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NUTRITION IN THE ZAMBIA CHILD HEALTH PROJECT

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TABLE OF CONTENTS

ACRONYMS v

EXECUTIVE SUMMARY 1
- Key Findings 1
- Recommendations 1

BACKGROUND 2

KEY FINDINGS 3
- Infant and Young Child Nutrition 3
- Current Nutrition-related Activities 3

OPPORTUNITIES AND CONSTRAINTS 5
- Health Reform 5
- Community/Health Center Partnerships 6
- Health Worker Attitudes and Beliefs 6
- Intersectoral Coordination 6

NUTRITION-RELATED INTERVENTIONS 7
- Breastfeeding Promotion, Protection and Support 7
- Promotion of Improved Complementary Feeding 7
- Growth Monitoring and Promotion 8
- Food Supplementation 8
- Micronutrient Deficiency Control 8

OPERATIONAL ISSUES 8

RECOMMENDED ACTIVITIES 9

PLAN OF ACTION FOR FIRST YEAR 11
- Formative Research and Strategy Formulation 11
- Nutrition Advocacy 13

APPENDIX People Visited or Interviewed by Phone

ACRONYMS

ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CHW	Community Health Worker
DHMT	District Health Management Team
DHS	Demographic and Health Survey
FHANIS	Food Security, Nutrition and Health Monitoring System
GMP	Growth Monitoring and Promotion
GRZ	Government of the Republic of Zambia
HEPS	High Energy and Protein Supplement
HIS	Health Information System
HRIT	Health Reform Implementation Team
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disease
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
JSI	John Snow Incorporated
MAFF	Ministry of Agriculture, Food and Fisheries
MCH	Maternal and Child Health
MOH	Ministry of Health
NFNC	National Food and Nutrition Commission
NGO	Non-governmental Organization
OMNI	Opportunities for Micronutrients
PAM	Programme Against Malnutrition
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
VIPP	Visualization and Participatory Process
WHO	World Health Organization
ZCHP	Zambia Child Health Project
ZDHS	Zambia Demographic and Health Survey

EXECUTIVE SUMMARY

In response to a request from USAID/Zambia, a joint team composed of representatives from JSI/OMNI, JSI/MotherCare, and the Manoff Group/BASICS was organized to assess the nutrition situation and make recommendations for program activities within the Zambia Child Health Project. The team reviewed available documents, interviewed key persons in the MOH, the Health Reform Implementation Team (HRIT), health centers, communities, UNICEF and other NGOs, and visited district health services in five provinces.

Key Findings

Chronic malnutrition measured by height-for-age is the most predominant form of malnutrition among children under five years of age. The 1992 Zambia Demographic and Health Survey (ZDHS) reported 40 percent stunting, 46 percent in rural areas, 33 percent in urban areas among that age group. Recently, the rate of chronic malnutrition is believed to be worsening in the urban areas, probably in connection with the removal of food subsidies as part of the structural adjustment program to revive the economy. Although drought in the southern part of the country and the removal of food subsidies highlight the need for food, the pattern of child malnutrition and the relatively steady trend in the previous 20 years suggest that poor feeding practices during the weaning period is an important contributor to malnutrition. However, there is inadequate information available on infant and child care and feeding practices and the factors that influence the decision-making in the home.

Within the health care system, child malnutrition is recognized as a problem, but child nutrition activities are oriented more towards the treatment of severe malnutrition than towards prevention. Although child growth monitoring is widespread, appropriate counseling is rare.

Recommendations

Recommendations are made to:

1) Raise awareness among key policy-makers on the importance of preventing malnutrition, rather than emphasizing treatment of severe malnutrition;

2) Perform formative qualitative research on child care and feeding practices in the home for:
   a) IEC strategy development;
   b) Improved counseling in breastfeeding and complementary feeding;
   c) Training of health providers, including integrated management of childhood illness (IMCI); and,
   d) Practical and acceptable feeding recommendations developed through dialogue with mothers.

