Program Review of

Nutrition Interventions

Checklist for District Health Services

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BASICS
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Acronyms

ARI	acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival
BCG	Bacillus of Calmette and Guerin (tuberculosis vaccine)
BF	breastfeeding
BFHI	Baby Friendly Hospitals Initiative
EBF	exclusive breastfeeding
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IU	international unit
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
IVACG	International Vitamin A Consultative Group
mg.	milligram
NID	National Immunization Day
OPV	oral polio vaccine
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAD	vitamin A deficiency
WHO	World Health Organization

Introduction

By making periodic reviews of district health programs, managers can find critical gaps and, subsequently, focus their resources on priority needs. This checklist for collecting information about priority nutrition activities is designed for district health teams that want to strengthen the nutrition components of their primary health care programs. It can be used by government and nongovernmental organizations, donors, and others who are interested in integrating nutrition interventions into maternal and child health. To understand or interpret the information collected, see the References section.

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

Health workers should provide the most cost-effective nutrition interventions, called the *Nutrition Minimum Package* (BASICS 1997).

The six interventions include the promotion, protection, and support of—

- Exclusive breastfeeding for approximately six months
- Adequate complementary feeding from approximately 6 to 24 months, with continued breastfeeding
- Adequate nutritional care of sick and malnourished children
- Adequate vitamin A status
- Adequate iron status
- Adequate iodine status

Lessons learned from past efforts show that to improve nutritional status and reduce childhood illness and deaths, these six priority interventions should be included in an integrated package with other health services. This integrated package should be provided at all health contacts.

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

- Prenatal contacts
- Delivery and immediate postpartum contacts
- Postnatal contacts
- Immunization contacts

- Sick child visits

- Well-child visits

These contacts have been identified as the initial targets for building improved nutrition content in district health programs. Based on national household surveys in developing countries in Africa, Asia, and Latin America, WHO estimates that every year—

- 75 million pregnant women receive at least one prenatal visit (WHO 1997),
- 45 million births are attended by trained health providers at health facilities,
- 25 million births are attended by trained health workers at home, and
- approximately 70 million infants or their caretakers come in contact with health workers within the first two months after birth (WHO 1997).

Building in proven nutrition interventions in each of these existing contacts can provide important benefits. In the annexes are summaries of the nutrition actions for these contacts. This checklist helps health managers identify whether or not these actions are being taken and what needs to be done to improve the actions.

The information needed for this rapid program review can be obtained by using existing data, observing and interviewing health staff, and visiting a limited number of health facilities and communities. This checklist is not designed to replace quantitative surveys or studies required to collect high-quality quantitative data on health worker knowledge and practices or in-depth qualitative research necessary to develop feeding recommendations.

How to Use This Checklist

- Make a list of hospitals, health centers and clinics, health posts, health huts, and rural maternities in the district. Include government and private facilities.

- Select a small number of health facilities on the list, and communities in the catchment areas around the selected facilities, that will provide a comprehensive picture of the current situation.

- Form two or more teams, including health staff from the selected facilities, and explain the objectives and methods of the program review.

- Invite key partners who will be supporting or implementing the follow-up actions, in addition to field teams, to plan the review (for example, donors, NGOs, private providers, and community committee members).

- Review and adapt the checklist. Agree on key questions, definitions, and descriptions of terms, protocols, and procedures for collecting data.

- Have a nutrition specialist provide an orientation for the health teams on technical questions and, if possible, an information, education, and communication (IEC) specialist on how to review IEC materials.

- Use locally adapted feeding guidelines based on the Integrated Management of Childhood Illness (IMCI) Counsel the Mother section of the chart book to assess the content of counseling (WHO/UNICEF 1995). Use national or international (WHO/UNICEF) protocols to review the adequacy of micronutrient supplementation services. These guidelines and protocols are also summarized in the job aids in Annex C.

- Collect information from health facilities and communities.

- Invite key partners, who will be supporting or implementing the follow-up actions, to participate in synthesizing and interpreting the information collected. Identify program actions to fill in the gaps found during the program review. Prioritize next steps and agree on responsibilities.

Nature and Magnitude of the Problem

Summary of Key Questions

1. Are stunting, wasting, or underweight in children; or underweight in women, problems in this district?

2. Are micronutrient deficiencies a problem in this district?

3. What are the maternal, infant, and child feeding problems in this district?

4. Are there gaps in the available information?

Note: See the References section at the end of this document for criteria and definitions of classification of malnutrition and adequate feeding practices.

Prevalence and Severity of Malnutrition

- Use existing surveys or other quantitative studies.

  - What percentage of young children are stunted (low height-for-age)?
  - What percentage of young children are underweight (low weight-for-age)?
  - What percentage of young children are wasted (low weight-for-height)?
  - What percentage of women are too thin for their height (low Body Mass Index)?
  - What percentage of children have a vitamin A deficiency (VAD)?
  - What percentage of women or pregnant women have anemia, and what percentage of infants and young children are anemic?
  - What percentage of adults and children show signs of iodine deficiency (goiter) or are classified as iodine deficient using other criteria?
  - Are these nutrition problems improving or becoming worse? What is the evidence?

- Interview health workers and other key informants.

  - Do health staff see a large number of very thin, emaciated, or severely malnourished children?
  - Do health staff see a large number of very thin women?
  - Is VAD a clinical or subclinical problem (for example, is there a local term for night blindness, and is night blindness reported among pregnant women or school children)?
  - Are there cases of visible goiter in the area?
  - Are these nutrition problems improving or becoming worse?
  - Is the problem seasonal, recent, or chronic? Why? What is the evidence?
  - According to health workers or key informants, what are the main causes of the observed nutrition problems? Are the causes primarily food, health/illnesses, or care/feeding practices?

