Report on capacity Strengthening activities.

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Background

Following the drought that is affecting mainly different provinces in Zambia, many areas have been affected by food insecurity. In all the districts classified in Phase 3 or worse, households are employing food-based coping strategies, such as reducing the number of meals and meal portions, with some having experienced problems in food access in the preceding 30 days. Routine data showed that the average reported mortality from severe acute malnutrition (SAM) in children under five years, from 2016-2018 was 8% (from children enrolled in a treatment programme), indicating poor quality of services for the SAM Children. This mortality rate, if applied to the estimated number of cases of SAM for 2019, tragically translates to an estimated 11,600 child deaths. Figures are likely to be higher if the amount of rains does nor increase. This data is likely to be under reported, due to documented problems with the information system and the limited coverage of the integrated management of acute malnutrition (IMAM) program.

The numbers of admissions of children suffering from SAM and moderate acute malnutrition (MAM) in the coming months is expected to be much higher compared to previous year trends, and this does not include children who don't seek treatment. There is need to improve the quality of the management of SAM cases and to absorb the potential increase of cases due to the drought and the revitalization of the active case finding, strengthen capacity to provide quality treatment (inpatient and outpatient) and prevention services to reduce excess morbidity and mortality associated with acute malnutrition.

Justification

UNICEF received funding from United Kingdom Government with the objective of enabling the health care system to respond to prevention and care for children with severe acute malnutrition. Under the leadership of the Ministry of Health (MoH) and National Food and Nutrition Commission, UNICEF is supporting the Government of Republic of Zambia (GRZ) in implementation of the IMAM Programme as part of the Nutrition Response plan in the health sector. Following the emergency need to have the program in place especially in the 58 most affected districts, UNICEF requested the Technical Rapid Response Team (Tech RRT) to provide technical CMAM support in the initial phase of the program. The IMAM advisor's overarching responsibility was strengthening the delivery of the IMAM response through the provision of senior leadership, technical support and capacity building to the nutrition sector partners during an in-country deployment supported by UNICEF Zambia. One of the deliverables in the TOR was a report on the capacity strengthening activities undertaken, including trainings, mentoring of partners and 'on-the-job' technical support provided (deliverable 2).

i) Planned Activities:

- Training of MoH and selected NGOs who will provide technical support during the implementation of the emergency IMAM (trainings on in and outpatient management of severe acute malnutrition and active case finding and referral.
- Exploratory visits in the existing facilities in the affected districts and making recommendations on how to improve quality based on findings.

ii) Deliverable outcome: One orientation on IMAM and the emergency support was done for nutrition officers (provincial nutritionists, district nutritionists, nutrition technologists- 65 participants). A full 5-days training was done for various health workers including nutritionists, nurse, midwives as representative from the 22 of the 58 districts (22 participants). These received complete training following the feedback after the field visit

and realisation that the capacity was lower than previously reported and therefore an orientation would not be sufficient.

iii) Current strengths

The national health systems structure is in place. Health facilities up to the lowest level have the basic structures in place-buildings, active health service management structure (District health Officers, provincial and district nutritionists), active health workers albeit not sufficient in numbers and an existing outreach strategy (neighborhood health committees, community-based volunteers and other community service providers and many community-oriented programs).

iv) Challenges

Although technical support and direct facilitation for some sessions during the orientation held in December 2019 was done, the lack of clarification from the team on the objective of the orientation led to poor coordination and thus affected the overall outcome of the orientation. It was planned as an orientation on the emergency project but later realised that what was required was more of knowledge on IMAM.

In the IMAM training held for the 22 districts, some of the participants are not involved in nutrition programming and/or decision making at the district level and so are most likely not able to support the start-up for the project in their respective districts. In addition, it was observed that some of the participants do not have the capacity to engage in orientation of health workers in their respective districts.

Having various activities involving the same MoH staff led to some of the nutrition officers not being available to participate in the training held in January. There were 3 activities taking place (the micro-nutrient survey, training for the national SMART survey and food consumption survey) of which some were already involved in and/or preferred to be part of those activities not the IMAM training. This contributed to the challenge above.

