Pathways to Quality Nutrition and ECD Counselling

Review of integration of maternal nutrition, IYCF and ECD counselling into the Health System in the ESA Region

Preliminary Regional Level Recommendations
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Image Courtesy: UNICEF

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Why this review?

"Counselling is a way of working with people so that you understand their feelings and help them to develop confidence and decide what to do."

(WHO & UNICEF)

Countries often struggle to provide quality counselling at scale.

- Counselling is often confused with telling clients **"what to do".**
- Lack of a solid foundation of technical knowledge and interpersonal skills for counselling, limited time and limited motivation.

Few studies have assessed the integration of counselling into the health system and determined how upstream barriers and enabling factors impact the delivery of quality counselling.

Note: In this report, the term **'counselling'** refers collectively to Maternal Nutrition (MN), Infant and Young Child Feeding (IYCF), and Early Childhood Development (ECD) counselling unless otherwise specified.

Overall integration by building block

- Highest under Governance, Human Resources and Service Delivery.
- Lowest for Finance, Supply and Information Systems.
- 8 of the 15 countries scored 50% of higher for overall integration of counselling throughout the HSBBs.

	Governance	Finance	Human Resources	Supply	Service delivery	Information system	Overall Integration
Angola	64.86%	76.00%	85.71%	45.16%	68.80%	67.21%	67.97%
Burundi	72.97%	48.00%	57.14%	29.03%	68.00%	32.79%	51.33%
Eritrea	45.95%	4.00%	29.76%	29.03%	39.37%	16.39%	27.42%
Eswatini	24.32%	52.00%	72.62%	41.94%	92.86%	63.93%	57.96%
Ethiopia	59.46%	40.00%	42.86%	35.48%	54.40%	62.30%	49.09%
Kenya	56.76%	48.00%	79.76%	51.61%	97.62%	50.00%	63.97%
Malawi	100.00%	16.00%	69.05%	61.29%	68.80%	29.51%	57.45%
Mozambique	16.22%	16.00%	66.67%	35.48%	40.48%	30.65%	34.25%
Rwanda	83.78%	4.00%	50.00%	61.29%	38.40%	0.00%	39.59%
Somalia	56.76%	20.00%	33.33%	35.48%	40.00%	25.81%	35.24%
South Sudan	37.84%	12.00%	41.67%	29.03%	62.90%	40.98%	37.41%
Tanzania	72.97%	36.00%	41.67%	41.94%	53.97%	18.03%	44.10%
Uganda	91.89%	3.85%	78.57%	61.29%	71.43%	57.38%	60.75%
Zambia	75.68%	36.00%	61.90%	64.52%	64.80%	44.26%	57.87%
Zimbabwe	72.97%	12.00%	100.00%	61.29%	81.60%	11.48%	56.57%

Note: Colour coding is done using a conditional formatting colour scale on Google Sheets.

- the minimum value 0% is red
- the maximum value 100% is green
- the midpoint value 50% is yellow.

Overall Integration by counselling topic

- Highest for IYCF followed by maternal nutrition with similar level of integration between the two.
- Three countries had notably lower level of integration for maternal nutrition compared to IYCF.
- ECD was moderately low to very low integrated for all countries.

	Maternal Nutrition	IYCF	ECD
Angola	80.22%	79.71%	47.71%
Burundi	63.20%	64.47%	31.42%
Eritrea	41.05%	44.61%	11.53%
Eswatini	67.31%	67.75%	48.27%
Ethiopia	67.63%	67.12%	18.15%
Kenya	70.76%	78.09%	47.33%
Malawi	58.60%	72.08%	43.09%
Mozambique	18.22%	54.13%	38.09%
Rwanda	41.02%	41.02%	39.51%
Somalia	51.96%	55.21%	7.99%
South Sudan	58.33%	57.57%	9.29%
Tanzania	47.50%	61.08%	31.85%
Uganda	69.97%	76.35%	41.94%
Zambia	64.00%	84.16%	28.69%
Zimbabwe	64.68%	65.52%	48.64%

Overarching Key Findings

Key finding 1.

