RAISING THE STATUS AND QUALITY OF NUTRITION SERVICES WITHIN GOVERNMENT SYSTEMS

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Strengthening Partnerships, Results, and Innovations in Nutrition Globally

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RAISING THE STATUS AND QUALITY **OF NUTRITION SERVICES** WITHIN GOVERNMENT SYSTEMS

About SPRING

The Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project is a five-year USAID-funded cooperative agreement to strengthen global and country efforts to scale up high-impact nutrition practices and policies and improve maternal and child nutrition outcomes. The project is managed by JSI Research & Training Institute, Inc., with partners Helen Keller International, The Manoff Group, Save the Children, and the International Food Policy Research Institute.

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Abstract

The equitable provision and utilization of high-quality nutrition-specific and nutrition-sensitive interventions is a global priority. Many of those interventions depend on the services of a range of providers, including community volunteers, health workers, teachers, agricultural extension workers, and other community actors. Services may include actions that directly affect nutrition, such as nutrition assessment, counseling, and care, as well as those that have a less direct relationship with nutrition, but are equally important. High-quality service delivery at scale requires a systematic and sustainable change process that considers the foundation underlying how services operate, provides adequate support to those service providers, and builds public demand for nutrition services. This guide provides government staff, USAID missions, and implementing partners with country examples, relevant resources, lessons learned, and key recommendations regarding this systematic and sustainable change process.

Cover photo: Lauren Crigler

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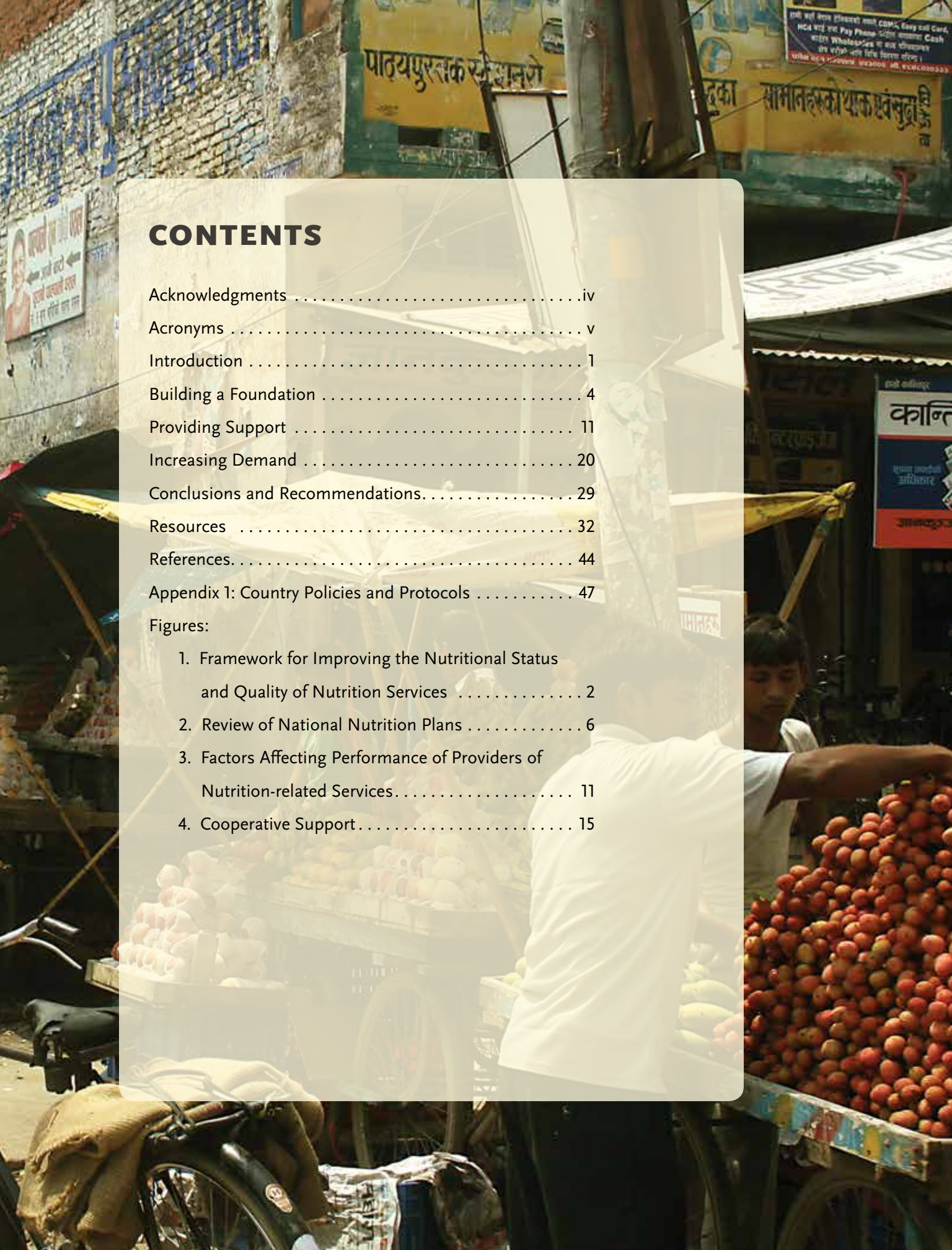

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ACRONYMS

CHW	community health worker
EHA	essential hygiene actions
ENA	essential nutrition actions
FP	family planning
HIV	human immunodeficiency virus
IMCI	Integrated Management of Childhood Illness
IYCF	infant and young child feeding
MSNP	Nepal's Multi-sector Nutrition Plan
NGO	nongovernmental organizations
PDQ	Partnership Defined Quality
PI	performance improvement
QI	quality improvement
RH	reproductive health
RING	Resiliency in Northern Ghana project
USAID	United States Agency for International Development

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INTRODUCTION

Nearly half of all deaths in children under five are attributable to undernutrition. Three million lives are lost each year to it (UNICEF 2016). Undernutrition not only increases the frequency and severity of common infections and the risk of dying from them, but it also has long-term consequences on growth and development and is associated with impaired cognitive ability, reduced school and work performance, and increased risk of noncommunicable diseases later in life. In response, in its recent Global Nutrition Coordination Plan 2016–2021, the US Government (USG) committed to "improving nutrition throughout the world in order to enhance health, productivity, and human potential" through a coordinated multi-agency response (USAID 2016). The Multi-Sectoral Nutrition Strategy 2014–2025 of the United States Agency for International Development (USAID) recognizes the need for increasing the equitable provision and utilization of high-quality nutrition-specific and nutrition-sensitive interventions.

