

SUSTAINABLE COMMUNITY NUTRITION PROGRAMMING
Enabling components for an effective program framework

These include community-based trainers, community service providers, village leaders, program committee members, and IEC agents.

Experience shows that stakeholders at all levels of the implementation process, including the central and sub-central levels, might need some type of training or capacity-building. This is particularly true for those who are expected to supervise community-level workers.

Ideally, a pool of trainers and trainees should be trained to avoid the risk of compromising the smooth progress of the program due to dropout or attrition.

● **What will they be trained in?**

Implementation of a successful and sustainable community nutrition program requires awareness, knowledge, and understanding of a variety of issues and approaches and proficiency in different skills.

The following issues could be considered as part of the content of a training plan:

- ◆ **Awareness** of the importance of community participation and engagement; the importance of integrating nutrition into community development programs; the importance of demonstrated political commitment; the role of gender in developing of community nutrition programs; and an active and participatory approach to community nutrition programming
- ◆ **Knowledge and understanding** of the Triple A cycle, the conceptual framework for malnutrition causal analysis; the goal and objectives of the program; the role of different partners; the nutrition problems and practices in the community and how they will be addressed; and the management information system, including how the program will be monitored and evaluated.
- ◆ **Skills** in participatory assessment; social mobilization; negotiation; teaching adults; counseling; financial management and entrepreneurship; IEC techniques; data collection methods; supervisory guidelines; and specific skills related to the program intervention strategies employed, such as weighing and measuring of children, etc.

● **Who will train?**

To the extent possible, training should be conducted in surroundings similar to those in which trainees work. For this reason, most training of community-based stakeholders is decentralized and facilitated by training teams operating from the regional and district levels. These teams are usually composed of nurses, midwives, program managers, and nutritionists who do not always have enough knowledge about the types of teaching methods that facilitate adult learning. Some CNPs now contract out training services to consultants or institutions specializing in training. See Box 13, page 43.

● **How will they be trained?**

Adults come for training with a wealth of skills, experience, and specialized needs, and teaching them requires the use of special skills and techniques. Some guidelines for teaching adults are provided in Box 17, page 52.

All community-based nutrition program workers receive on-the-job training during routine supervisory visits. Such training is usually conducted on-site and addresses the problems that hinder job effectiveness. In addition, refresher training at regular intervals is appreciated by community health workers as a motivating tool and as another way of increasing on-the-job effectiveness.

Training objectives and procedures must be tried, tested, standardized training manuals, and subjected to periodic review. Training manuals should contain the following information: learning objectives; steps, processes and activities to meet each objective; technical information for trainers; and teaching aids.

● **How long should training last?**

The duration of training will depend on a number of factors, such as the scope of the tasks the trainee is expected to perform and the previous training and experience of the trainee. Most training is not completed in a set period of time or at the end of the formal training course. Agricultural calendars should be considered when setting training schedules in rural settings.

Senegal**Box 17: WHAT TOPICS FOR COMMUNITY SERVICE PROVIDERS?****Training community agents responsible for the management of the community nutrition centers by AGETIP**

MODULES TREATED:	
1. Information on the Community Nutrition Program	<ul style="list-style-type: none"> • Planning of center and community activities • IEC techniques
<ul style="list-style-type: none"> • Genesis of the CNP • Organizational chart of the CNP • Organization of community nutrition centers 	5. Guides and tools for management of CNC
2. Entrepreneurship & contracting out services	<ul style="list-style-type: none"> • Presentation on CNP • Program targets • Organization of the CNC • Roles and responsibilities of Community micro-enterprises • Management tools • Activity reports • Monitoring of activities
<ul style="list-style-type: none"> • Presentation on private enterprise • Associations and income-generating associations • Private enterprises and the market • Contracts 	1. Organization and management of beneficiary contributions
3. Nutrition and health; basic concepts and strategies	
<ul style="list-style-type: none"> • Food groups and cooking demonstrations • Growth surveillance and promotion • Breastfeeding • Malnutrition, young child feeding • EPI, prenatal consultation, family planning, assisted delivery • Acute respiratory tract infections 	Source: Mr. Ibnou Gaye, AGETIP, Presentation on the Community Nutrition Project of Senegal. Presented at a Workshop on "Experiences from Community Nutrition Programs." 23-27 March 1998, Dakar, Senegal
4. IEC/ Social mobilization	
<ul style="list-style-type: none"> • IEC concepts and strategies 	

3. PARTICIPATORY APPROACHES FOR NUTRITION COMMUNICATION

Traditional nutrition education approaches based on health talks and the use of printed media have had limited reach and impact. The original approaches were essentially based on the transmission of knowledge from a health agent to targets considered to be "ignorant," using formal techniques based on lectures, during which the trainees remained passive listeners. Health agents were usually health professionals, such as nurses, nutritionists, and doctors, who tended to teach what they themselves learned during their professional training.

Nutrition education/communication strategies are now moving into more innovative and interactive spheres that place greater emphasis on social communication through interaction of trainers and

trainees of the same culture, using participatory learning techniques.

A number of approaches have been used. For example, traditional communicators—e.g., griots—have been used to relay health and nutrition information through theatre, role-plays, songs, and skits. Peer counselors have been used to promote best practices with regard to infant feeding and management of childhood illness, and community and religious leaders have been used to promote family planning and preventive health services.

The goal of any CNP/IEC strategy should be to deliver culturally appropriate nutrition messages using locally available communication channels.

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It should also foster a sense of friendly competition between and among communities.

Developing an IEC Strategy

Bringing about changes in nutritional status requires that target groups change deeply embedded cultural practices and perform these new behaviors be performed daily or more frequently over a period of years (Parlato & Seidel, 1998). Planning the IEC component of a community nutrition program is a complex exercise that requires careful thought and coordination.

