ANNEX 3 (A)

BANGLADESH CASE STUDY

BANGLADESH INTEGRATED NUTRITION PROGRAMME

Bangladesh Case Study

Contents

BANGLADESH INTEGRATED NUTRITION PROGRAMME

SUMMARY

The Bangladesh Integrated Nutrition Programme (BINP) started in 1995 and the expected completion date for the pilot stage is 2001. A successor programme, the National Nutrition Programme (NNP), is expected to be implemented soon with activities in BINP pilot areas to be continued as part of a phasing out-phasing in scheme.

Coverage

The first phase covered six *thanas* or *upazilas* [43] (subdistricts), 1,218 villages and over 55 unions reaching a total population of 1,235,576. Currently, BINP covers 60 *than*as. With the programme's expansion into NNP Phase 1 (of five years' duration), an additional 79 *thanas* will be added to the original 60 BINP areas including urban areas, totaling 139 *thanas*. NNP Phases 2 and 3 are envisioned to cover the entire country.

BINP was implemented under two modalities. One is Government of Bangladesh-led and non-governmental organization (NGO)-assisted. Here the existing network of the Ministry of Health and Family Welfare (MoHFW) was utilized for implementation. The other modality is NGO-led and Government of Bangladesh-assisted. The major NGO player was Bangladesh Rural Advancement Committee (BRAC) [44], which was later joined by other NGOs such as PROSHIKA. Funding has come largely from the World Bank, through its International Development Assistance programme (WB-IDA). UNICEF also provided some financial, material and technical support.

Objectives of the programme

The overall goal of BINP is to reduce malnutrition in Bangladesh until it ceases to be a public health problem and to improve the nutritional status of the population particularly of young children, women, and adolescent girls.

To attain this goal, specific objectives are as follows:

- improve the capacity of the country's national nutrition institutions, specifically in the areas of advocacy, analysis of causation and consequences of malnutrition and policy advice, operational research and operational support to national programmes;

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[43] Editor's note: Bangladesh is administratively divided into six divisions, 64 districts and 507 *thanas* (or *upazilas*). Each *thana* is divided into unions (nine unions per thana on average; total number of unions = 4,484). Each union administers about 15 villages.

[44] BRAC was established in 1972 as a relief and rehabilitation organization. It has gradually evolved into a large and multifaceted development organization with the dual objectives of poverty alleviation and empowerment of the poor.

- improve the capacity of communities, households and individuals in the project areas to understand their nutrition problems in practical terms and take appropriate action to address them at their own level;
- improve the nutritional status of the population in the project areas with special emphasis on pregnant and lactating women and children.

BINP has 3 main components: (1) national level nutrition activities; (2) intersectoral nutrition programme development; and (3) a community-based nutrition component. The third component, which focuses on the implementation of various nutrition interventions and community empowerment to promote participation, has the following specific objectives:

- develop community and family capacity to monitor nutritional status;
- develop community and family capacity to care for the vulnerable members especially pregnant and lactating women and very young children;
- strengthen the outreach and quality of maternal and child interventions and develop the government and community capacity to target them to the most nutritionally vulnerable;
- develop community and government capacity to harness the resources of local development programmes aimed at increasing income, food security and access to clean water, and target them to those most nutritionally vulnerable.

Programme impact

Based on mid-term review of the World Bank, the following achievements were noted:

- 92 percent of children now covered by the growth monitoring programme;
- 90 percent of village committees participate in decision-making;
- the number of underweight infants decreased by 30 percent;
- severe malnutrition (using MUAC with cut-offs of < 11.0 cm for 0-12 months and < 12.5 cm for the 13-24 months) fell from above 20 percent to around 3 percent in just two years (95-97).

Unofficial information from BINP national staff claimed 90 percent coverage for iron and vitamin A supplementation and for the delivery of IEC messages. It was also claimed that weight gain during pregnancy increased from an average of 4 kg to 7 kg.

Community participation

Community participation in the BINP areas can vary from participation for material incentives to functional participation to interactive participation. Communities in the early stages of BINP implementation are found in the lower levels of community participation. However, with the active involvement and intensive and aggressive social mobilization strategies employed by the NGOs, communities as well as community workers and local government units assume a more proactive role in decision-making and resource generation to support nutrition activities.

Lessons learned

Institutional aspects

- Community ownership of nutrition services can be generated through a carefully executed social mobilization process. Local communities need to be empowered to enable them to take effective actions to address their own nutrition problems. The NGOs can provide valuable inputs toward this end.
- While an intersectoral strategy is most desirable for vertical and horizontal integration, operationalizing convergence in a highly bureaucratic government structure can be more constraining than facilitating, in the absence of a clear-cut convergence mechanism.
- The high priority given to community-based nutrition interventions generated good returns for the project, such as improved and effective nutrition services delivery, high staff morale and satisfaction of NGO partners. Consequently, this became an advocacy tool, which forged a strong Government of Bangladesh and NGO partnership and promoted programme ownership.

Implementation

- At each operational level (i.e. district, *thana*, union and village), opinion leaders as well as gatekeepers need to be well oriented and motivated to actively participate in programme implementation. These people contributed to successful programme implementation.
- Locally selected female part-time workers, supervised by an all-female supervisory staff, can substantially improve maternal and child nutritional status.
- Pre-service and on-the-job training activities coupled with proper motivation, provision of incentives as well as other forms of support for community workers or volunteers can create an enabling environment for good performance.
- Village women, once motivated, trained, and supported, can manage community-based nutrition interventions effectively.
- NGOs can provide valuable assistance in national programmes in specific areas such as community mobilization, training of field workers, quick field testing of operational techniques, development and delivery of IEC messages, supply distribution and programme management at field level.

Management

- For timely and effective implementation of national nutrition programmes, the following issues are considered critical :
  - staffing of the programme management unit with technically qualified personnel
  - management information system (preferably computerized)
  - a transparent and efficient financial management and auditing system.

- A systematic mechanism is needed to operationalize convergence, to generate and promote partnerships between and among central agencies and partners such as NGOs.
- BINP has demonstrated a pioneering model for government-NGO partnership for a community-based nutrition strategy, which was adjudged feasible, highly effective, efficient and responsive to meet the varying local conditions and needs.
- Financial management, when combined with other functions in a single department, will likely compromise programme efficiency. External as well internal auditing is essential for a comprehensive and self-balancing accounting system.

Strengths, weaknesses, opportunities and constraints/threats (SWOC)

Strengths

- The Government of Bangladesh is committed to fulfill its pledge to the goals of the International Conference on Nutrition and the World Food Summit goals as evidenced by the formal adoption of the Bangladesh Plan of Action for Nutrition (BPAN) which identified BINP as one of the major strategies for nutrition improvement.
- The Government of Bangladesh's poverty alleviation programme recognizes the need to incorporate nutrition objectives and component.
- The Government of Bangladesh (particularly the MoHFW) has an existing network for effective delivery of nutrition services from national to village level which can accommodate a nutrition programme.
- Presence and willingness of NGOs to become partners in addressing nutrition and related problems through community mobilization.
- WB-IDA provides substantial financial inputs for jumpstarting BINP as well as to demonstrate the potentials of BINP in addressing malnutrition.
- Presence and willingness of multilateral and other international agencies to partner with the Government of Bangladesh in the implementation of BINP.
- Presence of nutrition institutions with improved capability for undertaking nutrition and related activities such as training, research, and management of BINP interventions.
- BINP is premised on a life-cycle approach for sustainable nutrition improvement.
- Shared programme ownership of government and local government units as well as some community groups and communities.
- Dedicated, motivated, and trained community nutrition workers.
- Strongly supported and well-financed training component.
- The major IEC component is supportive of the other community-based interventions.

- A comprehensive nutrition package for delivery in BINP areas (growth monitoring and promotion, supplementary feeding, environmental sanitation, livelihood component, IEC).
- The built-in monitoring and evaluation system facilitated and supervised by NGOs and selected national nutrition institutions.

Weaknesses

- selection of pilot areas despite availability of objective criteria was in some cases politically motivated;
- required qualifications for the selection of community workers were not fully enforced;
- intersectoral and convergence approaches not operationalized;
- weak advocacy at the national level;
- BINP national staff lacked the technical expertise to effectively carry out the work;
- BINP staff were on secondment, so tenure was temporary, hence the need for orientation every time new staff were recruited;
- the training curriculum did not include topics that deal with acquisition of knowledge and the development of skills on assessment, analysis, and action at all levels;
- programme design paid little attention to addressing the root causes of the problem (were more curative than preventive);
- heavy reliance on NGOs which require external funding support for operations;
- multiplier effect was not fully maximized; this could have partially addressed some of the constraints to participation by intended target groups;
- roles and responsibilities of various sectoral agencies and nutrition management committees not clearly spelled out or delineated;
- top-down approach in identification of nutrition interventions to be implemented.

Opportunities

- with the phasing in of NNP and phasing out of BINP (accompanied by increased funding support), there is great scope for programme design improvement: lessons learned from the pilot stage can be addressed in the next phase;
- increased involvement of other NGOs, international organizations such as the World Food Programme, and national nutrition institutions in programme implementation;
- strengthening the institutional capacity of national nutrition institutions to technically backstop the programme;
- expansion to urban areas;

- strengthening monitoring and evaluation particularly (process evaluation) and the Management Information System (MIS), and making these more participatory;
- strengthening of financial management and auditing system;
- hiring of sufficient and qualified programme staff;
- improving the training curriculum to include other relevant topics such as participatory food and nutrition programme planning and management;
- intensification of advocacy efforts at all levels;
- increased involvement of communities and other stakeholders in decision-making.

Constraints/threats

- withdrawal of external funding support: while the the Government of Bangladesh (GoB) is committed to addressing malnutrition, the present economy limits the GoB's ability to provide internal funding;
- ratio of community workers to clientele;
- political interference in selection of project sites;
- political interference in selection of community workers;
- political interference in the selection of the national project team;
- sociocultural, religious, and economic (households too poor to miss any opportunity to earn a living) constraints including gender bias;
- distance of community nutrition centres (which are provided by the communities) limits accessibility, and hence participation of some target groups;
- perennial *"hartals*" (strikes) called out by the opposition limits mobility which hampers project operations;
- bureaucratic government structure causes delays in fund release and timely delivery of the package of nutrition services;
- climatic conditions hamper the implementation of a number of planned activities.

Sustainability

Overall, BINP in the form of its successor nutrition programme, NNP, has a fair chance of achieving sustainability. Community participation ranks high in the programme's objectives. Seventy percent of total funding is expected to be channelled to community-based activities including social mobilization and capacity-building. The programme is well established within the government structure and partner NGOs, and national nutrition institutions have been identified and their roles specified. However, because of the massive infusion of external funding, withdrawal of donor support can at any time cause the programme to collapse. GoB's commitment at this point may not mean much since the government is unable to provide funds.

A: NATIONAL CONTEXT

Bangladesh is a tropical riverine country that lies in the southern part of the Indian subcontinent, between India and Myanmar. It has the largest delta in the world and the longest coastal length along the Bay of Bengal of 732 km. Except for the highlands of Chittagong and Chittagong Hill tracts and some parts of the northeastern provinces, the entire country is composed of alluvial flood-prone basin land and non-alluvial flood-prone plains. The country is also one of the monsoon areas of Asia. The combination of alluvial soil deposits and abundant rainfall gives the country a fertile agricultural base. Thus, 75 percent of the land area is devoted to agriculture with 66 percent of the population dependent upon it.

Despite an alarming population growth rate and slow economic growth, remarkable improvements in some key social and health indicators, namely life expectancy at birth, school enrollment, child immunization, access to safe drinking water and better sanitation, were noted since its independence in 1971. However, reduction in the prevalence of malnutrition has not kept pace with these improvements. The levels of malnutrition in the country remain among the highest in the world. More than 54 percent of preschool-age children are stunted, 56 percent are underweight and more than 17 percent are wasted. Nearly 50 percent of women suffer from chronic energy deficiency, the incidence of LBW is estimated at 45 percent, and micronutrient deficiencies are widely prevalent.

High infant, under five and maternal mortality still persist: 77,150 and 4.5 respectively, per 1,000 live births. About 75 percent of the child's life is spent in illness, mostly infections as a result of increased vulnerability owing to LBW and poor nutrition. Diarrhoea, respiratory infections, and neonatal tetanus are the major causes of death among infants while two-thirds of under five deaths are caused by malnutrition.

The determinants of malnutrition in Bangladesh are associated with the primary and most direct causes of malnutrition, namely food insecurity, poor health conditions and insufficient access to good health care services, and inappropriate maternal and infant feeding practices. From 1992 to 1994, the average daily per capita dietary energy supply was 1,950 kcal. Compared with FAO's average requirement of 2,310 kcal, the supply represents a 15 percent shortfall. About 15 percent of rural households are consuming fewer than 1,600 kcal per capita per day while 10 percent consume between 1,600-1,800 kcal.

While food availability and health status are important factors affecting nutrition, caring practices also play vital role in the nutritional status of Bangladeshis. Caring practices, which include feeding and culture-specific consumption practices, intrahousehold distribution of food and personal hygiene constitute the most significant unaddressed set of nutritional determinants.

Behaviour related to the feeding of young children have much to do with the serious problem of malnutrition in Bangladesh. Recent surveys showed a marked rise in acute and chronic protein and energy malnutrition in the age group 12-23 months, attributable to behavioural aspects of feeding. While most children are breastfed up to one to two years

of age and 10 percent only stop breastfeeding by six months, breastfeeding is usually combined with bottle–feeding, which often results to diarrhoeal episodes. About 15 percent of mothers do not offer colostrum to their babies. Complementary feeding is poorly practiced and complementary foods are of low nutrient density. Maternal nutrition is known to affect the nutritional status of the newborn. Ignorance, poverty and some cultural factors result in poor diets of women.

