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HIV TRAINING EVALUATION

Evaluation of the Scale-up of the PMTCT Infant Feeding Counseling Training Program in Tanzania

SEPTEMBER 2010

This HIV training evaluation was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). It was authored by Winnie Luseno of the University of North Carolina; Margaret Nyambo, Bart Burkhalter; Monica Ngonyani, and Davis Rumisha of URC; and Bupe Ntoga of the Tanzania Food and Nutrition Centre. The evaluation was funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and carried out under the USAID Health Care Improvement Project, which is made possible by the generous support of the American people through USAID.

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DISCLAIMER

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ACRONYMS

AFASS	Acceptable, feasible, affordable, sustainable, and safe
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
CTC	Care and Treatment Center
DMO	District Medical Officer
HCI	USAID Health Care Improvement Project
HIV	Human immunodeficiency virus
IF	Infant feeding
KCMC	Kilimanjaro Christian Medical Centre
MCHA	Maternal and child health aide
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Program
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
QAP	Quality Assurance Project
Q&A	Question and answer
RCH	Reproductive and child health
TACAIDS	Tanzania Commission for AIDS
TFNC	Tanzania Food and Nutrition Centre
TOT	Trainer of trainers
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
URC	University Research Co., LLC
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

From 2003-2006, University Research Co., LLC (URC), through the USAID-funded Quality Assurance Project, partnered with the Ministry of Health and Social Welfare (MOHSW), the Tanzania Nutrition and Food Centre (TNFC), and the Kilimanjaro Christian Medical Centre (KCMC) to develop an infant feeding counseling program based on the World Health Organization's guidelines on infant feeding in the context of HIV. In 2007, the MOHSW and National AIDS Control Program (NACP) formally endorsed the infant feeding counseling materials and the training program in their use that had been developed and tested by URC. The infant feeding (IF) counseling training program (hereafter referred to as the "PMTCT IF counseling training program" to differentiate it from the original PMTCT program that did not have an explicit focus on infant feeding counseling) was officially incorporated into the national program for the prevention of mother-to-child transmission of HIV (PMTCT). In addition, the MOHSW requested that URC, through the USAID Health Care Improvement Project (HCI), assist in planning and monitoring the scale-up of the infant feeding counseling training program.

The scale-up of the PMTCT IF counseling program began in 2008 and is still ongoing. This evaluation focuses on the PMTCT IF counseling training program, which consists of a five-day training of regional trainers-of-trainers (TOT), a five-day training of PMTCT counselors, a one-day orientation of health facility staff, and a three-hour sensitization of the site director, senior managers and supervisors. Job aids developed by URC for the PMTCT counselors were also introduced during the training. These include: a question and answer guide, counseling cards, and brochures for mothers to take home with information on exclusive breastfeeding and infant feeding options, how to feed a baby after six months, and maternal health during pregnancy.

Objectives

This evaluation sought to answer the following questions about the scale-up of the PMTCT IF counseling training program:

- Training trainers-of-trainers. Have all the trainers received the five-day training intended for them?
- Initial implementation at sites. Does each site that joins the PMTCT scale-up receive all five sub-components of the infant feeding counseling program at the time the site joins the PMTCT program?
- Scale-up schedule. Does the initial implementation of the infant feeding counseling program occur more or less at the same time that the site implements the PMTCT national scale-up?
- Training new staff at sites. As new counselors, site directors, and staff replace those who leave or are added to sites, are they trained, and if so, how soon?
- Inventory replenishment. Are job aids and take-home brochures at sites replenished before stock-out? If not, how long before replenishment occurs?
- Monitoring. To what extent are sites that have implemented the IF counseling training program during scale-up participating in the monitoring program for the infant feeding counseling program?
- Corrective action. When problems are identified (e.g., via the monitoring function), are corrective actions identified, communicated, and taken?

Methods

Twenty facilities in Iringa Region of Tanzania were visited for this evaluation. Data collection occurred in two rounds with two different teams. Data were collected through a structured questionnaire. Informal interviews were also conducted with MOHSW district level staff as well as EngenderHealth staff to assess whether sites that have implemented the PMTCT IF counseling training program are participating

in the monitoring and evaluation program established by NACP and whether corrective measures are taken when problems are identified. Two facilities that did not have staff trained in IF counseling were not included in the final analysis. Thus, the final sample for this evaluation consisted of 18 facilities.

Results

- Not all current PMTCT sites have staff trained in the five-day Infant Feeding Counseling Training program. A total of 69 staff in 13 (72%) facilities had received the five-day counselor training. The majority of those trained as counselors were nurses (56%). A total of 22 staff in 10 (56%) facilities had received the five-day TOT training. Of these, 68% were nurses, 18% were doctors, and the remaining 14% were other staff.
- Among those who had received the one-day orientation, about 46% were nurses, 11% were clinicians, and 6% were MCH aides. Only 5% were facility in-charges, and 1% were doctors.
- Out of the 18 facilities that had staff trained in infant feeding counseling, 33% had a complete set of job aids, 61% had a partial set, and 6% had no job aids in their facility.
- There are a total of six mother take-home brochures, but, brochures are given out to antenatal attendees according to their feeding choice. However, all women receive a brochure with information on nutrition during pregnancy and breastfeeding. Take-home brochures to be disseminated among pregnant women were currently completely out of stock in 75% of facilities. Only 6% had all six mother take-home brochures on site, and 19% had less than six. Almost all facilities reported that they did not have a procedure in place for ordering more materials.
- Except for Tosamaganga, all facilities reported that no refresher training had been conducted. New staff in only one facility and new supervisors in only one facility had received training, orientation or sensitization for the infant feeding counseling.
- No specific guidelines for monitoring the PMTCT IF counseling program have been developed, and a system has not been put in place for replenishment of materials.

Conclusions and Recommendations

Training of infant feeding counselors using the five-day infant feeding training program is not keeping pace with the scale-up of the PMTCT program. There is a great need to speed up the implementation of IF counselor training in order to get more counselors at the PMTCT sites.

Clear guidance needs to be provided during training of counselors on how to order replacement materials. Additionally, facilities need to be encouraged and assisted to put in place a system for the replenishment of materials. Finally, a central production and distribution point for the nation as a whole should be strengthened to ensure the quality and availability of the materials are maintained. Refresher training or regular debriefing among infant feeding counselors in facilities should be conducted to review guidelines and protocols pertaining to counseling and the distribution of take-home materials.

