

“Promoting Positive Pregnancies through Integrated Nutrition Interventions in the Republic of Guinea”

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AFRICARE



Presentation Outline

1. Background, Introduction and Justification – Public health statistics in Guinea
2. Materials and Methods – Positive deviance, and how to “FARNG”
3. Results - Program progress to date and preliminary effects
4. Conclusions and visions for the future

1. The Guinea Context

Guinea in the World

(Where in the World IS Guinea?)

Guinea in numbers

- Life expectancy at birth: 48 years (2003)
- Maternal mortality: 980 per 100,000 live births (DHS 2005)
- Infant mortality: 91/1000 (DHS 2005)
- Under five mortality: 163/1000 (DHS 2005)
- VAD 25%
- Anemia: **77%** of children under five and **53%** of pregnant women are moderately or severely anemic
- GNP per capita: \$2,130 US
- GNI per capita, \$460 US (WB 2004)
- 41% of the adult population (20% of women) can read and write.
- 40% live below the national poverty line (World Bank, 2003).
- 160 out of 177 in the UNDP Human Development index (2007)

2. What is Positive Deviance?

Positive Deviance

“Positive deviance is a development approach that is based on the premise that solutions to community problems exist within the community. It seeks to identify and optimize existing resources and solutions within the community to solve community problems.” *(Save the Children, PD Hearth Guide)*

3. How to “FARNG”

FARNG

- **F**oyer d'**A**pprentissage et de **R**enforcement **N**utritionnel des femmes en **G**rossesse (**F**rench)
- Site for Learning and Nutritional Support for Pregnant Women (**E**nglish)
- **B**ella Women's **S**upport **G**roups (BSG) in Sierra Leone

3 * 8

1. 8 key stakeholders or actors
2. 8 key program components
3. 8 steps to program implementation

8 Key People

1. Ministry of Health –
Vaccination
Outreach agents
2. District Health staff
3. Traditional and
religious leaders
4. Traditional Birth
Attendants
5. Community health
volunteers
6. Model mothers
7. Husbands
8. Pregnant women

8 Components

1. Outreach prenatal care and referral
2. Iron folate supplementation
3. Treatment for malaria
4. Deworming
5. Tetanus vaccination
6. Nutrition lessons and demonstrations
7. Vitamin A post partum
8. Iron folate post partum

8 steps

1. Train Ministry officials
2. Mobilize communities
3. Train health center staff, health committee members, health volunteers
4. Village census of pregnant women
5. ID and train Model Mothers
6. Organize hearths
7. Conduct monthly meetings
8. Monitor and evaluate

FARNG Partners

- Ministry of Health, Nutrition Program, Reproductive Health program, and Vaccination Program (all staffing), IMCI
- NGOs (Africare, OICI, PLAN, CCF, etc.)
- Health projects (MSH, GTZ)
- UN (UNICEF, WHO, WFP, UNFPA)
- Donors (USAID, DFID)

