TACKLING MALNUTRITION

No 145
October-November 1995

TACKLING MALNUTRITION

2 Editorial
3 Community-based nutrition programmes - can they work?

Inserts:
6 The world can be adequately fed
8 Zimbabwe experience
9 Growth monitoring
12 Breastfeeding: community groups in action
15 Resource materials on community nutrition

UPDATE
16 Meeting in Moshi, Tanzania, to plan closer working relationships between church health associations

NETWORKING
19 Useful contacts and publications, Letters, Announcements

Can community initiatives work?
How can we make the world a less hungry place? First, there is a need for a fairer distribution of resources. More sharing is needed at the international, national and local level. In particular, land redistribution is crucial. Very often it is the landless who are hungry.

Second, options and priorities in food and agricultural policies need to be addressed (see page 6). Governments need to give much greater attention to sustaining food production. At present, politicians are often tempted to use nutrition programmes to “buy” support. They forget or ignore the fact that food hand-outs and subsidies can have an adverse affect on food production. When free or subsidized food is available, it reduces the incentive for local people to produce their own food. The aim should be for food production to increase and for waste to be reduced. Governments can also help boost food production by not offering incentives for the production of cash crops. By diverting agricultural land to cash crops, the incomes of some may rise, but it may cause malnutrition for others.

In this issue of Contact, Dr Kenneth Bailey argues that the factors affecting nutrition are so complex that there is serious concern as to whether nutrition programmes can ever be the inspiration of the community itself. Looking back over his many years’ experience he concludes that, though complex, initiatives to improve nutrition can and must be community-based. Even though communities are often not convinced that nutrition is a problem at the start, awareness can be built. He goes on to argue that real improvements can be made when programmes are built on government commitment and people’s participation in defining the problems and carrying out and supervising the relevant action.

Awareness of community nutrition is vital for any lasting improvement in health in all parts of the world. The consumerist culture tempts people to spend their money on “junk” foods, soft drinks, alcohol, cigarettes and infant formula for bottle-feeding. Seduced by the advertising, we are lured away from what is best for us. If we are not careful, we begin to forget the value of homegrown green vegetables and mothers’ breastmilk.

The current push towards user financing and cost recovery schemes in health care can also cause malnutrition. As David Werner pointed out during a recent presentation here, poor families may be willing to pay for medicines but that does not mean that they can afford to pay for them. Poor families often spend the last of their pennies on medicines to save a dying child when they needed that money to feed the family.

At CMC - Churches’ Action for Health, we believe that everyone needs to become more aware of the root causes of malnutrition. Government and international commitment and effort are important and necessary. Nevertheless, there are local initiatives that can make a start on increasing knowledge and bringing about better nutrition. In this issue of Contact we introduce readers to the opportunities for communities to assess, analyze and act for better nutrition.

Diana Smith
COMMUNITY-BASED NUTRITION PROGRAMMES: CAN THEY WORK?

Australian Kenneth Bailey is a medical doctor with more than 35 years’ experience in countries of Africa and Asia. While in Congo, Central Africa, his commitment to local community health won him a government award. Now working as a consultant in the WHO nutrition programme, Geneva, Dr Bailey provides contact readers with a guide to the complex and difficult path to successful community nutrition initiatives.

Why the question-mark in the title? Surely now that we all advocate people’s participation and empowerment in all domains of development, the bottom-up, community-based approach to nutritional improvement is the only valid and viable approach?

It is tempting to answer “Yes” to this question. But it is far less easy to find examples of where this philosophy has been implemented and is working effectively. Why?

First, nutrition is a complex concept. Ask any ten people basic questions about nutrition, and each would give a different answer. For example, ask yourself the questions: “What is nutrition?” “What are the causes of malnutrition?” “Why is the nutritional situation improving in most parts of the world, but hardly at all in South Asia, and perhaps even regressing in Sub-Saharan Africa?” Each person would give a different response to these questions.

If defining nutrition and malnutrition and its causes is difficult, the action to improve nutrition, on any scale, is even more difficult. It is a far more challenging task than most other forms of health intervention. For instance, it is much easier to introduce a programme to immunize children against polio than it is to invent a programme which will reduce rates of malnutrition. Implementation of an immunization programme is...
In the late 1950s, I was assigned to work in a famine area of Gunung Kidul province in Indonesia. It was a limestone hill zone east of Jogyakarta and along the south coast of the main Indonesian island of Java. Each year, a dozen famine hospitals opened for 3-6 months during "the hungry season". Although there was child malnutrition, the elderly were particularly badly affected. Hospitalized cases were mostly elderly men suffering from undernutrition with oedema* (hunger oedema) after years of poor diet. The 11,000 beds made available each year could only touch the surface of the problem.

**Malnutrition and the environment**
The area of Gunung Kidul in which I was working was an ecological disaster. A hundred years before, natural teak forest had covered the hills. Gradually, on the orders of the then colonial administration, the trees had been cut down in order to plant coffee, and later cassava. Tragically, the coffee had not thrived and cassava was introduced as a major food crop. The soil had become progressively more exhausted and eroded. With less and less soil to cover it, large areas of limestone had become exposed.