The MOHSW and implementing partners should actively provide assistance and support for additional training of staff at the regional and district levels. Furthermore, a system for monitoring the implementation and results of infant feeding counseling needs to be strengthened at the facility, district, and regional levels.

I. INTRODUCTION

A. Background

From 2003-2006, University Research Co., LLC (URC), through the USAID-funded Quality Assurance Project, partnered with the Ministry of Health and Social Welfare (MOHSW), the Tanzania Nutrition and Food Center (TNFC), and the Kilimanjaro Christian Medical Center (KCMC) to develop an infant feeding counseling program based on the World Health Organization's guidelines on infant feeding in the context of HIV. The training program sought to improve the counseling of expectant mothers on infant feeding in the context of HIV/AIDS, by developing an integrated set of counseling materials that emphasized to the mother what are safe, affordable, and feasible infant feeding options and how these affect the risk of HIV transmission. Such counseling is considered to be a vital part of prevention of mother-to-child transmission of HIV (PMTCT). The materials were first pilot-tested on a small scale and the results used to refine the materials, which were then introduced in additional sites. Evidence indicates that in general more and better counseling of mothers yields better results,¹ and the pilot study of the Tanzania PMTCT infant feeding counseling training program showed that counselor and mother knowledge improved as a result of the program.^{2,3}

The PMTCT IF counseling training program consists of a five-day training of regional trainers-of-trainers (TOT), a five-day training of PMTCT counselors, a one-day orientation of health facility staff, and a three-hour sensitization of the site director, senior managers and supervisors. Job aids were also developed by URC for use by the PMTCT counselors and are introduced during the training. These include: a question and answer guide, counseling cards, and brochures for mothers to take home with information on exclusive breastfeeding and infant feeding options, how to feed a baby after six months, and maternal health during pregnancy.

After field testing and evaluation, in 2007, the MOHSW and National AIDS Control Program (NACP) formally endorsed the infant feeding counseling materials and the training program in their use that had been developed and tested by URC. The infant feeding (IF) counseling training program (hereafter referred to as the "PMTCT IF counseling training program" to differentiate it from the original PMTCT program that did not have an explicit focus on infant feeding counseling) was officially incorporated into the national PMTCT program. In addition, the MOHSW requested that URC, through the USAID Health Care Improvement Project (HCI), assist in planning and monitoring the scale-up of the infant feeding counseling program to the over 5,000 sites throughout the country providing PMTCT services.

The scale-up, which began in 2008 and continues today, is conducted through the assistance of HIV program partner organizations, each serving a different region of the country, under guidelines developed by the Government of Tanzania. The MOHSW has a team of national "trainers-of-trainers" who have received special training on infant feeding counseling and who train regional trainers that in turn train counselors employed by the government and private organizations in the different regions of the country.

¹ Piwoz EG, Humphrey JH, Tavengwa NV, et al. 2007. The impact of safer breastfeeding practices on postnatal HIV-1 transmission in Zimbabwe. *Am J. of Public Health* **97**(7): 1249-1254.

² Leshabari S, Koniz-Booher P, Burkhalter B, Hoffman M, Jennings L. 2007. Testing a PMTCT infant-feeding counseling program in Tanzania. *Operations Research Results*. Bethesda, MD: Published for USAID by the Quality Assurance Project, University Research Co., LLC.

³ Leshabari S, Koniz-Booher P, Blystad A., Burkhalter B, Kwesigabo G, Moland KM. Counselling tools and training on safer infant feeding practices improve nurse-counsellor performance and mother knowledge in the context of HIV in Kilimanjaro, Tanzania: A pilot study. November 2009. Submitted for publication.

At present, two different infant feeding counseling programs are being implemented in different sites: (1) the PMTCT IF counseling training program, and (2) an infant feeding component within the PMTCT training program.

This evaluation focuses on the PMTCT IF counseling training program. In addition to the components of the program assessed in the pilot study, the scaled-up program has added a 10-day training for the national trainers-of-trainers. The job aids and take-home materials developed by URC, MOHSW, TFNC, and NACP are important components of the infant feeding counseling training program. They feature high-impact graphics and easy-to-follow instructions, reflecting the international guidelines aimed at reducing the risk of transmission of HIV from mother to child. The job aids and counseling materials are used by PMTCT counselors to improve the quality and consistency of their counseling on infant feeding in the context of HIV/AIDS. These job aids and take-home materials, which are all published in English and Swahili, include:

1. **An HIV and Infant Feeding Question and Answer (Q&A) Guide** with answers to questions commonly asked by mothers, their families and communities. The question and answer guide is intended as a reference tool to provide health workers with information concerning updated international guidelines related to HIV and infant feeding. Health workers can refer to the guide to explain the complicated and difficult issues related to HIV and infant feeding, provide information and support to help prevent HIV transmission from women to their children, and increase the safety of all infant feeding options, including exclusive breastfeeding, commercial formulas, modified cows' milk, and expressed and heat-treated breast milk. It gives easy-to-understand answers to some of the most common questions that mothers, their families, and communities ask about HIV and infant feeding. The Q&A Guide is based on a generic UNICEF PMTCT infant feeding counseling tool and on the content of the WHO/UNICEF HIV and Infant Feeding Counseling Tools.
2. **Mother Take-Home Brochures.** The mother take-home brochures provide illustrated and easy-to-follow guidelines to enable prenatal and postpartum women to make informed decisions. The brochures graphically depict the step-by-step procedures for women to use in carrying out each of the four infant feeding options. There are six mother take-home brochures as follows: Exclusive Breastfeeding, Infant Formula, Cow Milk, Expression and Heat Treatment, Nutrition of the Pregnant and Breastfeeding Woman, and Feeding a Baby after Six Months.
 - i. **How to breastfeed your baby.** This take-home brochure provides mothers with an illustrated guide and detailed step-by-step instructions on how to start and continue breast feeding. It provides information on how to recognize and prevent problems, lists signs to look out for, and identifies what mothers need to remember and know.
 - ii. **How you can safely heat treat breast milk.** This is an insert which shows how to safely heat breast milk.
 - iii. **How to feed your baby fresh cow milk.** HIV-positive mothers who opt to feed fresh cow milk to their babies are given a complete list of steps and ingredients needed for safely modifying and feeding fresh cow's milk to babies. The brochure outlines how to make fresh cow milk more nutritionally appropriate for infants. It visually presents the preparation process, stresses the importance of hygiene, and encourages the use of cup feeding.
 - iv. **How to feed your baby infant formula.** HIV-positive mothers who opt to use commercial infant formula to feed their babies are given a complete list of steps needed to safely prepare formula and feed their babies. The brochure visually presents the preparation process, stresses the importance of hygiene and encourages the use of cup feeding.
 - v. **Nutrition during pregnancy and breastfeeding.** Pregnant and breastfeeding women are reminded of the importance of taking a test to determine HIV-status. By becoming aware of

