INTRODUCTION

Nutrition assessment, counselling, and support (NACS) aims to improve the nutritional status of individuals and populations by integrating nutrition into policies, programs, and health service delivery infrastructure. The NACS approach strengthens the capacity of facility- and community-based health care providers to deliver nutrition-specific services while linking clients to nutrition-sensitive interventions. The approach also strengthens the broader health system by building technical capacity that can be applied to other nutrition interventions, identifying referral pathways, establishing protocols for supervision and commodity management, improving client flow within health services, and improving data management.

Since 2008, FANTA has provided technical and financial support to the Government of Tanzania, Tanzania Food and Nutrition Centre (TFNC), and local Government Authorities, with support from the U.S. Agency for International Development/U.S. President’s Emergency Plan for AIDS Relief (USAID/PEPFAR), to integrate routine NACS into the continuum of health care delivery. Technical assistance has included establishing a technical group for NACS scale-up; developing national guidelines, training materials, job aids, and monitoring and evaluation tools; and scaling up NACS services with support from USAID Implementing Partners.

In 2011, the Tanzania National Nutrition Strategy amplified these efforts in order to prevent, control, and manage malnutrition. According to a 2014 Tanzania Smart Survey, 0.9% of children under 5 years of age were severely malnourished while 2.9% were moderately malnourished. Both severe and moderate acute malnutrition have detrimental growth and health effects for children, with severe malnutrition significantly increasing risk of mortality.

OBJECTIVES

To build the capacity of both health facility and community health care workers to deliver NACS services in an integrated manner along the continuum of care while linking clients to nutrition-sensitive interventions from health, agriculture, food security, social protection, education, and rural development sectors. This included enabling health care workers to measure height, weight, and mid-upper arm circumference, and to use World Health Organization cut-offs to categorize the nutritional status of clients, and where applicable, manage the conditions but also refer.

METHODOLOGY

A technical group involving Implementing Partners was formed under the coordination of TFNC which identified skills needed by trainees, established selection criteria, and developed a competency-based training package and job aids. The group piloted the training package, trained national and regional trainers, and trained health care workers. A series of orientation sessions were conducted among regional, district, and health facility authorities.

A combination of participatory methods were used to equip health care workers with adequate knowledge and skills. These included:

- Presentations and brainstorming
- Skills-building sessions consisting of role play, group work, and field practice
- Onsite mentoring with experienced health workers from neighbouring sites
- Supportive supervision followed by shared action points
- Distance consultation from neighbouring sites and implementing partners
- Site learning sessions to share successes, challenges, and strategies to address challenges

RESULTS

Since 2009 to date, program data as of March 2015 shows that 4,271 workers participated in NACS health facility, community, and sensitization trainings (see Figure 1).

FIGURE 1. CADRE AND TOTAL NUMBER TRAINED

DISCUSSION

The NACS training involved both health facility and community workers with the purpose of linking services between the health facility and community. Among the 4,271 participants, health facility-based training constituted 48% (2,034) of which 54% (1,042) were health facility care workers trained by FANTA or via cascade training (see Table 1P). In addition, there were 207 regional trainers trained and 885 regional, district, and community health authorities sensitized on NACS. Health facility-based training was conducted in 17 out of 26 regions: Arusha, Dar es Salaam, Iringa, Kagera, Kilimanjaro, Lindi, Mara, Mbeya, Mwanza, Njombe, Pwani, Ruvu, Rukwa, Shinyanga, and Tabora.

On the other hand, community-based NACS training reached 2,237 participants in 9 out of 26 regions: Dar es Salaam, Dodoma, Iringa, Morogoro, Njombe, Pwani, Singida, Tanga, and Ulanga. As shown in Table 2, 191 community trainers were trained and used to cascade the training. Among the 2,257 participants trained, 70% (1,559) were reached during the cascade training. However, only 31 community leaders have been sensitized on NACS services.

CONCLUSIONS & RECOMMENDATIONS

The engagement and partnership with government departments and Implementing Partners to develop and use a combination of training approaches to implement NACS allowed for systematic scale-up of NACS in health facilities and communities. Further strengthening of NACS service delivery along the health services delivery system, particularly at the community level, is a high priority.