Poor soil created new problems for those working on the land. Reduced harvests meant that when stocks ran out, poor farmers had to borrow to buy food supplies. The result was heavy indebtedness for these poor farmers. As soon as their first harvest was ready, they had to carry it - either as head-loads or on their backs - to Jogyakarta, to be given direct to moneylenders or sold in the market. The condition of the loan was often that it had to be paid back at the beginning of harvest. During this period, the price they obtained was very low. Subsequently, the price would skyrocket. If later, they ran short of staple food, it had to be bought at 4-10 times the price of the first harvest crop.

By the time I started working in Gunung Kidul, cassava had become the main energy-giving component in the diet. Little in the way of protein complement was available. Besides perennial young-
child malnutrition, adult hunger oedema was also a severe problem. It was particularly a problem in the pre-harvest season, a time in which hunger prevailed everywhere. The more fortunate families ate one meal daily; the less fortunate, one meal every two days. People kept the cardboard-like peel of cassava to be consumed in these months. There was nothing else to eat except the bark and the hard, green leaves of the few banana trees which grew on patches of fertile and well-watered land. Many of the adults who were subjected to this diet suffered from green diarrhoea, a result of eating indigestible banana leaves. For many, green diarrhoea was a sign that the terminal stage of their hungry existence had arrived.

**Government and people’s action**

With the backing of the local government, several initiatives were made to improve the situation. First, the district and village leaders were strongly sensitized on the dangers of soil erosion and exhaustion. Local officials recommended the construction of small bench-terraces with stony walls on the sloping land, and planting hedges (*Leucaena* or other leguminous shrubs) and other shrubs and climbing beans (eg *Mucuna utilisima*) on exposed areas of land.

The local government also made regulations that no staple food should be exported from any village until the village store contained enough food to last until the next harvest. If too much food did leave the village, there was a second safety check. At the provincial capital, through which all produce had to pass, stores were created and reserves had to be filled before staple food crops were allowed to be exported.

All this was done with minimal financial resources but active sensitization and advocacy at district and community level. By the time I returned to the area in 1971, the famine hospitals had been permanently closed. The terraces and hedgerows were abundant everywhere and there was an air of quiet stability. To me, this experience provides a valuable story of what can be done by a combination of government and people’s action.

When I left the area at the end of my assignment twelve years earlier, it had been with a good deal of pessimism (Bailey KV, Rural nutrition studies in Indonesia. XI. The Gunung Kidul problem. Trop. geogr. med. 1962, 14: 238-258). Since seeing the changes on my return, I hope I shall never again underestimate what the concerted efforts of government and people working together can achieve.

The story also illustrates what may be a general principle in successful initiatives in community nutrition. It appears
THE WORLD CAN BE ADEQUATELY FED

Options and priorities

Increase food production
At present 10% of the world’s land is used for farming. Another 5% could be used. Food production could be increased by irrigation, better credit systems, improved roads, etc.

Reduce food losses
One third of all the food produced is lost through disease, insects and rodents. Build better storage and develop disease-resistant strains.

Use appropriate technology
In some cases, this means low-cost tools that are easily maintained and repaired. Develop and use simple equipment that saves labour, eg bullock-drawn ploughs, irrigation pumps, etc.

Introduce a “new green revolution”
Continue development of new strains of locally-resistant seeds which do not require high inputs of fertilizers and reliable irrigation.

Enact land reform
Redistribute land so that a greater number of people may own their own land. Establish cooperatives to market the product of these smaller units. Prevent the uneconomic division of land.

Reduce dependence on cash crops
And reduce the control of production and sale of the cash crops by agribusiness based in the richer countries.

Waste not want not
Use existing food resources more thoughtfully.

Use of food aid only when appropriate
Emergency food aid will continue to be needed. Such aid should be given in ways which do not reduce the incentives for local people to produce their own food.

Help the poorest become wealthier
Undertake development strategies which have the objective of helping the poorest members of society so they can afford to buy food in times of poor harvest.

Objective
For everyone in the world to be adequately fed

that successful programmes usually require a strong combination of governmental action (or at least some external support), patient communications, and people's participation and enlightened self-help. This principle is one of the conclusions emerging from a series of studies of 17 successful nutrition programmes in 12 countries in all parts of the world. They are reported in "Managing successful Nutrition Programmes", compiled by national experts and the secretariat of the Sub-committee on Nutrition of the UN Administration Committee on Coordination (ACC/SCN). A symposium on these programmes looked at integrated PHC, growth monitoring and supplementary feeding; fortification and distribution systems, and food stamps and other forms of income support. Those taking part came to similar conclusions on the need for combined government action and people's participation.

Nevertheless, in itself this conclusion is not enough to enable us to define the factors which work towards, or against, success. For a clearer picture, we need particularly to look at the dynamics at the community level.

Dynamics at the community level
To the visitor from outside - both expatriates and even those from the capital city of the same country - most villages in developing countries look deceptively homogeneous and even harmonious. However, those who come from rural milieux or who have spent much time there know that things are usually much more complicated than they seem. There are traditional patterns of leadership and loyalty at the local level which are not instantly obvious. Many communities have more than one ethnic group which may complicate the introduction of any community initiative. Even if there is only one ethnic group, there are usually strong links, social and economic, within extended families and beyond to subclans or clans.