The first step to developing an IEC strategy will involve selecting the priority target audience group, identifying behaviors amenable to change, testing possible improvements in practice, and assessing the locally appropriate communication channels to reach the target.

A similar approach to identifying the target group for a community nutrition program should be applied. (Described in Section 3, step 3)

The next step involves the development of the IEC strategy itself. This includes defining the objectives of the strategy, (i.e. what changes are expected), determining suitable IEC activities needed to bring about the desired behavioral changes, developing the messages and recommended practices to be communicated, and choosing the most appropriate combination of communication channels.

Prior to message promotion at the community level, IEC communicators should be trained in nutrition education. As most programs use interpersonal communication as an outreach strategy, high priority should be given to training in interpersonal communication skills such as nutrition counseling, and conducting group discussions.

Burkina

Box 18

FUNCTIONAL LEARNING: TRAINING WOMEN ANIMATORS

1. Training of Trainers - *This is conducted over a period of five days by members of the “Cellule Technique Nationale” (CTN) made up of four members from the ministries of agriculture, health and social action. They train the trainers who are staff of the ministries of health, agriculture and social action. The trainers then team up in groups of two’s to train the women animators. A team of trainers is responsible for training 30 women animators. Trainers are chosen based on their experience, responsibility and capacity. They are also resident in the area covered by the animators they will train.*

2. Training of Women Animators- *There are two types of training conducted: a) the classic training course and b) the specific training course for animators from guinea worm endemic zones and zones with high rates of vitamin A deficiency. Each course is conducted in phases and begins with the treatment of specific subject themes, after which the women return to their communities to practice what they have learned. Training continues with a review of the themes addressed in the first phase. Animators are taught different communication techniques and then sent back to the field to start testing their skills with mothers from their communities. From each group of 30 women animators trained in one session, 3 women who can read and write are selected to serve as supervisors. They receive an additional one day training.*

Source: Ministries of Health, Agriculture, Social Action and UNICEF. The Village Women Animators Network in Burkina Faso. A presentation made at the UNICEF Technical Workshop on “Promoting Community-based activities” , 1-4 November 1997, Nouakchott, Mauritania.

4. PROGRESS AND IMPACT: MANAGEMENT INFORMATION SYSTEMS

The management information system (MIS) is an essential part of program management because it keeps program managers and decision-makers informed about impact and progress. Program managers and their counterparts at the national and community levels should use the information derived from the management information system on an ongoing basis to monitor program progress and identify logistical bottlenecks, flaws in program design, and other potential problems.

Successful management information systems are simple and straightforward to ensure that data gathered are error-free, understandable, and can be used reliably for decision-making. An MIS should be able to respond to the changing needs of the program, so that adjustments can be made in a timely manner.

The more explicitly defined the program objectives are, the easier it is to tailor the MIS to program needs. An ideal MIS should use simple ways to collect and present data to community members and other partners. In addition, the system should

serve the purpose for which planners, managers, and evaluators need the information.

The efficiency of any system will depend on an adequate understanding by program managers of the program objectives, procedures, and tools. Therefore, training and regular supervision of personnel on implementation of the MIS is of key importance.

An efficient information system requires:

- ◆ Clearly defined program objectives, to facilitate determine of pertinent activities and select useful and simple indicators.
- ◆ Simple and flexible data collection methods that can be easily presented to decision-makers.
- ◆ Simple methods to analyze data that facilitate feedback and understanding at the community level.
- ◆ A rapid analysis of information and interpretation at the decision-making level

Gambia

Box 19

THE KABILO APPROACH: AN INDIGENOUS HEALTH COMMUNICATION CHANNEL

In The Gambia, the Kabilo Approach is the name given to a health program in the North Bank Division piloted by Save the Children Federation USA and the Gambian Ministry of Health and Social Welfare. This approach to community health and family planning employs existing village social structures to channel development activities.

The strategy provides key women in the community with basic but important health information that gives them better control over their own lives. Because of the highly organized Kabilo structure, and because Kabilo women are so highly respected in their communities, the Kabilo approach was found to be ideal for disseminating health information. It helped reduce maternal and child mortality by increasing community participation in primary health care, and sought to change perceptions of family planning and increase the use of modern contraceptives.

Source: Social Mobilization for Community Health and family planning. The Kabilo/Imam Approach, Programme implementation manual by Save the Children USA and the Agency for the Development of Women and Children.

Burkina**Box 20****DEVELOPING AN IEC STRATEGY: STATING YOUR INTENT**

In Burkina Faso: The Nutrition Communication Project has been working with the Ministry of Health to improve the nutrition status of young women and children. The project has as its primary beneficiaries, pregnant and lactating women and children age 5 and under.

A qualitative study was conducted to identify behaviors amenable to change, and optimal messages and media for reaching the community and health workers. Mothers and fathers of children under 5 were identified as the primary target audience for messages. Health workers were designated as the main communication agents, with reinforcement from teachers and agricultural extension agents to influence fathers and increase community outreach.

For each primary target, a small set of “doable,” affordable, and culturally appropriate actions were promoted. Several key channels were selected to communicate the nutrition strategy: interpersonal communication, relying heavily on health workers to communicate basic nutrition information to households; health center talks, the radio, outreach to men through agriculture extension agents and literacy programs.

Source: Fishman et al. Assisting NGOs Incorporate Nutrition Communication in Child Survival Programs, in Margaret Parlato & Renato Seidel (eds) 1998. *Large-Scale Application of Nutrition Behavior Change Approaches: Lessons from West Africa*. Published for the USAID by the Basic Support for Institutionalizing Child Survival (BASICS) Project, Arlington, Va.