4. FARNNG results

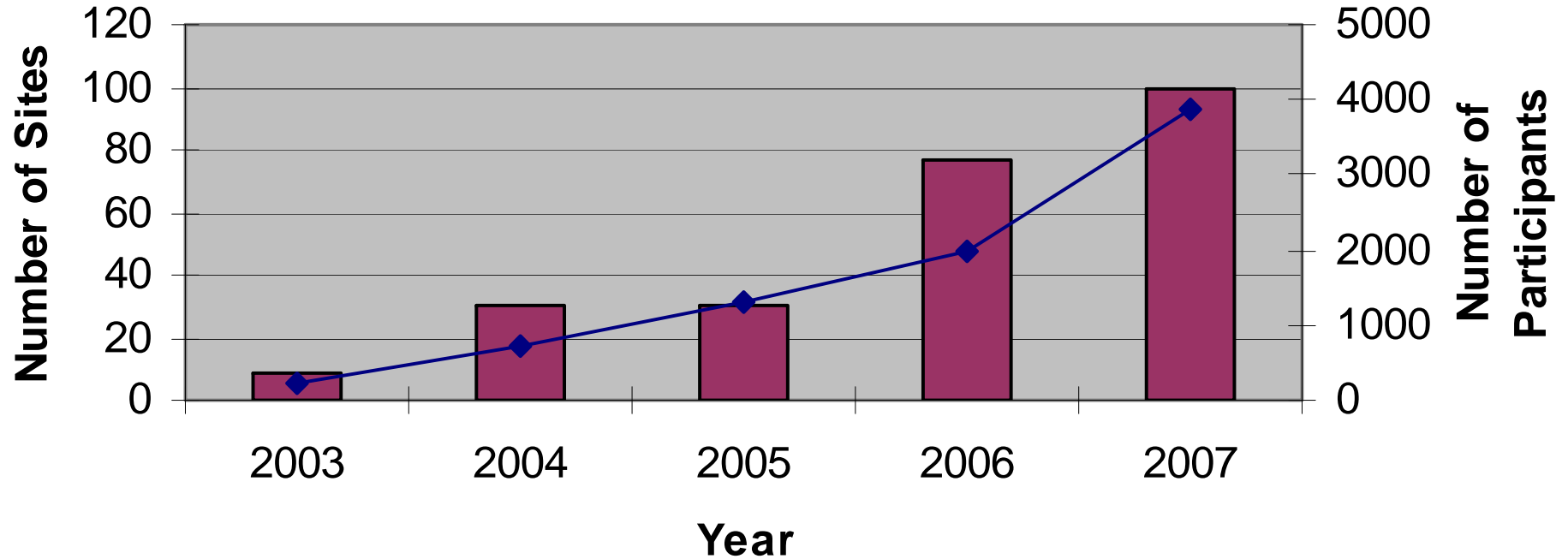
A. Routine Data

B. Qualitative Surveys

C. Impact assessment

Evolution of FARNG

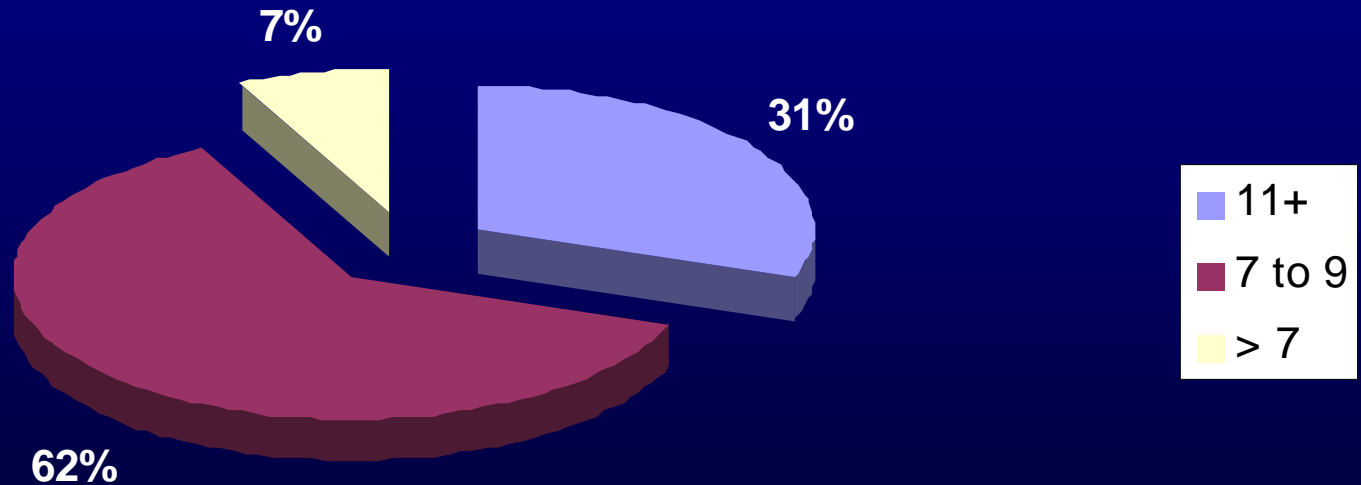
Evolution of FARNG Program



**Source of Data:
Routine monitoring
forms for participants
in pregnant women's
support groups
(Ministry of Public
Health, Guinea)**