- their status, HIV-positive women are then able to consult their healthcare providers to determine an appropriate course of action for antiretroviral therapy and nutrition. The brochure points out the importance of good nutrition for HIV-positive mothers and their infants and gives illustrated pointers on safely preparing foods and planning balanced meals. General points covering meal frequency, water consumption, and diet supplementation are given, and women are reminded to follow their healthcare providers' instructions.
- vi. **How to feed a baby after 6 months.** This brochure addresses questions that mothers may have regarding how to feed babies who, after six months, are beginning to eat semi-solid foods. HIV-positive women, the brochure notes, should consult a healthcare provider to determine whether it would be best to give another type of milk in place of breast milk. It points out that after 6 months, babies need to gradually begin eating a variety of foods and gives information on types of foods, as well as correct consistency and amounts, to give to babies aged 6, 7-8, 9-12, and 12-24 months. The brochure gives instructions for safe food preparation and storage and covers a range of other points.
3. **Counseling Cards.** These eleven laminated counseling cards provide illustrations that are easy to follow. They are intended for health workers to use during sessions with HIV-positive prenatal and postpartum women. Published in English and Swahili, the cards are tools that health workers can use to explain: the risk of transmission of HIV from mother to child when no preventive actions are taken and after preventive measures have been taken; infant feeding options for HIV-positive mothers; the concept of acceptable, feasible, affordable, sustainable and safe (AFASS) replacement feeding; and how to safely practice their chosen infant feeding method.

B. Objectives

The primary objective of this evaluation is to assist the program implementers to make improvements to the national scale-up of the infant feeding training program developed and tested originally by URC, MOHSW, TFNC, and KCMC. It focuses on the implementation of the program during scale-up and its sustainability after scale-up. This evaluation also tries to answer the following questions about the scale-up of the training program, including job aids and other materials:

1. Training trainers-of-trainers. Have all the trainers-of-trainers received the five-day training intended for them, and if any new trainers-of-trainers join, do they receive the five-day course?
2. Initial implementation at sites. Does each site that joins the PMTCT scale-up receive all five sub-components of the infant feeding counseling program (five-day training of counselors from the site, one-day orientation training of other health care staff from the site, three-hour sensitization for site directors, sufficient job aids for the counselors at the sites, sufficient inventory of mother take-home brochures) at the time the site joins the PMTCT program?
3. Scale-up schedule. Does the initial implementation of the infant feeding counseling program occur more or less at the same time that the site introduced the national PMTCT program?
4. Training new staff at sites. As new counselors, site directors, and staff replace those who leave or are added to the staff of sites, are they trained? How soon are they trained? Does the training of new staff occur at the same level as the original training?
5. Inventory replenishment. Are job aids and take-home brochures at sites replenished before stock-out? If not, how long before replenishment occurs? On average, what proportion of sites do not have inventory of job aids and/or take-home materials at any point in time? What does this imply for how many mothers are counseled without job aids or take-home materials?
6. Monitoring. To what extent are sites that have implemented the PMTCT IF counseling training participating in the monitoring program for the infant feeding counseling program, including

actions being taken by the sites (e.g., sending in data on key indicators) and by the central monitoring unit (e.g., establishing and operating an appropriate surveillance system)?

7. Corrective action. When problems are identified (e.g., via the monitoring function), are corrective actions identified, communicated, and taken? Do the corrective actions solve the problem, and if not, is further analysis and corrective action taken?

This evaluation did not attempt to answer questions about the impact of the program on practices or outcomes of mothers and their infants.

II. METHODS

A. Overview

In order to provide rapid findings so that improvements can be made quickly as well as due to budget and time limitations, this study was designed as a small scale evaluation with a short data collection period. The approach was limited to one implementing partner organization, EngenderHealth, which operates the ACQUIRE Tanzania Project, and selected districts from one of its implementing regions, Iringa.

Data collection occurred in two rounds with two different evaluation teams. The data collection team for the first round consisted of a staff member from the URC office in Tanzania, a staff member from TFNC, and a doctoral student from the University of North Carolina at Chapel Hill in the United States. The team for the second round of data collection consisted of two staff members from the URC office in Tanzania. Prior to departure for the field for the first round of data collection, the tool was reviewed, revised and finalized. No changes were made to the tool for the second round of data collection. The sample of facilities to be visited for the evaluation study was also selected and study procedures and logistics finalized prior to departure for the field.

Data were collected using a structured questionnaire administered to staff in health facilities (see Appendix). At each district, the evaluation team met and introduced the evaluation to the District Medical Officer (DMO) or available senior district-level staff, who then assigned a staff member to assist with providing directions to the facilities and in data collection. At each facility the evaluation began by explaining the purpose of the study to the hospital in-charge/facility director and obtaining permission for staff participation. Only staff who had received training in the PMTCT IF counseling program were interviewed for this evaluation. In each facility, the Reproductive and Child Health Coordinator or other supervisor aware of training programs attended by staff assisted in the identification of appropriate staff to be interviewed. Once all the staff to be interviewed were gathered, the purpose of the evaluation was explained to the group and verbal consent to participate obtained.

Interviews lasted approximately 40 minutes and began with study team members introducing themselves and providing a brief introductory statement about the evaluation study. The names and job titles of the facility staff being interviewed were then recorded. The tool covers six topics: 1) reach; 2) PMTCT roll-out; 3) infant feeding counseling program; 4) infant feeding counseling program training and materials at training; 5) new counselors and staff turnover; and 6) replenishment of materials.

In addition, informal interviews were conducted with MOHSW district level staff as well as EngenderHealth staff to assess whether sites that have implemented the PMTCT infant feeding counseling training program are participating in any monitoring and evaluation program established by either URC or NACP and whether corrective measures are taken when problems are identified.