3) Expand growth monitoring into communities (presently limited to very few communities);

4) Motivate community action to improve child health and nutrition, using growth monitoring results;

5) Develop guidelines and tools to aid service delivery; and,

6) Train relevant health workers to improve the delivery of nutrition-related activities within the integrated child health project.

A plan of activities for the first year of the formative research is provided.

BACKGROUND

The purpose of the trip was to assess the nutrition situation in Zambia, evaluate the institutions and programs that address nutrition issues, and to make recommendations on how nutrition-related activities can be incorporated into the USAID-supported Zambia Child Health Project (ZCHP). The four-member team was composed of representatives from three USAID cooperating agencies likely to implement nutrition-related activities within the ZCHP: Dr. Ian Darnton-Hill from the JSI/OMNI project (team leader); Dr. Stanley Foster of Emory University, also representing JSI/OMNI project; Ms. Rae Galloway from JSI MotherCare project; and, Dr. Adwoa Steel from The Manoff Group/BASICS. Dr. Foster was a member of the joint Government of Republic of Zambia (GRZ)-USAID team that had developed the ZCHP.

In Zambia, the team continued the review (begun in Washington) of the literature on health and nutrition in Zambia and the health reforms process; interviewed some key individuals in both governmental and non-governmental sectors engaged in addressing food and nutrition issues at the central, provincial, district, health center, and community levels; and, when possible, made observations in health centers and communities. Team members visited districts in five provinces (Lusaka, Central, Southern, Luapula, and Copperbelt). The sites visited were selected based on reports of notable efforts being made in those districts to foster health center/community partnerships to address health and nutrition issues. In the case of the Copperbelt Province, the team member accompanied members of the National Food and Nutrition Commission (NFNC) on a monitoring visit to the province.

The team's draft report "Incorporating Nutrition into The Zambia Child Health Project" reviews the nutrition situation and current activities in nutrition, and makes broad recommendations for addressing nutrition in the ZCHP. This trip report discusses only the highlights of the findings relevant to follow-up activities for the BASICS Project.

KEY FINDINGS

Infant and Young Child Nutrition

- Preliminary data from the 1995 Priority Survey II (PS II) suggest that the stunting rate (45 percent) in urban children under five years of age might have increased from 35 percent in 1991 (Priority Survey I) and 40 percent reported by FHANIS in 1993. The 1992 ZDHS reported 33 percent urban, 46 percent rural, 40 percent overall. Differences in sampling make comparison difficult, but if a recent increase in protein energy malnutrition in urban children under five years of age is real, it may be partly related to the removal of food subsidies which affects urban areas more than rural areas.

- As in many poor countries, the multiple causes of malnutrition include disease, inappropriate feeding practices, and social, political and cultural factors that adversely affect the health and nutrition of women and children. Recent years of drought and the effect of the removal of food subsidies have drawn increased attention to the lack of food as an important factor. However, the fact that the nutritional status deteriorates rapidly during the weaning period and stabilizes thereafter, and that young child nutritional status, though poor, remained relatively stable during a period of worsening economic conditions between 1970 and 1992 suggest feeding practices as important contributors to poor nutritional status. The 1992 ZDHS did reveal that there is room for improvement in breastfeeding practices. Food intake by weaning-age children has been reported to be lower than recommended in energy, protein and some minerals and vitamins such as iron, calcium, riboflavin and niacin[1]. Frequent infections are also immediate contributors to poor nutritional status.

- Protein energy malnutrition is recognized as a serious problem; 61 percent of the districts are reported to have identified young child malnutrition as a priority problem in their communities.

- There is inadequate information available on household behaviors regarding child care and feeding, the rationale underlying the behaviors and the factors likely to motivate change.

Current Nutrition-related Activities

Growth monitoring of children under five years of age, cooking demonstrations (often to mothers of malnourished children), the treatment of severely malnourished children and the distribution of a high energy protein supplement (HEPS) to families of children identified as malnourished

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[1] Hayes, R.E. et al. *Weaning Practices and Foods in High Population-density Areas of Lusaka, Zambia.* Ecology of Food and Nutrition, vol.33., pp.45-74.

are the main activities undertaken to control protein energy malnutrition. Recently, breastfeeding promotion is receiving some attention through the Baby Friendly Hospital Initiative.

