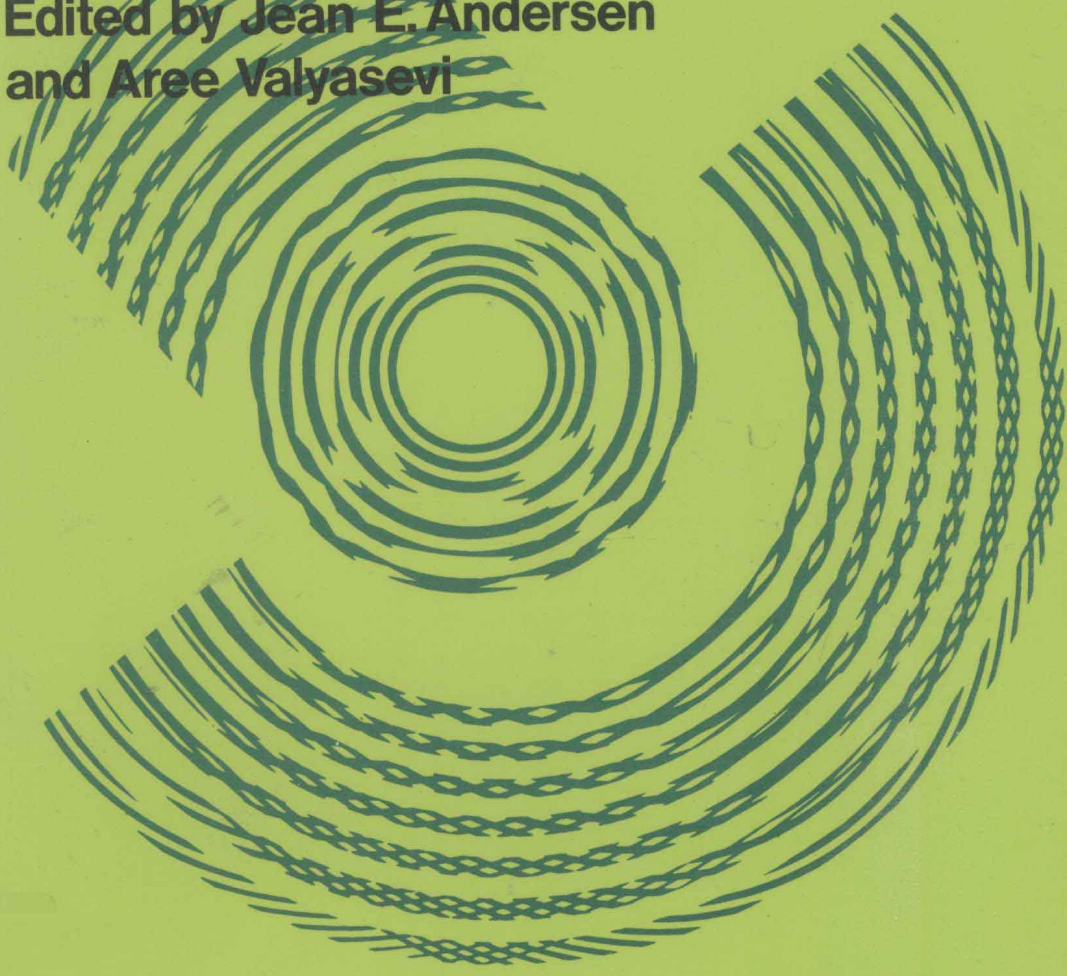
Effective Communications for Nutrition in Primary Health Care

Edited by Jean E. Andersen
and Aree Valyasevi



Effective Communications for Nutrition in Primary Health Care

Report of the Asian Regional Workshop, Bangkok, Thailand, 3–7 October 1983

Edited by
JEAN E. ANDERSEN and AREE VALYASEVI

The United Nations University

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This volume is a result of the interest of the United Nations University in the application of the results of its research networks conducting research on the food and nutrition problems of developing countries. It is based on a UNU co-sponsored workshop which summarized and evaluated the nutrition education programmes of Thailand and the Philippines and which also included in its proceedings the experiences with nutrition education in other Asian countries. The introductory contributions feature a critical review of existing methodologies for nutrition education in the Asian context. The experiences and lessons presented are of relevance and value to all developing countries.

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Foreword

It is known that good nutrition leads to good health, and vice versa. However, as long as people are ignorant of the proper ways and means to maintain good health and nutrition, the goal "Health for All by the Year 2000" will be extremely difficult to achieve. It is therefore necessary to seek the most effective and efficient ways and means to educate people, change their attitudes, and modify their practices so that they can keep themselves healthy.

