CURATED RESOURCES FROM ENN'S ARCHIVES

Emerging themes for SUN countries

SCALING UP NUTRITION-SPECIFIC ACTIVITIES

According to the Lancet 2013 series on Maternal and Child Nutrition, nutrition-specific interventions or programmes refer to those that address the immediate determinants of fetal and child nutrition and development. Examples include: adolescent, preconception, and maternal health and nutrition; maternal dietary or micronutrient supplementation; promotion of optimum breastfeeding; complementary feeding and responsive feeding practices and stimulation; dietary supplementation; diversification and micronutrient supplementation or fortification for children; treatment of moderate and severe acute malnutrition; disease prevention and management; and nutrition in emergencies.

Since 2015, there have been 103 articles in Field and Nutrition Exchange that relate, to varying degrees, to the topic of scaling up nutrition specific activities. This synthesis distils the learning from these articles.

Emerging themes

FOCUSING ON THE HEALTH SYSTEM

A key emanating theme highlights the importance of placing health centres at the heart of the expansion process. For scale up to be truly sustainable, it has to be integrated in the health system and incorporated as part of broader health interventions. As one study noted, 'The health structures provide an effective, sustainable model for provision of services'[1]. Even in articles where NGO's led scale up processes rather than Ministries of Health, there was a recognition that this needed to occur either in health facilities or as close to health structures as possible. In Ethiopia, a government led response to an emergency in 2016 began with an analysis of how the health system could respond to the nutritional crisis in order to not create a parallel system but also not to over-stretch the existing health structures[2].

Where governments are in the position to drive scale up, it is critical that the Ministries of Health buy in to the importance of integrating nutrition interventions with health services[3]. For example, it was noted that the expansion of nutrition services in Northern Nigeria was driven by the strong political will and leadership of the Ministry of Health[4]. In Afghanistan, the Ministry of Public Health incorporated nutrition services into the Basic Package of Health[5]. This focus on health structures inevitably however highlights the need for health system strengthening efforts and often conversations around expanding services need to incorporate a health system strengthening approach. Such broader elements of the health system potentially needing to be strengthened include: overall health facility infrastructure, human resources, health financing and resource mobilisation, governance and leadership, supplies of medical products and quality service delivery[3, 6].

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ADAPTING THE APPROACH

As part of the above, there is a need to recognise that no two health systems are the same, thus the way in which nutrition interventions are scaled up and integrated into health systems needs to be contextualised and adjusted to fit each country's set of needs. Consideration needs to be given to the multiple, diverse and sometimes complex contexts that nutrition services are scaled up in and various tools exist to support such analysis[7]. In Ethiopia, for example, as part of a Government led emergency response, a woreda capacity-mapping tool helped to identify the strongest and weakest woredas in order to tailor a scale up strategy based on the realities on the ground[2]. In Nigeria, a gap analysis in health facilities was conducted to inform the scale up of CMAM services[4].

For CMAM services, the bottleneck analysis (BNA) approach enables an analysis of barriers to effective service delivery coverage and is a useful tool prior to scaling up interventions. It provides a systematic way to look at the main obstacles to achieving service delivery at scale[8]. Prior to scale up, a BNA can help highlight barriers within existing services and facilitate a process to overcome such obstacles when examining programming at scale. For example, a BNA was conducted in Sudan, Kenya, Somalia, Afghanistan, India and Yemen prior to the scale up of CMAM interventions[7, 9, 10-13].

Sometimes it is not sufficient to contextualise approaches based on the health system realities alone but also to consider the broader population dynamics. Such contextualisation becomes critically important in conflict affected states where scale up is often needed in places with limited access, population displacement, a stretched health workforce and communities that are scattered. Such contexts provide challenges for scale up and achieving suitable coverage of interventions[7]. Creative solutions can be explored in such instances. For example, in Chad mobile health and nutrition clinics are used due to low population density and long distances between health sites[14] and a similar mechanism was used in Yemen where health facilities were destroyed and access to services was a challenge[15].

SCALING UP SLOWLY AND CONSOLIDATING EXISTING SERVICES

There is a need for expansion to happen relatively slowly to enable health facilities to be fully prepared and the impact of scale up on health facilities mitigated. The theme of needing to initially select pilots to test interventions, with a focus on extending to other areas if successful, emerged strongly from the field studies. There has been a recognition that countries need to start piloting interventions and gradually scaling up, generally through an incremental approach.

