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**International Nutrition Communication Service
(INCS)**

CONSULTANT REPORT

for

THAILAND

(January 5 - 22, 1983)

(Review and policy recommendation on overall strategy, training and communications components of the Nutrition/MCH Activities and Management Training under the Extended Rural Primary Health Care Expansion Project)

BY

Lukas Hendrata, M.D., Consultant

Through subcontract to
Manoff International Inc.
1789 Columbia Road
Washington, D.C. 20009 USA

Submitted by
Education Development Center
55 Chapel Street
Newton, MA 02160

To the United States Agency for International Development
Washington, D.C.

*This project has been conducted under Contract A.I.D./DSAN-C-0209,
Office of Nutrition, Development Support Bureau, Agency for International Development, Washington, D.C.*

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INTRODUCTION

INCS was honored to have been asked by the Ministry of Health and USAID to send a consultant to evaluate the nutrition/MCH activities and management training of the Thai Government's Extended Rural Primary Health Care Expansion Project. Thailand is a country where a great deal of excellent nutrition education work already has taken place, and where INCS can learn as much as it can contribute.

Lukas Hendrata, an Asian physician known for his nutrition education work on Indonesia's UPGK program, was selected by INCS for the Thailand assignment. Dr. Hendrata has devoted much of his time in Thailand to field visits of various Project sites. His recommendations reflect his experience with the use of growth monitoring as an educational tool, with the development of a well coordinated participatory training structure, and with the use of radio (and television) to transmit nutrition messages. Hopefully Dr. Hendrata's Report will provide decision-makers in Thailand with a useful insight into ways in which they can improve the nutrition education component of their rural primary health care program.

Ron Israel
Director, INCS

April, 1983

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ACKNOWLEDGMENTS

I would like to express my sincere gratitude to all those who took time from their busy schedules to provide me with guidance and information during my consultancy in Thailand. Special thanks to Dr. Puangtong Tantivongse, Director, Nutrition Division, Ministry of Public Health, who was so open and generous in giving me insights into the program.

Also to Dr. Chavalit Santikitrungrueng, Medical Officer, Nutrition Division, and Mr. Narintr Tima, Nutrition Project Specialist, USAID, for their tireless efforts to expose me to the program strategy through lively discussions and interesting field visits. My appreciation for the support given by Dr. David Oot, Director, Office for Population, Health and Nutrition, USAID, Thailand, who made the whole thing work, and finally to Ms. Kanda and Ms. Charunee for their kind help in the administrative work.

L. Hendrata, M.D.



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I. The Scope of the Assignment

As requested by Dr. David Oot, Director of the Office for Population, Health and Nutrition, USAID, Thailand, the consultant's assignment covers the following areas:

1. To review the overall strategy at the USAID-assisted "Nutrition/MCH Activities and Management Training under the Extended Rural Primary Health Care Expansion Project" and to provide policy recommendations.
2. To review the strategy and implementation of the training and communication components of the project and provide recommendations for further program development.

II. Overall Program Strategy and Management: Issues for Consideration

The decision of the Royal Thai Government to embark upon a large scale village level nutrition program covering a total of 5,000 villages reflects the strong commitment of the Government to address the nutrition problem. The transition from a pilot project to a national scale program always brings with it a new dimension of strategic and managerial problems.

The program's goal is to improve the nutrition status of the population under five years of age through a village-based intervention in the form of promotive educational activities and through curative treatment of the second and third degree malnourished children with the provision of a locally produced weaning food. While this strategy has a sound conceptual basis, there are some operational issues that could shift the delicate balance between the long-term promotive goal and the short-term curative objectives.

Specifically, the two main components of the program, the weighing program and the supplementary feeding program as it

is being implemented at present, tend to shift the balance toward the curative side. The weighing program is conducted on a quarterly basis with emphasis on surveillance: finding those children who are malnourished and providing them with supplementary food. This is probably the single most important issue on program strategy to be addressed by the national program leadership. Unless the weighing program is successfully transformed into a promotive educational activity, the total program outlook will be almost totally curative.

The role of the supplementary food in the total framework of the long-term behavior change objective of the program, which is the improvement of child feeding practices, needs further clarification. Is the supplementary food only a short-term solution to help the malnourished, or is it also to be institutionalized as the future weaning food for Thai children? A careful but clear choice has to be made, since each alternative has broad operational implications.

