Nutrition Assessment Counselling and Service (NACS)

Quality Improvement Training Workshop Report

PROTEA HOTEL HLUHLUWE, uMKHANYAKUDE DISTRICT
KWAZULU-NATAL PROVINCE

3rd-5th June, 2014
ACKNOWLEDGEMENTS

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INTRODUCTION

The training workshop was facilitated by Tina Maartens, Senior QI Advisor, URC South Africa and Tamara Nsubuga-Nyombi, QI Advisor URC Uganda.

The South Africa Nutrition Assessment Counselling and Service Training Program (NACS) is a USAID-funded program. The training was provided by University Research Co., LLC. The course is designed to assist the staff who work in the health sector to introduce and improve Nutrition Assessment Counselling and Service (NACS) in South Africa, drawing on the science of Quality Improvement (QI) and how this approach may be used to make health care provision better.

The course is designed around a real-life NACS case study located in South Africa. It takes the participants through a simulation exercise of a real NACS improvement journey. The fundamentals of improving health care, as well as the methods, are illustrated through a series of improvement modules. The initial three-day course is followed by six months of coaching and mentoring visits.

PARTICIPANTS

The course was attended by 30 participants from the National Department of Health, USAID, FHI360, the Provincial Department of Health of KwaZulu-Natal, and the uMkhanyakude district management and facility staff. Training was provided by two URC facilitators with support from two additional URC facilitators.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>1</td>
</tr>
<tr>
<td>NDOH</td>
<td>2</td>
</tr>
<tr>
<td>PDOH</td>
<td>1</td>
</tr>
<tr>
<td>District management</td>
<td>2</td>
</tr>
<tr>
<td>D0H Facility staff</td>
<td>10</td>
</tr>
<tr>
<td>FHI 360</td>
<td>13</td>
</tr>
<tr>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>URC</td>
<td>4 (facilitators)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>34</td>
</tr>
</tbody>
</table>
OBJECTIVES OF THE TRAINING

The intention of the Workshop was to provide training for the staff of FHI 360, USAID and NACS providers in Quality Improvement so that they are able to improve the quality gaps of nutrition assessment, counselling and support services provided in the facilities and districts in the KwaZulu-Natal Province. In the process of training, the participants would develop a basic understanding of quality improvement; be able to explain the concepts of quality, improvement and the quality improvement model in simple language to colleagues; and discuss the PDSA cycle, testing small changes, processes and systems.

Why is Quality Improvement required in relation to NACS? Statistics South Africa (2011) revealed that one-third of children under age five who die are severely malnourished and another third are underweight for their age. In the context of the high level of HIV/AIDS infections in South Africa, it is widely accepted that where nutrition is poor, this can accelerate the progression of HIV. It also impacts on the effectiveness of treatment including Anti-Retroviral provision. Children and adults at all stages of HIV infection are at increased risk of nutritional deficiency and consequent malnutrition.

Among the aims of the Workshop was to empower participants to analyze quality problems and processes; to measure quality improvement; to obtain the knowledge required to lead, facilitate and coach healthcare workers to plan and implement a Quality Improvement project; to design a plan of action for implementing Quality Improvement in health facilities; and to assist with training and mentoring district and facility level health service providers on Quality Improvement.

The process may be used as a starting point to build up a knowledge base, drawing on real-life experiences in health facilities. This knowledge and experience will be taken forward in the six-month mentoring period to build on knowledge and develop valuable case studies. Some of the more important questions to address in relation to Quality Improvement include how to sustain QI in large projects or facilities, and how to embed QI in all the facility processes to ensure sustainability.