Even in fragile and conflict affected states, where there was an urgency to reach all those in need, scale up was steady and gradualist in order to be successful. In Niger, an intervention to utilise 'Child Survival Weeks' to promote Vitamin A supplementation was initially piloted in 2010 in 17 health districts and gradually scaled up[16]. In the Democratic Republic of Congo, a programme to enhance the Baby-Friendly Hospital Initiative with a breastfeeding component was initially set up as randomised control trial to demonstrate proof of concept before being scaled up to maternity hospitals in the country[17].

DOCUMENTING STRATEGIES FOR SCALE UP

Careful planning for scale up is needed in order to ensure long term sustainability. As a mechanism to ensure that such planning takes place, many field studies have reflected on the importance of having policies, plans and strategies in place to facilitate scale up. For example, in Somalia a CMAM (known as IMAM) scale up strategy was developed to guide the process[12] and in South Sudan a Joint Nutrition Response Scale Up Plan supported the expansion of services[18, 19]. In Nigeria, a scale up strategy was developed by the Scale Up Technical Working Group[20] and in Kenya an urban nutrition strategy was developed to guide programme expansion in urban areas[20].

CASE STUDY

Harnessing the potential of India's medical colleges to bring maternal nutrition services to scale

India has a policy environment that is conducive to maternal nutrition (MN), however, antenatal care (ANC) services are recognised as being sub-optimal, particularly in relation to nutrition services. To improve this and upskill medical staff in relation to nutrition services, partnerships were forged between Alive & Thrive (A&T)[3] and eight government medical colleges (and attached hospitals) in the states of Uttar Pradesh (UP) and Bihar. The initiative aimed to support the integration and prioritisation of maternal nutrition in the undergraduate curriculum for doctors and in the antenatal service-delivery platform of the medical college hospitals.

A maternal nutrition-focused curriculum was developed and standard protocols were updated. Protocols covered: appropriate anthropometric measurements to assess nutritional status, counselling on healthy eating (dietary adequacy and diversity), micronutrient requirements (iron and calcium supplementation), gestational weight-gain monitoring, assessment of nutrition-related risks and appropriate management of nutrition for pregnant women, including a focus on the elevated nutritional and obstetric risk of adolescent pregnancy. To date, approximately 900 faculty and hospital staff are being trained in both states under the supportive leadership of the State directorate of Medical Education, State Health Mission and the Ministry of Health & Family Welfare (MoHFW).

www.ennonline.net/nex/southasia/indiasmedicalcolleges

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PRIORITISING ACTIVITIES AND AREAS

Given that the process of scale up can be relatively complex, there is a need to prioritise nutrition interventions to be scaled up as well as areas to initially be prioritised. In none of the field studies, were a broad range of interventions scaled up simultaneously but rather interventions were scaled up one at a time to enable high quality delivery to be achieved. In order to understand which interventions to prioritise and where to scale up interventions initially, good quality and regular data collection is critical to inform programmes and the process of scale up.

In order to prioritise interventions, a rich understanding of the nutrition situation and underlying causes is needed. For example, in Ethiopia, a causal analysis was conducted using both qualitative and quantitative mechanisms to understand the causes of malnutrition and tailor services accordingly[21]. Furthermore, the Link Nutrition Causal Analysis (NCA) approach offers a structured way of identifying the causes of undernutrition in a local context to inform programming[22].

In terms of prioritising areas, in general, areas of high rates of malnutrition were selected as those to be prioritised for CMAM scale up as well as IYCF (for example in Chad[23]; and Nigeria[24]). Similarly, in Ethiopia a woreda hotspot criteria has been developed which takes into account nutritional trends and admissions in order to identify the most in-need areas[25]. In other countries, areas with the lowest level of coverage were selected as priorities for scale up. For example, in Niger, districts selected for a Vitamin A supplementation programme were those with poor Vitamin A coverage and in Somalia, scale up was based on health service coverage[6, 16].