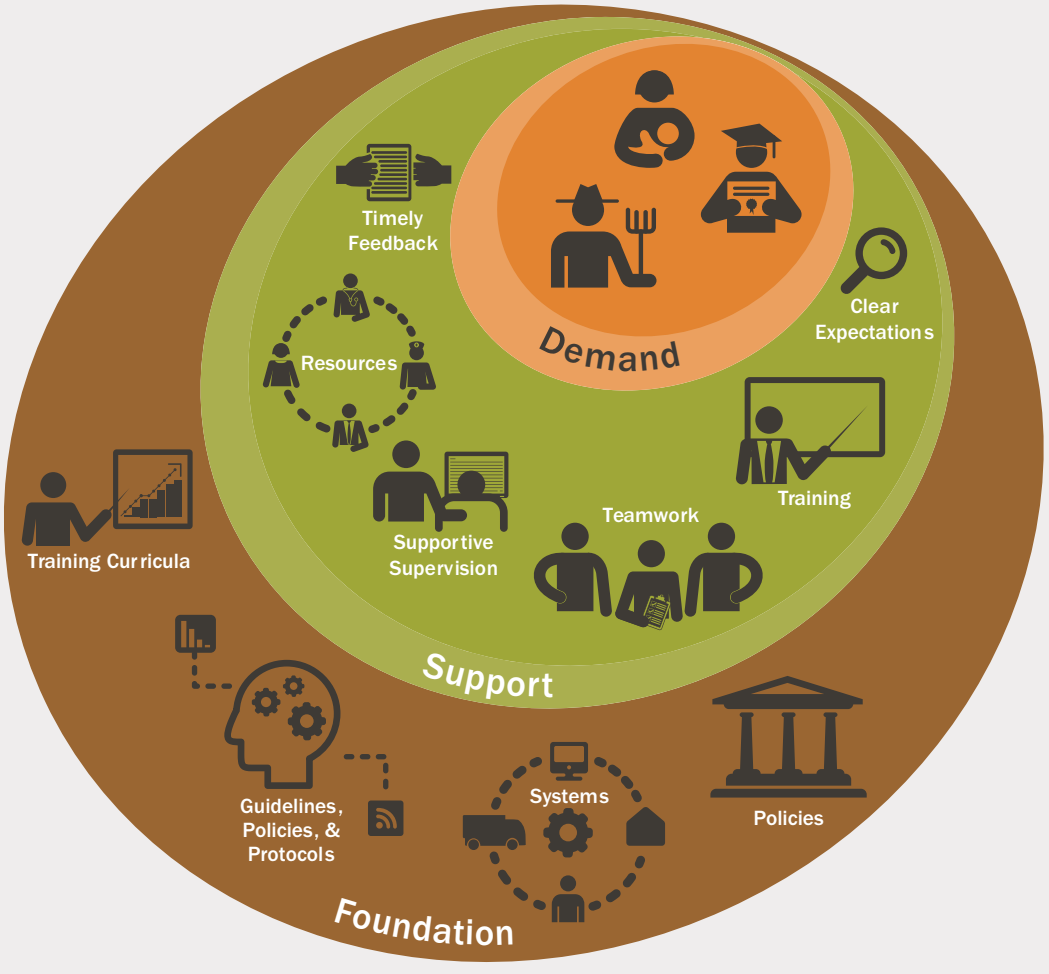
To achieve this commitment, **evidence-based, cost-effective interventions need to be scaled up.** Many of those interventions will require the services of a range of providers, including community volunteers, health workers, teachers, agricultural extension workers, and other community actors. Services may include nutrition-specific actions, such as nutrition assessment, counseling, and care, as well as more nutrition-sensitive approaches, such as supporting livelihoods; promoting nutrition-sensitive agricultural practices; teaching families about homestead gardening and food preparation; and providing training on the use of safe water, sanitation, and hygiene.

High-quality service delivery depends on the actions and behaviors of service providers. **A systematic and sustainable change process** and three complementary components are required to bring about meaningful change

in the behavior of service providers and, by extension, the nutrition services they provide (see figure 1):

- **A strong foundation** facilitates the provision of nutrition services. Often referred to as an "enabling environment," this foundation

Figure 1. Framework for Improving the Nutritional Status and Quality of Nutrition Services



consists of policies, protocols, guidelines, curricula, and systems—information, supervision and human resource—that integrate and address nutrition.

- **Support** for nutrition service providers at all levels and from multiple sectors is critical, including training, coaching, supervision, equipment, and supplies. Support must be provided in such a way that it is sustainable—ideally through existing government systems—as well as scalable.

- There must be a **demand** for quality services by men, women, and children who are educated and motivated to improve their nutritional status, use nutrition services, and engage with service providers to ensure that services meet their needs.

There are many approaches to building a strong foundation, supporting service providers, and creating demand for their services. Much has already been written about these approaches in terms of how they have been employed in the health sector, but less has been written about strengthening the quality of nutrition services and doing so within the context of other sectors. In this guide, we draw on the previous literature to propose a pathway for applying quality improvement (QI) approaches to the delivery of nutrition services. We strongly believe in the importance of integrating nutrition into existing systems rather than creating parallel and often unsustainable interventions as well as in addressing—or at least considering—the components of foundation, support, and demand. However, we also believe that there is more than one way to make this work. Countries, districts, and communities differ, and approaches must therefore adapt to meet their diverse needs.

This guide is written for government staff, USAID missions, and implementing partners interested in improving the quality of nutrition-

related services delivered at various levels and by a range of sectors. Country examples, links to relevant resources, and lessons learned regarding systematic and sustainable change processes are provided throughout the brief, which concludes with a presentation of key recommendations.

BUILDING A FOUNDATION

OVERVIEW

A strong foundation includes actionable policies that reflect best practices and a country's health and education goals. SPRING conducted a review of existing policies and strategies in the 33 countries prioritized by USAID for ending preventable maternal and child deaths and by the US government's Feed the Future initiative. We found that 30 of these countries have some form of **national nutrition plan or policy** (see appendix 1).

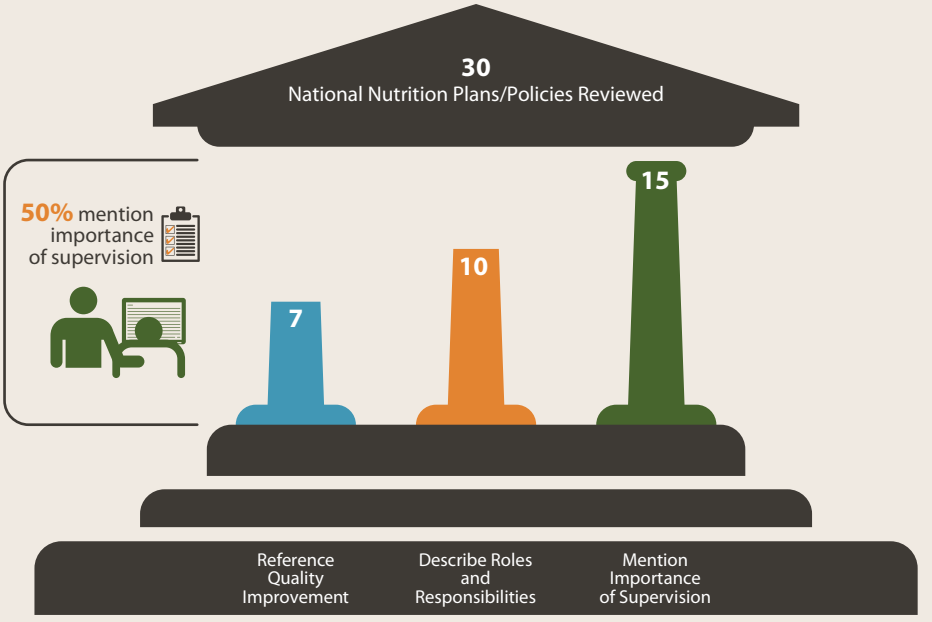
Having such a plan or policy, however, does not mean that it adequately or appropriately addresses the issue or that it effectively engages all relevant sectors. A recently proposed USAID indicator seeks to measure countries with a national nutrition plan or policy that has been officially endorsed by the government, generally recognized and/or signed by the ministry of health and the ministry of agriculture (as well as other relevant ministries and offices), and includes a minimum set of interventions.[1] Indeed, governments must define a nutrition *standard of care* within their national nutrition plans and policies; identify nutrition service providers—agriculture and food security extension workers, teachers, and health workers at all levels; and establish plans for supporting providers.

