"WE WILL NEVER GO BACK"

Social mobilization in the Child Survival and Development Programme in the United Republic of Tanzania

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EXECUTIVE SUMMARY

This case-study focuses on the vital role played by a process that took place in an integrated nutrition and health programme aimed at child survival and development in Tanzania. Currently covering nearly half the country's children, the programme has achieved significant impact by reducing severe malnutrition in some areas from as high as 8 per cent to under 2 per cent in a relatively short period of time and, even more important, maintaining these changes. The process of engaging and helping empower a variety of actors and forces at different levels of society in sustained and concerted action around a commonly agreed-upon objective provides a model of what might be called 'sustainable mobilization'.

Mortality and malnutrition rates among under-fives and mothers in Tanzania have been high, despite a progressive government health policy. The 1970s and 1980s witnessed a disastrous economic decline characterized by scarce resources, cuts in social services, deteriorating conditions in health systems, lowered food production, lack of adequate water supply and sanitation, and high malnutrition and infection rates among children.

In 1980, the World Health Organization and UNICEF initiated joint nutrition support programmes in several countries including Tanzania, with funding from the Italian Government. The Tanzanian Government was officially committed to popular decision-making and decentralized control of resources, and had long recognized the need for an integrated and multisectoral approach to malnutrition; many Tanzanian institutions also had experience in participatory development.

The Tanzania Food and Nutrition Centre first developed a 'conceptual framework' to help identify, and to deepen analysis of, the causes at different levels of malnutrition and child death. For example, insufficient household food security and health services plus inadequate maternal and child care represent some of the underlying causes, while economic and political structures are examples of basic or root causes.

One region, Iringa, was selected to begin the programme as a pilot project. The Iringa Nutrition Programme used the conceptual framework and a three-step assessment-analysis-action process (known as the triple-A cycle) to make explicit the basis of rational decision-making and to show how action could be modified or redirected when warranted by new information or improved analysis. Used together, the conceptual framework and the triple-A cycle had a powerful effect, allowing a broad perspective both to guide information gathering and to stimulate reflection as a proper basis for action. Community-level analysis of child malnutrition showed the most immediate problems to be inadequate dietary intake and disease. This meant tackling some underlying causes by such methods as increasing feeding frequency, using energy-dense foods and reducing women's workload.

Animation, a way of facilitating group interaction and fostering empowerment, increasingly became an important tool in the programme. Trained animators helped

villagers to identify problems affecting their lives, to explore the causes and to work out practical ways to address those problems. The role of the animator is to help foster genuine dialogue among members of the group, whereby each shares his or her experience, and listens to and learns from the others. Villagers learned to propose feasible solutions that decreased dependency on outside aid and increased their self-reliance.

The results of the programme were rapid and extensive. Profound and lasting changes took place when communities and families saw for themselves what improved nutrition practice could achieve, notably a dramatic and sustained drop in rates of severe malnutrition — by as much as 77 per cent in some regions. Results also included widespread immunization coverage and increased use of health services by pregnant women, as a follow-on benefit from the consistently high participation in sessions to weigh babies and monitor growth.

Other regions requested expansion of this strategy into their areas, and some communities even began similar activities on their own. For its part, the UNICEF-assisted Child Survival and Development (CSD) Programme now reaches almost half the population of Tanzania, with other donor agencies and non-governmental organizations supporting CSD activities elsewhere in the country. By 1996, all regions in the country are expected to be covered.

The enabling components of this experience included:

- **animation** — methods of stimulating and engaging all participants in the process of awareness-raising, critical analysis, debate, decision-making, action for development, reflection and further action;
- **participation** — ensuring community ownership of the process, internalization of new information and joint responsibility for action;
- **capacity-building** — training and orientation of actors at various levels in the use of the conceptual framework and triple-A cycle to improve analytical processes and commitment to the action that ensued;
- **a holistic perspective** — allowing a multifaceted approach to intervention, based on analysis by each village of its unique situation; and
- **the use of relevant data** — providing a concrete basis for needs assessment, prioritizing and targeting of attention on those most in need.