With regard to hygiene and sanitation, 44 percent of households use sanitary latrines. Open space is commonly used for waste disposal. About 96 percent of households have access to a tube well for drinking water. However, in recent years, problems associated with the presence of arsenic in drinking water have limited supply.

In response to these problems, the GoB, in cooperation with international funding and donor institutions and NGOs working for nutrition and related fields such as health and agriculture, implemented several intervention programmes. Among these are the Fourth Population and Health Project, BINP (both under MoHFW) and the Control of Iodine Disorders implemented by the Bangladesh Small and Cottage Industries Cooperation of the Ministry of Information.

About 50 percent of the population has access to health care facilities through a network of Thana Health Complexes, Rural Dispensaries, Community Clinics and Union Health and Family Welfare Centres, but the services are of poor qualiy and underutilized. Since 1982, satellite clinics were established by female field workers to deliver maternal and child health and family planning services.

Aside from building networks and linkages, recent advances in primary health care activities include: training of mothers in the preparation of oral rehydration solution for better management of diarrhoea and a wider coverage of immunization (about 70 percent) through the EPI. The GoB's Health and Population Sector Programme is also offering an integrated package of services on health and population. Currently, there is still concern for improving accessibility to more effective and better quality health care, especially maternal and child health.

B: PROGRAMME DESCRIPTION

The BINP was said to be patterned on an improved version of the Tamil Nadu Integrated Programme and was the first attempt of the GoB to develop a comprehensive and coordinated national intersectoral programme for addressing malnutrition. With an offer of funding up to US$ 59.8 million from the World Bank (i.e. donor-driven), "the GoB welcomed the opportunity to undertake a national nutrition programme". It should be made clear, however, that prior to the World Bank offer, there was already widespread recognition of the gravity of the malnutrition problem and its debilitating consequences. Unfortunately, the GoB was not financially able to underwrite a large scale nutrition programme. The support to BINP was augmented by UNICEF.

Initial activities for BINP started in 1993 when BRAC undertook a nutrition modelling project in Muktagacha to draw lessons for designing a workable strategy for a national nutrition programme. These lessons along with the Tamil Nadu Integrated Programme experiences were consolidated by a group of international and national consultants and experts in a series of project preparation and consultative meetings. From the GoB, the Ministry of Health and Family Welfare (MoHFW) was identified as the implementing agency with the actual implementation of the six-year programme beginning in 1996. However, in practice, the MoHFW acted more as a coordinating agency for all activities, which were contracted out to some NGOs and national nutrition institutions. The latter were involved as resource centres for trainers. This was a missed opportunity for the MoHFW, namely to be in the forefront of an important nutrition undertaking, inasmuch as their responsibility was relegated to monitoring which also suffered eventually due to fast turnover of programme staff.

The ultimate goal of BINP is to reduce malnutrition so that it ceases to be a public health problem. Specifically targeted by BINP are the under five children, women, adolescent girls, and newly wed couples (this was later dropped from the list of targets). To achieve this goal, the programme had identified the following objectives:

- improve the capacity of the country's national level nutrition institutions, specifically in the areas of advocacy, analysis of causation and consequences of malnutrition, policy advice, operational research, and operational support to national programmes;
- improve the capacity of communities, households and individuals in the project areas to understand their nutrition problems in practical terms and take appropriate action to address these at their own level;
- improve the nutritional status of the population in the project areas with special emphasis on pregnant and lactating women and children.

BINP has three major components namely: the national level nutrition activities, intersectoral nutrition programme development, and a community-based nutrition component.

The national level nutrition component has four subcomponents. These are: (1) programme development and institution-building aimed at developing national capacity in nutrition and promoting policy and operations-oriented research; (2) information, education, communication (IEC) for assessing current behavioral aspects relevant to nutrition and developing appropriate IEC activities through interpersonal methods at the community level and through the mass media at the national level; (3) strengthening of existing nutrition activities; and (4) project management, monitoring and evaluation. Of these subcomponents, only the IEC component was strongly implemented and to a certain extent ongoing nutrition activities were improved in terms of making them available on time, more regular and more targeted. It was unfortunate that the original intention of integrating direct nutrition interventions with development-oriented interventions was not fully realized inasmuch as intersectoral coordination proved elusive.

The second component is the intersectoral nutrition programme development aimed at improving nutrition by emphasizing the nutritional aspects of activities in various sectors and supporting innovative actions. The lack of a clear-cut mechanism for operationalizing this constrained the programme in many ways. Through this component, it was intended to provide additional human and material resources as well as make the BINP truly holistic and integrated.

The third component is the community-based nutrition component, which focuses on growth monitoring and evaluation with targeted and supervised supplementary feeding at the village level. The activity takes place in community nutrition centres, which also act as a venue for interpersonal IEC and community mobilization. Since this is the main focus of BINP, the majority of resources were earmarked for this component.

For geographical coverage, initially six *thana*s were selected as pilot areas. These were Gabtoli, Banaripara, Mohammedpur, Shahrasti, Faridpur, Sadar and Rajnagar. Based on the baseline survey conducted by BRAC, a total population of 1,235,576 was reached by the programme, in 1,218 villages in over 55 unions. In 1998, BINP expanded in phases until all 60 *thanas* were covered. This represents 15 percent of the country's total population.

World Bank (1999) reports note marked reductions in malnutrition. Using MUAC as the indicator, the prevalence of severe malnutrition fell from 13 percent to 2 percent in the project areas. The number of underweight infants also decreased by as much as 30 percent.

During the duration of BINP implementation, the country suffered from a number of natural calamities and political upheavals. However, the GoB remained committed to the implementation of BINP, which through the years relied heavily on NGO partners. Formally adopted in 1997, the BPAN highlights BINP as one of the flagship programmes for nutrition.

With the completion of the pilot phase, the GoB is committed to expanding BINP into a nationwide National Nutrition Programme (NNP). World Bank along with other donors and international agencies have also committed to providing funding to enable the GoB to implement the improved nutrition strategy throughout Bangladesh, including urban areas. By the year 2015, it is envisioned that the entire country would have been reached. It is expected that the total funding for the first five years will reach around US$ 125 million, 92 million of which is credit from the World Bank, and the rest from the Netherlands Government, Canadian International Development Agency and from WFP through its Vulnerable Group Development Programme.

C: PROGRAMME IMPLEMENTATION

The strategy adopted by BINP is to provide a unique model of government-NGO partnership in the field of nutrition. Bangladesh is probably the first country to have formally taken NGOs as an official partner for undertaking nutrition improvement activities, from programme design, implementation through to monitoring and evaluation.

NGOs play a major role in BINP. Originally, it was envisioned to have two modalities for implementing BINP. The first model is GoB led and NGO-assisted. Here, the GoB relies on its own management structure to run programme activities with the Assistant Thana Family Planning Officer as the lead person. The partner NGO provides assistance in the areas of community mobilization, training and technical supervision of field personnel, logistics for preparation, packaging and distribution of food supplements as well as quality control.

The second model is NGO led and GoB assisted. *Thanas*, under this scheme, were contracted out to NGOs for the management and implementation of all community-based nutrition activities. As such, full responsibility is assumed by the NGO. These responsibilities would include training of the various field personnel, community mobilization, procurement, preparation, packaging and delivery of food supplements, procurement of equipment and supplies, quality control, supervision and monitoring. Whenever necessary, they are able to make use of government infrastructure and established service delivery systems.

Of the two models, the GoB led and NGO assisted was eventually phased out and all *thanas* were placed under the charge of NGOs. The lack of manpower and incentives on the part of GoB workers constrained GoB's implementation of the programme. For the first phase, BRAC was chosen as the partner NGO. The partnership was formalized through the signing of a Memorandum of Agreement, placing 3 *thanas* (Shahrasti, Banaripara and Gabtoli) under BRAC.

During the first six months of village level programme operations, preparatory activities included the setting up of the management infrastructure at the *thanas*. Staff, particularly Community Nutrition Promoters (CNPs) and Community Nutrition Organizers (CNOs), were recruited following a set of predetermined criteria, then trained and deployed. Both CNPs and CNOs must be females and have well-nourished preschool children to set good examples for the intended targets. Community Nutrition Centres (CNCs) were also established as close as possible to existing EPI Outreach Centres and satellite clinics. These CNCs served as village counterparts for the programme. Various nutrition management committees were also established at the district, *thana*, union and village levels. *Thana* managers, field supervisors and trainers were then deployed to the field on a full-time basis. A core team composed of Management Information System (MIS) assistants, Regional Managers and Programme Manager was established. The Programme Manager serves as the overall coordinator working directly under the guidance of the Director of the Health and Population Division of the MoHFW.

In order to mobilize and build a good working foundation, various meetings were held with the different stakeholders in the community. In its three *thanas*, BRAC staff planned and managed meetings with local government and health and family planning staff in the community. Meetings were held to build a foundation for a good working relationship with the different stakeholders in the community. In the other three *thanas*, meetings were conducted by the Assistant Thana Family Planning Officer with the assistance of the BRAC staff. Several other meetings with the different social groups in the community such as the doctors, and the female and male groups were held every month to discuss health and nutrition issues. Such meetings were also conducted to mobilize and empower the people in the community.

BRAC staff also collaborated with the existing women's group in the community created earlier by development NGOs. These groups were responsible for food supplementation management and are composed of 9-11 members. In *thanas* where groups did not exist, women were recruited. Selection was open to resident women with a minimum of 12 years education willing to spend several hours of the week for the programme. Final selection was done by BRAC and the Thana Nutrition Management Committee as appropriate. CNCs were established in all the *thanas*. All CNCs were provided with appropriate equipment and supplies. To date, all CNCs are operational.

BRAC also conducted household surveys in all six *thanas* from 1996 to 1997 to identify target groups or beneficiaries and estimate the population to be covered by the intervention, and to assess the type and frequency of monitoring that would be feasible for a particular population. Results of the survey were also used to assess the programme's progress, and by the CNPs during household visits as a basis for nutrition and health counselling.

As part of manpower and capacity development, the project office conducted carefully and systematically developed training courses. Planned in a cascading manner, the training targeted programme participants at various levels. A Core Training Team was formed at the national level, composed of 12 members, four of whom came from BRAC. The team is responsible for the conduct of a four-week training course to the Thana Training Team. *Thana* level officers from different ministries such as Health and Family Welfare, Agriculture, Livestock, Fisheries, Youth Development, Women's Affairs, Education, Village Defence Party, and representatives of NGOs participated in the training. At the *thana* level, the Thana Training Team and their supervisors facilitated a 34-day theoretical and hands-on basic training to the CNOs and CNPs. Refresher training activities were also given to CNOs and CNPs according to a planned schedule and curriculum. Special training on the MIS was also given.

The Family Welfare Visitor, Family Welfare Assistants, Health Assistants and their supervisors were oriented on BINP structure and nutrition activities. They were also informed about the identification and management of malnutrition, vitamin A deficiency, iodine deficiency disorders, LBW, family planning as well as the current nutritional status of the country. How to promote and effect intersectoral cooperation and coordination were also topics discussed. Another activity was the training of the women's groups on food supplementation management, from procurement to distribution to CNCs. Training also

included topics such as nutritional problems in the community and feasible strategies for combating them.

The training activity prepared the CNPs, CNOs and the Women's Group for their roles in the *thanas*. The trained CNP played a key role in the implementing of the Community Based Nutrition Component. The CNPs were responsible for monthly home visits to all the families in the village, conduct of growth monitoring, health and nutrition counselling, supervision of micronutrient distribution and supplementary feeding at the CNCs. In addition, they referred mothers and children to EPI outreach centres, and to Satellite Clinics of Family Welfare Centres for antenatal care. They also compiled information on vital events such as births, deaths, marriages, and migration for their catchment population. Each CNP is assigned to 1,500 individuals in the community. CNPs also supervised the Women's Group in the procurement of raw materials and in the preparation and distribution of food packets to community nutrition centres, and were responsible for the conduct of refresher and on-the-job training to these groups.

Each CNO was assigned to supervise 10 CNPs. The CNOs organized on-the-job training sessions and monthly meetings with the CNPs under their supervision. They collaborated with the Family Welfare Visitor for strengthening linkages with allied institutions and facilities and the referral of nutritionally at-risk cases to secondary and tertiary service centres. The CNOs also attended refresher-training activities conducted by field supervisors (aside from providing education and information for various groups).

With the integrated efforts of these nutrition actors, the following were implemented under the Community-based Nutrition Component: (i) growth monitoring and promotion; (ii) identifying targets for supplementation; (iii) health check-up and referral; (iv) immunization, vitamin A distribution and deworming; (v) health and nutrition education; (vi) strategy for the newly-wed couple; and (vii) management information system. The target beneficiaries were all the pregnant and lactating women and children under two years of age. In Gabtoli, a pilot intervention was conducted to target the newly-wed couples and their children and all severely malnourished children.

For the growth monitoring and promotion component, all children born in the community were registered and weighed within 72 hours of birth by the CNP. The mothers of children under two as well as those with the newly born were mobilized by the CNPs to bring their children for the growth monitoring and promotion sessions held every month at the CNC. Monthly weights were plotted on growth charts, progress assessed and explained to the mothers each month. The height and weight of all pregnant women were also monitored.

In the food supplementation scheme, children who were severely malnourished, based on the growth charts, or those with faltering weights were given food packets made from a combination of rice powder, pulse powder, molasses and oils (the latter being added just prior to feeding). They remained under supplementation for 90 days at the CNC. Their weights were monitored monthly and if no improvements were seen, supplementation was continued for an additional 30 days. Pregnant women also benefited from the programme if they were found to have a body mass index of less than 18.5 kg/m^2. Two members from each of the Women's Groups managed the supplementation programme. The amount

given to children and pregnant women varied depending on the severity of the beneficiary's nutritional status. The CNP was present to ensure that the foods were consumed. They also offered nutrition education and counselling to mothers.