High Risk Groups, Areas, and Seasons

- Use existing surveys or quantitative studies and interview health workers and other key informants.

  - What geographic locations, communities or ethnic groups, seasons, age groups, and males/females are more likely to have nutrition problems?
  - Where, when, and in what group are underweight/stunting/wasting in children and underweight women most common?
  - Where, when, and in what group is VAD most common?
  - Where, when, and in what group is anemia most common?
  - Where, when, and in what group is iodine deficiency most common?

Problem Feeding Behaviors

- Use existing surveys or quantitative studies.

  - What percentage of infants under 4 months are exclusively breastfed?
  - What percentage of infants 6–9 months of age are fed adequate complementary foods?

- ✦ What percentage of children 20–24 months are breastfed?

- ✦ What percentage of children who were sick in the previous 2 weeks were given extra food during recovery?

- ✦ What percentage of pregnant and lactating women increase the number of meals and snacks and choose more diverse ingredients to meet their increased nutritional needs during pregnancy and lactation?

- Interview health workers and other key informants.

  - ✦ Are young children fed adequate diets (for example, do types and amounts of food given, preparation and feeding methods, and frequency of feeding provide at least the minimum requirements for energy, protein, vitamins, and minerals)?

  - ✦ Do women consume adequate diets (for example, to meet their requirements for energy, protein, vitamins, and minerals) during pregnancy and lactation and when they are not pregnant or lactating?

Priority Nutrition Activities in Health Facilities

Summary of Key Questions

1. What services are offered by health facilities (including government, nongovernment, and private)?

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

3. What is the quality and coverage of nutrition services provided by health workers?

Note: Use the *Essential Nutrition Actions in Health Services* in Annex A, *Recommended Practices for Maternities* in Annex B, *Nutrition Job Aids* in Annex C, and *Counseling Guide* in Annex D to guide data gathering at facilities.

Services Provided by Health Facilities in the District

- Make a list of hospitals, health centers and clinics, health posts, health huts, and rural maternities—include government and private facilities.

  ✦ Which of the following services are provided by each facility on the list?

    - Maternal/reproductive health services:
      - Prenatal care
      - Assisted deliveries and postpartum care
      - Postnatal care
    - Child health services:
      - Immunizations
      - Sick-child care or management of severely malnourished children
      - Well-child care

Nutrition Content in Maternal/Reproductive Health Services

Note: For each category of facilities that provides prenatal care, delivery/postpartum care, or postnatal care, review the content of nutrition in these services, as described in the following text.

- Visit health facilities and directly observe the health worker (observe the management of at least one or two women). Use the job aid checklists in Annex C–1, C–2, and C–3 to determine the key elements to observe. Record the following:

    - Do pregnant women receive prophylactic iron correctly?

- Are pregnant women given the correct antenatal counseling regarding the following:
  - diet during pregnancy
  - compliance with iron/folate tablets
  - preparation for breastfeeding
- Do postpartum women receive support to initiate breastfeeding?
- Do postpartum women receive a dose of vitamin A?
- Do women seen during the first two weeks after delivery receive counseling on breastfeeding and their diet?

◘ Visit health facilities, interview health workers, and directly inspect supplies and equipment.

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

For example—
- Are vitamin A capsules, iron/folate, mebendazole, and chloroquine available on the day of the visit?
- Are counseling/IEC materials available for prenatal visits, delivery/postpartum, and postnatal counseling?
- What is the number of stock-outs (days when no stocks are available) of vitamin A capsules, iron/folate, mebendazole, or chloroquine in the 30 days before the visit?

✦ What percentage of health workers providing services have received primary health care training that includes key nutrition elements?

For example—
- In the previous three years, in how many facilities have more than half the health workers in this service category been trained in methods that include preventive iron/folate supplementation, anemia assessment and treatment, postpartum vitamin A supplementation, breastfeeding counseling, and dietary adequacy in women?

✦ Are supervisory visits being made to the facility?

For example—
- In how many facilities have there been at least one supervisory visit during the previous four months that included observation of nutrition counseling of prenatal, postpartum/delivery, and/or postnatal cases, and immediate feedback?

✦ Do monthly reporting forms for each clinical service include information on the number of prenatal women given iron/folate, number of iron/folate tablets distributed, cases of anemia detected, postpartum vitamin A supplements given, counseling given on diet, and preparation for breastfeeding?

✦ In how many facilities are all essential monthly reporting forms available and up to date?

- ✦ Do health workers know the correct way to record on the mother's health card the iron/folate tablets given, counseling on her diet, breastfeeding support provided, and postpartum vitamin A supplements given?

- ✦ Do health workers demonstrate adequate counseling skills?

  For example—
  - In how many facilities did more than half the workers require no improvement in the steps listed in the counseling checklist (see Annex D)?

- ✦ Do the health facilities follow the national micronutrient protocols and, if births occur in the facility, the "Ten Steps" of a Baby Friendly maternity?

  For example—
  - How many facilities have national vitamin A and iron supplementation guidelines available?
  - How many maternities follow the ten steps of Baby Friendly guidelines (see Annex B)?

- ✦ What is the health worker's relationship with the community?

