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MULTI-SECTORAL HEALTH/NUTRITION METHODOLOGY

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FOREWARD:

The Agency for International Development, Technical Assistance Bureau/Office of Nutrition, in an attempt to focus on the need for involving private voluntary organizations (PVO) in national nutrition planning, sponsored a series of nutrition planning workshops. The national nutrition planning thrust had special relevance to the larger PVO's whose programs are large enough to influence the national nutrition programs for almost any developing country. However, this is not the case for the smaller PVO. The very nature of the smaller agency demands that their planning activities be primarily concerned with the national nutrition plan insofar as it affects the local level. Moreover, the need for defining and developing community based techniques for nutrition planning was made clear in several informal discussions. In that connection it struck the writer that a PVO such as Save the Children Federation/Community Development Foundation should work toward developing a generic methodology appropriate to the special capabilities inherent in the smaller agency.

One of the unique capabilities of the smaller PVO is its ability to work effectively at the "micro" rather than "macro" level of the national nutrition planners. National nutrition planning is concerned with general solutions adapted to a broad, statistical view of the population. On the other hand community based integrated rural development encourages local solutions in keeping with grass roots realities as perceived by rural citizens and sees nutrition linked with other health concerns.

Most planning at the national level is done by national bureaucracies whose objectives are to achieve the goals set for macro-measuring. The macro goals are often unrelated to the needs as perceived by the people in the rural community. SCF/CDF, by involving local community members in the planning of nutrition programs, can bridge this gap and encourage a spirit of cooperation and help establish a dialogue between the people and their government.

Therefore, a program or methodology was developed to accommodate the specific capabilities of SCF/CDF. While this methodology is meant to complement a national nutrition plan of a host country whenever possible, the primary aim is to meet the felt needs of the community.

I. INTRODUCTION:

A. Save the Children Federation/Community Development Foundation.

The Save the Children Federation (SCF) was organized in 1932 and the Community Development Foundation (CDF) was organized in 1957 as a sister agency.

SCF/CDF has dedicated its efforts to assisting the economically disadvantaged in whatever part of the world they may be located. Currently, programs are operating in the following LDCs: Bangladesh, Indonesia, India, Haiti, Korea, Colombia, Dominican Republic, Honduras, Tanzania, as well as in Lebanon, Israel, Greece, Mexico and in the United States. Programs initiated after World War II are phasing out in Austria, Finland, France and Italy.

The underlying principles of SCF/CDF are demonstrative of its belief in the potential of physically, socially and economically deprived human beings to meet their needs and desires and to attain their potential for human dignity. At the core of SCF/CDF's approach is the theme that self-determination, self-motivation and self-help are the keys to maximum progress. This is the means by which other elements of the development process - increased productivity, nutrition and literacy - can be introduced in a less costly way and also institutionalized at the local level without generating an attitude of apathy and dependency.

B. Community Based Integrated Rural Development

1. Definition

Community based integrated rural development (CBIRD) is an approach to development that produces growth and change in rural areas through community participation. It is an effort to enable the maximum local input of decision-making and labor to the multiple constraints which a group will face now and in the future in striving to meet its needs.

2. Concept of Integrated Development

SCF/CDF believes that real development involves two fundamental components - human resources and physical infrastructure/productivity. Each is recognized to be linked causally to the other, and each is essential

to total human development. The community based integrated rural approach which SCF/CDF supports is believed to be the most valid way to help to effect progress because the two components of development are dealt with simultaneously; the approach encourages each component to develop and, in so doing, builds upon the potential of one to promote the progress of the other.

3. Goals

SCF/CDF's goals for community based integrated rural development are:

1. To help the target population create effective grass roots infrastructure and processes of decision-making for the articulation of community priorities and the local implementation of activities to meet those priorities.
2. To develop the incentive in decentralized populations for cost-effective, appropriately scaled programs in health/nutrition, agriculture, and family planning.
3. To encourage development of local financial networks and investment policies which recycle the added income of the rural poor back into the economy of the target population.
4. To attack comprehensively the basic deficiencies of the target population through an integration of component services rather than through a single specialized emphasis.
5. To identify the deficiencies in the health and nutrition sector through investigation of the food system i.e. the process by which people get, grow, process, distribute, and prepare food.
6. To involve local target communities with appropriate regional and national agencies and institutions at the time when such linkages are necessary for further development.

Fundamental to the SCF/CDF approach are:

- a) a systematic understanding of the interrelationships of the many essential sectors of development;

and

- b) an emphasis on the grass roots motivation and initiative components as a prerequisite to ultimate institutionalization at the community level.

