Growth Promotion for Child Development

Proceedings of a colloquium held in Nyeri, Kenya, 12-13 May 1992
Growth Promotion for Child Development

Proceedings of a colloquium held in Nyeri, Kenya, 12–13 May 1992

Edited by
J. Cervinskas, N.M. Gerein, and Sabu George

Co-sponsored by
the Canadian International Development Agency (CIDA), Cornell University, and the International Development Research Centre (IDRC)
Contents

Foreword vii
Acknowledgments xi
Dedication xii

The Nyeri Declaration on Growth Promotion for Child Development 1

History, Principles, and Implementation of GMP

Growth Promotion for Child Development
Michael C. Latham 5

Growth Monitoring and Promotion: A Development Strategy
Lukas Hendrata 19

Growth Monitoring in Primary Child Health Care in Developing Countries
C. Gopalan 23

Evaluation and Policy Change in UNICEF: The Case of GMP
Roger Pearson 33

Frameworks for Growth Assessment and Promotion

Summary 45

Conceptual Analysis of GMP
Urban Jonsson 52

Challenge of Policy Formulation for Growth Promotion
Yves Bergevin and Nashila Mohamed 59
Causal Factors Influencing Childhood Malnutrition
*Carl E. Taylor and Mary Ann Mercer* 73

Individual, Family, and Community Perspectives on Growth Promotion
*Gail G. Harrison* 92

Culture and Growth Promotion
* Cecile De Sweemer-Ba 106

**Research, Evaluation, and Case Studies**

Summary 113

Growth Monitoring and Promotion in the Health Services Setting
*A.A. Kielmann* 119

When Research does not Shape Programming: GMP in Zaire
*Nancy Gerein* 129

Successful Growth Monitoring in South Indian Villages
*S.M. George, M.C. Latham, and R. Abel* 150

Evaluation of the Community-Based GMP Program in Embu District, Kenya
*John Njera Gacoki* 167

Growth Monitoring in Rural Kenya: Experiences from a Pilot Project
*G.A. Ettyang, A.A. Kielmann and G.K. Maritim* 178

Community-Based Growth Monitoring
*David Morley and Mike Meegan* 188

Tamil Nadu Integrated Nutrition Project (TINP), India
*M.C. Latham* 195

GMP Implementation in Indonesia: Does Behaviour Change Take Place?
*Satoto* 197

GMP Programs in Ecuador
*Marta Medina* 208
Action, Research Needs, and Policy

Summary 217

Nutrition Improvements in Thailand: National Policies and Strategies
Kraisid Tontisirin 226

Growth Monitoring in Health and Nutrition Information Systems: Tanzania
Björn Ljungqvist 232

Growth Promotion in Primary Health Care
Carl E. Taylor and Mary Ann Mercer 259

Terms 265

Participants 267
Nutrition Improvements in Thailand: National Policies and Strategies

Kraisid Tontisirin, Professor and Director, Institute of Nutrition, Mahidol University, Thailand

Over the last few decades, many nations and concerned international agencies have been working to improve the nutritional status of vulnerable population groups, especially young children. The 60s brought with it the decade of the applied nutrition program (ANP) wherein various sectors had their own programs to promote nutrition. In the 70s, there was a call for multisectoral integrated efforts to alleviate malnutrition. Since 1980, and continuing to today, community-based interventions emphasizing community participation form the basis for many local and national programs.

During this period, strategies for the implementation of effective nutrition intervention programs have been sought. These strategies have stressed not only the feasibility of implementation and short-term outcomes, but also efforts to promote sustainable nutrition programs.

Currently, nutrition intervention programs in Thailand are implemented both as vertical programs within a single line ministry (sectoral intervention) and as integrated programs involving several sectors and agencies (multisectoral approach). Although there is no rule as to which strategy should be used in what situations, the sectoral approach works best when the problem is relatively serious, such as high prevalence of moderate and severe malnutrition. Immediate actions are necessary to prevent death and help ensure child survival. Medium- to long-term programs generally involve more intersectoral and horizontal approaches. Sectoral implementation of nutrition intervention varies, with involvement most frequently from the health and the social welfare agencies.

A multisectoral approach comes into consideration when the multifaceted causes (e.g., biological, sociocultural) of malnutrition are being targeted for change. Integrated efforts for tackling such underlying causes are theoretically the most effective strategy. In reality, however, such efforts are very difficult to implement and a "top-down" approach is still overwhelmingly used. Unless,
however, the community is involved in all intervention program stages (problem identification, intervention planning, implementation, monitoring, evaluation), the multisectoral implementation is unlikely to succeed.