Traditional leadership usually comprises a headman and a trusted group of "elders". These are the individuals with whom, formally or informally, discussions on key issues of community life may be held. Sometimes, there is also a parallel "official" village development committee with its own officers. Particular persons are allocated areas of responsibility, such as agriculture, health and social affairs, education, local trade, and security. As well as the groups of traditional leaders and the village committee, there are often several other traditional groups. For example, there may be two or more religious groups in the same village.

There are also often women's groups. These are sometimes traditional and sometimes "created" prior to building a cooperative of producers and/or consumers, for example. Alternatively, there may be women's groups resulting from women's welfare activities in the village stimulated by the district level. Any outside support coming for a particular nutrition initiative may well succeed if linked with the appropriate group. However, it may wither if linked with the wrong type of group.

Tensions concerning matters of land and territory are not uncommon. For example, it may be very difficult to organize a regular, monthly weighing of village children at one place. This is because each piece of land belongs to one particular sub-clan. Members of another sub-clan, living in another section of the community, may be reluctant to enter that territory.

Village meeting: understanding the dynamics of the community is vital if programmes are to succeed.

Those who come from a rural milieu know that things are usually much more complicated than they seem.
There may also be tensions relating to the choice of personnel involved in village health activities. A village health worker may have been appointed by the village committee, but in reality have been chosen because she is the daughter of a prominent person.

Hence the process of "dialogue", which is usually advocated as the means to introduce, stimulate or explore a nutritional initiative, is not as straightforward as it seems. It is likely to involve women because outsiders are likely to choose to link up with women's groups and health workers. But men must also be involved. Another problem is that direct discussions between outsiders, especially male outsiders, and the women of the community may be culturally unacceptable to the men. In any case, it is likely that several lengthy dialogues over a period of months will be required before reaching any durable conclusions.

Dialogue may be easier if there are formal community structures, such as a village development committee. Where this is not the case, it is much more difficult to ensure effective interlocking of ideas. While agreement may be reached among a group who meet for the dialogue, it may not produce a response nor a commitment from the rest of the community.

**Can programmes be community-generated?**

The theoretical ideal is that a community identifies that it has a nutritional problem and comes forward with proposals for action to remedy the situation. The action may be entirely within its own self-help possibilities, or it may require government or other "external" support (that is, support from outside the village).

From the point of view of the government health services, nutrition is a part of maternal and child health (MCH) and PHC. But for village people, the priority health need is usually that of access to health services, especially in emergencies, and essential drugs. Nutrition is seldom a perceived need of the community. Only when there has been a considerable educational process at the community level will it become one. Even local health workers conceive their functions mainly in relation to provision of first aid and treatment of common ailments, particularly infectious.

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**ZIMBABWE: COMMUNITIES WORK FOR BETTER NUTRITION**

Programme (SFPP) originated as a child feeding project soon after the independence of Zimbabwe in 1981. Although not planned as an emergency programme, by the time the project started drought and famine had created a community awareness of the need for food relief. The original and most important objective of the programme was to encourage communities to work together to meet the demand for nutritious foods, particularly for young children.

The programme was highly successful during its first few years. An evaluation of the programme in 1984 recommended it that it should be extended. Since then, the programme has spread to cover most districts in the country and grown to include over 6,000 ongoing projects nationwide. These projects comprise initiatives aimed at improving rainfed crops, vegetable gardens and small animal production.

Two of the most successful aspects of SFPP are the establishment of intersectoral collaboration and the increase in community participation and awareness of nutrition issues. There is active collaboration from key sectors, such as Agriculture, Community Development, Local Government, and Education in nutrition projects. The SFPP is now integrated into the Agriculture Sector plans, indicating a level of involvement and support from agricultural extension workers. In terms of community participation and awareness of nutrition issues, an evaluation in May 1989 indicated a high level of community participation. This augers well for the sustainability of the programme. A number of projects have been able to endure as a result of community contributions of labour, implements and even cash.

Source: Adapted extracts from "Managing successful Nutrition Programmes"; a report based on a UN Administration committee on Coordination - Subcommittees on Nutrition (ACC/SCN), Geneva.
diseases. If preventive aspects are envisaged at all, efforts are towards improving the safety of water supplies and sanitation. It would be rare for communities - other than those in near-famine conditions - to identify nutrition as a priority need. This is true despite the fact that poor nutrition is a major factor underlying most of the childhood deaths.

**Primary health care approach**

A more mature understanding of the importance of nutrition can however be stimulated. It may come through good development of local MCH services, particularly growth monitoring (see page 10). Even if this growth monitoring is done only at health post level, it may produce changes in thinking about nutrition. If it is done at village level, preferably by trained community persons themselves, it is especially likely to produce results. Involving local people requires well-developed and wide-coverage PHC programmes which are rare. At the same time, nutrition - although one of the eight essential elements of PHC - is often missing or a poorly-developed component.

However, PHC is an important "gateway" to community-based nutrition programmes. It is a logical entry point since the general PHC system provides a good framework in which selected community persons can be trained for modest but feasible nutrition activities. These include growth monitoring, nutrition education and possibly prevention of micronutrient deficiencies, such as of iron, iodine and vitamin A. This PHC framework should be enough to sustain genuine community-based nutrition activities.