  For example—
  - Do health workers provide training; supplies; and supervise or meet with TBAs, private providers, and health workers in the community at least once every four months, in each community?
  - Do health workers monitor nutrition problems in the community (for example, women with palmar pallor, night blindness, "insufficient milk," bottlefeeding, iodized salt supplies not available, or others)?
  - Do health workers inform community leaders or representatives about nutrition problems and progress?
  - Do health workers keep lists of communities with special problems (for example, communities with no trained birth attendant or breastfeeding counselor, and no local supplier of iron/folate tablets)?

Nutrition Content in Child Health Services

- Review the content of nutrition for each category of facilities that provide immunizations, treatment for sick children, or well-baby services, as shown below.

- Visit health facilities and directly observe the health worker (observe the management of one or two children). Use the job aid checklists in Annex C–4, C–5, and C–6 as guides to the key elements that need to be observed.

Nutrition Checklist

- Record the following:

  - Are caretakers of children under 2 years of age asked about breastfeeding and complementary feeding practices?
  - Are children who receive immunization services checked for their vitamin A supplementation protocol and given vitamin A correctly?
  - Do sick children have their nutrition status assessed (for example, plot on a growth chart, look for pallor, look for visible wasting, and look for edema)?
  - Are caretakers of sick children advised to give extra fluids and to continue feeding?
  - Are sick children given adequate vitamin A?

- Visit health facilities, interview health workers, and directly inspect supplies and equipment. Record the following:

  ✦ Are all essential drugs/micronutrients and equipment available on the day of the visit?

  For example—
  - Do facilities have vitamin A capsules, iron, mebendazole, and chloroquine available on the day of the visit?
  - Do facilities have counseling/IEC materials for assessment and counseling on child feeding?
  - Do facilities have weighing scales and weight-for-age charts?
  - What is the number of stock-outs (days when no stocks are available) of vitamin A capsules, iron/folate, mebendazole, or chloroquine in the 30 days before the visit?

  ✦ What percentage of health workers providing services have received primary health care training that includes key nutrition elements?

  For example—
  - How many facilities have more than half the health workers in this service category trained in the past three years in topics that include nutritional status assessment, visible wasting/edema (weight-for-age, anemia assessment, and treatment), assessment and counseling on feeding problems, and vitamin A supplementation for sick and well children?

  ✦ Are supervisory visits being made to the facility?

  For example—
  - Have facilities received at least one supervisory visit during the previous four months that ined observation of assessment and counseling on feeding, vitamin A supplementation, nutritional status assessment (wasting or edema, weight-for-age, and palmar pallor), and immediate feedback?

- ✦ Do monthly reporting forms for each clinical service include information on the number of cases of malnourished children, palmar pallor, and feeding problems; and vitamin A supplements given?

- ✦ Do facilities have all essential monthly reporting forms with nutrition indicators available?

- ✦ Do health workers know the correct way to record on the child's health card the child's weight-for-age, feeding problems and counseling, and vitamin A supplements given?

- ✦ Do health workers demonstrate adequate counseling skills?

  For example—
  - How many facilities have more than half of the workers requiring no improvement in the steps listed in the counseling checklist (see Annex D)?
  - In how many facilities do more than half the workers use IMCI-based feeding recommendations for all children under 2 years; and children older than 2 years who are assessed as low weight-for-age?

- ✦ Do the health facilities follow the national micronutrient protocols and feeding guidelines that are locally adapted forms of IMCI feeding guidelines?

  For example—
  - Do facilities have national vitamin A and iron supplementation guidelines available?
  - Do facilities use locally adapted feeding guidelines based on IMCI feeding guidelines?

- ✦ What is the health worker's relationship with the community?

  For example—
  - Do health workers provide training; supplies; and supervise or meet with private providers and health workers in the community at least once every four months, in each community?
  - Do health workers monitor nutrition problems in the community (for example, children with signs of malnutrition, palmar pallor, night blindness, "insufficient milk," bottlefeeding, lack of weight gain, "poor appetite," or lack of iodized salt, and others)?
  - Do health workers regularly communicate nutrition problems to community leaders and health volunteers?
  - Do health workers know which communities have more nutrition problems or low access to services and supplies? Do they have charts or lists with nutrition statistics by community (for example, the number of underweight children, reported night blindness, lack of iodized salt)?

Status of Priority Nutrition Activities in Communities

Summary of Key Questions

1. What health and nutrition services are offered in communities?
2. Do community workers include key nutrition tasks in their routine practices?
3. What is the quality of nutrition services provided by community workers?
4. Are essential commodities locally available?

Sources of Health Care, Commodities, and Diet/Health Counseling in the Community

- Make a list of the types of sources in the community selected for the visit.

Note:
Interview key informants who are knowledgeable about the community. In the list, include health huts, health volunteers/community workers, TBAs, private practitioners, traditional healers, dispensaries, pharmacies, drug vendors, and others, in each community. Include government and private sources, and health/non-health workers who provide nutrition-related services.

✦ Which of these services is provided by each?
  - *Prenatal* health/dietary care, counseling, tonics, and drugs
  - Support, care, drugs, and tonics *for deliveries and after delivery*
  - Counseling, care, and drugs when infants and *children are sick*
  - Counseling, care, and preventive medicine or tonics for *maintaining good health in infants and children* (for example, guidance on feeding, immunizations, and others)

- Describe the nutrition care, counseling, and commodities in the community.

  - Visit the community health/nutrition site or make home visits and directly observe community health worker practice. Observe the management of at least one or two women and one or two children. Use the job aids in Annex C as a guide. Record which of the actions in the job aids are implemented by care providers and which action are not. Ask why some actions are not taken and what needs to be done.