ENSURING SUFFICIENT STAFFING FOR SCALE UP

All discussions on scale up need to reflect on ensuring sufficient and dedicated staffing to carry out interventions at a large scale[7, 26]. Consideration needs

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to be given to how many additional staff are needed at health facilities as well as how existing staff can incorporate nutrition activities in their daily work. Ensuring sufficient staffing is often deemed a major challenge when expanding services[19, 27-29], for example, a study of 13 countries in West Africa noted a critical shortage of skilled nutrition professional in all countries with limited supervision of nutrition activities, particularly for frontline workers[30]. Thus, many programmes have utilised nutrition volunteers[10, 31] or incorporated nutrition interventions into community health workers (CHW) roles. Generally, the CHW package of care includes screening for malnutrition, nutrition education, breastfeeding counselling and support during campaigns such as vitamin A[29, 32, 34, 35]. A recent study from Mali, found that CHWs, with minimal training, were able to treat SAM in the community effectively, with similar treatment outcomes and improved defaulter rates compared to children treated at a facility level[32, 33].

While ensuring sufficient staff is critical, it is important they acquire the knowledge and skills to carry out nutrition interventions[4]. Thus capacity-building initiatives are vital. At a structural level, Kenya developed a Nutrition Capacity Development Framework, created by the Government, in partnership with international and local NGOs[36]. The framework outlined mechanisms to identify capacity gaps in the health workforce and approaches to implement and monitor capacity initiatives[36].

Another mechanism for capacity building is locally organised cascade training or on-the-job training and mentoring[9, 28, 30]. On-the-job training to develop the workforce to act at scale requires new and/or unconventional methods of capacity development and various countries have explored using a mix of distance learning, video-conferencing training and periodic coming together with tutors and mentors[30, 37, 38]. For example, in Mali, in order to address capacity

gaps in relation to SAM treatment, the 'URENI' (Units of Recovery and Intensive Nutrition Education) School model was developed in response to capacity-gap needs[39]. ALIMA, in partnership with UNICEF and the Nutrition Division of the MoH, established a three-week training programme in which trainee doctors worked with URENI doctors and nurses to gain hands-on experience in malnutrition treatment[39].

CONSIDERING SUPPLY CHAINS

Without adequate and predictable supplies, scaling up of interventions cannot be achieved[5, 40-42], thus strengthening delivery systems is a core element of expansion plans. In reflecting on scaling up supply chains, many articles note the instrumental role that UNICEF has played in ensuring the supply of nutrition products, particularly for CMAM interventions[3,19]. However, this can create challenges as nutrition products are therefore seen as 'external products'. Integration of the nutrition products supply chain in regular delivery mechanisms is an important contribution towards normalising these products and supporting a strong supply chain[3, 43].

In order to limit stock outs, countries have taken a number of different approaches. In Zimbabwe, SAM treatment products were added to the Essential Medicines List which helped to improve quality assurance, integrate nutrition products in the distribution system and improve the data availability of stocks[44]. In South Sudan, World Vision secured 'buffer' stocks for programme sites to ensure that stock outs did not occur[19]. In Nigeria, the Yobe State Primary Healthcare Management Board forecasts quarterly supply requirements and UNICEF delivers nutrition supplies based on this[4].

LEVERAGING OPPORTUNITIES TO SCALE UP

One critical finding from the articles is that scale up can be achieved through leveraging pre-existing platforms to enhance nutrition services. For example, in Nigeria IYCF activities were integrated into child health days in order to expand services[40]. In Malawi, CMAM activities in the past, were delivered as a separate clinic one day per week and it was thus seen as an 'add on' to routine services rather than an integral component of routine child health services. Thus, as part of their scaling up plans, nutrition was integrated into health services such as twice yearly Child Health Days and malnutrition screening was combined with Vitamin A campaigns[31]. In Yemen, malnutrition screening was integrated into a polio campaign to increase active case finding of malnourished children[9]. Similarly, in Pakistan, IYCF education was incorporated into vaccination campaigns [45]. One key integration opportunity is that of linking

CASE STUDY

Child Survival Week as a platform for promoting vitamin A supplementation in Niger