Severely malnourished children and all the children whose weight failed to improve in the supplementation programme were referred to the Thana Health Complex. Children with suspected diseases such as diarrhoea, pneumonia, measles and skin diseases, and pregnant women at risk of malnutrition, identified during home visits, were also brought to the Health and Family Welfare Centres or Thana Health Complexes. If not treated at these centres, they were referred to secondary and tertiary levels. The pregnant women were motivated to visit the satellite clinics for antenatal check-ups, which included (i) documentation of the women's general obstetric history; (ii) checking for anemia, jaundice and high blood pressure; (iii) preabdominal examination; and (iv) examination of urine for sugar and albumin. Pregnant women were also given iron and folic acid (250 mg Fe + 40 mg folate) supplements for daily consumption. Other services offered to children and pregnant women were immunization, vitamin A supplements and deworming medications for helminthiasis, at the satellite clinics and EPI sessions. Lactating women were given 200,000 IU of vitamin A at home by the CNP, within two weeks of delivery.

Nutrition education classes and fora were also held to bring about changes in feeding and health care habits of the people. Pregnant and lactating women were taught about their nutrition needs and the importance of colostrum and breastfeeding. Mothers with LBW babies (i.e. birth weight below 2.5 kgs) were provided with special education on health and nutrition. IEC materials were made available at the CNCs and were also distributed during cluster meetings and home visits.

Newly-wed couples were also targeted in the Community-based Nutrition Component. This strategy was introduced as a pilot intervention in Gabtoli Thana. Specific interventions were focused on the newly-wed women together with the husband and mother-in-law from the time of marriage until after the first child had reached the age of two. This strategy was intended to improve health and nutrition status during pregnancy, safe delivery and prevention of LBW babies.

The CNOs and field supervisors collected field-based data. Monthly performance reports on growth monitoring, nutritional status, and supplementation were submitted to the head office from the three BRAC-operated *thanas* using a standard format. Reports were then sent from the head office to the project office and were computerized and analysed by BRAC.

D: MACROCONTEXTUAL FACTORS

The macropolitical and policy environment is favourable for BINP implementation. There is national recognition of the importance of good nutrition in achieving overall development for the country. This, together with international events such as the 1992 International Conference on Nutrition and the 1996 World Food Summit provided the impetus for making nutrition a top priority for development. In 1997 the Bangladesh Plan

of Action for Nutrition was formally adopted as the national umbrella programme for all nutrition activities, and sectoral focal points were identified along with national steering and working committees. The BPAN is a comprehensive document that identifies short and long-term strategies for addressing nutrition problems and their causes. It also incorporates an integrated strategy underscoring the need for intersectoral coordination, and identifies sectoral responsibilities.

Initially, the government formed a National Working Committee with the Additional Secretary, MoHFW, as its Chairperson. Through this, the BPAN developed with inputs from the ministries of Health and Family Welfare, Agriculture, Food, Fisheries and Livestock, Environment and Forest, Women and Children Affairs, Social Welfare, Disaster Management and Relief, Local Government, Rural Development and Cooperatives, Education, Information, Planning, and Finance. Intersectoral coordination and support also involved other government departments, namely Primary and Mass Education Division and NGO Affairs Bureau. As part of the steps considered in the implementation of the BPAN, GoB would also strengthen the Bangladesh Institute of Research and Training on Applied Nutrition to incorporate nutritional objectives and considerations in the agriculture sector. Through the BPAN, nutritional objectives and considerations are incorporated in the development policies and programmes of the government, particularly on food security issues, and targeted to women and nutritionally vulnerable and socio-economically deprived groups and those in distress.

GoB considers poverty reduction as its top priority. Hence various poverty alleviation programmes are planned and implemented. The following are some of the programmes supported by the GoB and international and bilateral organizations [45] :

- rural maintenance programme;
- poverty eradication programme;
- rural development programme coordinated by the WFP;
- food for work;
- rural women's employment creation programme;
- NGO community-based programme for women and children;
- rural women's development programme;
- vulnerable group development programme coordinated by the WFP;
- women's vocational training for population activities.

Incorporated in these programmes are social mobilization and motivation strategies to empower the community, especially the vulnerable groups and their caregivers.

[45] WFP, ILO, UNDP, FAO, UNICEF, Asian Development Bank, World Bank, Department for International Development (UK), Canadian International Development Agency, Swedish International Development Agency, Netherlands Organization for International Development, Norwegian Agency for Development Cooperation, Aga Khan Foundation, United States Agency for International Development, CARE.

E: COMMUNITY PARTICIPATION

From the original design of BINP, it is evident that its operations were largely community-based but required technical assistance and support from higher levels of administration, both aspects having implications for the final outcomes of the programme.

Training was deemed essential for achieving the desired results of the programme and was targeted to different groups. It should be emphasized, however, that since there were different key actors and roles and requirements at each operational level, the content of the training curricula and strategies need modification, which is already under way.

While the potential benefits of community participation are many, BINP has not yet fully realized these potentials because of problems associated with actual implementation. In BINP, *thanas* and villages are the focal points of community participation. However, since the types of interventions to be carried out have been predetermined at the national level, there appears to be a homogeneity - as if all the *thanas* and villages had the same problems and concerns. Very similar projects were identified repeatedly. This, as mentioned, is due to the very manner in which community participation has been structured by BINP proponents, beginning with the same standardized plan after training is conducted in which virtually the same information and techniques are introduced in each village. Moreover, since approval and decisions are usually taken at a higher level, community discretion and choice were further restricted.

In some BINP areas, people participate by being told what is going to happen or by simply giving information when asked. However, for the longstanding BINP areas, the villagers are more vocal about their views and the local workers are showing more regard for people's opinions and needs. While material incentives may have been the impetus for participation initially, there are signs of some BINP areas graduating to functional participation although more directed towards selecting members of women's groups, generating additional local resources rather than in the selection of projects and activities.

F: SUSTAINABILITY

Judging from the strengths, weaknesses as well as opportunities and constraints in the implementation of BINP, one can conclude that the programme has a fair chance of achieving sustainability, albeit with continued reliance on external funds. The lessons learned from the BINP pilot implementation as well as those drawn from the villages have been incorporated in the revised version of NNP. Intersectoral involvement as well as making the programme more integrated and comprehensive will be intensively pursued within the NNP framework. Roles and responsibilities will be clearly defined. Financing schemes will be made more flexible, ensuring the timely and adequate release of funds for programme inputs and operations. More importantly, while it will continue to harness the goodwill of NGOs to be active partners in NNP, there will be a deliberate effort to also build capacities of national nutrition institutions and gradually mainstream them as allies. This will reduce dependence on NGOs, which by themselves are largely dependent on

external funding for operations with the possible exception of BRAC, a longstanding and well-established NGO.

The effect of a strong nutrition advocacy component on the sustainability of NNP, or any nutrition programme for that matter, cannot be overemphasized. It is envisioned that these efforts will convince and influence various stakeholders toward an accelerated adoption of policies and implementation of programmes for nutrition improvement. The national scenario is cognizant of the importance of nutrition but this has to be translated into actual programmes and concrete actions that can be felt at the grassroot level. A parallel move at the village level of community organization and mobilization toward increased community participation will undoubtedly have synergistic effects.

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ANNEX 3 (B)

PHILIPPINES CASE STUDY

LAKASS PROGRAMME

Philippines Case Study

Contents

LAKASS PROGRAMME

SUMMARY

Coverage

The LAKASS Programme (*Lalakas ang Katawang Sapat sa Sustansiya*) [46] started in 1989 and is ongoing in selected areas throughout the Philippines. The programme is funded by the Government of the Philippines (GoP), from the GoP-Japan Increased Food Production Programme. It covers 175 nutritionally depressed municipalities in the country.

Objectives of the programme

LAKASS aims to: (a) improve the nutrition situation in all identified nutritionally depressed municipalities; and (b) provide effective and sustainable services for the community to improve their nutritional status.

Programme impact

LAKASS has demonstrated its effectiveness in attaining its immediate goals. Its operation has been expanded to other depressed *barangays* [47] within the targeted municipality through the initiatives of local chief executives and village-level core groups.

Significant improvements in the nutritional status of malnourished children (using weight-for-age) of as much as 71.4 percent and 46.6 percent in severe and moderately underweight cases have been observed (in the area of Pateros, 1997) although, of the total number of households with moderately and severely underweight preschoolers, only 90 percent were reached. An increase of the households' purchasing power (28 percent increase in income) among LAKASS beneficiaries (Pateros, 1997) through the provision of small capital loan assistance was likewise noted.

Community participation

As a community-based nutrition programme, community involvement was an integral component of LAKASS from project identification, implementation and management, and was based on an in-depth analysis of causes of malnutrition at the community and household levels. This programme has generally led to people's empowerment and mobilization, which enabled the villagers as well as local chief executives to build and sustain their capabilities to improve their own nutrition situation. Innovative strategies for

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[46] LAKASS is an intensive nutrition action programme formulated and coordinated by the National Nutrition Council of the Philippines. LAKASS is an acronym standing for a Philippine statement meaning: "The body will become robust and healthy with adequate nutrition" (Stuart, T.H. 1995. Rome, FAO).

[47] The smallest political subdivision of the Philippines.

ensuring a high loan repayment rate and for generating resources ensured the expansion of LAKASS beyond the initial scope of loan provision, to increase the number of those able to access loans.

Initially, community participation was motivated by prospects of material incentives, in this case the loan. However, with advocacy, orientation, training, technical backstopping and recognition of good performance, communities eventually graduated to self-mobilization.

Lessons learned

- An integrated, multidisciplinary programme is able to exploit possible complementarities of various nutrition interventions (short and long-term). For example, health, sanitation, supplementary feeding programmes and food production complement each other.
- Community involvement permits better targeting of beneficiaries.
- Community consultation can help identify the "best practices", those congruent with local culture, capabilities and the physical environment.
- Community participation is an orientation, which must not be taken for granted; it should be an overriding and conscious concern, so as to avoid degenerating into mere rhetoric.
- Community mobilization of resources lessens the burden on Government resources. Schools have been very effective in generating funds for nutrition and health programmes.
- Proper training is a critical component of an integrated, community–based programme, and must not neglect topics such as proposal preparation, resource generation, evaluation.
- To ensure proper coordination, there should be a clear assignment of roles and tasks among key programme actors, especially when implementing a mix of interventions.
- The lack of a good monitoring and evaluation system is an obstacle to the effective operation and implementation of community-based programmes.
- Participatory planning (based on a sound situation analysis), implementation and monitoring and evaluation contribute to successful project implementation at the community level and ensure sustainability.
- Partnerships (Government – NGOs – private sector – academe) can contribute immensely towards effective integration as well as resource generation, and should be encouraged.
- Development and mobilization of indigenous development workers (e.g. *barangay* nutrition scholars) should be based on the most effective worker:client ratio.

- Consistent with devolution, there is a need to emphasize area-based bottom-up planning.
- Strong political will is a necessary ingredient that can be generated through strong advocacy efforts.
- Nutrition advocacy and resource generation should be further coordinated. The lack of appreciation for the importance of good nutrition among many local leaders or sectoral workers clearly justifies such efforts.
- Resource generation for nutrition involves three levels of implementation in a devolved government structure. At the national level, budget allocation to nutrition-related expenditures should be maintained and advocacy should press for funding. At the local level, there should be a better sharing of internal revenues with the national government, and strong initiatives to exploit tax powers. Finally, at the community level, local organizations and even beneficiaries can help to generate resources, if only to avoid developing or perpetuating a welfare mentality among the latter.

Strengths, weaknesses, opportunities, constraints/threats (SWOC)

Strengths

- recognition that malnutrition is a development problem, which calls for an integrated and multidisciplinary approach;
- from an economic viewpoint, LAKASS was able to maximize complementarity and the synergistic effects of interventions;
- effective targeting using predetermined and agreed set of selection criteria;
- intensive and effective advocacy from national to village level;
- strong support and involvement of local chief executives (includes Mayor, Municipal Development Council members) and *barangay* officials as attested by issuance of relevant memos, circulars and fund allocation as local counterpart for LAKASS funds;
- committed and good leadership of municipal (municipal nutrition action officers as well as members of the Municipal Nutrition Committee) and village workers (*barangay* nutrition scholar, LAKASS officer and LAKASS core group members);
- well-defined roles and responsibilities for programme functionaries particularly the full-time LAKASS focal point;
- training which developed technical know-how of the programme functionaries;
- strong social preparation component;
- functional municipal and *barangay* nutrition committees which translated into intersectoral support and cooperation;

- strong community and agency involvement in programme implementation;
- regular, effective technical backstopping from regional and provincial nutrition offices;
- establishment and training of a *barangay*-based LAKASS core group which included treasurer, *barangay* nutrition scholar, day care worker, *barangay* health worker, and *barangay* councillors;
- intensive follow-up of LAKASS beneficiaries by LAKASS officer;
- programme ownership from municipal to village level;
- transparency and accountability of LAKASS officers and coordinators at different levels;
- recognition of performance through nutrition awards provides a non-monetary incentive.

Weaknesses

- limited funds and delays in fund release caused frustration and disappointment among programme beneficiaries;
- lack of focus of skills development in the training conducted;
- misconception regarding loan repayment;
- inadequate supply of programme inputs, such as animal stock for animal dispersal projects and water supply for food production;
- limited participation of provincial level staff;
- limited support of governor;
- lack of recognition of the importance of good nutrition;
- in the not-so-successful LAKASS areas, the following were particularly noted:
  - non-functional Municipal Nutrition Committees (MNCs)
  - lack of social mobilization
  - lack of programme orientation which resulted in some confusion among programme implementers and beneficiaries.

