Community Participation in Nutrition Programmes for Child Survival and Anemia

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This is a copy of the final published version of a report written by the Centre for Public Health Nutrition, School of Integrated Health, University of Westminster, London, July 2007.

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This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. GHS-A-00-05-00012-00. The contents are the responsibility of the Academy for Educational Development and do not necessarily reflect the views of USAID or the United States Government.

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TABLE OF CONTENTS

Executive Summary

This review presents a critical analysis of the role of community participation in enhancing the uptake of nutrition interventions for child survival and anemia and whether any such increases in uptake are sustainable and scaleable. One of the on-going challenges in assessing the role of community participation in health improvements is defining the characteristics of different forms of community participation and their impact on health/nutrition. To address this and to provide a methodological tool for this review, an evaluation framework has been developed that incorporates a typology of community participation. This framework has been applied to five case-studies of program experience in which community participation was a key element of the program design and/or delivery. From this analysis some general findings emerge.

Firstly the framework allowed for a nuanced analysis that showed the differing nature of community participation achieved within each of the programs, where this fell along the community participation continuum in the framework, and how it related to program outcomes.

In terms of program outcomes, positive impacts were seen on uptake and on various health indicators in all of the programs, but these were achieved in different ways indicating that there is no single “right” approach to community participation. Child Health Days achieved a good community response in two programs and in one was linked with a broader community health and development strategy. This suggests that it may be possible to use community development approaches as a channel for more vertical interventions, although the wider process should not be forgotten. Community health workers or volunteers were involved in all programs, but again in different ways that have implications for sustainability.

All programs were scaled-up to some degree. The more vertical single intervention approach of the NVAP in Nepal has been scaled up and expanded to achieve national coverage and deliver a wider range of interventions, and there is anecdotal evidence to suggest that the type of community participation may be evolving from mobilization into something wider. However, firm conclusions cannot be drawn as to whether the different types of community participation lend themselves more or less to scaling-up because of our lack of understanding about the process and hence replicability of different community participation approaches.

Clearer differences were seen in relation to the different types of community participation and sustainability; the greatest potential for sustainability was seen in those programs that tended towards the community development end of the continuum and where health outcomes were part of a broader package, but inevitably change was not instant. The case-studies show that whilst vertical interventions can produce comparatively rapid results, their sustainability still requires long-term money and support. These are necessary, but each by itself is not sufficient to ensure success;

sustainable change is more likely when programs address wider development issues rather than narrow behavior change objectives alone.

To conclude, this review and analysis demonstrate that community participation can enhance the uptake and response to health interventions, their scale-ability and sustainability, but that the process by which these programs are implemented is crucial. There remains a need for more prospective rigorous evaluations of community participation that examine the role of process as well as impact on outcomes.

1. Introduction

1.1 Background and rationale

This review has been prepared at the request of the A2Z project. The mandate of the USAID-funded A2Z Project (Micronutrient Leadership and Support and Blindness Activity, funded by USAID) is to implement and strengthen micronutrient programs to improve the nutrition and health of vulnerable populations; provide global technical leadership in micronutrients; and support organizations which work to prevent child blindness. With a focus on the sustainability of programs, A2Z aims to expand coverage of vitamin A, zinc, anemia reduction, and iodine interventions primarily through country and regional programmes.

Globally micronutrient deficiencies remain major public health challenges and nutrition interventions to address these are a key part of child survival packages. While the scientific evidence-base regarding effective interventions to address micronutrient deficiencies is comprehensive, there remains uncertainty as to the most effective means of delivering interventions in ways that can be scaled up and sustainable in order to achieve the Millennium Development Goals for child survival. There have been numerous calls for a focus on enhanced delivery systems (Bryce *et al,* 2003), but there are few reports of success, at least for nutrition-related interventions. The involvement of communities, either as a compliment to the formal delivery system or independently of it, has long been identified as a critical component necessary to achieve effective and sustainable programs for health improvement and to address the social determinants of ill-health (Assai *et al,* 2006).

Following Alma Ata and as part of the primary health care movement there was much activity in the 1980s using community-based approaches and community/village health worker programmes were set up in many countries to implement a range of health interventions. Interest waned in the 1990s, but recently there has been a renewal of interest in the potential of community-based approaches and particularly in the potential of community health workers (Haines *et al*, 2007). As Hossain *et al* (2004) have pointed out, however, it remains difficult to provide evidence of a direct link between community development and health outcomes and a challenge remains in delineating the characteristics of different types of community participation and their impact on health, including the process by which interventions are implemented. This is due in part to on-going challenge of defining and distinguishing the terms participation and empowerment. There is thus a need for a rigorous examination of the evidence relating to the role of community participation in enhancing the delivery and uptake of health interventions, particularly in the light of recent criticisms of participatory development (Cooke and Kothari, 2001).

1.2 Overview and aims

The purpose of the review is to provide a critical appraisal of the current literature and illustrative program experience in relation to community-based approaches to implementing nutrition programmes, particularly those relevant to child survival and anemia.

The review will address the primary question: *What is the evidence that community participation enhances responses by the general population and/or health care providers to health interventions for child survival packages, and further what is the evidence that this uptake is sustainable?*

Secondary questions addressed are:

1) How do we define community participation and what is its relation to community mobilization and empowerment?
2) Having created a typology based on these definitions, which of these works best for the uptake of child survival packages and which works best for enhancing the sustainability of child survival packages?
3) What is the evidence that these approaches can be scaled up? What is the evidence that these approaches are sustainable?
4) Based on these findings, which are the most critical areas requiring further investigation?

1.3 Methodology of the review

A selective and critical approach has been taken to the review (given the timeframe a full systematic review would have been impossible and also the nature of the evidence does not lend itself to such an approach). Previous work by the authors has been used as the starting point for the review (for example: Rifkin *et al*, 2000; Rifkin, 1996; Rifkin, 1985). This has been extended and updated to include:

- Published material since 2000
- Recent reviews on community participation and empowerment in health
- Case-studies of programme experiences focusing on nutrition-related programmes and interventions relevant to child survival in which women are the main beneficiaries. The case-studies will include a range of motivational strategies, including the AIN-C and similar programs.

Using this evidence, a typology of community participation has been developed and factors critical in programmes where community participation has been the basis for successful health outcomes have been identified. These have been used to develop a framework to evaluate the process of community participation and its relationship with health outcomes. This has then been applied to selected case-studies of actual program experiences to assess the role of community participation on the uptake and sustainability of child survival interventions, with particular emphasis on analyzing the process of implementation. From these key lessons learned have been drawn and areas requiring further research identified.

2. Community participation and health

In 1978, the member states of the World Health Organization (WHO) voted to adopt the policy of Primary Health Care (PHC) in each country. In doing so, they recognised that health improvements were not merely the result of health service delivery and medicines. Reflecting recognition of social determinants of health which included social, economic and political concerns, PHC was based on the principles of equity and community participation and supported by recognition of activities for appropriate technology, multi-sectoral collaboration and sustainability (WHO, 1978).

The idea that community lay people had a crucial role to play in health improvements was rather surprising to the health professionals. However, there were several reasons for this principle in the PHC policy. These included:

1. Community resources including money, materials and time can make a contribution to health improvements.
2. Peoples' health is not merely an outcome of health services but equally important is what people do to and for themselves.
3. Health improvements and sustainability of community health programmes depend on community people defining their needs and taking action to meet these needs. (Rifkin, 1990)
4. "Social learning" where professionals and community people learn from each other enables both groups to define joint purposes and build partnerships. (World Bank, 1996)

In the years following the acceptance of PHC, efforts were made to integrate the principle of community participation into health planning and health care. However, this was not an easy task. A major reason was that standard definitions of the terms "community" and "participation" could not be agreed. "Community" is usually often defined in geographical terms, but this does not always capture the deeper reality in which groups form around identities, ideologies, religions, income, etc. and do not necessarily want the same thing at the same time (Jewkes and Murcott, 1996). Defining "participation" is equally complicated. As noted by Oakley (1991), participation can be active or passive; can be contributive, collaborative or transformative. In addition, authors such as Nelson and Wright (1995) directly addressed the question of the exercise power in community participation and how participation reflected who had power and for what was it used.

Community participation was traditionally seen by the medical establishment as mobilizing people to uptake an intervention. A typical example is mass campaigns for immunization days (Gonzalez, 1965). Programmes like these, however, have proved difficult to sustain because of their high demand for resources and the challenge of covering populations in outlying areas. PHC tried to address this by implementing wider interventions that were part of the whole fabric of development. Centrally-driven, stand alone Child Health Days do not reflect the principles of PHC that strives to address the wider social and structural determinants of health.

To understand the experiences of integrating community participation into health care programmes, Rifkin developed a typology which enabled planners to view how they approached community participation in their own programmes (Rifkin, 1985). These approaches were:

1) The medical approach in which planners defined health as the absence of disease and participation as having people do what the professional advises. This approach may be seen as one of mobilising communities.
2) The health services approach in which health is defined by the WHO definition as "the physical, mental and social well being of the individual" (WHO, 1946) and participation as a contribution of the community's time, materials and/or money. This approach might be viewed as collaboration, but with the professionals defining what is needed.
3) The community development approach in which health is defined as a human condition and participation as the planning and managing of health activities by the community using professionals as resources and facilitators. This approach might be seen as one of empowerment (defined as creating opportunities for those without power to gain knowledge, skills and confidence to take decisions that affect their own lives) (Rifkin and Pridmore, 2001).

Although these approaches are not mutually exclusive, each is based on a particular view of health and community actions that lead to different definitions of expected inputs and outcomes.

Reviewing the literature on the way in which community participation has affected health and poverty eradication, Rifkin *et al* (2000) have traced the historical development of these different approaches to community participation in health improvements. The review brought out some critical points in the relationship between better health and community participation. These included:

1. Community participation is best understood as a process that is situation specific. The search for a "gold standard" for replication and evaluation is not realistic or appropriate. Although the biomedical model is dominant in the health field with the expectation that direct causal relationships can be identified and acted upon, such a paradigm is not valid when we look at social processes; as widely recognized in the social sciences, these are complex, context specific and hard to predict and are not equivalent to physiological processes.
2. Case studies suggest that more sustainable improvements are possible when community empowerment through participatory approaches are pursued. However, programmes pursuing empowerment confront a number of challenges which include the need to address issues of power and control.
3. Case studies reflect developments in a specific situation and therefore are mainly anecdotal. While the review notes some of these studies, a more extensive investigation has been published by Taylor-Ide and Taylor (2002) that discusses in detail the results of improvements in health and overall development of community participation.

4. There is little evidence of how interventions can be replicated or of the nature of the relationship between community participation and health outcomes. This point was confirmed in a publication by Hossain *et al* (2004). To quote:

> "In these years, of research and project implementation, one can observe a myriad of factors that may have played a role in improving health, but the challenge remains to find the definite answers regarding the share between interventions and the process of implementation (influence of community empowerment or development) in improving the health of communities and at what level and scale."

These conclusions help to define the challenges for assessing the role of community participation on health outcomes in nutrition programmes for child survival and anaemia.

3. Evaluating community participation in health

PHC assumed that community participation was critical for health improvements. As noted above, however, evidence to directly link participation and health improvements has been scarce. There is much evidence to indicate that without community participation health and development programmes flounder (Pritchett and Woolcock, 2004). The search for the converse has proved to be illusive. For example, in trying to address the direct impact of participation on health improvements Manandhar and colleagues proved how participation in women's groups in a controlled study in Nepal improved ante-natal outcomes (Manandhar *et al,* 2004). The tightly controlled epidemiological study illustrated a causal relationship. However, the study and subsequent publications have so far failed to describe how these women's groups functioned and whether each group had exactly the same intervention. This example shows how difficult it is to identify and describe the process by which communities are involved in health programmes.

Others have attempted to develop assessment frameworks using qualitative indicators and/or combining these indicators with quantitative information to examine the participation process in detail. Most recently, the Population Reference Bureau published an issue of their Health Bulletin that proposed a community participation development continuum (Gryboski *et al*, 2006; see Appendix 1). The authors then examined five programmes from developing countries and assessed where they fitted in the framework, giving each a score according to the above description. The assessment used both quantitative and qualitative indicators and described each case study in terms of background, participatory approach and outcomes.