Thailand has adopted the primary health-care (PHC) approach for its health-care service. The Ministry of Health and Mahidol University jointly provide training for PHC workers from Thailand and other ASEAN countries. The Institute of Nutrition has also conducted operational research using various communications techniques, including radio and video tape. Rotary International has given us financial support for the operation of the project. His Excellency Mr. Bhichai Rattakul, the former governor of District 330 of Rotary International, has assisted us in acquiring this support.

The studies in Thailand as well as in other Asian countries indicate the urgent need for innovative and effective communications. As Asian countries have many health problems in common, so they share many socio-economic, cultural, and nutritional similarities. We sincerely hope that the workshop will provide an excellent opportunity for us to share our experience and knowledge as well as to recommend future plans for nutrition and health communication programmes for this region.

There are 47 participants from 13 countries; all of them have been, and still are, actively taking leading roles in health and nutrition education in their respective countries. There are resource persons from the United States and from one Asian country, who have travelled several thousand miles to participate in this workshop. On behalf of the organizers, I should like to express our sincere appreciation for their time and efforts. The outcome of the workshop will feed in to the Fourth Asian Congress of Nutrition, to be held in Bangkok from 1 to 4 November. It is hoped that the Asian nutritionists will derive benefit from our deliberations. Finally, I hope that we will be able to achieve fruitful results and recommendations that will be applicable to each of our respective countries.

During the organization of this workshop, we had valuable advice from the principal

consultant, Ms. Jean Andersen, and Professor Nevin Scrimshaw. The organizers wish to express their gratitude for financial support provided by the United Nations University (UNU), the United Nations Children's Fund (UNICEF), and the Coca-Cola Company, Atlanta, Georgia. Dr. L.J. Teply of UNICEF-New York, Mrs. Titi Memet, and Dr. Lay Maung of UNICEF-EAPRO facilitated the attendance of Asian participants at the workshop; Mrs. Jane Bunnag of UNICEF-EAPRO provided advice and assistance during the initial planning; and Mrs. Suchada Sangsingkeo of UNICEF-EAPRO rendered valuable assistance in corresponding with workshop participants.

A. Valyasevi

Preface

The Asian Regional Workshop on Effective Communications for Nutrition in Primary Health Care was organized with the purpose of evaluating, expediting, and expanding the progress made with communication for health and nutritional improvement. This report on the workshop proceedings includes the papers of resource persons as well as the country or project reports presented during the workshop. Three case-study presentations from the Philippines, Indonesia, and Thailand give insights into some of the efforts made by Asian countries in their attempt to develop effective communication for health and nutrition in primary health care.

The main objectives of the workshop were to:

- review the current nutrition and health communications programmes reaching mothers and children at the village level in Asia;
- assess the impact of these health and nutrition communication programmes and determine which approaches have been most effective to date;
- determine which health and nutrition communication approaches have been most cost-effective in the Asian village setting;
- identify areas where more information is needed for better planning of effective communication programmes for nutrition and health in Asian communities; and
- set up a mechanism for further sharing of information and experience in communications for nutrition and health between Asian countries.

It is hoped that the proceedings will be widely distributed, not only to inform, but also to motivate various national and international agencies and institutions in other developing countries to join us in this effort to achieve health and nutritional improvements for all people.

Opening Address

It gives me great pleasure to preside over the opening ceremony of the Asian Regional Workshop on Effective Communications for Nutrition in Primary Health Care.

Science and technology have progressed very rapidly during the past few decades. However, many health problems still exist, especially among poor rural communities in less developed countries. Progress in medical science has, in the past, emphasized the provision of curative health care. Problems of inadequate health personnel are commonly encountered. In recent years, it has been recognized that preventive and promotive health measures are necessities in a comprehensive and effective approach to health-care service.

To enable people to contribute to their own health care, access to information regarding proper practices is crucial. Gaining information, however, does not always lead to appropriate attitudes and practices.

The process of communication we are concerned with is the transfer of messages, the creation of awareness, and the encouragement of sound practices. Communication for behavioural change is not a simple matter, as behaviours or practices may result from years of accumulated experiences from childhood on. The anthropological and sociological backgrounds of population groups are also influential. Communication with the rural poor is difficult because illiteracy and traditional beliefs and practices further complicate the challenge of effective communication.

