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Delivering Community-based Child Feeding Counseling, One Child at a Time

An AIN-C *monitora* uses counseling cards to explain child feeding practices to a mother and negotiate an improvement she'll be willing to try. The red stripes on the card mean that this mother's child did not gain adequate weight during the previous month.

Children's eating habits can vary widely, from the foods they prefer, to the portions they are willing to eat, and the frequency with which they take meals. To ensure adequate growth, caretakers must find a way to provide nutrient-rich, energy-dense meals that meet these habits. Individualized guidance to help caregivers who have difficulty solving this "equation" is difficult to provide in community settings, where trained nutritionists are scarce.

The *Atención Integral a la Niñez en la Comunidad* (AIN-C) program in Honduras, which has been operating at national scale for the past 8 years, represents a successful approach to meeting the challenge of providing individually tailored infant and child feeding counseling in a community setting. Five preparatory steps were important for achieving this success: 1) conducting research to determine the most common feeding problems; 2) formulating solutions that are feasible, even for resource-poor caregivers; 3) testing advice with caregivers to ensure that identified solutions work, and that caregivers are willing and able to adopt them; 4) creating counseling tools to guide community volunteers in indentifying feeding problems, offering solutions appropriate to the problems, and negotiating adoption of a solution chosen by the caregiver; and 5) training volunteer counselors to weigh children and counsel mothers using the tools. Intense efforts during program implementation to achieve early and universal enrollment, and high rates of monthly participation ensured community-wide impact based on individualized counseling.

By following these preparation and implementation standards, AIN-C participants effectively increased the practice of key nutritional behaviors within 5 years. For example, the practice of exclusive breastfeeding was 16 percent higher than among mothers who did not participate in AIN-C, and the median duration of exclusive breastfeeding was nearly two times longer. Moreover, continued breastfeeding for 12-23 month-olds was 12.5 percent higher, appropriate frequency of complementary feeding was nearly 3 times higher, and correct feeding practices for sick children was 3 times higher.

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Key preparation steps taken in designing the AIN-C program in Honduras contributed to its success in delivering individualized child feeding counseling in community settings, and universal enrollment and regular participation helped to translate individual attention into community-wide impact. Replication of these preparatory steps, with adequate attention on enrollment and participation, should produce similar community-wide impact in settings where households have sufficient resources to adopt new feeding practices.

The AIN-C final report is available on the *Nutrition for Children and Infants* page of www.basics.org, and can also be found by using the document search engine on the site's Publications & Resources page.

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Integrating Quality Postnatal Care into PMTCT

A midwife in Swaziland examines a newborn before discharge.

Maternal and newborn health services in Swaziland have been integrated with a successful national program for the prevention of mother-to-child transmission of HIV/AIDS (PMTCT). As is the case in most countries in the region, postnatal care is weakest of all—although the greatest numbers of maternal and newborn deaths occur within 48 hours of birth, most Swazi mothers and infants do not receive their first postnatal check-up until at least four weeks following delivery.

From 2006 to 2007, USAID/BASICS implemented *Repositioning Postnatal Care in a High HIV Environment,* a facility-based operations research project, with the Population Council and the Elizabeth Glaser Pediatric AIDS Foundation. The research effort covered 7 facilities, where more than 11,000 births occur annually, and was designed to test the feasibility of introducing improvements to postnatal care and counseling for all mothers and babies, and addressing specific gaps for those affected by HIV/AIDS. USAID/BASICS trained supervisors and health providers in newborn health and some aspects of maternal health; also reinforcing selected aspects of antenatal, labor, and delivery care.

Of 132 personnel trained, knowledge on how to properly maintain a newborn's temperature directly after birth increased by 25 percent, and recognition of the danger signs of newborn infection and illness rose by 50 percent. Most importantly, the improvement in service quality and in the counseling of mothers led directly to greater service uptake. A 12-fold increase was achieved in the utilization of services within the first week after birth, with a 20-fold increase specific to the first 3 days following delivery.