Rifkin *et al* (Bichmann *et al*, 1989; Rifkin *et al*, 1988) have also developed a tool for assessing participation that has been used in both developed and developing countries. This includes a visualisation called a spidergram that links five continua together with narrow participation at one end and broad participation at the other (see Figure 1 below). It was designed to assess changes in five factors (needs assessment, leadership, organisation, management, and resource mobilization) by first recording the breadth of participation at the beginning of the programme as a baseline (see Figure 2) then at designated times during programme development (see Figure 3). This tool can

enable planners to see whether participation has changed in any one factor and to discuss why this had happened with programme participants.

Figure 1: Diagram for assessing community participation in a health programme
(Bichmann et al, 1989)

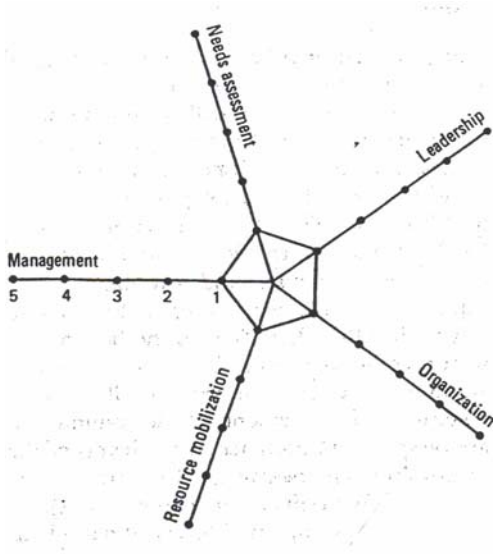


Figure 2: Baseline assessment of community participation in a health programme
(Bichmann et al, 1989)

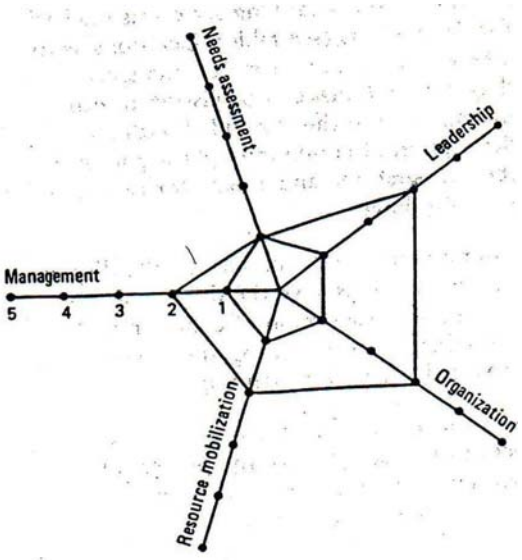
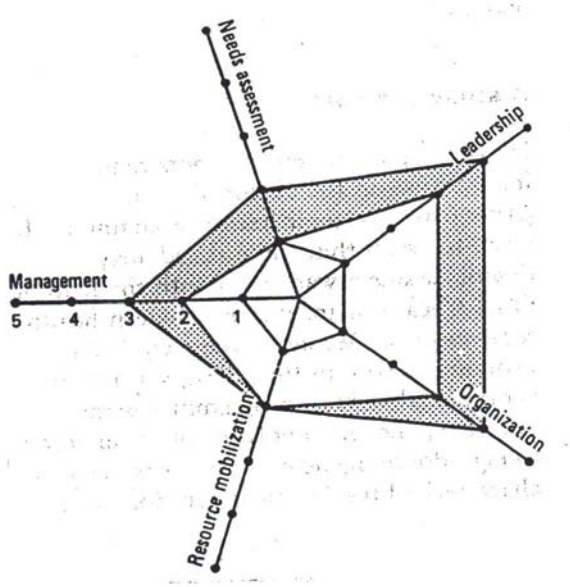


Figure 3: Changes between first and second assessments
(Bichmann et al, 1989)



To create a spidergram for a program, a set of questions is developed to assess where the marks should be placed on each of the five continua. The continua are arranged in a spoke-like configuration to show their inter-relationships and the marks display how wide or narrow participation is; it is narrow at mark one and widest at mark five. Figure 1 shows the diagram for assessing participation; Figure 2 shows how marks can be placed at the baseline for a hypothetical program; and Figure 3 shows the comparison between the baseline and an assessment done at a later time. Two points need to be noted: 1) the pentagram at the center of the diagram reminds the assessors all communities have some degree of participation. This means no mark can be placed at the center of the continuum; 2) changes do not necessarily reflect a widening of participation; they also can show a diminishing of participation. The indicators are purely descriptive; they do not tell planners whether participation is good or bad, they only allow the planner to see change and to explore the processes which allow that change to take place.

Building on the spidergram, Laverack (2004) developed a framework for evaluating empowerment. He identified nine domains (participation, leadership, organisational structures, problem assessment, resource mobilisation, asking why, links with other people and organisations, the role of the outside agent, and programme management). He suggested that by collecting information on each of these domains the process of empowerment can be examined and promoted.

These frameworks all attempt to incorporate and understand process and its relationship to health outcomes. Using these experiences, a new framework can be suggested that would combine both the qualitative and quantitative indicators and help identify lessons that can be useful to planners in nutrition intervention programmes.

4. A framework for evaluating the role of community participation in nutrition programmes

A framework is needed that can examine the role and function of community participation and experiences suggest that such a framework should include the following features:

1. Both qualitative and quantitative indicators.
2. The framework should help assess process – a visualization of a continuum allows the programme process to be assessed in a dynamic way.
3. The framework can be used to assess a specific programme, but the findings are not intended to imply that the process is replicable in all programmes.
4. The framework should be robust and flexible, so that new indicators can be added if they are appropriate to reflect the programme under assessment, e.g. equity.

A framework that allows us to do this is one based on two axes or continua. The first is the continuum of community participation based on Rifkin's typology described earlier with community mobilization at one end of the continuum and community development at the other. The other axis is five factors that recent reviews on community participation in health programmes, including maternal and child health, have identified as critical in programmes where community participation has been the basis for successful health outcomes (Gryboski *et al,* 2006; Murthy and Klugman 2004; Rifkin, 1990; Rifkin *et al*, 1998, 2000; Wallerstein, 2006; Zackus and Lysack 1998). These factors are:

Leadership – Local leaders should serve as role models for other community members. It is important that they act out of concern for all community members, not just those with whom they have a special relationship. This should ensure that the programme benefits everyone, especially the most in need and hence is more effective. If leadership and governance/democracy skills are weak within the community, efforts should be made to build these skills so strong, sustainable and open leadership is engendered. With regard to external leadership for specific programme promotion, it is important this leadership builds partnerships with local people, respecting views and contributions, and eventually responsibility for the new programme.

Planning and management – communities need planning and management skills if a health programme is to be equitable and sustainable. Good planning abilities mean they will be able to plan around their needs in a locally appropriate way, which may also contribute to a sense of local ownership of a programme as it will have stemmed from local people's ideas and their investment of time. Strong planning and management skills will also mean that the community will be more likely to be able to adapt the programme to changing circumstances, thus maintaining the effectiveness of the programme. Activities to promote and develop these skills include active participation in needs assessments and monitoring and evaluation.

Women's involvement – the involvement of women in improving community health is an important component of equity in primary health care. Community participation

approaches endeavour to empower women so they have the confidence and skills to take on new and senior roles. This not only promotes equity, but may also benefit child health outcomes as women are more likely to use any improved knowledge or income for their children.

External support for programme development – full community participation in designing a health programme is likely to lead to a locally appropriate design that addresses community priorities. This may increase programme effectiveness and enhance community ownership of the programme, contributing to its sustainability and encouraging local people to invest their resources in it. If communities are taught how to seek and secure resources (including materials, money, and human resources) from within and outside the community, they will gain valuable skills that will enable them to try to sustain the programme in the future and be self-reliant. In the context of financial empowerment, the community can negotiate funding for other health and development activities, enabling them to diversify their self-help efforts.

Monitoring and evaluation – community participation means that measurement and analytical skills are transferred to the community as they learn how to define indicators, and monitor and evaluate in a way that is meaningful to them. The community therefore becomes better able to analyse its actions and their effects and to respond appropriately. This will help maintain programme effectiveness and sustainability.

Such a framework reflects the rationale that community participation may help achieve effective and sustainable changes in health and promote equity within the community. A community development approach to participation aims to give a community the skills, experience, and confidence to sustain a programme without external support and adapt it to changing circumstances, to diversify their activities to pursue their own development, and to protect the weak among them.

The framework is shown below in Figure 4. The typology of community participation is on the horizontal axis and the five critical factors on the vertical axis. The latter have been operationalized for each cell of the matrix to define, for instance, the various types of leadership as they fall along the continuum of community participation.

Figure 4: Framework for analysing community empowerment in health programmes

Component of Participation	Community Participation Typology		
	Community mobilization	***Community collaboration***	***Community development***
Leadership *Of the community where the intended beneficiaries are living and of the professionals introducing the health interventions*	Health professionals assume leadership of programme – decide and direct programme activities. Leadership within the community is not necessarily concerned with widening the decision-making base in the community. The community leadership does not question the health professionals or its own role in programme implementation.	Decision-making is collaborative between health professionals and community leaders. Local leadership seeks ways of presenting the interests of various groups, particularly the poor.	Programme is led by community members who are selected through a representative process and who act in everyone's interests. They are accountable to the community and responsive to change. If leadership initially weak in the community, health professionals train and support members to assume programme leadership. Local leadership is a role model and ensures that the interests of various groups are represented in decision-making and /or it provides opportunities for different groups to actively participate in decision-making, especially women and vulnerable groups.
Planning and Management *How partnerships between professionals and the community are forged*	Health professionals conduct the needs assessment and decide the programme's focus, goals and activities and provide the necessary resources. Timescale of programme is at health professional's discretion.	A collaboration is created at the instigation of the health professionals. Needs assessment is conducted by the professionals by asking local people for information.	Partnerships between communities and other health care professionals are created or re-negotiated with representatives of the community and are institutionalised.

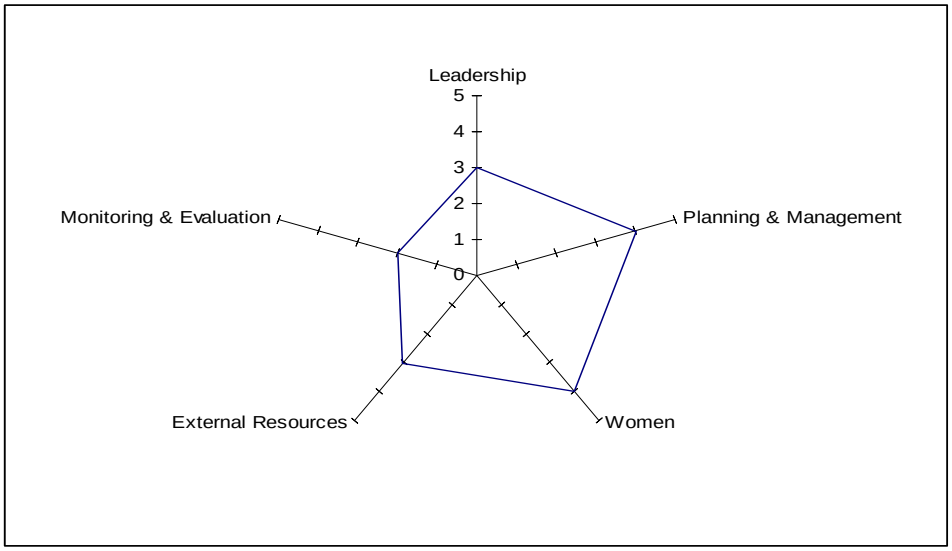
Planning and Management (cont'd)	Decisions are not necessarily transparent and no mechanisms to hold health professionals accountable to the community are established. Health professionals tell the community how they may participate. Minimal transfer of skills: technical training if necessary.	Health professionals have a predetermined remit, but invite the community to participate and respond to the their priorities within that remit and in ways that are negotiated with and involve community members and existing community organizations. Programme goals are negotiated. Processes and decision-making work toward transparency. There is some flexibility in the time- scale of the programme. Both professionals and community members provide resources. Community members provide materials, money and human resources e.g. volunteers, local NGO participation. Some transfer of skills: capacity-building and training are undertaken.	Professionals act as facilitators to enable the community to plan and manage the programme. Needs assessment conducted by the community, possibly with professional help. Programme priorities are defined by community members and advocated by them. Local people's knowledge and understanding of an issue is the starting point for exploring solutions. Programmes are integrated into existing organizations. Organizations are supported and members learn any skills they lack for programme management and evaluation and assume these tasks. Mechanisms are established for the community to hold health professionals and local programme management accountable.
Women's involvement	The inclusion of women is not specifically sought outside of their traditional roles and they are told how to participate. Their priorities are not investigated nor their active participation	Women actively participate in some aspects of the programme and their opinions are sought. They are asked to contribute to the programme, particularly when it affects them directly,	The active participation of women at all stages and in positions of decision-making and responsibility is a programme objective.