Establishing a nutrition fund at the village level is one of the most innovative activities of the program. Each project village will be given a start-up fund of 3,000 Baht (about US\$150.00) worth of materials and food stuffs to start producing the supplementary food. Community members are given the opportunity to buy shares to add to the starting capital, which then entitles them to the profit generated by the sales of the supplementary food (at 2 Baht per 100 gram package, or US\$.10). Through this scheme the third degree malnourished children will get the package free.

The economic feasibility of the scheme is being tested. It is true that similar schemes for the provision of simple drugs have been very successful. However, the two schemes have a completely different market structure. The drug scheme basically satisfies the existing demand of the community for drugs, and the market potential (those who can afford to buy) is high. With supplementary food the situation is quite different. Those who need it most are those who have low purchasing power and a low

level of understanding and appreciation of the benefits of the product.

Even if the marketing campaign for the product is successful in creating a demand, there is still a question of whether it could reach the poor, who need it most but cannot afford to buy it. The "free of charge" arrangement does not seem to be compatible with the business and entrepreneur spirit underlying an economically successful scheme.

The feasibility of the scheme will determine the long-term weaning food policy and strategy. If the scheme proves feasible, then it will answer the weaning food problem. However, if the fund cannot be sustained locally, it will need continuous financial input from the Government, which is unlikely to be forthcoming. In that case, a completely new strategy on weaning food that is affordable for the country will need to be developed.

Among the management issues, the question of integration is crucial. Nutrition is just one among the many programs implemented at the village level. Other programs include family planning, MCH, and PHC, and each is coordinated by different divisions in the Ministry.

A strengthening in the coordination mechanism among these programs is badly needed, since duplications of field activities often occur. The situation is especially serious at the village level, because all the programs are implemented through the existing Village Health Volunteers (VHVs) and Village Health Communicators (VHCs) originally trained by the PHC program. Each program has its own package of activities for the volunteers, which if fully implemented, would represent a formidable task beyond the capacity of the volunteers. The lack of coordination among programs could result in overloading the system to the point of total collapse.

An example of this is the training program. Since each program has its own training and refresher courses and the village representatives to the different programs are usually the same people, the volunteers often find themselves spending a great deal of their time attending the various training and

refresher courses.

Three areas of program activities particularly demand an immediate improvement in coordination: training, reporting, and supervision.

Better coordination will also maximize the utilization of resources. The strong communications component of the Family Health Program, for instance, could share its resources, both in expertise as well as in on-going communication activities, to support the nutrition program. Manuals on teaching methodology for community work, developed by the PHC Division, should be made available for training activities of other programs.

Judging from the present load at the provincial and district levels, the decision to create a new full-time position for a nutrition officer is timely. The additional load created by the new nutrition program activities cannot be handled by the existing staff. The present difficulties in ensuring funds from the Budget Bureau for the position should be overcome. The involvement of the highest level representatives from the Ministry of Health in discussions with the Budget Bureau is crucial, because without the additional staff, it will be difficult for the program to achieve its objectives, thus wasting all the investment in training, supplies, and funds.

In order to maintain continuity in program activities, an appropriate monitoring system needs to be developed. The system should be designed primarily as a tool for stimulating and motivating project personnel and only secondarily as an information collecting device. Therefore, the system must be simple and easily understood at the community level. In accordance with the community participation strategy of the program, the monitoring system should be based on the principle of the "community monitoring its own progress." Immediate and regular feedback needs to be ensured from each managerial level. The present system, which consists mostly of information on nutrition status based on the quarterly surveillance, needs further development.

III. Training

The training methodology used in the health programs is similar at each level. It starts with an orientation to program strategy, which is given by the national level inter-sectoral team. Then, provincial officials present the nature of the problem at the provincial level. On the second, third, and fourth days, the training session moves to a village, which becomes a trial area. At the end of the five-day training, the volunteers of the village, with some assistance from the trainees from higher administrative levels, are able to produce a village action plan for nutrition activities.

This approach is innovative in the way it brings the program managers from various levels to work directly with the village situation. However, the training process, especially at the village level, seems to follow the conventional lecture model. A more active and participatory process should be encouraged.