Despite these difficulties, I believe that various countries, governments, and institutions have been seeking ways and means to eradicate the problems. The participants in this workshop, I trust, will use their considerable abilities, knowledge, and experience to the ultimate benefit of all Asian people.

Nutrition surveys have shown that in Asian countries the prevalence of malnutrition is still as high as 50 to 75 per cent among infants and pre-school children. While it is fairly obvious that economic factors are important in uplifting the well-being and nutritional standards of the populace, studies carried out by the FAO in Thailand, Malaysia, and the Philippines clearly reveal that increased income is not always related to improved nutrition, although it does play a significant role. Moreover, an adequate national food supply is certainly not equivalent to adequate nutrition for all a nation's people.

A recent survey of rural villages in Thailand undertaken by the Institute of Nutrition at Mahidol University, under the supervision of Professor Dr. Aree Valyasevi, has shown that regular and frequent nutrition education, provided with health-care and food-producing and income-generating activities, resulted in a striking improvement in the nutritional status of infants and pre-school children in those areas.

It is clear, therefore, that providing sound nutrition information is vital. Food taboos and antiquated food beliefs and practices that have been passed on for generations have always been a great barrier to modifying eating behaviours or habits. Functional illiteracy related to malnutrition and the poor learning environment in rural settings and among disadvantaged urban groups are among the ecological factors that maintain the vicious cycle leading to malnutrition.

In order to break this cycle, an effective means of continuously transferring information on sound nutrition is imperative. This information must be communicated to people with the aim of creating an understanding of its urgency and importance so that people will be convinced that new patterns and practices related to nutrition are in their own interest.

The use of communication techniques to effect behavioural changes is by no means new. Commercial advertising is a good case in point. Those working in health or nutrition education may gain a great deal by examining such communication techniques and using any aspects that would be appropriate for their field. Health and nutrition educators must be guided by the understanding that communication is the art of giving a part of oneself to other people in such a way that they willingly accept this offering.

Advances in communication technology have enabled us to speak with people around the globe. Very often, however, we see that we cannot even bridge the ever-widening communication gaps within our own families.

The challenging task is to find effective communication techniques for nutrition and health education. The questions to be answered are:

- What kinds of personnel or volunteers will be necessary to carry out the job?
- What kind of logistics will be required to implement and monitor the programme?
- How does one integrate the technical know-how of communications into primary health care?

H.E. Mr. Bhichai Rattakul
Deputy Prime Minister

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PRIMARY HEALTH CARE IN THAILAND

The problem of under-utilization of health centres and hospitals in rural Thailand led to the initiation of a pilot project on primary health care (PHC) in Sarapee District, Chiang Mai Province, in 1969. The project was designed mainly to extend various health services to cover a greater portion of the population in the area. The initial estimation for coverage of existing health services was below 20 per cent of the total population at that time. Recognizing that the health-service delivery structure was not covering all the health and medical demands of the community, the project organizers' strategy was to train people selected by the community to function as intermediaries between the peripheral *tambon* (community of villages) health officers and the community, adding to the existing health-service delivery on a voluntary basis.

Evaluation of the pilot project revealed that there was increased coverage of the population with basic services. Since then, several pilot projects have been carried out in other parts of the country and the results have been satisfactory. Studies have also been done on various aspects of the volunteer service, such as the method of selection, the types of people who are best suited to perform health services on a volunteer basis, etc. The experience gained from these studies led to the development of a nationwide programme of primary health care in 1977.

THE CONCEPT OF PHC IN THAILAND

The concept of PHC in Thailand has been developed from the country's experience in solving the health problems of underserved people in the rural areas. The concept of community participation – consisting of the contribution of ideas, manpower, money, and materials by the community – is fundamental and provides the key to the success of the PHC programme. To educate a community to be self-reliant or self-supportive is another basic concept that the programme fosters. The Ministry of Public Health

(MOPH) is aware that the strengthening of a health-services delivery system and development of a referral system is essential to support the PHC activities.

In the National Seminar on Health for All by the Year 2000, conducted in December 1979, it was decided that primary health-care activities should comprise the following elements: (1) health education; (2) local endemic disease control; (3) maternal and child care, including family planning; (4) immunization against communicable diseases; (5) provision of essential drugs; (6) treatment of common diseases; (7) nutrition promotion; and (8) sanitation and safe water supply.

Furthermore, the participants in the seminar felt that PHC activities could be changed according to community awareness of the problems to be solved. Because health is only one part of development, other aspects such as education, agriculture, community development, etc., should also be considered.