	seen as necessary for programme success.	however they have minor decision making roles.	
External support for programme development *In terms of finance and programme design* ***External support for programme development (cont'd)***	Programme is funded from outside the community (Government / large NGO) on a scale and timeframe determined by the funder / health professionals. Health professionals acquired the funding, allocate it, and are responsible for it. Programme components are designed by health professionals to address health outcomes they prioritise and in ways they deem appropriate. Community participation in ways determined by health professionals.	Majority of funding is external to the community. Local people are asked to contribute time, money and materials to the programme. Resource allocation is determined by the professionals although they may consult community members. Programme is designed by health professionals in discussions with community representatives. Role of each in the programme is negotiated. The participation of women / minority groups is not necessarily incorporated into the design.	Community members decide programme priorities and work towards finding ways of mobilising resources to meet them, which could include approaching external funders. They seek ways of maintaining the programme with their own resources, which could include micro-financing and income generating activities. Programme is designed by community members to address their priorities. Technical advice from health professionals on request. The needs and involvement of women / minority groups are integral to the design. The design is flexible and incorporates wide community participation.
Monitoring and evaluation *How intended beneficiaries are involved in these activities*	Health professionals design M&E collection protocols, choose the outcomes and analyse the data in ways to suit their or their donor's information needs. Approach is mainly one of hypothesis testing and	Health professionals design M&E protocols and perform analyses, but community members are involved in data collection. Mixed methods (including qualitative methods) are used to	Communities are actively involved in monitoring the programme and in deciding how to respond to findings from monitoring data. Participatory M&E is an essential component of overall evaluation which uses

	statistical analysis of health-related outcomes. Feedback from the community is not necessarily solicited. Health professionals define 'success'. Community members may be involved in data collection using methods prescribed by the professionals. Communities are not necessarily made aware of the final evaluation findings.	capture wider outcomes and the context. Broad definition of 'success' used. Responses to monitoring findings are jointly decided. Information needs of health professionals are met and community feedback is both sought and given in an appropriate format.	both quantitative and qualitative methods. Communities conduct an evaluation which produces locally meaningful findings and are involved in any wider dissemination. A variety of locally appropriate data collection methods are used. The community chooses the indicators for success. Professionals provide advice and assistance where necessary and as requested by the community. Communities contribute to any wider external evaluation conducted by/for the programme funders.

To apply and visualize this framework, we can return to the spidergram described in section three. An example is shown below in Figure 5.

Figure 5: Spidergram visualization of community participation based on the new framework



As in the original spidergram, each of the five factors is scored and then visualized using the spidergram to show how wide or narrow participation is. As described there, this maps the overall nature and extent of participation at a particular point in time and shows at what point a program is, between community mobilization and community development. It may show that the degree of participation is not equal across these five factors, and, if applied at different time points, can show changes over time. To show how the framework can be implemented, the next section gives examples using case-studies in a retrospective analysis.

5. Case studies

The case studies were selected from community-based programmes that addressed maternal and child health. They were purposively selected to reflect the range of approaches to community participation across the typology (section 2) and to give a geographical spread.

Each case study was analyzed with reference to the five components of participation using the framework (Figure 3). For each component, the case was given a 'score' ranging from 1 (the case most closely reflected the mobilization form of community participation) to 5 (the case most closely reflected the community development form of community participation).

5.1 AIN-C Programme, Honduras

Atención Integral a la Niñez en la Comunidad (Integrated Community Child Health Programme)

History and objectives

AIN-C is the national GMP strategy in Honduras and the centrepiece for integrating child health programmes. It was conceptualized and developed by the Honduran MOH (with assistance from BASICS) from AIN, the existing facility-based GMP programme. The BASICS evaluation of the successful AIN-C pilot in 1996 led to the programme's refinement, strengthening, and rapid expansion in 1997. By 1998 the programme covered one third of the population and in 2000 it was adopted as the national child health programme.

Through AIN-C the MOH decentralizes health service provision focused on hard-to-reach populations to achieve better efficiency, equity, and participation, and to increase community participation which is a central tenet of AIN-C. The programme focuses on services that prevent health problems as well as treat them, and on community management supported by occasional consultations from health centre staff.

AIN-C moved GMP from health facilities into the community. The community has responsibility for selecting the AIN-C team (volunteers work in groups so responsibility is shared), reviewing children's progress and solving detected problems that impede child health. It brings equity by insisting on complete coverage of under twos, and it decentralizes decision-making to the community and household, recognizing that the root of many problems is local. AIN-C aims to give the family the opportunity and confidence to nurture children within its own resource base. In cases where a household cannot do so, the community is asked to take on some of the responsibility.

AIN-C is regarded as a model programme and has been replicated elsewhere in Central America and in Africa.

Programme outline

AIN-C relies primarily on volunteers to pro-actively engage families and communities to monitor and maintain the adequate growth of children under two years of age. AIN-C also treats and refers sick children under five years to health services.

Health sector nurses train local health centre staff in AIN-C. As part of this activity, meetings are held with community leaders (communities are selected by the health sector nurse) to determine their interest in their community having an AIN-C programme and whether they will be supportive of it. If the community leaders pledge their support, a meeting is held to discuss the programme, in which the community selects three people to serve as AIN-C volunteers (Monitoras) and the community leaders agree to attend tri-annual community meetings to discuss the programme.

Monitoras' teams (frequently women) are trained and supervised by a local nurse auxiliary. The AIN-C structure focuses on monthly GMP sessions held in the community. At each session, Monitoras weigh each child under two years of age, assess the child's growth rate relative to expected weight gain, plot the growth curve on the child's card, and provide counselling. The Monitoras inquire about the child's health and the caretaker's care and feeding practices, use a diagnostic decision-tree analysis to identify the causes of inadequate weight gain, and give key messages on breastfeeding, child feeding, illness care, and hygiene. Health centre personnel are also often available for immunizations, vitamin A and iron supplementation, and family planning. Monitoras make home visits for newborns, children who do not attend sessions, and children with inadequate weight gain or illness.

To support families' efforts to improve care in the home, Monitoras hold community meetings three or four times a year to discuss the growth of the children and to plan collective actions that will create a favourable environment for child growth. These meetings, attended by community leaders, formally recognise and confirm the importance of the Monitoras and are important in shaping the community's response to and support of the AIN-C programme. They provide a regular public forum for identifying, discussing, and addressing the roots of common community health problems affecting children that are beyond the power or authority of any one family to address (e.g., polluted water supplies).

The programme is implemented by NGOs in some areas with weak MOH presence and there is an AIN-C inter-institutional committee led by the MOH. Implementing NGOs include the Red Cross, CARE, and World Vision. NGOs

implementing AIN-C have promoted community-based democratic processes through the selection of Monitoras, the formation of community health committees, and strengthening the linkage between the community and local / national institutions. They have also assisted communities to develop adjunct sustainable activities, such as rotating community medicine chest funds, income generation activities, and improvements to water and sanitation.

Outcomes

A mid-term evaluation conducted by BASICS staff compared sixty AIN-C communities with control communities. It used questionnaires and looked at a variety of outcomes around programme attendance and child health care practices. Some of the findings included:

- Enrolment of children under two years: 92% AIN-C communities vs. 21% control communities. Enrolment in GMP programmes in AIN-C communities before the programme started was 30%.
- 62% of AIN-C mothers could interpret their child's growth card vs. 31% in controls.
- Iron supplement coverage for children over four months: 47% AIN-C children vs. 9% controls
- Vitamin A supplement coverage for children over 6 months: 80% AIN-C children vs. 65% controls
- Vaccinations: 76% of AIN-C children were fully immunized vs. 66% controls.
- Oral Rehydration Therapy use increased from 37% to 57% in AIN-C communities vs. 36% to 42% in control communities.
- AIN-C exclusive breastfeeding (EBF) rates increased from 27% to 49% for children under 4 months and from 21% to 39% for children under 6 months of age, while control rates decreased from 20% to 17% for children under 4 months and from 15% to 13% for children under 6 months.
- AIN-C mothers had significantly better knowledge on a range of child feeding practices, including the optimal period of EBF, appropriate age of introduction of complementary foods, appropriate consistency of soup, techniques for making thick soup, and ways to stimulate a child's appetite than counterparts in control communities.

The final impact evaluation (conducted in 2002) found that full participation in AIN-C was associated with significantly better weight-for-age and height-for-age.

A report of the experiences of the collaborating NGOs found that they thought AIN-C actively involved communities and families in the achievement and maintenance of adequate growth in young children and that it had improved access to and use of health services.

Community participation framework

Leadership – 3

- MOH leads the programme at the national level.
- At the village level, the Monitoras lead GMP activities with the support and supervision of local health centre staff or NGOs. Monitoras decide how to organize their activities. The community selects the Monitoras, but detail is lacking on how this happens.
- The programme tries to draw existing leaders into the programme and use them to galvanise community action.

Planning and management – 3

- Health professionals instigate the programme and define its priorities. MOH staff and Monitoras work together: health centre staff supervise Monitoras and attend GMP sessions to immunize children, give out supplements, etc. Monitoras plan and manage their activities.
- The needs assessment (in this case the pilot evaluation was used as the basis for planning the revitalised AIN-C so can be considered the needs assessment) was conducted by BASICS. AIN-C in its current form was designed by the MOH with BASICS's technical assistance.
- MOH restricts the expansion of the programme for financial reasons – recommends two communities per health centre. Nurses select which villages to offer the programme and the community is invited to select Monitoras.
- MOH, communities, and NGOs provide money and human resources.
- Monitoras are extensively trained and given new counselling tools to use.
- Communities analyse village-level problems and identify action solutions with the Monitoras. (Health centre staff only attend the first two community meetings.) This local flexibility is intended to promote local ownership of the programme.
- Accountability of the MOH or health staff to the community is not mentioned in the documents reviewed.

Women's involvement – 2

- Women are quite heavily involved in the programme as the majority of Monitoras are women, but they are not specifically targeted for this role. Frequently they have served as community volunteers before.

External support for programme development – 2

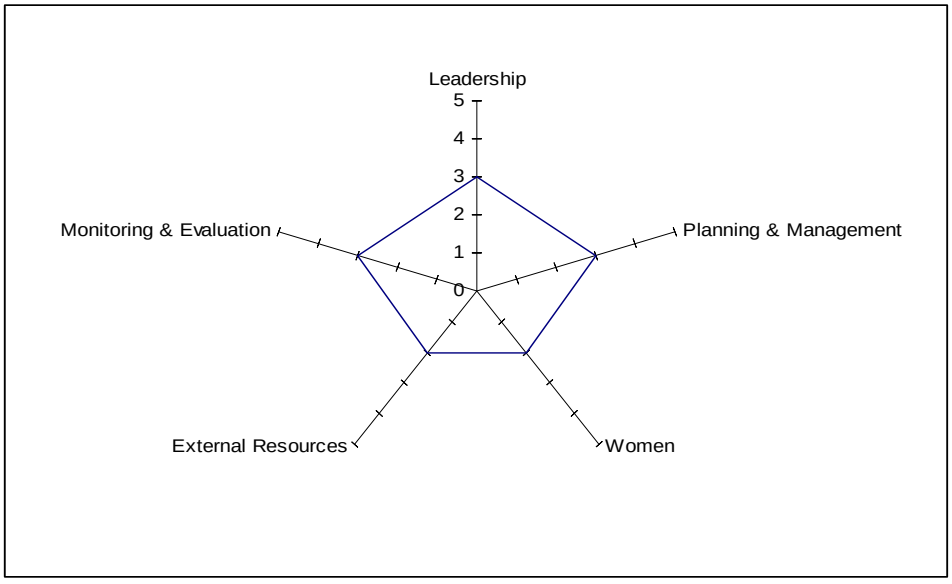
- The programme is funded from outside the community, by MOH and in some areas by the implementing NGOs. Communities contribute

Monitoras to the programme. (Monitoras receive free state health care.) It is not clear how community level activities are funded.