Poor planning/communication by the MoH led to some participants coming a day after the training had started and nutrition officers/representatives from the proposed NGOs that will support the project were no invited and thus missed an opportunity to have their staff participate in the IMAM training.

There was a generalisation as part of my debriefing at the beginning that there is an existing IMAM program, trained staff and trained trainers of IMAM. This led to tailoring technical support on that assumption which affected the orientation and discussions on the M&E tools. This was however found not to be the case. This led to shaping the second training to focus on increasing technical knowledge for the participants instead of focusing on the project strategy and planning for implementation.

v) Deliverable execution and results

Process:

The capacity building entailed mainly training, orientation, on-job mentorship during the field visit and support in the review of the M&E tools and other documents to use during the implementation of the program to ensure that they reflect current updates in IMAM.

The field visit to do mapping on capacity and resources in the 2 districts in the Western province provided a good insight into the exact situation on the ground. The mapping included a checklist that looked at capacity as a composite assessment indicator including assessment on detection and awareness of malnutrition, following the medical and nutritional protocols, registration and reporting, supplies/stock management, IYCF and WASH. Group discussions were held with some of the community members found at the health facilities or the communities nearest to the health facilities. The discussions looked at the communities' awareness about the program, uptake of the services, IYCF,challenges and recommendations and active case finding in the community

Achievements

- Developed mapping tools and carried out a mapping of the technical capacity and resources in 11 heath facilities in Sioma and Shang'ombo districts in Western province. Refer to the field visit report for the details
- Supported orientation of nutrition officers form 36 districts (provincial and district nutritionists, nutrition technologists) on the proposed intervention supported by UNICEF.
- Carried out an IMAM training for 22 health workers who included community heath officers, hospital nutritionists, midwives and nurses from the 22districts less affected out of the 58 districts.
- In collaboration with the MoH, the data collection and reporting tools were revised and updated based on the IMAM updates and the draft national guidelines.

Recommendations.

- The program is delivered through government system. As is the case here-low GAM countries, the best is to have the government provide universal coverage more so when the structures are in place. The program should aim to build on the existing structures and capacity. This will entail improving the capacity of the existing health workforce through; supporting strengthening of the leadership capacity and visibility of the nutrition department within the MoH structure from the national level to the district level, IMAM training, strong mentorship and support from the national and provincial teams and robust supervision.
- Training of District Health Officers and other health and nutrition program officers on IMAM to have an impact as they are the decision makers and planners at the district level.
- Completion of the revision (there are a number of errors in the guidelines and this same observation was made in the report by Michael Golden) and validation of IMAM guidelines to be used as the principal technical document for the implementation of the program. This is very imperative as any support requires official information to back it up which would best be achieved through validated guidelines.
- Capacity building and orientation of the NGOs that will come on board on the project- basics of IMAM, key areas to support/monitor.
- Re-training of all nutrition officers on the full IMAM package and refresher trainings

and these should be supported by good mentorship mechanism.

- Ensuring the continuum of care. The in-patient therapeutic care component of the IMAM is managed by the clinical services department while the other three components are under the public health department. To ensure that the continuum of care is effective, it is important to involve representatives and technical support from both departments in building the capacity of the staff managing the children the in-patient wards/facilities and supervision. There is need to have a clear guidance/strategy to facilitate the leadership, management and technical care and ensure coordination between the 2 departments with regards to effective and efficient service provision in the in-patient care facilities and linkages between the other components of IMAM.

Conclusion

Technical capacity ensures provision of quality prevention and treatment services and effective utilization of resources. The capacity to implement nutrition programs in the country is low and requires not only basic trainings but systematic on-job coaching and performance reviews not focusing only on the project indicators but a deeper review of the capacity of the health workers through technical capacity assessments and inclusion of health workers across the spectrum for better integration. Repeat trainings should be carried out targeting staff found to need more support and also ensure that the turnover does not create gaps as new staff will be trained during these repeat trainings. Trainings should be accompanied by ensuring availability of job aids and all reference materials.