The lack of participatory training results because most of those doing the training are managers, not trainers. They focus on an orientation to program strategy and function. They have few training skills, especially with regard to community organization and communications.

At present, the training of the district level officials is half finished, and the training of Tambon officials and VHVs/VHCs will start next month. It is hoped that training at the village level will be conducted in a more participatory manner.

To strengthen this component of the program, it is recommended that during the next month of village level training, the team of central level trainers join the training sessions to assess the process and methodology.

IV. Communications

In any project whose goal is to achieve permanent behavioral change in child feeding and health care practices, communications plays a vital role. The Thailand project has this goal and it could be said that the whole project is an exercise in communications.

The communications component has been active in project implementation. Production and distribution of communications support materials have been carried out as planned, and the quality, in the case of the printed materials, is very satisfactory.

What needs further review is the overall role of communications in the context of program strategy and operational realities. Some of these areas are:

1. Weighing Program

It is generally acknowledged that weighing is one of the most effective methods for nutrition surveillance. What is often not realized is that, in addition to that, monthly weighing is the most powerful communication forum for the promotion of good nutrition through the promotion of growth.

It is the only forum which provides regular contact between program personnel and the mothers in the community. It is also a forum that is based on a positive, concrete, and practicable message: gain weight every month.

There is still the tendency of some of the health workers to view the weighing program merely as a tool to identify the malnourished children. This has to be corrected--since it will make the program completely curative in nature, an approach that we know is very costly and ineffective.

Some suggestions to maximize the effectiveness of weighing sessions for communication and education are as follows:

a) Conduct the Weighing Sessions Every Month

The decision to conduct weighing sessions quarterly in the expanded program areas is understandable in view of the workload of the Tambon level health staff. However, we need to carefully assess the wider implications of the decision on the nature of the program. First of all, quarterly weighing is not adequate for surveillance purposes from the mother's standpoint. While "management's" needs may be satisfied by a quarterly report, a mother needs monthly information with regard to the progress of her child in order for her to take timely actions to prevent her child from becoming malnourished.

From the communications point of view, monthly weighing provides a number of advantages:

- Regular contact between mothers and health workers with a frequency adequate to maintain continuity of interest.

- By looking at the result of the weighing and comparing it with the previous month's figures, the workers will be able to develop nutrition education messages that will be specific (for that particular month), positive and action-oriented. For example, a second degree malnourished child who gains weight should be given positive feedback, even though s/he is still in the second degree category. The important thing is not where s/he is (second degree), but where s/he is going (up!). The child is doing very well this month, and his or her mother should be encouraged to continue the good practice. On the other hand, a "normal" child who does not gain weight will get a timely warning. His or her mother should give more attention to the child's feeding so that s/he can gain weight the next month. In a quarterly arrangement, this child could easily fall into the category of mildly

malnourished by the next weighing session, three months later. If conducted monthly, the weighing sessions could become a highly interactive nutrition communication and education forum with a strong focus on action.

b) Limit the Number of Children in One Weighing Group

In many villages the sizes of the groups at weighing sessions are too large. Often there is a group of 50 or more children--many of them crying--plus their mothers. In those cases weighing programs become a ritual (a rather troublesome one at that) in which the main concern of everyone involved in the activity is how to get done with it as quickly as possible. Clearly this is a situation where meaningful communication cannot occur.

It is therefore recommended that a weighing group consist of no more than 40 children. If the number exceeds 40, then the group should be divided into two subgroups that meet on different dates each month. In addition, if the number is restricted, the VHC could be asked to make follow-up visits to mothers with under-five children in his/her cluster. This will provide a more intensive and personalized communication opportunity with the mothers. During a weighing session the VHCs could discuss among themselves and with the VHV and the Tambon staff the nutrition problems of the children in their clusters. This exchange of concrete and practical experience among workers is very educative and helps create closer teamwork.