- Some NGOs have established income-generating schemes as an adjunct to the programme, but this is not an integral part of the programme.
- The basic structure of the programme, including the manner of community participation, was designed by the MOH and it sets the programme's goals. The community then responds to these as they see fit. The participation of women was not specifically incorporated into the design.
- The programme targets all children under two in an attempt to ensure equity of provision and collaborates with NGOs to cover regions MOH cannot reach.
- At the village level, the programme is flexible as Monitoras can manage their own activities, involve the community as much as they can, and address locally relevant problems.

Monitoring and evaluation – 3

- Health professionals designed the monitoring protocols, but they are implemented and analysed by Monitoras: Monitoras collect data at each session and produce bar charts showing number of children enrolled, attending, with adequate weight gain etc. They use these to monitor themselves and in their discussions with the community. Communities decide how to respond to the findings.
- Evaluations have been conducted by BASICS and by the CORE NGO group. BASICS evaluations have been quantitative questionnaire-based designs, analysed outside the communities. It is not clear if evaluation findings have been fed back to communities.



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5.2 Basic Development Needs Programme (BDN), Djibouti

History and objectives

BDN was launched by WHO in its Eastern Mediterranean Region (EMRO) in 1987; the first field site was Somalia.

BDN is a process that aims to achieve a better quality of life and health for all by building communities' capacity to find local solutions to local problems and create and manage sustainable development activities. BDN strategies facilitate access to social services and appropriate technologies and provide financial credit with the explicit aim of promoting fairer distribution of resources to achieve equity at grass roots.

BDN recognises the intrinsic link between poverty and health and aims, through community empowerment and leadership, to improve access to basic needs. It is a needs-based, bottom-up strategy that pursues integrated socioeconomic development based on the involvement of all social groups supported by strong, co-ordinated intersectoral collaboration. It fosters community empowerment by

promoting self-reliance through self-management and self-financing by the people.

Under BDN, health is a contributor to and a product of development. The programme recognises that it is unrealistic to expect substantial improvements in health without addressing the wider determinants of health and that multisectoral efforts are crucial in achieving this. BDN therefore seeks better health through alleviating poverty, creating awareness, building capacity, enhancing literacy, and providing essential nutrition and health services.

BDN's inherent flexibility and locally sensitive operational mechanisms means it can be adapted to different socio-political contexts. Today twelve EMRO countries are implementing BDN programmes. Djibouti launched its programme in four sites in 2001 and extended it to a further four in 2004/5, covering 16,600 people.

Programme outline

In each BDN site a village development committee (VDC) was established. The VDC consists of a president, vice-president, secretary-general, treasurer, youth representative, women, local association members, public sector employees (e.g. nurse, teacher) and zonal representatives. (A zone is 30 to 50 households and is represented by one man and one woman.) VDC members are local notables, including traditional leaders, and chosen for being actively involved in community development. VDC membership is voluntary.

The BDN co-ordinating team then train local people, especially VDC members, zonal representatives and District co-ordinators. VDC treasurers and presidents are trained in financial management and methods of recovering loans and other training, appropriate to what the community wants, is provided e.g. handicrafts, health, fish breeding.

The VDC conducts a needs assessment, prioritizes the identified needs and develops an action plan. Using their training and with support from local public sector departments (e.g. health, agriculture) they implement and manage their own projects.

The Djiboutian Government has initiated the training of two community health workers (CHWs) and one midwife for each programme village. It has also integrated health education and immunization into the BDN.

Across the BDN villages, local projects have included:

- Promoting use of health services by CHWs and midwives

- Creation of MOH trained community health volunteers who conduct health promotion: school health, immunization, nutrition, environmental health, malaria and HIV
- Anaemia screening of women
- Malaria control programmes
- Refuse collection programmes, wells and water tanks, latrines, agricultural plots, tree planting
- Interest free loans for income generation activities: the poorest community members submit loan applications to the VDC who select a number to be submitted to the national BDN administrators at the MOH and WHO.
- Literacy classes: VDCs have supplied materials and covered salary costs and health promotion messages have been reinforced in classes
- VDCs have constructed health centres with MOH support and constructed / renovated primary schools.

Outcomes

Collection of baseline data in BDN villages was poor. In comparison to national averages, however, a number of health indicators are positive, despite the fact that only 14 out of 34 social projects were directed towards health:

- Infant mortality / 1000 live births ranges between 14 and 65 in programme sites vs. national average of 103;
- Under 5 mortality / 1000 live births ranges between 12 and 25 in programme sites vs. national average of 124;
- Vaccine coverage at < 1 year ranges between 96 and 99% in programme sites vs. national average of 64%;
- Women vaccinated against tetanus ranges between 96 and 99% in programme sites vs. national average of 64%;
- Growth monitoring in under fives ranges between 91 and 98% coverage in programme sites vs. national average of 23%.

Programme managers see BDN as a good point of entry for future health interventions.

Note: substantial improvements in vaccination coverage have been reported in BDN programmes in other EMRO countries (e.g. Afghanistan and Pakistan), and in Somalia BDN initiatives have survived civil strife as there was strong community ownership.

Community participation framework

Leadership – 4

- The programme is locally led by community members who act in the community's interests and represent a range of groups in the community.

Women have a role in programme leadership. It is not entirely clear how VDC members and zonal representatives are selected / elected.
- Traditional community leaders have an active leadership role within the programme.
- At the central level the programme is led by the MOH with technical support from WHO.

Planning and management – 4

- The VDC is created to manage the programme locally and its members are trained for their roles. The VDC seeks partnerships with potential funding bodies.
- The VDC identifies community needs, creates a plan of action and manages projects at the local level. Decision-making is local and transparent. VDC treasurers are responsible for administering loans in their village, but final decisions on recipients are made by MOH/WHO.
- BDN is to be institutionalised by the MOH integrating it into national health and development policy.

Women's involvement – 5

- BDN focuses on women in health and development and sees their involvement as essential. The majority of projects are directed toward the socioeconomic and health situation of women. Projects for women include vocational centres, literacy training, computer training, and income generation.
- Women are actively involved in the programme and present on all VDCs; one is headed by a woman. In another village the hygiene and environmental health is headed by a woman.

External support for programme development – 4

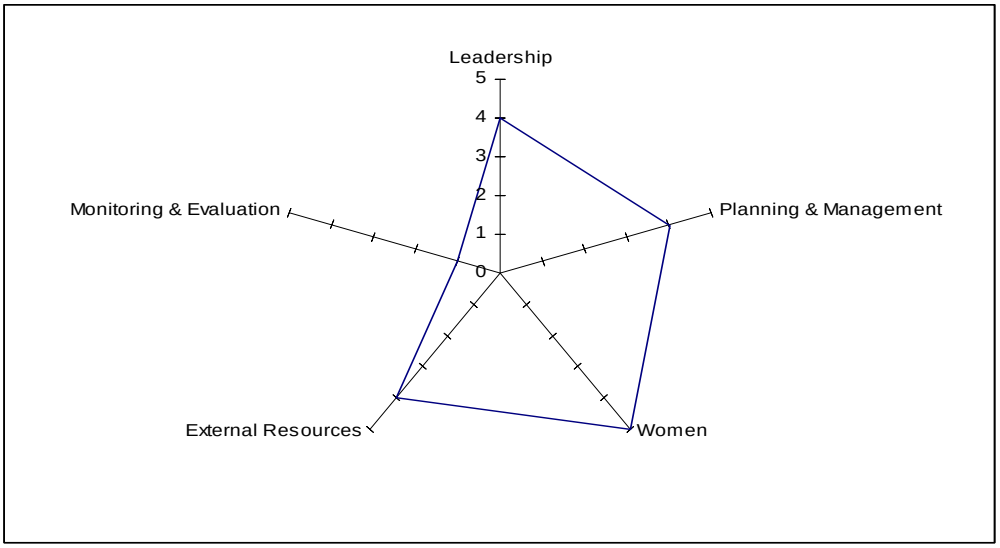
- The BDN approach asserts that the community should contribute 30% of funds invested, with the remainder coming from Government and other agencies. So far in Djibouti, communities have contributed 5 to 21% according their length of time in the programme.
- Communities are taught skills to mobilize the resources available to them. One VDC created its own fund for those in need through community donations, whilst others have mobilized aid from Government ministries, NGOs, UN Agencies, and bilaterals. One VDC sought funding from an Islamic organization in London to build a primary school.
- Loan repayments carry an additional 10% levy and this is used by the VDC to finance social projects. Communities also provide human resources and local materials.
- Centrally, BDN has mobilized the intervention of a number of partners: USAID, WFP, AFD, UNICEF, UNDP, CIDA, the US Embassy, and the

National Union of Djiboutian Women. Government ministries include the MOH, Agriculture, and the Ministry of Women's, Family and Social Affairs.

- The overall structure of the programme was designed by WHO but its local features are designed by the community in response to their priorities. Wide community participation is encouraged as is the participation of women.

Monitoring and evaluation – 1

- The programme evaluation was requested by the Djiboutian Government. It was conducted by WHO staff, MOH staff, and District Co-ordinators. Its purpose was, in part, to improve the programme.
- Overall, data collection, recording and reporting systems are weak and monitoring needs to be improved.
- What supervision and monitoring there is, is carried out by technical officers of WHO and MOH. Monitoring has tended to focus on income generation projects.
- Baseline surveys have been conducted in new villages and are being analysed by the MOH.



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5.3 Essential Nutrition Actions Programme (ENA), Nigeria

History and objectives

ENA is a BASICS II initiative that builds on a country's existing nutrition work by using delivery channels within and outside the formal health structure to link nutrition with health services and community based organizations to attain high coverage.

ENA focuses on six technical interventions:

- Adequate intake of iodine by all members of the household;
- Exclusive breastfeeding (EBF) for six months;
- Adequate complementary feeding (CF) from about 6–24 months with continued BF for at least two years;
- Appropriate nutritional care of sick and severely malnourished children;
- Adequate intake of vitamin A for women and children; and

- Adequate intake of iron for women and children.

The ENA approach explicitly emphasises universal and frequent contact with every mother and child to improve growth and nutritional status. ENA interventions concentrate on prevention and emphasize community-level actions with strong links to the health system. The ENA approach does not assume that inadequate nutrition is due only to lack of knowledge in families, but recognizes that household food insecurity, inadequate societal support for women, poor access to health care, and unhealthy environments cause or exacerbate nutritional problems. The ENA approach encourages ongoing advocacy on these issues while implementing near-term solutions.

ENA has evolved into a comprehensive programme implementation strategy that is suitable for resource-poor settings. ENA has three main strategies to improve child health:

1. *Integrating the six nutrition interventions into existing maternal and child health services and systems strengthening.* This includes assuring the availability and use of supplies such as micronutrient supplements and vaccines, improving health provider performance, and building an enabling policy environment.
2. *Capacity building and mobilization in communities* by, for example, strengthening women's groups; recruiting and supporting volunteers to promote increased participation in health services and practice of desired behaviours; increasing participation of marginalized groups; and engaging community leaders.
3. *Multi-channel, ongoing communications* to inform, sensitize, and motivate key groups with information about priority behaviours and services.

ENA has been implemented in four African countries and India. It was launched in Nigeria in 1999 and operates at the national, state, local Government area (LGA) and at the community level. The programme operates in three states: Lagos, Kano, and Abia.

Programme outline

In addition to the community, ENA involves primary health centre (PHC) and LGA health staff, who manage community-based activities, state government nutrition officers, international agencies (UNICEF and USAID) and the national planning office's food and nutrition task force, which has been at the forefront of advocacy efforts.

The programme operates through a three-pronged approach:

- At the federal level it sensitizes policymakers on ENA and advocates for inclusion into the national policy to provide an enabling environment for the implementation of ENA interventions.
- It trains health workers on ENA to enable integration of priority nutrition actions into existing maternal and child health services, and provides them with counselling materials to encourage health staff to incorporate key ENA messages and services at each maternal and child healthcare contact.
- It promotes enhanced infant feeding practices at community and household levels through (a) building capacity among community residents (community leaders, volunteer Community Health Promoters (CHPs), and TBAs); and (b) mass media communications through multiple channels.

