



Speaker Summary Note

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Title: Thailand's Community-Based Nutrition Improvement

Thailand has implemented the first multi-sectoral nutrition policy and planning in 1977, under the national economic and social development plan (1977–1982). Building up a critical mass and availing information on magnitudes and severity of the problem was found to be essential in order to communicate the urgency of the problems, and convey messages on possible actions to policy makers and planners. One of the early key messages was that malnutrition must not be perceived as a health problem, but rather a result of compromising social, economic development which will impact human capital development. In addition, investing in nutrition program should be viewed as a national investment for intermediate and long-term growth, not simply short-term gains, or welfare expenses. These attitudes are very crucial at all levels, and “nutritional literacy” should be an integral part in planning and implementing nutrition programs.

Although having a multi-sectoral policy and plan is a major step in nutrition improvement efforts, it was found to be only the first step. The implementation in the first five years have encountered several challenges, especially on how to implement the program in an integrated manner. In planning for the fifth national development plan, Thailand's “Poverty Alleviation Plan (PAP)” was a spearhead of the rural development program which can be viewed as a quasi-decentralization effort with focus on poverty stricken areas. During this period, nutrition programs were employed as stopgap measures to relieve the most severe forms of malnutrition until systematic solutions could bring about long-term, sustainable improvement. The main thrust of the Fifth Plan's nutrition policy lie in its program of poverty alleviation for development of backward areas and the nationwide launching of primary health care (PHC). Specific nutrition indicators were set as common goals to be achieved by all relevant ministries.

The PAP was one of Thailand's first efforts to bring about effective and efficient infrastructural reforms conducive to rural development. Effective organizational structure and managerial mechanisms to coordinate and integrate multi-sectoral efforts at various administrative levels and within the communities was critical. Single coordinating organization with full authority and mandates at each level was felt to be better than several organizations with overlapping responsibilities. Four major ministries, i.e., Health, Agriculture, Education, and Interior (Community Development Unit), were involved and streamlined the integrated budgetary allocations to target poor villages through community's Village Committee. Each ministry also strengthened the intra-sectoral collaboration among its various departments or divisions.

PAP employed four key programs, namely, (1) **Rural Job Creation** to create jobs for rural people during dry season so that they remain in the communities and participate in community development; (2) **Village Development Projects** included village fish ponds, water sources, prevention of epidemic disease of poultry, cattle and buffalo bank, and other development projects focused for improving their economic status and household food security; (3) **Provision of Basic Services**, i.e., health facilities and

health services, clean water supplies, illiteracy education programs, were implemented in the target areas; and (4) **Agricultural production Program** included nutritious food production (e.g., crops for producing complementary foods), upland rice improvement and soil improvement project. Income generation and household food security were the direct benefits. During the five years of PAP, 32 development projects were implemented in 12,562 poor villages in 38 provinces. Approximately 60,000 families utilized new agricultural technologies for agricultural production, and there were 2,655 new village fish ponds. The cattle and buffalo bank was able to lend animals to 20,000 families. Health services through the primary health care approach (see below) reached more than 80 percent of the targeted villages. Only about one percent of the annual government budget was actually allocated under the PAP programs.

The Ministry of Public Health had a prominent role via the primary Health Care (PHC) acts as a core of all nutrition related activities. By 1986, 550,000 village primary health care volunteers were trained, covering almost every rural village in the country. Nutrition activities were integrated within the PHC with other health services, such as, maternal and child health, family planning, immunization, clean drinking water supply. PHC movement was most successful in mobilizing the community to address malnutrition. It was also recognized that successful nutrition programs should not be centrally planned and made into ready-made packages. Rather, they should serve as broad guidelines. Key nutrition programs included nutrition surveillance and community-based growth monitoring, nutrition information, education and communication (emphasizing food security, nutrition knowledge focused on pregnancy and lactation, promotion of breastfeeding, complementary food, increased awareness of nutritious foods, food hygiene and correction of false food beliefs and taboos). Agriculture sector promoted the production of nutritious foods in the communities (e.g., home gardening, fruit trees, cultivation of legumes and sesames, fish ponds, and prevention of epidemic diseases in poultry). Specific focus of young child nutrition included complementary food production and feeding programs at village level, with participation of the women's groups and primary health care volunteers. Salt iodization and distribution targeted at endemic goiter areas were implemented. Extensive capacity building of health personnel, village-based primary health care volunteers and community leaders at grassroots level was to mobilize community participation. Nutrition training was also provided to personnel of various sectors, such as, agriculture and education.

Another major breakthrough was the adoption of the Basic Minimum Needs (BMN) approach in village-based social planning. This is a process for empowering people using BMN indicators in problem identification, prioritization and decision making which has unleashed village resources for community development. Community participation through the PHC and BMN approaches were translated into concrete actions in rural areas in Thailand. Nutrition interventions and indicators were made a part of the community development process, and in planning, monitoring and evaluating development programs. Therefore, the impressive reduction of malnutrition could not be totally explained by the implementation of direct nutrition intervention programs (notably growth monitoring, supplementary food and nutrition education).

In summary, achieving nutrition goals, not only food and nutrition policy are relevant, but also other policies (like primary health care and poverty eradication, as in Thailand), with concrete nutrition objectives. These objectives must be translated with a practical value in mind and explicitly targeted to those in greatest needs. Community-based nutrition intervention programs have a better chance of sustainability if they emphasize community organization for planning and management. Community manpower development based on appropriate technology and information, and a viable self-perpetuating community financing scheme are crucial element of successful nutrition improvement in Thailand. Special efforts should be made to empower people for self-reliance and self-determination so they become agents of change and not simply recipients of societal benefits. Evidence of the sustained impacts on nutrition was also evident from several subsequent national representative surveys of maternal and child nutrition.