Note: During each contact with community providers and caretakers, if direct observation is not possible, discuss the nutrition activities provided.

Nutrition Content in Prenatal Care

- Is there community-based distribution of iron/folate tablets? Is there a convenient location when pregnant women can get iron/folate tablets?
- Do pregnant women receive counseling about their diet?
- Do pregnant women and their families receive counseling to prepare for exclusive breastfeeding?
- Do pregnant women receive appropriate counseling on compliance with taking iron/folate pills, how to manage side effects, and how many tablets to take?

Nutrition Content at Delivery and in Postpartum Care

- Is breastfeeding initiated immediately (within about one hour) after delivery?
- Do mothers receive support to initiate breastfeeding?
- Do mothers receive counseling about their diet?
- Do mothers receive postpartum vitamin A?

Nutrition Content in Sick-Child Care

- Are breastfeeding and complementary feeding practices assessed and appropriate counseling given?
- Are vitamin and iron supplementation protocols and the content of counseling or feeding consistent with district guidelines?
- Are sick children weighed and plotted on growth charts? How is this information used?
- Are sick children routinely screened for visible wasting/edema, very low weight, acute respiratory infection (ARI), diarrhea, malaria, measles; are the children referred appropriately and given follow-up care according to district guidelines?

Nutrition Content in Well-Baby Care

- Are the breastfeeding and complementary feeding practices of children adequately assessed?

- ✦ Is appropriate counseling given?
- ✦ Is there community-based distribution of vitamin A at least twice a year?
- ✦ Is the status of vitamin A supplementation checked when immunizations are given?
- ✦ Are children regularly weighed in the community? Is vitamin A supplementation and feeding assessment guidance linked to weighing sessions?
- ✦ Are the results of weighing sessions reported to caretakers and community leaders regularly?
- ✦ Are children who are not well frequently followed up and counseled or referred for medical care ? Are other actions taken to reduce the number of children who are not growing well (for example, providing food supplies, day care, and other social support)?

Nutrition Supports at the Community Level

- Visit communities, interview community health workers, and directly inspect supplies and equipment.
  - ✦ Is there a trained child feeding counselor (trained in breastfeeding, complementary feeding, and feeding during and after illness) in or near the community?
  - ✦ Is there a source for iron/folate tablets for pregnant women, and is there a source for iodized salt, in or near the community, that can be purchased by families?
  - ✦ Are the protocols/content of counseling that are routinely given to pregnant women and caretakers of children 0–24 months of age consistent with district guidelines?
  - ✦ Have any community workers received nutrition-related training or supplies from health facilities' staff in the past four months?
  - ✦ Have community workers received at least one supervisory visit in the past four months that included a review or discussion of nutrition assessment, micronutrient supplementation, testing iodized salt samples, and assessment and counseling on feeding?
  - ✦ Is there any record of nutrition services being given in the community on the child's or mother's cards, or registers, or on records for immunizations and/or deliveries?
  - ✦ Are IEC materials used? Are they adequate for effective counseling on priority nutrition messages?
  - ✦ Are other sectors involved in supporting priority nutrition behaviors (for example, do

school children test salt samples or help in child weighing, do agricultural extension workers assess and counsel on feeding practices, are religious/social/political leaders involved in monitoring and promoting priority behaviors and assuring adequate nutrition resources to support good nutrition in the community)?

Community Leaders' Awareness of and Commitment to Nutrition

- ✦ Do social/political leaders, teachers, priests, health workers, and others know that—
  - Nutrition problems may be widespread in their area even if severe malnutrition or extreme food shortages do not exist.
  - Approximately half of all child deaths are associated with malnutrition.
  - The foundation for nutrition is laid down before birth; so the health, care, and diet of women is crucial to ensure a well-nourished population.
  - Malnutrition is caused by a combination of inadequate diet, frequent illnesses, and insufficient care given to mothers and children.
  - Malnutrition increases the severity of common illnesses, increases the chances of becoming disabled or blind, lowers intelligence, and reduces the ability to work.

- ✦ In the community, are the following present:
  - A committee or group of community members that are responsible for health and nutrition issues; do they take action when a problem is detected?
  - At least one person in each community selected by the community and trained in priority nutrition actions for maternal/reproductive health and child health; is this person(s) widely known by families and adequately supported by community leaders and resources?
  - Community ownership of the nutrition and primary health care activities (for example, is there substantial, broad-based involvement by the community in decision making, and are resources provided by the community to support health and nutrition activities)?

Nutrition in District Health Services

Summary of Key Questions

1. What is the scale and coverage of district health services?

2. Are district resources adequate to manage nutrition activities?

3. Are district nutrition policies and guidelines adequate?

4. Are key nutrition activities integrated into all services?

Note:

District staff play a key role in planning for priority nutrition actions. Setting reasonable targets for nutritional improvement and allocating enough resources in district health plans to reach these targets are important steps for achieving the integration of nutrition with health. In this section, the need for better plans, adequate resources, and coordi-nation are identified.

Scale and Coverage of District Health Services

- Identify facilities that have integrated nutrition activities into routine services.

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

  - ✦ What percentage of governmental, nongovernmental, or private facilities provide the six main categories of maternal and child health services? What percentage of these facilities have incorporated key nutrition activities? Are priority nutrition activities included in both facilities-based and community-based or outreach services?

  - ✦ How can these services be introduced, improved, or expanded to incorporate key nutrition activities?

Coverage of Maternal and Child Health Services

- Review district records to answer the following questions. Then, identify actions to integrate nutrition in these sites. How can coverage be increased?