Opportunities

- introducing and utilizing new technologies in, for example, agriculture and infant feeding mixes;
- initiating group actions towards shared responsibility at different operational levels;
- forging stronger coalitions between government organizations, non-governmental organizations, the private sector and academic institutions;
- creating heightened awareness of nutrition;

- infusion of additional resources from the private sector and civic organizations such as Rotary Club, Kiwanis, Lions and Jaycees;
- closer interaction between municipal and village workers;
- expansion to other areas with high repayment;
- institutionalization of the LAKASS;
- exploitation tax powers at the *barangay* level to generate resources for nutrition.

Constraints/threats

- change in political leadership (development vs. traditional politicians);
- poor climatic conditions;
- armed conflict due to differences in political ideologies and religious affiliations;
- inaccessibility of some nutritionally depressed villages or households;
- lack of mobility and communication facilities;
- welfare mentality as well as *"ningas-cogon"* [48];
- poor transportation facilities and roads;
- limited funds for loan scheme;
- inadequate material inputs for some LAKASS projects.

Sustainability

After more than 10 years of implementation, LAKASS has a good chance of sustainability. The LAKASS rollover scheme is designed in such a way that funds are only provided once to the municipality. As loans are repaid, other households are expected to enter the scheme. Recognizing that the initial amount given is inadequate, local leaders and community people have generated additional resources for the project. The initial loan given has also in most cases built up confidence and made the households creditworthy, thus enabling them to access other lending institutions.

[48] "*Ningas-cogon* means a lot of initial interest which fades fast. It is used to describe people's attitude of being very enthusiastic at first, but this enthusiasm dies rapidly." Source: personal communication to the editor by Prof. Delia Rodríguez Amaya, University of Campinas (UNICAMP), Brazil.

A: NATIONAL CONTEXT

Location: The Philippines is an archipelago located in Southeast Asia, with a total land area of almost 300,000 sq km. It is located north of Indonesia, east of Viet Nam, and southeast of China.

Demography: The total population as of July 2000 was 81,159,644, with an annual growth rate between 2.0 percent to 2.5 percent. The age structure shows 37 percent of the population in the 0-14 years age bracket, with the majority of the population (59 percent) within the 15-64 years age bracket. Only 4 percent of the population is within the 65 years and over age bracket.

Health: Selected health indicators are shown in Table 1. Although the infant mortality rate is relatively high in the Philippines, a gradual decline in the trend has been observed since 1990 (from 56.7 per 1,000 live births in 1990). However, a large disparity in infant mortality rates has been observed within the population, where very high infant mortality rates were observed in certain provinces (ranging from 65.8-69.1 infant deaths per 1,000 live births). The top ten causes of infant deaths (five-year average from 1991-1995 and in 1996) were: respiratory conditions of the foetus and newborn, pneumonia, congenital anomalies, diarrhoeal diseases, birth injury and difficult labour, septicemia, measles, meningitis, other diseases of the respiratory system, and vitamin and other nutritional deficiencies. Infant deaths were higher in mothers who received no antenatal care or medical assistance at the time of delivery (DoH, 1999). A similar decline in the trend for under five and maternal mortality since 1990 was also noted, but large differences in child and maternal mortality rates exist among different provinces.

Access to health services appears to be a major obstacle to health care delivery. Recent data show that a lower percentage of children in rural areas are taken to a health facility compared to urban areas. Moreover, it was noted that children whose mothers have higher levels of education account for a greater percentage of those brought to health facilities.

The leading causes of morbidity (all ages) were largely the communicable diseases. However, the ten leading causes of mortality (all ages) during the same period were mainly non-communicable diseases, such as cardiovascular diseases, malignant neoplasms and diabetes mellitus.

Table 1 Health indicators: Philippines

Life expectancy at birth, 2001	68.60
- Male	66.03
- Female	71.28
Crude birth rate, 2001 (per 1000 popn), 1997	28.4
Crude death rate, 2001 (per 1000 popn)	6.10
Infant mortality rate, 1995: rate (per 1000 live births)	48.93
Maternal mortality rate, 1995: rate (per 100,000 live births)	190

Source: Department of Health, National Objectives for Health 1999-2004 (June 1999)

Economy: the Philippine economy is based on a mixture of agriculture, light industry, and supporting services. The GDP growth rate declined from 5.1 percent in 1997 to –0.5 percent in 1998, with much of the decline in growth seen in the agriculture and forestry sectors and also from decreased investments. Some economic recovery was noted in 2000 when the country experienced a 3.3 percent growth rate in GDP (National Economic and Development Authority, 2001). Recent economic thrusts include major changes in the taxation system to increase government revenues, deregulation and privatization of the economy, and improvement of infrastructure.

Minimum basic needs indicators: in October 1999, the National Statistics Office conducted a nationwide Annual Poverty Indicators Survey for the second time, covering 41,000 sample households all over the country. Minimum basic needs indicators were classified as those on survival, security, and enabling. Some examples of data collected are given in Table 2.

Table 2 Minimum basic needs indicators, Philippines (1999)

1. SURVIVAL INDICATORS	
FOOD AND NUTRITION **Recipients of iron supplements** **Recipients of iodine supplements**	• A total of 1.6 million or 10.7% of the total families had married female family members 15-49 years old who were pregnant and/or lactating from April 1 to September 30, 1999. Of these, about 1 million or 64.8% were recipients of the iron supplements. • Three out of five of these families belonging to the lowest 40% income stratum received iron to supplement the needed vitamins during pregnancy. • Approximately 910.0 thousand (or 57.5%) of families with married pregnant/lactating women received iodine supplement during the period April 1 to September 30, 1999.
HEALTH	• Three out of five families with pregnant and/or lactating married members who were 15-49 years old in 1999 were given at least two shots of tetanus toxoid. • 91.7% of families with married women 15-49 years old had access to family planning in 1999 but only 35.8% were practicing any family planning method.
ELECTRICITY, WATER AND SANITATION	• 73.3% of families had access to electricity at home. • The number of families with access to safe drinking water was 79.2% in 1999. • The number of families with sanitary toilets was 12.142 million in 1999.
2. SECURITY INDICATORS	
SHELTER	• A total of 7.750 million families (52.6 %) had housing units made of strong materials. • Percentage of families owning the house and/or lot they occupy was 68.6%. Of the 10.1 million families that owned their house and/or lot in 1999, only 5.9% were able to get the assistance of the government housing or financing programme. • One in every five families owned land for purposes other than residence. Of these families, 288.0 thousand (0.9%) acquired their land through the Comprehensive Agrarian Reform Programme (CARP) for 1999.
EMPLOYMENT	• Labour force was estimated at 32 million in 1999. This was classified as agriculture 39.8%, government and social services 19.4%, services 17.7 %, manufacturing 9.8%, construction 5.8%, and others 7.5%.
3. ENABLING INDICATORS	
EDUCATION	• Percentage of families with children 6-12 years old was 52.7% in 1999. Of this number, the percentage of families with children 6-12 years old who were enrolled in elementary schools was 83.9% in 1999.
INVOLVEMENT IN PEOPLE'S ORGANIZATION, NGO (*) AND/OR COOPERATIVE	• Some 4.097 million families or 27.8% of the total number of families have at least one family member involved in any people's organization/non-governmental organization involved in community development in 1999. • The number of families with members in cooperatives was 16.2%.
AVAILMENT OF LOANS FOR ENTERPRENEURIAL ACTIVITIES/ BUSINESS	• Three in every five families in the country were engaged in entrepreneurial activities. • In terms of availing loans, the number of families availing of loans for business was 2.173 million (25%) in 1999. • High interest rates, having no collateral, and no knowledge where to get loans were among the reasons given by families in the bottom 40% income group who could not avail of credit for their entrepreneurial activities.
PRESENCE OF WORKING CHILDREN	The number of families with working children 5-17 years old was about 1.511 million (14.7% of total families with children 5-17 years old) in 1999 who allowed their children to be employed.

Source: Annual Poverty Indicators Survey, October 1999, National Statistics Office, 2000, Manila, Philippines.
(*) non-governmental organization

The Philippine health sector

The Department of Health (DoH) is responsible for the administration of regional hospitals, medical centres, and specialized hospitals. Each region in the country has a DoH regional field office. Some important developments have occurred in the country's public health care system and health care delivery over the past 25 years:

- In 1979, the primary health care approach was adopted.
- In 1983 Executive Order 851 mandated the integration of public health and hospital services.
- In 1987 the DoH was further reorganized to streamline health care delivery.
- In 1992 a major change occurred in the devolution of health services to local government units. The DoH is now further streamlining its organization and functions (GoP 1999).

After the devolution of health services to local government units (1992), provincial and district hospitals were administered by provincial governments, while Rural Health Units and Barangay Health Stations located in different municipalities were placed under the municipal governments.

To achieve national health objectives, GoP has identified general strategies to improve the health care delivery system at different levels (DoH, 1999). These strategies include:

- increased investments for primary health care;
- development of national standards and objectives for health;
- assurance of quality health care;
- support for local health system development;
- support for frontline health workers.

Nutrition in the Philippines

Historical perspectives

Some significant national government policies and activities on nutrition have been undertaken over the past decades. These include:

- the creation of the Nutrition Service of the Department of Health in 1968;
- the creation of the National Food and Agriculture Council in 1969;
- the creation of the National Nutrition Council (NNC) in 1974;
- acceleration of the supplementary school feeding programme of the national government, with particular emphasis on Mindanao in 1977;
- reorganization of the Food and Nutrition Research Institute in several stages in 1982;
- implementation of the Milk Code rules and regulations covering the advertising, promotion, and marketing of breastmilk substitutes;

- reorganization of the NNC in 1987 and transfer of its administrative responsibility from the Department of Social Welfare and Development to Agriculture in 1988;
- the enactment of the Salt Iodization Law nationwide (ASIN law);
- implementation of the *Sangkap Pinoy Seal* Programme (food fortification) and the *Araw ng Sangkap Pinoy* (ASAP), a supplementation programme incorporated with National Immunization Day in 1993-1995;
- the issuance of an executive order making national nutrition surveys into critical statistical data in 1996.

Key players in nutrition in the Philippines

The Philippines has a Medium Term Philippine Food and Nutrition Plan (MTPFNP). This has also been referred to as the Philippine Plan of Action for Nutrition (PPAN), which serves as the country's blueprint for nutrition improvement. The current PPAN covers the period 1999-2004. The PPAN is an integral component of the Medium Term Development Plan for the Philippines. The NNC is the main policy-making body for nutrition and is responsible for formulating the MTPFNP/PPAN. A distinct feature of the PPAN is the systematic collaboration of national government agencies, local government units, NGOs and the business sector. The PPAN uses existing organizational structures at the national and subnational levels for the implementation, monitoring, and evaluation of nutrition interventions.

The NNC is the main coordinator for all nutrition-related activities of both government and private sectors. At the national level, the NNC is composed of a Governing Board that includes ten department secretaries (Agriculture; Health; Education, Culture and Sports; Science and Technology; Trade and Industry; Economic Planning; Social Welfare and Development; Interior and Local Government; Budget and Management; Labour and Employment) and three representatives from NGOs. The NNC Governing Board is chaired by the secretary of the Department of Agriculture. The main functions of the NNC Governing Board are the formulation of national food and nutrition policies and strategies and the coordination of planning, funds release, implementation, monitoring and evaluation of nutrition programmes. Technical assistance is provided to the NNC Governing Board by the Technical Committee, which also facilitates interagency communication and coordination. The NNC Technical Committee is composed of representatives from government departments and agencies, the academe (University of the Philippines at Los Baños), and NGOs. The NNC also has a Council Secretariat that advises the Governing Board on matters related to food and nutrition policies, programmes, and projects, as well as providing technical, financial, and logistical support to local governments and agencies for the development and implementation of nutrition programmes and projects. At the local level, local nutrition committees, chaired by local chief executives, serve as the planning and coordinating body at the local level. A designated Nutrition Action Officer assists the local chief executives on matters and activities related to nutrition and food. At the *barangay* level are the frontline community-based or volunteer workers who provide basic nutrition-related services that include growth monitoring and promotion, promotion of home and community food production, and the conduct of nutrition education activities, among others (NNC, 1995).

Nutrition policy directions

The Philippine Nutrition Programme is premised on a nutrition-in-development perspective. It adheres to the principle that a healthy well-nourished population is a prerequisite to attaining national development goals. Health and nutritional well-being is considered an integral part of national socio-economic development, guided by the following policy directions (NNC, 1995):

- focus public resources toward the implementation of community-based nutrition interventions and poverty-alleviation measures in identified nutritionally depressed areas targeting nutritionally at-risk families and individuals;
- promote a supportive policy environment across development sectors to ensure nutritional improvement;
- integrate nutrition considerations in sectoral development plans and programmes that pursue the reduction of poverty and address its causes, increased food availability, improved environment, better health, and increased productivity and economic growth;
- strengthening local government units and community capability to plan, implement, monitor, and evaluate sustainable and integrated nutrition programmes;
- improve and strengthen existing mechanisms for nutrition planning, policy formulation, implementation, monitoring, evaluation, surveillance and advocacy at all levels;
- conduct basic, applied, and operations research on nutrition; strengthen research utilization and technology transfer; and regularly assess plan implementation;
- increase the emphasis on the vital role of information and development communication in promoting good nutrition;
- involve NGOs including people's organizations and the business sector more systematically in plan implementation.

Five nutrition interventions have been identified as the primary impact programmes of the PPAN (1993-1998). These are:

- home and community food production;
- micronutrient supplementation and food fortification;
- nutrition information, education and communication;
- food assistance programmes: these include supplementary feeding, production and distribution of complementary food, and targeted food discounts; food assistance is undertaken using three approaches: nutrition wards in hospitals or space in rural health units, centre-based feeding or on-site feeding, or the dry ration (take-home) scheme;
- credit assistance for livelihoods: this provides for income generating projects such as meat processing, fruit processing and preservation, and aquaculture and livestock production.