4. Assumptions of Community Based Integrated Rural Development

a) Local Citizen Participation

1. People in a rural community are or can be motivated to work together to meet their common needs.
2. Local individuals know what are the needs of the community.
3. Wide-scale participation in the decision-making implementation process is the most effective and just means to progress.

b) Multi-Sectoral Approach

1. Progress in community development is a process which cannot be met exclusively by an attack solely on one pressing constraint,
2. For community progress, the realization of goals and objectives therefore require the alleviation of each and all of the constraints of underdevelopment in whatever sector, whenever they arise,

and

c) Synthesis

Skills can be developed in remote, often illiterate people to work together effectively and to recognize and synthesize coherent strategies for resolution of the inter-related problems of underdevelopment.

5. Validity of CBIRD

A fundamental premise of the validity of CBIRD is that an integrated (multi-sectoral) approach to development is more successful than an exclusive attack on one pressing constraint. Problems in underdevelopment areas do not exist in isolation. For example, illiteracy may be related to poor or nonexistent educational facilities, or it may

be attributed to malnutrition in the early years of life (thereby contributing to permanent retardation), or it may be the result of labor demands put on a child early in life which cause the young person to drop out of school, etc. Because of the complex interrelationships of the causes of underdevelopment and due to the need for the wholehearted commitment of target populations to resolve their plight, optimal solutions to the constraints of the world's underprivileged people are engineered when local citizens are involved in the identification of their problems and are encouraged to take a primary role in programs to deal with their situation. SCF/CDF believes that properly administered and managed community based integrated rural development is able to combine simultaneously and systematically the maximum available human and material resources for resolution of the problems of poverty, malnutrition, ignorance and disease.

II. METHODOLOGY:

Multi Sectoral Health/Nutrition

The Multi Sectoral Health/Nutrition methodology is based on practical experience and on the importance of small local functioning units i.e. communities, committees, etc., operating autonomously within a larger support structure of authority and guidance. A major goal in health/nutrition planning is to ensure self-sustaining activity. SCF/CDF believes that health and nutrition programs which are conducted by the community have a greater likelihood of continuing for the long term. This methodology uses a technique for problem identification whereby the community is involved through (1) survey/anthropometric measurements and other data collection; (2) analysis of the data and determination of what is, and to what degree, a problem exists and (3) the short and long term implications of the problem as it effects the community.

A. PROBLEM:

Due to the alarming incidence of hunger and starvation threatening the populations of many of the less developed countries; and, the growing evidence indicating irreparable physical and mental damage to children who suffer from malnutrition, the methodology stresses the need for local citizens to address the problems of malnutrition at the village level. Because the causes of malnutrition are multi-faceted a multi-sectoral program is indicated. Some of the problems are as follows:

- High infant mortality
- Poor nutrition
- Low agricultural productivity
- High underemployment and unemployment
- High incidence of infectious diseases
- Poor sanitation
- Low access to health care services
- Maldistribution of food, land and income
- Low self-actualization, which blocks self-reliant action
- Too rapid population growth

This project will not attempt to alter the problems of maldistribution except within the nuclear family. All of the problems listed above may be seen to be symptoms - effects - of a more fundamental two-faceted problem: the lack of 1) a clear understanding of the causal relationships between poor health and underdevelopment and 2) a technical capacity of local people to deal effectively with the causal constraints. The problems listed above which block self-reliance will also be addressed directly through community organization, community action and personal development. This will provide a solid basis for community participation in local projects to attack the other problems listed.

B. Goal Of The Multi-Sectoral Health Program

The overall goal of the SCF/CDF multi-sectoral health program is to improve the health and nutritional status of local citizens in SCF/CDF project areas. It is anticipated that the program activities will help to decrease infant mortality rates by dealing with the appropriate constraints. SCF/CDF wishes to institutionalize the awareness and capability of local citizens to identify problems, plan projects, and use proven methods to deal with the numerous blockages to good nutrition in their rural areas. To achieve the above overall strategy the purpose of this multi-sectoral health program is to capacitize local people to commence village nutrition and health programs.

C. Objectives of the SCF/CDF Multi-Sectoral Health Program

Objectives of the multi-sectoral health program are:

1. To assist people in a process of investigation by which they can identify nutrition/health problems and plan appropriate interventions. See work plan Step III.
2. To train community people in the areas where the village community committee has identified primary constraints.