B. Selection of Study Region, Districts, and Sample Facilities

The target facilities for this study were health facilities with staff that had received the five-day counselor training in infant feeding counseling. Iringa Region was selected for the evaluation activity because: (1) at

16%, the region has the highest HIV prevalence in the country⁴; (2) the PMTCT implementing partner, EngenderHealth, was willing to participate in the study; and (3) the evaluation study compliments the ongoing URC quality improvement program.

Round 1 data collection: Njombe, Mufindi, Iringa Rural and Iringa Urban Districts were selected purposively because they are conveniently located and fairly typical of the other three districts in the region. First, a sampling frame of 363 health facilities from the region was obtained from the MOHSW PMTCT Unit. Facilities that were not in the four districts selected for this study were not eligible for selection and were therefore dropped, leaving 240 facilities which were grouped into three strata (8 hospitals, 21 health centers, and 211 dispensaries). This list of facilities was presented to MOHSW staff in the selected districts who identified the facilities with staff trained in infant feeding counseling. Based on this information, a total of 11 facilities were visited for the first round of data collection for this evaluation study.

Round 2 data collection: Makete District was specifically selected for the second round of data collection because of information obtained during the first round that indicated additional infant feeding counseling training sponsored by UNICEF was done by TFNC in this district. A total of 10 facilities in Makete District out of the 20 that had received the training sponsored by UNICEF and conducted by TFNC were visited for the second round of data collection.

C. Field Implementation

The first round of data collection took place between June 24 and July 2, 2010 and the second round occurred between August 9 and 11, 2010. Using the finalized data collection tool, the teams interviewed staff at the selected PMTCT health facilities. Eighteen of these interviews were conducted in group format (i.e., face-to-face visits to most facilities),⁵ and three were telephone interviews⁶. The same data collection form was used for both methods. Data were collected by both methods for one facility (a hospital), initially by telephone and five weeks later by a visit to the facility, each by a different data collector. The two data collectors were not aware of the other contact. This enabled a comparison of the answers that the facility provided by the two data collection methods (telephone and face-to-face) in order to assess the agreement of the two methods. The data from the face-to-face interview were used for the evaluation.

Staff at district government offices and at the EngenderHealth ACQUIRE office were also interviewed to evaluate sustainability of the program after scale-up.

D. Data Management

Data collection forms were entered into an Excel spreadsheet in the field and at URC Tanzania. Excel was also used for data management and analysis. Quantitative analysis was descriptive, and no statistical tests were used. Information obtained from interviews with staff at district government offices and EngenderHealth/ACQUIRE was recorded by hand and summarized for this report.

⁴ Demographic and Health Survey (2008). Tanzania: AIS, -08 – HIV Fact Sheet. Available at http://www.measuredhs.com/pubs/pub_details.cfm?ID=883&srchTp=advanced

⁵ Njombe District Hospital, Ilembula Lutheran Hospital, Makambako Health Center, Roman Catholic Makambako Dispensary, Mafinga District Hospital, Iringa Regional Hospital, Ngome Health Center, Tosamaganga District Hospital, Bulongwa Hospital, Ikanda Mission Hospital, Maliwa Dispensary, Mangoto Dispensary, Lupalila Dispensary, Ipelele Health Center, Luhumbo Dispensary, Isapramo Dispensary, Utanziwa Dispensary, and Ukwama Dispensary.

⁶ Bulongwa Hospital, Makete District Hospital, and Ilula Hospital.

III. RESULTS

C. Characteristics of the Facilities Visited for Data Collection

The characteristics of the facilities visited for this evaluation are summarized in Table 1. Data from a total of 20 facilities are presented. The average number of pregnant women receiving antenatal counseling each month per facility ranged between 5 and 150. In general, dispensaries had fewer pregnant women receiving antenatal counseling each month. Makambako Health Center, Ngome Health Center, Mafinga District Hospital, and Iringa Regional Hospital which are urban-based had 100 or more pregnant women receiving counseling per month.

Table 1. Characteristics of the sample of facilities

Name of Facility	Type of facility	District	Average no. pregnant women/month	No. staff trained in IF counseling	Counselor: Client ratio
Round 1 Data Collection					
Njombe District	Hospital	Njombe	50	5	1:10
Ilembula Lutheran	Hospital	Njombe	30	N/A	
Makambako	Health center	Njombe	150	3	1:50
Roman Catholic Makambako	Dispensary	Njombe	50	N/A	
Mafinga District	Hospital	Mufindi	141	3	1:40
Iringa Regional	Hospital	Iringa Urban	150	7	1:21
Ngome	Health center	Iringa Urban	100	1	1:100
Tosamaganga District	Hospital	Iringa Rural	42	3	1:14
Makete District	Hospital	Makete	30		
Ilula	Hospital	Kilolo	85	2	1:42
Round 2 Data Collection					
Ipele	Health center	Makete	10	5	1:2
Utanziwa	Dispensary	Makete	6	2	1:3
Isapulano	Dispensary	Makete	5	2	1:3
Makiwa	Dispensary	Makete	5	2	1:3
Mang'oto	Dispensary	Makete	5	1	1:5
Bulongwa Lutheran	Hospital	Makete	10	5	1:2
Luhumbo	Dispensary	Makete	7	1	1:7
Lupalilo	Dispensary	Makete	7	0	
Ukwama	Dispensary	Makete	5	1	1:5
Consoleta H Ikonde	Hospital	Makete	20	2	1:10

All facilities had a PMTCT program for antenatal clinic attendees and had staff who had received training for the program. Most facilities indicated that their PMTCT program is supported by EngenderHealth. According to the staff interviewed, other implementing partners providing assistance in this region include International College for Health Cooperation in Developing Countries (CUAM), TUNAJALI, Family Health International (FHI), and United Nations Children's Fund (UNICEF).

While all facilities visited by the evaluation team counseled antenatal clients on infant feeding practices based on the original PMTCT program, three (Ilembula Lutheran Hospital, Roman Catholic Makambako Dispensary, and Lupalilo Dispensary) did not currently have staff trained in the PMTCT infant feeding counseling program. The data show unequal distribution of infant feeding counselors; where there is high demand, the counselors are few. The ratio of counselors to clients ranges from 1:2 in Ipele Health Center to 1:100 in Ngome Health Center. Counselors trained in the PMTCT infant feeding counseling program ranged from 0 to 7 per facility.