**Primary school approach**

A second approach to community nutrition activities can be through primary schools.

School feeding programmes may be developed using food donations or food produced in school gardens or both. These programmes are particularly effective when associated with nutrition education by teachers and others at the community level. Such education can be very effective in generating improved home gardens, particularly for the prevention of vitamin A and iron deficiencies. The Philippine Applied Nutrition Project, initiated in the 1960s, put quite a lot of effort into this approach. The emphasis was on promoting the production and consumption of green leafy vegetables and orange-coloured fruits and vegetables in both school and home gardens. It proved to be both low-cost and effective.

Community education may also produce greater attention to the overall food needs of the community and of families. In the Iringa nutrition programme in Tanzania, nutrition education led to families being taught how to assess their food needs. Once they knew their needs for the family until the time of the next harvest, they were encouraged to...
Children who are growing adequately never suffer from malnutrition. To see that children are growing regularly, some system of monitoring is essential. In an attempt to make this possible, growth charts have been widely recommended by international organizations such as WHO, Unicef and Save the Children Fund. Unfortunately, there have been difficulties in such programmes, partly due to lack of resources but even more to lack of training amongst village and front-line health workers. In most school systems in developing countries, graph paper is not found in primary schools and the whole concept of graphs and histograms is not easily understood by large sections of the population.

For this reason, a simple growth chart is not easily understood by the mother. Too frequently the significance of variations in the growth curve are not comprehended even by health workers. The movements of the growth curve are not easily interpreted into appropriate advice and action. For many years, the standard equipment for weighing children, particularly at village level, has been the hanging Salter scales. However, these are quite expensive and the reading of a dial and completing of a chart may be difficult. Fortunately, a new development of a direct recording scale, in which the chart is fitted and a mark is made at the top of a spring which stretches accurately 1 cm a kilogram and records the next point on the child's growth curve, has been introduced (see drawing).

It is hoped that these TALC direct recording scales* may take the weighing of children away from the clinic into the community, where the grandmother, father and other members of the household can be involved in discussing the child's growth and making decisions which are often difficult for the mother to make. Instructions to help the mother must be simple and must be in terms of a discussion with her - a discussion in which she is fully involved.

Promotion of growth must be part of primary health care with growth monitoring as one of the central issues. If weighing of the small child can be undertaken in or near the home, this should be an occasion for discussing other health measures, such as immunization, oral rehydration and eye care. At the same time, any health problems affecting the whole family can be considered. Weighing the small child can be made an entry point for considering the total family health and welfare.


*TALC direct recording scales are available from Teaching, Aids at Low Cost (TALC), PO Box 49, St Albans, Herts, AL1 5TX, UK.
find out whether they had enough cereal crop to meet these needs. Only then could they quantify the surplus and discover how much they could safely sell.

**Drought-related approach**

A third circumstance in which nutrition activities can be stimulated is when there is drought or a famine from other causes. In this unfortunate situation, the community is well aware of the food shortage. The people do not need education to be conscious of the problem. The difficulty is that the community is inevitably heavily dependent on outside help during the early emergency stages.

However, if food supplements are needed, every effort should be made to ensure that the foods provided are the same as the traditional local ones. Village leaders and those in charge of village sub-divisions, or hamlets, need education on appropriate patterns of feeding for young infants so that they can pass this information on to others.

The Zimbabwe programme (see box on page 8) started as such an emergency programme, and was afterwards developed as a self-help community food production programme for young-child feeding.

The Zimbabwe experience provides useful lessons. It would be highly desirable if all emergency feeding programmes could be tackled by dividing efforts into the three phases of relief, rehabilitation and reconstruction.

**Getting started**

Although starting an essentially self-reliant approach to community nutrition poses some problems, it should not be too difficult. Experience shows that people at all levels are usually at least partly aware of deep underlying nutritional problems. What they are usually less well informed about are the specific problems in a particular area or community. Often, they know even less about how best concretely to tackle the problems.

At the local level, UNICEF has advocated the "Triple-A approach" of "Assess, Analyze and Act", in which people are empowered to find the best intervention, technical or otherwise, in a given situation. Based on the experiences of the Tanzania nutrition programme, primary problems are identified by simple question-and-answer sessions at the community level (Assessment). For instance, protein-energy malnutrition affecting young children may well be recognized by local people. Some may even be able to identify several of the main contributing causes. However, community members seldom have enough technical knowledge to carry out this assessment.
BREASTFEEDING: COMMUNITY GROUPS IN ACTION

Not only is breastfeeding the best way of feeding babies, it also prevents diarrhoea and saves money that might otherwise be wasted on infant formula and commercially-produced weaning foods. The following are three examples of community initiatives to promote better infant feeding and to spare women the misery of sick babies and empty purses.