  - ✦ What percentage of all deliveries are assisted by trained birth attendants, including clinics/posts and in the community?

- ✦ What percentage of pregnant women have at least two antenatal visits?
- ✦ What is the immunization coverage for all immunizations, including measles? What are the trends over time?
- ✦ What proportion of the population lives within one hour of a health facility?
- ✦ What proportion of the population lives in communities visited by health center staff at least three times a year?
- ✦ How does coverage vary by geographic area, ethnic groups, and seasons?
- ✦ How can coverage be improved?

Nutrition-Related Maternal/Reproductive and Child Health Policies and Guidelines

- ◘ Interview district health staff and review their guidelines. Determine if they are consistent with national and international standards.
  - ✦ What are the policies for the use of vitamin A and iron supplements for infants and children?
  - ✦ What is the policy for iron/folate supplementation of pregnant women?
  - ✦ What is the policy for postpartum vitamin A supplementation of women?
  - ✦ What is the policy for the duration of exclusive breastfeeding?
  - ✦ Are women counseled in the first few months postpartum that exclusive breastfeeding is a family planning option until about six months postpartum?
  - ✦ Is there a policy on breastfeeding and HIV/AIDS?
  - ✦ Is there a policy to train staff and revise maternity procedures according to the Baby Friendly Hospital Initiative (BFHI) "Ten Steps" (see Annex B)?
  - ✦ What are the policies and guidelines for complementary feeding and nutritional counseling guidelines during illness and during good health?
  - ✦ What is the policy on the promotion of iodized salt by health workers?

Staff Responsible for Priority Nutrition Actions in the District Health Services

- Interview district health staff.

  - At what level and by whom are decisions made about policies and technical content of protocols? Do the decision makers have updated nutrition protocols for priority interventions?

  - Who is responsible for managing and coordinating primary health care and nutrition activities? Are they familiar with essential nutrition actions (see Annex A)?

  - Is there adequate leadership and coordination?

Training and Allocation of Health Staff

- Interview district health staff and review records and materials. Identify actions that should be taken.

.

  - Is enough staff available at facilities to provide essential nutrition services as part of primary health care?

  - What percentage of staff have received integrated primary health care training that includes key nutrition activities?

  - Is there a system for providing supervision, support, and follow-up for trained health workers?

  - Are training materials and methods consistent with national and international standards on nutrition?

  - Has there been an evaluation of the quality of health worker nutrition and health practice?

  - How can training materials and methods related to nutrition actions be improved?

  - How can support to health workers be improved to sustain practice of priority nutrition activities?

  - How can the needs of unpaid or volunteer workers involved in providing nutrition services be met?

How Nutrition Activities Are Integrated in Health Systems at the District Level

- Interview district health staff and review records. Determine what actions should be taken.

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

Nutrition Targets, Resources, and Plans

- Interview district health staff and review records. Identify actions to fill in the gaps.

    - What is the current prevalence and the expected reduction of the following:
        - low birth weight
        - underweight/stunting/wasting
        - vitamin A deficiency
        - anemia
        - iodine deficiency
        - women with low Body Mass Index (too thin for their height)
    - What are the targets for the following:
        - improving women’s diets
        - breastfeeding practices
        - complementary feeding practices
        - improving quality of nutritional care for sick and malnourished children
        - vitamin A supplementation
        - iron/folate supplementation for women

- iodized salt intake

✦ Are targets well disseminated and known to staff?

✦ Are targets understood and attainable?

✦ How is the progress toward targets being measured?

✦ Are the staff and budgetary resources that are allocated for priority nutrition actions consistent with desired targets and operational needs and plans?

✦ Are steps being taken to implement the plans?

✦ How were program priorities set? Were the views of community representatives considered when the priorities were set?

✦ Are data on priority problems, high risk areas and groups, causes of nutritional problems, and operational difficulties used to allocate resources?

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

✦ Do donors or other organizations contribute to budgets or plans?

✦ Are donor contributions from different sources coordinated to meet district needs and to avoid duplication?

Using the Information for Planning

Summary of Key Questions

1. What activities are needed to improve nutrition programming?

2. Who will be responsible for implementing activities?

3. What is the timetable for implementing activities?

4. What resources are required for implementing activities, and are the resources available?

Actions for District Planning

- ✦ What actions are needed to ensure effective coordination, planning, and budgeting of nutrition activities at the district level?

- ✦ Has a coordinator been identified? What is the coordination mechanism with non-health and nongovernmental sectors?

- ✦ Is better/more information needed about nutrition problems, behavior of households, and community needs?

Actions to Support Nutrition Interventions at Health Facilities

- ✦ What changes are needed in maternal/reproductive health and child health policies and technical protocols or procedures for the following:
  - breastfeeding
  - micronutrients (vitamin A, iron, and iodized salt)
  - management of sick and malnourished children
  - nutrition and diet of women

- ✦ Does new information need to be collected or analyzed before the necessary revisions can be made?

- ✦ What actions need to be taken to improve supplies of the following:
  - iron/folate
  - vitamin A
  - salt testing kits
  - counseling cards
  - other IEC materials

- equipment (for example, weighing scales)

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

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

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

✦ What actions are needed to strengthen the routine monitoring of nutrition activities? What tools and methods are required to conduct routine monitoring?

Actions to Support Nutrition Interventions at the Community Level

✦ Do district staff and health workers know how important it is to sensitize/mobilize community leaders to give priority to maternal and child nutrition? Do they need training in how to do this?

