

Part I: Transforming Nutrition Interventions



CHAPTER 2

On the Front Line

Community Nutrition Programming

STUART GILLESPIE AND JUDITH HODGE

WHATEVER ADVANCES HAVE been made in terms of technologies, interventions, and their delivery platforms in recent decades, it is households and communities that remain on the front lines in combating malnutrition. During the past half century, several significant attempts have been made to initiate and implement community-based nutrition programs. This chapter assesses the evolution and performance of such approaches, highlighting several case studies.

In what follows, we differentiate between *community based* (which refers to the location of the intervention) and *community driven* (implying an active involvement of community members in designing and/or implementing the intervention). Several different communities may reside in any one village or urban slum—geography is only one of several factors that bring people together, or divide them. We also remind the reader that several of the interventions described in the first two sections of this book can be combined and delivered within community nutrition programs. In this sense, this chapter focuses more on the *how* of local

nutrition-relevant action than on any one type of intervention (the *what*).

The literature on community nutrition programming includes various studies, evaluations, and reviews, with a particular concentration of scholarly studies in the 1990s. These include the following:

- three comprehensive reviews carried out by the United Nations Standing Committee on Nutrition, which attempted to unravel the dynamics underpinning success in nutrition, either at the national level or with regard to a specific program¹;
- a review of community-based programs that led to the formulation of the highly influential UNICEF nutrition strategy²;
- a World Bank review of another four African programs³;
- a questionnaire survey of 66 programs in Africa, also by the World Bank⁴;
- a UNICEF-led appraisal of 22 community-based nutrition programs in South Asia⁵;

- a review of 8 effective programs in Africa⁶;
- a review of successful programs in Asia, undertaken by the International Food Policy Research Institute (IFPRI) for the Asian Development Bank⁷;
- a USAID review of 10 community-based nutrition programs carried out in Kenya, Tanzania, and Uganda⁸; and
- further analyses undertaken as part of a joint World Bank–UNICEF assessment of nutrition policy and practice that culminated in the 2003 book *Combating Malnutrition: Time to Act*.⁹

The genesis of this 1990s attention to community nutrition in fact lay in experiments and experiences from the 1980s. Three of these were particularly influential: the Iringa program in Tanzania (see [Box 2.1](#)), the Tamil Nadu Integrated Nutrition Project (TINP) in southern India (see [Box 2.2](#)), and the Thai experience (described in Chapter 10).

In general, the assessments and evaluations listed above concurred in emphasizing the importance of four factors: the context, the process leading to the development of the program, the choice of activities, and the process adopted to manage and implement the program. Before highlighting

BOX 2.1 Iringa: Africa's shining star

Tanzania's Joint Nutrition Support Program in the country's Iringa region was a landmark success story in community-based nutrition programming during the 1980s. A collaboration between the Swedish International Development Authority (SIDA), the Tanzanian Food and Nutrition Centre, and UNICEF/WHO, the Iringa Nutrition Program was scaled up to cover more than 50 districts between 1983 and 1989.¹⁰ The program emphasized social mobilization, local problem assessment and action planning, and tailor-made combinations of nutrition and food security interventions at the community level. Community workers monitored child growth to identify and assess families in which a child was malnourished and then worked with families to analyze possible causes and draw up an action plan in conjunction with local government organizations. Depending on the cause, interventions varied from counseling, to referral to the health service, to participation in a livelihood-creation, microcredit, or social protection program.¹¹

Such active community involvement at each stage of the nutrition improvement process was pioneering (reflected in the use of the "triple A approach"—assessment, analysis, and action) and addressed the human rights of individuals and vulnerable groups.¹² In five years, the program almost eliminated severe child malnutrition (from 6.3 percent to 1.8 percent) and reduced moderate malnutrition by half.¹³ Its dramatic success led to its national replication in the early 1990s as the Child Survival and Development Program, as well as to a number of lessons learned in terms of programming concepts and practice and to participatory development in general.¹⁴ The program also became a leading community-based model, adopted in and adapted for many countries in Africa and Asia.

Aligning nutrition with community development, however, had a price. The Iringa experience was not sustained in Tanzania, and after a change in government in the late 1990s, it effectively fell through the institutional cracks.¹⁵ In the new era of reform and cost-cutting, the community mobilization processes required for lasting change were considered too slow moving. Nutrition, increasingly equated with vertical micronutrient programs, was not considered an essential part of health reform.¹⁶ Yet Iringa has had a lasting legacy by leading to the development of the hugely influential UNICEF conceptual framework of the causality of nutrition still in use today (see Chapter 1).