1 Indicator description available at: https://www.spring-nutrition.org/sites/default/files/events/06_abbott_thurber_nutrition_indicators_west_africa_msn_glee_draft_1_20_no_notes_.pdf

Photo credit: Lauren Crigler

Governments must strengthen **systems** to implement, communicate, monitor, and evaluate nutrition services. Indeed, a review of the early Integrated Management of Childhood Illness (IMCI) experiences in five countries, noted that "the full weight of health system limitations on IMCI implementation was not appreciated at the outset, and only now is it clear that solutions to larger problems in political commitment, human resources, financing, integrated or at least coordinated programme management, and effective decentralization are essential underpinnings of successful efforts to reduce child mortality" (Bryce et al. 2005). Situation analyses conducted by Alive & Thrive in Bangladesh, Ethiopia, and Vietnam showed that full implementation of policy mandates for the support and promotion of universal access to breastfeeding and complementary feeding was lagging (Sanghvi et al. 2013). The authors explain, "to enact the policies required extensive advocacy, evidence, dialogue, partnership formation, and capacity-building across varied programs and institutions. Once this was in place, scaling up the main components of service delivery required

Figure 2. Review of National Nutrition Plans



leadership, financing, logistics and supplies, and partnerships" (2013). Unfortunately, systems are often underfinanced, weak, top-down, and vertical, which creates an obvious disconnect for services such as nutrition, which crosses both vertical and horizontal boundaries of care.

Strengthening systems to support nutrition-related services means integrating nutrition into existing platforms or developing new **protocols, guidelines, curricula, training materials, and job aids** to enable the scaling up of equitable nutrition services. Of the 30 national nutrition plans and policies reviewed, 26 mentioned capacity building or training of service providers (see figure 2). The importance of better preparing workers to deliver nutrition-related services is echoed throughout international public health literature and program documents. Abosede and McGuire

(1991), in reviewing for the World Bank several successful and innovative approaches to addressing nutrition problems in Africa, found a "need for training in nutrition at all levels from physicians down to village health workers." Unfortunately, nutrition has been largely neglected in the training of health service providers and most certainly in pre-service training of nutrition-sensitive sectors, such as education and agriculture. And only 15 of the 30 national nutrition plans/policies that we reviewed mentioned the importance of supervision (sometimes referred to as "supportive supervision"); 10 described roles, responsibilities, and/or job descriptions of various cadres of service providers; and only seven made a reference to "quality improvement."[2] The review found only seven national strategies and/or guidelines for supervision and QI.[3] All but one of these touched on nutrition in some way.

EXAMPLES FROM THE FIELD

Nepal

Nepal's ***Multi-sector Nutrition Plan***[4] (MSNP) prioritizes routine and joint sector monitoring of implementation, including a joint supervision mechanism with key sectors represented to conduct regular supervision, provide regular feedback to concerned ministries or bodies, and develop a reward system based on sector performance. The first task of the plan is "to conduct an assessment of the nutrition training needed by the various professionals that implement the MSNP, including frontline workers, district level managers and specialists at the central level" (Government of Nepal 2012). Other national nutrition action

2 See the following section on "support" for further explanation of this approach.

3 This includes provincial-level guidelines for the government of Sindh in Pakistan, where government is highly decentralized.

4 http://scalingupnutrition.org/wp-content/uploads/2013/03/Nepal_MSNP_2013-2017.pdf

plans and policies can be found on the Scaling Up Nutrition[5] (SUN) Movement's website. In addition, the MSNP emphasizes the importance of clearly defined roles and responsibilities so that nutrition professionals can be held accountable for managing nutrition-related (nutrition-sensitive and nutrition-specific) activities, especially at the district and local level.

Ghana

In 2013, Ghana finalized its ***National Nutrition Policy (2014–2017)***,[6] which laid out a number of important principles, including the recognition that "adequate nutrition is a universal human right," and that "nutrition issues are multidisciplinary in nature, and therefore will be best addressed through well-coordinated multi-sectoral approaches," using a decentralized approach. In an effort to bring about meaningful change in the quality of nutrition services, the USAID-funded **Resiliency in Northern Ghana**[7] (RING) project works through the government of Ghana to build resilient systems that are better prepared to identify and address nutrition and livelihood needs and to do so in a more inclusive manner. RING has done this by empowering and strengthening the capacity of Municipal or District Assemblies (the district-level local government structure) to fund nutrition activities, which has set the stage for joint planning, budgeting, and implementation of activities and has increased each sector's understanding of its role in improving nutrition. This has also enabled district-level Ghana Health Service staff (through logistical and technical support) to conduct routine supportive supervision of both health workers

5 http://scalingupnutrition.org/sun-countries/about-sun-countries/

6 https://extranet.who.int/nutrition/gina/sites/default/files/GHA 2013 National Nutrition Policy.pdf

7 http://www.globalcommunities.org/ghana

Photo credit: Lauren Crigler

responsible for providing nutrition services at the health facility level and community health volunteers at the community level.

Uganda

At the request of Uganda's Ministry of Health, SPRING and the German Foundation for World Population organized a multi-sectoral **nutrition budget analysis training**.[8] The purpose of the workshop was to strengthen capacity for nutrition budget planning and analysis among those identified in the Uganda Nutrition Action Plan as being responsible for its implementation. At the

8 https://www.spring-nutrition.org/about-us/news/spring-co-hosts-training-workshop-strengthen-budget-planning-and-analysis

end of the three-day training workshop, representatives from the key government ministries of trade, agriculture, health, education, finance, and gender called for increased nutrition funding at the national, district, and community levels.

Ethiopia

Ethiopia's Health Extension Program was designed to improve access to and utilization of quality preventive, promotive, and curative health care services that were provided by more than 30,000 frontline community health workers (CHW). The USAID-funded Integrated Family Health Project worked with the Ministry of Health to roll out an **integrated supportive supervision**[9] approach covering the health workers' delivery of nutrition services, among other services.

LESSONS LEARNED

Every country will need to develop its own approach for building or providing the necessary foundation for the delivery of nutrition services. However, some characteristics have emerged from our research that facilitate the delivery of high-quality quality nutrition services across the reviewed countries.

- A comprehensive nutrition policy provides a framework around which different sectors can coordinate and plan nutrition programming. To best support quality service delivery, these nutrition plans should—

be officially endorsed by the government

9 http://www.ethiopianreview.com/pdf/001/Supervision%20Guideline.PDF

be recognized and/or endorsed by the health, agriculture, and other relevant ministries and offices

recognize frontline workers from multiple sectors and outline how they will be supported in the delivery of nutrition-related services

clearly identify basic standards of care for nutrition services.

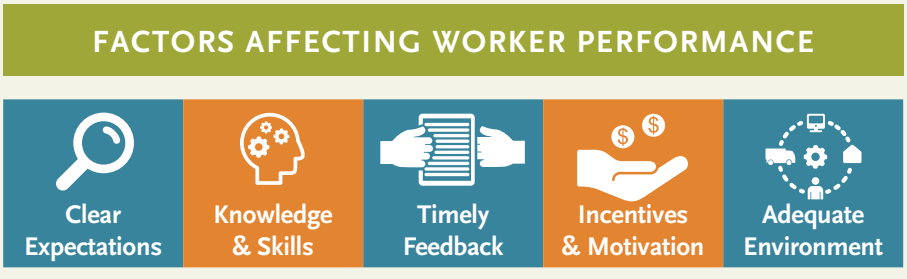
- National indicators, information systems, guidelines, protocols, job descriptions, training curricula, and supervision tools that address the delivery of nutrition services.

PROVIDING SUPPORT

OVERVIEW

The essential role of any organization, ministry, or system, as previously described, is to provide a vision of quality nutrition services and a clear managerial structure with roles, responsibilities, and specific expected

Figure 3. Factors Affecting Performance of Providers of Nutrition-related Services



results. Policies, systems, protocols, guidelines, and training curricula help to communicate and carry out this vision through its workers. In addition, workers require organizational support in order to perform well and achieve the desired results. As illustrated in figure 2, effective support will need to address a number of factors that affect performance by providing clear performance expectations; preparatory and ongoing training to build knowledge and skills; timely feedback on performance; remuneration and incentives to increase motivation; and an adequate environment, including information, tools, and supplies (Menon et al. 2014).