At the federal level, the programme spearheaded the integration of vitamin A into National Immunization Days (NIDs). As NIDs was phasing out, the programme piloted a Child Health Week in Lagos state as a possible transition strategy for vitamin A supplementation. Child Health Weeks were subsequently held in all three states. Continuous communication and advocacy at the federal level has led to the recognition of ENA as an appropriate and effective approach for improving child nutrition and its incorporation into the National Plan of Action for Food and Nutrition.

The programme instituted a strategy called **Catchment Area Planning and Action (CAPA)**, a community-based approach to strengthen partnerships, planning and action with the participation of all stakeholders in child health, including health providers at the state and LGA levels, NGOs, and community members. Community participation was the core of the CAPA process and was realized through two groups: a CAPA Committee (CAPA-C) and the CHPs. To encourage state ownership the programme secured the states' input and approval from the outset by seeking their input on how to shape the design and implementation of ENA to the local context. State MOHs were asked to review ENA materials such as the training manuals to make them more culturally sensitive.

LGAs have two main responsibilities in the CAPA process: 1) To guarantee support, including supplies, infrastructure, and human resources, to ensure the provision of quality care at the PHCs, and 2) to supervise and manage the CAPA process through the formation of a CAPA Coordinating Committee (CCC). (Use of CCCs is not uniform across all areas.) The CCC comprises two representatives of each CAPA-C and the LGA CAPA Focal Person. CCC members select their own executive leaders. The CCC brings the CAPA-Cs together to share ideas and liaise with the LGA as one body.

The goal of CAPA is to create community understanding and ownership of child-health issues leading to local decision-making and cooperation. It seeks to

empower all partners and is designed to achieve sustainable change through action at community level. The CAPA process focuses on improving the utilization of health services. In the programme the “community” comprises three components:

- Community structures/organizations (e.g. existing leaders, community-based organizations (CBOs), associations, etc.);
- Private sector health providers (e.g. traditional birth attendants (TBAs), traditional healers, private clinic staff, etc.);
- and public health service providers.

The programme trained state and LGA CAPA facilitators. The latter then conducted advocacy meetings with indigenous community leaders (chiefs, ward heads) to explain the CAPA process. The team encouraged these leaders to identify and send approximately 30 representatives of community groups to attend a 3-day CAPA workshop. Typically such community representatives came from markets, community based organizations, religious groups, schools, trade groups, and neighbourhood associations. (The indigenous leaders did not participate in the workshop, as their role is normally to be impartial patrons of various community development efforts.)

At the CAPA workshop the attendees received technical training on nutrition, immunization and malaria, and training on the processes of community education and mobilization and the duties of a CAPA Committee. The CAPA training was a participatory learning process for both participants and facilitators.

At the end of the workshop each group developed a simple workplan on how to sensitize and mobilize community members to improve child nutrition. They were equipped with materials such as infant feeding posters and home health booklets to assist them in community mobilization. At the end of the workshop the attendees and the PHC staff became the CAPA committee (CAPA-C) and selected their own executive committee.

CAPA-Cs work to improve health facilities – both the physical plant as well as the staff’s relationships with the community. They also undertake community development activities, sometimes linking up with other local CBOs / associations. Advocacy to the LGA is also part of their role although in practice advocacy efforts have varied. They also recruit and supervise the CHPs. CAPA-Cs hold monthly meetings to discuss their activities with the PHC and to hear back from CHPs.

The bulk of financing of CAPA activities comes from personal donations of members. When funds are not available, some CAPA-Cs write to the LGA. Some community projects are co-sponsored with other CBOs, such as school improvements in collaboration with the PTA. A few have contacted local

philanthropists. Some have established a small scale business, e.g. palm oil, and used the profits in the community.

The CAPA-C members networked through their leadership and organizational networks to find suitable volunteers to be CHPs (between ten and 40 were trained in each area). Often CAPA-C members themselves volunteered to be CHPs, and later some CHPs joined the CAPA-C. CAPA-C members were mandated to supervise CHP activities.

Whilst the CAPA-C serves as the leadership in the CAPA process, the role of the CHP is primarily that of implementation of essential interventions. The CAPA-C undertakes planning, fundraising, general public awareness, and advocacy, while the CHPs perform health education and referral, primarily at the household level but also within clinics under the supervision of health staff, e.g. ORT demonstrations. The overall role of enhancing clinic utilization is central to CHP activity.

CHPs were oriented on ENA messages and how to use materials such as counselling cards, home health booklets, and infant feeding plan posters. They often organized their own community outreach schedules and provided house-to-house education, conducted community campaigns, mobilized the community before Child Health Weeks, and spoke at community gatherings. They identified women needing antenatal care (ANC), children requiring immunization, and sick people needing treatment, all of whom were referred to the PHC. CHPs have taken the initiative on other community health issues besides those on which they were trained, e.g. HIV/AIDS, and environmental sanitation exercises.

Outcomes

Improvements were seen in a number of child feeding practices and caregivers' knowledge on these topics. The percentage of mothers reporting exclusive breastfeeding increased in all three states between 2000 and 2003:

	2000	2002	2003
Lagos	12%	39%	36%
Kano	3%	20%	34%
Abia	11%	15%	29%

In 2003, following Federal legislation in 1990 that banned non-iodized salt and made iodization of salt produced in Nigeria mandatory, salt iodization rates at the retail and household level had reached 98% nationally.

The overwhelming consensus among management staff, officers-in-charge, and CAPA-C members was that CAPA activities were reaching increased numbers of caregivers and increasing utilization of services at health centres.

CAPA-Cs, however, have varied in their effectiveness. Whilst some were exceptionally strong and well run, making major clinic improvements and undertaking community development projects with significant financial inputs from members and the community, others had problems going any further than awareness raising / education because of attrition of members, finding funding, and bad local infrastructure.

In Kano State, the CAPA process was expanded to cover all 44 LGAs under the name of PLACO – participatory learning and action for community ownership.

When ENA interventions were assessed in 1999, there was no identified national nutrition policy or strategy and leadership on nutrition issues was weak. Technical leadership of the programme led to recognition of ENA at the national level: vitamin A supplementation was integrated into NIDs and the programme contributed to the development of the National Plan of Action for Food and Nutrition, into which ENA was incorporated.

The programme also successfully launched Child Health Weeks in the three states. These were well attended and deemed a success by programme partners.

Community participation framework

Leadership – 3

- Health professionals provided leadership at state and LGA level. At each a 'focal person' was appointed. At the LGA level this was usually (but not always) a person from the primary health care department. At state level the person was in the MOH.
- Existing leadership within the communities sanctions the programme in the village, but does not play an active role beyond that.
- No formal electoral processes were put in place for the CAPA-C's. The programme assumed that democracy was 'on the ground' in Nigeria and CAPA-C members chose their leadership at the end of their training in a manner they chose. The formality of this process varied; although there were no guidelines, members were encouraged to think carefully about leadership criteria and the positions their CAPA-C needed.
- Several CAPA-Cs had members who were also local political leaders, e.g. elected LGA councillors
- The accountability of CAPA-C members to their communities is not clear since their selection process was informal.
- CAPA-C activities were led by its members. They were not provided with leadership or governance training. Women were CAPA-C members and in some cases leaders, but this was not a programme objective.

Planning and management – 3

- Health professionals decided the programme's focus and goals and the framework under which community participation would operate, but local needs and activities were decided and managed by CAPA-C's and CHPs. Initial workplans were drawn up by CAPA-C members at the training workshop with the facilitation of LGA and PHC staff.
- CAPA-Cs were created for the programme and given technical and mobilization training, but no training on management, administration, and leadership.
- Partnerships were created between the CAPA-C's and their PHC (and other CBOs).
- Resources (human and financial) were provided by the community and the LGA, although what was supplied by the latter was highly variable. The programme provided training and new counselling materials.
- Staff at state and LGA level were designated as ENA 'focal persons' to help institutionalise the programme. Advocacy at the federal level also institutionalised the programme by incorporating it into national policy.

Women's involvement – 4

- Women are the target beneficiaries of the programme and are involved through CAPA membership or volunteering to be CHPs. Women leaders exist, but are not an objective of the programme.
- In Kano state there are parallel male and female leaders and there are separate women's meetings. Female CHPs do house-to-house education and mobilization whilst male CHPs meet other males at public functions, in the market, at ceremonies and at the mosque.
- In one Kano state CAPA-C, the women's group started a business to provide funds for their work.

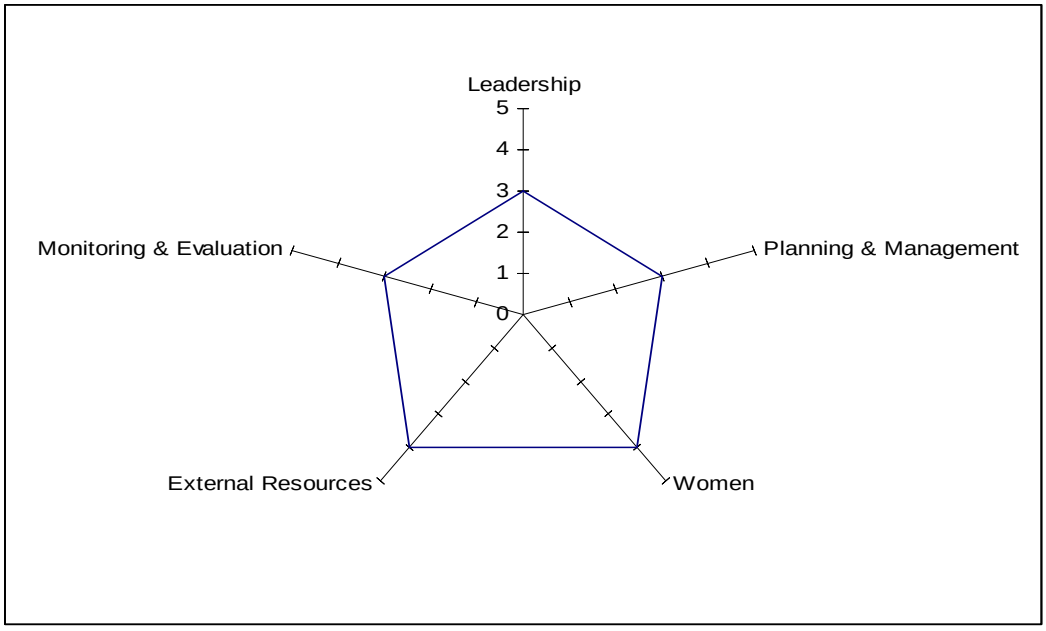
External support for programme development – 4

- CAPA-Cs were responsible for finding the means to finance their activities. The bulk of financing for their activities comes from personal donations of members. When funds are not available, some CAPA-Cs write to the LGA. LGAs responses to these requests vary and they may or may not be met with funding or actions. Some community projects are co-sponsored with other CBOs, such as school improvements in collaboration with the PTA. A few CAPA-Cs have contacted local philanthropists and some have started income-generation activities. In some CAPA-Cs, a few key individuals bear the bulk of project expenses.
- Members' personal funds were not always able to stretch to meet CAPA-C aspirations, and in many poor communities, alternatives were unavailable.
- Training activities at the state level were heavily reliant on donors.

- Community participation was framed by health professionals who saw the CAPA model as a means to the end of increasing immunization coverage and other health indicators.
- Health professionals designed the overall programme structure and determined the six technical interventions and programme goals.
- CAPA-Cs determined their own activities at the local level, but were addressing the priority areas the health professionals had decided.

Monitoring and evaluation – 3

- CAPA-C monthly meetings are a forum for monitoring activities, but it is unclear if formal records are kept. No monitoring protocols were provided.
- Monitoring at the state level is weak
- A qualitative evaluation was conducted by US and Nigerian academics. They interviewed people from all levels of the programme, but FGDs with caregivers were largely to assess their knowledge of care practices. The findings of this evaluation were fed back at the national and state levels. The participants in the state-level meeting were from the state MOH, LGAs, PHCs and communities.
- Quantitative evaluation data comes from BASIC's Integrated Child Health Cluster Surveys.
- The programme did not build the capacity of partners to monitor and evaluate ENA activities.