3. To increase individual and collective ability to plan, implement and evaluate small scale health and nutrition projects.
4. To institutionalize local sensitivities and abilities to work toward better nutrition and health in the community.

The SCF/CDF multi-sectoral health program will organize subcommittees. Through local investigation and group processes (facilitated by project staff and contractors) these community subcommittees will assess needs of the community and plan projects to meet these needs. The communities will be encouraged to give first attention to MCH/NUT and agricultural production projects. Other sectoral possibilities will be left open. To facilitate planning and later implementation, one volunteer member of each of four local subcommittees will receive thorough, appropriately scaled technical training. Other members of communities or subcommittees will receive a short course. In addition to technical skills, the courses will include social skills related to community organization.

D. Structure

Key component personnel of the methodology are as follows:

1. Field Coordinator

- a. Functions as a community organizer with the community committee to establish the desirability and acceptance of the health/nutrition program in the village.
- b. Initiates, with the community committee, a planning process through which the community commits itself to the health/nutrition program by allocating a substantial percentage of its annual funding for the health/nutrition program and by identifying individuals who will head-up the health/nutrition subcommittee.
- c. Identifies, with the committee, the kinds of input the community will be contributing to the project, i.e., donated use of a public room for a clinic, 2 days a week, etc.

2. Social Development Coordinator

- a. Makes contact with the community (on site)

through an introduction by the field coordinator.

- b. Assists in a needs assessment, problem identification and in developing sound subcommittee procedures - participation, involvement, etc.
- c. Helps develop a plan, program, and budget for health/nutrition activities.
- d. Serves as a consultant to the committee on assistance - technical, material, educational and financial.
- e. Serves as a link to existing health facilities (municipal, regional and country level).
- f. Helps coordinate meeting with actual and potential technical assistance agencies.
- g. Supervises the activities of the village health workers giving assistance when needed.
- h. Develops and administers regional workshops.
- i. Identifies available foods, their nutritional values, and local dietary habits.
- j. Implements a nutrition program through introduction and development of weaning foods made from locally available foods.
- k. Monitors health records kept by the village health workers (patients histories).
- l. Establishes continuing education and training for village health workers.
- m. Helps develop an agricultural program with a trained horticulturalist. This program, when coordinated with the other sectors of improved health/nutrition, serves as a demonstration and incentive for local food production.
- n. Motivates community interest in the program.
- o. Meets bi-monthly with the communities to facilitate community activities.
- p. Obtains technical information for community organizations.

- q. Arranges for the training of village health workers through qualified contractors identified by the project coordinator and country director.
- r. Assists specialists in making any needed agency contacts.
- s. Sees that the project targets are met.
- t. Collects program data for control and improvement.
- u. Identifies family planning services in area and makes appropriate contacts.
- v. Encourages community commitment to and involvement in education and motivation for family planning where appropriate.

3. Health/Nutrition Subcommittee

- a. Composed of 10-15 people from the community who volunteer their participation. This will fluctuate according to the size of the community and interest level. This committee's primary responsibility is to help the community committee with all programs relating to health and nutrition.
- b. It is foreseen that the social development coordinator will be instrumental in the beginning organizational efforts of the community health nutrition subcommittee. During the first stage of the program's development, the social development coordinator will function as a community organizer helping with the following:
 - 1. General discussions of common interests, desires and needs;
 - 2. Identification of major problems relating to health and nutrition;
 - 3. Defining project activities to be initiated.

The process will occur with the participation of the four selected village health workers prior to their training. The information generated through these discussions will help determine the type of training the village health workers should receive.

- c. Following the return of the four village health workers from their training program, it is envisioned that they will appoint one member of the subcommittee to function as chairperson. The chairperson has the responsibility for maintaining the committee.
- d. When the community arrives at the point where medicines and services are to be dispensed, it will be the responsibility of the health/nutrition subcommittee to recommend to the community what the pricing systems shall be and when and how services will be delivered.

4. Village Health Workers

Village health workers are members of the target area who will receive training in 1) technical skill areas related to team objectives, 2) methods for clarifying local problems, and 3) techniques for group motivation in order to prepare them to function as group facilitators. They will serve as technical assistants to the health/nutrition subcommittee and will mobilize a committed citizenry to participate in the MSHP.

The MSHP design therefore incorporates four people trained from each cluster of villages or target area. These four village health workers will comprise a team; however, each one will have responsibilities for specific sectors relating to improved health and nutrition. An example of team effort between these personnel would be the close collaboration of the paramedic, the hygiene specialist and the MCH/N worker to mobilize the local population in a drive to eradicate intestinal parasites. This is only one example of the many ways SCF/CDF expects the VHWS to complement one another in an integrated health/nutrition program.