Angola
In early 1994, even before it was clear that there was any hope of peace in Angola, the Christian Youth Association of Angola (ACJ) had started working on how to reconstruct their country. They had chosen to begin by building up the health and well-being of babies and infants, society's hope for the future. In October 1994, ACJ organized Angola's First Conference on Breastfeeding. Fifty-six participants met in Luanda, the Angolan capital, including representatives of several UN and government organizations as well as churches and several NGOs involved in health in Angola. The result of the conference was a series of recommendations and an action plan for breastfeeding. In order to ensure the support of as many groups as possible, a cooperation protocol between Unicef Angola and ACJ was signed for the implementation of the action plan.

Ghana
The Ghanaian Infant Feeding Action Group (GINAN) has chosen another approach. They aim to promote "exclusive" breastfeeding in the marketplaces of Ghana. "Exclusive" means breastfeeding only and giving no other baby milk or liquid at all for the first months of a baby's life. In Ghana, as in many parts of the world, most women breastfeed their babies but they give supplements too early.

International agencies such as WHO and Unicef recommend breastmilk only for the first 4-6 months of life. So far, GINAN has trained 13 carefully-selected market women who work in the markets of Makola and Kâneshe in the Accra metropolis. They used participatory learning methods such as role-play, songs and group work. Now, these trained women support and counsel other sellers. The aim is to ensure that all market mothers make their choices about how best to feed their babies on the basis of information which is free of advertising pressures.

Cameroon
While mothers in Ghana breastfeed their babies at the market, market mothers in Cameroon tend to leave their babies at home. This presents a risk of the dangers of bottle-feeding. The Cameroonian Infant Feeding Action Group (CIFAS) based in Yaoundé therefore decided to organize a crèche in Elig-Edzoa market. The premises were provided by the town council and include a kitchen and nursery. Trained staff counsel and support breastfeeding mothers, and CIFAS members provide on-the-spot training outside the crèche about the benefits of breastfeeding and the dangers of bottle-feeding.
process adequately. Government personnel are probably needed to facilitate this assessment stage. For example, they could help determine the main difficulty in young child-feeding. They would help to define whether the problem is lack of suitable foods or missing nutrients due to lack of variety or the fact that food is given too infrequently or in too dilute a concentration, or whether the first weaning food is an energy-poor porridge. In the same way, the community would seek information in order to make an analysis of the causes of the problem.

In remote areas hardly accessible to poor governments, such expertise can often be provided on a small scale by a non-governmental organization (NGO) having the personnel and logistical resources to get to village level. Whether the support is from the government or an NGO, the priority is to define the nutritional problems clearly and correctly, to analyze them (Analysis) and then to implement feasible and appropriate measures (Action). The implementation of some action requires the involvement of another level. For example, salt iodization has to take place at sites of local salt production or importation. However, with correct analysis of the problem, effective action can very often be undertaken by the local community. For success, the emphasis needs to be on making the correct assessment of the problem, on communications, and on the training of local people to carry out and supervise the relevant measures.

**Going to scale**

In many countries appropriate community-based activities have been well developed, particularly with the help of NGOs. However, very often this involves an intensity of input - both in terms of finances and expertise - that cannot be made available to a wider area or to the whole country. Many governments have nevertheless committed themselves to such processes on a large scale, particularly in the context of PHC. Even in a country where PHC currently reaches only 10% of the population, there may be plans for its gradual extension. The nutrition component may be known to be weak but efforts can be made to strengthen it. At village level, health volunteers can be trained in each hamlet. Some can be trained for environmental health aspects, others for mother and child care. If effectively guided, these volunteers can do much to recognize early under-nutrition, perhaps with the help of some form of growth monitoring. They can also help to prevent under-nutrition by educating the mothers, with whom they can work out how best to make use of local nutritious foods which are already available or can be promoted. Two of the most important messages are exclusive breastfeeding for the first 4-6 months, and appropriate use of local foods in complementary feeding.

*Image: Urban Industrial Mission programme of Indonesian Council of Churches trains community organizers to help slum dwellers press for better housing, water supplies and sanitation.*

*If effectively guided, these volunteers can do much to recognize early under-nutrition.*
Governments are making efforts towards PHC programmes that are both village-based and sustainable in terms of the inputs required. An approach which emphasises a minimum of equipment, plus training and supervision of community-supported volunteers seems to be the right one. However, it is an approach which calls for patience, thoroughness and persistence.

As mentioned earlier, there are many pitfalls along the path to genuine and effective participation of the community leaders and members. In some circles, there is a certain scepticism and impatience about PHC. My experience has been that when issues are discussed clearly, thoroughly and frankly with community leaders and the people, their response is strongly positive. Mistakes will always be. Some opportunists exist at community level who will exploit the situation for their own advantage. But in the main, experience justifies optimism in the process.

Such programmes are continuing to extend, albeit slowly, in most countries of Asia, Africa and the Americas. Communities have shown, time and again, that when they are taken seriously and involved in their own assessment and analysis, it is much more likely that action will lead to a positive impact on health and nutrition.