A more mixed set of outcomes was experienced in the counseling that trained staff provided to caretakers on key aspects of neonatal care. For example, breast feeding in the first hour after delivery increased by 50 percent. Yet, only about 15 percent of mothers who were interviewed could cite at least two newborn danger signs. In response and with a view to further increasing the utilization of postnatal services,

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discussions were held with national trainers on how to enlist community health workers in advising families on appropriate care seeking, HIV/AIDS services, and other key issues.

Repositioning Postnatal Care in a High HIV Environment showed that, with appropriate attention to the quality of care, integrating routine maternal and newborn health services with PMTCT programs can result in early follow-up and improve the care of mothers and newborns. Such integration is important to guarantee that costly investments in PMTCT are safeguarded by preventing maternal and newborn deaths due to more common causes during the critical early postnatal period.

The final report of *Repositioning Postnatal Care in a High HIV Environment* is available on the Swaziland page of www.basics.org, and can also be found by using the document search engine on the site's Publications & Resources page.

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Mystery Clients:

Engaging Community Members in Evaluating Private Sector Providers

A 2006 evaluation of malaria treatment for children in Rwanda included scripted "mystery client" encounters with private drug sellers, like those working in the *Comptoir Pharmaceutique Kwizera*. The private sector is an important role player in the battle against malaria in Rwanda, but workers often lack sufficient training to provide appropriate advice and treatment.

In 2004, Rwanda's Integrated National Malaria Control Program (INMCP) developed a strategy for home-based management of fever, primarily to increase the percentage of children under the age of five who receive correct treatment within 24 hours of the onset of malaria symptoms.

Two years after implementing the strategy in six of the country's fourteen districts, the INMCP requested technical assistance from USAID/BASICS and USAID/RPM Plus to conduct an evaluation of the program, specifically to gauge its impact on case management, care-seeking, and overall malaria control, and to inform program scale-up nationally.

An important aspect of the evaluation was to try to target as many private sector providers as possible, including pharmacies, dispensaries, *comptoirs pharmaceutiques*, and informal vendors because these are important providers of treatment in the community. In addition to formal data collection on antimalarial availability and provider knowledge, "mystery client" observations were conducted to assess private drug seller practices. With this methodology, local community members were recruited by the assessment team to conduct a simulated purchase, avoiding the potential bias of external evaluators. The mystery clients were given a standard scenario to use with targeted drug sellers. In this case, they were instructed to tell the drug seller that they had a two-year-old child at home with fever for two days. If asked, they were to report that the child had not yet been given any medicines for this illness and had no other symptoms. The mystery client then reported back to the data collectors on what the drug seller asked the client, what was prescribed and dispensed, and any advice provided.

The client observations of *comptoirs pharmaceutiques* showed deficient practices in treating malaria. Of 23 cases, only 57 percent of mystery clients were sold an antimalarial treatment. Of those sold an antimalarial, only 23 percent were sold the correct antimalarial according to national guidelines. Worryingly, 22 percent of the simulated cases of fever (presumed malaria) were neither treated nor referred. Although

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sales attendants generally asked for some history, only 52 percent checked for danger signs indicating referral of the case was required. And, although 74 percent of clients were given some verbal instructions on dosing, little other advice on the management or prevention of the condition was provided.

The use of mystery clients is a tried and tested, effective methodology for evaluating private provider practices. Use of external data collectors can create bias in the response of the seller. Thus, using community members is a better way to guarantee that the simulated interactions are not detected. Information collected by this method is an accurate way to understand actual provider practices and is essential for corroborating results from evaluator-led knowledge assessments. The combination of objectively observed performance and stated knowledge is a powerful tandem for formulating recommendations that directly address and resolve program weaknesses.

The External Evaluation of the Pilot Phase of the Home-based Management of Malaria Program in Rwanda of which the simulated client assessment was a part is available on the Rwanda page of www.basics.org, as well as on www.msh.org/rpmlus.