- ◆ Application of mechanisms that allow for verification and validation of data
- ◆ Effective training, understanding, and regular supervision of community agents and other program personnel on the monitoring and evaluation procedures and systems.

Monitoring and Evaluation

Monitoring and evaluation are the systems through which information collected by the MIS is used to follow the process of implementing of program activities and measuring their impact. Specifically, monitoring is the collection of valid, accurate data on processes and outputs that are useful for making program decisions. Unlike program monitoring, which involves comparing a program’s results to its own targets, performance or impact evaluation assesses the overall outcome or public health impact of a program against more objective measures such as changes in key behaviors, capacities, or health status (BASICS, 1998).

The monitoring and evaluation system should be designed to facilitate the program’s ability to show impact using a variety of tools, such as routine reporting systems, periodic KPC surveys, and operations research using relatively inexpensive rapid assessment methods to address specific implementation concerns as they are identified, impact evaluations.

Selection of Indicators

The selection of indicators is seen by many as the essential first step in designing a monitoring and evaluation system, since it is the process of defines what will be measured during the course of the program.

Several considerations must be kept in mind for each indicator. These include:

- ◆ what is the nature of the issue being measured;
- ◆ what system will be used to collect the information (e.g., routine or special survey);
- ◆ how feasible is it to make accurate measurements of the issue;

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- ◆ are the resources available; and
- ◆ does the program have the capacity to monitor and supervise the program?

Characteristics of good indicators

- ◆ **Must be relevant:** must tell something about the status of a program and should allow better decision-making or suggest corrective action.
- ◆ **Must be measurable:** since indicators are used to measure status with regard to achieving an objective, it must be possible to know whether any progress has been made since the last time information was collected. In many cases, this may mean that an indicator should be quantifiable.
- ◆ **Must be economical:** every indicator costs time and money to collect. It is important to balance the cost of collecting an indicator with the value of the information.
- ◆ **Must have a time dimension:** since an indicator will be used to measure status with regard to achieving an objective, the indicator must specify the time by which a change should be seen.

A typical set of indicators used in community nutrition programs is presented in Box 21. The most common types of indicators used are result indicators. Few impact or performance indicators are used. The latter type of indicators is useful as it shows progress toward the attainment of program objectives and can be used as proxy impact indicators where these are difficult to collect.

Appropriate data collection methods for community nutrition programs

The issue of “how,” “when,” and “from whom” to collect data is a difficult one for program planners. There is a constant need to balance the desire for more and better data with the cost in time and money of collecting those data and the capacity of the persons responsible for collecting the data. Care must be taken not to allow the program to be driven by information needs.

Common tools for program monitoring include management information systems and existing data sources, such as growth-monitoring registers, village registers, training and meeting reports, and

Box 21: INDICATORS USED BY COMMUNITY NUTRITION INTERVENTIONS

Indicators used by the CNP implemented in Dioffior, Senegal

1. Number of old registrations for the month
2. Number of new registrations for the month
3. Total number of infants registered
4. Number of infants present
5. Total number of infants 0-36 months who gained weight
6. Total number of infants 0-36 months who did not gain weight (weight stayed stable)
7. Total number of infants 0-36 months who lost weight
8. Total number of infants with moderate malnutrition
9. Total number of infants with severe malnutrition
10. Number of IEC sessions

Indicators used by the SIAC in Guinea:

1. Percentage of infants weighed in the month
2. Percentage of infants who gained weight
3. Percentage of infants whose weight stayed stable
4. Percentage of infants who lost weight
5. Number of meetings organized with the community
6. Number of nutrition education activities conducted (cooking demonstrations, health talks with mothers)

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supervisory and progress reports submitted by program staff from different operational levels.

Some useful tools for performance and impact evaluation include: population-based household surveys, community assessment and planning exercises, mid-term and final evaluation exercises, and knowledge, practice, and coverage surveys.

Operations research is another evaluation tool that can be used to develop and test approaches

that address specific implementation concerns as they are identified. It should be triggered by questions raised during routine monitoring procedures and evaluation exercises. Operations research should be easy to do and analyze, and technical assistance should be sought where necessary from other partners, such as local universities and research institutions. The results generated should be fed back into management decisions to improve program strategy.

KEY ISSUES TO BE CONSIDERED WHEN SELECTING A DATA COLLECTION METHOD

- ◆ **Value vs cost:** All data cost time and money to collect, and some data collection methods, especially surveys, can be very expensive. It is important to balance the cost of data collection with the value of the information the data will provide.
- ◆ **Health worker load:** Health workers who are already busy providing services for their populations will provide almost all data. Data collection systems must not overload these workers with filling out forms and other reporting requirements.
- ◆ **Data quality:** It is easy to collect data; it is not so easy to collect data that are representative and accurate. Biases are often inherent in data collection systems and must be considered in designing what data to collect and how to collect them.
- ◆ **Analysis and interpretation:** It is easy to collect data; but it is relatively more difficult to analyze and interpret them. The use of the data should be well understood at the beginning to simplify the data collection process, ensure that key questions are being answered, and avoid “fishing expeditions.”

Making good use of collected data

In most programs, data are collected and sent to a higher level, either the sub-central or central level, where they are analyzed, interpreted, and presented in the form of a report. A management information system will be little use if it does not result in appropriate action being taken. Sometimes, information flows to the top and never comes down again.

Data collected must have a visible impact on decision-making at all levels. Effective feed-back mechanisms should be established to solve problems and promote identified successes.

Community leaders and community agents need to use the data directly for continuous reviews of performance, without having to send them up to the next level and wait for feedback. Community members also need to get a clear picture of how the interventions being taken are having an impact on their community. This is a great motivating factor, particularly for personnel involved in local implementation and sustaining community interest.

