6	20	73

Table 2: Nutrition Activity Work-plan

	Activity		J	F	M	A	M	J	J	A	S	O	N	D
	National coordination													
1	Participate in MOH Nutrition TWG/partner meetings													
2	Provide Updates from the TWG to STRIDES and share with Regional Nutrition Coordinators													
3	Draft Pilot Project Implementation plan													
4	Design training modalities (theoretical, practical, on the job)													
5	Develop of community mobilization and IEC strategy													
6	Develop monitoring plan													
7	Discuss and agree on overall plan with STRIDES Management													
8	Orientation of project and partner staff													
	District Coordination Activities													
9	Orientation/sensitization meeting with District Health Management Team (DHMT) and other stakeholders													
10	Review of District action plan													
11	Select district Nutrition focal person													
12	Establishment of district Nutrition coordination team													
13	Regular district coordination meetings for review of progress													
	Materials and training													
14	Obtain IMAM training guidelines, modules and manuals from MOH													
15	Obtain Nutrition counseling IEC material (Health Facility, Outreach/community)													
16	Obtain community awareness and outreach IEC material													
17	Printing of referral slips and patient cards													
18	Printing of registration and reporting formats as per M&E requirements													
	Scale Up IMAM Approach													
19	Identify trainers for IMAM and PD/Hearth													

	Monitoring and Evaluation																			
68	Baseline nutrition rapid assessment																			
69	Define common indicators and definitions																			
70	Determine monitoring system through standard registration and reporting formats																			
71	Regular supportive supervision and monitoring																			
72	Monthly Health Facility level data compilation and submission to DHO																			
73	DHO level joint analysis and reporting on monitoring indicators to MOH and STRIDES																			
74	Feedback on monthly reports by STRIDES to District level																			
75	Dissemination meeting on pilot progress																			
76	Coverage assessment																			
77	Overall Pilot Evaluation study																			
78	Presentation and discussion on evaluation with all stakeholders/partners																			