✦ Are district staff and health workers aware that other sectors (for example, education and agriculture) are also important in solving the nutrition problem; are they working with other sectors to solve the problem?

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

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

✦ Have market channels for improving access to iodized salt, iron/folate, and other commodities been explored? Have private practitioners planned ways to improve practices? What support can the district health team provide to private retailers and service providers?

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

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

Actions to Support Nutrition at the National Level

✦ Is better coordination needed between health and non-health sectors?

- ✦ What are the national protocols, policies, and standards, and do they need to be updated or changed to support work at the district level?
- ✦ What is the national training strategy in nutrition (pre-service and in-service) and how can that be strengthened to support work at the district level?
- ✦ How does the national supply system for commodities (for example, micronutrients) affect work at the district level, and how could that be improved?
- ✦ Do national policies on nutrition use information collected at the district level? Are national figures on nutrition shared with the districts?

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Annexes

A. Essential Nutrition Actions in Health Services

B. Ten Steps for Baby Friendly Hospitals

C. Nutrition Job Aids for Health Contacts

D. Guidelines on Counseling

Annex A: Essential Nutrition Actions in Health Services

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

Annex B: Recommended Practices for Maternities

Ten Steps for BFHI (based on UNICEF/WHO, Baby Friendly Hospital Initiative 1992)

1. *Breastfeeding policy* routinely communicated to all health staff: (a) explicit written 10-step policy; (b) prohibit all promotion and group instruction on substitutes, bottles, teats, or others; (c) give policy to all maternal and child health staff; (d) post and display policy in all areas; and (e) put a mechanism in place for evaluating program effectiveness.

2. *Train all health staff* in necessary skills: (a) all staff must be aware of benefits and policy; (b) train all new staff within 6 months of joining staff; (c) cover at least 8/10 steps in training; (d) provide at least 18 hours of training, with 3 hours of supervised clinical experience, and (e) provide some staff with 40 hours of more specialized training.

3. *Inform all pregnant women*, pregnant women attending antenatal clinic, outreach or inpatient, about the benefits and management of breastfeeding.

4. *Help mothers breastfeed immediately after birth*: (a) for normal deliveries and cesarean sections, mothers should have physical contact with infants within 30 minutes after birth.

5. *Show mothers how to breastfeed and maintain breastfeeding even if they are separated from their infants*: (a) mothers in postpartum wards should be given help within 6 hours after delivery and shown how to express milk, (b) mothers with babies in special care should be given help to initiate and express breastmilk, and (c) staff should be able to demonstrate manual expression.

6. *Newborns should receive no water, food, or fluids* unless *medically* indicated: (a) mothers are not permitted to give food or fluids, (b) infant foods, drinks, and related apparatus may not be displayed or promoted, and (c) staff should know acceptable medical reasons for giving other fluids, milk, or foods.

7. *Mothers and infants should practice rooming-in* for 24 hours a day: (a) mothers and newborns should remain together after leaving the delivery room, day and night, except for up to 1 hour for special procedures.

8. *Encourage breastfeeding on demand*: (a) mothers should know that there are no restrictions on frequency or duration of each breastfeed, and (b) health staff should place no restrictions.

9. *No artificial teats or pacifiers* (dummies or soothers): staff and mothers should know not to give these objects to infants.

10. *Encourage the establishment of support groups* and refer mothers on discharge: (a) staff should discuss mothers' plans after discharge, (b) tell mothers about support groups in the local area, and (c) encourage mothers to return for checkups.

Annex C–1: Nutrition Job Aid for Prenatal Care Contacts

Why? Why is nutrition important? Poor nutrition in pregnant women endangers the lives of mothers and newborns.

What? What can you do to help? At each prenatal contact with mothers, check and complete the following activities.

Who?	How Much/Content?	Duration?
All pregnant women	• One iron/folate tablet daily (60 mg. iron + 400 micrograms folic acid) • Counsel on compliance, safety, side-effects.	180 days, starting at first prenatal visit and continuing until all 180 tablets are taken.
Pregnant women with pallor (pale eyelids and palms)	• Two iron/folate tablets daily (120 mg. iron + 800 micrograms folic acid) until pallor disappears, followed by 1 tablet daily (60 mg. iron + 400 micrograms folic acid). • Counsel on side effects, compliance, safety.	Two tablets daily until pallor disappears or a minimum of 90 days. Continue taking one tablet daily until all 180 days of iron supplementation are complete; continue taking tablets postpartum.
All pregnant women	Assess and counsel to prepare for exclusive breastfeeding; counsel for breastfeeding immediately after baby is delivered.	Counsel at every prenatal contact.
All pregnant women	Counsel on adding 1 meal per day, more vitamin A- and C-rich foods, and getting extra rest.	Start as soon as pregnancy is detected and continue during lactation.

How can the recommendations be accomplished?

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

Note: Many women in your catchment area probably do not come for prenatal visits or they come very late. To reach them, work with community midwives (matrons) or trained birth attendant (TBAs); train, supply, and supervise matrons and TBAs.

Annex C–2: Nutrition Job Aid for Delivery and Postpartum Contacts

Why? Building a strong foundation for successful breastfeeding and giving vitamin A to mothers and infants increases their ability to fight infections and prevents infant disease and deaths.

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

Who? All women.