International Initiative
In 1992, the International Conference on Nutrition, convened by Food and Agriculture Organization (FAO) of the United Nations and World Health Organization (WHO), adopted the World Declaration and Plan of Action for Nutrition. It includes nine goals for nutritional improvement in this decade. It also identified nine strategies through which the goals could be attained (Information sheet available from WHO nutrition programme, address on page 15). The 160 signatory countries committed themselves to draw up and implement a national plan of action for nutrition based on this broad commitment. Most countries are well advanced with this process. A key concept in this approach is that there must be at the same time:

i) overall policy commitment, a national strategy and plan of action;

ii) implementation of programmes at the local (district level) coordinated by the local government services;

iii) full community participation in the planning, implementing and evaluating of the programme. The full involvement of the communities is clearly crucial to success. Only time will tell whether this crucial concept and approach is satisfactorily incorporated in the national plans of action.

Without community participation little can be achieved. To achieve participation, vigorous technical support from the district level is needed, preferably in partnership with NGOs. Equally vital is that community plans take into account nutritional objectives and considerations of national socio-economic development plans.

NGOs, including several religious-based ones, played a significant role in contributing to the formulation and adoption of the World Declaration and Plan of Action for Nutrition. They continue to have an important part in supporting and participating in the implementation of the national plans of action. In particular, they could play a crucial part in strengthening the community-based components.
This list includes some useful publications and newsletters on nutrition. Unless otherwise stated, these publications are available in English only. Addresses of distributors are provided in the Address box in the margin.

**Food Cycle Technology Books** form a series on the processing of different foods. For example, Cereal Processing looks at traditional and improved methods of processing four cereals - maize (or corn), rice (or paddy), sorghum and wheat, as well as information about equipment. Details of the series from Intermediate Technology Publications.

**Guidelines for training community health workers in nutrition**, Nutrition learning packages, The community health worker, and The growth chart: a tool for use in infant and child health care are just a few of the titles in WHO training materials on nutrition. More details from Food and nutrition programme, WHO.

**Food Safety** catalogue provides bibliographic and descriptive information for over 40 WHO publications focused on the massive public health problems caused by food-borne diseases and by food losses due to contamination and spoilage. Also available are WHO Golden Rules for Safe Food Preparation poster, Facts about Infant Feeding and Hygiene in food-service and mass catering establishments (WHO/FNU/FOS/94.5). Write to: Food and Nutrition Programme, WHO.

**Development and health in Pahou, Benin** includes a series of publications in French and English about a project which focuses on community participation in primary health care approaches, rapid appraisal methodologies, nutrition and causes of malnutrition. For more details write to: KIT Press, Royal Tropical Institute.

**Helping mothers to breastfeed** provides health workers with practical guidance on how to prevent problems. Written by Felicity Savage King, it is available in English and Spanish from TALC. Price £2.50, plus postage and packing (£2.50 for surface and £3.00 for airmail).

**Nutrition books** in a series 14 from South Pacific Community Nutrition Training Project include titles such as Food, Drinks and Life, Preparation of Pacific Island Foods and Developing Community Nutrition Programme. All are well-illustrated and provide practical manuals for community workers. For more details write to Extension Services, The University of the South Pacific.

**Nutrition for developing countries** brings the subject up-to-date but retains a simple approach. Written by Felicity Savage King and Ann Burgess, it is available from TALC. Price £2.50, plus postage and packing (£2.50 for surface and £3.00 for airmail).

**Nutrition handbook for community workers in the tropics** contains information on different health, food and nutrition subjects. Each chapter starts by telling you what you should be able to do when you have finished studying the chapter. It was produced by Caribbean Food and Nutrition Institute (PAHO/WHO) and Ministry of Health, Jamaica in collaboration with Caribbean Food and Nutrition Institute. It is available from TALC. Price £4.50, plus postage and packing (£2.50 for surface and £3.00 for airmail).

**Ceres** is the bi-monthly magazine of the Food and Agriculture Organization (FAO). It provides a forum for discussion on rural development, farming, fisheries and forests, and on related issues such as justice and equity (for example, with regard to land reform and gender), the environment, trade and food security. Subscriptions cost US$33 for six issues per year. Write to Ceres, FAO, Viale delle Terme di Caracalla, 00100 Rome, Italy.

**Mothers and Children** is published three times a year in English, French and Spanish by the Clearinghouse on Infant Feeding and Maternal Nutrition. It is distributed free in Asia, Africa and Latin America (US$10 per year to readers in North America and Europe). For more information, contact International Clearinghouse, American Public Health Association, 1015 15th Street NW, Washington, DC 20005, USA.

**Nu. Nytt om U-Landshållsvård** (News on health care in developing countries) is a forum for discussion (in English) on current health care issues and information exchange. It often features issues in nutrition. Published four time a year, it is available free of charge from NU. Nytt om U-Landshållsvård, ICH, University Hospital, Entrance 11, S-751 85 Uppsala, Sweden.
CHRISTIAN HEALTH ASSOCIATIONS MEET TO SHARE AND COORDINATE

CMC - Churches' Action for Health organized the Second Consultation of Christian Health Associations (CHAs) in the quiet shade of the Lutheran Uhuru Hostel below Mount Kilimanjaro in Tanzania. Representatives from CHAs in 17 African countries, from India, Philippines, Papua New Guinea, Jamaica and CLAI (Consejo Latinoamericano de Iglesias) in Ecuador met to share experiences and build plans for the future. The meeting produced the following statement which built on the declaration produced at the first meeting held in New Delhi in 1992.