Recent years of drought led to the creation of the Programme Against Malnutrition (PAM), an NGO initially charged with the distribution of food but now being funded to promote activities to improve household food security.

Program Focus

- The focus of most activities is treatment of malnutrition in young children rather than the promotion of good growth. Prevention of malnutrition receives little emphasis even in growth monitoring. Counseling is weak.

- Available public education materials tend to be informational on specific issues, have no consistent theme and do not attempt to motivate change.

- The role of men, fathers or other household members in decision-making has not been explored. Men reportedly feel excluded from the messages given to women in the clinics.

Facility-based Activities

- Growth monitoring of children under five is carried out on days set aside for that purpose in health centers and at children's clinics in hospitals. Unfortunately this is not used as an opportunity to promote and celebrate good child growth, but rather as an opportunity to identify "underweight" children in order to receive the high energy protein supplements (HEPS). Health workers are vague on the criteria for the distribution of the supplement. Mothers, it is reported, come to clinics hoping to receive the supplement.

- Although widely acknowledged that, in the home, the supplement (which may be one kilogram for one month) is not fed only to the "underweight" child, there have been no attempts to search for strategies to deal with that issue.

Community-based Activities

Community-based growth monitoring and promotion (GMP) is feasible, and is happening, though on a very small scale. Below are two examples that illustrate what could occur on a larger scale.

- In the Kapyanga area in Mumbwa District (Central Province), women from six villages, prompted by a Zambian woman visitor to their community, organized themselves into a club of 25 women calling themselves the *Atusole* ("Let's Try") Club, and have learned to weigh their own children. Empowered by their ability to monitor the growth of their own children, the group has added several activities: immunization of their children by the

health center staff and income-generation activities (farming, sewing, corn-milling). They feel that the income-generation activities have kept them together for the past seven years.

Though not supportive at first, the men in the villages now help with heavy manual work and are on the group's "advisory committee." The community is now constructing a school building. Two other mothers' clubs in the district also conduct their own child growth monitoring.

- In Kawambwa District (Luapula Province), the staff from some health centers join community health workers and TBAs at community outreach points for growth monitoring and immunization sessions. Some of the CHWs are able to conduct the child weighing sessions if the health center staff are unable to join them.

Weaning Food Research

Scientists at the National Scientific Research Center in Lusaka have received help intermittently since 1985 from a consultant[2] from Olivet Nazarene University in Kankakee, IL, to formulate a "computer-optimized weaning blend"of Zambian foods. The formulations were based on various foods consumed by children as reported in 24-hour dietary records kept by lower income mothers selected from those attending clinics in urban Lusaka. In October 1995, the team is supposed to select possible formulations for commercial production and/or home preparation. The results of this research will be reviewed to determine if the formulations can be tested by mothers in recipe trials during the proposed formative household research.

OPPORTUNITIES AND CONSTRAINTS

Health Reform

- The health reform process now in progress appears to be warmly embraced by the districts the team visited. The district personnel have welcomed the chance to manage their own affairs and appear to accept consultations between health centers and communities as necessary in identifying and planning for their health needs.

- The health reform process so far has concentrated on helping the districts set up their management, financial, and planning mechanisms. The Health Reform Implementation Team (HRIT) states that the technical packages will be formulated in the future. However, technical activities, including those that are nutrition-related, are taking place according to the priorities identified by the districts

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[2] IBID

- Although "nutrition" is included in the proposed minimum package of services it is not clear that its full importance and influence on other diseases is appreciated. The HRIT members complain that they have received little input from the NFNC; NFNC members say they have participated in the reform process when asked to do so. It would appear that NFNC needs to be a stronger advocate for nutrition.

- The issue of equity between the districts is reported to be important to the government. It is not clear at this time how that is going to be played out in terms of testing innovative approaches through pilot and demonstration activities.