**National Food and Nutrition Programs**

Until the mid 70s, Thailand's nutrition program was one component of the nation's health plan. Thereafter, the National Food and Nutrition Plan (FNP) was, for the first time, included as a separate entity in the Fourth National Economic and Social Development Plan (NESDP) (1977–81). The most significant accomplishment of this plan was the creation of a strong awareness about major nutritional problems among the public and private sectors at all levels. This led to strong political commitments in terms of the country's nutrition policies.

A multisectoral approach was adopted and implemented by four main ministries: Health, Agriculture, Education, and Interior (community development department). However, early on the nutrition program was not fully implemented because of a lack of inter- and intrasectoral collaboration. Further, there was no change in program planning and the budget allocation structures to support multisectoral efforts. There was also very little participation by the community. Consequently, many of the activities did not achieve their set objectives, such as, centrally produced supplementary food, and nutrition rehabilitation in rural villages. When the national nutrition surveillance data first became available at the end of 1982, there was a strikingly high prevalence of PEM (51%) among preschool children. Overall, nutrition programs employed during the Fourth NESDP were only stopgap measures to relieve the most severe form of malnutrition. Systematically planned, long-term solutions were perceived as necessary for sustained improvement of the population's nutritional status.

The Fifth NESDP (1982–86) continued to include the FNP. However, the concept and planning approach changed, because malnutrition was recognized as a manifestation of poverty and ignorance. Two important national policies, rural poverty eradication and primary health care (PHC), were adopted at the Fifth NESDP. Both policies have nutrition concerns as a main component. The nutrition policy was rooted in one broader government policy of poverty alleviation and rural development (an approach known as the "Poverty Alleviation Plan" or PAP). Health for All by the Year 2000 strengthened and accelerated the implementation of the successful community-based nutrition programs. This was an important turning point in the nation's developmental approach, which formerly focused attention on overall economic growth and its trickle-down effects on rural development.
The rural poverty alleviation policy aimed to integrate and coordinate activities in rural development at central and local levels. The policy focused on identifying poverty areas needing urgent attention, which then served as the target areas for implementation agencies. There was also a striking organizational change for rural development. One national committee was created to replace several separate sectoral developmental committees, which was in charge of planning and executing development policies for infrastructural development from the central to village levels.

During the Fifth NESDP, the nutrition situation of infants and preschool children improved dramatically. Severe PEM was practically eliminated and only a small percentage of moderate PEM remained (Table 1). Weighing by simple beam balance and use of growth charts by the village-based health volunteers and communicators (VHVs and VHCs, trained under the PHC strategy) and mothers were found to be feasible and useful for problem identification and growth assessment. Simple technology for village-level processing of supplementary food was promoted to overcome the disrupted distribution of centrally produced supplementary food. Village self-financing schemes were also attempted with some success.

Table 1. Percentage prevalence of protein energy malnutrition (PEM) in preschool children (wt/age), Thailand.*

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of children</th>
<th>Nutritional status (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Normal PEM</td>
</tr>
<tr>
<td>1982</td>
<td>1,000,000</td>
<td>49.21</td>
</tr>
<tr>
<td>1983</td>
<td>1,270,393</td>
<td>64.77</td>
</tr>
<tr>
<td>1984</td>
<td>1,590,830</td>
<td>70.67</td>
</tr>
<tr>
<td>1985</td>
<td>1,620,518</td>
<td>71.55</td>
</tr>
<tr>
<td>1986</td>
<td>2,277,908</td>
<td>74.91</td>
</tr>
<tr>
<td>1987</td>
<td>2,351,521</td>
<td>77.11</td>
</tr>
<tr>
<td>1988</td>
<td>2,435,129</td>
<td>78.85</td>
</tr>
<tr>
<td>1989</td>
<td>2,539,407</td>
<td>79.14</td>
</tr>
</tbody>
</table>

During this period the concept of "having an improved quality of life" was introduced to replace that of "having good health." The quality of life (QL) concept was translated into actions via the "basic minimum needs" (BMN) approach and was implemented as a pilot trial in 1983. The measurement of BMN is based on eight categories of indicators (or QL indicators). These indicators were used for problem identification and setting the goals for development by the community leaders and local level public personnel.

**Eight Groups of BMN or QL Indicators**

- **Adequate food and nutrition.** This includes nutrition surveillance from birth to 5 years; school feeding; pregnancy care, and services.

- **Proper housing and environment.** This includes housing that lasts at least 5 years, hygienic housing and environment; owning a hygienic latrine, and access to adequate, clean drinking water all year round.