Data collected must be simple enough to allow for analysis and interpretation for decision-making at all levels of the implementation process, particularly the community level. For example, after weighing sessions, members of the community must be informed about the total number of children weighed, and how many were in the different malnutrition zones (green, yellow, and red). See Box 22 Information from previous months will make it easy to determine progress. This information can be posted in a prominent position on the community board for all to see.

Guinea

Box 22

COMMUNITY BOARDS FOR DISSEMINATING NUTRITION INFORMATION

In Guinea, after the village weighing sessions, the weight of all children is recorded on a community board. This board has a growth curve divided into three zones: a well-nourished zone shown as green, a moderately malnourished zone shown as yellow, and a severely malnourished zone shown as red. The board is placed in a part of the village where it can be seen by everyone.

A village meeting is convened with the head of the village, opinion leaders, political and administrative leaders, and women. The two community agents present the results of the last weighing session to the community, particularly pertaining to those children who are malnourished, and the village is asked to propose solutions to address the malnutrition problem.

Types of decisions that have been taken:

- *Building of improved latrines aimed at reducing the extent of diarrheal disease in the community*
- *Establishment of a women's vegetable garden*
- *Establishment of a community farm where half of the produce is used in weaning food demonstrations and the other half is sold by the women's groups*
- *Assistance to community agents in their local agricultural plots*
- *Construction of supplementary classes at the local primary school*

Source: Interview with Dr Macoura Oularé, Section Alimentation-Nutrition, Ministère de la Santé, Republic de Guinée.

Supervision

Regular and effective supervision of community-based agents is a management tool to ensure that these agents accomplish their roles efficiently, and that community-level activities are in line with the objectives of the program. Yet supervision is a weak point of most programs.

Most programs have supervision plans, that are not followed because:

- ◆ supervisors do not always accord much priority to their supervisory roles;
- ◆ it is not always clear who is to supervise whom and how;
- ◆ supervision is often only one of many roles given to supervisors;
- ◆ supervision calendars are fully charged and unrealistic;
- ◆ the resources to facilitate regular supervision are inadequate, especially when supervisors are far away from those they are to supervise;

- ◆ and supervisory guidelines are unclear.

Supervision is particularly crucial where community agents are volunteers because it helps legitimize and give credibility to their role.

To put an efficient supervision system in place, the following factors must be considered:

- ◆ **Strengthen supervisory skills** through initial and ongoing training. The topic of supervision should be integrated into the initial training of all health agents with supervisory responsibilities. Supervision should not be seen as a "policing" mechanism but as part of a training and motivation strategy;
- ◆ **Establish a simple information system:** Supervision activities should be linked to this system;
 - ◆ *Using the results of supervision:* Information gathered from supervisory activities should be used at all levels to orient the program

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Senegal

Box 23
SOME TIPS FOR GOOD SUPERVISION

In Senegal: The objective of supervision for the AGETIP community nutrition program is to ensure that community nutrition agents accomplish their roles effectively, and that center performance is in line with the objectives of the program.

Roles of the supervisor

- ◆ to ensure and respect procedures;
- ◆ to control the quality of information;
- ◆ to evaluate the performance of community agents (MICs);
- ◆ to evaluate the quality of services offered at the center;
- ◆ to ensure feedback of information to agents;
- ◆ to inform the community;
- ◆ to help resolve a center's problems;
- ◆ to provide on-site continuous training; and
- ◆ to motivate agents.

Methods of supervision

- ◆ Direct methods are used, such as observing of agents at work, talking with agents and analyzing information collected.

Supervision tools

- ◆ Supervision calendar
- ◆ Supervision form
- ◆ Monthly activity report
- ◆ Activity report summary form
- ◆ Table for monthly follow-up of performance

Organization of supervision

- ◆ Supervision ration—one supervisor per 20 agents
- ◆ Frequency of supervision—each center should be visited once a week

Source: AGETIP. Presentation on Community Nutrition Programs. Presented during the Regional Workshop on "Experiences on Community Nutrition Programmes", 23-27 March 1998, Dakar.

and should be disseminated at the level of the community;

◆ *Reinforcing the supports need for supervision:* The resources needed for supervision should be anticipated during the planning of the program. In addition, a strategy for the motivation of supervisors should be considered;

◆ *Integrate agents from other sectors* to reduce the burden of supervision on health agents;

◆ *Establishment and maintenance of supervisory schedules:* A lot depends on the number of contacts community service providers have with their supervisor. Each program should have a supervisory plan which details, the number of persons to be supervised by a supervisor and the frequency of supervisory visits. Although it

is important to follow, these schedules, it may in some cases be necessary to adjust the frequency of visit, according more visits to those communities with problems.

CHARACTERISTICS OF AN EFFECTIVE SUPERVISOR

- ◆ Should take time at his/her work
- ◆ Should create a climate of security
- ◆ Should respect those he/she supervises and their contributions
- ◆ Should have the ability to resolve conflicts.

CONCLUSION & LESSONS LEARNED

Over the past two decades, there has been considerable success in identifying workable solutions to the nutrition problems of African communities. A substantial body of evidence exist to suggest that the nutrition status of poor population groups in developing countries can be improved through community nutrition programs, if certain critical elements are built into such programs from its inception and remain as salient characteristics throughout the program implementation phase.

Most of the lessons learned that are presented below are not new. The challenge now remains for governments, key partners, and communities to act collectively in transforming such information into positive action.