In health centers and at the community level, counselling was near universally misunderstood and reported to be the provision of messaging mostly through groups.

- Counselling in most countries was synonymous with delivery of information sessions, provision of IEC materials, group education sessions and delivery of key messages.

Key finding 2.

Providing the skills and tools needed for counselling alone is insufficient to ensure quality counselling.

- Time poverty of the health worker and community worker was the leading barrier to delivery of messaging
- In Malawi, health workers and community health and nutrition cadres received timely MIYCN training, had supportive supervision in place and had job aids available however were not delivering counselling due to time limitations.

Enabling Factor 1.
All countries had components from each of the six-health system building blocks in place

Governance

The provision of communication strategies for IYCF are included in most documents and for maternal nutrition in many.

Information System

Most countries had indicators to measure the delivery and/or receipt of IYCF counselling with a focus on receipt of messages on breastfeeding in their HMIS

Finance

Kenya, Zambia, Angola, and Ethiopia have budget lines for MIYCN-ECD counselling or for programs that explicitly outline the delivery of MIYCN-ECD counselling

Service Delivery

In many countries, counselling for MIYCN was linked to all health facility and community level contact points.

Human Resources

In most countries, the job descriptions of Community health and nutrition cadres highlight the provision of communication for nutrition including aspects of MIYCN-ECD.

Supply

Job-aids are well-developed in most countries, and many integrate components of early stimulation, nurturing care and developmental milestones.

Enabling Factor 2.
Community level systems integrate MIYCN counselling for all countries with community health and nutrition cadres well positioned to provide quality counselling for MIYCN-ECD.

Community level systems had a higher level of integration for counselling in comparison

CHNCs are providers of messages and counselling at both the health facility and community

More likely to have MIYCN counselling included in their job descriptions, training and supportive supervision checklists

Well-developed job aids, tools, and guidelines for community level systems are in place for most countries.

Community level services include MIYCN and increasingly ECD counselling as a key activity.

Resilient, when they lacked counselling job-aids, they often turned to the child health book to provide messaging support.

Showed pride in their work and were well-aware of the issues preventing good nutrition in their communities.

Demonstrated skills of empathy, consideration and kindness.

Barrier 1.
Systems across the six building blocks are in place but serious gaps remain, limiting the ability of health workers and community health and nutrition cadres to provide effective counselling

Barrier 2.

Health workers, community health and nutrition cadres and mothers have competing demands and limited time

There are many urgent demands at the health center

- Stockout of essential medicines and supplies
- High demand for services in the morning
- Staff shortages
- Poor infrastructure

CHNCs are responsible for a long list of health, nutrition, WASH, social protection and social policy actions

- Prioritization is often provided to actions supported by partners
- Activities that are closely monitored are prioritized

Women have many demands on their time

- “Women want to go back to their business and put pressure on health providers to make lines faster hence no time for counselling”
- “Women do not have time”

Counselling is rarely provided

Barrier 3.

Key messages to increase dietary diversity are not implemented in the community, leaving health workers, community health and nutrition cadres and mothers feeling discouraged

The barriers to dietary diversity are complex and not addressed well by existing messages

- “They will say, “How can I spend 20 shillings for 1 egg for 1 child, yet the same amount is enough for 1/4 kg maize for the whole family”
- “they don’t have time; we women need to fend for our family”
- Selling of nutritious crops and eggs for income was seen as a problem of education not an economic need

Lack of sufficient social protection programmes to link food insecure families to

- Low coverage of social protection programmes
- Poor linkages between health system and enrollment
- Most health workers and CHNC were not aware of available programmes.

Women are not able to implement messages on dietary diversity and complementary feeding; creating a negative feedback cycle for both the delivery and receipt of nutrition counselling.