- **Adequate basic health and education services.** This includes full vaccination with BCG, DTP, OPV and measles for infants under one year; primary education for all children; vaccination with BCG, DT, and typhoid vaccine for primary school children; literacy for 14–50 year old citizens; monthly education and information in health care, occupations, etc. for the family; and adequate antenatal care and services.

- **Security and safety of life and property.**

- **Efficiency in food production by the family.** Includes growing alternative crops or soil protection crops; utilization of fertilizers to increase the yields, pest prevention and control in plants; prevention and control of diseases of animals; use of proper genetic plants and animals.

- **Family planning.** Not more than two children per family are recommended and adequate family planning services are to be provided.

- **People's participation in community development.** This includes promotion of the family as a member of self-help groups; involving the village in self-development, and care of public property; care and promotion of culture; preservation of natural resources; active participation in voting; encouraging village committees to plan and implement projects.
• **Spiritual or ethical development.** This includes being cooperative and helpful in the village; family members involved in religious practice once a month; neither gambling nor addiction to alcohol, etc., by family members; and modest living and expenditures.

In the Sixth NESDP (1987–91), similar strategies were continued and the basic minimum needs approach was adopted nationwide to strengthen the integration of sectoral efforts. The rural development plan (RDP) of the Sixth NESDP continued to utilize the PAP approach with emphasis on improvement of the quality of life of the all rural people so that they would be capable of self-help and able to adapt to the changing economic environment. The BMN approach resulted in both a better integration among the ministries involved, i.e., the ministries of agriculture, education, interior and public health, and in a more active community participation in development.

To select poverty areas in need of urgent attention, the following classification of villages into three levels of development has been used:

- **Backward or poor areas** where people are facing four or five problems such as: transportation difficulties; owning no agricultural land; low agricultural productivity or low income; poor health; inadequate, clean drinking water; and ignorance in quality of life improvement. There are 5787 villages in this category requiring intensive government support as in the PAP.

- **Intermediate areas** where people are facing one to three of the problems mentioned above: 35,514 villages in this group require government input.

- **Advanced areas** where people are economically better off and have economic potential, facing few of the problems mentioned above. These 11,621 villages will be encouraged to work with the private sector.

In all areas, BMN or QL indicators will continue to be used for problem identification and goal setting for development. Improvement of planning processes at all levels will also continue. Management of information and data concerning rural development continues to be strengthened at the provincial, departmental, and national levels for planning, coordination, and evaluation.

By 1989, more than 580,000 VHCs and 62,000 VHVs were trained, covering almost 100% of rural Thai villages. As a result of this approach, nutrition improvements continued, and the most recent nutritional surveillance report showed that the prevalence of severe malnutrition is almost nil, and moderate malnutrition has reduced sharply (see Table 1).
Conclusions

This case study of the Thailand effort to alleviate malnutrition has shown encouraging results. The entire period of this endeavour required 10–15 years as 5–6 years or even longer was needed to create awareness and a strong political commitment. The subsequent implementation period of 5–9 years was essential for the consolidation of political support, effective managerial structures and functioning for efficient coordination and integration of development activities, establishing detailed operations for each activity based on research and experience, and stimulating active community participation.

In the past, during the first three NESDPs, the solution of nutrition problems relied only on the health sector for treatment and prevention. The first attempts to coordinate efforts among the ministries of agriculture, interior, education and public health were not so successful during the Fourth NESDP, 1977–81. However, nutrition surveillance (growth monitoring) and mortality data of preschool children that were made available to the public resulted in the creation of awareness and subsequently political commitment.

Since 1982, malnutrition has been considered as a symptom of poverty and ignorance, and the poverty alleviation plan targeted the areas with the highest concentration of poverty. This holistic approach was implemented through a restructuring of the managerial process of the National Rural Development Committee down to the provincial, district, Tambon, and village level. Nutrition activities, primary health care, nutritious food production, and other basic social services were integrated in the target villages under PAP. The BMN or quality of life indicators had also been developed and used for problem identification and goal setting for development and evaluation. People or community participation has been an essential part of the development process.

It would seem that explicit policies for food and nutrition, either as a self-contained policy or a component of broader development policies, strengthens and facilitates nutrition improvement efforts. It must also be concluded that a high degree of political stability and commitment, economic growth, and organizational structures are favourable factors for successful, large-scale nutrition programs. Although recognizing that each country has its own special conditions and circumstances, the results of Thailand's experiences during the last decade are significant and need to be tested further in other developing countries. These experiences have shown that significant progress is possible in nutrition improvement.