Addressing all areas of worker performance can be difficult and costly, particularly in countries with limited resources. As a result, often only one or two performance factors are prioritized—typically, the provision of training to build **knowledge and skills,** which is popular and can be provided as a discrete action. However, only providing training without addressing other performance factors is an ineffective use of resources (Crigler et al. 2006; Mucha and Tharaney 2013). This is especially true for nutrition services, which are provided by a wide range of actors—each with a unique role in the community and in the provision of those services.

In Cambodia, conventional classroom training to service providers had not worked well in settings with limited human resources. Training outside the workplace attracted only the chief of facilities who often was not the person who provided nutrition services. In response, USAID | Cambodia is now applying team-based on-site mentoring for all health facility staff.

—Sopheanarith Sek, USAID | Cambodia

While there is no silver bullet for supervision, some countries are changing their approach to rely less on distance supervisors who are rarely at the frontline and more on local resources—facility managers, community committees, community members, and peers to close some of the gaps.

Before training, **clear expectations** set out in detailed and meaningful job descriptions are needed. Research shows that health workers who have been given written job descriptions provide higher-quality care than those who have not. Job descriptions provide structure, guidance, accountability lines, minimum skills and qualifications standards, and performance benchmarks. If job descriptions do not exist or are too vague, workers can become frustrated when their roles overlap with others, are overburdened, or are just unclear as to how to do their jobs. Furthermore, since nutrition services can and should be provided by multiple sectors, it is important that they are harmonized—that teachers, agricultural extension workers, and community health workers all know, exactly what is expected of them, that they are supported in doing their work, and are clear on how they should interact with each other. Unfortunately, many health workers in low-income countries do not have a job description or information on their expected roles and responsibilities; and it is likely that even fewer have such information about the nutrition services they are expected to provide. According to data from Service Provision Assessments, only 57 percent of health workers in Namibia and 38 percent in Kenya had job descriptions (Sheahan 2014).

Once frontline workers are clear on what their jobs are and how to do them, they will need **timely feedback** to reinforce what they know, to fill in gaps of what they do not know, and to correct mistakes. When successful,

supervisors can help improve the workers' understanding of expectations and reinforce their knowledge and skills. Ideally, supportive supervision is "a process of guiding, monitoring, and coaching workers to promote compliance with standards of practice and assure the delivery of quality care service" (Crigler et al. 2013). Lehmann and Sanders (2007) concluded from a review that they conducted that "the success of [community health worker] programs hinges on regular and reliable support and supervision."

In large-scale CHW programs, providing effective supervision is not easy and is expensive. If programs are not appropriately budgeted and planned, they will probably not be well implemented. Poor supervision has been shown to be as ineffective as no supervision. Studies in both Kenya and Benin showed that most health workers felt that supervision was an act of control and criticism and reported that it was infrequent, irregular, and

lacking in feedback (Mathauer and Imhoff 2006). A recent study from Zambia makes it clear that supervision is not always perceived as helpful by the workers. Following introduction of CHWs into Zambia's primary health care system, 78 percent of those interviewed reported regular (monthly) supervision, but 48 percent mentioned that supervision did not have any benefit to them. In this example, supervisors did not utilize a standardized method or checklist when conducting supervisory visits (Stekelenburg et al. 2003).

With the increased recognition that traditional training and supervision are difficult to implement effectively and therefore may have little impact on the quality of services delivered, countries are exploring alternatives. While there is no silver bullet for supervision, some countries are changing their approach to rely less on distance supervisors who are rarely at the frontline and more on local resources—facility managers, community committees, community members, and peers to close some of the gaps. For example,

Figure 4. Cooperative Support

managers can be trained to explain, demonstrate, coach, and mentor service providers on their roles and tasks according to guidelines and thereby clarify expectations to workers. Some approaches—such as listing tasks on walls and cross-training workers to perform various roles and tasks—are extremely effective in clarifying expectations and building team work, allowing workers to focus less on "my job" and more on "our job" in serving the community, their families, and their friends.

Team-based approaches, such as QI or performance improvement (PI) have also become important contributors (Winch et al. 2003; The ACQUIRE Project 2005). Typically, these approaches—

engage and empower teams of service providers and stakeholders to develop and test solutions

focus the needs of providers

analyze systems and processes through root cause analysis

use data to measure results

develop relationships with communities.

See *Capacity Assessment* in the Resources section.

Just as ministries perform the tasks that only they can perform—updating policies, protocols, guidelines, and curricula—so too can frontline workers and community members take on the role of supporting local services. While they may not be able to do all that supervisors do, they can help

identify problems related to the quality and coverage of nutrition services, conduct root cause analyses, design and implement solutions, and encourage and motivate colleagues to succeed. As illustrated in figure 3, organizational support can provide the elements that these teams cannot provide, and team engagement strategies can help provide the support that workers need on the ground. These team-based dynamic processes can encourage communities to take responsibility for their own nutritional needs and to seek out quality services.

EXAMPLES FROM THE FIELD

Bangladesh

In Bangladesh, counseling on infant and young child feeding (IYCF) is one of a number of nutrition interventions mainstreamed through health service delivery under the Ministry of Health and Family Welfare. IYCF counseling is supposed to be provided during antenatal and postnatal care visits at all levels, but implementation presents many challenges. In response, UNICEF and the government of Bangladesh, with support from the Children's Investment Fund Foundation and the Bill and Melinda Gates Foundation, are working to strengthen subnational human resource capacity of the competencies required to deliver quality nutrition services, particularly breastfeeding support and promotion at the facility level and in garment factories. Capacity strengthening of health staff at facilities focuses on specific skills and competencies required by service providers and their supervisors at each level of service provision. This **training** was designed to ensure that the service provider not only has the knowledge but develops the necessary skills required to perform their assigned tasks.

Ghana

In Ghana, SPRING introduced **quality improvement** as an approach to accelerate the improvement of health and nutrition services in health facilities. Teams of health providers are trained in QI, and these teams receive monthly coaching visits to help them identify gaps, generate and implement solutions, and monitor outcomes. QI teams also attend learning sessions to share experiences and exchange ideas. To ensure sustainability and encourage country ownership, SPRING conducts joint supportive supervision visits with the Ghana Health Service. Although the impact of this approach on maternal and child health outcomes has not yet been measured, the project has seen improvements in how child health cards have been completed. This has helped to improve targeted IYCF counseling conducted by health workers.

"In Rwanda, the government and donor agencies (particularly USAID and UNICEF) supported the rollout of national cascade training targeting health service providers and community health workers on maternal, infant, and young child nutrition to improve their knowledge and skills around nutrition. We have since realized that agriculture extension workers in agriculture and food security should be considered in the future. These folks meet mothers and fathers on a daily basis in various agriculture and food security value chains, and having some nutrition knowledge to share with beneficiaries will help us improve dietary diversity and address the challenge of lower minimum acceptable diet for children."

—Silver Karumba, USAID | Rwanda

Kyrgyz Republic

In the Kyrgyz Republic, SPRING trained health workers to counsel women on infant and young child feeding. Recognizing that training alone would not be enough, following these trainings, SPRING provided **nutrition-supportive supervision,** using checklists adapted from the *Supervision, Mentoring, and Monitoring module* (UNICEF 2013) of the generic *Community Infant and Young Child Feeding Counselling Package.*[10] Supportive supervision visits are conducted in collaboration with designated health managers or "kurators" to ensure the sustainability of the work; and efforts are underway to integrate the IYCF-supportive supervision process and tools into the country's existing systems for improving the quality of care.