PARTICIPANT EXPECTATIONS

Participants were asked about their expectations of the training so that adjustments could be made where possible to meet these expectations. These were discussed and noted as below:

- To learn about NACS
- To learn more about QI and how it relates to NACS
- To develop a common understanding of QI and how to apply it
- To learn how to integrate QI into service provision for MCH
- To be able to use QI in work
- To use QI to strengthen referrals
- To apply the QI approach in resource-limited settings
- To learn about the key components of QI and their application in nutrition
- When to use QI and when to use Monitoring & Evaluation
- Learning more about coaching and mentoring
- Strategies to sell QI to colleagues within a health facility
- How to integrate QI into all service provision in a health facility
- Ways of simplifying QI at the community level
Each facility will have an FHI360 partner to support the QI work over the next six months who will assist in developing a change package and monitor implementation over time. Identifying challenges and building success stories will form part of the process. The role of Management will be to create an enabling environment for QI to take place successfully.

**TRAINING CONTENT**

The training content draws on a comprehensive training manual titled How To Improve Health Care: *Case Study for Nutrition Assessment Counselling and Service (NACS)* which provides interactive content, presentations and practical application of the theory being developed by URC. The content addresses basic quality concepts, identifies and explains the tools that can be used to identify quality gaps, understand systems and monitor performance, and shares Quality Improvement models and strategies.

**Health MDGs Scorecard**

<table>
<thead>
<tr>
<th>Metric</th>
<th>World</th>
<th>Africa</th>
<th>Americas</th>
<th>Eastern Mediterranean</th>
<th>Europe</th>
<th>South-East Asia</th>
<th>Western Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 mortality per 1000 live births</td>
<td>65</td>
<td>142</td>
<td>18</td>
<td>78</td>
<td>14</td>
<td>63</td>
<td>21</td>
</tr>
<tr>
<td>Measles immunization % coverage</td>
<td>81</td>
<td>73</td>
<td>93</td>
<td>83</td>
<td>94</td>
<td>75</td>
<td>93</td>
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<tr>
<td>Maternal mortality per 100 000 live births</td>
<td>400</td>
<td>900</td>
<td>99</td>
<td>420</td>
<td>27</td>
<td>450</td>
<td>82</td>
</tr>
<tr>
<td>Skilled birth attendant % births</td>
<td>66</td>
<td>47</td>
<td>92</td>
<td>59</td>
<td>96</td>
<td>49</td>
<td>92</td>
</tr>
<tr>
<td>Contraceptive use % married women aged 15-49</td>
<td>62</td>
<td>24</td>
<td>71</td>
<td>43</td>
<td>68</td>
<td>58</td>
<td>83</td>
</tr>
<tr>
<td>HIV/AIDS prevalence % adults aged 15 – 45</td>
<td>0.8</td>
<td>4.9</td>
<td>0.5</td>
<td>0.2</td>
<td>0.5</td>
<td>0.3</td>
<td>0.1</td>
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<tr>
<td>Malaria mortality per 100 000 population</td>
<td>17</td>
<td>104</td>
<td>0.5</td>
<td>7.5</td>
<td>-</td>
<td>2.1</td>
<td>0.3</td>
</tr>
<tr>
<td>TB treatment success rate %</td>
<td>86</td>
<td>79</td>
<td>82</td>
<td>88</td>
<td>62</td>
<td>88</td>
<td>92</td>
</tr>
<tr>
<td>Water % using improved sources</td>
<td>87</td>
<td>61</td>
<td>96</td>
<td>83</td>
<td>98</td>
<td>86</td>
<td>90</td>
</tr>
<tr>
<td>Sanitation % using improved facilities</td>
<td>60</td>
<td>34</td>
<td>87</td>
<td>61</td>
<td>94</td>
<td>40</td>
<td>62</td>
</tr>
</tbody>
</table>

Data from World Health Statistics 2010

**OVERVIEW OF THE KZN NUTRITION PROGRAM**

NACS provides a roadmap for nutrition in HIV programs in South Africa and will assist to implement improved nutrition at facility level. The aim is to make improved nutrition a central focus of health care implementation. There is a strong commitment to this objective at the provincial and national levels. The uMkhanyakude District provides a useful pilot site for both data collection and developing case studies for scale-up across the Province.