Barrier 4.
Community health and nutrition cadre delivery of messages on complementary feeding, nurturing care, responsive feeding and early stimulation were limited

Child food poverty in Eastern Africa is 81% and in Southern Africa 61%

- Often, complementary feeding messages are not provided at all with 70-88% of mothers NOT receiving ANY messaging from a health worker on how or what to feed their child (DHS)

Several countries integrated the delivery of ECD messages through community health and nutrition cadres however training was available for only a subset of community workers

- Most community health and nutrition cadres had not received training and did not provide counseling
- Updated job-aids with integrated ECD were unavailable for most, child health books were used as reference for ECD where they contained key messages.

Overarching actions

1. Identify specific Community Health and Nutrition Counselors from community health and nutrition cadres and provide a supportive environment for them to provide quality tailored counselling to at-risk women and children.

2. Link key messages for stimulation and nurturing care with MIYCN counselling.

3. Support local production and consumption of First Foods to address unaffordability of a healthy diet and preparation barriers

4. Enable health workers and Community Health and Nutrition Counsellors to link caregivers and their children to available social protection services and programs

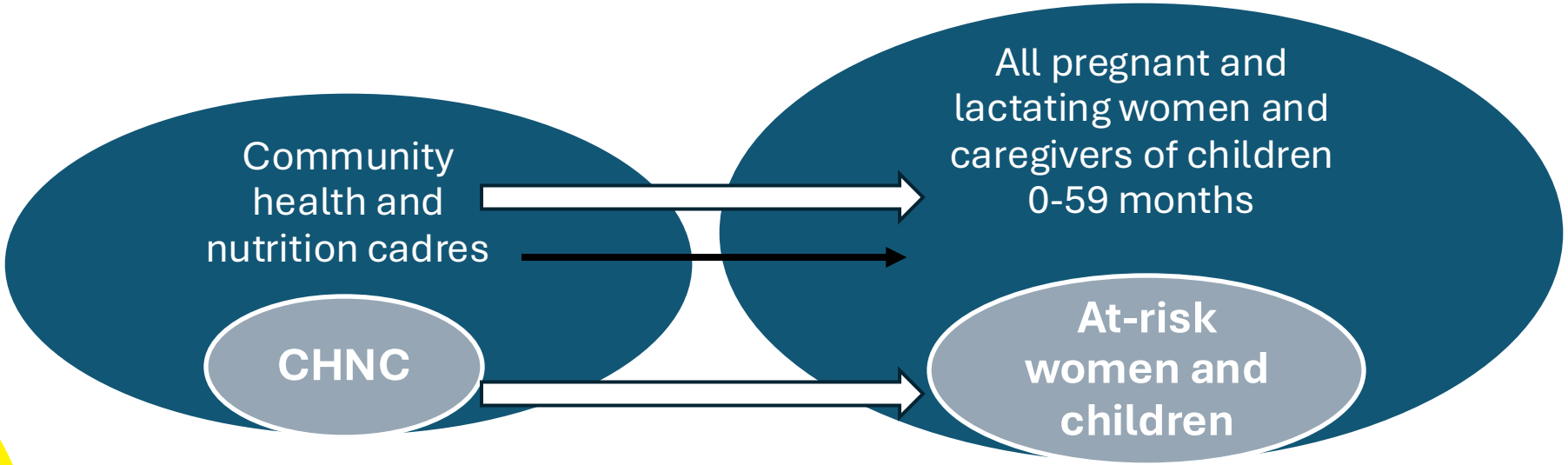
5. Count the delivery of counselling and messaging separately through routine and survey information systems

Action 1. Identify specific Community Health and Nutrition Counselors from community health and nutrition cadres and provide a supportive environment for them to provide quality tailored counselling to at-risk women and children.

In all 15 countries assessed, health workers and community health and nutrition cadres consistently stated that they did not have time to provide tailored counselling due to competing priorities.