Factors affecting the success of the CSD Programme in Tanzania have included at the local level: the one-party structure, which organized all households into 10-cell units; the decentralization policy, which allows village governments to collect and use levies, and to enact by-laws supporting programme objectives and decentralized or 'bottom-centred' planning that allows local-level control of resources and decision-making. At the intermediate level, the authority of the District Executive Director, the principal development officer, over the various sectoral agencies allows for multisectoral collaboration. Multisectoral technical advisers found themselves challenged as self-reliant villagers requested their assistance and resources. The constant flow of data from villages facilitated immediate follow-up and feedback; comparing accomplishments among villages made for some healthy competition. Strong support was maintained at the policy level, where an intersectoral ministry — Planning — was able to ensure coordination with the help of that support.

UNICEF support has included materials (vehicles and drug kits), funding for training and technical expertise, as well as advocacy and public reinforcement through the media. UNICEF's commitment over time (more than a decade at the time of writing) has permitted sustained support for the evolution of the programme. Operating costs and other direct support have declined markedly, as the initiative has become more self-sustaining. Currently, it is estimated that the level of external funding needed to keep malnutrition down to these levels would be no more than 10 per cent of the foreign assistance available for the social sector each year. Nevertheless, the issues of multiparty democracy, structural adjustment and possible changes in foreign development assistance may have effects that cannot be known at this point.

While this experience has increased women's participation in community decision-making, many disparities remain — including some concerning the division of labour between women and men, and access to and control of resources. As it continues, however, the flexibility of the process does allow new goals to be identified that could address problems such as health of pregnant women, income generation and, more recently, education.

Overall, as a result of this process, individuals and communities seem more able to act for the benefit of their children, and indeed to increase their options for action and to manage better the forces that shape their lives. The approach followed in this programme seems not only to have produced some outstanding results but also to have laid a solid foundation for those achievements to be sustained and, even more, to be extended into other areas where action is required.

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I. INTRODUCTION

Objective of the case-study

The term 'social mobilization' was coined by UNICEF and added to the development vocabulary in the mid-1980s. There are varying opinions as to exactly what is meant by the term and how the process is carried out. To increase understanding of the process, UNICEF has undertaken the development of a series of case-studies that will explore in depth experiences in several different countries where social mobilization has apparently been effectively employed. From the lessons learned, UNICEF hopes to arrive at a clearer appreciation of social mobilization, what it contributes to the achievement of development goals, and how the process is initiated, implemented and sustained. By understanding what facilitates and what inhibits social mobilization specifically in the Tanzanian context, UNICEF and others involved in community-based development will be able to build on the experience.

Two factors stand out as important to the success of the programme in Tanzania: a) close cooperation with the national Government and use of the parallel government and party structures to implement activities all the way from the regional level down to the villages, and b) social mobilization. UNICEF has collaborated with the Government of Tanzania for nearly a decade in developing and implementing an integrated community-based nutrition and health programme. During that time, the organization has learned many lessons about: a) how to involve villagers substantively in programming, b) how to increase government participation and dedication to child survival activities, and c) how to link the community and the government infrastructure, and what can be gained by doing so. A great deal has been published on the initial Iringa Nutrition Programme and, to a lesser extent, the follow-on effort, the Child Survival and Development (CSD) Programme; there is still much more to learn about social mobilization from this initiative.

Tanzania and the CSD Programme were chosen as the subject of one of the social mobilization case-studies because they provided an exceptionally rich experience from many different perspectives — political, organizational, economic, developmental and nutritional. As will be pointed out, this integrated nutrition and health programme has achieved unprecedented impact. Only Indonesia, Thailand and the state of Tamil Nadu in India have been national in scale and had similar successes, but none has involved such effective social mobilization or has produced such an outstanding and sustained impact. In some areas, severe malnutrition was reduced from as high as 10 per cent (e.g., in parts of Mtwara Region) to between 0.3 and 2.8 per cent in a relatively short period of time — and these rates have been maintained. The population benefiting from the expanded CSD Programme is large, involving close to half the country's children under five (approximately 2 million). The results indicate that significant behavioural changes have taken place. It is difficult to conceive of a community-based, integrated programme like CSD having such an impact, much less maintaining it, without the vital role played by social mobilization.

In fact, the approach pioneered in Tanzania has now been endorsed by UNICEF to achieve its global nutrition goals for the year 2000.