Disaggregated data is presently being collected in relation to various aspects of NACS. This will assist in improved analysis in relation to nutrition needs.
Continual training is a key aspect of the NACS, as seen in the national commitments expressed by the Department of Health. While it is acknowledged that implementing NACS at facility challenges may not be easy, it is an important component of quality healthcare delivery and thus has a high level of support.

**QI IN NUTRITION SERVICES**

The Millennium Development Goals that relate to health outcomes are not being met in Africa. Current health needs are being met to some extent but many challenges remain to be addressed. The World Bank has stated that too much work is being done around what needs to be done (policy development) rather than simply doing what needs to be done (implementation) and this is a concern shared in South Africa where there are excellent policies in place, but where there is a disjuncture between policy and implementation. This is a concern that is seen across government departments.

There is a view that Quality Improvement is an expensive intervention, but in fact the costs of dealing with the negative consequences of poor quality delivery are far greater. In South Africa in particular, which carries the greatest HIV and AIDS burden, there is a negative outcome on HIV treatment where nutrition is poor. Many children are lost before their fifth year due to poor nutrition.

While there is a clear need to improve nutrition, the critical question remains – how is good nutrition identified? The standards that should inform good nutrition need to be examined and agreed and common definitions refined and shared.

*“The world has invested too much in what to deliver and too little in how to deliver it, with the result that “it” often fails to reach and benefit people.”*  
Adam Wagstaff, World Bank

To begin to implement NACS more effectively in health facilities, as with all health interventions the patient must be at the centre. Behaviour change must be encouraged. Timeliness is important since the support must be available when the patient needs it rather than when the healthcare professional feels like delivering it. Efficiency and effective use of available and scarce resources is critical, especially in the context of reduced donor aid and many demands being made on government. South Africa is fortunate to have health resources available. The challenge for all health departments is to ensure that these resources are optimally utilized. This links to the need to improve co-ordination of health provision overall.

Equity of health provision is a key principle, and gender equity remains a concern. Clinic provision must link to demographics and numbers that are drawn on to identify need.

Within the facilities the most common patient complaints relate to long waiting times, poor staff attitudes and for hospital stays, the poor quality of food. It has further been identified that a majority of health professionals lack a common understanding of the policy and legal frameworks that inform their work such as laws, statutes, international instruments, policies, guidelines and regulations. A concrete example in the current training was that most people in the room were not aware that there was new information from 2013 related to infant and child nutrition and feeding.

How can these gaps and oversights be addressed and by whom? In KwaZulu-Natal the requirement is that there is a Nutrition Adviser in every health facility who will conduct Nutrition Assessments of patients. Nutrition counselling is done by nutrition advisers and/or dietitian as well as health care professionals, and in some cases by community care workers. In practice, nutrition counseling is largely done by health care workers since they have the most contact with patients. Nutrition advisors can also do MUAC and are doing MUAC in KwaZulu-Natal. There is also a need for a common understanding amongst healthcare workers of all levels of the basic requirements for nutritional assessment.
NACS is essentially a platform for integration and nutrition into the continuum of health care. The NACS process consists of a series of steps which are Nutrition assessment; Classification of nutritional status; Nutrition counselling; Nutrition support; and Referral follow-up.

According to the *Nutrition Assessment, Counselling and Support for People Living with HIV (PLHIV): Operational Guidelines*, NACS providers should measure height for adults on the first visit and measure weight and calculate BMI or measure MUAC on each visit. Children should have weight and height measured on each visit. Assessing only clients who look malnourished can miss moderately malnourished, overweight and obese clients who need treatment or counselling.

Workshop participants shared their experiences in the facilities in relation to nutrition assessment. In some satellite clinics, patients were checked for height, weight, MUAC, data assessment, biochemical assessment such as hypertension or diabetes as well as clinical assessment. Thereafter, patients were interviewed by Nutrition Advisers who assess their food security needs.

Participants who were professional nurses explained that they would check the weight of the patient, MUAC, patient condition and then refer to a nutrition adviser, with a note made to follow up with the patient where possible.