Duties of the Village Health Workers

1. Village Health Worker Specializing in Maternal Child Health & Nutrition Education.

- a) Develops a nutrition education effort starting with individual consultations with mothers. This is a most significant part of the village health workers role. It will develop confidence and support for the health/nutrition committee and community committee.
- b) Through group participation, shows how to prepare weaning foods from food locally available.

- c) Discusses effects of too frequent pregnancies on the nutritional and health level of both mothers and children.
- d) Holds frequent health/nutrition clinics followed by home visits to those needing special attention, i.e. malnourished infants.

2. Village Health Worker Specializing in Paramedical Services

- a) Provides specialized health services such as:
 - 1. taking vital signs;
 - 2. weighing of infants and children;
 - 3. curative consultation;
 - 4. treatment within range of expertise;
 - 5. referrals to government clinic when appropriate;
 - 6. family planning;
 - 7. immunizations.
- b) Collaborates with the MCH worker to develop a nutrition education program.
- c) Assists the MCH worker with health/nutrition clinics and home visits.
- d) Recognizes symptoms of common medical problems and prescribe treatment that is realistic and available.
- e) Starts a simple record keeping system for patient history.
- f) Holds a monthly review with the social development coordinator of all activities and treatment prescribed.

3. Community Hygiene Specialist

- a) Offers instructions and assistance in constructing home storage facilities.
- b) Encourages and assists local people in construction of sanitary latrines.
- c) Has primary responsibility for the prevention of contamination of village water supplies.
- d) Directs village waste disposal.

- e) Examines potential for improved water sources.
 - f) Gives attention to village households and the specific problems of a community's hygiene.
4. Village Health Worker Specializing in Agricultural Improvement
- a) Provides training and demonstration to local families in:
 - 1. improved agricultural techniques;
 - 2. feasible new crop varieties;
 - 3. low cost, simple animal protein production schemes.
 - b) Encourages and assists in the creation of home horticultural plots.
 - c) Evaluates local agricultural practices.
 - d) Identifies problems relating to locally grown foods.
5. Coordination of Village Personnel in Health/Nutrition

The primary linkages within the structure of these health/nutrition personnel were created principally to assist the local community committee, particularly the health/nutrition sub-committee, to solve problems identified with health/nutrition status of the community. These linkages include a field coordinator, social development coordinator and four village health workers for each cluster of villages or district.

One of the key links in the chain is the social development coordinator. This person has access to the resources of the field coordinator, who has general development responsibilities. The field coordinator is in a position to provide technical liaison services to the community health/nutrition program.

Health/nutrition problem solving at the local level using a committee structure requires technical support starting with the village health workers. From time to time this will be augmented by the social development coordinator or field coordinator.

The above methodology would be applied primarily

when a community based integrated rural development program is already functioning in target communities i.e. where some type of citizen's committee is working for general village welfare and is using principles of local decision-making, participation, etc. The MSHP could, however, be used by new target areas and villages as a vehicle for its community-based integrated development program. Application of the MSHP in this latter instance would require thorough investigation of the potential for cohesive target area activity.

E. Training

SCF/CDF believes that deprived people in rural areas, when properly motivated, trained, and supported, can deal more effectively with the inter-related set of constraints that define their everyday circumstances.

In this connection, the training support needed for this methodology becomes an important and essential part of the whole. One of the difficulties encountered in the search for appropriate training is that most of the existing health and nutrition training is geared to persons who have completed secondary school. This training requires developed skills in order to absorb the information and technical expertise. Other than school teachers, persons who have completed secondary school are rarely found in most of the rural villages of the LDCs.

It is the experience of most PVOs that village people, when properly motivated, are equal to the task of learning the necessary health skills to start the community on a health development program. The most important part of this type of opportunity and training is that it will be realistic to their needs, results-oriented to solve their problems, and generally uncomplicated.

Therefore, criteria for selection of an appropriate training program should be:

1. The program philosophy should focus on developing the potential of the rural poor in terms of dealing with day-to-day health nutrition problems of the villagers.

2. The curriculum offered by the program should include the specific training objectives listed below:

Training Objectives

1. To provide social development training to village health workers. Emphasis is placed on leadership, community organization, working with a group, communication skills, administrative skills, etc.

2. To provide skill training in the following disciplines to village health workers who in turn will have the responsibility to transfer their knowledge to the local people.