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5.4 Hôpital Albert Schweitzer (HAS), Haiti

History and objectives

HAS was founded by an American couple and opened in 1956 in Deschapelles in the rural Artibonite River valley. Initially only a hospital, HAS began community health activities in the 1960s with a tetanus immunization campaign for women. In the 1980s HAS recruited, trained, and supervised medical auxiliaries who manned six outlying dispensaries so that primary health care services would be geographically closer to the communities served. (Rural Haitian mothers do not carry their babies on their backs or in a sling, so services must be within an hour's walk of their homes for them to come regularly to surveillance or immunization services.) A more comprehensive approach grew from this and HAS gradually introduced a community health programme with paid community health workers assisted by community volunteers who offered preventive services at village assembly posts.

HAS has become an integrated rural health system providing medical care and community health and development programs for 285,000 impoverished people in its service areas. Approximately a third of this population live in isolated mountain villages. Visiting medical professionals from abroad work with a permanent Haitian staff of almost 900. HAS's annual operating budget is US$4.9 million and financial support comes from partner organizations and private individuals around the world.

Programme outline

The HAS community-based primary health care programme consists of:

- 1500 volunteer community health workers (Animatrices; mostly women), one for every 15 households, who provide peer-to-peer health education, conduct ‘Hearth’ sessions for malnourished children, assist with Mobile Clinics and Rally Posts, assist with referral to higher levels of care, and promote community involvement in planning, implementation and evaluation of services;
- 80 paid Health Agents (mostly men), one for approximately every 400–500 households, who make regular home visits and direct monthly Rally Posts for immunizations, vitamin A distribution, growth monitoring for under 5s, nutritional counselling and referral;
- eight Monitrices (Monitors) who provide liaison with and training of lay midwives and Animatrices and who supervise the community-based nutritional rehabilitation programme (Ti foyer / Hearth);
- seven tuberculosis Accompagnateurs and nine tuberculosis Agents who follow up on tuberculosis contacts and provide directly observed therapy for tuberculosis patients in the home;
- Mobile Clinics at which an auxiliary nurse visits isolated communities every 1–2 months to provide basic curative and family planning services and to refer patients when indicated; and,
- seven Dispensaries/Health Centres, where curative care, immunizations, and family planning services are provided.

HAS’s programmes are designed to promote equity by ensuring that those most in need have ready access to essential services and by ensuring that health services reach every home. Many services are provided free of charge, including immunizations. Mobile Clinics are held in the most isolated areas and almost all primary health care services are accessible within a 1–2 hour walk.

HAS has strengthened the role of lay midwives and traditional healers by providing training and involving them as integral members of the health system.

In addition to its community health programme, HAS has a Division of Community Development. This operates programmes for improving water and sanitation, promoting vegetable gardens and reforestation (by selling seeds and providing technical assistance), providing opportunities for micro-credit for women by establishing savings and loan groups, providing literacy training and support of primary education, and operating programmes to promote animal husbandry (including the training and support of veterinary technicians) and to improve agricultural production (including soil conservation).

Outcomes

In 2000 the coverage of key child survival services was greater in the HAS service area than in Haiti as a whole:

- The percentage of children receiving vitamin A during the previous six months was 2.8 times greater in the HAS Service Area;
- The percentage of children who received the total recommended series of immunizations was 2.4 times greater,
- The prevalence of exclusive breastfeeding was 2.3 times greater,
- The contraceptive prevalence rate was 1.8 times greater,
- The percentage of most recent births attended by a trained health care provider was 1.5 times greater,
- The percentage of children with symptoms of serious acute respiratory infection who obtained medical treatment was 2.6 times greater, and
- The percentage of children with diarrhoea receiving oral rehydration therapy was 1.5 times greater.

In 2000, the percentage of children aged 6 to 59 months receiving at least one dose of vitamin A during the previous six months was 90.9% in the HAS service area; 32.5% in rural Haiti; and 31.6% in all Haiti.The prevalence of exclusive breast feeding at 0 to 5 months of age was 53% in the HAS service area and 24% in all Haiti.

Between 1995 and 1999, the risk of death before age five among live-born children was 58% less in the HAS Service Area compared with rural Haiti. The infant mortality rate was 48% less and the 1 to 4 year old mortality rate was 76% less. The neonatal mortality rate was 28% less (not statistically significant) and the post-neonatal mortality rate was 62% less. Over this period the mortality rate before age 5 was 62.3 / 1,000 live births in HAS and 149.4 / 1,000 live births in rural Haiti.

Levels of childhood malnutrition in the HAS Service Area, however, are essentially the same as those in rural Haiti and in Haiti nationwide. Levels of low height-for-age in 6 to 59 month olds, for example, are about 22.6% in the HAS service area and across Haiti.

Community participation framework

Leadership – 2

- HAS is lead by health professionals, both Haitian and those from overseas.
- Leadership within the community is not discussed in the documents.
- The role of women and vulnerable groups in programme leadership is not clear.
- Animatrices are not elected by their community, but selected by the local Health Agent who selects women s/he believes will be capable, motivated and have leadership skills.
- The HAS Youth programme develops leadership in young people.

Planning and management – 2

- Health professionals decided the programme's focus and activities and provide resources.
- Accountability of HAS to the community is not clear.
- Communities provide resources in the form of volunteers; financial resources come from outside the community.
- Extensive transfer of skills occurs, both in the form of training community volunteers and through the community development programmes where literacy, business and technical skills are transferred.
- Local community development committees are formed and trained, but further information on these is lacking.

Women's involvement – 3

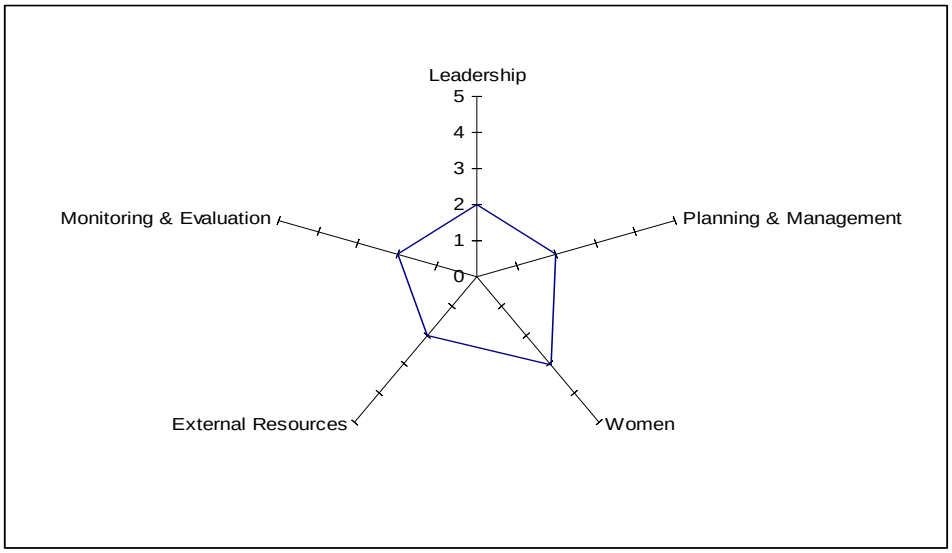
- Women participate in the programme as beneficiaries and as volunteers.
- The loans and income generation programme focuses on women.
- Women are not propelled to positions of responsibility and decision-making as a programme objective.

External support for programme development – 2

- The programme is funded from outside the community, including the Haitian government, NGOs such as Caritas, and individual donations
- Health professionals acquire the funding and allocate it.
- Some micro-financing projects exist to help individuals.
- The programmes are designed by health and community development professionals and they frame the way the communities participate. The participation of women and marginalized groups is taken into account and efforts are made to make all programmes equitable and available to all.

Monitoring and evaluation – 2

- Evaluations of HAS have been conducted by health professionals and international academics.
- Professional staff at HAS keep records and conduct health surveillance. Volunteers report events such as births to health staff.
- It is unclear what feedback is given to communities.



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5.5 National Vitamin A Programme (NVAP), Nepal

History and objectives

In January 1992, the Nepali Government's Ten-Year National Programme of Action detailed the target for achieving virtual elimination of vitamin A deficiency and its consequences by 2001. In February major research findings on periodic dosing of young children with high-dose vitamin A were discussed at a National Vitamin A Workshop in Kathmandu. This advocacy meeting, called by the Ministry of Health, drew senior representatives from the Ministries of Agriculture, Education and Local Development, the National Planning Commission, the Nepal Research Council, UNICEF, WHO, USAID, and a number of national and international NGOs. The workshop recommended that Nepal develop a national, multisectoral vitamin A programme in 32 priority districts, to be phased-in over a 4-year period. Vitamin A supplementation was recommended as a strategy and the recommendations were translated into a "Guideline for Implementation" which was adopted in November 1992. The Guidelines specified that the control of vitamin A deficiency be achieved through a multi-sectoral approach which would mobilize different ministries of the government and various NGOs, INGOs and donor agencies.

Implementation began in 1993 with eight districts in the first year, expanding in phases thereafter. In 1997 policymakers decided to expand NVAP to all 75 districts of Nepal.

The objectives of NVAP were:

1. To reduce child mortality and prevent xerophthalmia through supplementation of children aged 6 – 60 months with high-dose vitamin A capsules and to reduce vitamin A deficiency to a level that it no longer constitutes a public health problem.
2. To bring about a change in behaviour so as to increase dietary vitamin A intake of the target group through nutrition education, increased home production, consumption and preservation of vitamin A-rich foods, proper breastfeeding and child feeding practices, and increased maternal literacy.

Community participation was seen to underpin NVAP as it would engender ownership at the grassroots by centering on the mobilization of district and village officials and the existing network of unpaid Female Community Health Volunteers

(FCHVs). FCHVs were seen as a bridge between the health services and the community, capable of mobilizing community members and sustaining the momentum of community participation.

The original objectives of the FCHV programme (created in 1988) were:

- to empower local women with basic knowledge of primary health care, especially related to the health of mothers and children;
- to enhance community self-help in primary health care through increased knowledge and mobilisation of local women and other resources;
- to promote community participation by creating awareness of the maximum utilisation of available health and family planning services in order to reduce infant, child and maternal mortality and the fertility rate; and,
- to create community awareness of public health issues.

Over 40,000 FCHVs existed, supervised by local health facility staff, usually the Village Health Worker (VHW) of the Village Development Committee. The FCHV Programme had become largely moribund by the early 1990s and FCHVs were underutilized and unmotivated.

Programme outline

The NVAP distributes vitamin A capsules through FCHVs and supports them in this by organizing and conducting multi-sectoral training on vitamin A and implementing a well planned and highly structured programme that delivers on its promises.

Extensive advocacy at the national level – building alliances with other government departments and organizations – has helped legitimize intensive mobilization at the district and village level to reach the ultimate target beneficiaries. Partnership building was actively promoted at every level, with support filtering out from the first tier to the second, e.g. from the District Education Office to schools, principals, teachers, and students.

NVAP training brings together important members of the community to meet with the FCHV, to recognize her role and to support her – both in the logistics of the distribution campaign day requirements and more generally in educating the public about vitamin A. This recognition and the act of working together empowers and motivates the FCHV. The training philosophy maintains that it is the training process, rather than the curriculum, that is the most critical aspect of the training. The multi-sectoral approach to training, including its training of local politicians and the FCHVs' immediate superiors within the MOH, contributes to the high visibility of the programme.

When the programme is introduced in a new district, it provides extensive training to MOH primary health care personnel at the district, health post, and community levels. The District Health Officer also invites district representatives of line ministries and influential NGOs to join a three-day training course. Trainees include representatives of the Ministries of Agriculture, Education, and Culture and Local Development, local politicians, and NGOs such as the Red Cross, CARE, and the Save the Children.

Training is conducted by the Nepali Technical Assistance Group (NTAG), an NGO established to help the MOH expand the NVAP. The training has three goals: (1) to educate participants about vitamin A, (2) to train them in the logistics of the vitamin A campaign distribution days, and (3) to empower FCHVs. NTAG training is hands-on and participatory in nature and designed to empower and motivate FCHVs.

NTAG conducted initial and refresher training in each District before handing over on-going training to the District Health Office. NTAG remained available to help if problems arose and also conducted national-level vitamin A promotional activities and monitoring surveys.

FCHVs have three roles: to create and maintain a registry of all children aged under 6 years in her village, to promote and run bi-annual vitamin A days where young children are supplemented, and to provide on-going nutrition and health education to mothers.

Developing the registry requires that the FCHV visit every household in her community. This gives her the opportunity to promote vitamin A to mothers and she becomes known as the person in charge of the vitamin A capsule distribution day and a source of information on vitamin A. The register also enables FCHVs to trace and follow up families who did not attend.