How Much/Content?	Duration?
Put the baby to the breast immediately after delivery.	Continue to keep the baby with the mother in the same bed or adjacent cot for unlimited breastfeeding.
Give no water, glucose water, teas, or any fluids to the baby.	Birth until about 6 months.
Teach mothers correct attachment. Baby should be turned completely toward mother. Chin should touch mother's breast, mouth wide open, lower lip turned outward. More areola visible above than below the mouth. Infant should take slow, deep sucks (these should be audible), sometimes pausing. Show mothers different breastfeeding positions.	One time or more until mother is confident.
Counsel mothers about eating an extra meal and foods rich in energy, protein, and vitamins; reduced workload.	For the first 4 to 6 months after delivery.
Give one 200,000 IU dose of vitamin A as soon as possible after delivery but no later than 8 weeks (or 6 weeks if she is not lactating).	Once only.

Note: Women should continue taking iron/folate tablets after delivery, for a total of 180 days.

How?

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

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

C–3: Nutrition Job Aid for Postnatal Contacts

Why? Lack of follow up to support women in exclusive *breastfeeding during the first week or two* often leads to infants receiving other fluids/foods too early. This, in turn, causes diarrhea, reduction in milk supply, and the danger of another pregnancy in the first few months.

What? In the first week or two after delivery, contact each mother and review the information on the following chart.

Who? All women who delivered a child in the past few weeks.

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

How?

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

Note: Most women do not have postnatal visits at clinics or they come only for problems. Determine who can follow each postpartum mother to provide counseling. Work with community agents, such as women's groups, social workers, midwives (matrons), or trained birth attendants. Train, supply, and

supervise agents.

Annex C–4: Job Aid for Giving Vitamin A with Routine Immunizations

Why? Lack of vitamin A damages the body's ability to fight infections and causes blindness.
What? At each immunization contact with mothers and children, check and complete the following.

Note: Give children who are not sick or malnourished preventive doses of vitamin A, including two doses between 6–12 months of age, spaced about 4 to 6 months apart. Continue the doses, spaced about 4 to 6 months apart, until the child is 5 years old (60 months). Use the chart below to determine how much vitamin A to give.

Possible Immunization Contact	**Age Group/Timing**	**Amount of Vitamin A**	
		If using 100,000 IU capsules	If using 200,000 IU capsules
Tuberculosis vaccine (BCG) contact up to 8 weeks.	Mothers up to 8 weeks postpartum	Two capsules	One capsule
Any immunization contact from about 6 months.	Infants 6–11 months	Drops in one capsule	Half the drops in a capsule
	Children 12 months or older	Drops in two capsules	Drops in one capsule
Measles vaccination contact.	Infants 6–11 months	Drops in one capsule	Half the drops in a capsule
	Children 12 months or older	Drops in two capsules	Drops in one capsule
Booster doses, special campaigns, delayed primary immunization doses, immunization strategies for high-risk areas or groups.	Infants 6–11 months	Drops in one capsule (every 4 to 6 months until 59 months of age)	Half the drops in a capsule (every 4 to 6 months until 59 months of age)
	Children 12 months or older	Drops in two capsules (every 4 to 6 months until 59 months of age)	Drops in one capsule (every 4 to 6 months until 59 months of age)

How?

1. Check the dose in the vitamin A capsules, the child's age (for mothers, the date of delivery), and when the last dose of vitamin A was received. Mothers who are not breastfeeding should be dosed within six weeks after delivery.
2. Cut the narrow end of each capsule with scissors or a nailcutter, and squeeze the drops into the child's mouth. Ask mothers to swallow the capsule in your presence. Do **not** ask a child to swallow the capsule. Do **not** give the capsule to the mother to take away.
3. To give less than one capsule to a child, count the number of drops in a sample capsule when a new batch of capsules is first opened. Give one-half or one-quarter the number of drops from the capsule.
4. Record the date of the dose on the child's card, and the mother's dose on the mother's card.
5. On the tally sheet/register, place a mark for each mother dosed, and another mark for each child dosed. Make a monthly/quarterly/annual chart of vitamin A doses the same way immunization coverage is charted. Routinely report coverage of mothers' dose; first dose for infants; and second, third, fourth, etc., doses with immunization coverage.
6. Advise the mother when to return for the next doses of vitamin A, and encourage completion of immunization protocols.

Annex C–5: Job Aid For Nutrition Services for Sick Children

Why? Illnesses drain a child's nutrition reserves, interfere with feeding, and makes children more susceptible to getting sick in the future. It can increase the duration and severity of diseases, and increase the risk of death and disability.

What? At each contact with a sick child, health workers should assess, classify, and treat the child using IMCI guidelines, as shown below (also see complete IMCI protocols, WHO/UNICEF). For treating severely malnourished children, use WHO's *Management of Severe Malnutrition*, 1999.