c) Promote the Proper Use of the Weight Chart

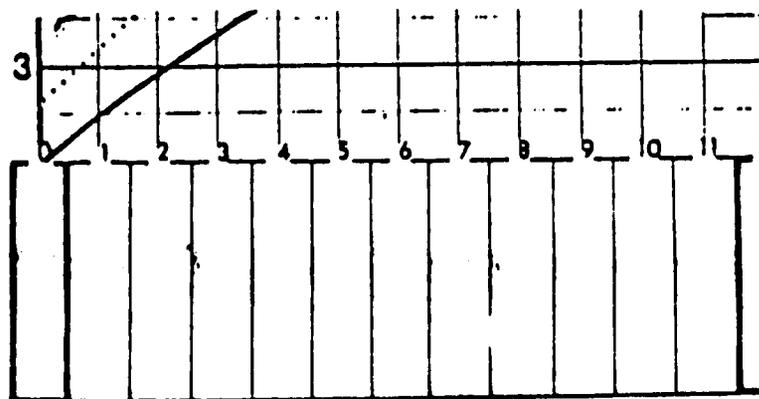
The proper use of the weight chart as a communication and education tool for mothers needs to be emphasized. At present there is still the tendency among some health workers to view the weight chart merely as a tool to record the anthropometric measurement of a child, ignoring its central and most important

function as a communication and education tool for mothers. Because of this perception, some health workers are reluctant to put the weight chart in the hands of mothers, for fear that it might get lost. There is indeed a risk that some of the charts will get lost (the loss rate is 5 to 10 percent in other programs), but the benefit certainly far outweighs the cost. To be an effective communication tool, weight charts should be in the hands of the mothers.

It is also important to stress that weight charts should be used to record all the health and nutrition related episodes that the child experiences, such as diarrhea, fever, immunization, starting of solid food, loss of appetite, etc. This will make the weight chart a comprehensive health and nutrition "passport" for the child. Mothers should be encouraged to bring the weight chart--the child's "passport"--along when she brings the child to a weighing session, health centre, or any other health facility.

Some field personnel suggested a minor change in the design of the present weight chart: instead of using numbers indicating the age of the child (in months) there should be boxes to put the names of the months in, beginning with the child's birth month.