The biannual rounds of distribution are carried out as campaigns with intensive promotion of the ‘event’ taking place immediately prior to each round, along with logistical management by the District Health Office to ensure that adequate supplies are made available to each FCHV. NTAG launches a nationwide promotional campaign including radio and television broadcasts and pamphlet distribution. Locally, FCHVs work with VHWs and others to promote the day, e.g. organizing rallies, using town criers and giving talks in schools. On the day mothers bring their children to the arranged location, e.g. a school, and their children are supplemented and they receive information on vitamin A. VHWs and communities participate on supplementation day by assisting the FCHV with completing her register and helping organize activities.

In between supplementation days FCHVs motivate and educate mothers and community members on vitamin A, mother and child health, family planning and community health. With the support of health personnel the FCHVs promote

health services such as immunisation and family planning and they distribute pills, condoms, first aid, and oral rehydration salts. The role of FCHVs is also expanding to include treatment of ARI, pneumonia, intestinal worms, and vitamin A supplementation of mothers immediately post partum.

Outcomes

In 1998 the National Micronutrient Status Survey reported that 87% of children living in districts with the NVAP (42 of 75 at that time) had received a vitamin A capsule in the previous round. Furthermore, coverage was significantly higher in rural than in urban areas (89% vs. 67%) and children with lower nutritional status were significantly more likely to have received capsules than children with better nutritional status.

NTAG mini-surveys, conducted after each round, consistently show coverage of over 90% since 1993, reaching 98% of targeted children by 2002. Coverage in conflict areas is also high (>95%) and the addition of deworming treatments to vitamin A supplementation activities has either not affected or increased coverage.

NTAG mini-surveys have also found that maternal knowledge of food sources of vitamin A has increased, e.g. knowledge that dark green leafy vegetables are a good source increased from 38% of mothers in 1996 to 91% in 2002, and that pumpkin is a good source from 10% in 1996 to 35% in 2002.

NVAP has also affected the FCHVs and their relationship with their communities. Trust has developed between the FCHV and the community who view the FCHVs as credible sources of health information, and FCHVs report being utilized more frequently for minor injuries and ailments. The success of the NVAP has brought national attention and recognition to the critical role played by FCHVs and the programme has reinvigorated the FCHV network and transformed it into an important vehicle for improving the public health care system.

FCHVs report feeling more confident and able to offer other health services and interact with people from outside their community. Some FCHVs have pushed for initiatives such as savings groups, local women's development groups, literacy classes, and election to political office.

Community participation framework

Leadership – 2

- Health professionals in NTAG and donor agencies lead the programme at the national level and decide what activities the FCHVs will undertake, e.g. expanding their duties to include ARI.

- NVAP has not been institutionalized within the MOH, in part because the programme has been donor-driven and organized and administered independently of the MOH (by NTAG). In the early stages of the development of the NVAP, the MOH was undergoing major institutional changes, and did not provide the necessary cadre of programme coordinators, who constitute more than half of the NTAG's personnel and are the primary interface with the FCHVs. Hence, at the Central Office level, the MOH has not been involved much in the NVAP, primarily because it has not made a commitment.
- At the community level, FCHVs are supposed to be selected by Mothers' groups. Many wards, however, do not have a Mothers' Group and the FCHV is often designated by the ward chief, VHW, or by the health post in-charge.
- FCHVs have reported feeling accountable to their communities as demand for vitamin A supplements from the community grows. FCHVs lead the promotional activities that precede the supplementation days. They are supported by other community leaders and members.

Planning and management – 2

- NTAG decided the programme's focus, goals, and activities and provides resources (training and manpower). International NGOs provide funding and capsules. The timescale of the programme, including when supplementation days are to be held and the rolling out of the programme, is at the discretion of health professionals. No mechanism to hold NTAG accountable to communities is apparent.
- The programme is highly structured and local leaders and FCHVs are provided with a largely set agenda on how to conduct the supplementation campaign and day. NTAG's reliability on consistently delivering the supplements on time is believed to have engendered trust in FCHVs of the health system, and yielded trust in communities of the programme.
- Community contributions were invited by NTAG and directed by them initially. As a District gains experience, however, NTAG reduces its role and the District Health Office does more and the programme becomes institutionalised at the District level.
- Skills transfer occurs as FCHVs and health staff are trained on vitamin A and logistics. Literacy training, however, seems to be absent and the FCHVs illiteracy seems to be worked around rather than addressed.
- FCHVs presumably manage their own activities in between supplementation days, under the supervision of health staff.

Women's involvement – 3

- The programme specifically used women as their community agents and through this role FCHVs gained respect and recognition. It is not clear,

however, if the selection of women for the CHV role would have been a programme objective if the FCHV network did not already exist.

- The NTAG training aimed to empower the FCHVs through psychosocial competence building, focusing on self -awareness and critical thinking skills to cultivate a strong sense of self -worth and self-efficacy. Greater self-confidence enabled them to lobby for more support from various sectors, build alliances with other grassroots workers and communicate with families.

External support for programme development – 1

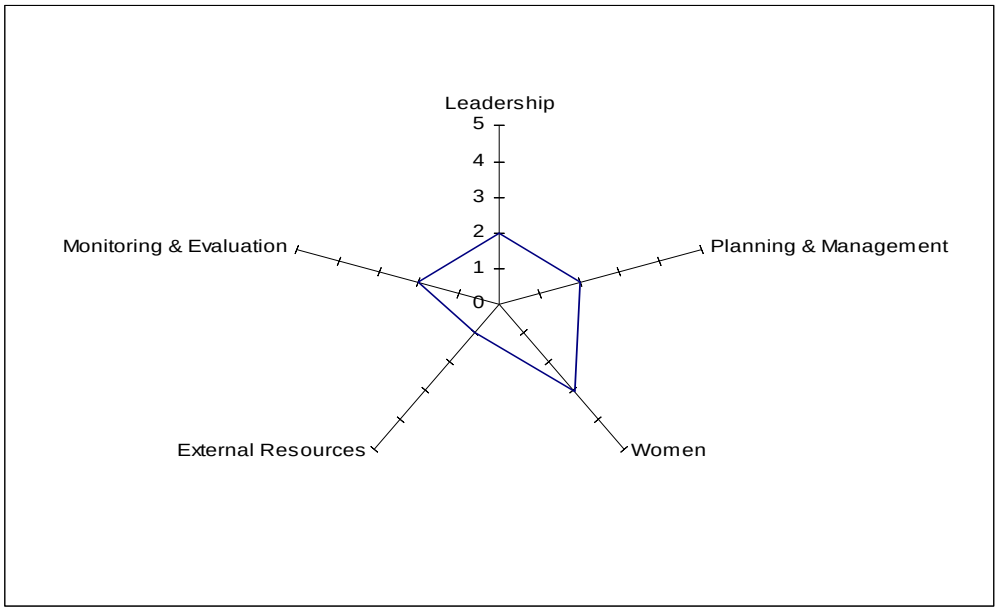
- The programme is dependent on international assistance for 70% of its total operating costs. UNICEF, USAID, and Helen Keller International have been major contributors throughout, the first providing the capsules. Part of the success of NTAG training and the high participation rates is attributable to relatively high training allowances and per diems that are paid to trainees.
- NTAG, created specifically for NVAP, was originally funded entirely by USAID. It has begun working in a number of related fields, independently of USAID, and by diversifying its portfolio of activities and funding sources is better ensuring its ability to survive over the longer term, but it is not yet independently sustainable.
- The Nepal Micronutrient Status Survey was sponsored by UNICEF and the Micronutrient Initiative.
- Communities pay no part in funding the programme or deciding how funding will be allocated. Communities are not seeking ways to make the programme locally financially sustainable, but Village Development Committees contribute money to a FCHV endowment fund, the utilization of which is decided by FCHVs. The fund motivates the FCHVs by recognising their welfare needs and generates a financial incentive for them.
- NVAP was designed by health professionals to address their priority of vitamin A deficiency and the framed the way in which the community and District level officials would participate.
- The participation of women was incorporated into the design.

Monitoring and evaluation – 2

- The FCHVs' registers are used as a monitoring tool for FCHVs and VHWs.
- Beyond this, NTAG and health professionals conduct all monitoring and evaluation to suit their needs.
- NTAG conducts mini-surveys after each round of capsule distribution to monitor coverage.
- Quantitative evaluations have been conducted using DHS data, the Nepal Micronutrient Status Survey and others outside the community. It is

unclear if the findings of these evaluations have been fed back to communities.

- A qualitative evaluation to understand the process of empowerment has been conducted by NTAG and JSI.



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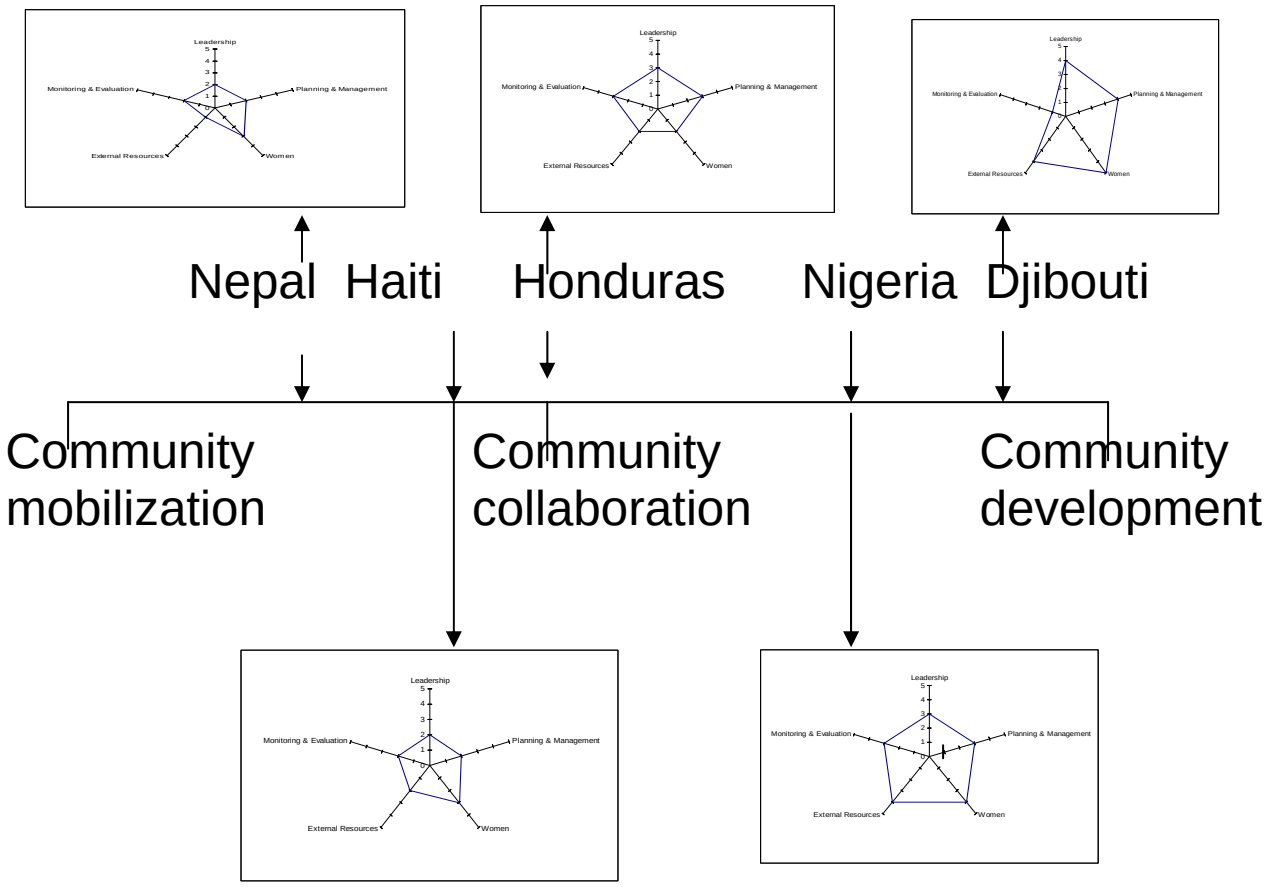
6. Lessons learned

This review has collated and analyzed evidence on the relationship between community participation and the uptake, scaleability and sustainability of health interventions for child survival. As part of this, an evaluation framework has been developed based on a typology of community participation and key factors that have previously been identified as key to success. This framework has then been applied to a series of case-studies chosen to illustrate the range of ways in which communities can be mobilized around health issues and to develop stronger links with their PHC services. The approach to, and extent of, community participation in the case studies varies along the continuum from mobilization to community development as shown in the figure below.

