

Care groups and community-based approaches for improved maternal and child survival and development

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A recent discussion paper published in *World Nutrition* has once again confirmed the importance of “Care Groups” for improving maternal and child undernutrition (Ncube-Murakwani et al. 2020). The critical factors considered responsible for the 7 percentage point reduction in young child stunting in rural Zimbabwe due to the Care Groups of the Amalima program included 1) conducting formative research; 2) ensuring context specific approaches and adaptive management; 3) leverage on social capital and cohesion; 4) investing in human capital; 5) prioritising quality assurance and reviews. These factors are largely in agreement with the those described in another review by Perry et al. (2015) which the authors cite. Another relevant review article on critical design elements of community-based nutrition programmes was also published in *World Nutrition* (Shantha & Shrimpton, 2017). But in addition to the points listed above, Ncube-Murakwani et al. provide no real description of the true origins of the concept of “Care” in nutrition programmes, which is something this commentary aims to provide.

The principle drive for promoting and clarifying the concept of care in relation to young child nutrition originated in UNICEF several decades ago. The UNICEF nutrition strategy (UNICEF, 1990) included a conceptual framework with “Food”, “Health” and “Care” as the underlying causes of young child malnutrition, as shown in Figure 1. The conceptual framework was developed to guide the “Triple A” process of Assessment, Analysis and Action, to be conducted at the community level to help decide what if anything needed to be done to improve food intake, health inputs, or care practices, as each was recognized as being necessary but alone insufficient for improving young child nutritional status.

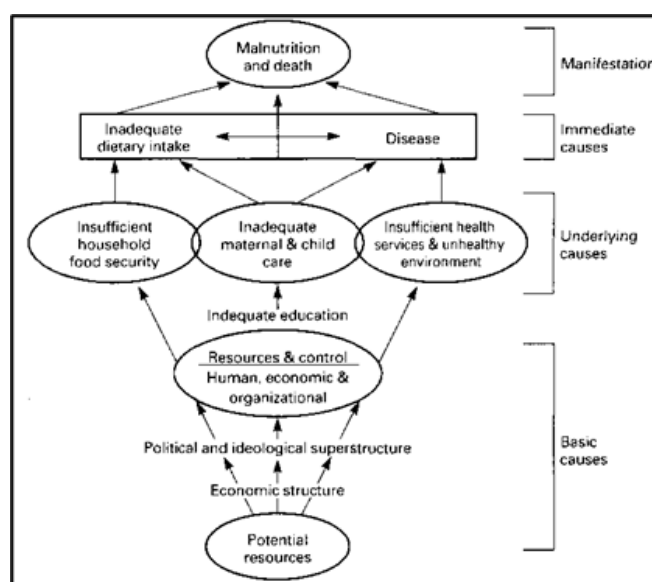


Figure 1. The UNICEF Nutrition Conceptual Framework

Prior to 1990, UNICEF health-oriented efforts had largely concentrated on the promotion of a small group of interventions such as growth monitoring, oral rehydration, breastfeeding, and immunization that gained the acronym GOBI (Cash et al., 1987) during the time of a very top-down “Child Survival Revolution”. Indeed, the role of care in nutrition programmes prior to 1990 was a very neglected essential ingredient (Longhurst & Tomkins, 1995).

Growth monitoring, although successful in small-scale projects, proved less so in large-scale programmes (Pearson, 1995). It was found that while community workers could assess nutritional status through growth monitoring, the capacity to analyse the causes of growth failure and counsel caregivers on the actions to be taken was rarely adequate when such projects were taken to scale. Based on the new Nutrition Strategy and the Triple A Approach, a Care Initiative was promoted (Engle et al., 1997) to help communities work out for themselves what needed to be done in terms of care for women and children in order for children to grow normally.

In addition, greater recognition was given in nutrition programmes to the fact that development could not be just top down, or bottom up, but had to be a combination of both (Shrimpton, 2002). Community-based nutrition programmes need to be locally specific to suit varying conditions, finding local solutions for maternal and childcare problems such as suboptimal breastfeeding and inadequate complementary feeding for example. Community-based programmes were initially constructed on top of programme thrusts promoted by the health sector, such as immunization and oral rehydration, and then these interventions were expanded to include the Essential Nutrition Actions (WHO, 2013) which eventually became labelled as the nutrition-specific interventions (Bhutta et al., 2013). The addition of other sectors such as sanitation and social security also gave rise to the addition of nutrition-sensitive interventions to the programme mix (Ruel et al., 2013).

With this expansion of the realm of interventions in community-based nutrition programs, capacity building and training became increasingly important. Government workers had to be trained to build the capacity of community volunteers to facilitate household and community level Triple A processes. Training of government workers was no longer just about the “What” to do, but also about the “How” to do it, with participatory methodologies and counselling forming the core of the task-based training. The focus now was on skills, attitudes, and behaviour rather than knowledge alone. Experience from programmes in multiple countries has shown that the ratios of government workers to community volunteers are typically most effective with 10-20 families per volunteer and 10-20 volunteers per government worker (Mason et al., 2006), as per the Amalima program from Zimbabwe.

With the growing importance of capacity development in public health nutrition programmes, the need for management tools to be able measure whether such efforts were on track became evident. A practice framework was agreed for measuring nutrition capacity development (Shrimpton et al., 2013) and a national nutrition workforce strategy and implementation plan was considered an essential element of any national nutrition plan. Measures for assuring the quality of workforce preparation when scaling up nutrition programmes were developed, with a framework covering four

dimensions of capacity development: system, organisational, workforce and community levels (Shrimpton et al., 2016).

Indeed, if capacity building efforts only consider the workforce level, without considering the community, organisational and system-wide dimensions, the effectiveness and the sustainability of any such efforts are likely to be short-lived. Such broad capacity building efforts should be part of a national nutrition workforce strategy which should be measured through multiple indicators, including the numbers of front-line workers at both facility and community level by sector, as well as the nutrition training they have had (Shrimpton et al., 2017). Only by adopting such a national nutrition workforce strategy and implementation plan can the six global nutrition targets to be achieved by 2025 be realized, which now include both under and overnutrition of mothers and their young children (WHO, 2012).

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