The final sample of facilities for this evaluation study consisted of 18 health facilities. Two facilities (Ilembula Lutheran Hospital and Roman Catholic Makambako Dispensary) that did not have staff trained in the PMTCT infant feeding counseling program were dropped from the analysis. Although Lupalilo Dispensary did not currently have any staff trained in the program, it was decided to keep the facility in the sample because it had trained staff in the past who had since stopped working there.

D. Training in Infant Feeding Counseling

Training for the roll-out of the PMTCT infant feeding counseling program in Iringa Region is being conducted on a different schedule from the scale-up of the PMTCT program. Additionally, not all current PMTCT sites have staff trained in the IF counseling program. Staff from a total of 33 facilities in the six districts had received training in infant feeding counseling. Out of these, staff in 13 facilities had received training coordinated by EngenderHealth through the ACQUIRE Project. An additional 20 facilities in Makete District had received training conducted by TFNC and sponsored by UNICEF.

Information obtained during round 1 of data collection from EngenderHealth/ACQUIRE indicates that to date they have organized one five-day TOT course that occurred in March 2009 with 16 participants and one five-day training of counselors in late March to early April 2009 with 30 participants. About two participants from each of the seven districts in Iringa Region were invited to participate in the TOT training with the expectation that they would roll out the various training components (i.e., five-day training of counselors, one-day orientation, and three-hour sensitization) in their respective districts. Participants in the five-day training of counselors were also from all seven districts. Specific details are not known about the trainings coordinated by TFNC with financial assistance from UNICEF except that they occurred between 2008 and 2009. However, from data obtained during round 2 data collection, we know that through the TFNC/UNICEF trainings in Makete District, an additional six TOT and 39 counselors were trained.

The types of training received and the breakdown of facility staff by cadre who received training are presented in Table 2. Out of 22 staff in 10 (56%) facilities who received the five-day TOT training, 68% were nurses and 18% were doctors. Facility in-charges, clinicians and maternal and child health aides (MCHAs) were each 5%. Thirteen (72%) facilities had staff who had received the five-day training for counselors. The majority of those trained as counselors were nurses (56%). Facility in-charges (9%), doctors (3%), clinicians (9%) and MCHAs (3%) had also received counselor training. About 79 staff in 13 (39%) facilities had received the one-day orientation. About 46% of these were nurses, 11% were clinicians, and 6% were MCHAs. Only 5% of facility in-charges and 1% of doctors had received orientation on the infant feeding counseling program, and only one facility in-charge had received sensitization on the program.

Table 2. Types of training received and proportion (n) of staff who have received training in the infant feeding counseling program

	Number of facilities	Total N	Facility in-charges n (%)	Doctors n (%)	Nurses n (%)	Clinicians/ clinical officers n (%)	MCHAs n (%)	Others n (%)
TOT	10	22	1 (5)	4 (18)	15 (68)	1 (5)	1 (5)	
Counselors	13	69	6 (9)	2 (3)	39 (56)	6 (9)	2 (3)	14 (20)
Orientation	7	79	4 (5)	1 (1)	46 (58)	9 (11)	5 (6)	14 (18)
Sensitization	1	1	1 (100)					

Table 3 presents nurses in a supervisory role who had received TOT and counselor training, as well as orientation in the IF counseling program. Not all nurses trained in the PMTCT IF counseling program were in a supervisory role. Out of 12 supervisors trained as TOT, about 33% were supervisors in reproductive and child health (RCH), 13% in maternity, 7% in HIV Care and Treatment Centers (CTC), and 27% in pediatrics. Out of 39 supervisors trained as counselors, 18% were supervisors in RCH, 15% each in maternity and CTC, and 8% in pediatrics. Out of 46 supervisors who received the one-day orientation on infant feeding counseling, 15% were supervisors in maternity, 7% in pediatrics, 4% in RCH, and 2% in CTC.

Table 3. Types of training and proportions (n) of supervisors among nurses who have received training in the infant feeding counseling program

	Total N	RCH n (%)	Maternity n (%)	CTC n (%)	Pediatrics n (%)
TOT	12	5 (42)	2 (17)	1 (8)	4 (33)
Counselors	22	7 (32)	6 (27)	6 (27)	3 (14)
Orientation	13	2 (15)	7 (54)	1 (8)	3 (23)

E. Materials at Training and Replenishment

All staff interviewed for this evaluation reported that they all received job aids and take-home brochures during training. Table 4 shows responses as to whether materials provided during training were currently present in the facility at the time of the interview and whether mother take-home brochures were currently in stock. Of the 18 facilities that had staff trained in infant feeding counseling, 33% had a complete set of job aids (i.e., 11 counseling cards, one Q&A booklet, and six take-home brochures), 61% had a partial set (i.e., missing either the counseling cards, Q&A booklet and/or some or all take-home brochures), and 6% had no job aids (i.e., no counseling cards, Q&A booklet or take-home brochures) in their facility.

Table 4. Availability of job aids and mother take-home brochures in the facilities (N=18)

	Facilities with complete set ¹ n (%)	Facilities with partial set ² n (%)	Facilities with none ³ n (%)
Job aids (N=18)	6 (33)	11 (61)	1 (6)
Mother take-home brochures(N=16) ⁴	1 (6)	3 (19)	12 (75)

1. For job aids, this means 11 counseling cards, one Q&A booklet, and six take-home brochures. For mother take-home brochures, this means all six brochures. 2. For job aids, this means missing the counseling cards, Q&A booklet and/or some or all take-home brochures. For mother take-home brochures, it means missing some brochures. 3. For job aids and mother take-home brochures, none were present at the facility. 4. Two facilities with missing data not included.

Take-home brochures to be disseminated among antenatal women were currently completely out of stock in 75% of facilities. Only 6% had a complete set of mother take-home brochures and 19% had a partial set. Almost all facilities reported that they did not have a procedure to order more materials. Only one facility indicated that they had a procedure whereby the facility in-charge placed an order for take-home brochures with the quarterly report.

F. Refresher Training, Staff Turnover, and New Counselor Training

Except for Tosamaganga, all facilities reported that no refresher training had been conducted. The refresher training in Tosamaganga was conducted twice by the TOT, a medical doctor, and focused on orientation of staff. New staff with no previous training in infant feeding counseling participated in the refresher orientation.