In Niger, National Vaccination Days are being replaced with local days that have more limited coverage of target children; integration of Vitamin A Supplementation (VAS) into routine health services is not widespread. To address this gap, in 2013, pilot Child Survival Weeks (CSWs) were implemented by the Ministry of Public Health across 17 health districts with the support of UNICEF, the Micronutrient Initiative (MI) and Helen Keller International (HKI). High-impact services, such as deworming and VAS, were provided with high investment in leadership, management-strengthening, logistics, community sensitisation, and monitoring and evaluation. The district VAS coverage (104%) exceeded the national target (80%). More than two-thirds of children received vitamin A in the course of the CSW campaign and at home. The post-campaign reported lower coverage (average 45.2%) but, due to recall bias, is difficult to interpret (it was conducted four months post-campaign rather than one month later). Leadership and management-strengthening activities have been crucial to effective implementation of CSWs in Niger. State funding was low (8%); this has implications for sustainability. The CSW proved a feasible platform for VAS; strengthening routine nutrition activities of health centres and of community activities and addressing obstacles (particularly state funding) are critical to the future of VAS in Niger.

www.ennonline.net/fex/51/childsurvivalweekvita

nutrition interventions with integrated community case management (iCCM). Initially this included screening for malnutrition and checking for danger signs but it has recently been shown that community workers are able to treat malnutrition at this level as well (as noted above)[32, 33, 46]. Sexual and reproductive health clinics were found to be useful sites to expand nutrition related antenatal services and IYCF interventions[9, 37, 47, 48]. Using multiple platforms to deliver nutrition services is a simple mechanism for expanding services and opportunities and should form part of scale up plans[4].

INVOLVING THE COMMUNITY

Meeting and sustaining the objectives of nutrition programmes depends on successfully engaging with the communities involved and creating demand for services. This enables a better response to community needs, concerns and ensures that services are more accessible, culturally appropriate and community owned. It is critical to get community buy-in prior to scale up and ongoing dialogue should be established[9, 14, 37, 48]. Community participation is critical in identifying nutrition problems and facilitating access to treatment [42, 49]. In order to achieve this, influential community members such as school principals, traditional leaders, tribal leaders and religious leaders should be consulted prior to and during service expansion[34].

Community ownership is a critical factor for success; both to empower communities to utilise services as their 'right' and to challenge programmes to continually improve[34, 41]. Thus, a focus on the community should not be neglected when considering scale up. In Nigeria, to ensure that this was achieved, a task force for community mobilisation was formed to facilitate a harmonised community approach[20].

Furthermore, harnessing the community can contribute to efforts to prevent malnutrition. For example, building the capacity of key community influencers such as men, grandmothers and mothers-in-law in relation to IYCF practices can be an important mechanism for improving childcare practices[7, 24, 50]. Mothers themselves have proved critical in enhancing IYCF activities and identifying malnutrition. A study in Niger found that mothers with minimal training can measure their child's mid-upper-arm circumference to classify the nutritional state of their children[51]. Care Group models have also been recognised as a mechanism for involving the community in both preventing and treating child nutrition concerns[52, 53]. For example, in Nigeria, 'Porridge Mum's' support groups were trialled to provide a platform for women to come together to learn and discuss child feeding practices[24].

LEARNING FROM AND ENGAGING WITH NGOS AS ALLIANCES IN SCALE UP

In many of the examples on scale up, NGOs have played an integral role in supporting expansion. While ideally governments should lead on expansion efforts, opportunities to learn from and leverage NGO partnerships and presence should be welcomed. Examples of NGOs support included assistance during emergencies when relatively rapid scale up is required [31, 34, 37, 50, 54]. For example, in Kenya, Action Against Hunger supported the expansion of maternal, infant and young child nutrition interventions in Dadaab refugee camps in 2011 – supporting the building of structures, conducting training and setting up a M&E system[50]. In Malawi, during a flooding emergency, Concern Worldwide supported the scale up of CMAM interventions with similar interventions[31].

NGOs can also be valuable in providing technical assistance and training in countries. In Ethiopia, the role of NGOs has shifted from direct service delivery to technical backstopping, capacity building and logistical support in priority areas[25]. In Somalia, NGOs facilitated the strengthening of the Ministry of Health's structures through supporting human resource development, resource mobilisation, building leadership and supporting service delivery[6]. Similarly in Kenya, Concern Worldwide supported the strengthening of county government health systems by conducting trainings, mentoring and providing technical support[28]. Governments can utilise the experiences and knowledge of NGOs working in country to support scale up efforts and help to provide a contextualised approach to expansion[42].

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