Haiti

In Haiti, SPRING worked closely with the *Ministère de la Santé Publique et de la Population* to develop tools to provide **technical support and supportive supervision** of nutrition services delivered at the health facility level, and advocated for greater focus on nutrition services by facility-based QI teams. See SPRING's *Data Collection and Quality Improvement Report.* [11]

LESSONS LEARNED

Many factors affect worker performance, and there are even more approaches to addressing issues. Each country will need to develop its own approach to supporting those who provide nutrition services, but our review of country experiences, tools, and research point to the following key characteristics:

10 https://www.unicef.org/nutrition/index_58362.html

11 https://www.spring-nutrition.org/publications/reports/data-collection-and-quality-improvement-report

Training must address the specific skill gaps of service providers and be seen as a continuous process requiring follow-up and evaluation and the engagement of actors from multiple sectors, as appropriate.

Supervision from a distance is costly, difficult to implement, and usually ineffective. Countries, sectors, and programs may therefore wish to consider local alternative approaches to distance supervision, such as group, peer, and community supervision.

Team-based QI and PI approaches require the empowerment and active engagement of service providers and community members.

INCREASING DEMAND

OVERVIEW

The nutrition services discussed in this guide aim to reach individual men, women, and children in order to improve their health, growth, development, and well-being. If these individuals do not see the value of good nutrition and the services offered, then uptake of services will remain low. Without demand for services, good policies and programs are meaningless.

Community leaders and frontline workers can play a critical role in increasing demand and making the link between demand and the services provided. Indeed, during the past decade there has been an increase in interest in health system reform that is demand-driven and accountable to clients (World Bank 2003). However, this approach is not new: in 1978, the Alma-Ata Declaration promoted the engagement of communities in the process of taking responsibility for their health and addressing the environmental, social, and cultural factors that produce ill health, including

inequality and deep poverty (WHO 1978). Lessons learned over the past several decades of implementing programs with this foundational concept include a global lack of funding for programs, an overall insufficiency in training and incentives for CHWs, poor supervision, and a lack of supplies for workers (Berman et al. 1987).

Fortunately, there are an increasing number of methods and tools to engage communities in problem solving. Below are several examples of methodologies that can be employed to encourage participation in setting nutritional goals, addressing behavioral and cultural barriers, and empowering communities to help themselves by engaging in the services they need.

An important step in increasing the engagement of community members is to gather community-based data and facilitate the use of such data by and for community members themselves. A great deal of information is gathered at the community level, but often it is not effectively used—in some cases, it is not used at all—due to inadequate feedback mechanisms or onerous data collection and reporting systems. However, with the right information and with strong accountability systems in place, a community can take ownership of its path to improving its nutrition status. Where the community is consulted effectively, people show enthusiasm and keenness to take up their new roles.

Frontline workers can learn a lot about the communities they serve by engaging them in the process of improving nutritional practices. Frontline

An important step in increasing the engagement of community members is to gather community-based data and facilitate the use of such data by and for community members themselves.

workers can work with community leaders and existing community organizations to jointly develop goals and increase accountability. In many developing countries, establishing regular communication mechanisms, defining specific roles for community members and frontline workers across sectors, and using training materials to reorient workers from their original training to deliver a package or a message to a participatory approach are underway (FAO 1997).

EXAMPLES FROM THE FIELD

Bangladesh

In Bangladesh, in addition to training and conducting supportive supervision visits to health facilities with the Ministry of Health and Family Welfare supervisory level staff, SPRING has been building demand at the community level through the nomination of community nutrition champions.[12] One champion is nominated by each cohort of women trained by a farmer nutrition school in Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA). These volunteers are asked to keep the motivation around ENA/EHA alive and strong, to help women in their communities remember the key actions and behaviors for nutrition—especially new pregnant mothers—and to help link community members with extension services. To date, 6,421 farmer nutrition schools have been established, and each has a community nutrition champion.

Malawi

In Malawi, a community-led quality improvement approach [13] to improving early childhood development and nutrition led to an increase of 90.2 percent in the number of children aged 3–6 years

12 https://www.spring-nutrition.org/countries/bangladesh

13 http://www.urc-chs.com/sites/default/files/Malawi_ImprovingECDandnutritioninBlantyredistrict_June2013_0.pdf

old attending community-based childcare centers in a community in the Blantyre District of Malawi. As a result, the community identified 217 malnourished children and, by working with existing government structures and community and local support agencies, managed to improve the nutritional status of 178 of those children (82 percent) (Moyo 2012).

Zambia

The Citizen Voice and Action[14] approach (World Vision International 2012) builds social accountability, which is increasingly invoked by global health policymakers and programmers as a way to improve health care responsiveness and quality. The approach involves: (1) citizen mobilization and civic education; (2) participatory performance monitoring and the development of corresponding action plans; and (3) improving services and influencing policy. A qualitative evaluation of the World Vision approach in three rural districts in Zambia found that the Citizen Voice and Action approach substantially improved knowledge of health policies among citizens as well as their competence and willingness to advocate for these entitlements.

Ethiopia

In Ethiopia, the Community Health Worker Improvement Collaborative,[15] supported by the project, introduced a strengthening approach for their community health system to "improve the competence and performance of CHWs; strengthen the linkage between the community and the health system; and improve the capacity of community groups to take ownership

14 http://www.wvi.org/article/citizen-voice-and-action

15 http://www.urc-chs.com/sites/default/files/CommunityHealthSystems_Oct11.pdf.

of health programs in their catchment areas and establish an effective community health system" (Shrestha 2012).

Nepal

In Nepal, female community health volunteers were engaged in promoting and distributing vitamin A supplements. Support from family members, community groups, local leaders, and schools was a main contributor to the volunteers being able to reach over 90 percent of the children in their communities with vitamin A capsules. Recognizing the way that people in rural villages seek help, support one another, share information, and address issues, the informal community systems[16] were leveraged to support the female community health volunteers; they provided channels to reach all households with health information. Village committees provided operational management to the community systems. Program staff met with community members and village committees, which served to mobilize them and fostered their sense of ownership of the vitamin A program. This supportive environment made the female community health volunteers feel respected and special in the community, motivating them to continue with their work. Through the village committees, the volunteers also shared health information with representatives of various community groups, who then shared it with other group members and with members of their households. Similarly, household members and group members gathered information and brought it back to the village committee, to the health volunteers, and to the health facility.

16 https://www.usaidassist.org/blog/interview-dr-ram-shresthasupporting-community-health-workers-where-do-we-stand

Photo credit: Sascha Lamstein, SPRING

Vietnam

In Vietnam, World Vision International (WVI) has worked in partnership with local- and district-level health and agriculture staff, local authorities and schools, the National Institute of Nutrition, and the ministries of health and agriculture to implement an integrated, community-led approach to behavior change. Through the establishment of and support to "nutrition clubs,"[17] World Vision and its partners have sought to improve the quality of nutrition services provided by various sectors and create demand for those services among community members, especially families with children under the age of five. While building the capacity of service providers and strengthening government-led supportive

17 http://wvi.org/nutrition/nutrition-clubs-vietnam

supervision, World Vision has also established 895 multi-sectoral nutrition clubs. The clubs, consisting of approximately 40 families each, meet twice a month. The meetings are facilitated by CHWs or other community members and involve participatory communication (e.g., games, quizzes, meal preparation, and competitions) on topics such as child care, hygiene, nutrition, agriculture, and health. Growth is also monitored during meetings, and follow-up care is provided to households with malnourished children. With a relatively minimal cost per established (US$350) and maintained (US$935) nutrition club, World Vision has noted an impressive increase in the uptake of maternal and child health care services, exclusive breastfeeding rates have increased, and malnutrition rates have steadily declined.

Nigeria

In Kano, Nigeria, the United Nations' Food and Agriculture Organization (FAO) used a participatory approach[18] toward decreasing malnutrition, engaging communities and frontline providers in establishing goals and responsibilities. Results showed that by using this approach, communities felt more engaged in the process, and frontline workers were retrained to listen to community members rather than approach them from the top down and simply "deliver services" to them.