To address the ultimate limiting factor of time, 3 steps are recommended:

1. Reframe the provision of tailored counseling from an All-to-All approach to a targeted approach for women and children at highest risk.
2. Identify interested and motivated community health and nutrition workers and promote them to become Community Health and Nutrition Counselors (CHNCs) within the existing community health and nutrition cadre structure.
3. Implement a referral system to the CHNC for delivery of tailored counseling



Action 2.
Link key messages for stimulation and nurturing care with MIYCN counselling and messaging.

At the health facility level

- CHNC provide tailored counselling for caregivers of at-risk children on early stimulation and care, recognize early warning signs, and responsive feeding
- CHNC provide early stimulation and care message delivery for at-risk pregnant and lactating women
- Integrate stimulation and care message delivery into PNC and delivery services
- Health workers and CHNC provide referrals where available for developmental delays

At the community level

- Integrate stimulation and care messaging with IYCF into growth monitoring and community IMCI programmes
- Integrate assessment for development milestones and sharing of messages on developmental milestones into growth monitoring with referral for detected delays
- Integrate early stimulation and care message delivery with breastfeeding messages for pregnant and lactating women.

Action 3.
Support local production and consumption of First Foods to address unaffordability of a healthy diet and preparation barriers

- There are multiple barriers to implementing recommendations for a diverse diet for children that are not addressed by messaging on diverse diets

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- Affordability: 72% of household can not afford a healthy diet and 30% of children have severe food poverty
- Limited time to shop and prepare
- Limited cooking space, pots, fuel and storage

- A First Food* easily prepared or added to a portion of the family meal for the child would provide essential protein, vitamins and minerals to address dietary insufficiencies without adding to the workload of the mother.

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- Link to entrepreneurship opportunities, CHNC sell health and nutrition products to aid distribution and incentivize them
- Large scale social marketing

- It is vital that the First Foods be readily available and affordable.

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- Link messaging and counselling to the purchase and consumption of the First Food.
- Linkages between an affordable First Food and existing social protection programmes to ensure affordability for the most vulnerable

Action 5.
Count the delivery of counselling and messaging separately with integrated ECD through routine and survey information systems

Currently, there is no distinction between the delivery of counseling and the delivery/receipt of key messages, group information sessions, and exposure to IEC materials in collected indicators on MIYCN-ECD counselling.

HMIS and community information systems need to disaggregate collection from CHNC and community health and nutrition cadres

Without data on the delivery, quality and receipt of MIYCN-ECD counselling little connection can be made to changes in MDD, EBF, MDD-W and children receiving early stimulation and responsive care.

What does a supportive environment for MIYCN-ECD counselling look like in the six-Health System Building Blocks?

Linkages to First Foods for older infants and young children to address preparation barriers

Linkages to social protection services and programmes to address affordability barriers

GOVERNANCE

The delivery of counselling for MIYCN/ECD through the health system is included in National Policies, Strategies, Plans and Guidelines as an essential component of service delivery for ANC/PNC and U5 Child Care.

INFORMATION SYSTEM

Data of the delivery and receipt of quality counselling for MIYCN/ECD is routinely collected through HMIS , community systems and surveys and utilized for decision making and performance reviews.

FINANCE

Consistently available and sufficient funding for CHNC and nutrition commodities for counselling including job-aids, supportive supervision visits and in service learning.

SERVICE DELIVERY

CHNCs have a supportive environment in which they are supervised, evaluated and given opportunities for in-service learning, skill building, sharing of best practices and experiences and recognition.

HUMAN RESOURCES

CHNC are responsible for the delivery of counselling in their job descriptions and performance evaluations and provided quality training on technical and interpersonal counselling skills for MIYCN/ECD with opportunities for career development.

SUPPLY

Tools and job aids, inclusive of ECD, are readily available, routinely budgeted for and included in quantification and forecasting systems.

Building a healthier future

Integrating Maternal Nutrition, IYCF and ECD Counselling into the Health System

Thank you

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