With regard to patients being supported within their community, it was explained that nutrition advisers will refer the case to a community caregiver. It is important to be aware if a particular patient has sufficient food supply in their community, and this kind of information is shared at monthly meetings that include local community care workers. For example, the Khumasake Multi-Sectoral Forum includes personnel from the Department of Social Development and the Department of Agriculture as well as Health. Clinic information goes up to the multi-sectoral forum in the district via monthly forum meetings, and information is also shared with ward councillors as to who in their particular ward is experiencing food insecurity or other health challenges or concerns.

It appeared that much good work is being done across structures but the communications processes are not clear. For example, information from local clinics is shared at district and provincial level but it is not clear whether the information is drawn on in a way that will contribute to improve the organization of tasks at the macro level. There appears to be a disjuncture between policy and guidelines when weighed against the realities of implementation in the facilities and the communities.

It was noted that recent research undertaken in Uganda showed that volunteers within the communities play an important role, and that the Mid Upper Arm Circumference or MUAC basic tool is a starting point. BMI is used for everyone and MUAC is used for patients considered to be compromised in some way. Community care workers are trained to do MUAC because there is no equipment to do BMI. MUAC is also used for pregnant woman. There were some concerns expressed as to how data is captured and used and rolled up to national level.

Nutrition Advisers in the workshop explained that where patients were considered to be nutritionally compromised they would be supplied with enriched maize porridge and energy drinks. However, if their condition was considered to be severe, or where medical complications were evident, the nutrition adviser will immediately escalate the patient to the dietician and nutritionist. KwaZulu-Natal Province has clear protocols that are followed in relation to nutrition. Once a patient requires a higher level intervention, the dietician provides intensive support which may also include hospital admission.

Quality Improvement integrates Content of Care and the Process of Providing Care. South Africa generally suffers from poor knowledge management in government which is sometimes linked to the gate-keeping of resources in a specific department. This reduces options for Shared Learning to take place.
In order to implement Quality Improvement methodology successfully, it is necessary to have the most accurate information possible so as to measure, analyse and assess the extent of impact of an intervention. This is best done by involving all stakeholders, and integrating all existing community resources, down to church soup kitchens.

QUALITY IMPROVEMENT METHODOLOGY

When beginning to develop a Quality Improvement intervention, there are clear steps to be applied incrementally to improve a nutrition program. The first is to develop an aim statement to explain what must be achieved. It is necessary to know how the system is presently performing so that a specific improvement goal that is expressed as a percentage improvement can be set. It is important to know both the actual numbers as well as the percentage being aimed for. This links to measuring improvement and how best it can be done.

A baseline is required, which could express any number of things. At facility level it could be based on the numbers of people to be impacted through Quality Improvement. Identify the problem accurately at the outset so that the QI team is clear as to the aims and objectives.

It is not always easy to set up a QI team. Challenges include the assumption that a problem is known by all – this may not be the case and will require a common understanding of terms, parameters and processes. The appropriate management systems must be developed to ensure sustainable change. It is important, therefore, to have all levels of government and the development partners in the same room to collaboratively develop QI interventions, keeping in mind that NACS is a highly complex area of work.

Quality Improvement Methodology

1. Identify
2. Analyze
3. Develop
4. Test and Implement

Adapted from: T. Nolan et. al. *The Quality Improvement Guide*
DEVELOPING A QUALITY IMPROVEMENT SYSTEM

Extensive group work was undertaken by the participants. A practical exercise involving the use of the Fish Bone tool was used in each group to examine the various aspects of Quality Improvement and how this can be applied in a health facility.

It was agreed that problems related to the process by which care is delivered are caused by methods, materials, equipment, and the environment, and all contribute to NACS challenges. In tackling problems, analysis must first be undertaken. The team needs to explore solutions that are both creative and feasible. For example, if clinic hours are not long enough for working people, the facility could close at 15h00 on a certain weekday and then be open on a Saturday.