OBJECTIVES OF THE PHC PROGRAMME

The objectives of the programme, formulated on the basis of various concepts, were:

1. To expand the coverage of the health services, particularly among the underserved rural population, and to help the people help themselves.
2. To utilize community resources and encourage community participation in order to solve individual health problems, and eventually to establish self-help programmes at the village level.
3. To promote the dissemination of health information to local people, as well as to integrate all data that would reflect the needs and improve the health of the communities.
4. To make basic health services available, accessible, and acceptable to the people.
5. To promote better health for rural people as well as to enhance their awareness of health problems and problem-solving.

PRIMARY HEALTH-CARE WORKERS

Based on experience in Thailand, it is recognized that potential human resources exist in the community and are waiting to be mobilized. Two types of primary health-care workers have thus been developed: village health communicators (VHCs) and village health volunteers (VHVs), who promote rural health and other development efforts through an organized community. The VHCs are responsible for a cluster of 8 to 15 households, the VHVs for the whole village. The functions of VHCs are to impart health education (prevention and promotion), and to disseminate and obtain health information from the villagers. The VHVs perform the same functions as VHCs, but also have the duty of caring for people who have had simple accidents or injuries and those with common diseases.

Both VHCs and VHVs work on a voluntary basis. However, the government provides them with free medical services and a certificate when their training is completed. Other intangible incentives such as recognition from their peer group are also present.

SELECTION OF PRIMARY HEALTH-CARE WORKERS (VHVS AND VHCS)

To prevent a high drop-out rate for PHC workers, proper procedures for selection are critical. Community preparation prior to selection is necessary. A simplified house-to-house survey proved suitable for identifying the right people.

TRAINING OF PHC WORKERS

An informal five-day training course for VHCs, covering the use of self-instruction modules, health problem identification, team working, etc., is organized by subdistrict health personnel. The 35 self-instruction modules for VHCs cover curative, preventive, and promotive measures. The VHCs are expected to be able to disseminate such knowledge and gather information from villagers. VHVs obtain 17 additional modules on simple curative care and are trained for an additional two weeks.

When the programme was first implemented nationally in 1981, a training scheme extending from the central MOPH to the peripheral level was developed (fig. 1)

The central trainers are staff members of the MOPH trained in the principles of teaching and learning, using 7 modules on self-teaching and learning. These trainers then developed simplified modules for training the provincial and district trainers and became involved in curriculum planning and training of VHCs and VHVs.

The provincial/district trainers consisted of provincial health staff from the training section and one staff member from each district health office. This team was responsible for training *tambon* health personnel to conduct the training of VHCs and VHVs.

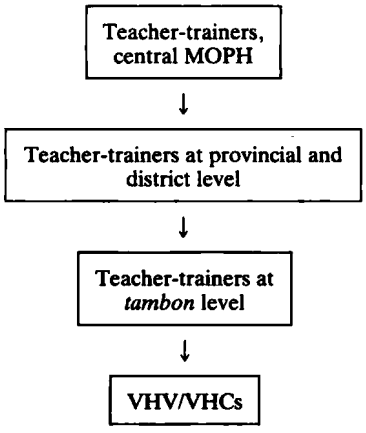

Fig. 1. Plan for training the trainers at different levels.

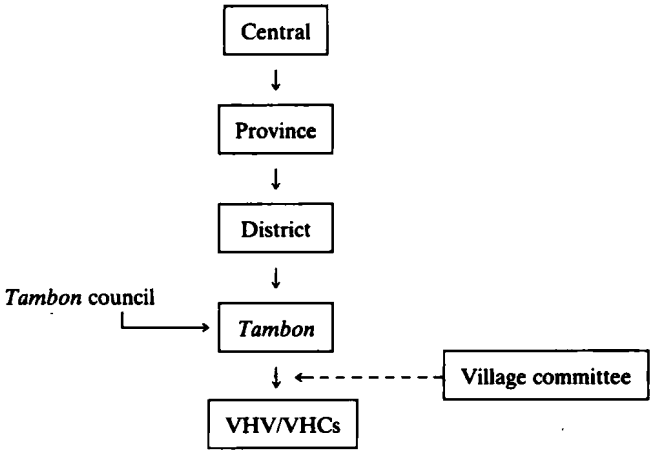

Fig. 2. Health service network.

SUPERVISION AND SUPPORT

The Office of Primary Health Care in the Ministry of Public Health is responsible for supervision and support of the PHC programme through the existing health infrastructure (fig. 2)

The purpose of supervision is to strengthen the performance of personnel and volunteers at all levels in order to achieve the goals of PHC. The scope of supervision includes programme planning and monitoring, continuing education, provision of material supports, and selection of VHVs and VHCs.