Results - Anemia Reduction

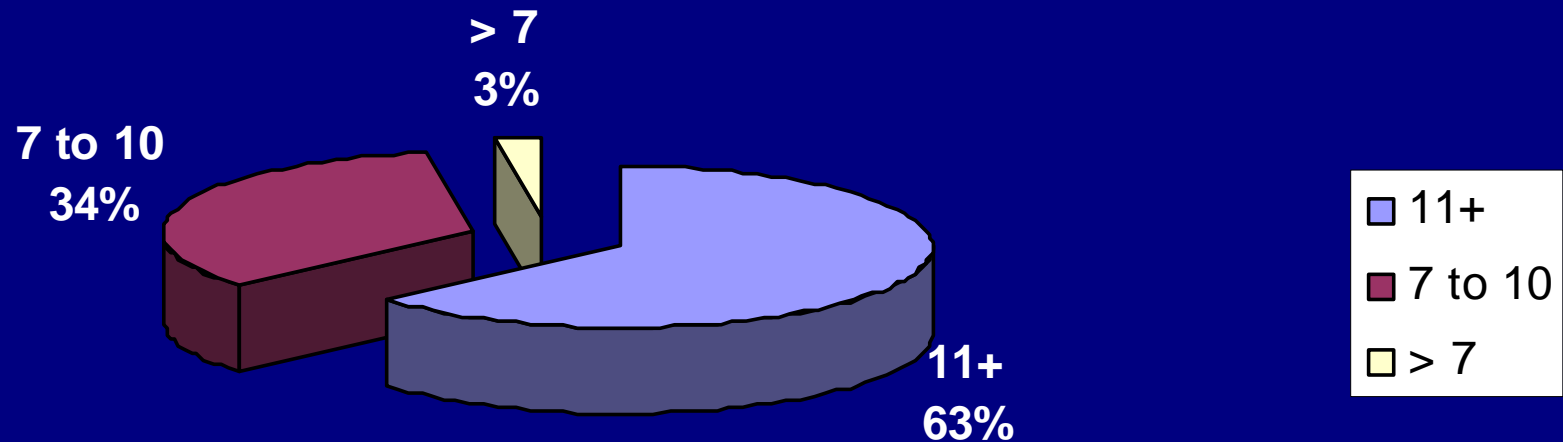
Initial Hb levels of 1046 participants



Date from routine health system, women who participated from 2003 – 2005
(2235 women; only about ½ have initial Hb levels)

Results - Anemia Reduction

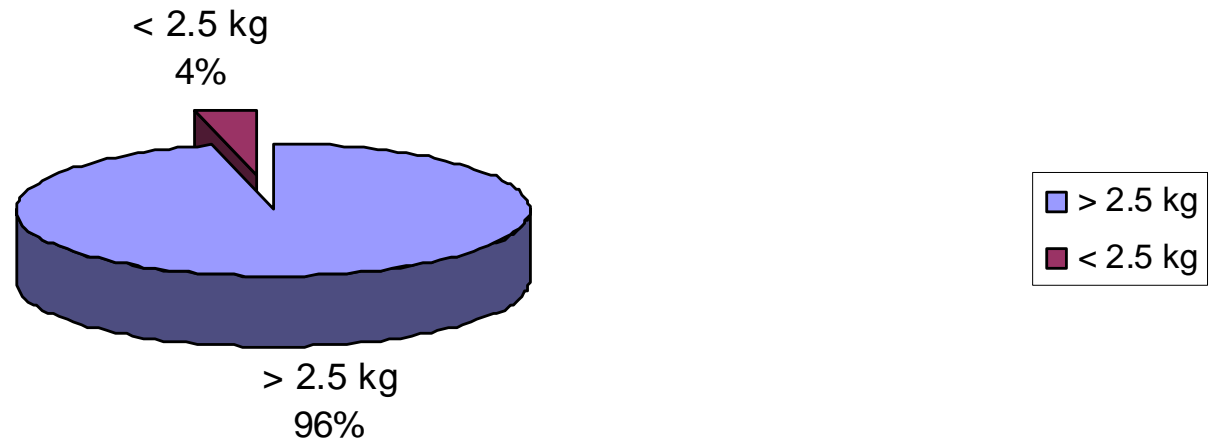
Final Hb levels of 576 participants (g/dl)



Date from routine health system, women who participated from 2003 – 2005
(2235 women)

Low Birth Weight

Birth Weight of Children born to 991 participants, 2005



Date from routine health system, women who participated in 2005
(1297 women)

FARNG Effects (routine data collection + focus group surveys)

- Increased Hb levels
- Reduced percentage of low birth weight babies
- Easier and faster delivery
- Quicker post partum recovery
- Increased assisted deliveries
- Improved immediate and exclusive breastfeeding
- Decreased morbidity during pregnancy, and in first six months of infancy
- Increased demand for health center services

FARNG Impediments (from qualitative assessments)

- Lack of availability of essential drugs
- Lack of motivation of some health center staff to participate in outreach programs
- No change in percentage of health center deliveries (30%), but increased assisted births
- Lack of food during certain periods for household contribution to shared meals.