The Fish Bone Exercise is a high level tool to generate all aspects of a problem. It also helps to identify what can be tackled as a team and what is unlikely to succeed. It is a first step, and the group can then decide on which aspects of the challenge to take forward, adding more detail, and using the Five Whys, which is an iterative question-asking technique used to explore the cause-and-effect relationships underlying a particular problem. The primary goal of the technique is to determine the root cause of a defect or problem by asking the question Why? at least five times.

Information was presented on Developing a Progress Flow Chart where the aim is to improve the process of care. The first step is to accurately identify what is currently happening. The process flow chart provides a common understanding of the task at hand in the required level of detail and also breaks down the steps of sequencing.

Examples of Fish Bone diagrams developed during group work
Clinic
- Lack of training
- Inadequate registers
- No protocols and guidelines policies
- Poor referral system
- Poor integration of services
- Poor implementation of policies
- Too many recording tools

Role
- Clarification
- Poor health seeking behaviour
- Late presentations
- Cultural beliefs
- Religious beliefs
- Not honouring follow up dates

Staff
- Not trained on how to classify
- Poor recording
- Attitude
- Understaffing

Resources
- No functional equipment and tools
- No supplements
- No registers

Client
- Poor case MX of severe acute malnourished children under 5
- High under 5 mortality and morbidity due to SAM

Example of a flow chart for integrating NACS into HIV care

Example of a process map for HIV clinic (Client flow)
DEVELOPING INDICATORS FOR QUALITY IMPROVEMENT

The training also discussed measurement of data, including outcome and process indicators. The aim is to determine the indicators which demonstrate that the required improvements have been made.

The following are the minimum requirements for good indicators:

- Clear and unambiguous (teams will not confuse what is meant by the indicator)
- Quantifiable
- Identifies the source of the data and the person responsible for collecting it
- Identifies a clear numerator and denominator
- Identifies the frequency with which the data should be collected

Flow Charting the process will allow the team to standardize an understanding of the new process; provide a reference for people to adhere to; and allow the team to review the system as part of the iterative process of improvement.

Ideas for implementing positive change can be obtained from relevant literature, guidelines, normative documents, benchmarking, knowledge management and Improvement Team Problem-solving.

When deciding what aspects of the challenge to address, and how this will be done, the team should consider fresh approaches, considering solutions that may not have been considered previously, don’t stay in a rut. Do c- Something that you’ve never done before, something you can do tomorrow and/or Something that worked somewhere else

Teamwork is important for Quality Improvement because healthcare processes consist of interdependent steps that are executed by different people and because quality faults often occur in the hand-over between these different people. It was emphasized that where staff are afforded the opportunity, they can often identify problems and generate ideas to resolve them without much difficulty. Participation improves ideas, increases buy-in, and reduces resistance to change. Furthermore, accomplishing things together increases the confidence of each team member, and this helps to empower the organization or the facility.

FINDINGS FROM THE WORKSHOP

The main findings from the three-day workshop, as observed and deduced by the URC Team, included the following:

- There was a high level of active participation from all the participants and a keen interest in the content. The sessions commenced in a timely manner.
- The National DOH, PDOH, USAID and FHI staff provided valuable and extensive support during the training.
- Participants had only limited existing knowledge about improvement concepts and processes and how Quality Improvement differs from Monitoring & Evaluation.
- None of the participants had been trained on NACS prior to the workshop. This required the facilitators to provide general information on NACS.
- There does not seem to be any specific focus on HIV or TB clients, and the NACS focus seems to be mostly on children.
- MUAC and BMI are conducted to a large extent, but there is little follow-up action in relation to the results.
- The participants were professionals who are keen to embrace new knowledge and expressed a strong commitment to implementing Quality Improvement in relation to NACS work.
A Mini Case Study from Hlabisa District Hospital