Supervision of the district level by the provincial level is scheduled three times a year, as is supervision from district to subdistrict level; from district level to VHVs and VHCs no fewer than three villages per district are sampled.

The overall organizational framework of PHC is illustrated in figure 3.

NUTRITION FOR HEALTH AND GROWTH

Nutrition, as one of the elements of PHC, is a major determinant of health and growth. Nutrition and health are not synonymous, but without good nutrition health cannot be optimum.

The consequences of food and nutrition processes and their relation to health are shown in figure 4.

In 1960, the first National Nutrition Survey was conducted by a joint Thai–American team, the Interdepartmental Committee on Nutrition for National Defense (ICNND). The results showed that the civilian population consumed 100 kcal per day below the average requirement of 1,871 kcal. Anaemia and iodine deficiency (goitre) were commonly found. A survey in 1982 still showed a high prevalence of malnutrition, despite several programmes implemented to eradicate nutritional problems.

In a review of past experience, the following factors were found to be the major constraints:

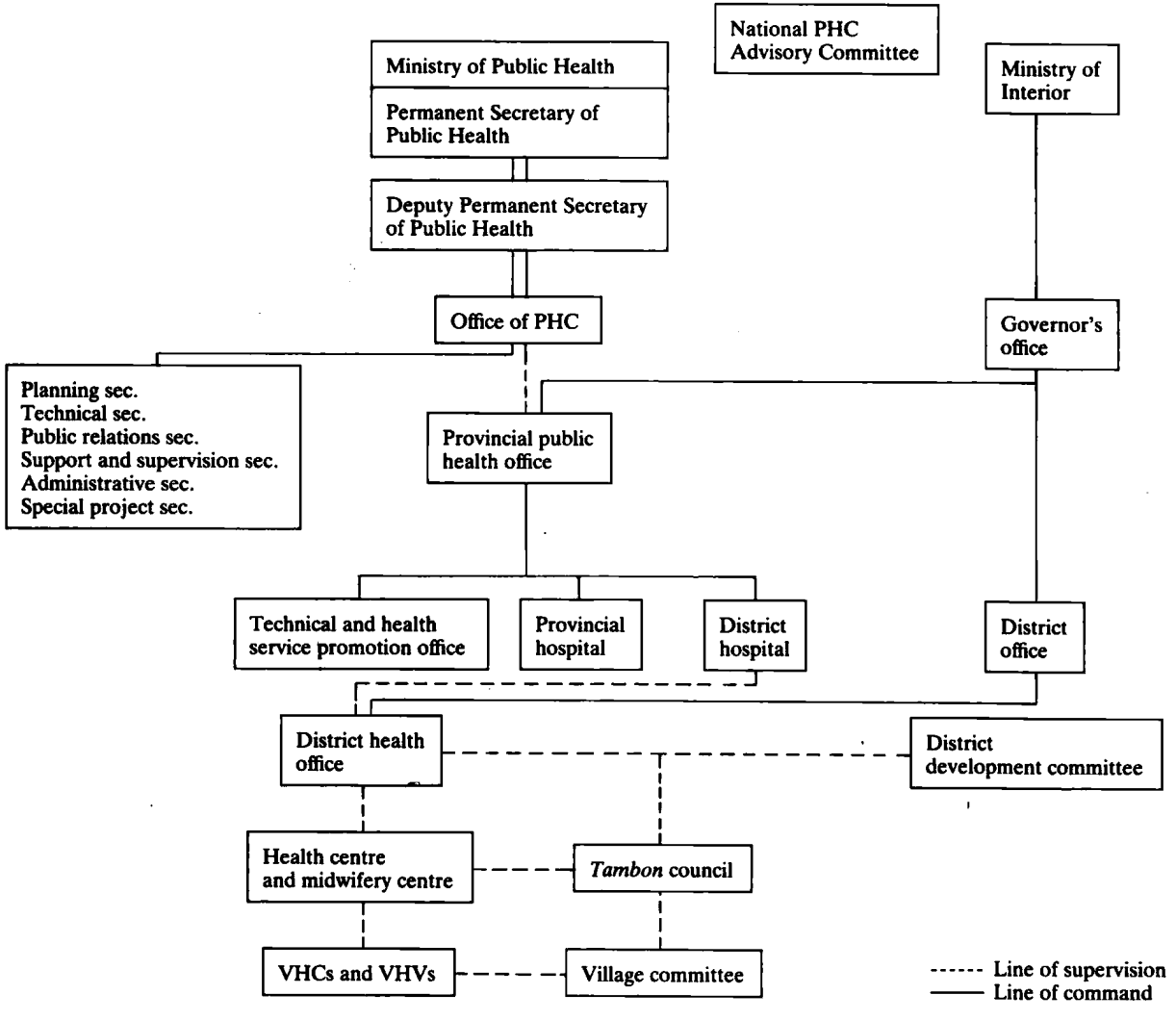

Fig. 3. Organization of PHC programme.

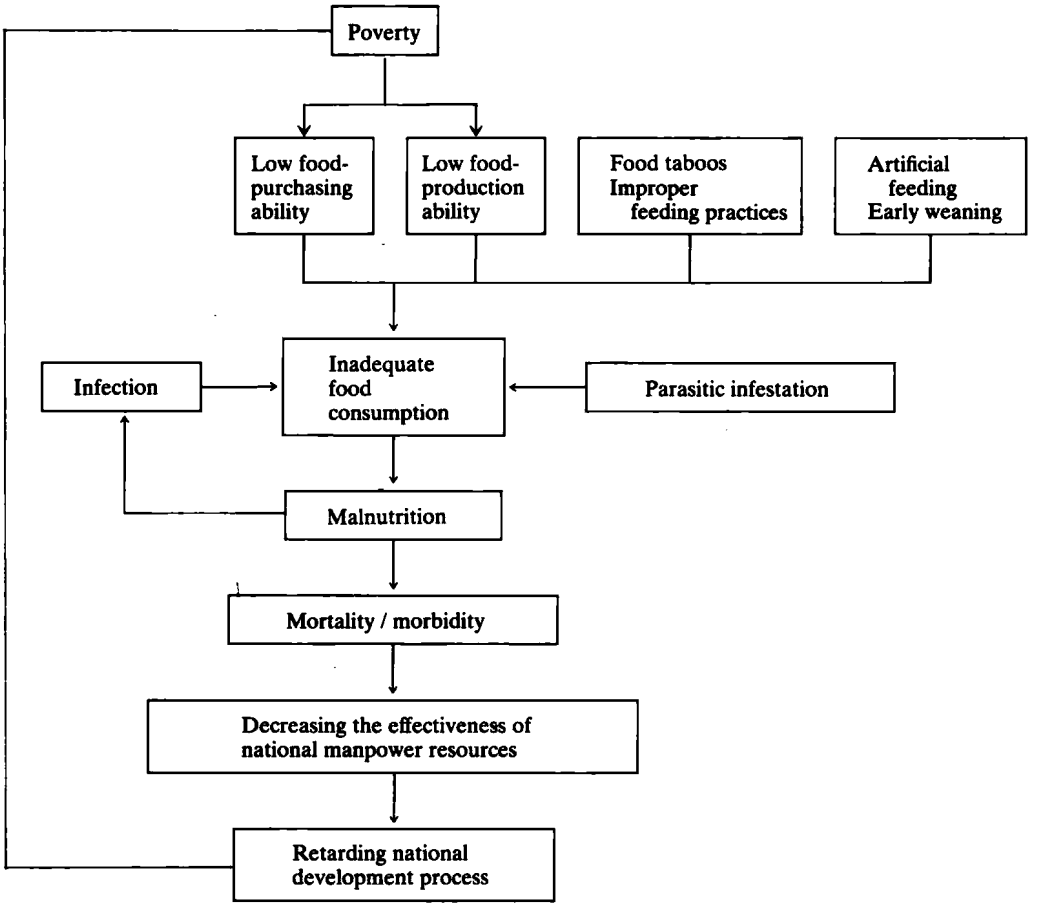

Fig. 4. Food and nutrition in relation to health.

Existing Health Delivery System

During the past 40 years, health delivery in Thailand was based on the Western concept of having a centre for treatment. It was found that only 20 per cent of the population was served by this system. A midwifery centre existed in only 4 per cent of the villages and a health station in 8 per cent. Mobile clinics have been an alternative giving more outreach, but are limited by logistics problems.

Lack of Community Awareness

Thinness and small body size are perceived as normal by rural villagers. Therefore, the involvement of the community in nutrition programmes has been minimal. Furthermore, improvement in a child's nutritional status is neither apparent nor rapid and may require a change in infant feeding practices.