BOX 2.2 Community nutrition programming in India

In Indian nutrition programs, the practice of active community involvement has often lagged behind rhetoric—the programs may be community based, but few are community driven.¹⁷ India's national Integrated Child Development Service (ICDS) scheme—the world's largest nutrition program—was launched in 1975 to address the health and nutrition needs of children under the age of six years. The program, which incorporates health, nutrition, and education interventions, operates through a network of *anganwadi* centers (AWCs) to provide services for adolescent girls, pregnant and lactating women, and children aged six months to six years. Individual or group counseling is delivered by community health workers or *anganwadi* workers. There is one AWC per village or for a population of 1,000 (700 in tribal areas).¹⁸

Although the ICDS has the potential to reach even the most vulnerable communities, evaluations suggest that gaps in program implementation result from factors such as poor targeting, poor coverage, and poor quality of service delivery.¹⁹ Echoing findings across many evaluations of ICDS, a 2001 ethnographic study²⁰ found the ICDS to be concerned primarily with proper regulation, enumeration, and upward accountability rather than outcomes for children, and to be focused on delivering and documenting a narrow set of supplementary food outputs rather than the wider integrated services intended by the state.²¹

In sharp contrast, the Tamil Nadu Integrated Nutrition Project (TINP), launched in 1980 and developed alongside ICDS, achieved a significantly greater impact on child undernutrition than the national program. Between 1980 and 1989, the prevalence of children who were underweight dropped by approximately 1.5 percent a year in participating districts—twice the rate of nonparticipating ones.²² The success of TINP was based on several factors, including selective feeding (the careful focus on supplementing the dietary intake of young children when their growth falters and until their growth resumes), favorable worker-to-supervisor ratios (see previous discussion of intensity), clear job descriptions, and a highly focused monitoring system.

The second evolution of TINP (TINP-2, launched in 1991 in 318 of Tamil Nadu's 385 rural blocks) sought to move beyond reducing severe malnutrition and to make a significant dent in the high prevalence of children suffering from moderate malnutrition by shifting toward a more preventive focus. Building on lessons learned from TINP-1, TINP-2 focused on strengthening local capacity, mobilizing the community, and targeting interpersonal communications, all aimed at improving home-based care and feeding of children younger than age 2 in order to prevent their becoming malnourished. This task was more difficult; some progress was made, but it was not as spectacular as that of TINP-1.²³ Later on, the TINP model became subsumed within the national ICDS program as the central government pursued universalization. As with Iringa, this high-intensity, time-intensive community program—however effective—did not sit easily with those pushing for scaling up a centralized program nationally. In the process, the political incentive to scale up coverage—in other words, a focus on quantity—trumped quality.

Although the ICDS, a national program that has been active for more than 40 years, has had limited success at the national level, there are signs of what can be done with higher-level commitment and stronger incentives for implementation and achieving results on the ground. The states of Odisha (described in Chapter 17) and Maharashtra are recent examples. In Maharashtra, key drivers associated with the rapid improvement in child nutrition included a doubling of spending on nutrition and a focus on filling vacancies among frontline workers in the ICDS scheme. Stunting in children under age five declined from 36.5 percent to 24.0 percent between 2005–2006 and 2012, and access to the ICDS was one of the determinants that improved the most between surveys.²⁴ Odisha, Maharashtra, and the earlier example of TINP show what can be achieved if community-based systems—supported by higher-level structures and incentives—are made to work effectively for communities.

several case studies and experiences, we dig deeper into these factors, listing key lessons and recommendations that emerged from these reviews.

Context

The degree to which program implementers can influence context is limited, at least in the short term. Several reviews have called for a two-pronged approach that involves catalyzing the development of programs where the context is favorable while promoting enabling environments through advocacy and social mobilization at all levels. Many reviews converged on the following contextual factors as being important:

- Political commitment at all levels of society and a conducive policy environment with supportive structures and policies. For programs to succeed in the long run, a context or environment that is enabling must be in place or created. Some of these contextual factors (for example, high literacy rate, women's empowerment, community organizational capacity and structures, appropriate legislation) may be particularly influenced by policy, others less so;
- The presence of complementary ongoing nutrition-sensitive programs from other sectors and/or local government;
- A culture of participation, particularly with regard to women;
- Community awareness, either existing or created, of the magnitude and consequences of malnutrition and a degree of commitment and knowledge to address them;
- Community organizations (such as women's groups, people's nongovernmental organizations [NGOs], credit associations, youth clubs, farmers' associations) along with adequate

infrastructure for delivering basic services, including committed and capable staff; and

- Charismatic community leaders who can mobilize and motivate people to do more for themselves in a genuinely self-reliant way.