Figure 6: Visualizations of the five case-studies mapped onto the community participation continuum



The value of the spidergrams is that they illustrate the nature and process of community participation achieved. This analysis was retrospective and only shows one point in time, but to explore their full potential they should be used over at least two time points. This could be either be retrospective or prospective, for instance at baseline and at later stage to capture changes over time and how participation may expand or diminish. The reasons for these changes can be identified leading to program re-adjustment.

While it is not possible on the evidence from these case-studies alone to identify general principles, nonetheless two points emerge regarding the utility of the framework. Firstly, that it allows for a more in-depth and nuanced analysis of the relationship of community participation to program objectives and outcomes. Secondly, it enables those who do the analysis to gain a greater understanding of the process of participation and develops their capacity to better understand the dynamics of community involvement in their programs.

Using the framework to analyze the case-studies allows us to make some general comments on community participation in nutrition programs relating to uptake, scalability, and sustainability.

Delivery and uptake of health interventions

Broadly, all of the case-studies show a positive outcome in relation to various health indicators, such as vaccination coverage, growth monitoring, and supplementation coverage, although this was achieved in very different ways.

Two of the case studies (Nepal and Nigeria) included Child Health Day (CHD) type interventions. Both of these programmes achieved a good response to the CHDs by using community participation, but their strategies were quite different. Essentially, both used a mobilized cadre within the community to promote the CHD, but in Nigeria that activity was nested within a much broader community health and development strategy.

This raises the questions of can and how does a CHD combine with a community development approach to improving health. The former was originally a more ‘vertical’ intervention determined primarily by health professionals with the FHCVs delivering the intervention(s), whilst the latter is ‘horizontal’ and facilitates active participation and a strengthened PHC system. Can a CHD be integrated into a community development approach in a way that is not detrimental to the local PHC system and strengthens or enhances community development (Oliveira-Cruz *et al*, 2003)?

Programmes such as ENA (Nigeria) and BDN (Djibouti) present a channel through which a CHD can be delivered, as was seen in Nigeria. A mobilized community can be asked to promote and help deliver the CHD whilst working on their own health and development activities throughout the year. This approach

may be more sustainable in the long term than the NVAP (Nepal). There the CHDs themselves and, particularly, the reliable supply of supplements, strongly influenced the FCHVs credibility with the community. The FCHVs status therefore seems vulnerable to logistical problems that are beyond their control. With a community development approach, however, the community's empowerment is more broadly rooted and it may therefore be more likely to withstand problems with a CHD as the Day is seen as only one part of their function. This approach to enhancing the response to CHDs may be slower to establish, but ultimately more sustainable.

A second issue the case studies raise is appropriateness of CHDs. In Honduras 92% of children in the AIN-C project areas were being enrolled by Monitoras and the programme strengthened the link between the community and the PHC. If a community – based programme such as AIN-C has the capacity and resources to reach and include all local children and is well integrated with the PHC system, then the necessity of a resource intensive CHD seems questionable, unless that style of delivery is suited to the local culture and context. Care is needed, however, not to reinvent the community health worker "wheel" of the 1980s and issues such as community health worker burden, PHC capacity, and monitoring of coverage, need to be borne in mind.

Scaleability

Financial resources and political will are prerequisites for expanding health programmes, but does the position of a programme on the participation continuum influence its potential to be expanded? Examples of programme expansion within countries (Honduras, Nigeria) and between countries (ENA, BDN) can be found among the case studies, but examples of community development programmes becoming fully mainstreamed into countries' healthcare programmes are rare (Gillespie, 2003). The NVAP in Nepal has 'gone to scale' and covers the whole country, but it also illustrates the relationship between scalability and sustainability: resources can be used to expand a programme, but they can also make the programme vulnerable. The NVAP program also illustrates some of the potential tensions of the benefits of single vertical interventions versus more horizontal interventions aimed at wider health improvements. These echo some of the earlier debates of comprehensive versus selective primary health care (Rifkin and Walt, 1986). While there has been some expansion of the role of the FHCVs in delivering a wider range of interventions in Nepal (eg de-worming and pneumonia management), evidence is currently lacking to show that the latter has led to sustained uptake.

A large part of a programme's scalability is also related to its replicability. The replicability of community development programmes, however, is not a question of transferring specific interventions to a new location; rather it is the transfer of particular principles and approaches that underpin community participation and empowerment (Gillespie, 2003). It is essential to recognize that participation and

empowerment are not technical interventions, rather they are processes which require skilled facilitation and are governed by the social, political, economic, and gender context. The manifestations of a community development approach and the speed at which it unfolds are therefore variable and unlikely to look the same when applied across a range of contexts. Expansion plans therefore need to allow for local flexibility, including varying degrees of external facilitation, and encourage local diversity, whilst monitoring the implementation of the principles of community participation.

For large agencies with single intervention programs the question of scaleability is not merely one of coverage, but also of sustainability. It can be argued that sustainability is probably better ensured where communities have some control and ownership of these programs, ie, as in a community development approach, rather than effecting community mobilization around a single interventions as a means of achieving health improvements.

Sustainability

But does community participation lead to more sustainable health outcomes? Programmes toward the community development end of the continuum suggest sustainability of outcomes is certainly possible; BDN for example has been operating since the late 1980s and has survived turbulent political periods in some countries. Nepal has been sustainable to date, but relies on substantial external financial support. Many community health worker programmes that emerged after Alma Ata, however, have failed or faltered. Despite their theoretical commitment to community development, in practice various professional groups asserted their influence on PHC and as a result many programmes were situated closer to the community mobilization end of the continuum (Stekelenberg *et al,* 2003); this may have contributed to their poor sustainability (Walt, 1988).

The issue of support, is also relevant to sustainability of health outcomes, as well as to achieving them in the first place, because an enabling policy environment may help to institutionalise community participation and strengthen sustainability. Both participation and its products, such as Village Health Committees, need to be embedded into the country's political and institutional fabric (Gillespie, 2003), for example through national policy, district health plans. and University health curricula (Gonzales *et al,* 1998). As cautioned above, however, the support itself needs to be sustainable too.

Support for community development

A factor which emerged from the case studies is the issue of strong, early, and on-going support for community participation, both within all levels of the health system and across sectors. For example, the ENA programme worked simultaneously at central, state, and local levels from the outset and the BDN

programme drew in a number of Ministries to support efforts to tackle the social determinants of health. Community participation does not mean the community does everything and the issue of creating and maintaining committed support has been raised repeatedly and refers not only to written policy, but to attitudes and financial resources (Tontisirin and Gillespie, 1999; Gillespie, 2003; Ismail *et al,* 2003). The decline of nutrition programmes in Tanzania illustrates the need for maintained support: there, shifts in donor priorities and the waning of two bodies that had advocated for nutrition at the central level (the Planning Commission and the Tanzania Food and Nutrition Centre) saw nutrition slip from the country's policy agenda (Dolan and Levinson, 2000). Likewise, in Pakistan, the Family Health Project faltered because not enough was done initially to communicate the project's overarching concept to key Government stakeholders. Consequently the provincial Finance Department failed to invest in Village Health Committees as they were not convinced of their value and the MOH gave only lukewarm support to District Health Management Teams which had been formed with wide community participation (Israr and Islam, 2006).

Effective multi-sectoral support needs personnel in Government bodies (and collaborating NGOs) to have clearly defined roles and responsibilities (Gonzales *et al,* 1998; Gillespie, 2003). ENA's strategy on this was to have a designated 'focal person' at State and LGA levels, the latter not necessarily being in the Health Department. Support for community development also needs the relevant bodies to have the capacity to respond to communities' growing demands. Community self-reliance does not necessarily mean self-sufficiency and increased local capacity to make demands (Gillespie, 2003). In Nigeria, for example, some CAPA-C's requests to the LGAs were not acted on.

7. Conclusions

Overall, these case-studies demonstrate that community participation can enhance the uptake and response to health interventions, their scaleability and sustainability, but that the process by which these programs are implemented is crucial. Communities themselves are heterogeneous and complex and their participation needs to be viewed as a process. That said, the evidence presented here and elsewhere suggests that where participation tends more towards the community development end of the continuum, that sustainability is greatest, but that change is not instant. Although the technical interventions can produce comparatively rapid results, their sustainability takes time and money. Both are necessary, but each by itself is not sufficient to ensure success; sustainable change is more likely when programmes address wider development issues rather than narrow behaviour change objectives alone.

We need process evaluations of community-based programmes to understand more fully why particular programmes lead to specific outcomes and to understand the processes of community participation and empowerment both within pilot programmes and as they expand into new environments. Process

evaluation can elucidate the key contextual influences and programme components that led to the programme's outcomes. This information can then be used to assess the replicability of a programme's principles and basic framework to other areas of the country and it can inform understanding of successful (or unsuccessful) programme roll outs. Some guides to, and lessons from, taking nutrition projects to scale exist (Contreras *et al,* 2004; Gonzales *et al,* 1998; Gillespie, 2003), but this is an issue that requires further research.

Gaps remain in our understanding:

- As noted above, more understanding is needed about the process of particular programs and the impact of particular contexts on the process of participation. There have been few studies in the health field examining this, although there is some work in other fields such as development studies. The framework used here could be a useful tool.
- Despite attempts to define and evaluate it, empowerment remains a rather nebulous concept although the work of social psychologists links the domain of the individual with that of the wider social group could be brought to bear here.
- Related to this, processes of behavioral change are still poorly understood and what factors other than information provision alone shift patterns of behaviour.
- Reasons for the decline of community health worker programs in the 1990s. Given the current resurgence of interest, it would be relevant to examine this and any reasons for their failure.

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Appendix 1: Community Participation Program Development Continuum

From: Gryboski, K., Yinger, NV., Dios, RH., Worley, H. and Fikree, FF. *Working with the Community for Improved Health*. (Health Bulletin 3) Washington, DC: Population Reference Bureau, 2006

	1 (low)	**2 (moderate)**	**3 (high)**	**4 (highest)**
Equity/ Inclusiveness	Health professionals assume leadership for program activities. Community leaders are primarily or exclusively men who represent traditional power structures.	Community leaders involved in program activities rely heavily on direction from health professionals and rarely have input in program decisions. Community leaders are aware of interests of various community groups.	Community leaders and representatives work in partnership with health professionals to participate in decisions. Community leaders regularly confer with representatives of all community groups (ethnic, women, poor) to include their perspectives in decision-making.	Communities create a representative process for community leadership positions. Women and other vulnerable groups play a strong role in health program initiatives.
Management	Health professionals identify needs, and develop and manage health services. Communities depend primarily on resources provided by the health system to carry out activities.	Community members have basic needs-assessment, planning, and/or implementation skills. Decisions are largely made by health professionals who provide guidance and make primary decisions about program	Community members have strong needs-assessment, planning, management, and resource mobilization skills. Communities may be able to advocate for their needs, mobilize and access human and other resources from	Community members are highly skilled in all phases of community health needs assessment, planning, and management. Communities effectively mobilize and access resources, advocate for their needs, and create

	Health professionals generally direct community contributions and input.	activities and resource use.	institutions outside the community. Communities make decisions in partnership with health professionals through ongoing mechanisms. Health professionals provide ongoing support and guidance to strengthen community capacity and preventive health knowledge.	partnerships to collaborate within and outside the community. Community members have strong knowledge of preventive health practices. Community members play a lead role in identifying program priorities.
Process and Outcome Evaluation	Communities have no opportunity to give feedback about the program and are not aware of program evaluation design or results.	Evaluators and health professionals make decisions about evaluation design and interpretation of results. Evaluators may explain the process to community members whose perspectives regarding evaluation design may be included. Results may	Communities are active in deciding what to evaluate, and/or in gathering and interpreting information to evaluate program effectiveness. Mechanisms are developed to facilitate community collaboration with health professionals and evaluators to improve activities. Communities	Communities are active in evaluating effectiveness of programs and deciding how to make improvements. Communities seek advice on their own initiative from health professionals and access evaluation expertise as needed.

		be presented to the community.	receive technical advice and ongoing support for evaluation.	