Philippines

In the Philippines, Save the Children used the Partnership Defined Quality[19] (PDQ) approach along with the Appreciative Community Mobilization (ACM) approach as well as behavior

18 http://www.fao.org/docrep/X0051T/X0051t06.htm

19 http://www.coregroup.org/storage/documents/Workingpapers/PDQ_Philipines_2008a.pdf

change communication to increase demand for health and nutrition services and the practice of healthy behaviors among children under 5 and pregnant and lactating women. Through PDQ, all members of the partnership come to understand their responsibilities. In this way, PDQ is useful for promoting coordinated collaborative efforts (Save the Children/CORE Group 2008).

LESSONS LEARNED

Once again, each country will need to develop its own approach for building demand for nutrition services and, simultaneously, ensure that services address demand. Each country, district, or community will need to identify and make use of existing platforms for the promotion and delivery of nutrition-related services. In addition, our work suggests the following:

Community engagement and involvement remains a core element to increasing demand and encouraging community commitment to better health.

It is essential that services focus on the needs of the clients. Frontline workers need to be engaged in and trained to use participatory approaches.

The use of data at the community level can increase demand for nutritional knowledge, services, and products.

Volunteers require at least as much support as paid agricultural extension workers, teachers, and health service providers. Support to community leaders and volunteer community workers should be prioritized.

Photo credit: Sascha Lamstein, SPRING

CONCLUSIONS AND RECOMMENDATIONS

To sustain and scale up quality nutrition services, countries will need a strong foundation, support for the workers who are expected to deliver nutrition-related services, and increased demand from communities and individuals for those services. Throughout this, brief we have shared country examples and provided guidance for addressing each of these components. In summary, our priority recommendations to countries and programs for raising the status and quality of nutrition services are as follows:

Assess the landscape and determine what frontline workers currently do to promote maternal, infant, and young child nutrition—directly or indirectly—and how prepared and able they are to perform expected tasks (in terms of training, tools, and supplies).

The delivery of nutrition services is often overlooked by training institutions, managers, and service providers and in training curricula, job descriptions, and job aids. To improve this, we must understand the baseline. Only after the landscape of nutrition-related services is understood can the steps described throughout this guide be prioritized, adapted, and implemented to build demand, support the services, and strengthen the foundation for the multi-sectoral delivery of pro-nutrition services. [20]

Emphasize the delivery and coordination of nutrition services at the foundation in new multi-sectoral nutrition policies and plans.

20 See Resources, Capacity Assessment

Nutrition as a service area often gets lost between ministries, or ministries do not consider it critical. Policymakers can and must integrate and emphasize nutrition within multiple sectors through policies and funding allocations. This will require country ownership, including the political commitment and engagement of multiple sectors and levels of government, adequate funding, and a "nutrition champion" to promote the at-scale delivery of quality nutrition services through government systems. Ministries must coordinate the delivery of nutrition services to harmonize actions and messages, ensure complementarity, and avoid duplication of efforts. See SPRING's brief, *Toward Shared Goals: Building Multi-Sectoral Coordination for Nutrition.* [21]

Integrate nutrition into existing systems and programs, protocols, guidelines, curricula, supervision, monitoring, and service delivery from the outset.

Rather than creating parallel systems to conduct distinct trainings, supervision visits, and coaching sessions, stakeholders should integrate nutrition into those that exist. Indicators and quality standards for nutrition must be developed, monitored, and used for decision making. This will further encourage shared ownership and responsibility for nutrition.

Develop clear and rational role descriptions for frontline workers, including nutritional tasks to be performed. Communicate these expectations in a written job description.

In order to do this, country stakeholders, managers, and service providers will need to assess and harmonize or rationalize roles and responsbilities for nutrition across sectors.

21 https://www.spring-nutrition.org/publications/series/pathways-better-nutrition-country-case-studies

Explore alternatives to standard training and supervision.

Training, incentives, and supervision systems are important, yet they face serious challenges. While improving these systems by using the tools, research, and techniques already internationally available, ministries should focus on team-based approaches that build the capacity of service providers and managers to identify and solve key problems related to quality and performance. [22]

Engage communities from the start to determine community needs and build demand for nutrition outcomes.

Communities should be viewed as active participants in improving nutrition programs. Engaged communities can be powerful forces when they are adequately involved and prepared. Without community demand, an acceptance of the services offered at health centers, and a willingness to interact with frontline providers, nutrition behaviors are unlikely to change.[23]

Share and learn from successful and unsuccessful experiences.

Finding examples of projects, programs, and countries that were strengthening nutrition-related services was not easy. Either they do not exist or they are not made publically available. Countries, donors, researchers, programs, and projects must make an effort to share our successes and failures with one another toward the greater good of improving the nutritional status of children, women, and men around the globe.

22 See Resources, Coaching

23 See Resources, Community Engagement

RESOURCES

The following resources were collected and reviewed for the development of this guide. Many are also referenced in the brief. Governments and implementing partners can consult these as examples and resources to follow the proposed guidance and recommendations.

CAPACITY ASSESSMENT

Cause-and-Effect Analysis.

USAID ASSIST Project. 2014.
https://www.usaidassist.org/resources/cause-and-effect-analysis

This brief summary describes a participatory approach and several tools for exploring possible causes and effects for the identified problem. These include the Fishbone Diagram, Tree Diagram, and the Five Why's.

Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services.

Crigler, Lauren, Kathleen Hill, Rebecca Furth, and Donna Bjerregaard. 2011. Bethesda, MD: USAID Health Care Improvement Project, University Research Co. (URC).
http://www.who.int/workforcealliance/knowledge/toolkit/54/en/

The Community Health Worker Assessment and Improvement Matrix (CHW AIM) tool can be used to assess and improve community health worker program functionality, engagement, and performance.

Guide to Optimizing Performance and Quality: Stages, Steps, and Tools.

Murphy, C., and B. Sebikali. 2014. IntraHealth International, Chapel Hill.
https://www.intrahealth.org/opq/wp-content/uploads/2014/06/OPQ_Guide_Final_June-2014.pdf

This guide does not address nutrition service delivery directly, but the stages, steps, and tools could be adapted to do so. The tools have been widely used for stakeholder-driven problem solving and capacity building. Optimizing Performance and Quality (OPQ) is IntraHealth's signature approach for problem-solving and capacity building. It is a stakeholder-driven, cyclical process for analyzing human and organizational performance and for setting up interventions to improve performance and quality or building on strengths and successes.

Health Workforce Productivity Analysis and Improvement Toolkit.

CapacityPlus Project. 2015.
https://www.capacityplus.org/productivity-analysis-improvement-toolkit/

While they do not address nutrition services directly, this approach and its tools could be adapted to serve that purpose. The toolkit was designed to measure the productivity of facility-based health workers, to understand the underlying causes for productivity problems, and to identify potential interventions to address the problems and improve health service delivery. It was intended for use by a variety of national stakeholders assisting facility-level health workers to improve their productivity and contribute to the meeting of health program goals. The toolkit's methods can be integrated into routine supervision in order to support health workers in improving their productivity. Local supervisors can be instrumental in helping to understand some of the underlying causes of productivity challenges and in monitoring productivity and progress on the implementation of productivity improvement interventions.

How to Conduct a Root Cause Analysis.

Health COMpas. nd. USAID Health Communication Capacity Collaborative (HC3) Project. http://www.thehealthcompass.org/how-to-guides/how-conduct-root-cause-analysis

This "how-to" guide introduces root cause analysis for social and behavior change communication (SBCC) to examine differences between what is

desired and what is happening now (current situation). It includes links to several other resources and templates for conducting a root cause analysis, including an example exploring the causes of malnutrition among children under five.

Nutrition Workforce Mapping Toolkit.

SPRING. 2014. Arlington, VA: USAID/Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project. https://www.spring-nutrition.org/publications/tools/nutrition-workforce-mapping-toolkit

This tool can be used to assess nutrition services delivered by the health system as determined by job descriptions, training materials, and the recall of health workers at various levels.