Process in Developing the Program

Community-driven programs are rarely initiated to improve nutrition alone (communities have broader priorities), so means must usually be found to foster multifaceted programs in which nutrition and health activities can be embedded (see the discussion of Bangladesh's SHOUHARDO program later in this chapter).

As mentioned, most reviews of community nutrition action cited have emphasized the processes involved—that is, the *how* questions of program development, implementation, and expansion. But what is a good process? Most reviews concurred that it is one in which participation, local ownership, and empowerment are driving forces. A focus on process tends to align with the human rights rationale for action, wherein beneficiaries are considered subjects of their own growth and development rather than passive recipients of transfers or handouts. In the past, top-down, outcome-focused service delivery or nutrition interventions (for example, the Integrated Child Development Service [ICDS] in the 1990s, discussed below) tended to dominate the field of nutrition. With limited community ownership and little attention, if any, to the strengthening of local nutrition-improving processes, their long-term effectiveness was low. In contrast, process-focused development projects emphasize working from the bottom up on participation and empowerment, are often supported by NGOs (as in the case of SHOUHARDO), and are often—at least initially—small scale.

The reviews highlighted the following factors as important to program development:

- Promoting and supporting a process whereby individuals and communities participate in *assessing* the nutrition problem, *analyzing* its causes and their available resources, and *acting* in response. This three-step iterative cycle—the “triple A” approach of assessment, analysis, and action—emerged from the Iringa experience in Tanzania described below and became the cornerstone of the UNICEF nutrition strategy²⁵;
- Finding an appropriate entry point that is relevant and responsive to the community’s wishes and needs;
- Clearly identifying and defining time-bound goals and targets (young children, pregnant and lactating women, and adolescent girls are normally the focus);
- Identifying and supporting appropriate numbers and ratios of facilitators and community mobilizers, thereby providing a sense of joint ownership of the program or project by the community and the government (see the discussion of intensity under “Program Management and Implementation” below);
- Allocating adequate funding and time by donors and program managers to program development.

Program Design and Content

Community-based programs include a range of activities and interventions (see Chapters 3–5 in particular). For children, such programs could include any combination of the following: growth monitoring; infant and young child feeding; disease management, including feeding during and after diarrheal and oral rehydration therapy; micronutrient supplementation, such as promoting

consumption of iodized salt; deworming; and possibly targeted food supplementation. For women, activities included in ante- and postnatal care strategies can encompass tetanus toxoid immunization, micronutrient supplementation (including iron and folic acid tablets for pregnant women and possibly a postpartum vitamin A megadose in cases where vitamin A deficiency is known to be a problem), iodized salt consumption, food supplementation during pregnancy, malaria chemoprophylaxis in endemic areas, and reproductive health education.

Along with program content, two key design considerations relate to program coverage and targeting. Coverage relates to the percentage of the at-risk population participating in the program, while targeting concerns the degree to which this



Panos/G. Pirozzi

A child is measured at a health clinic in Zimbabwe.

coverage is oriented toward the neediest among potential responders. Well-conceived programs may be ineffective simply because their coverage is too narrow to have a broad impact on the problem, they do not reach those most in need, or both. Coverage and targeting often work in opposite directions: that is, large-scale programs might have wide coverage but be poorly targeted, whereas small-scale programs (often run by NGOs) may be well targeted but have limited impact owing to their limited coverage.

Other key findings of reviews of community nutrition action are as follows:

- The promotion part of growth monitoring and promotion programs is key. Growth monitoring and promotion works better when it is group based, when proper feedback and counseling are provided, and when information is used efficiently at all levels;
- Nutrition education should be related to tangible resources, conveyed as behavior change communication (as in participatory educational theater) and as positive deviance;
- Credit and income-generating activities should be provided for women;
- Care for women and children should be improved by reducing women's workloads using appropriate technology, such as milling machines, solar dryers, and water wells; and
- A multisectoral approach should be adopted to maximize convergence with other relevant programs, such as those that deal with underlying food, health, and care-related causes of malnutrition.