Five key enabling mechanisms have been identified to support the implementation of PPAN's impact programmes. These include:

- human resource development, focusing on the training of programme implementers and managers in programme or project management, primarily through nutrition planning workshops; community-based volunteers and representatives of relevant organizations are also trained to develop skills of implementers and beneficiaries on nutrition intervention programmes;
- nutrition advocacy, targeted to national and local policy-makers, local chief executives, decision-makers in international organizations and the business sector;
- resource generation, through regular allocation of the national government as well as through fund-raising activities in cooperation with NGOs; efforts to access funds for PPAN programmes from international funding organizations are pursued; at the local level, local government units are encouraged to allocate funds for local nutrition plans from local governments' budgets;
- research activities focus on issues related to emerging nutritional problems and operations research on issues regarding effective implementation of nutrition programmes; research findings are also intended for immediate dissemination to serve as a basis for decision-making by policy-makers and programme managers;
- overall planning, management, coordination and surveillance efforts to ensure that needed policy and programme adjustments are made towards the achievement of PPAN goals and objectives.

The magnitude of the malnutrition problem

The nutrition situation in the Philippines is in the transition phase of development (Acuin and Javellana, 1998), where undernutrition remains a major health problem and nutrition problems related to overweight and obesity such as cardiovascular disease, diabetes, and cancer have been emerging. These have been attributed to the disparity in rate of development, particularly between urban and rural areas, as well as the unequal distribution of wealth in the country. Nutrition problems prevailing in the country are protein-energy malnutrition, vitamin A deficiency, iron deficiency anaemia, and iodine deficiency disorders. Nationwide nutrition surveys conducted by FNRI, the latest of which was in 1998, have revealed that malnutrition remains a public health concern in the Philippines.

Some salient findings of the most recent survey by FNRI (Fifth National Nutrition Survey, 1998) include the following:

- 8.4 percent of preschool children (0-5 years old) are underweight
- 7.4 percent of school children (6-10 years old) are underweight
- 4.6 percent of preschool children are wasted (acute malnutrition)
- 6.6 percent of school children (6-10 years old) are wasted
- 5.1 percent of preschool children are stunted (chronic malnutrition)
- 5.5 percent of school children are stunted.

A total of 1.5 million Filipino children (0-10 years old) are underweight and about 988,000 are stunted. Regions V (Bicol), VI (Western Visayas), and VIII (Eastern Visayas) appear to be more nutritionally at risk than other regions of the country. Based on the 1997 Family Income and Expenditures Survey (National Statistics Office, 1999) these three regions have the lowest average family income in the country, thus poverty appears to be a major factor involved. Remote rural communities and urban poor areas are more likely to be affected by the malnutrition problem.

Causes of malnutrition

Two immediate causes of malnutrition have been identified as having a major negative influence on the nutritional status of Filipinos. These are:

- Inadequate food intake: The average Filipino diet consists mainly of boiled rice complemented with boiled fish and vegetables, with the bulk of the diet provided by rice. Based on the 1993 dietary survey conducted by the FNRI, only protein intake was above 100 percent of the recommended daily allowance, while the intakes of energy and a number of micronutrients were below 100 percent of recommended daily allowance. This was attributed to food insecurity due to low income, insufficient food production, poor purchasing power of the local currency coupled with price increases of many foods.
- Infectious diseases: the incidence of infectious diseases in the Philippines continues to be a primary cause of morbidity, particularly in children.

Three underlying causes of inadequate dietary intake and infectious disease are considered as exerting significant influence. These are:

- inadequate access to food in a household because of poverty;
- insufficient health services: in poor urban and remote rural communities, access to health care and safe water is inadequate, and poor sanitation and unhygienic conditions prevail;
- inadequate care for children and women: excessive dependence on bottle-feeding of breastmilk substitutes and poor complementary feeding practices have been identified as contributory to poor protection from infection, compounded by the limited availability of sound health information. In addition, unequal division of labour and resources among certain communities and families may adversely affect the health of pregnant and lactating women.

Some basic causes of malnutrition are considered to contribute to the persistence of the malnutrition problem in the Philippines, including micronutrient malnutrition (Institute of Health Policy and Development Studies, Briefing Paper, 2001). Some of these factors include:

- a political and economic system that determines distribution of income and assets;
- the presence of incongruent ideologies and policies that govern the social sectors;

- problems in collaboration and coordination in nutrition among different agencies involved;
- limited evaluation of the effectiveness of nutrition intervention programmes;
- a top-down programme planning approach that does not involve the community as equal partners and key actors in nutrition planning, management, and evaluation;
- lack of timely nutrition data for use in planning effective programmes.

B: PROGRAMME DESCRIPTION

The *Lalakas ang Katawang Sapat Sa Sustansiya* (LAKASS) is a community-based nutrition action programme which combines the delivery of direct nutrition services with effective and sustainable development programmes to ensure the nutritional well being of the population within the framework of community development.

Objectives

As a strategy to alleviate poverty and malnutrition in the most depressed areas of the country, the programme has the following objectives:

- to improve the nutrition situation in all the identified nutritionally depressed municipalities;
- to provide effective and sustainable services for and by the community to improve their nutritional status.

Key features

The programme embodies a number of key features including the use of a set of predetermined criteria for the selection of target areas and beneficiaries as preconditions for its implementation.

- Prevalence of malnutrition: the most nutritionally depressed *barangays* in the poorest municipalities are prioritized for LAKASS implementation. Within these *barangays*, families most at risk of malnutrition are selected as programme beneficiaries.
- Programmes and projects, designed to prevent and treat malnutrition and promote good nutrition, are identified, implemented and managed by the community with government agencies and NGOs extending technical, financial, or material assistance.
- Communities are mobilized and empowered to build and sustain their capabilities to improve their own nutrition situation.

Programme history

The LAKASS Programme was initially implemented in 125 of the most nutritionally depressed municipalities of the country in 1989, as a programme component of the PPAN, which was formulated and coordinated by the NNC. The latter is the main policy-making body for nutrition and is responsible for formulating the Medium Term Philippine Food and Nutrition Plan (MTPFNP) also known as PPAN. The programme was then launched by the NNC Governing Board as a strategy to alleviate poverty and malnutrition in the depressed areas of the country.

As a backdrop, the PPAN, an integral component of the Philippine Development Plan, is the government's response to the country's malnutrition problem. The PPAN is a broad, multilevel programme concerned with such far-ranging policies and programmes as food production and supply, industry, livelihood, infrastructure, health, education, population and employment, among others. Its overall objective is to promote food security, improve the nutritional status of the population and thus improve the quality of life of Filipinos. At the same time, the NNC Governing Board recognized the urgency to address the problem of malnutrition particularly in areas that remain unserved and depressed, and the need for a package of preventive and curative services that would reach the most needy areas in the shortest possible time. Further, the NNC Governing Board envisioned a programme that incorporated the government's thrust of promoting the capabilities of communities in planning, implementing, and managing programmes and projects responsive to their needs: thus, the birth of the LAKASS Programme.

The 1992-1994 progress report on LAKASS Programme Expansion 1 records that 175 nutritionally depressed municipalities were covered since its inception in 1989. At the same time, the programme recognizes its bigger challenge in reaching a large number of nutritionally depressed municipalities. Anchored on a rollover scheme for implementation of projects, it is envisioned that once the loaned out funds are repaid more nutritionally depressed households can benefit.

In addition, the urban LAKASS was implemented in 1990 to improve the nutrition situation in the depressed areas in Metro Manila. It covered the following areas: the cities of Manila and Quezon, and the municipalities of Malabon, Marikina, Navotas, and Pateros. From each of these cities and municipalities, the two most depressed *barangays* were selected as initial project sites of the programme.

The programme reports improvements in nutritional status among the children in the coverage areas, and in the economic conditions of the family beneficiaries. Specifically, there was a significant decrease in the prevalence of underweight, stunting, and wasting by 16 percent, 21 percent, and 16 percent, respectively. The improvement in economic conditions of family beneficiaries relate to the increase in their annual income by 3 percent, and the improved diversity of foods consumed.

Overall programme structure

As a component of the PPAN, the LAKASS Programme utilizes the existing structure of the PPAN (see Appendix). In this structure, the NNC Governing Board is the country's highest policy-making body on nutrition. It is composed of ten national government agencies and three private sector representatives, with the Secretary of Agriculture as chairman. Similar interagency structures called local nutrition committees operate at subnational levels. At the regional level, the Regional Nutrition Committee (RNC) is usually chaired by the regional director of a national government agency. However, the local chief executive chairs the provincial, city, municipal, or *barangay* nutrition committee. Even prior to the LAKASS Programme, local chief executives have served as chairpersons of local nutrition committees. They assume a lead role in planning, organizing, implementing, and monitoring their local nutrition programmes.

The NNC Governing Board sets policies and guidelines for the implementation of the LAKASS Programme. The NNC secretariat provides technical support to the NNC Governing Board. It also attends to the day-to-day operations of the LAKASS Programme at the national level. It likewise provides technical assistance on nutrition programme management to local nutrition committees, primarily through its Regional Nutrition Programme Coordinators. The RNCs and the Provincial Nutrition Committees (PNCs) provide technical assistance and supervise programme implementation at regional and provincial levels, respectively. The City/Municipal Nutrition Committee (MNC) manages the municipal or city nutrition programme. These are the people who provide the most direct assistance and supervise the programme implementation at *barangay* level.

Funding

The GoP through the Department of Agriculture funds LAKASS. Each municipality is provided with seed money of about P 230,000 for viable and sustainable projects. This amount supplements the available resources of the community, as well as those of government and non-governmental organizations. In this context, the general funding scheme of the programme is viewed as a means of channelling additional resources more quickly and effectively to nutritionally needy groups.

During the period 1992-1994, the National Agricultural and Fishery Council of the Department of Agriculture allocated a total of P 15 million, of which P 14.96 million has been released to the NNC. Fifty percent of this was earmarked to fund projects in 42 nutritionally depressed municipalities and their priority *barangays.* Funds were sourced through the Republic of Philippines-Japan Increased Food Production Programme.

C: PROGRAMME IMPLEMENTATION

Core implementation structure

The core of programme implementation is at the municipal and *barangay* levels. At the municipal level, the MNC directs and manages the implementation of the LAKASS Programme. It reviews project proposals for LAKASS funding and packages these into the municipal LAKASS proposal for submission to the NNC. The MNC also generates additional funds for LAKASS projects. It likewise assists *barangays* in implementing LAKASS projects. Thus, the municipal mayor, as chairman of the MNC, is accountable to the NNC for the full implementation of the programme. At the *barangay* level, LAKASS projects are implemented and managed by community-based organizations or LAKASS core groups, with the guidance of the Barangay Nutrition Committee (BNC). Provincial and municipal LAKASS officers, hired or designated by the governor or mayor, attend to the day-to-day operations of the programme at their respective levels.

Components of programme implementation

Social mobilization

The programme, being an area-based nutrition action programme, requires mobilization of people and communities, to bring together as many individuals and groups as possible whose capabilities and resources can be harnessed in order to improve the nutritional status of the population. The strategies and activities of this component at various levels are as follows:

National level

- conduct regular or special meetings of the NNC Governing Board and the Technical Committee to continuously update on LAKASS Programme;
- prepare a mass information campaign for the general public and target beneficiaries;
- conduct regular consultative meetings and conferences with Nutrition Programme Coordinators, with Provincial/Municipal Nutrition Action Officers, with Provincial/Municipal LAKASS Officers, and with local government executives;
- conduct briefings and regular meetings with State colleges and universities who will act as external evaluators;
- circularize programme developments and expectations from Regional Offices;
- conduct training and continuing education for Provincial/Municipal LAKASS Officers.

Regional level

- conduct regular briefings and orientation of the Regional Development Council on the PPAN and the LAKASS Programme in order to solicit its endorsement and support;
- conduct regular meetings of the RNC and of the Regional Technical Working Group;
- circularize RNC member agencies' roles and commitment;
- active participation in the Social Development Committee and other committees of the Regional Development Council;
- revitalize and organize nutrition committees in LAKASS areas;
- creation of a core group within the RNC to monitor and evaluate LAKASS;
- conduct training for Provincial and Municipal LAKASS Officers;
- prepare a mass information, education and communication campaign for the programme;
- conduct consultative meetings for local chief executives on the LAKASS.

Provincial level

- conduct regular PNC meetings and provide feedback to member agencies on the local food and nutrition programme and on LAKASS;
- advocacy with members of the *Sangguniang Panlalawigan* [49] to approve funds for the nutrition programme and LAKASS projects;
- revitalization or organization of MNCs and BNCs;
- creation of core group within the PNC to monitor and evaluate LAKASS implementation;
- circulate information on agency roles and commitments;
- conduct consultative meetings with Municipal Nutrition Action Officers and Municipal LAKASS Officers;
- develop and disseminate indigenous information, education and communication materials.

Municipal level

- revitalization or organization of BNCs with active membership of NGOs;
- development and packaging of indigenous information, education and communication materials;
- conduct regular MNC meetings and provide feedback on programme implementation;

[49] *Sangguniang Panlalawigan* = Provincial Council.

- creation of a core group within the MNC to monitor and evaluate LAKASS implementation;
- advocacy with members of the *Sangguniang Bayan* (Municipal Council) [50] to allocate funds for the nutrition programme and LAKASS project;
- conduct regular community assemblies at all stages of programme implementation;
- conduct training and continuing education;
- harnessing support and participation of NGOs;
- clearly define roles and commitments.