COACHING

Coaching as a Tool to Support Quality Improvement Teams.

Integrated Family Health Program—Projet Intégré de Santé Familiale (PISAF) 2011. University Research Company, Inc. (URC). https://www.usaidassist.org/sites/assist/files/pisafcoachingmanual_english_2011_final.pdf

This tool describes the role of the coach, the installation and supervision of coaches, and the process of sustaining a culture of quality.

Health Facility Coaching Guides.

USAID Applying Science to Strengthen and Improve Systems (ASSIST). 2013. Partnership for HIV Free Survival (PHFS): https://www.usaidassist.org/resources/phfs-coaching-guides

Developed by USAID ASSIST Uganda staff, these guides help coaches from the Ministry of Health and implementing partners to support quality improvement teams at health facilities to achieve four essential steps of postnatal mother-infant care that results in excellent nutritional and human immunodeficiency

virus (HIV) care for both HIV-exposed and non-exposed infants over the first 24 months of life.

COMMUNITY ENGAGEMENT

Citizen Voice and Action: Civic Demand for Better Health and Education Services.

World Vision International. 2012. Monrovia, CA: World Vision International.
https://docs.google.com/file/d/0B01TNkdJ61czcVhlUUt1dzN0ODg/edit

Citizen Voice and Action is a social accountability approach that can be used in schools and health facilities, with local water authorities, or with agricultural extension services. It promotes engagement between citizens and government through a combination of civic education, a community score card of local services, monitoring of government standards, meetings that bring together all stakeholders, and community-driven advocacy.

Partnership Defined Quality: A Tool Book for Community and Health Provider Collaboration for Quality Improvement.

Lovich, Ronnie, Marcie Rubardt, Debbie Fagan, and Mary Beth Powers. 2003. Save the Children.
http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/PDQ-Manual-Updated-Nigeria.pdf

This guide provides an overview of partnership-defined quality and outlines phase-by-phase guidance for implementers—from design and planning to evaluation of process and outcomes.

The Role of Social Accountability in Improving Health Outcomes: Overview and Analysis of Selected International NGO Experiences to Advance the Field.

Hoffmann, K. D. 2014. Washington, DC: CORE Group.
http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf

The Community Score Card is a process for engaging community members in service delivery. It can "increase participation, accountability and transparency between service users, providers and decision makers." Health centers and community groups alike can use score cards to identify gaps and improve services. Unfortunately, we were unable to find any examples of this approach being used to improve the quality of nutrition services, but it could easily be adapted and applied to "score" nutrition services and outcomes.

COMPETENCY-BASED TRAINING

Effective Teaching: A Guide for Educating Healthcare Providers.

World Health Organization and Jhpiego. 2005.
http://www.jhpiego.org/en/node/387

This reference manual contains 12 modules on topics such as facilitating group learning, managing clinical practice, and preparing and using knowledge and skills assessments.

Learning for Performance: A Guide and Toolkit for Health Worker Training and Education Programs.

IntraHealth 2007.
http://www.intrahealth.org/page/learning-for-performance

This toolkit provides a systematic process that helps connect learning to specific job responsibilities and competencies. It includes guidance on learning goals and objectives and specific activities for meeting those objectives and evaluating the effectiveness of specific training efforts.

TEAM-BASED APPROACHES

Data Collection and Quality Improvement Report.

SPRING. 2015. Arlington, VA: Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project.
https://www.spring-nutrition.org/publications/reports/data-collection-and-quality-improvement-report

This report, written for USAID/Haiti and various implementing partners, describes the monitoring and quality improvement activities that have been conducted by SPRING over the last several years. It includes tools used and developed by the project in collaboration with the ministry of health: the Ministère de la Santé Publique et de la Population (MSPP).

Guidance for Program Staff: Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services.

The ACQUIRE Project. 2005. New York: The ACQUIRE Project/Engender Health.
http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Guidelines_pi_qi_pla_06-16-05.pdf

This document was developed with a focus on reproductive health to help staff of the ACQUIRE Project blend PI, QI, and participatory learning and action approaches to "catalyze and reinforce improvements in provider performance and service quality, while simultaneously improving clients' and communities' knowledge and awareness of [reproductive health] services." The ultimate goal of this approach is to "better meet clients' needs and achieve the ultimate results of increased access and use of reproductive health (RH) and family planning (FP) services."

Partnership Defined Quality: A Tool Book for Community and Health Provider Collaboration for Quality Improvement.

Lovich, Ronnie, Marcie Rubardt, Debbie Fagan, and Mary Beth Powers. 2003. Save the Children.
http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/PDQ-Manual-Updated-Nigeria.pdf

This guide provides an overview of partnership-defined quality and outlines phase-by-phase guidance for implementers—from design and planning to evaluation of process and outcomes.

Performance Improvement Stages, Steps and Tools.

IntraHealth. 2002.

http://www.intrahealth.org/sst/

This online toolkit provides information on performance improvement with tools that can be used for every stage of the performance improvement process—from performance assessment to monitoring and evaluation.

Quality Improvement and Verification Checklists: Online Training Module, Training Files, Slides, QIVCs, etc.

Davis, Thomas. 2012.

http://www.fsnnetwork.org/quality-improvement-verification-checklists-online-training-module-training-files-slides-qivcs-etc

This online resource provides training modules, verification checklists, and other resources for quality improvement that can be used to track and enhance health worker performance and motivation.

Quality Improvement Technical Reference Materials

K4Heath. https://www.k4health.org/toolkits/qa-trm

These technical reference materials, produced by the United States Agency for International Development, Bureau for Global Health, Office of Health, Infectious Diseases, and Nutrition (USAID/GH/HIDN), include "guides to help program planners and implementers consider the many elements in a particular technical area of the Child Survival and Health Grants Program (CSHGP). These guides are not an official policy for practice; rather, they are basic everyday summaries to be used as field reference documents." Many of the resources, while not specific to nutrition, could be adapted for that purpose. The materials include a summary of principles underlying the most successful efforts at improving the quality of services.

SUPPORTIVE SUPERVISION

Facilitative Supervision.

EngenderHealth.
https://www.engenderhealth.org/pubs/quality/facilitative-supervision.php

The EngenderHealth website includes a repository of technical publications and resources on facilitated supervision. Facilitative Supervision for Quality Improvement[24] is a 13-module curriculum that emphasizes collaboration and two-way communication between supervisors and supervisees.

Guidelines for Implementing Supportive Supervision: A Step-by-Step Guide with Tools to Support Immunization.

Children's Vaccine Program at PATH. 2003. Seattle, WA: PATH.
http://www.path.org/vaccineresources/files/Guidelines_for_Supportive_Supervision.pdf

This resource on adaptable supportive supervision provides guidelines, checklists, and tools for immunization programs in middle- and low-income countries.

Guidelines for Supportive Supervision in the Health Sector Volume 2: Management Standards and Supervision Tools.

Southern Nations Nationalities and Peoples Regional Health Bureau. 2008.
http://www.initiativesinc.com/resources/publications/docs/SSguidevol2_ISCLs_SNNPR.pdf

This resource provides management tools and integrated supervisory checklists for health staff at various levels, from the zonal health bureau to the health post.

24 http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Facilitative-Supervision/default.htm

"Module 4: Supportive Supervision." ***Training for Mid-Level Managers (MLM).***
World Health Organization. 2008.
http://www.who.int/immunization/documents/mlm/en/

This module is for training mid-level managers in maximizing the effectiveness of supportive supervision visits, covering topics such as supervisor training and joint problem solving.