Program Management and Implementation

The issue of intensity is key in program design and implementation. Intensity relates to resource

use per participant, expressed either as dollars per participant per year or in population and worker ratios (for example, the number of children per community-level worker or mobilizer, or the number of facilitators or supervisors per mobilizer). Past experience suggests that effective programs require approximately \$US5–15 per participant (at 1991 rates) per year excluding additional food, which roughly doubles the cost.²⁶

With regard to personnel ratios, the successful example of Thailand (see Chapter 10) adopted a benchmark ratio of 1:20—that is, one community mobilizer per 20 households with young children, and one facilitator/supervisor per 20 mobilizers. In contrast, in India's ICDS in the 1990s, ratios approached 1:200—that is, one community-based *anganwadi* worker managed activities designed to cover approximately 200 households. Not surprisingly, the ICDS program was center-based and oriented to handing out food to individuals who attended (see [Box 2.2](#)). The critically important human dimension of counseling to improve home-based care and nutrition, tailored to the specific needs of individual children, was relatively neglected. In Tamil Nadu, on the other hand, TINP adopted a two-worker model (as opposed to just one worker) to increase intensity, with the second worker focusing primarily on home visits for the youngest growth-faltering children. Other key management and implementation factors underpinning successful programs included:

- Community involvement in program planning and implementation using participatory processes such as the triple-A approach, participatory rural appraisal, and community representation and voice within program hierarchies;
- Capacity development and training for programming staff and community members that is task oriented and part of the staff's professional development;



Panos/S. Das

Workers at an anganwadi center, which provides basic nutrition and health services, weigh an infant in Bihar, India.

- Strong leadership, training, and supervision of facilitators and mobilizers; an appropriate balance between top-down and bottom-up management; and links to effective community-based monitoring; and
- The involvement of local NGOs, which often provided excellent facilitators as well as culturally relevant training. They were usually accountable to the community, which facilitated sustainability.

SHOUHARDO in Bangladesh

Bangladesh's sustained success in reducing the prevalence of underweight and stunting among children during the past two decades (see Chapter 12) has not been linked to any particular nutrition

intervention but rather to multidimensional drivers. Key likely contributors to this decline include improvements in household assets, parental education (both maternal and paternal), sanitation coverage, gender empowerment, and healthcare use.²⁷ Such a multipronged approach has been integral to the success of the SHOUHARDO (Strengthening Household Ability to Respond to Development Opportunities) community-based program.

SHOUHARDO I was a large-scale, five-year program (2004–2009) that aimed to reduce malnutrition and chronic food insecurity in vulnerable households in 18 of the poorest and hardest-to-reach districts of Bangladesh, serving a population of 2 million people.²⁸ The program provided both direct nutrition interventions, such as food aid and maternal and child health activities, and services for improving water, sanitation, and hygiene (WASH)

and homestead food production. But what differentiated SHOUHARDO from other large-scale, community-based interventions was its use of a rights-based livelihoods approach for both addressing the conditions of poverty and promoting a “culture of equal citizenship rights.”²⁹

SHOUHARDO (which means friendship in Bengali) targeted the poorest and most vulnerable households living in the most poverty-stricken and remote chars and *haors* (unstable islands and wetlands formed of silt deposits) as well as coastal and urban slums. Household targeting within each village began with a participatory “well-being analysis.” This involved grouping community members into economic categories based on criteria such as land ownership, income level, and food insecurity. The final participants chosen included 400,000 households, representing about three-quarters of all households in project villages.³⁰

The program implemented a wide range of activities, recruiting community members to be facilitators and trainers in agriculture, fisheries, livestock, and other income-generating activities often focused on economic activities around the homestead.³¹ A team of approximately 45 partner NGOs were responsible for implementing the program, with CARE Bangladesh playing the supervisory role.

Empowering Marginalized People

The program aimed to empower some of the most marginalized populations (women and adolescent girls in particular) to realize their basic rights, directing them to existing social protection schemes and mediating their interaction with duty-bearers (usually government officials).³² This focus on rights was combined with a livelihoods approach, which takes a holistic view of people’s lives to inform program design. The livelihoods perspective breaks down the traditional sectoral view that people’s lives are composed of unconnected pieces; instead, it

looks for synergistic impacts from cross-sector combinations of interventions based on an understanding of the strategies that households use to survive.³³ Within this model, SHOUHARDO also focused on factors that have a well-documented relationship with improved nutritional status and children’s survival. These factors included education of women and girls and women’s empowerment and control of resources.³⁴

SHOUHARDO addressed not only the availability, access, and utilization issues that led to food insecurity but also the underlying structural issues that contributed to vulnerabilities specific to the population in its operational area.³⁵ Structural causes of food insecurity included not only poverty, poor sanitation, and frequent natural disasters but also power inequalities between women and men and between economic classes—politically sensitive areas that development agencies often steer clear of but that are crucial for tackling malnutrition in a sustainable manner. And such a radical departure from business as usual paid off. The program’s results showed exceptionally large reductions in stunting between 2004 and 2009: a decline from 56 percent to 40 percent among children aged 6 to 24 months in the program’s operational area. Furthermore, stunting reductions were far greater for the extreme-poor project households than for the poor (21.3 percent versus 12.7 percent). During the same period, levels of stunting remained unchanged in the country as a whole, and increases even occurred at some point owing to a food price crisis and extreme weather conditions.³⁶ So how did this community-based intervention achieve such success?