Results of an independent assessment (March 2007)

- 400 participants, 200 non participants, stratified by region (3)
- Random sampling of participants
- 5 hypotheses to test (nutritional knowledge, nutritional practices, morbidity, nutritional status of women, nutritional status of children)

Key Indicators

Results table

Better nutrition knowledge

- 95% of participants and 80% of non participants could name at least one sign of anemia (average 2 signs to 1).
- 99% of participants and 81% of non participants could name foods rich in iron (3 vs. 1)
- 75% of participants and 40% of non participants could name at least one sign of VAD.
- 98% of participants and 62% of non participants could name foods rich in vitamin A.

Better prenatal care practices

	Participants (%)	Non participants (%)
Tetanus	98	80
Iron folate	99	79
Deworming	77	44
Malaria	91	72
Vitamin A post partum	86	51
Post partum iron folate	62	37

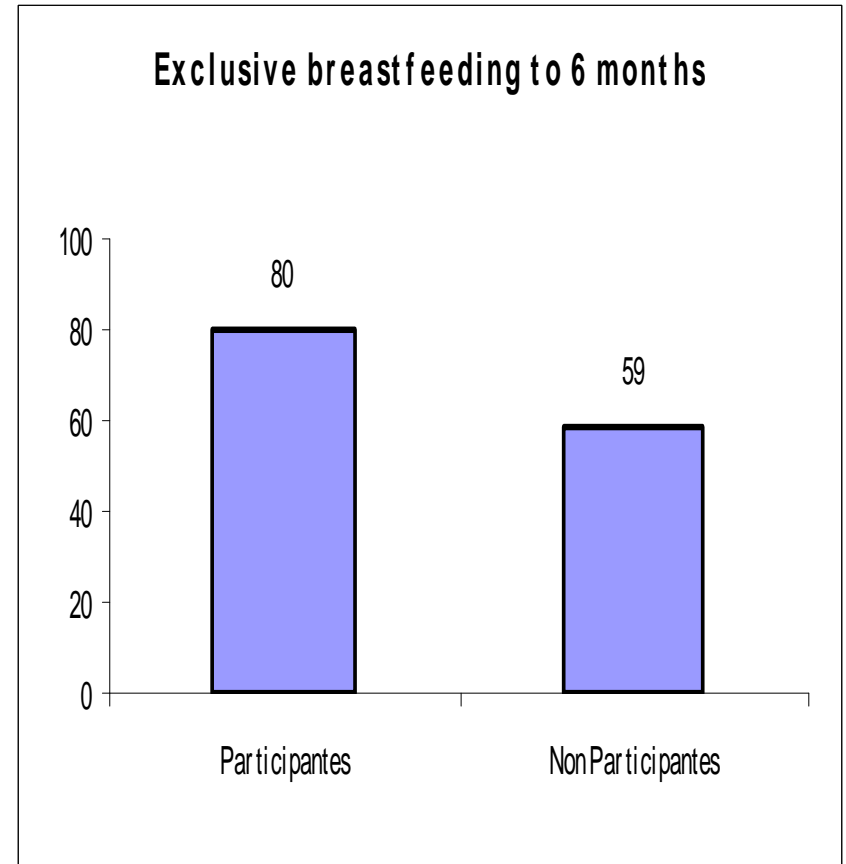
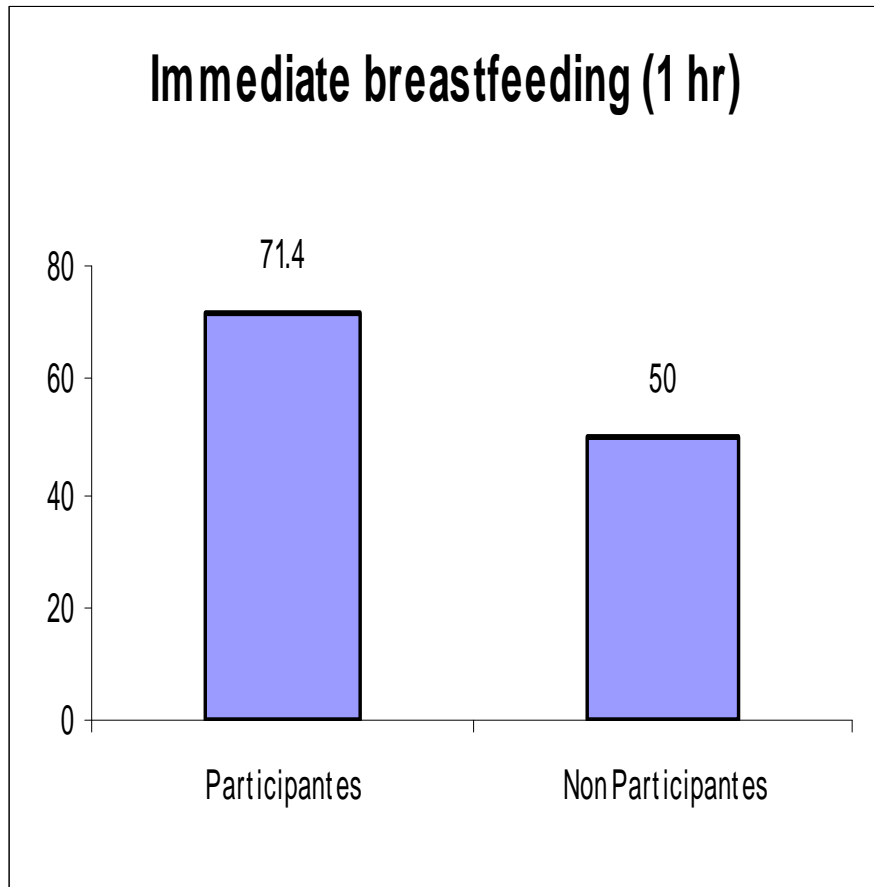
Better nutritional status of women