Supervision and On-the-Job Training for Supply Chain Management at the Health Facility.
USAID|DELIVER PROJECT. Task Order 1. 2011. Arlington, VA: USAID, DELIVER project.
http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/OJT_SCMHealFaci.pdf

"This document provides basic guidance and tools for supervision of health facility staff and on-the job training for commodity management/logistics activities at the health facility level. The tools can be customized and tailored to specific program and country needs. Use of the tools will help the supervisor and facility staff to identify and address areas that need attention and subsequently improve staff and logistics system performance. These guidelines should be used along with any standard operating procedures (SOPs) that are already used at the country level. Finally, these guidelines are specific to commodity management and logistics; they can be combined with other available tools or resources that focus on other areas of health facility operations, such as client service, service provision, or management and administration."

"Supervision of Community Health Workers." ***Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide for Program Managers and Policy Makers.***
Crigler, Lauren, Jessica Gergen, and Henry Perry. 2013. Washington, DC: Maternal and Child Health Integrated Program (MCHIP).

http://www.mchip.net/sites/default/files/mchipfiles/CHW_ReferenceGuide_sm.pdf

This reference guide is for program managers and policymakers, particularly as they consider taking to scale programs that work with community-level workers. It offers "suggested issues and principles to consider and, when possible, brings in relevant program experience." It does not include tools for supervision.

Supportive Supervision/Mentoring and Monitoring for Community IYCF: The Community Infant and Young Child Feeding Counselling Package.
United Nations Children's Fund (UNICEF). 2013. New York: UNICEF.
http://www.unicef.org/nutrition/files/Supervision_mentoring_monitoring_module_Oct_2013(1).pdf

As part of the Community IYCF Counselling Package, UNICEF developed this training module, which provides detailed and adaptable instructions on how to conduct a one-day training session on supportive supervision and mentoring.

OTHER CROSS-CUTTING RESOURCES

CapacityPlus Knowledge Library.
http://www.capacityplus.org/about-us

This range of publications covers topics from gender discrimination in human resources development to assessing motivation among health workers. In particular, see: https://www.capacityplus.org/files/resources/compendium-education-training-tools.pdf.

Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide for Program Managers and Policy Makers.
Maternal and Child Health Integrated Program (MCHIP). 2013.
http://www.mchip.net/sites/default/files/mchipfiles/CHW_ReferenceGuide_sm.pdf

This resource for program managers and policymakers provides guidance on how to effectively scale up and maintain community health worker programs.

Human and Institutional Capacity Development Handbook: A USAID Model for Sustainable Performance Improvement.

USAID. 2011. https://usaidlearninglab.org/library/human-and-institutional-capacity-development

This handbook provides guidance to Missions in how to implement Human and Institutional Capacity Development (HICD) in development programs. While not specific to the delivery of nutrition services, as stated in this handbook, "HICD can be successfully applied to any type of organization including government organizations, non-profit organizations and professional associations. HICD will enable these organizations to responsibly meet the needs of their countries and their citizens."

Human Resources for Health.

http://www.hrhresourcecenter.org

This digital library is for developing and maintaining human resources in the global health care field. The site offers a free e-learning program to advance the capacity and skills of country-based users.

Initiatives Inc. CHW Central.

http://www.chwcentral.org/

CHW Central includes publications on various topics related to improving community health worker performance and motivation, including the crucial role of supportive supervision.

"Principles of Practice" Guiding Principles for Non-Governmental Organisations and Their Partners for Coordinated National Scale-Up of Community Health Worker Programmes.

Walker, P., S. Downey, L. Crigler, and K. LeBan. 2013. CHW. Washington, DC: CORE Group, World Vision International.
http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/CHW_Principles_of_Practice_Final.pdf

This document provides guiding principles for nongovernmental organizations (NGO) and their partners for the coordinated scaling up of community health worker programs at the national level. The Principles of Practice are "intended as a framework for advocacy, programming and partnership between implementing NGOs, government and donor agencies." They encourage NGOs to "work with existing health structures through strong, long-term partnerships in order to deliver consistently high standards of quality implementation, training and support."

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APPENDIX 1: COUNTRY POLICIES AND PROTOCOLS

					Elements Included in National Nutrition Policy/Plan				Quality Improvement (QI)/Supportive Supervision (SS) Policies and Protocols	
Country	SPRING Country	Priority Country—Maternal, Neonatal, and Child Health	Priority Country—Feed the Future	Has a National Nutrition Policy or Plan*	Supportive Supervision	Quality Improvement	Training or Capacity Building of Service Providers	Defining Role or Job Description of Service Providers	Has QI/SS Policy, Protocol, or Guideline	Nutrition Service Delivery
Afghanistan		✓		✓		✓	✓		✓	✓
Bangladesh	✓	✓	✓	✓						
Burkina Faso	✓			✓	✓		✓			
Cambodia		(other)	✓	✓		✓	✓		✓	✓
Democratic Republic of Congo (DRC)		✓		✓	✓	✓	✓			
Ethiopia		✓	✓	✓	✓		✓	✓	✓	✓
Ghana	✓	✓	✓	✓		✓	✓		✓	✓
Guatemala		(other)	✓	✓	✓	✓	✓			
Guinea	✓	(other)		✓			✓			
Haiti		✓	✓	✓	✓	✓				

					Elements Included in National Nutrition Policy/Plan				Quality Improvement (QI)/Supportive Supervision (SS) Policies and Protocols	
Country	SPRING Country	Priority Country—Maternal, Neonatal, and Child Health	Priority Country—Feed the Future	Has a National Nutrition Policy or Plan*	Supportive Supervision	Quality Improvement	Training or Capacity Building of Service Providers	Defining Role or Job Description of Service Providers	Has QI/SS Policy, Protocol, or Guideline	Nutrition Service Delivery
Honduras		(other)	✓							
India		✓		✓		✓	✓	✓		
Indonesia		✓		✓			✓	✓		
Kenya		✓	✓	✓	✓		✓	✓		
Kyrgyzstan	✓	(other)								
Liberia		✓	✓	✓	✓		✓	✓	✓	✓
Madagascar		✓		✓			✓	✓		
Malawi		✓	✓	✓	✓	✓	✓	✓		
Mali	✓	✓	✓	✓			✓			
Mozambique		✓	✓	✓	✓		✓			

					Elements Included in National Nutrition Policy/Plan				Quality Improvement (QI)/Supportive Supervision (SS) Policies and Protocols	
Country	SPRING Country	Priority Country—Maternal, Neonatal, and Child Health	Priority Country—Feed the Future	Has a National Nutrition Policy or Plan*	Supportive Supervision	Quality Improvement	Training or Capacity Building of Service Providers	Defining Role or Job Description of Service Providers	Has QI/SS Policy, Protocol, or Guideline	Nutrition Service Delivery
Nepal		✓	✓	✓	✓		✓	✓		
Niger	✓	(other)		✓	✓		✓			
Nigeria	✓	✓		✓	✓		✓	✓	✓	
Pakistan		✓		✓					✓	✓
Rwanda		✓	✓	✓	✓		✓	✓		
Senegal	✓	✓	✓	✓			✓			
Sierra Leone	✓	(other)		✓	✓		✓	✓		
Sudan		✓								
Tajikistan		(other)	✓	✓						
Tanzania		✓	✓	✓	✓		✓			

					Elements Included in National Nutrition Policy/Plan				Quality Improvement (QI)/Supportive Supervision (SS) Policies and Protocols	
Country	SPRING Country	Priority Country—Maternal, Neonatal, and Child Health	Priority Country—Feed the Future	Has a National Nutrition Policy or Plan*	Supportive Supervision	Quality Improvement	Training or Capacity Building of Service Providers	Defining Role or Job Description of Service Providers	Has QI/SS Policy, Protocol, or Guideline	Nutrition Service Delivery
Uganda	✓	✓	✓	✓			✓	✓		
Yemen		✓		✓			✓			
Zambia		✓	✓	✓	✓		✓			

* Although we are aware that Tajikistan has a Nutrition and Physical Activity Strategy, we were unable to find a copy of it for the production of this guide.

Photo credit: Lauren Crigler

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