Fostering political commitment and collaboration between key partners and the community

1. The promotion of CNPs as an approach for improving nutrition in developing countries must start with advocacy. Decision-makers need to be convinced of the importance, feasibility, and cost-effectiveness of investing in nutrition at the community level.
2. The strategies to be considered must be supported by clearly articulated national policy guidelines accompanied by clearly defined institutional frameworks. Governments need to create a political environment conducive for partnership and collaboration among multiple partners from the private and public sectors and for success factors to emerge.
3. For communities to be motivated and remain committed to solving their nutrition

problems, there is a need to create awareness of: (i) the high prevalence and the serious consequences of malnutrition, and (ii) the availability of low-cost solutions to the nutrition problem.

Building on existing community resources and organizational systems

4. The importance of community participation cannot be overemphasised. Community participation is crucial to ensure the appropriateness and sustainability of intervention strategies and ultimate ownership of the program by the community. Decision-makers and other partners must be convinced of the importance of involving the community in all phases of program planning and implementation.
5. Community nutrition programs are more sustainable when designed within the context and capability of a country's local resources. Community involvement in the mobilization of financial and material resources required for the management and implementation of CNPs reinforces ownership and will ensure that interventions lie within the scope of the community. All programs must plan to progressively increase community responsibility for the financial costs of the program.
6. Programs should be built around existing community knowledge making maximum use of existing organizational frameworks, such as local women's groups and community development committees, for key management and decision-making responsibilities.

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7. Service providers identified from the community develop local capacity and bridge the gap between the service provider and the recipient. These community service providers should be supported with training, regular supervision, and creative approaches to recognizing and awarding their efforts.

Strengthening the support infrastructure

8. Good management and guaranteed quality of service demands committed, motivated and results oriented staff with effective leadership. Relatively large investments are therefore needed in simple and on-going program relevant and program-driven training for all levels of staff.
9. Widening the net to include partners from the non-governmental and private sectors maximises the use of available resources and expertise. The use of a contracting approach to commit private sector partners to their roles promotes good governance and accountability.

The programmatic context

10. Due to the complex nature of malnutrition, there is a critical need to complement nutrition activities with other components, in particular food security, credit and income generation, functional literacy, and potable water supply.
11. To have an impact, programs should adopt simple, do-able intervention strategies that work and that communities themselves can manage. Priority should be given to those activities that comply with

communities' felt needs and promote solidarity among community members.

12. During targeting, a holistic approach should be adopted to ensure that all those at nutritional risk, in addition to key persons and factors that influence the practices and behaviors of those at risk are taken into consideration.
13. A simple management information system with linkages at all levels, supported by regular monitoring and supervision at the community level, is crucial for assessing impact and progress of the program.
14. Communities' needs and priorities are dynamic. Program managers and key partners should use the lessons learned and conclusions drawn from the program to reassess and revise program priorities and strategies.

To end this contribution to the reflection of the nutritional situation in Africa, we recommend that you keep in mind that a nutrition intervention, specifically a community nutrition intervention, must be seen as an evolutionary and dynamic process, rich in learning experiences which are well worth promoting.

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GLOSSARY OF TERMS

Community : A collection of individuals living in the same geographical area, united by common interests and sharing the same preoccupations.

Community participation: It is the process by which populations are involved in a conscious and voluntary manner to take control of their preoccupations.

Empowerment: A social-action process that promotes participation of people, organizations and communities towards the goals of increased individual and community capacity and control, political efficacy, improved quality of life and social justice.

Good governance: This is the administration, supervision and overall administration of a program in a fair and egalitarian manner.

IEC: The definition of IEC varies depending upon the context it is used. In this document, IEC can be defined as a learning and teaching approach provides information, education and communication in a participatory manner and aims towards achieving behavioral change in the long run.

Negotiation: The process that takes place when individuals having different needs and perspectives strive to obtain common goals and objectives.

Nutrition Intervention: A series of program strategies and actions that are required to change behaviors in a household or community with aim of improving nutritional status.

Political commitment: Sincere and steadfast dedication by political persons and/or bodies to a particular cause. This requires advocacy and support for the cause as well as direct or indirect involvement.

Social mobilization: A process by which a variety of actors and forces at different levels of society engage in a sustained and concerted social action around a commonly agreed-upon or accepted objective or purpose.

Stakeholders: Those who hold a particular interest in a program and are thus involved in some aspect of it. Examples of stakeholders of a Community Nutrition Program are Ministries of Health and UNICEF, who would have political and financial interest respectively.

Sustainability: It is the extent to which a programs operational, management and financial systems can be maintained over an extended period of time to assure continued existence and success of the program.

APPENDIX 1: SUMMARY INFORMATION ON SOME COMMUNITY NUTRITION PROGRAMS IMPLEMENTED IN AFRICA

Name of Program/ Country	Executing Agency	Duration of Program	Size of population covered	Principal nutritional activities	Key partners	Total cost of Program	Major achievements
Community Nutrition Project - Senegal	Agence d'Execution des Travaux d'Intérêt public (AGETIP)	5 years 1995-2000	350,000 women and children from urban and peri- urban areas	<ul style="list-style-type: none"> ▪ Nutritional Services (Growth monitoring and promotion and IEC) ▪ Provision of potable water ▪ Dietary supplementation 	<ul style="list-style-type: none"> ▪ National Commission against Malnutrition ▪ Donors (World Bank, German Cooperation, World Food Program, NGOs) ▪ Associations of doctors and pharmacists ▪ Youth Associations ▪ Private sector at community level ▪ Community Development Committees 	\$14 million	<ul style="list-style-type: none"> ▪ 90% of children registered are weighed monthly ▪ 75% of mothers registered attend monthly health talks ▪ 85% of children in Dakar and 61% in St Louis gain weigh after 6 months of supplemental rationing
Dioffior Community Nutrition Project - Senegal	District of Dioffior	6 years Phase 1: 1992-1996 Phase 2: 1997-2001	33,168 inhabitants 5,306 children 0- 36 months	<ul style="list-style-type: none"> ▪ Growth monitoring for children 0-36 months ▪ Nutrition education for women 	<ul style="list-style-type: none"> ▪ Women promoters ▪ Chief Nursing Officer ▪ SISSP District ▪ BRAN District ▪ SANAS ▪ BASICS 	50,000,000 CFA (approx. \$90,000)	
Community Based Information System - Guinea	Ministry of Health	7 years	25,120 children 0- 36 months	<ul style="list-style-type: none"> ▪ Growth monitoring ▪ Breastfeeding promotion ▪ Infant and young child feeding promotion ▪ Oral rehydration therapy ▪ Nutritional recuperation ▪ Fight against micro-nutrient deficiencies 	<ul style="list-style-type: none"> ▪ Ministries of Health, Education and Agriculture ▪ UNICEF, WHO, World Bank ▪ NGOs, AFRICARE ▪ Communities 		