	Participants (%)	Non participants (%)
Morbidity	49	60
Anemia (Hb < 11 g/dL)	28	44
Night blindness	37	47 (not ss)

Labor and delivery practices

	Participants	Non participants
Home Delivery	65%	76%
Health center	24%	15%
Unassisted birth	5%	10%
12 hr+ labor	7%	11%
Recovery after labor (days)	4	8

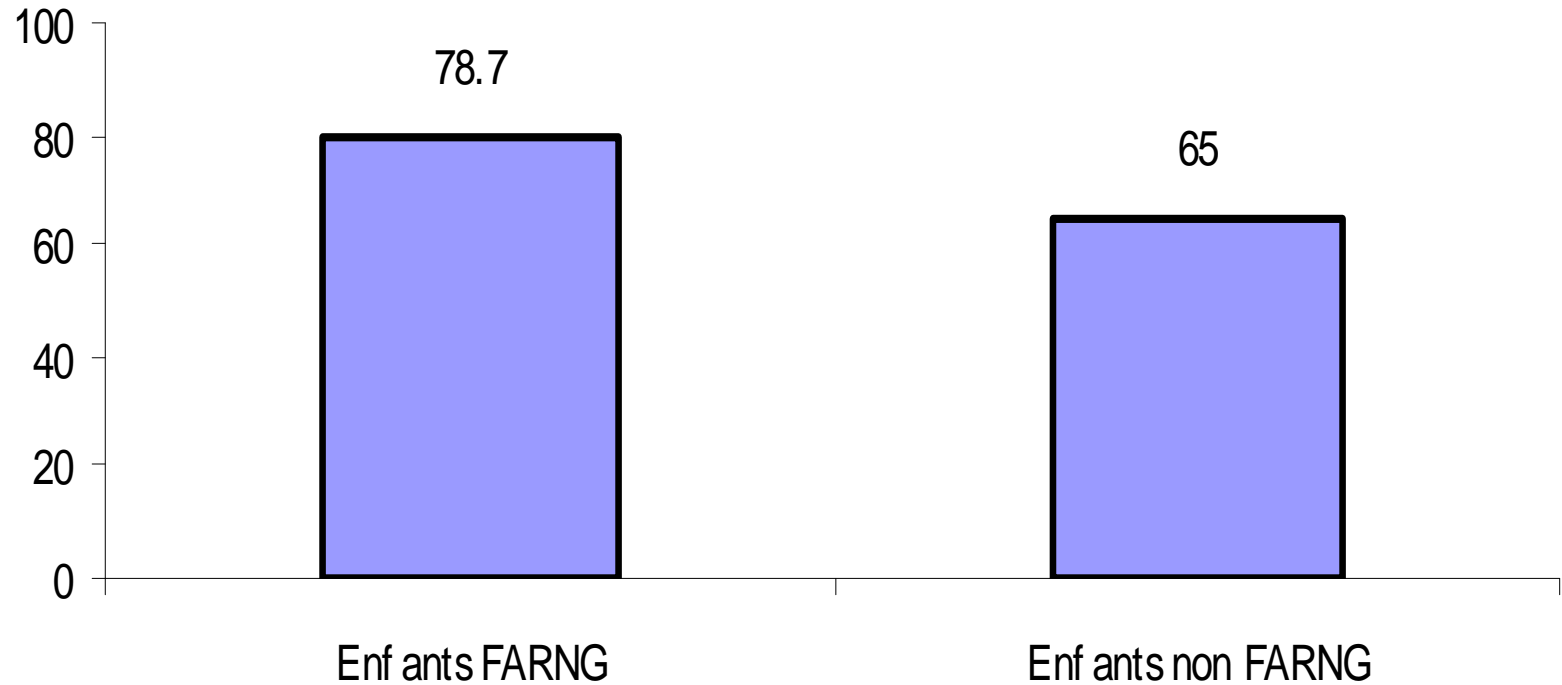
Breastfeeding



« Pendant les six premiers mois de vie de (prénom) lui avez-vous donné à boire ou à manger autre chose que le lait maternel (y compris l'eau)? »

Vaccination

Children vaccinated against measles



Child health

	Participants (%)	Non participants (%)
Weighed at birth	75	45
LBW (<2.5 kg)	3	7
Vitamin A	83	74
Deworming	57	33
% Children vaccinated	96	86
Morbidity	35	46

Nutritional status of children

	Participants (%)	Non participants (%)
Anemia	69	78 (nss)
Stunting (H/A)	28	27 (nss)
Wasting (W/H)	6	10 (nss)
Underweight (W/A)	21	27 (nss)
Underweight 12 – 23 months	28	53 (ss)

Benefits of the program, according to participants

1. Easy and fast delivery
2. Feel better and learned a lot
3. Free access to medicines, learning to prevent disease
4. Good food during food demonstrations
5. Solidarity among women

Constraints to program implementation, according to health agents

1. Availability of prenatal care medicines
2. Community health volunteer and health agent motivation
3. Food and money for communal contributions
4. Women's time