Approximately 61% (11 out of 18) of facilities reported that new staff had been hired since staff received training for infant feeding counseling. However, new staff in only one facility had received training for the infant feeding counseling. Additionally, 28% (5 out of 18) of facilities reported that new supervisors had been hired since supervisors in the facility received orientation and sensitization on infant feeding counseling. Only one facility reported that new supervisors had received orientation/sensitization.

Further, 33% (6 out of 18) reported that staff who had received training in infant counseling were no longer working at the facility. Only one facility reported that supervisors trained in infant feeding counseling had stopped working at the facility.

G. Monitoring and Evaluation

Specific guidelines for monitoring and evaluation of the PMTCT infant feeding counseling program have not been developed. However, guidelines for evaluation and monitoring developed for the PMTCT infant feeding component are currently being applied to the PMTCT infant feeding counseling program. These include a set of four questions in the site supervision checklist used during quarterly monitoring visits to PMTCT facilities:

1. Is infant feeding counseling offered to HIV-infected mothers at ANC, at discharge from labor and delivery, and at postnatal and follow-up?
2. Are infant feeding counseling options conducted considering the following aspects: exclusive breastfeeding for six months, exclusive replacement feeding if AFASS, and danger of mixed feeding?
3. Is there any demonstration and materials for infant feeding options (replacement feeding)?
4. What support is available for infant feeding? Positioning and attachment of the infant to the breast? Educational materials on infant feeding? Support groups (community, health facilities, etc.)?

Information on what is done with this information was not obtained for this evaluation.

With respect to corrective action none appears to be taken when problems are identified. For example, a large proportion of facilities visited for this evaluation had partial or incomplete sets of job aids and mother take-home brochures. Many of these facilities indicated that they did not have a formal procedure to order materials. A number reported having mentioned their need for more materials to EngenderHealth who in turn had tried but been unable to order more materials from MOHSW. It does not appear that any measures had been taken to address this problem of replenishment of materials.

In the facility that received both a telephone interview and a face-to-face visit (Bulongwa Hospital), the majority of questions were answered the same by both methods. But several questions were answered differently. Of the 66 questions on the data collection form, 42 (64%) were answered the same by both methods and 24 (36%) were answered differently. (The number of questions on the form varies

depending on if sub-questions are counted as separate questions and on how the “skip” questions are handled.) The questions (and groups of questions) with different answers are listed below:

- Number of pregnant women counseled monthly (Telephone-20, Visit-10)
- Who is the implementing partner for the facility?
- Explanations and suggestions written in were much richer for many questions in the visit, and nearly non-existent by telephone.
- Number of facility staff receiving training by type of provider and type of training were different for the two methods, although totals similar.
- Were take-home brochures disseminated at trainings? (Telephone-Yes, Visit-No)
- At training, were job aids and take-home brochures distributed and used, distributed but not seen, or not distributed (Telephone-distributed but not seen, Visit-never distributed).
- How many new staff has facility hired since training? (Telephone-0, Visit-3)
- Who is responsible for ordering more job aids and take-home brochures (Telephone-?, Visit-RCH Coordinator).

All other questions were answered the same by both methods. The answers for this facility obtained during the visit are assumed to be correct and were used for analysis in the study; the data obtained by telephone were not used.

IV. DISCUSSION AND RECOMMENDATIONS

HIV prevalence among antenatal women in Tanzania is estimated at 6.2%, and one in seven children dies before age five.⁷ Mother-to-child transmission of HIV is a critical factor in child mortality in Tanzania, and poor infant feeding practices are the cause of about one third of the transmissions⁸. This evaluation focused on the scale-up of the infant feeding counseling training program originally developed and tested by URC, MOHSW, TFNC, and KCMC for PMTCT counselors in Tanzania to improve their counseling of expectant mothers on infant feeding in the context of HIV/AIDS.

The primary objective of the evaluation is to assist the program implementers to make improvements to the national scale-up of the PMTCT infant feeding counseling training program. It focuses on the implementation of the program during scale-up and its sustainability after scale-up.

The evaluation results indicate that the national roll-out of the PMTCT infant feeding counseling training program begun in 2008 is not proceeding at the pace needed to effectively cover the country. To date, staff in only 33 PMTCT sites in Iringa Region have officially received five-day training in infant feeding counseling. Data from 18 of these 33 facilities are presented in this evaluation. This implies that the PMTCT scale-up is not going hand in hand with the training of counselors in infant feeding in the respective sites. There is a great need to accelerate infant feeding counseling training to catch up with the PMTCT sites. More collaboration between implementing partners is also required for achieving better coverage.

A total of 22 trainers-of-trainers (TOT) had been trained in 10 facilities. Most of those trained as trainers were nurses with minimal representation from other cadres. It is important to ramp up TOT training among other cadres, especially medical doctors and clinicians. This is because these are more

⁷ UNGASS Country Progress Report Tanzania Mainland. Reporting Period: January 2006 – December 2007. Submission date: 30th January 2008. The Executive Chairman; TACAIDS. PO Box 76987, Dar es Salaam, Tanzania, East Africa.

⁸ USAID Health Care Improvement Project. 2008. Quality Improvement in HIV/AIDS Care, Prevention of Mother-to-Child Transmission, and Related Services. Collaboration between the Ministry of Health and Social Welfare and USG-Supported Partners in Tanzania. Bethesda, MD: University Research Co., LLC.

senior staff than nurses who may be involved in planning, budgeting and other administrative activities at the facilities. If these staff are trained and see the value of the PMTCT infant feeding counseling program, they may allocate more resources for roll-out of the program at their facility. The data show increased roll-out of the program at Tosamaganga District Hospital where a medical doctor was trained as a trainer. Information obtained for this evaluation indicates that all TOTs underwent the five-day TOT course, TOT and counselor training occurred within a month of each other, and orientation and sensitization occurred at a relatively later date in the individual facilities.

A total of 69 PMTCT counselors from 13 sites (including hospitals, health centers and dispensaries) had attended a five-day training-of-counselors workshop, at which time they also received job aids and take-home brochures for their facilities estimated to be sufficient to last for one year.