<table>
<tr><th>Classification</th><th>Age in Months</th><th colspan="2">Management</th><th>Follow Up</th></tr>
<tr><td>Any sick child without a severe classification.</td><td>≤ 24</td><td colspan="2">• Assess the child's feeding and counsel the caretaker according to the IMCI food box from the Counsel the Mother chart.
• Check and complete the preventive vitamin A dose; one age-appropriate dose every 4–6 months.
• Check the child's weight-for-age.</td><td>• If there is a feeding problem, follow up in 5 days.
• Advise the caretaker about danger signs that would require her to return immediately.</td></tr>
<tr><td rowspan="4">Measles (severe complicated measles, measles with eye and mouth complications, or uncomplicated measles).</td><td colspan="2">Age-Appropriate Dosage</td><td rowspan="4">Give two doses, one day apart. If eye signs are present or clinical VAD exists in the area, give a third dose, 2 weeks later (the caretaker can give the third dose at home).</td><td rowspan="4">• Give single dose and refer immediately if severe, complicated measles.
• For other classifications: treat conjunctivitis with tetracycline eye ointment and mouth ulcers with gentian violet. Follow up in 2 days if there are complications.</td></tr>
<tr><td>0–5</td><td>Vitamin A 50,000 IU per dose</td></tr>
<tr><td>6–11</td><td>Vitamin A 100,000 IU per dose</td></tr>
<tr><td>12 +</td><td>Vitamin A 200,000 IU per dose</td></tr>
<tr><td>Severe malnutrition or severe anemia.</td><td>0–59</td><td colspan="2">• Give single dose of vitamin A according to dosage schedule shown above.</td><td>• Refer to hospital .***</td></tr>
<tr><td>Anemia or very low weight.</td><td>0–59</td><td colspan="2">• Assess the child's feeding and counsel the caretaker according to the attached IMCI food box on the Counsel the Mother chart.
• If pallor: give iron (give half a tablet of iron (30 mg. iron)* daily to children >12 months for 2 months or until pallor disappears. For younger infants give 20 mg. elemental iron.**
• Give antimalarials if high malaria risk.
• Give mebendazole if child is 2 years or older and has not had a dose in the previous 6 months.</td><td>• Advise mother about danger signs that require her to return immediately.
• If pallor, follow up in 14 days.
• If very low weight for age, follow up in 30 days.</td></tr>
</table>

* Ferrous sulfate 200 mg.=60 mg. elemental iron.

** Give drops, if possible, or powder ferrous sulfate tablets (two tablets contain 10 mg. iron each) and give by spoon, mixed with a liquid (WHO, IMCI guidelines).

*** Referral hospitals or clinics treating severe malnutrition should follow WHO guidelines in *Management of Severe Malnutrition*, 1999.

How?

1. Give each sick child the recommended vitamin A doses listed on Annex C–4. For children not in the classifications listed above, check and complete their preventive vitamin A and iron doses (see job aids for well-baby contacts and immunization contacts).
2. Vitamin A dosing. See Annex C–4.
3. Assess, classify, and treat all sick children according to IMCI guidelines (obtain IMCI checklist from WHO or UNICEF). Assess child's feeding and give nutritional counseling according to attached IMCI guidelines.

4. Record the classification and treatment given on the child’s card. Place a mark on the tally sheet for each child assessed, dosed, counseled, and referred.

Annex C–6: Nutrition Job Aid for Well-Baby Contacts

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

What? Follow this protocol at each contact with a well child. Use IMCI Counsel the Mother chart for feeding assessments and recommendations.

Check and Complete Vitamin A and Iron Protocols for Prevention	Age in Months	Amount of Vitamin A		No. of Vitamin A Doses	Iron
		If 100,000 IU capsules are used	If 200,000 IU capsules are used	One dose every 4–6 months from about 6 months of age to 59 months.	See INACG/UNICEF/WHO guidelines, 1998.
	6–11	Drops in one capsule	One-half drops in one capsule		
	12 or more	Drops in two capsules	Drops in one capsule		

Assess and Counsel for Feeding Difficulties	Age in Months	Assess and Classify		Counsel/Treat
	0–5	Assess breastfeeding.	Identify difficulties.	Exclusive breastfeeding until about six months. Correct attachment, position, other difficulties; encourage longer duration and more frequent feeds.
	6 or more	Assess complementary feeding.	Identify difficulties: poor appetite, frequency, amount per feed, density, hygiene, feeding style.	Strategies to correct problems in food content and feeding style. Increase amount and enrichment after illness. Continue breastfeeding for at least 24 months.
Screen for Severe Anemia	Screen for palmar pallor using IMCI guidelines.			Give half a tablet of iron (30 mg. iron)* daily to children >12 months for 2 months or until pallor disappears. For younger infants give 20 mg. elemental iron.**
Screen for Malnutrition	Screen for severe wasting, edema of both feet. Weigh all children and determine if the child is growing adequately.			If severe malnutrition is found, give vitamin A and refer to hospital immediately.

* Ferrous sulfate 200 mg. (60 mg. elemental iron).

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

How?

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

6. Record treatment for severe malnutrition and anemia on the child's card.

7. Mark the daily tally sheet for vitamin A, feeding assessment/counseling, and treatment.

Annex D: Counseling Guide

Note: Supervisors and observers should use this table to check, record, and give feedback to health workers who counsel mothers and caregivers.

Stages	Good	Needs to Improve
1. Entry/climate setting:		
Kind and reassuring.		
Makes client feel comfortable.		
Uses gestures and responses that show interest in the client.		
2. Agenda setting:		
Announces the subject.		
Asks consent of client.		
Assures it is a subject of interest.		
3. Find out what client knows and believes:		
Asks open-ended questions.		
Repeats/reflects back what the client says.		
Accepts or validates feelings of the client. Doesn't challenge what the client feels.		
Avoids words that sound as if the client is being judged.		

Stages	Good	Needs to Improve
4. Explains connection between desired outcome and behavior:		
Uses simple language.		
Makes suggestions, not commands.		
Gives only that amount of information or advice that can be remembered and followed.		
5. Ask the client how she can achieve this behavior:		
Recognizes and praises what the client is doing correctly before suggesting changes.		
Checks what is practical and possible for the client to do.		
6. Verify clients comprehension and intention to try it.		
7. Plan for next appointment.		
Overall Listening Skills:		
Uses encouraging non-verbal communication (facial expression, body language).		
Empathizes—shows that he/she understands how the client feels.		