Community/Health Center Partnership Development

- There is already a move to train health workers in methodologies intended to facilitate their interaction with communities. Health workers in 10 districts have been trained in community participatory methodologies, such as the visualization and participatory process (VIPP). However, with the exception of a few instances, the trained workers have not yet used their new skills to encourage community involvement in health delivery. It is possible that this will change when the proposed neighborhood health teams have been formed, although workers may still need further guidance on how to use the new training in the field.

- In some health centers, the lack of personnel makes it unlikely that the health center staff (sometimes only one individual) can stimulate **and** nurture several community-health center partnerships within the health center catchment area in addition to performing the health center duties.

- There are reportedly many civic and church-related women's groups in both rural and urban areas which can be channels for community-based program implementation and information dissemination. Whether and how such groups will be linked with the proposed neighborhood health teams remains to be worked out.

Health Worker Attitudes and Beliefs

- Interviews with a small number of health workers revealed that some health workers themselves are not convinced of the benefits of some of the services they are expected to promote; some also hold beliefs that may inhibit their effectiveness in delivering nutrition-related and family planning services. Training of health workers needs to address health workers' own beliefs and attitudes.

Intersectoral Coordination

- Intersectoral collaboration within districts was often cited as necessary for addressing nutrition needs. Community groups such as the active nutrition groups or mothers' clubs

that address nutrition are often also interested in income-generation activities that require assistance from more than just the health services sector.

- However, collaboration among different government sectors towards a common goal is reportedly not easy to achieve, according to discussions with district personnel (the District Health Management Team in Kawambwa and the District Intersectoral Committee in Mumbwa). One reason offered for difficulties in cooperation among sectors is that, unlike the MOH, other ministries are not decentralizing; therefore, it is not easy for other district-level personnel to make their own decisions. At the community level, this cooperation is sometimes easier and will need to be nurtured whenever possible.

NUTRITION-RELATED INTERVENTIONS

There are plans and efforts underway by the government and NGOs to improve the food supply at both national and household levels. These include the establishment of the Department of Food Security within the Agriculture Ministry headed by the Permanent Secretary, and seed multiplication programs that provide seed directly to farmers with the understanding that the farmers will make the same amount of seed available to other farmers after the harvest. These efforts are steps towards reversing the effects of the long-standing policy that promoted maize at the expense of other food crops. Given that these and other efforts, including the promotion of vegetable gardens, income-generation activities, and labor-saving devices, are all potentially beneficial to nutrition, the ZCHP should collaborate with these efforts whenever possible.

The interventions below are made for infants and young children from the point of view of the health sector with which the BASICS project will be associated. They are generally interventions already in place on a limited or large-scale basis, but ineffectively executed. The results of the formative research (aided by operational research in some instances) will help specify the most effective ways to implement these interventions in the fight against protein energy malnutrition in children.

- **Breastfeeding Promotion, Protection and Support**

  - Protect the current widespread initiation and fairly long duration of breastfeeding.
  - Support mothers in breastfeeding exclusively for the first six months after delivery.

- **Promotion of Improved Complementary Feeding**

  - Promote the feeding of improved complementary foods from age six months while breastfeeding continues through age two years.
  - Promote improved infant and child feeding through practical and acceptable approaches developed in consultation with mothers during the formative research.

- **Growth Monitoring and Promotion for Children Under Three Years of Age**

  - Conduct growth monitoring and its promotion for children under three years of age in health facilities and within communities.
  - Extend GMP beyond "children's clinics" by weighing and counseling during all contacts with children.
  - Improve individual counseling through training with development and use of counseling tools.
  - Motivate community-action on health and nutrition through community dialogue on growth monitoring results.

- **Food Supplementation** (if and when necessary)

  - develop guidelines for targeting those in need of food supplements;
  - explore ways (through community involvement) of ensuring that children in need actually receive the food supplements.

- **Micronutrient Deficiency Control**
  (in collaboration with OMNI project, which is expected to lead this effort)

  - Provide iodine supplementation through iodide-fortified salt.
  - Provide treatment of iron deficiency anemia and prophylaxis for pregnant women.
  - Provide vitamin A supplementation in postpartum mothers and children, according to guidelines set by the MOH.