Two young men were interviewed who work as Nutrition Advisers at Hlabisa District Hospital, which has 17 satellite clinics. They were both in their mid-twenties and both were born and raised in Hlabisa area. They had previously worked as Community Care Givers and because of their dedication to their work, had been identified by the Provincial Department of Health and further training opportunities were offered to them. They went for a one-year full-time accredited training course as Nutrition Advisers and are now each based in a large satellite clinic of Hlabisa District Hospital. Working conditions are good. Their contribution is recognized and valued and they are happy to make a positive impact on their communities. They link up with NGOs working in the area where extra help is needed for a patient. It is possible to do upward referrals to District where the patient needs more assistance. There is patient transport from the Clinic to Hlabisa three times a week which is free, arrives on time and works well for the village community. However, food security at the homes of patients remains a concern. The communities are very poor and so patients are encouraged to develop even small food gardens at home. Fresh water supplies are a big challenge in the whole of the uMkhanyakude district. There are some NGOs that provide training on food gardens and growing vegetables but much more needs to be done.

PARTICIPANT OUTPUTS

The workshop was highly interactive and included extensive group work. All participants engaged actively and positively and with a strong task-oriented focus. These were the outputs from each day.

Day 1:
- Developed an improvement aim based on case study
- Identified members of an improvement team based on case study
- Developed a fishbone to analyze a problem based on their facility situation
- Developed a flow chart based on the case study or their current NACS process

Day 2:
The participants were divided into 5 groups, each group containing a member from a facility. The groups:
- Developed indicators to measure performance in NACS
- Plotted a time series chart based on case study data
- Developed a graph to demonstrate data
- Developed a change package of improvement interventions

Day 3:
- Developed an improvement plan for NACS based on the existing facility’s service and challenges
- Developed a process flow chart based on the improvement plan
PRE- AND POST-TESTING AMONG PARTICIPANTS

The pre-test was written on Day 1 before training started and the same test was written as a post-test on the last day of training before closure of the workshop. The outcomes are presented below.

**NACS QI TRAINING PRE AND POST TEST SCORES:**
*Hluhluwe 3 – 5 June 2014*

<table>
<thead>
<tr>
<th></th>
<th>Pre test</th>
<th>Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of tests</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>Average score</td>
<td>11%</td>
<td>72%</td>
</tr>
<tr>
<td>Lowest score</td>
<td>0%</td>
<td>28%</td>
</tr>
<tr>
<td>Highest score</td>
<td>35%</td>
<td>100%</td>
</tr>
<tr>
<td>Number scoring &lt; 50%</td>
<td>100% (31/31)</td>
<td>18% (5/28)</td>
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<tr>
<td>Number scoring 50% - 75%</td>
<td>0% (0/31)</td>
<td>25% (7/28)</td>
</tr>
<tr>
<td>Number scoring &gt; 75%</td>
<td>0% (0/31)</td>
<td>57% (16/28)</td>
</tr>
</tbody>
</table>

NACS QI Training Hluhluwe: 3-5 June 2014

**The Steps in Quality Improvement**

1. Identify
2. Analyze
3. Develop
4. Test and implement
5. Evaluate
6. Scale-up

**The Way Forward**

- Establish a quality improvement team
- Establish a collaborative
- Convene regular QI meetings
- Test change ideas
- Continuously monitor the data; improve accuracy & feedback
- Share learning and review decisions and plans. Make adjustments as necessary
- Work with the support of Partners and DOH managers
PLANS FOR SIX MONTH PERIOD JULY 2014 – JANUARY 2015

