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## Community-level perceptions of drivers of change in nutrition: Evidence from South Asia and sub-Saharan Africa

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## ABSTRACT

Changes in the immediate, underlying and basic determinants of nutritional status at the community- and household-level are a logical and empirical prerequisite to reducing high levels of undernutrition in high burden countries. This paper considers these factors directly from the perspective of community members and frontline workers interviewed in six countries in South Asia and sub-Saharan Africa. In each country, in-depth interviews were conducted with mothers, other community members and health workers to understand changes in health and nutrition practices, nutrition-specific interventions, underlying drivers and nutrition-sensitive interventions, and life conditions. Overall, the need for basic improvements in livelihood opportunities and infrastructure are solidly underscored. Nutrition-specific and -sensitive changes represented in most cases by deliberate government or NGO supported community interventions are rolling out at a mixed and uneven pace, but are having some significant impacts where solidly implemented. The synthesis presented here provides an invaluable source of information for understanding how community-level change occurred against a wider backdrop of national level progress.

### 1. Introduction

Across the globe, countries are stepping up their efforts to tackle high levels of child undernutrition. To reach the ambitious global targets set by the World Health Assembly in 2012 (including to reduce child stunting, which represents chronic undernutrition, by 40% by 2025), national and international actors need to learn from successful (and less successful) country-level examples of undernutrition reduction. The *Stories of Change* initiative carried out mixed-methods research in six countries in South Asia and sub-Saharan Africa to bring together lessons from experiential learning in improving nutrition. While the other papers in this Special Issue address countries' respective "stories of change" as well as the quantitative changes in stunting, this paper focuses solely on community-level findings. The paper summarizes community level perceptions in changes in nutritional outcomes and determinants across six country contexts over a

period of at least a decade (Table 1). It provides a unique insight into community-level changes, a yardstick – indicative rather than representative – of how far, and in what ways, national and global action has affected ground-level realities.

### 2. The role of community level studies in charting nutritional change

The community as a unit of study and intervention has long been established in nutrition practice and research. Work at this level has arguably spawned the most important conceptual framework, brought together by UNICEF in 1990, in response to community level experimental work in Tanzania's Iringa region (Gillespie and Hodge, 2016 – see the Lancet Nutrition Series adaptation in Fig. 1 below). This describes how the determinants of nutritional status go beyond immediate level causes in terms of nutrient intake and health/immune

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**Table 1**  
Sampling for community-level interviews.  
Source: Compiled by authors, based on information in SoC country reports.

	Villages/ward	Data collection methods	Respondent type and sample	Selection criteria
<b>Senegal</b>	<b>Villages: n=4.</b> 1 Wolof or Mandinka speaking village randomly selected in each Collectivités Locale (CL) (district subdivision); 4 CLs randomly selected from total of 9 CLs in a selected department.	<b>Semi-structured in-depth Interviews (IDIs)</b>	<b>FLWs: n=24.</b>  <b>Mothers: n=18.</b>  <b>Households: n=30.</b>	<i>CL level:</i> 4 community development agents (Agent de Développement Communautaire (ADC)), 1 chief nurse of health post (Infirmier Chef de Poste (ICP)) (total n=5).  Village level: 17 community health volunteers (relays), 1 female nurse (matrone), and 1 village birthing assistant (bajen gox) (total n=19). 4 mothers selected per village from each age bracket, 2 additional. Age brackets: mothers with children aged 0–3, 4–7, 8–11, and 12–15. Mothers selected randomly within these criteria.
<b>Ethiopia</b>	<b>Village: n=1.</b> 1 iddir (informal organizing community structure / village) selected from 1 Kebele in Sodozuria Woreda in Wolaita Zone in SNNPR region. Selection of this case study area was determined by the lead researcher's familiarity with the zone, woreda, and community from previous research, as well as the opportunity to examine a community without significant NGO involvement.	<b>IDIs</b>	<b>Households: n=30.</b>	30 households randomly selected from a total of 86. Included 3 current/former PSNP beneficiaries. SSIs carried out with men and women (mix of together and separate).
<b>Zambia</b>	<b>Villages: n=8.</b> 4 villages randomly selected in 2 wards (Shimbizhi and Nangoma)	<b>Key Informant Interviews (KIIs)</b> <b>Focus Group Discussions</b>	<b>Headmen/headwomen: n=4.</b>  <b>Groups of mother/programme beneficiaries: n=14.</b>  <b>Mothers: n=20.</b>	4 Key Informant Interviews with headmen and headwomen in 4 villages 14 FGDs (8 with mothers beneficiaries of the RAIN programme, 4 in each ward; 4 with men from beneficiary households, 2 in each ward; 2 with younger women, 1 per ward). Each FGD had 10–12 participants. 1 mother per 5 year period in each of the 4 wards. Five year periods: mothers who gave birth between 1990 and 1995, 1995 and 2000, 2000 and 2005, 2005 and 2010, and 2010 and 2015.
<b>Nepal</b>	<b>Wards: n=4.</b> 2 <i>terai</i> districts (1 covered by the health/nutrition programme Suaahara, 1 without a large scale health/nutrition programme). In each district, most disadvantaged village development committee (VDC <sup>c</sup> ) selected; within each VDC, 2 wards closest to each other selected.	<b>IDIs</b>	<b>Individuals: n=293.</b>	113 men and 160 women from 161 households, interviewed separately. Households selected as subsample of a CPRC-IFPRI-DATA longitudinal study of dynamics of poverty in rural Bangladesh (which included 2152 households (1907 original households) from 8 of 14 districts.
<b>Bangladesh</b>	<b>Villages: n=16.</b> 16 villages selected from 8 districts (2 villages per district) (life history interviews conducted in 2007 and re-analyzed for purposes of SoC). The districts consisted of: Manikganj, Nilphamari/Kurigram, Mymensingh, Tangail, Kishoreganj, Jessore and Cox's Bazar.	<b>Life History Interviews</b>	<b>Individuals: n=293.</b>	113 men and 160 women from 161 households, interviewed separately. Households selected as subsample of a CPRC-IFPRI-DATA longitudinal study of dynamics of poverty in rural Bangladesh (which included 2152 households (1907 original households) from 8 of 14 districts.
<b>Odisha (India)</b>	<b>Villages: n=5.</b> Drew from an existing study selection (from the POSHAN project <sup>a</sup> ) of 100 villages in Kalahandi district; 5 villages randomly selected for SoC.	<b>IDIs</b>	<b>FLWs: n=20.</b>  <b>Mothers: n=25.</b>	5 Anganwadi Workers (AWWs); 7 Accredited Social Health Activists (ASHAs); 8 Auxiliary Nurse Midwives (ANMs) (3–5 total FLWs/village). 5 mothers selected from each of the 5 villages, so that each had a newborn between 1990–1995, 1995–2000, 2000–2005, 2005–2010, and 2010–2015.

<sup>a</sup> Government of Nepal defines VDCs as disadvantaged based on the following criteria: food sufficiency less than 3 months, marginalized groups, lack of access, low level of representation of women, Dalits and Janjatis in formal decision-making, and prevalence of vulnerable groups.

<sup>b</sup> See <http://poshan.ifpri.info/>

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