Understanding Success

Analysis (using a mixed-method approach) of SHOUHARDO’s success highlighted the impact of various interventions. Improved nutritional status of children was associated with a combination of nutrition-specific (direct) and nutrition-sensitive

(indirect) approaches. Direct interventions included food assistance (for children aged 6–24 months and lactating mothers) and health, hygiene, and nutrition support to mothers. SHOUHARDO's courtyard sessions on health, hygiene, and nutrition appeared to have made a significant impact on mothers' caring practices for their children and on their own antenatal care. More indirect interventions were those that improved households' economic conditions (for instance, participation in core occupational groups) and provided WASH support (that is, assistance with tubewells, a type of well in which a tube or pipe is bored into an underground aquifer to obtain safe water, and access to safe latrines).³⁷

Many of the improvements in women's empowerment that occurred over the program's duration could be attributed to SHOUHARDO initiatives. The degree to which women participated in Empowerment, Knowledge, and Transformative Action (EKATA) and other program groups was linked to significant improvements in their influence on household decisions, freedom of movement, and reportedly, in patriarchal attitudes. In general, the more that household members had been involved in multiple SHOUHARDO interventions, the better off they became in terms of food security status, equality of power between female and male household members, and the nutritional status of young children.³⁸

Building on Success: SHOUHARDO II

The program's second phase (SHOUHARDO II, 2010–2015) maintained a strong emphasis on improving livelihood security, food security, nutrition, and women's empowerment at the community level. However, this phase incorporated lessons learned from Phase I, with additional components aimed at strengthening local governance and improving adaptation to climate change. The program reached a further 370,000 households in 1,573 villages in 11 districts, targeting poor and

extreme-poor households.³⁹ SHOUHARDO II prioritized community-based interventions, such as the capacity of village development committees to not only assess local factors constraining food security but to oversee program efforts to address them.⁴⁰ A final impact evaluation report suggests that SHOUHARDO II was associated with reducing stunting prevalence among children under age five from 61.7 percent at the time of the project's inception to 48.8 percent only four years later—a total reduction of 12.9 percentage points. Success was attributed to the program's nutrition-specific maternal and child health and nutrition interventions, as well as interventions designed to empower women, promote livelihoods, and improve health environments at the household level.⁴¹

Where Are We Now?

Compared with the 1990s, the importance of community-driven approaches in nutrition seems to have fallen behind in the wider literature on participation. While the *Lancet* Nutrition Series of 2013 discussed platforms at the community level for delivery, for example, it did not address community-driven approaches as they relate to active involvement of community members in program design and implementation. SHOUHARDO may be an exception (albeit one that was initiated more from a food security than a nutrition perspective). It stands in contrast to the frequent application of participatory approaches to livelihoods, agricultural development, women's empowerment, sanitation, and other sectors that only indirectly impact nutritional status.

In the 2000s, increasing attention was paid to the concept of community-driven development (CDD), with the World Bank supporting and evaluating a range of CDD approaches in different countries.⁴² Reviews of these programs tended to

focus on the crucial need to adapt interventions to the local context (including community-level perceptions of development) and on the importance of responsive state involvement in delivering public services and fostering downward accountability.⁴³

While the issue of accountability in the delivery of public services has gained significant traction in recent years,⁴⁴ it had been relatively neglected in nutrition until recently. In identifying this gap, Nisbett et al.⁴⁵ pointed to the findings of a trial in Uganda that involved community meetings to reflect on scorecards of community healthcare provision in that country; the trial was associated with significant accelerations in decline in child mortality and wasting rates.⁴⁶

Things are changing, however, and accountability in nutrition is moving to center stage. This trend was highlighted in a recent consultation among Scaling Up Nutrition (SUN) member countries⁴⁷ and through the way in which the annual *Global Nutrition Report*—in shining a light on the translation of stated commitments into action on the ground—positions itself as an accountability intervention, not just a simple report. Is community accountability for nutrition (building on past lessons described here and in Chapter 10 on Thailand) the new window of opportunity to ensure that the voice of local people will help them achieve their own nutrition security?