Figure 1

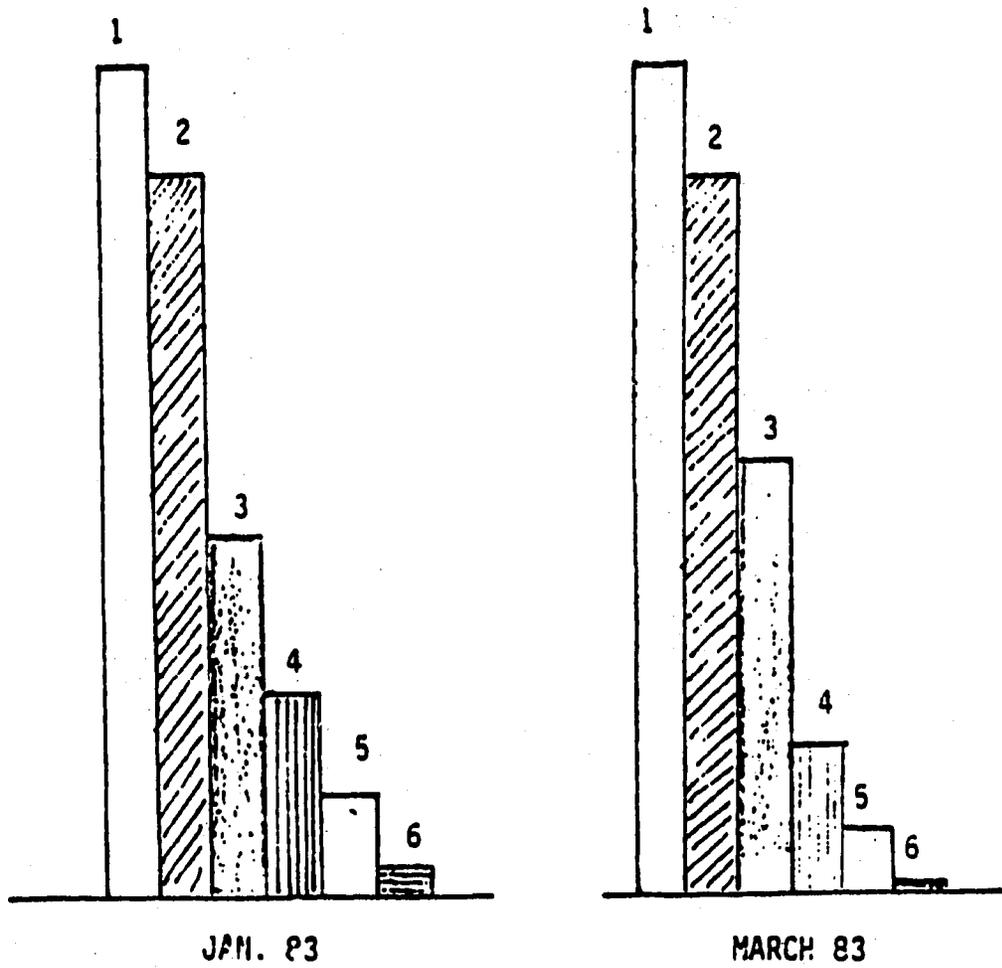


↑ Fill in this box with the birth month of the child. Then fill in all the following boxes with the consecutive months.

Some instruction should be added on how to fill in those boxes (see illustration above). This will simplify the workers' task and will avoid the troubles and errors caused by having to calculate the exact age of the child (in months and days) every time s/he comes to the weighing session. (These problems escalate when the child comes irregularly to the weighing sessions and when the child is older than two years.) In the proposed method, after filling in the names of the months in all the boxes, the worker only needs to find the right box with the name of the month when the weighing takes place and plot the weight accordingly. No calculation is necessary.

In addition to the weight chart for mothers, a large poster version of the weight chart has been produced for use in the community centre. The results of weighing (every three months is sufficient for this purpose) of all children will be plotted on this poster, and since the poster will be displayed in a community centre, the community will be able to monitor the nutrition status of the underfives in their village. A simpler version in the form of a base diagram (Figure 2) may convey the message more clearly and should be tested. This diagram could easily be made by the VHVs themselves.

Figure 2



- 1 : total no. of underfives in the village
- 2 : total no. of underfives being weighed
- 3 : normal
- 4 : first degree malnutrition
- 5 : second degree malnutrition
- 6 : third degree malnutrition

2. Nutrition Education Activities

At the community level the most effective strategy is one developed along the "dialogue" model, which emphasizes sharing information among equal communication participants. In their relationship with the community, it is important that the VHCs and the Tambon health staff see themselves as friends who try to facilitate a discussion around a certain topic. It is crucial to give mothers an active role in this forum; a mother whose child is growing well should be asked to share her experience in dealing successfully with the feeding of her child. The "wisdom of village mothers," which contributes positively to the health and nutrition status of their children, should be explored and used in education activities. Nutrition concepts such as "five food groups," "introduction of solid food," "supplementary feeding," etc. should be introduced through and in harmony with local beliefs and customs. (The successful introduction of supplementary feeding powder by mixing it with "kaotom," or rice soup, in the Sri Muang Mai pilot project is the best example of this strategy.)

The use of local food stuffs and dishes for "communications support materials" should be encouraged. At present there seems to be a rather heavy reliance by the workers on the use of centrally produced posters and other communications support materials. With regard to messages on food, this may not be the best strategy, since food preference and availability vary regionally as well as seasonally. Moreover, no communications support materials on food can be as relevant and concrete as the actual local food stuffs and dishes. More attention should be given to this issue in the coming training and refresher courses.

a) Production of Communications Support Materials

Apart from the growth chart, which has been produced in a large quantity (200,000) with UNICEF and USAID assistance, quite a number of posters and brochures have been produced.

The four posters focus on (1) baby weighing, (2) the growth chart, (3) breastfeeding, and (4) infant feeding. One hundred twenty thousand sets of these posters have been printed and distributed.

In addition, 50,000 brochures on breastfeeding and another 50,000 on infant feeding have been produced and distributed.

It would be impossible at this stage to give a detailed assessment of each material. However, in general the design and printing quality are very satisfactory. What is needed now is further refinement of the messages and the presentation of the ideas. This can be achieved only through intensive discussion with community members and the health workers in the field.

Organizationally, the production of communications support materials for a nutrition program is the responsibility of the Nutrition Education Section under the Division of Nutrition. While the unit has done well thus far, it is recommended that their communication capability be strengthened to provide the needed support for this new nutrition initiative. This could be accomplished either by adding new personnel with communications backgrounds, or by getting closer cooperation with other units (inside and outside the Ministry of Public Health). In this connection, the IE&C Section of the Family Health Division, with its huge staff (more than 50) and long experience in the field of communications, seems to be the logical first choice.

b) Radio and Other Communications Media

The emphasis in the communications efforts to support the program has been on printed materials. The use of radio is limited to a biweekly program (usually taking the format of a "15 minutes' nutrition talk") broadcast centrally during the morning hours. In addition to that, some of the regional stations may broadcast another one or two programs per month with a similar format.