OPERATIONAL ISSUES

There are a number of operational issues that have to be solved, possibly through operational research, for effective delivery of services.

- The lack of staff to maintain support of community partnerships in some locations has been mentioned. The program may have to experiment with trained community persons as the bridges between the health center and the communities.

- New approaches for using information from child growth monitoring in order to stimulate community action will need to be explored, such as the use of a master growth chart for the community.

- The use of support groups for mothers or specially-trained infant counselors will need to be explored for community-level support of breastfeeding and complementary feeding.

RECOMMENDED ACTIVITIES

The recommended activities, presented here under the ZCHP outputs, are designed to enhance the chances of success of the above interventions. BASICS or other donors will provide technical assistance and/or funding.

Output 1: Establish Health Center and Community Partnership for Improved Health

- Review community participatory methodologies to use in conjunction with growth monitoring results to motivate community action in child health and nutrition.
- Conduct formative qualitative research in the care and feeding of infants and young children within the household (see plan of action below).
- Review community groups to determine the role they can play in improving child health and nutrition.
- Develop district and health center capacity to conduct operational research on how to improve infant and child feeding using community resources (e.g., support of exclusive breastfeeding by TBAs or by mother support groups).

Output 2: Improve Pre-service and In-service Training of Health Center Workers

- Conduct qualitative research among health center and district staff to gain insight into their attitudes, beliefs, resistances, service delivery, and possible motivations for improved service delivery.
- Based on results of formative household research on child feeding, develop and test guidelines and materials with health workers for counseling during growth monitoring and in the context of the integrated case management.
- Assess curricula needs for upgrading information on nutrition and interpersonal communication on child feeding.
- Develop the capacity of training institutions to upgrade the training in nutrition and interpersonal communication, taking account of research information.
- During training of health workers, address upgraded knowledge in nutrition (such as exclusive breastfeeding), interpersonal communication on child feeding, and dialogue with communities on child health and nutrition.

Output 3: Strengthen MOH Central, Regional and District Technical Capacity

- Increase awareness among key district and central personnel of the epidemiology of malnutrition, the importance of its prevention and the role played by all degrees of malnutrition in morbidity and mortality.

- Train key personnel to assess the full effect of malnutrition when setting priority activities in the district.

- Develop the capacity of district staff to promote and support health center/community partnerships to promote improved child feeding.

- Develop the capacity of district staff to assess and monitor the performance of nutrition activities.

- Develop the capacity of district staff to assess the need for operational research and include this in district program plans.

- Strengthen the capacity of the NFNC to be an effective advocate for nutrition.

- Strengthen the capacity of the National Food and Nutrition Commission to provide appropriate guidelines, norms, and counseling tools to the districts, related government sectors, and NGOs for training, service delivery, monitoring and support of nutrition-related activities.

Output 4: Strengthen Health Management Information System at Community, Health Center, District and National Levels

- During planning of activities with community groups, include the selection of indicators to be monitored (such as children gaining weight, number of children participating).

- Develop appropriate indicators for nutrition-related activities at the health center, district and national levels within the health information system.

- Develop, through participation of intended users, mechanisms for analysis of information collected and its feedback for action.

Output 5: Strengthen the Public/Private Sector Partnership for Child Health

- Raise the awareness within the NFNC to assess and develop partnerships with the private sector when necessary for design and implementation of child nutrition services (e.g., in social marketing).

- Develop district capacity to assess all available local resources, including within the NGO and private sector, for the effective delivery of child health and nutrition services.

PLAN OF ACTION FOR FIRST YEAR

As an integrated project, the overall planning and implementation of the ZCHP will include all the program components (nutrition, control of ARI, control of malaria, etc.). However, nutrition-specific materials need to be developed for input into advocacy, IEC, training, interpersonal communication and the integrated management of childhood illness. To obtain the necessary information, formative research will be conducted during the first year to elaborate the nutrition strategy and the materials needed for effective delivery of child nutrition services. In-country or international technical assistance will probably be needed to assist the NFNC during the qualitative research phase and also for material development.