Barangay level

- revitalize or organize *barangay* networks (with NGOs and recognized leaders);
- develop indigenous information, education and communication materials;
- conduct community assemblies, dialogues and other informal discussions to generate mass support and participation for the programme;
- conduct regular meetings of the BNC and the Barangay Development Council;
- conduct reinforcement training and consultative meetings;
- conduct regular monitoring activities.

Training

This component views people as the key factor in the success of the programme. As such, the conduct of training aimed at providing participants with necessary knowledge, skills and attitudes on various topics depending on identified training needs are as follows:

National level

- planning, implementing, managing and supervising development-oriented nutrition action programmes and projects;
- managing *barangay* level training on nutrition programme management.

Municipal level

- planning, implementing, managing and supervising municipal and *barangay* development-oriented nutrition action programmes;
- managing *barangay* level training on nutrition programme management;
- project development and packaging of proposals.

[50] Editor's note: The *Sangguniang Bayan* is composed of the Municipal Vice-Mayor as Presiding Officer and eight (8) regular *Sanggunian* members. It serves as the legislative arm of the municipal government. The body enacts ordinances and lays down policies and programmes for the upliftment of the community. Sources: www.sanmateorizal.net/sb.htm www.buhi.com/buhi/government/sbayan.htm

Barangay level

- planning, implementing, and managing community-based and development-oriented nutrition action projects
- project preparation and management.

Planning

Formulation of nutrition action programmes has been an institutionalized activity of local nutrition committees. The nutrition action plan serves as the key document and basis for the integration of nutrition considerations into the local development plans. It also serves as the working document and guide for field implementers and for monitoring and evaluation. The planning activity is initiated by the Municipal Mayor as Chairman of the MNC, while the municipal nutrition action officer coordinates the activity.

Project preparation, appraisal, and implementation

The provision of funding support to local government units is intended only to supplement the municipality's existing resources. It may be used for the implementation of new projects identified by the community as well as ongoing intervention activities of the local Food and Nutrition Programme.

The preparation, appraisal and implementation of projects for funding under the LAKASS Programme are guided by the following:

- selection of priority *barangays* for project implementation;
- first five depressed *barangays* identified during the municipal planning activity with an organized Barangay Development Council;
- selection of project for funding;
- proposed project addresses an identified problem;
- community selects the projects under the supervision and guidance of the MNC;
- criteria are applied to select appropriate interventions: relevance, feasibility, integration with similar existing programmes, effectiveness, ease in targeting and evaluation, cost-effectiveness and likelihood of becoming a long-term ongoing programme;
- project funds of up to P 230,000 per municipality can be used to fund projects identified by the community; of this, at least 80 percent is allocated for productive projects and a maximum of 20 percent for consumption projects; productive projects are those which are revenue-generating and transferable through a rollover or repayment mechanism; consumption projects are those that are direct, non-transferable and non-revenue generating activities.

The NNC, through the Nutrition Programme Coordinator and the PNC, releases the LAKASS project funds in the form of cash advance to the Municipal/City Mayor in his/her capacity as chairperson of the MNC. The participating Governors and Mayors are responsible for the monitoring of all project funds to the NNC. The Nutrition Programme Coordinator assists the local chief executives and ensures the proper disbursement of project funds.

Monitoring and evaluation

The project components of the LAKASS programme are monitored and evaluated to determine the following: (1) extent of project implementation relative to the approved project plan; (2) status of fund utilization; (3) problem and difficulties encountered during project implementation; (4) beneficial effects for the project beneficiaries and the community.

Organization and management

Decentralization was implemented in 1992. While the LAKASS Programme is a national programme, its concepts, approaches, and main features reflect the decentralization process. A feature of decentralization is the strengthened networking of line agencies at the local level. Member agencies of the NNC are represented at the local level team as members of various nutrition committees together with the representatives of various line agencies.

At the national level, the ten member agencies from the government sector are as follows:

1. Department of Agriculture, which assumes the Chairmanship of the Council
2. Department of Health
3. Department of Social Welfare and Development
4. Department of Education, Culture and Sports
5. Department of Interior and Local Government
6. Department of Science and Technology
7. National Economic and Development Authority
8. Department of Labour and Employment
9. Department of Trade and Industry
10. Department of Budget and Management

The private sector agencies represented in the Council are: Nutrition Centre of the Philippines, Philippine Business for Social Progress and the Rural Improvement Club. LAKASS utilizes existing intersectoral organizational structures (specifically the development council and nutrition committees) at various administrative levels, namely: regional, provincial, municipal or city and village or *barangay*.

D: MACROCONTEXTUAL FACTORS

Actors and sequences

A historical perspective of the development and implementation of LAKASS as a government initiated strategy to address the prevalent and persistent problem of malnutrition in the Philippines is indeed very complex.

Coordination has been a key feature of LAKASS's success. Good coordination is essential in the LAKASS Programme because most activities are budgeted for and implemented by independent groups. In fact, coordination seems to require an almost continuous process of coalition building.

Policy environment

The country is at a stage where popular participation is strongly promoted, in line with the 1991 Local Government Code. Under this law, local government units are recognized as individual and independent corporate entities, responsible for the delivery of basic services which include those of nutrition. Also, making sure that nutrition concerns are integral to local development plans and programmes has become an important challenge to address. Likewise, the prevailing policy environment in rural development and poverty alleviation is generally supportive of the goals of the LAKASS Programme. However, it would be naïve to claim at this point that nutrition is a priority concern at the different government levels in spite of the heightened awareness that the programme has generated.

The concerns of the programme, namely poverty and nutrition, are universally articulated such that they transcend movements in administration and organization. Nevertheless, it is important that decisions are reaffirmed or altered with each new budget passed or leader installed, or new structures of potential cooperation are installed to enlarge and deepen the scope of LAKASS.

E: COMMUNITY PARTICIPATION

While the programme appears to have drawn clear-cut components and procedures, there exist considerable variations between and among municipalities, and even within them. Considering the range of possibilities that come with the 'community-based' nature of the programme, examining manifestations leaves no room for rigid comparisons. Thus, the programme cuts across the range in levels of community participation. However, functional and interactive participation seem to be the dominant levels regardless of actual details at project levels.

Many of the differences in programme implementation lie in the kind of participation that it receives at the community level, not to mention the range of alternative modes for solving different or same types of problems. The programme is broad enough that it attracts and involves most of the groups in the community. It encompasses a range of

issues that appeal to the many interest groups that constitute the community. The structures and procedures described earlier inevitably draw in many people to take part in the joint decisions and actions of the programme or its projects. The leaders and members realize that their purpose is to build a strong network that can be a capable partner with government and the private sector in the community's development efforts and that can mobilize resources for real self-help projects. Participants are able to identify their problems on their own and plan out their course of action. Leaders emerge from the community, because of their proven ability to help and serve the people.

The kind of participation observed in LAKASS, encompasses the following: people's involvement in decision-making processes, involvement in implementing projects and decisions by contributing various resources or cooperating in specific activities, sharing in the benefits of development projects and involvement in efforts to evaluate such projects.

Following the structure of the programme, community participation cuts across the following groups: local residents, local leaders, government, and private personnel. It is often difficult for local people to participate as a group in decision-making, thus the emergence of local leaders. What distinguishes them from other local people is their role as acknowledged spokespersons for the community or group. Sometimes, it is difficult to distinguish them from government personnel as they may be appointed by the government or even receive some remuneration. What sets them apart is that they are not civil servants or bureaucrats.

F: SUSTAINABILITY

Analysis of the elements needed for ensuring sustainability such as administrative capability at various operational levels and management processes involved in the implementation of LAKASS show that there is sufficient evidence to conclude that the programme has a good if not excellent chance of sustainability.

Management resources (social mobilization, training, leadership, implementing structure and support) and management processes (planning, implementation, monitoring, and evaluation) are all embedded in the programme's features and strategies. The regular feedback or monitoring and evaluation which is a feature of LAKASS allows programmatic adjustments from time to time or troubleshooting to address weaknesses and constraints in programme implementation.

The implementing structure of LAKASS closely adheres to the decentralized, and organizational framework of the national food and nutrition programme making it more workable. With a largely democratic and consultative leadership coupled with clear delineation of roles and responsibilities of various line sectoral agencies, integration and coordination is achieved through a shared view of the goals and objectives of LAKASS. Moreover, while most municipal and *barangay* governments are unable to provide funding for loans, they have provided counterpart funds for the salaries of employees or incentives for overseers of the LAKASS programme.

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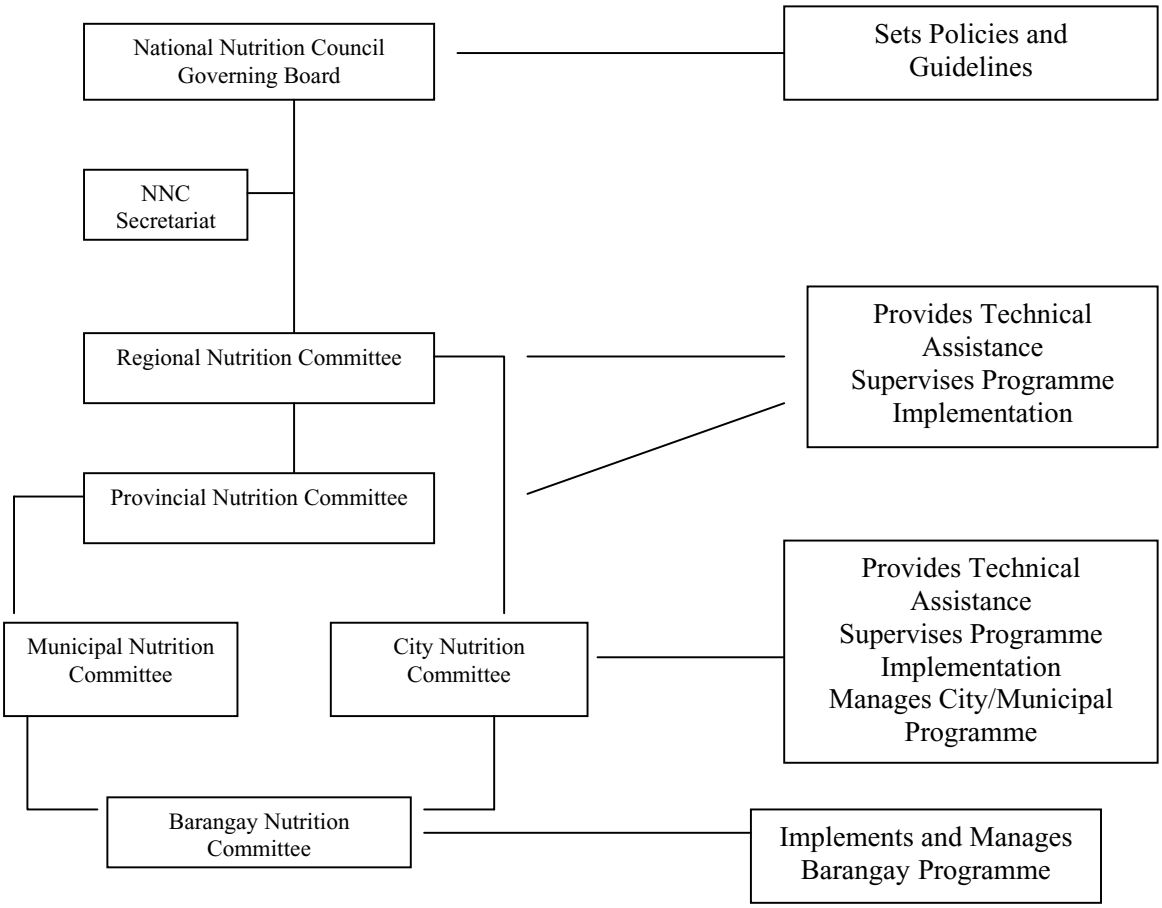
Appendix

Structure for implementing LAKASS



ANNEX 3 (C)

SRI LANKA CASE STUDY

SAMURDHI PROGRAMME

Sri Lanka Case Study

Contents

SAMURDHI PROGRAMME

SUMMARY

Coverage

In 1994, the Samurdhi (or Prosperity) Programme was launched by the newly elected Sri Lankan Government as a national strategy to alleviate poverty, and the Samurdhi Ministry was established. The present government is likewise committed to the ideals and goals of the programme and plans to further intensify and improve the approach based on its initial experiences are under way.

This programme covers one-third of the entire population of Sri Lanka, about 1.2 million poor families. It is funded in its entirety by the Government of Sri Lanka.

Objectives of the programme

The main thrust of the Samurdhi Programme is poverty reduction by ensuring participation of the poor in the production process. Implicit in the strategy is the enhancement of the health and nutritional status of the poor.

The stated main objectives of the programme are as follows:

- broadening opportunities for income enhancement and employment;
- organizing youth, women and other disadvantaged sections of the population into small groups and encouraging them to participate in decision-making activities and developmental processes at the grassroots level;
- assisting persons to develop their latent talents and strengthening their asset bases through productive employment;
- establishing and maintaining productive assets to create additional wage employment opportunities at the rural level.