Moshi Declaration 1995

We, the representatives of Christian Health Associations (include national/regional church health coordinating bodies/health desks and Christian medical associations) met in Moshi, Tanzania, 18-25 June 1995, and appreciated the opportunity of renewing contacts, making new friends and sharing experiences. We recognized that there are ways in which we can help each other in strengthening the Church in its ministry of health, healing and wholeness. We thank CMC, Geneva, for making it possible to meet at the second international consultation. In recommitting ourselves to promoting the ministry of health, healing and wholeness we affirm:

1. The 1991 New Delhi Consultation Statement and the various background papers and recommendations in the final report.

2. That the Church is called to a ministry of health, healing and wholeness as
an integral part of its life and witness in the world today.

3. That the overall goal of ministry of health, healing and wholeness of the Church is to promote the Kingdom of God - the building of a healthy, just and self-sustaining society.

4. That the ministry of health, healing and wholeness is concerned with promoting fullness of life - including physical, mental, social, economic, spiritual and political dimensions of wellbeing of all God's people with a preferential option for the poor, oppressed and marginalized.

5. That the ministry of health, healing and wholeness goes beyond hospital care and medical models and involves restoring healthy relationships between God, human beings and all creation.

6. That CHAs are all part of the Church with a specialized role of promoting the ministry of health, healing and wholeness.

7. That the churches have been and should be involved in health, through hospitals, clinics and community-based programmes, and that there has been a need for coordination and cooperation for equipping the churches to cope with emerging problems and challenges in health.

8. That CHAs recognize the differences which exist among them in their history, realities, limitations and constraints, but agree to work together and strengthen each other for the glory of God.

9. That belief in God provides us with hope and enables us to experience a spiritual dimension to health, healing and wholeness through Jesus Christ.

Christian Health Associations (CHAs)

Goal:
The overall goal of CHAs (its members and organizational structures) is to facilitate the involvement of the Church, its health units/community programmes and members, in the promotion of the ministry of health, healing and wholeness towards building a just, healthy and self-sustaining society.

Common functions:
- Strategic planning (with emphasis on community participation) and regular evaluations.
- Empowering communities for social change and the building of healthy communities.
- Advocacy between and among health units, governments and other agencies (liaison/representation role).
- Networking with non-governmental organizations (NGOs), and govern-

Young girl in Tanzania carrying home water.

Empowering communities for social change and the building of healthy communities.
Creating awareness through effective communication on health and health-related issues.

- Coordinating activities of CHA member units/programmes/institutions for the realization and improvement of health.
- Creating awareness through effective communication on health and health-related issues.
- Encouraging documentation, information sharing and relevant research.
- Organizing/undertaking human resource development (training) for member units and others.
- Providing a forum for sharing on health issues, Christian fellowship and witness.
- Becoming a source for and mobilizing resources within the community, government, donors and other agencies.
- Handling matters of consultancy, capacity building, monitoring, evaluation and reflection.

We want to share, both the report of the New Delhi Consultation and this one with our members, churches, national and regional ecumenical bodies and the world-wide community of Christians committed to improving the health and wellbeing of all people. We would wish to widen our fellowship with countries not represented here including those of the North. We ask CMC/WCC to help facilitate some of the exchange and support to help each other. More specifically we request CMC/Geneva to assist us by:

- making available a directory of Christian health agencies throughout the world
- providing space in Contact for regular information on CHAs and the promotion of health, healing and wholeness
- facilitating the exchange of resources and needs in training, capacity building and support for CHAs and their members; and also to collect and disseminate appropriate information in this area periodically
- encouraging sharing and support for South to South exchange

During the consultation we have made personal contacts, commitments and plans for our CHAs and networks. We have also shared some of our problems, concerns, needs and possible resources.

As in our previous consultation four years ago, we, the participants, commit ourselves to:

- keep in touch with each other and ensure some follow-up;
- share information with CMC and others;
- help to provide hospitality and support, where possible, for exchange persons we receive in our country;
- raise resources, where feasible, for greater South to South solidarity and exchange;
- pray for one another.

Did you see Contact 137 Coordinating Agencies - Churches' working together for health? If not, we would be happy to send you a copy if you write to us (address on back page).
AHRTAG (Appropriate Health Resources and Technology Action Group) is a unique source of information on primary health care in developing countries. Among the group's many publications, AHRTAG Update, published 10 times a year, provides a listing of all books, manuals, journal articles, conference reports and other items entered each month into the bibliographical database of AHRTAG's resource centre. The resource centre collection focuses on the practical aspect of primary health care, particularly on issues concerning implementation and resource materials useful for the education and training of health and community workers. For further information, write to: AHRTAG, Farrington Point, 29-35 Farrington Road, London EC1M 3JB, UK. Fax: 44 171 242 0041. E-mail: (Internet) ahrtag@geo2.geonet.de

FAKT (Association for Appropriate Technologies) is a German consultancy which can help you ensure that purchases of equipment and donations from overseas are appropriate for your primary health care programme. FAKT was founded in 1986 by organizations of the Protestant Church in Germany. Since then, many consultancy services have been provided to overseas partners on projects financed by Bread for the World, GTZ, Misereor and so on. FAKT also provides on-going consultancy arrangements in which it promotes appropriate management of hospital equipment and provides back-up for those responsible for maintenance of technology at the primary health care level. For more information, write to: Hospital Technology Consulting Service, FAKT, Gänseheidestr. 43, D-70184 Stuttgart, Germany. Tel: 49 711 210 95-0. Fax: 49 711 210 95 55.