5. Lack of nutritional surveillance indicators within the health care system (forms)

Constraints to participation (W)

Conditions	N	%
Attendance for 9 months	47	11.2
Attendance at all sessions	69	16.4
Payment for food	86	20.6
Food contribution	108	25.7
Household visits	25	5.9
Cost of prenatal care	10	2.3
Cost of delivery	10	2.4
No problems	211	50.3

Constraints to scale up (W)

Conditions	%
Lack of health agents	3.9
Lack of time (women)	11.4
Lack of family support	13.8
Lack of food	13.0
Lack of money	9.2
Lack of medicine	0.3
Other difficulties	2.7
No difficulties	65.8

Vision for the future

- Detailed cost evaluation
- Adding breastfeeding support groups, infant and young child feeding components, and nutrition gardening
- Expansion nationally in Guinea, and in neighboring Sierra Leone
- Increasing partners

Opportunities for modification

1. Modify role of model mothers
2. Modify role of health volunteers
3. Distribution of other products by health volunteers
4. Nutritional gardens
5. Add breastfeeding support groups
6. Modify approach depending on partner availability and capacity in the field
7. Modify approach depending on the structure of the health system

Summary

1. 3 X 8 (EZ)
2. Positive deviance
3. Integrated components
4. Integrated into existing health center practices
5. Integration and collaboration with
COMPLETE COMMUNITY SUPPORT

**Thank
You!**