Programme impact

Based on the programme design, the key components of the Samurdhi include compulsory and voluntary savings, human resource development (productivity development training, training in accounting functions, training of executive committees and material resource development), establishment of Samurdhi Bank societies (responsible for the provision of credit), a community development programme, labour-intensive peoples' projects, small industries development and social development programmes. Thus, as part of its monitoring and evaluation, programme impact was assessed using output indicators for each of the above-mentioned components:

- Compulsory and voluntary savings – from 1996 to June 2000, there was a decrease in the total number of families participating in compulsory savings. However, the cumulative savings increased almost four-fold during the period (1.517 million rupees to 5.893 million rupees). On the other hand, those who made voluntary savings increased from 116,565 in 1997 to 366,234 in 2000, resulting in a doubling of accumulated savings.
- A total of 905 Samurdhi Bank societies were established throughout the country with a total membership of 1,427,322 families. Of these members, 322,984 accessed loans valued at 1.685 million rupees.
- The programme also documented a number of achievements in terms of training activities conducted. Training topics varied according to the clientele. At the beneficiary level, the topics focused on skills development and entrepreneurship allowing them to undertake agricultural, fisheries, animal husbandry and small industry projects. For Samurdhi workers, training topics dealt mostly with how to develop managerial skills.
- Necessary infrastructure as part of a community development programme was also provided. This included construction of irrigation canals, dams, fairs and other marketing centres. For social development programmes, activities focused on efforts to curb drug abuse, illiteracy and gender inequality. Child care and preschool education programmes were also implemented.

The programme can be commended for a number of notable achievements. However, no information was available to enable assessment of the social, health and nutrition impacts.

Community participation

Samurdhi as a programme is premised on participatory development principles. By design, all aspects of decision-making centre around the *balakaya* (village)[51] and cluster levels where the programme is planned and implemented by the organizations set-up for this purpose.

With the help of Samurdhi animators, economic development activities based on specific family needs, skills, assets and other abilities of participating families, were identified. Families were encouraged to engage in developmental activities of their own choice from planning to monitoring of the programme implementation. However, after six years of implementation, communities vary substantially in the level of community participation. Participation of targeted households is equally variable. Broadly community participation ranges from the low level of passive participation to the higher levels of functional and interactive participation.

[51] Editor's note: *balakaya* is a group. In Sanskrit, bala means strength.

Lessons learned

- The poor are not always able to fully participate in the regular services provided by the Government.
- Specifically targeted programmes with a strong social mobilization component are needed to empower the poor.
- Social mobilization, which builds on the creation and strengthening of awareness and confidence can be an effective means for generating interest and involvement of the poor.
- It is possible to alleviate poverty using a targeted poverty reduction programme.
- People's participation in planning, implementation and monitoring is essential for sustainable poverty alleviation programmes.
- A well-structured and organized network of programme implementers from national to the village level is necessary for effective implementation of the national programme.
- Convergence of various government services in one area leads to more effective and efficient implementation.
- Government ownership translates to provision of funds. Samurdhi is a programme fully financed by the Sri Lankan government.
- Training of various programme functionaries for human resource development is an integral component of a poverty alleviation programme.
- Strong village-based organizations can facilitate as well as ensure people's participation.
- Programmes based on felt needs are likely to be more successful

Strengths, weaknesses, opportunities, constraints/threats (SWOC)

Strengths

- The scheme guarantees the ultra poor at least 10 percent of their food requirements.
- Targeted families are encouraged to engage in productive activities based on a careful assessment of their capabilities and access to locally available resources.
- Strong established linkages with training institutions providing skills training.
- Programme ownership by the government as demonstrated by its full funding support to bear all the costs of training, provision of incentives to Samurdhi workers, seed capital for loans, infrastructure development and other social welfare components of the programme.

- Community ownership facilitated through the compulsory and voluntary savings scheme.
- Strong involvement of community leaders, workers and targeted families in decision-making, particularly in project identification, targeting and monitoring.
- Initiatives taken by communities are matched with government schemes through provision of technical, managerial and financial resources by various government sectors
- Availability of entry criteria for targeting of family beneficiaries.
- Indigenous workers are employed as Samurdhi Programme functionaries.

Weaknesses

- The longstanding welfare approach adopted by the government has led to a chronic dependency of the people on the State.
- Government officials and politicians are reluctant to adopt approaches other than a welfare approach for fear of political repercussions.
- The welfare approach destroys the capacity of families to explore other indigenous coping mechanisms.
- Despite the availability of screening criteria, they may in some cases not be enforced leading to politically motivated selection of families as well as communities.
- The difficulty of linking the programme with other developmental activities, particularly those implemented by non-governmental organizations.
- In some areas there is compartmentalization of services rather than convergence.
- Lack of marketing facilities for products of income generating enterprises.
- For the ultra poor, financial support provided by the government is barely sufficient to meet subsistence requirements and thus cannot be used for productive purposes.

Opportunities

- the increased commitment of the present government to sustain and strengthen implementation of Samurdhi;
- the recognition of the need to adopt a multidisciplinary approach to address poverty (but greater efforts are needed to operationalize the approach);
- linkages with other successful government programmes such as the Participatory Nutrition Improvement Programme (implemented by the Ministry of Plan Implementation and Parliamentary Affairs with technical and financial support from UNICEF);
- better coordination with various government sectors towards an authentic multisectoral, integrated and holistic strategy;

- with the government's recognition of the importance of nutrition, the time to promote the issue of nutrition is opportune;
- improve entry criteria and establish exit criteria.

Constraints/threats

- political instability;
- armed conflict with the Tamil Tigers restricts the implementation of the programme;
- political interference in selection of beneficiaries;
- lack of political will to change from a welfare to a developmental approach.

Sustainability

The programme has already demonstrated its sustainability with funding support provided solely by the Sri Lankan Government. It is a well-established programme with strong support structures from national to village levels, foremost of which is the Samurdhi Bank, which on a continuous basis, extends loans to individuals or groups. Communities have been empowered to seek whatever technical assistance they may need. The macropolicy environment is also supportive of Samurdhi.

A: NATIONAL CONTEXT

Sri Lanka is an island country in the Indian Ocean, covering an area of 65,610 sq km. Its land is generally flat except for a mountainous area in the central regions. It has three agricultural zones: dry, wet, and intermediate zones brought about by two monsoon seasons occurring in the period of June to August (southwest monsoon) and November to January (northeast monsoon). Environmental concerns in the country include soil erosion, deforestation and air pollution.

In 1999, Sri Lanka recorded a mid-year population estimate of 19 million, which makes it one of the most populated countries in the world. The country has a population growth of 1.4 percent and a population density of 304 persons per sq km. Approximately 70 percent live in the rural areas while the rest are in urban areas and on estates.

Sri Lanka is a multiethnic society composed mainly of the Sinhala, Tamils, and Moors. The Sinhala represent the largest ethnic group, about 74 percent of the population. The people are also of different religions: most (about 69 percent) are Buddhists, others are Hindus, Christians, and Muslims.

Before independence in 1972, Sri Lanka's economy was mainly dependent on agriculture, but as economic liberalization progressed, dependence on agriculture declined. The manufacturing and service sectors led the improvement of the economy. The external trade sector also benefited from liberalization and, at the same time, contributed significantly to economic recovery. In 1996, the country's economic resilience was seen: it achieved a growth rate of close to 4 percent despite experiencing the worst drought in the country's history.

The country's population below the poverty line declined with the gradual rise in the per capita GNP. Despite this, poverty remains a serious problem. The country still faces a range of economic problems, particularly unemployment and poverty. The number of poor families, which represented 19 percent of the population during the period 1978-1979, rose to 27 percent during 1986-1987. However, the proportion classified as low income declined from 40 percent in 1993 to 14.8 percent in 1997.

Deep concerns about the need to alleviate poverty and unemployment continue. The problem is compounded by the difficulty of distinguishing between and characterizing the unemployed, underemployed, and poverty stricken groups in the society. It was observed that many of the unemployed were not poor. Likewise, the poor may also be found among the employed. But in general, most of the poor are engaged in activities providing low marginal productivity. Thus, most of them do not receive sufficient income to meet their basic needs.

Just like other countries in Asia, Sri Lanka is still facing widespread health and nutrition problems. Malnutrition is prevalent among preschool children. The Demographic and Health Survey (Sri Lanka, DHS 2000) showed that in 2000, nearly 14 percent of the preschoolers were stunted with the 4-5 month old babies most affected. The highest

prevalence was found in preschoolers living on the estates while the lowest was observed in the urban areas. In the same survey, it was reported that about 14 percent of preschoolers are wasted. Children aged between 12-23 months were most affected. The highest percentage (16 percent) of affected children was found in the rural areas while the lowest (6 percent) in the Colombo metropolitan area.

Five years before the survey, 17 percent of children were born with low birth weight, with the prevalence of low birth weight highest in the estate sector. Child mortality, on the other hand, has declined. The proportion of children surviving has risen from 94.8 percent to 95.2 percent in 1993.

Micronutrient deficiencies strike both children and women in Sri Lanka. No statistics were reported in the DHS 2000, however other surveys showed that deficiencies in iron, iodine, and vitamin A are the most damaging forms of micronutrient deficiencies. In 1999, FAO reported that the prevalence of anaemia was 40 percent among pregnant women and 45 percent among children under five years of age (FAO/RAP Working Paper, 1999). The prevalence of iodine disorders in schoolchildren was 18 percent, while for vitamin A deficiency in preschool children it was 0.6 percent.

The health system in Sri Lanka has a well-established network for delivering both preventive and curative services in the country. Public health services focus on family health, particularly maternal and child care. Antenatal care and assistance at delivery are provided to pregnant women. The DHS 2000 stated that 98 percent of women in the country received antenatal care, and 97 percent of women who had live births five years prior to the survey were assisted during delivery by trained personnel. Tetanus toxoid vaccination was routinely administered to pregnant women.

Information on children's health and development is monitored through the Child Health Development Record, issued by the health authorities at the time of birth. The record includes the vaccinations received and other information regarding the child's development. Universal BCG vaccination was achieved in 1993, while complete DPT immunization coverage was 87 percent in 1993 and for polio and measles, it stood at 86 percent and 80 percent, respectively.

In Sri Lanka, 51 percent of children are exclusively breastfed only during the first four months of their lives. The highest proportion is seen in the rural areas (53 percent) and the lowest on the estates (37 percent). Mean breastfeeding duration is 25.6 months. The promotion of exclusive breastfeeding in the first four months may have been one of the reasons for a decrease in the cases of diarrhoea in infants below six months.

With regard to other health indicators, three out of every four households in Sri Lanka have access to safe drinking water. Piped water is the main source of water in the urban area. In the rural areas, protected and unprotected wells are the main sources of water, while on the estates, drinking water is obtained from rivers, tanks, and streams. Of those surveyed 73 percent claim to have access to sanitary facilities. However, when disaggregated by location, the estates and Metro Colombo have the highest proportion of households with access to adequate sanitation.

B: PROGRAMME DESCRIPTION

Samurdhi, derived from a local term meaning prosperity, is a national programme launched by the new government in 1994, and is intended to alleviate poverty and unemployment among the youth. Its characteristic feature is entrusting leadership to younger men and women and encouraging them to have direct participation in the activities.

The main thrust of Samurdhi is to ensure the participation of the poor in the production process by increasing access to resources for self-employment, enhancing their health and nutritional status as well as improving rural infrastructure. Also, it attempts to enhance the capacity of the poor to take initiatives to improve the quality of life of the family through sustained provision of technical, managerial and financial support based on a consultative process. The main objectives of the Programme are as follows:

- broadening opportunities for income enhancement and employment;
- organizing youth, women, and other disadvantaged segments into small groups and encouraging them to participate in decision-making activities and developmental processes at the grassroots level;
- assisting persons to develop their talents and strengthening their asset bases through productive employment;
- establishing and maintaining productive assets to create additional wage employment opportunities at the rural level.

These objectives are translated into activities that involve people in development by exposing them to the empowerment process. Thus, the programme encompasses several important actions:

- assessing the community situation and adopting approaches to encourage participation in activities beneficial to the target beneficiary community;
- creating an atmosphere conducive to group formation and identification of leaders;
- encouraging group savings, intragroup and revolving fund-based lending, maintenance of simple accounts and generation of report savings and credit at the group level;
- formulation of feasibility studies and project reports on income-generating enterprises.

Groups at various levels are created by the programme to mobilize and encourage participation. The main components of Samurdhi are welfare, savings and credit programmes, and training and social development programmes as integral support activities. Several action groups are organized in each *balakaya* (i.e. village). One form is the five-member group, which is organized to consolidate and hone the member's skills and abilities. Another is the Samurdhi task force consisting of young men and women aged 18-35 years who contribute to providing the necessary infrastructure to villages under the Community Development Project. Advisory councils are also formed to provide guidance and advice to the task forces. Councils are comprised of intellectuals, elders, and

clergy residents in the area. Moreover, two types of committees are also organized, the divisional and the district Samurdhi committees. The first is responsible for the implementation of Samurdhi within the division. The Divisional Secretary is the chairman and all public officers and heads of government establishments are its members. The District Samurdhi Committee is comprised of all the heads of government establishments located in the district. Another group is the *maha sangam* [52], which is set up to cover 10,000 beneficiary families. It is administered by an executive committee comprised of 21 members, selected among the presidents of Samurdhi societies. *Maha sangam* is responsible for the coordination of all activities in the area of authority.

In 1998, the Samurdhi Programme covered one-third of Sri Lanka's entire population, approximately 1,200,000 families estimated to be at the bottom of the income scale. About 100,000 of these families belong to the poorest of the poor category, and earn a monthly income of about Rs 700 while the remaining 1,100,000 families were estimated to earn an average of Rs 1,200. Through the Samurdhi welfare programme, each family income is increased to Rs 1,700 through direct income transfers, respectively. A family exits the programme if its income has exceeded Rs 2,000 per month for a continuous period of six months, or when at least one member of the family finds employment. As beneficiaries exit, new entrants are recruited. In 2000, the Samurdhi Authority of Sri Lanka reported that the welfare programme had already covered 21 administrative districts with 1,982,017 family beneficiaries. Families with a monthly income below Rs 1,000 are eligible for relief ranging from Rs 100 to Rs 1000[53].

In the savings and credit programme, poor households can choose to be borrowers (in groups) or savers. Compulsory savings of Rs 100 and Rs 200 per month from the savers accumulate in a group savings account at a selected State bank, and the interest is paid to the saver.