Directory of Training Courses 1995
Issue 4.94 “Training and training opportunities” oINU.Nytt om U-Landshälsovård (News on health care in developing countries), contains a useful directory of a selection of training opportunities around the world. It lists some 230 courses and conferences related to health care in developing countries. This issue, and others (see page 15), is available free of charge from NU. Nytt om U-Landshälsovård, ICH, University Hospital, Entrance 11, S-751 85 Uppsala, Sweden.

Tuberculosis epidemic
WHO has announced its recommended strategy to “Stop TB at its Source”. The source of the epidemic’s uncontrolled spread is sick and infectious TB patients who are not cured. WHO therefore recommends DOTS, or directly-observed treatment, short-course, in which health workers watch as each patient takes the correct medication. Once people are cured of TB, they can no longer infect others. The strategy is made available through the publication of a very colourful, attractive and readable report on the 1995 tuberculosis epidemic. It details the problem, the solution and the key plans in the battle plan to fight TB. Stapled into the centre of the report is an illustrated story book which explains to children how to fight the oldest disease known to humanity. Write for a copy to: Tuberculosis Programme, WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

It is a joy for us in the medico-social section of the Daughters of Mary mission in Haiti to have the opportunity to be in direct contact with Contact magazine. We are happy to thank the current editorial committee, as well as all those who worked on the magazine in the past, for the immense service that Contact gives. It is such a useful tool for those of us who work at the grassroots level.

What captures our interest most is Contact’s sense of mission and the universal nature of the articles. This quality permits us to benefit from experiences similar to our own. All are projects in which the poor, in the widest range of countries, do their best to bring about change by using their own creativity. Another attraction is Contact’s overall concept of health. This concept perceives the human person as a whole, and as part of an environment in need of change.
We like the news and the sharing of experiences. These show the determination of Third World people to take action and to invent processes which respect their identity and their know-how. We like the variety of the themes, the presentation of the studies, and the rigour of the research. We like the ethical concern in efforts to improve individual and community life, and establish links between health and faith.

For us, Contact is an excellent work tool which has given inspiration and dynamism to our research in community health over the past two decades. Our work has included the first popular, progressive medico-social centre in Plaisance in the north of Haiti; the nutrition centre de Sans-Fil in Port-au-Prince; the recent experience in Mothers’ Clubs; the preschool nutrition monitoring and rehabilitation course; and the training for our community health volunteers at the grassroots in Martranc, a village near Jérémie, in Plaisance, and in areas of the Dominican Republic where Sisters of Mary are working.

Here in Haiti we join all Contact “fans” in wishing you well for your future success and long life on the occasion of your 25th anniversary. Ad multos annos!

Comité Médico-Social de la mission Filles de Marie
Bel-Air, Port-au-Prince, BP 1374, Haiti

FEEDBACK

Contact 145 August-September 1995

“Women and AIDS”

In response to the suggestion “there was a deliberate conspiracy of silence about refugee women and HIV/AIDS on the part of the international organizations” (Contact 145, “Conference findings” page 11), Dr Doris Schopper of WHO writes:

Several UN agencies have recently begun action to address sexually-transmitted diseases (STDs) and HIV/AIDS in refugee situations. An inter-agency symposium on Reproductive Health in Refugee Situations was held in Geneva, Switzerland, 28-30 June 1995. It was hosted by UNHCR and UNFPA, in collaboration with WHO and Unicef, and attended by several hundred people coming from the range of UN, NGO and other organizations involved in addressing refugee situations. HIV/AIDS and STDs formed an important theme of this symposium. The two hosting agencies, with the technical support of WHO, are currently finalizing a field manual for reproductive health in refugee situations, a chapter of which is devoted to HIV/AIDS and STDs.

In a parallel initiative WHO and UNHCR have jointly prepared detailed guidelines for HIV interventions in the early phases of emergencies in general and plan to extend these guidelines to the post-emergency phase.

The various UN organizations can be contacted for more information.

Dr Doris Schopper
Global Programme on AIDS
WHO, Geneva, Switzerland

Erratum

Anne Skjelmerud, author of “Women and the AIDS crisis” (Contact 145, pages 3-7), would like to correct the impression given at the beginning of this article that she undertook research in Uganda. In fact, the example about the Ugandan secondary school youth was taken from Tony Barnett and Piers Blakie “AIDS in Africa: Its present and future impact” 1992.

Contact is a periodical publication of “CMC-Churches’ Action for Health” of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya, and Arabic in Cyprus. Present production exceeds 32,000 copies.

Contact deals with varied aspects of the community’s involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to Contact, the publication of CMC-Churches’ Action for Health, WCC.

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The average cost of producing and mailing each copy of Contact is Swiss francs (CHF) 4 (US$ 3.50), which totals CHF 24 (US$ 21) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to Contact to cover these costs. Please note that orders of back issues of Contact are also charged the above rate.