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APPENDIX 1: SUMMARY INFORMATION ON SOME COMMUNITY NUTRITION PROGRAMS IMPLEMENTED IN AFRICA (2)

Name of Program/ Country	Executing Agency	Duration of Program	Size of population covered	Principal nutritional activities	Key partners	Total cost of Program	Major achievements
Expanded Food Security and Nutrition Project (SECALINE) - Madagascar	Ministry of Health	5 years	54,227 pregnant & lactating women and children under 5 years	<ul style="list-style-type: none"> ▪ Growth monitoring of children <5 years ▪ Food supplementation for moderately malnourished children ▪ Therapeutic rehabilitation for severely malnourished children ▪ Income generation activities ▪ IEC activities for mothers 	<ul style="list-style-type: none"> ▪ Regional Coordination ▪ Malgache Government ▪ NGOs ▪ Communities ▪ World Bank, WFP, UNICEF and Japan 	\$32.4 million	<ul style="list-style-type: none"> ▪ 78.1% coverage ▪ 15% reduction in malnutrition ▪ Improved knowledge of mothers on themes addressed by IEC strategy ▪ Change in improper practices e.g. Increase in no. of children exclusively breastfed
Household Food Security/Environment and Nutrition Program (PNSAF/E) - Niger	Ministry of Public Health	11 years	Population of 2.5m inhabitants	<ul style="list-style-type: none"> ▪ Promotion of consumption of micro-nutrients ▪ Community based growth promotion ▪ Support for household food security 	<ul style="list-style-type: none"> ▪ Village communities ▪ Field level staff ▪ Regional Development Committees ▪ Nutrition Division ▪ UNICEF 	\$6.6 million	<ul style="list-style-type: none"> ▪ 84% coverage ▪ 4% reduction in malnutrition ▪ Implementation Income generation activities ▪ Construction of shelters for growth monitoring activities ▪ Production and consumption of foods rich in vitamin A

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APPENDIX 2 : COMMUNITY PARTICIPATION MATRIX

Indicators for Participation	Narrow (none) 1	Restricted (small) 2	Average (fair) 3	Open (good) 4	Wide (excellent) 5
Needs Assessment / Project Planning	Community needs defined/ imposed from outside the community, based on epidemiological /economic data only.	Outside point of view dominates an 'educational' approach. Community interests are also considered.	CW is active representative of community views, and assesses community needs.	CPG is actively representing community views, and assesses the needs.	Community members in general are actively involved in needs assessment (e.g. through PAR).
Representativeness/ Leadership	Project organization assumes leadership; one-sided (i.e. wealthy minority); imposing community chairman or leader.	CPG not functioning, but CW works independent of social interest groups (e.g. wealthy minority).	CPG functioning under the leadership of an independent CW.	Active CPG, taking initiative.	CPG fully represents variety of interests in the community, and controls CW's activities.
Organization	CPG imposed/ induced by the project organization and inactive.	CPG imposed by the project organization, but develops some activities.	CPG imposed by the project organization, but became fully active.	CPG actively cooperating with other community organizations.	Existing community organizations have been involved in creating the CPG.
Resource Mobilization	No resources raised or contributed by the community. CPG does not decide on any resource allocation.	Small amount of resources raised by the community. CPG has no control over allocation of resources collected.	Community resource mobilization, and CPG control of expenditures for select activities (e.g. community drug fund).	Community resource mobilization, and CPG control and allocation of resources.	Community monitors resource needs, raises resources when needed, and allocates them.
Management / Implementation	Induced by project organization. CPG only supervised by project organization.	CW manages independently with some involvement of the CPG.	CPG self-managed without control of CW's activities.	CPG self-managed and involved in supervision of CW.	CW responsible to the CPG and actively supervised by CPG.
Evaluation	Evaluation conducted by project organization staff. Criteria for success determined entirely by project staff.	Evaluation conducted by project staff. Criteria for success determined by project staff, with some input from CW.	Evaluation conducted by project staff. Criteria for success determined by project staff and CW, with input from CPG.	Evaluation conducted by project staff and CW. Criteria for success set by CPG, with assistance from project staff.	Evaluation conducted by CPG. Criteria for success set by CPG, with assistance from project staff.

CW = Community worker (affiliated with project organization)

CPG = Community project group

*Adapted from Rifkin, S.B., Muller, F., Bichmann, W. (1988) «Primary Health Care: On Measuring Participation.» *Social Science and Medicine*. 26(9): 931-940.