A Samurdhi *niyamaka* (SN) mobilizer [54] is tasked to define a target group of 45 to 50 households based on the survey they conducted. They are also required to initiate voluntary savings of Rs 25 per month aside from the Rs 100 and 200 compulsory monthly savings. At the end of the year, the SN mobilizer allows the households identify an income generating project. Loans for these projects can be accessed by individual participants on the basis of the collective guarantee of the group of five (each group is expected to employ a system of "sticks and carrots", to ensure repayment). Small individual loans ranging from Rs 2,000 to 10,000 can be obtained when the first loan is repaid within 12 months and when that loan is of a higher value. Lending under Samurdhi follows established lending practices of successful non-governmental organizations. Samurdhi savings and credit societies joined established state banking institutions, such as the People's Bank and Bank of Ceylon, to deposit the group's savings fund. From these banks, loans can be accessed, initially drawing from the group's savings and from other funding sources.

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52 Editor's note: *maha sangam* is a group of people working together for a common goal.

53 The range was revised to Rs 125 – Rs 1000 in the year 2000.

54 The *niyamaka* mobilizer coordinates or handles activities and is responsible for conducting such activities.

C: PROGRAMME IMPLEMENTATION

Samurdhi is based on participatory development principles. All aspects of decision-making are centred in the *balakaya* and cluster levels, where designated organizations plan and implement programmes under the Samurdhi. The Samurdhi Programme coordinates all programmes implemented by various government and non-government agencies at the village level while reducing unnecessary overlap.

The Samurdhi *balakaya*, also called the Samurdhi Task Force, is the grassroots level organization formed to implement the Samurdhi Programme. It is comprised of all youths in the village aged 18 to 35 years, and has an elected Executive Committee of seven persons, two animators, and seven other members representing government and non-government agencies engaged in youth, sports, and rural activities in the village. An advisory council whose members are appointed from non-youth residents provides advice and assistance to the Task Force.

The two animators or Samurdhi *niyamakas* (SNs) work full time and are trained to conduct surveys in the village using a structured questionnaire. The SN conducts family profile surveys, particularly about the socio-economic conditions of all the families in the village, to ascertain the income level of each family and identify beneficiaries for the welfare component of Samurdhi.

The Samurdhi Task Force is entrusted to undertake five clearly defined areas of activities:

- conduct family profile surveys to determine the number of families in need of welfare;
- identify community projects that will address the economic and social needs of the village and provide employment opportunities on a casual basis;
- form small groups of beneficiaries who will then be encouraged to participate in small savings and credit activities in the village;
- encourage and assist persons to undertake self-employment projects;
- implement nutrition, health and other relevant programmes.

A simple self-monitoring mechanism at the household level and a more complete data reporting system were designed for the programme to monitor the progress of household activities. This monitoring and evaluation scheme includes assessing the programme's impact through indicators of its key components which include compulsory and voluntary savings, human resource development (productivity development training, training in accounting functions, training of the executive committee and material resource development), establishment of Samurdhi Bank societies, the community development programme, labour-intensive people's projects, small industries development and social development programmes. The results are as follows:

- There was a decrease in the total number of families participating in the compulsory savings scheme from 1996 to June 2000. However, the cumulative savings increased almost fourfold during the period (1.517 million rupees to 5.893). On the other hand, those who made voluntary savings increased from 116,565 in 1997 to 366,234 in 2000, resulting in a doubling of the accumulated savings.
- A total of 905 Samurdhi Bank societies were established throughout the country. Out of 1,427,322 member families 322,984 accessed loans valued at 1.685 million rupees.
- The programme documented achievements in the different training activities conducted. At the beneficiary level topics included skills development and entrepreneurship, assisting them to undertake agricultural, fisheries and animal husbandry and small industry programmes. For Samurdhi workers, topics included development of managerial skills.
- Necessary infrastructure as part of a community development programme was also provided. This included the construction of irrigation canals, dams and markets. For social development programmes, activities addressed drug abuse, illiteracy and gender inequality. Child care and preschool education programmes were implemented.

D: MACROCONTEXTUAL FACTORS

Sri Lanka is one of the first developing countries to opt for economic liberalization (in 1977). However, it has not reaped the full benefits of global integration owing to lack of proper budgetary planning and weak macroeconomic conditions arising from successive high budget deficits. Initial reforms of removing trade and exchange controls and raising public investments failed to encourage private investments to improve the competitiveness of domestic industry and agriculture. It also failed to improve the education system sufficiently to meet the needs of the private sector. Broadly, economic fundamentals and development priorities were overlooked. Recognizing this, the new government in 1994 decided to address these issues as well as structural constraints in a planned policy framework with a clear strategy.

Underpinning this strategy is the targeting of priority sectors for incentives, tackling large scale corruption and waste, attracting long-term investments, reducing barriers to global trade, maintaining a flexible exchange rate policy, and widening financial and capital markets. A social safety net was established to protect sections of society vulnerable to the accelerated transformation. Sector specific policy strategies were promoted to hasten the development of agriculture, industry, services and vital infrastructure. Agricultural sector policies were also created to increase productivity and agricultural income, at the same time reducing costs to consumers. These policies also aimed to develop the quality of research and extension support and ensure the availability of seeds, materials and financial assistance in the form of loans. Among other priorities were the improvement of rural infrastructure, storage and marketing facilities and providing agricultural lands to both private and public sectors.

As early as 1940, the food ration system was adopted by the Government of Sri Lanka to assure the availability of a minimum quantity of food to households. Such a system is still used though with some modifications. Food subsidies and food stamps contributed much to improved food security in the country. The Janasaviya, Midday Meal and the Food Stamp Programmes were among those that offered such interventions. However, when the Samurdhi Programme was introduced, these three programmes were discontinued.

Nutrition programmes and activities are implemented by the Ministry of Plan Implementation and Parliamentary Affairs (MPIPA) through the National Nutrition Coordinating Committee (NNCC), chaired by the Secretary of MPIPA. NNCC became a venue for representatives of relevant agencies to discuss nutrition and the causes of malnutrition in Sri Lanka. After the International Conference on Nutrition (1992), a multisectoral National Nutrition Plan of Action (NNPA) was prepared by various sectors under the overall coordination of MPIPA. Officials from different ministries and UN agencies were involved from preparation to full development. The plan has already been reviewed, discussed and amended at two national workshops held in 1995. However, owing to institutional problems, finalization of the plan for submission to the Cabinet was delayed. In 1998, a subcommittee reviewed and updated the NNPA. Further, the President appointed a Committee on National Nutrition and Food Security, to prepare action plans for key sectors. When action plans are submitted, finalization of the NNPA will follow.

MPIPA is also in charge of reviewing and monitoring the following UNICEF-assisted nutrition activities and, to a certain extent, in programme development:

- nutrition education
- participatory nutrition improvement project
- micronutrient deficiency control
- promotion of breastfeeding
- hygiene education.

MPIPA also created several subcommittees to coordinate and supervise other nutrition activities, such as the Iodine Deficiency Control Programme and the Sri Lanka Breastfeeding Code. MPIPA is also responsible for monitoring the progress of national food security especially among the poor and other nutritionally vulnerable groups.

E: COMMUNITY PARTICIPATION

The Samurdhi Programme was initiated by the Government, and hence employed a top-down approach. However, given Sri Lanka's long history of a welfare approach, and of perpetuating a culture of handouts resulting in a heavy financial burden, the government wants to use the Samurdhi as a transition programme to replace most of the welfare programmes and to promote self-reliance among the people, particularly the poor.

Social mobilization and training activities played important roles in bringing about community involvement and eventually people empowerment. As a programme anchored in participatory development principles, involvement of communities and beneficiaries in

various aspects of programme management from planning to monitoring is encouraged. With most of the activities taking place at village and cluster levels, community workers work with beneficiaries and leaders to agree on the course of action, especially the type of developmental activities the households will engage in. With the assistance of Samurdhi animators, community elections are held to select the members of the Samurdhi Task Force, which is the developmental task force of the village. Emphasis is on building people's capacities and on the use of indigenous resources. While most of the projects are predetermined by the government, deviations were later accommodated as the process of community participation was enhanced. Monitoring was actively carried out by all involved, although the system focused mainly on repayments and compulsory savings. This is understandable since future opportunities for loan availability (and its increase), relied on loan recovery by Samurdhi Banks.

F: SUSTAINABILITY

The programme has already demonstrated its sustainability. Funding is provided solely by the government. Moreover, the scheme is sustainable because of the high rate of repayment of loans, compulsory and voluntary savings, and its focus on the use of local resources This is further reinforced by group structures and participation in the selection of beneficiaries, identification of projects to be undertaken, collection of repayments and savings and monitoring.

The programme is supported by an organizational infrastructure, including the establishment of its own Ministry, whose network extends to the village level where paid Samurdhi animators function. Though the salary is minimal for almost a full-time job (seven days a week on call with two days' mandatory reporting to district level supervisors), the animators perform their roles with commitment and dedication. To most, it is an opportunity to work for the village and its most needy members.

Multisectoral involvement is also considered to be an important component to the successful implementation of the programme, although at present this is weak. Those involved, particularly at the district level, recognize that this should be pursued and encouraged. Linkages with other programmes such as nutrition and health programmes, whether implemented by government or non-governmental organizations, will likewise be established in the near future. Macropolicies in support of Samurdhi have long existed in the country since poverty alleviation always ranked high in the government's priorities.

At the local level, communities have a sense of ownership of Samurdhi and, with their active involvement in decision-making, there is room for innovation and sustaining ongoing efforts. A crucial feature of the programme that may ensure sustainability is the establishment of Samurdhi Banks, perceived as people's banks. These banks have increased their capital and investment portfolio through the years. With an easy lending scheme, beneficiaries are encouraged to save and access the banks' services.

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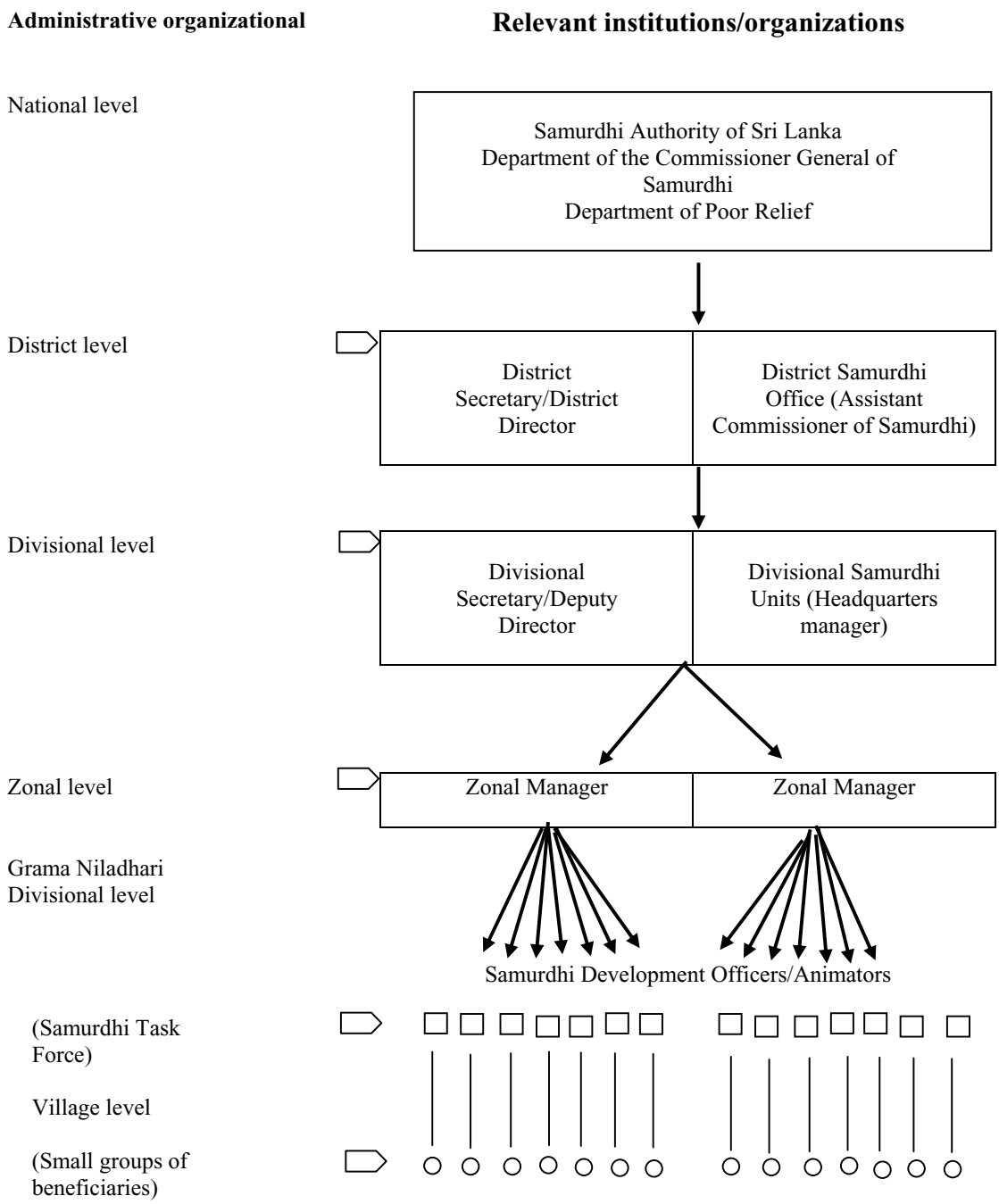
Appendix

Institutional and organizational structure for the implementation of the Samurdhi Programme



Source: Samurdhi: National Programme for Poverty Alleviation. Monitoring and Evaluation Division. Samurdhi Authority of Sri Lanka, 2000.