---Maternal skills

- meal planning
- maternal-child care during pregnancy and child-birth (practical care, not obstetrics-gynecology)
- child care
- hygiene in the home (must be practical, realistic, and economical)

---Paramedic skills

- first aid
- cooking for the sick, use of bed rest, isolation, etc.
- basic family planning techniques
- use of over-the-counter drugs
- when to make referrals to a doctor (and how)

---Community hygiene

- garbage disposal
- animal control
- sewage control
- water resource development
- food storage and hygiene in handling

---Agricultural improvement

- new techniques
- crop diversification
- demonstration projects in horticulture and animal husbandry

3. To enable village health workers and the community health/nutrition committee to create new programs for improved health and nutrition that can be replicated.

4. To motivate village health workers and the health/nutrition sub-committee to promote integrated development.

5. To strengthen the communication link between community people and their government.
6. To learn and practice training techniques and methods for acquiring a knowledge of training resources.
7. To provide a forum for ideas, experiences, and problem-solving.
8. To acquire a knowledge of health and nutrition resources, services, and procedures necessary to obtain them for community benefit.

As much as possible, the training resources available in country or in the region will be identified prior to the arrival of the project coordinator in order that the training can be observed. It has been our experience that there are few training organizations with experience in training village people to carry out health/nutrition responsibilities. However, we have found that with encouragement organizations are often willing and anxious to accept the challenge.

The Social Development Coordinator (SDC) will receive orientation for four weeks with the Field Coordinator. This will familiarize the SDC with the project area, the community committees, and the process used by the Field Coordinator to facilitate group process. The SDC may also receive any additional training in specific skill areas such as family planning, health and nutrition.

The Village Health Workers will receive training for four to eight weeks initially and have yearly follow-up training for a one-two week period. Additionally, the SDC will be reinforcing the training through supervision and instruction.

Village people will receive training from the village health workers, the SDC, and outside personnel (e.g. government extension workers) who will use methods of demonstration, nutrition education, and personal consultation.

F. Implementation Plan

SCF/CDF believes in the essential involvement of local citizens in development activities. Hence, the schedule of implementation of multi-sectoral projects is protracted by the process of identifying and training citizens to assume the duties of the Health/Nutrition sub-committee and village health workers. The delay, however, should not be considered "lost time". Indeed, citizen "capacitization" is the emphasis of SCF/CDF's H/N methodology and is crucial to the achievement of purpose and sub-goal of the multi-sectoral health program.

SCF/CDF Program Coordinators recognize the time-consuming nature of local human resource development. Consequently, the implementation plan reflects an initial period when the achievement in sectors cannot be the primary focus. During the first twelve months of our involvement in a community, the entire process of preparation for outreach to local citizens will be undertaken. Hence, the real achievement indicators, in terms of the effect of projects on the population at large, will only begin to be monitored after the first year of implementation of the MSHP. It is anticipated that community-level project activity can be a continuous process following development of local resources to train and motivate villagers to work both in the home and in the community to improve their nutrition and health status.

Implementation of MSHP in a Country

First Year: The multi-sectoral health program begins with communication between the SCF/CDF Program Coordinator and in-country or regional development resources. The concept of that program is introduced to the community, followed by the appointment of the SDC to the target area. During this period, training resources are identified and engaged for the skills development of the village health workers. With the existence in the community of a H/N sub-committee, Social Development Coordinator, and four target area Village Health Workers, the plans, needs assessments, and surveys are conducted in the villages. District-level resources are then gathered for implementation of training and other activities.

Second Year: The process of securing resources is a continuous one. Local villagers are trained in classes, demonstrations, etc. and health improvement projects (e.g. water supply, sanitary latrines, etc.) are implemented by the local population.

Third Year: The communities are expected to continue a process of project endeavor which was begun in the second year and which will be strengthened and institutionalized in the third year.

G. Evaluation:

The evaluation of the SCF/CDF MSHP will be conducted in two ways. There will be continuous monitoring of individual sector changes, e.g. the effect of nutrition interventions as measured by height and weight data, etc. The village level health workers will be responsible for monitoring relevant changes in their own specialized fields in the target areas. Evaluation plans for the individual projects will be defined during the planning stage at the community level.

SCF/CDF will also be evaluating the MSHP for its suitability as a vehicle for delivery of a health and nutrition component to the agency's programs. SCF/CDF will be eager to analyse the scale of the programs in each area and to simplify or bolster the personnel and program activities as is appropriate for the greatest efficiency of the program.