Formative Research and Strategy Formulation

Conduct Qualitative Research

- To learn about the care and feeding practices of the infant and young child in the home;
- To understand the rationale underlying the feeding practices;
- To identify current positive practices that may guide needed changes;
- To determine the resistances or constraints (cultural, social, household, etc.) that child caregivers have to overcome to feed infants and young children better, as well as the factors likely to motivate change;
- To identify the most effective means of communicating child feeding information to mothers and other caretakers;
- To understand the attitudes, beliefs and resistances of health care providers in delivering nutrition-related services; and,
- To determine options for improving feeding practices.

Estimated duration: 12 weeks
Technical assistance: 3 weeks

Test Improved Feeding Practices with Intended Users

- Test responses of mothers and children to new feeding practices; and,
- Analyze results to determine what actions are acceptable and practical, including constraints and motivations.

Estimated duration, including analysis: 6 weeks
Technical assistance: 3-4 weeks

Formulation of a Strategy to Improve Child Nutrition

Based on the results of the qualitative research and existing information, formulate a strategic plan for improving child nutrition with input from representatives of relevant governmental and non-governmental organizations. The strategy will:

- Outline a programmatic vision for child nutrition;
- Define intervention approaches;
- Outline IEC package components;
- Identify relevant personnel from all sectors to be trained; and,
- Identify other program inputs revealed as necessary by the research.

Estimated duration, including three-day workshop: 1 week

Production of Draft Materials

- IEC materials aimed at identified segments of the public;
- Counseling and training materials aimed at and for use by health providers; and,
- Other products identified by the research.

Estimated duration: 12 weeks

Testing of the Materials

- All materials are pre-tested with intended target populations and users to ensure that intended objectives will be achieved.

Estimated duration: 4 weeks

Finalization of Materials

Estimated duration: 10 weeks

Training of Health Providers

The training of the health providers for IMCI and in the use of educational materials, the development of a monitoring strategy, the establishment of a baseline for selected indicators and the implementation of the program will proceed within the overall project timetable as determined by the MOH and spread over the life of the project.

Selection of Sites for Formative Research

Sites for the formative research will be selected to represent: predominant ethnic groups; differences in food habits; eco-agricultural differences; urban and rural locations; proximity to major transportation; and other factors considered to affect child care and feeding. The final selection and scope will be made based on discussions with the NFNC and possibly the HRIT.

Nutrition Advocacy

NFNC needs to raise awareness of nutrition issues among policy makers at the central level and the planners in the districts, beginning in the first year.

- Assist NFNC to review child nutrition information on Zambia, including breastfeeding, in the context of published information assessing the impact of child malnutrition on morbidity and mortality; and,
- Assist NFNC to package the information for easy assimilation for use in a series of seminars for key persons.

Estimated duration: 6 months
Technical assistance: UNICEF (?)

NEXT STEPS

- Finalize the team's report, "Incorporating Nutrition into the Zambia Child Health Project," after comments have been received from the GRZ, USAID/Zambia, USAID/Washington and the cooperating agencies.

- Communicate and plan with NFNC the scope of the research, cost estimates and logistic support. Identify the needs for staff (both central and district).

- NFNC will consult with UNICEF to determine what financial support could be expected from UNICEF. (UNICEF indicated during the trip that it might be able to offer some support for the research and/or material development.)

- NFNC will identify potential in-country resources available to supervise and guide the research. (A list of companies and individuals available as resources for health-related IEC that was compiled for the USAID-funded Zambia Family Planning Services Project was obtained during the trip to Zambia). NFNC will make the selection of the most appropriate in-country resources with the aid of a consultant who is familiar with the nutrition formative qualitative research process.

- NFNC and the consultants will finalize a work plan for the formative research and strategy formulation.

- NFNC members and field workers will be trained with consultant help, prior to launching of the research. In-country consultants will be responsible for the continued daily supervision of the research with input from expatriate consultants as needed.

APPENDIX

PEOPLE VISITED OR INTERVIEWED BY PHONE

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Ms. Violet Kahwata
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Charity Muwo
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