APPENDIX 3

TECHNIQUES TO COLLECT INFORMATION FOR ASSESSING THE NUTRITION SITUATION

Techniques involving the community

- ◆ *Negotiations/Discussions with key members of the community* - such as community leaders, women's groups, traditional health workers such as community health workers and traditional birth attendants, family members and potential beneficiaries such as women of child bearing age. The guiding principle to such discussions is the understanding that populations have the capacity and the creativity to use their own resources to ameliorate their standard of living. Techniques that can be used are key informant interviews and focus group discussions with the conceptual framework as a guide.
- ◆ *Participatory Rural Appraisal methods* –These are a collection of methods, such as those described in table 3 below, that can be used to collect information from community members about a range of issues, from community organization and structures to traditional beliefs and working practices.

PRA methods for sensitizing and mobilizing communities

Method	Description	Potential Uses in Nutrition Situation Assessment
Community mapping	Community members draw a map of their community, including geographical features, other resources.	Ice breaker Identify community resources Defining the community boundaries, fields, gardens
Seasonal calendars	Identifies activities, problems, and opportunities taking place throughout the year; shows how things change throughout the year	Household food security Food prices Work patterns Water availability Disease patterns
Venn diagrams	A social (organizational) data gathering tool that shows how institutions in the community are linked using circles and a map	Identifying potential organizations and structures that can be involved in solutions to priority problems
Three pile sorting	Pictures are sorted into categories such as good (beneficial), neutral, and bad (harmful) practices; facilitated discussions of reasons why, and how to move from harmful to positive categories/ practices	Categorizing foods Categorizing practices Identifying ways to move from bad to neutral to positive practices or situations Identifying locally feasible solutions to problems
Pocket voting	Simple method for collecting opinions on problems, causes, solutions	Causes of malnutrition, poverty, health problems Priorities in the community
Matrix sorting	Method of ranking alternatives according to community determined criteria; useful in process of building consensus to move forward	Prioritizing actions and solutions
Story with a gap	Before and after scenes are given and community members are asked how to move from the before to the after; a pre-planning tool	Hygiene conditions/ behaviors Sanitation conditions/ behaviors feeding behaviors
Community action plan	A plan developed with/by community members	Defines the way forward

Source: Developing an Integrated Nutrition Program through Assessment, Analysis and Action: A trainer's guide. The University of Western Cape and the Academy for Educational Development (AED), 1998, (draft).

OTHER SOURCES OF INFORMATION

- ◆ **Review of nutrition situation analysis reports** - Such reports although they may provide more country specific than area specific data are a source of valuable information on the extent and trends in nutritional related problems, efforts to address such problems, how they were addressed and who was involved.
- ◆ **Rapid Knowledge, practice and coverage studies** - The R-KPC is a tool to collect baseline information, evaluate programs and to focus on priority health needs of populations. It can be used to provide reliable indicators of knowledge, practice and coverage status on the topics such as: Breastfeeding and infant nutrition, growth monitoring and vitamin A supplementation, diarrhoeal disease, acute respiratory tract infections and maternal health/family planning.
- ◆ **Ethnographic studies on maternal and child feeding practices** - such studies can provide a solid base of information leading to a broader understanding of the range of biological, cultural and environmental factors influencing diet and nutritional status. They are particularly useful for the development of appropriate IEC strategies.
- ◆ **Expert advice**- Each country has a pool of persons who can serve as sources of technical and up-to-date information. They include researchers, health and medical professionals, economic planners, demographers, extension agents, government planners etc.

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TYPES OF INFORMATION COLLECTED DURING NUTRITIONAL STATUS ASSESSMENT*

SUBJECT STUDIED	FACTORS	INDICATORS
Nutritional status	Growth faltering	% of babies born with low birth weight ☹ % of infants with height <90% of the standard height for age ☹ % of infants with weight <80% of the standard weight for height ☹
	Clinical malnutrition	% of persons examined with clinical signs of: goitre, night blindness ☹
	Biochemical methods	% of individuals with hemoglobin levels less than the norm fixed for their age, sex and physiological status ☹
Economic Factors	Food Prices	Average price of «household food basket» ☹ Average price of staple cereals (or vegetables) during a definite observation period ☹
	Food Expenditures	Average expenditure on food as a percentage of total expenditure ☹
	Income	Average household income per capita ☹
	Employment	Proportion of population in active employment ☹ Proportion of mothers working outside the home ☹ Average time spent by mothers on child care ☹
Food Production	Production	Number of kilos of basic foods (cereals, vegetables, etc.) produced per family per year ☹ Monetary value of annual food produced per family ☹
	Factors affecting production	Number of hectares of arable land per capita ☹ Average annual rainfall in mm ☹
Health factors	Morbidity	Proportion of infants with one or more episodes of diarrhoea in the last month ☹ Proportion of consultations (admissions) related to diarrhoea, out of the total number of consultations (admissions) for a given age ☹
	Health and Nutrition Services	Number of hospital beds /1000 persons ☹ Number of doctors/1000 persons ☹ Proportion of communities with access to health services ☹ Proportion of persons correctly immunized in the target population by vaccine ☹ Number of pregnant women with prenatal care out of 1000 live births ☹ Proportion of children 6-71 months who received at least two vitamin A capsules within the past 12 months ☹ Proportion of households using iodized salt ☹ Proportion of women who took the recommended number of iron/folate tablets during their last pregnancy
	Environmental hygiene	Proportion of households with access to potable water ☹ Proportion of households with access to safe latrines ☹
Education	Level of education	Proportion of persons > 15 years with complete primary level education (out of total population or population of women) ☹ Proportion of persons >15 years who can read or write (out of total population or population of women) ☹
	Community mobilization	Number of community based groups that can be mobilized for action ☹ Nature of leadership ☹
Other types of information	Development activities	Number of development efforts initiated by the community or their leaders ☹
	Community resources	

☺ = frequently used ☹ = often used ☹ = rarely used

*Based on a review of 6 community nutrition programs implemented in the sub-region