Facility teams developed Action Plans for Quality Improvement for coming six months, as summarized in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Aim statement</th>
<th>Change/ activities</th>
<th>What we expect to achieve</th>
<th>Who and by when</th>
<th>Proposed indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhlwathi</td>
<td>Reduce malnutrition (under nutrition) among &lt;5 year children: by increasing knowledge of mothers of 0-24 months infants in optimal IYCF by (%?) in Inhlwathi catchment area within 18 months</td>
<td>Health education on introduction of complementary feeding, Counselling on breastfeeding, Strengthen support by CCG</td>
<td>Increased knowledge on introduction of complementary feeding, Increased EBF rates, More mothers supported</td>
<td>Nurses, nutrition advisor, CCGs, within 18 months</td>
<td>Proportion of mothers counselled on breastfeeding, Proportion of mothers referred by CCG, Proportion of mothers reached with HE message on introduction of complementary feeding</td>
</tr>
<tr>
<td>Kwa Msane</td>
<td>To improve nutrition assessment for all &lt;5 children using MUAC by 50% in August 2014</td>
<td>Feedback session, Baseline assessment, On-site capacity building, On-going capacity building by champions, Doing MUAC for all under 5, Strengthening recording and reporting, Integration of NACS at all service points</td>
<td>All staff members informed of QI project, To review data and get baseline, Building capacity of champions (one of each category), 50% of all staff categories trained on MUAC, All children &lt; 5 MUAC is done, All assessments are recorded- All sheets collected from Philomtwanas, Strengthened linkages with CCG’s and Philomtwanas Centres all services</td>
<td>Sr. Ndaba, Sr. Mduli 13.6.2014 FHI 360 Nutrition Advisor</td>
<td>% of staff who received feedback, % staff capacitated by FHI 360, % staff capacitated by nutrition advisor, % children who were assessed using MUAC</td>
</tr>
<tr>
<td>Site</td>
<td>Aim statement</td>
<td>Change/ activities</td>
<td>What we expect to achieve</td>
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<tr>
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<td>Counselling on breastfeeding</td>
<td>Increased EBF rates</td>
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<td>Proportion of mothers referred by CCG</td>
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<td></td>
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<td>Strengthen support by CCG</td>
<td>More mothers supported</td>
<td></td>
<td>Proportion of mothers reached with HE message on introduction of complementary feeding</td>
</tr>
<tr>
<td>Kwa Msane</td>
<td>To improve nutrition assessment for all &lt;5 children using MUAC by 50% in August 2014</td>
<td>Feedback session</td>
<td>All staff members informed of QI project</td>
<td>Sr. Ndaba Sr. Mduli 13.6.2014</td>
<td>% of staff who received feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baseline assessment</td>
<td>To review data and get baseline</td>
<td></td>
<td>% staff capacitated by FHI 360</td>
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<td></td>
<td></td>
<td>On-site capacity building</td>
<td>Building capacity of champions (one of each category)</td>
<td></td>
<td>% staff capacitated by nutrition advisor</td>
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<td></td>
<td></td>
<td>On-going capacity building by champions</td>
<td>50% of all staff categories trained on MUAC</td>
<td></td>
<td>% children who were assessed using MUAC</td>
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<td></td>
<td></td>
<td>Doing MUAC for all under 5</td>
<td>All children &lt; 5 MUAC is done</td>
<td></td>
<td>All assessments are recorded- All sheets collected from Philomtwanas</td>
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<tr>
<td></td>
<td></td>
<td>Strengthening recording and reporting</td>
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<td></td>
<td>Strengthened linkages with CCG’s and Philomtwanas</td>
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<td></td>
<td></td>
<td>Integration of NACS at all service points</td>
<td>All children MUAC is done</td>
<td></td>
<td>All services</td>
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<tr>
<td>Hlabisa Hospital</td>
<td>To improve EBF rate recording by 90% at 14 weeks within 6 months in Somkhele clinic</td>
<td>Assign one nutrition advisor to be responsible for the recording EBF at 14 weeks</td>
<td>To increase recording of EBF rates at 14 weeks</td>
<td>Nutritional advisor By 9th June 2014</td>
<td>Proportion of EBF babies at 14 weeks (HEP 3rd dose) per week</td>
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<td>Improve sequence of steps in patient flow – move nutrition advisor to waiting area</td>
<td>Integrate nutritional assessment and management skills in the consulting room by the clinician</td>
<td>Rearranges for efficiency to cut out delays and duplication</td>
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<td>% of OPD staff trained to do MUAC</td>
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<td></td>
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<td>All children categorized</td>
<td></td>
<td># of coaching visits to CPD</td>
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<td></td>
<td>Review procurement flow- for possible improvement</td>
<td>All managed well</td>
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<td></td>
<td>All clients reaching referral destination and receiving appropriate management</td>
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<td>Identify gaps for improvement</td>
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