Interviews with 18 sites indicate that a majority does not have a complete set of job aids, and only one has a complete set of mother take-home brochures. Although the job aids are still in use, many of the facilities have partially stocked-out of job aids, and none of the facilities know how to obtain more job aids or take-home brochures or even realize they should. These findings regarding stock-outs of job aids and take-home brochures suggest either clear guidance was not provided during training of counselors on how to order replenishment materials (e.g., not clearly stated how to order or whom to order from) or there was an assumption that the training organizers will continue replenishing the job aids and take-home brochures. It also may mean that there is no replacement modality in place for the Iringa Region. There is therefore a need to determine whether there is a system in place for production and ordering replenishment materials and to provide this information to all sites. If no such system exists, then efforts need to be directed at putting one in place. A central production and distribution point for the nation as a whole is recommended to ensure that the quality of the materials is maintained.

Take-home brochures are to be given to mothers according to their selected feeding option. Anecdotal data suggest that a majority of women choose to breastfeed and therefore one would expect brochures about breastfeeding to be out of stock but not those about how to feed a baby with infant formula or cow milk, as these are not in as high demand. The fact that 75% of the facilities had no take-home brochures of any kind in stock is disturbing. It may mean that brochures are given out randomly irrespective of the chosen infant feeding option, or they are left in an open place for people to pick freely. Such procedures would contradict WHO guidelines to provide women with information pertinent to their selected infant feeding option. It is important that infant feeding counselors receive refresher training or debrief regularly at each facility. This may serve as a way to remind counselors about guidelines and protocols pertaining to counseling and distribution of take-home materials.

About 79 staff in seven facilities had received the one-day orientation on the PMTCT infant feeding counseling program. The majority of staff trained as TOT and counselors, as well as those receiving orientation, were nurses. Additionally, new staff hired by the facilities, including supervisors, had not received training in the PMTCT infant feeding counseling program. The slow progress of the roll-out of the infant feeding program may be due to limited funds to organize and conduct the trainings. With limited resources, training on the PMTCT infant feeding counseling program may not be a priority for the implementing partners in the Iringa Region or the government.

Transfer of staff between facilities or departure of trained staff will also influence the number of trained counselors available at any given site. Although evidence of this was not seen in this evaluation, it may begin to play a role with time. Additionally, in the ongoing scale-up of the PMTCT program, implementing partners may not have established a clear distinction between the seven-hour sub-component on infant feeding in the original PMTCT program and the more intensive infant feeding counseling program. If so, this would cause less demand for the latter.

Another related reason for the slow progress may be because the PMTCT program and infant feeding counseling program are seen as two separate activities rather than as complimentary to each other. This

is evidenced by their separate rather than coordinated training schedules. There is a great need for the MOHSW to emphasize the importance of and their commitment to the infant feeding counseling program to regional- and district-level supervisors as well as to its implementing partners.

No evidence of monitoring or corrective actions specific to the infant feeding counseling program was uncovered. There is an urgent need to develop and put in place a monitoring system to identify and correct stock-outs of program materials. Such a system could be developed by MOHSW in collaboration with implementing partners and facility managers. The PMTCT and CTC supervisors will be key to the coordination and implementation of monitoring activities.

V. CONCLUSION

To keep pace with the national scale-up of PMTCT across Tanzania, which includes infant feeding counseling in the context of HIV/AIDS, more counselors will need to receive training on infant feeding counseling. With more counselors trained there will be an even greater demand for job aids and take-home brochures. There will also be a need for a well-functioning replenishment system and procedures established in facilities and known to staff involved in infant feeding counseling to minimize stock-outs of materials.

It is possible that orientation of new employees engaged in maternal and child care in the facilities was not regarded as an important issue and new employees were therefore not trained to ensure continuity of infant feeding counseling activities. Supervisors trained as either TOT or counselors have not played their part in ensuring that high quality of services is maintained. They should be tasked with the responsibility of ensuring that their supervised facilities have adequate job aids all the time and that roll-out of the trainings are done with the intention of improving PMTCT services.

APPENDIX: DATA COLLECTION FORM

Evaluation of Sustainability of PMTCT/Infant Feeding Counseling Program Scale-up in Tanzania

1. Introductory Statement

We are from an organization called University Research Corporation (URC), which is based in Dar es Salaam and the USA. We are doing a research study to evaluate the Ministry of Health's rollout of the PMTCT and Infant Feeding counseling program so that we can know how to make these programs work better. Some of the issues we are interested in are staff training, access to and availability of job aids and mother take-home brochures. We appreciate your time and assistance.

2. Identification Information

Date: _____ Names of interviewers: _____

Name of District: _____ Health facility name: _____

Name of town/village where health facility located: _____

Names and job titles of interviewees: _____

3. Reach

3.1. On average, how many pregnant women receive antenatal counseling each month?
_____ Average number of pregnant women receiving antenatal counseling each month

4. PMTCT Roll-out

4.1. Does your facility have a PMTCT program for antenatal clinic attendees?

YES If YES, skip to Q. 4.3. NO

4.2. If NO, please explain why.

End interview here and verify why on list.

4.3. Is the PMTCT program supported by an implementing partner?

YES NO DON'T KNOW/UNSURE

4.3.a. If YES, please provide the name of the implementing partner.

4.4. Have staff in this facility received training for the current PMTCT program?

YES NO DON'T KNOW/UNSURE

4.5. If YES, when was the last PMTCT training received by staff in this facility?

_____ Date (month and year) staff last received PMTCT training.

5. Infant Feeding Counseling Program

5.1. Does your facility have an Infant Feeding counseling program for antenatal clinic attendees?

YES If YES, skip to Q. 5.3. NO

5.2. If NO, please explain why.

End interview here and verify why on list.

5.3. Was the Infant Feeding counseling component started at the same time as the PMTCT program?

YES NO

5.4. If NO, please explain why not.

Statement: Please note that the remainder of the questions is about the Infant Feeding Counseling Program.