APPENDIX 5

STRATEGIES EMPLOYED BY COMMUNITY NUTRITION PROGRAMS

- ◆ **Promotion and monitoring of growth** – it permits the early identification of malnourished children. Growth monitoring can be used as an educational tool to teach mothers how to monitor the progress of their child's growth and detect when things begin to go wrong in order to seek special attention. Community participation can be enhanced with the use of community based growth monitoring which has the capacity to promote empowerment at the community level to the extent that mothers in particular can understand and monitor the health of their own children. It can be linked with food supplementation programs to screen for eligible beneficiaries.
- ◆ **What should/could it involve?**
 - Community based weighing of children between the ages of 0 and 3 years, and interpretation of the growth curve so that a mother can follow the progress of her child's growth
 - Counseling to identify causes of poor growth, discuss remedial actions, and give encouragement when things are going well
 - Referral of children identified as malnourished to the nearest health facility
 - Follow-up of malnourished children at the home level to monitor progress and identify possible obstacles and constraints to adoption of good practices.
- ◆ **The fight against micro-nutrient deficiencies** – it favors the reduction in prevalence rate of micro-nutrient deficiencies at levels of public health concern. Due to the relationship between the deficiency of certain micro-nutrients and some childhood diseases, micro-nutrient interventions are sometimes employed to reduce the risk of childhood diseases such as measles, acute respiratory tract infections and diarrhoea. The micro-nutrients most often considered are vitamin A, iron, folic acid and iodine..
- ◆ **What should/could it involve?**
 - Distribution of micro-nutrient supplements, in the case of vitamin A, iron and folic acid
 - Promotion of production and consumption of micro-nutrient rich foods
 - Deparasitisation in areas of parasitic infestation
 - Malaria prophylaxis particularly to reduce risk of anaemia in pregnant women
 - Salt iodisation to address iodine deficiency.
- ◆ **The utilization of participatory IEC techniques** - it is aimed at helping individuals make informed choices that will result in behavioral and attitudinal change where inappropriate behavior, attitudes and practices as a result of cultural beliefs, poor education, poverty are contributing factors towards high malnutrition. It can be used to favor the adoption of best practices by the community.
- ◆ **What should/could it involve?**
 - Interpersonal communication (peer counseling – improves outreach and community participation)
 - Cooking demonstrations, promotion of weaning foods based on locally available products
 - Mass communication,
 - Participatory/interactive methods of communication (e.g. griots, role plays, songs, games, opinion leaders e.g. religious leaders)
- ◆ **The prevention and management of childhood diseases** – e.g. diarrhoea, malaria and acute respiratory tract infections. Childhood infections are a major cause of malnutrition and mortality.

◆ **What should/could it involve?**

- Promotion of ORS/ORT
- Education on appropriate feeding of sick children during and after illness
- Promotion of good hygiene and sanitation
- Referral of sick children to an appropriate health facility for treatment of infections
- Immunization against childhood communicable diseases

- ◆ ***Promotion of maternal health*** – it is aimed at improving well-being during pregnancy and preventing childhood malnutrition through the reduction in incidence of low birth weight babies. Maternal health interventions are usually employed in communities where poor access to proper antenatal care, inadequate food intake during pregnancy, high fertility rates and high rates of pregnancy anemia are major factors contributing to childhood malnutrition and maternal morbidity and mortality.

◆ **What should/could it involve?**

- Promotion of good ante-natal care
- Promotion of family planning and birth spacing
- Promotion of improved maternal dietary practices (Maternal dietary supplementation should only be considered where the supplement is based on locally available commodities and if the community is able to provide some of the resources needed for the procurement of the commodities).

- ◆ ***The implementation of community development activities*** – these involve strategies to address the basic causes of malnutrition such as insufficient income, illiteracy, high maternal workload, food insecurity etc. They contribute indirectly to the improvement of nutritional status.

◆ **What should/could it involve?**

- Functional literacy and numeracy skills training,
- Promotion of income generation activities, (micro-enterprise development)
- Promotion of agricultural diversification
- Promotion of increased food security,
- Construction of cereal banks,
- Promotion of animal husbandry,
- Training in food preservation and processing techniques,
- Improved access to credit,
- Improved access to labor saving devices.

APPENDIX 6
GUIDELINES FOR TEACHING ADULTS

- **Lessons should be well organized and prepared at a basic level.**
- **Lessons should be brief and to the point.** Most adult trainees will forget the essential points if too much is presented at one session.
- **Teach the skills that the trainees want to learn.** The order of the sessions can be changed to suit the needs of the group. Begin with those topics of most interest to the trainees.
- **Teaching adults new techniques and ideas is a slow process requiring repetition.** Tact and patience is needed. Repeat all important ideas and procedures, several times, if necessary. Use the beginning of each session to revise the lessons of the previous session. Repeat important ideas at the end of each session. Go through the revision questions at the end of the session and/or at the following session.
- **Demonstrate all lessons where this is possible.** For example, bring real foods and cook a balanced meal. Ask the trainees to demonstrate and practice all practical skills. Go to a family compound for demonstrations when possible.
- **Conduct role playing exercises.** This is a very good way to act out a procedure or a problem situation. Take care to explain the purpose of the role play clearly. Avoid criticizing a trainee during a role play or demonstration. Afterward, discuss what happened and what was learned.
- **Encourage trainees to participate in discussions as equal partners.** Trainees have valuable experiences and knowledge of local conditions. They understand the customs, beliefs and practical problems faced by their communities. Questions and discussions keep trainees alert and interested. Do not be judgmental, nor criticize opinions with which you disagree; rather, facilitate a discussion to obtain different opinions.