It is clear that the use of radio--which is available in

90 percent of the households in Thailand--for nutrition education has not realized its potential. The same is true for television, which is seldom utilized in the present program in spite of its tremendous communication potential (a significant number of rural communities have access to electricity).

A comprehensive communications strategy to support the nutrition program as well as other programs aimed at rural areas (PHC, MCH, Family Planning, Poverty Eradication Program) is critically needed and will aid the program integration process at the community level.

V. Recommendations

1. The weighing program should be carried out monthly and should stress promotive educational activities rather than simply surveillance.

2. Interprogram coordination within the Ministry of Public Health should be strengthened, especially in the areas of training, monitoring, and supervision. This would involve the Divisions of PHC, Family Health, and Nutrition.

3. Steps should be taken to review and evaluate the training component of the program. Special attention should be given to the village level training methodology to ensure that it supports the overall participatory strategy of the program.

4. The communications program should be reviewed to strengthen the educational, promotive aspect of the program. More intensive use of mass communication media, especially radio, should be considered.

5. A community-based, responsive monitoring system needs to be developed. It should include more indicators than the nutrition status information gathered from the quarterly surveillance activities. The growth of the nutrition fund and its beneficiaries has to be monitored carefully.

6. Improved manpower capability at the provincial and district levels for the new nutrition program is critical to

the success of the entire program. The plan to add a full-time staff position for nutrition at those levels should be carried out after overcoming the present budgetary problems.

7. A comprehensive interprogram supervision scheme for the district and Tambon levels needs to be jointly designed by the three major Divisions: Family Health, Nutrition, and PHC. It must contain a definite visitation schedule and a checklist of specific activities to be conducted during a supervisory visit.

VI. Future Needs in Technical Assistance

1. Orientation on national nutrition program strategy.

A study visit to observe nutrition programs in the Philippines and Indonesia (two weeks in each country) would be very helpful for the key program managers. This comparative study on different approaches in developing a community-based national nutrition program will provide a broader horizon of strategy alternatives and practical managerial insight for key personnel.

2. Training in participatory training methodology for members of the National Training Team. Some members of the team expressed their need to strengthen their knowledge and skills in participatory training methodology. The Department of Adult Education of the Ministry of Education, Thailand, has competent resources in this field and should be able to provide their services within the framework of interministerial cooperation to the project. An orientation on how this participatory training methodology is applied to the nutrition program could also be given in Indonesia through the YIS training program.

3. Training in the development of a communications strategy and communications messages for nutrition. This training, which could be provided through short- or long-term assistance, is needed in the further development of the national nutrition program. More work needs to be done with the community on message design and then community information can be incorporated into a

coherent strategy that can be developed and implemented under a formative evaluation framework.

Persons Contacted During the Assignment

1. Dr. David Oot Director, Office for Population, Health, and Nutrition, USAID, Thailand.
2. Dr. Amorn Nondasuta Director General, Dept. of Health, Ministry of Public Health.
3. Dr. Puangtong Tantivongse Director, Nutrition Division.
4. Mr. Narintr Tima Nutrition Project Specialist, Office for Population, Health, and Nutrition, USAID, Thailand.
5. Dr. Chavalit Santikitrungrueng Medical Officer, Nutrition Division.
6. Dr. Aree Valyaseri Director, Nutrition Research Institute, Mahidol University, Ramathibodi Hospital.
7. Ms. Oratip Tanskul Director, Social Projects Division, NESDB.
8. Dr. Pricha Desawadi Director, PHC Division.
9. Dr. Anchalee Leesavan Programme Officer, UNICEF.
10. Ms. Siriporn Chitplee Nutrition Officer, Nutrition Division.
11. Ms. Piyanuch Amornchewin Public Relations and Information Section, Family Health Division.
12. Ms. Piengchan Sweatsrisku Public Health Officer, PHC Office.
13. Ms. Puangtip Monarumit Administrative Officer, Nutrition Division.