6. Infant Feeding Counseling Program Training and Materials at Training

6.1. Have any staff in this facility received training on Infant Feeding counseling?

YES NO DON'T KNOW/UNSURE

If NO, DON'T KNOW/UNSURE End interview here

6.2. When was the last Infant Feeding counseling training received by staff in this facility?

_____ Date (month/year) staff received Infant Feeding counseling training.

6.3. How many staff in this facility have been trained for the Infant Feeding counseling program?

_____ Number of staff trained for the Infant Feeding counseling program.

6.4. What types of staff have received training for the Infant Feeding counseling program?

- a. Doctors YES NO
- b. Nurses YES NO
- c. In-charges/Site supervisor YES NO
- d. Clinicians/Clinical officer YES NO
- e. Maternal and child health aid YES NO
- f. Other, please specify _____

6.5. Please indicate how many of each type of staff have received each type of training?

	Doctors a	Nurses b	Supervisors				Clinicians/ Clinical Officers g	MCHA h	Others j
			RCH c	Maternity d	CTC e	Pediatric f			
TOT (t)									
Counselor (c)									
Orientation (o)									
Sensitization (s)									

6.6. Has the in-charge of this facility received:

- a. Training-of-Trainers (TOT) YES NO
- b. Counselor training YES NO
- c. Orientation training YES NO
- d. Sensitization training YES NO

6.7. Did the TOT and Counselor training received by staff provide any of the following?

- a. Job aids YES NO
- b. Mother-take-home brochures YES NO

6.8. In this facility, do you **currently** have any documentation or materials (e.g., manuals, job aids, mother-take-home brochures) from the training (s) that has (have) been conducted?

- a. Facilitator's manual YES, not seen YES, seen NO
- b. Participant's manual YES, not seen YES, seen NO
- c. Counseling cards YES, not seen YES, seen NO
- d. Question & Answer booklet YES, not seen YES, seen NO
- e. Lishe Wakati wa Ujauzito YES, not seen YES, seen NO

f. Jinsi ya Kunyonyesha Mtoto YES, not seen YES, seen NO

g. Kutimia Maziwa ya Kopo YES, not seen YES, seen NO

h. Maziwa Mabichi ya Ng'ombe YES, not seen YES, seen NO

i. Kupasha Moto Maziwa ya Mama YES, not seen YES, seen NO

j. Ulishaji wa Mtoto...miezi sita YES, not seen YES, seen NO

k. Other materials, please specify _____

6.9. Were staff who attended trainings given job aids for your facility?

YES NO DON'T KNOW/UNSURE

6.10. In your opinion, were there any problems with the training or materials provided during training? If yes, please explain

6.11. Do you have any suggestions to improve the Infant Feeding counseling program training or materials provided during training? If yes, please explain.

6.12. Since the Infant Feeding counseling program was started at this facility, has there been any refresher training in Infant Feeding counseling provided to staff?

YES NO DON'T KNOW/UNSURE

If NO, DON'T KNOW/UNSURE skip to Section 7.

6.13. If YES, please explain what type of refresher training staff in this facility have received (e.g., TOT, counselor training, and/or orientation).

6.14. How many times has refresher training for staff on the Infant Feeding counseling program been conducted?

_____ times

6.15. In your opinion, were there any problems with the refresher training or materials provided during the refresher training? If yes, please explain.

6.16. Do you have any suggestions to improve the refresher training for the Infant Feeding counseling program or materials provided during the refresher training? If yes, please explain.

7. New Counselor and Staff Turnover

7.1. Since staff (not including site supervisors) in this facility received training for the Infant Feeding counseling program, have any new staff been hired?

YES 7.1_num. How many? _____ NO **If NO, skip to 7.3.**

7.2. Have any of the new staff received training for the Infant Feeding counseling program?

YES 7.2_num. How many? _____ NO

7.2.a. If YES to 7.2., on average how long do newly hired staff work at this facility before receiving training for the Infant Feeding counseling program?

_____ months.

7.3. Since staff in this facility received training for the Infant Feeding counseling program, have any of the trained staff stopped working at the facility?

YES NO

7.4. Since supervisors in this facility received orientation/sensitization training for the Infant Feeding counseling program, have any new supervisors been hired?

YES NO **If NO, skip to 7.6**

7.4.a.

	RCH	Maternity	CTC	Pediatric
How many new supervisors hired?				

7.5. Have any of the new supervisors received orientation/sensitization training for the Infant Feeding counseling program?

YES NO **If NO, skip to 7.6**

7.5.a.

	RCH	Maternity	CTC	Pediatric
How many new supervisors trained?				

7.5.a. If YES to 7.5., on average how long do newly hired supervisors work at the facility before receiving orientation/sensitization training for the Infant Feeding counseling program?

_____ months.

7.6. Since supervisors in this facility received orientation/sensitization training for the Infant Feeding counseling program, have any of the trained supervisors stopped working at the facility?

YES NO **If NO, skip to 8.1**

7.6.a.

	RCH	Maternity	CTC	Pediatric
How many supervisors stopped working?				

8. Replenishment of Materials

8.1. Does this facility currently have a complete set of job aids (i.e., Q&A booklet, counseling cards, and mother-take-home brochure samples) for the Infant Feeding counseling program?

YES NO

8.2. Have job aids for the Infant Feeding counseling program been ordered by this facility when needed (e.g., for newly hired counselors or due to loss of previous job aids)?

YES NO **If NO, skip to 8.5.**

8.3. How many times in the past has this facility ordered job aids for the Infant Feeding counseling program?

_____ Number times ordered more job aids.

8.4. Did this facility receive the job aids for the Infant Feeding counseling program that were ordered?

YES NO

8.5. Does the facility currently have in stock all mother-take-home brochures for the Infant Feeding counseling program?

YES NO

8.6.a. If NO to 8.5, which mother-take-home brochures are currently out of stock?

a. Lishe Wakati wa Ujauzito YES NO

b. Jinsi ya Kunyonyesha Mtoto YES NO

c. Kutimia Maziwa ya Kopo YES NO

d. Maziwa Mabichi ya Ng'ombe YES NO

e. Kupasha Moto Maziwa ya Mama YES NO

f. Ulishaji wa Mtoto...miezi sita YES NO

8.7. Have mother-take-home brochures for the Infant Feeding counseling program been ordered by this facility when stock was running low?

YES NO **If NO, skip to 8.10.**

8.8. How many times in the past has this facility ordered mother-take-home brochures for the Infant Feeding counseling program?

_____ Number times ordered more mother-take-home brochures.

8.9. Did the facility receive the mother-take-home brochures that were ordered when stock was running low?

YES NO

8.10. Does this facility have a procedure to order more job aids for the Infant Feeding counseling program and mother-take-home brochures when needed?

YES NO

8.11. Who is responsible for ordering more job aids for the Infant Feeding counseling program and mother-take-home brochures when needed?

_____ Job title of person responsible for ordering job aids and mother-take-home brochures.

8.12. Please describe the procedure used by this facility for ordering more job aids and mother-take-home brochures for the Infant Feeding counseling program when stock is running low.

9. Do you have any questions or comments?

Thank you!

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