The success of the Tanzanian CSD Programme is rooted in both the overall approach and the specific environment or context. Chapter II begins with a description of the programme and an analysis of its components, followed by sections on the role played by each government and party level, and the contributions and involvement of international donors, particularly UNICEF. The chapter concludes with a section on what the next steps could be, discussing problem areas which may arise in the CSD Programme in Tanzania as it expands while still maintaining and enhancing sustainability. Chapter III examines the context, including both historical and environmental perspectives, starting with a review of the health and nutrition status of women and the vulnerable under-five population. The highlights of the development history of Tanzania are then discussed, particularly the political, cultural and economic backgrounds that influenced the Iringa Nutrition Programme and the subsequent CSD Programme. Finally, in Chapter IV, key lessons and implications for the social mobilization approach as carried out in the CSD Programme in Tanzania are identified for anyone wanting to initiate the process elsewhere.

Definition

UNICEF sees social mobilization as a strategy that substantively involves the community in the process of developing, planning, implementing and evaluating programmes that affect its quality of life. Sustainable social mobilization is defined by those involved in its promotion as a process by which a variety of actors and forces at different levels of society engage in sustained and concerted social action around a commonly agreed-upon or accepted objective or purpose. The basic premise is a commitment to human development of the poorest and the marginalized, recognizing that the poor already have well-developed survival strategies and can be responsible for their own development. In the words of a Tanzanian Basic Services Programme specialist, "When the higher bodies neglect the intellectual ability of the village residents, the implementation of projects continues to be static."

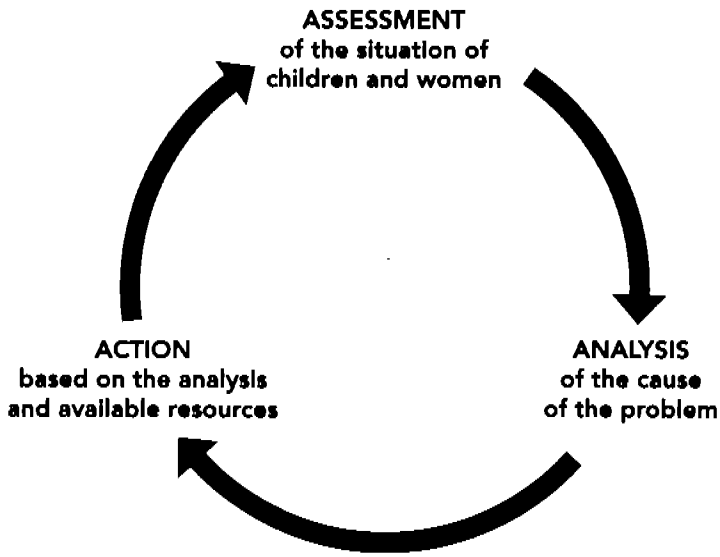
Social mobilization in its fullest manifestation aspires to national scope and presumes that participation relates directly to empowerment and sustainability. The process supports popular action and facilitates the redirection or creation of human and material resources for the development and realization of national and community goals. Ultimately, sustainable mobilization must go beyond the mere carrying out of specific programmes and result in widely held capacities for self-managed action. Alliances of empowered and organized groups allow more realistic and equitable dialogue with government, leading to a more effective role in setting strategies and taking decisions on the allocation of resources.

In Tanzania, the term social mobilization began to be used in the mid-1980s in the Iringa Nutrition Programme and meant engaging the population in health and nutrition efforts. In 1987, UNICEF organized a Social Mobilization Workshop which analysed the process within a broader context, including advocacy, training and

publicity at all levels, from the capital to the village. Instead of being passively acted upon, the villagers were to become actively involved in recognizing their nutrition/health-related problems, identifying the causes and solutions, and implementing activities to improve their situation. All levels, from the individual household to the national Government in Dar es Salaam, would be effectively mobilized and their energies directed to eradicate the problems underlying malnutrition. As part of the expanded scope, participation and empowerment were of utmost importance, particularly at the household and village levels.

The social mobilization training in the CSD Programme utilizes several key tools. The first of these is the **triple-A cycle** (figure 1): **assessing** the child nutrition and health problem facing the household or community, **analysing** the causes underlying those problems, and, finally, developing **actions** to resolve the problem. After the situation has been assessed and analysed and actions have been implemented, it is necessary to reassess the impact of the actions, and then to re-analyse it again. This process will lead to further actions that are likely to be more effective and better focused. The triple-A construct, which articulates the common process by which action is taken in all aspects of life, was used by the CSD Programme graphically to convey and formalize the stages by which communities could proceed to solve their problems. The familiar triple-A diagram makes it easy for villagers and those involved in the CSD Programme to understand the process.

Figure 1. Triple-A Cycle

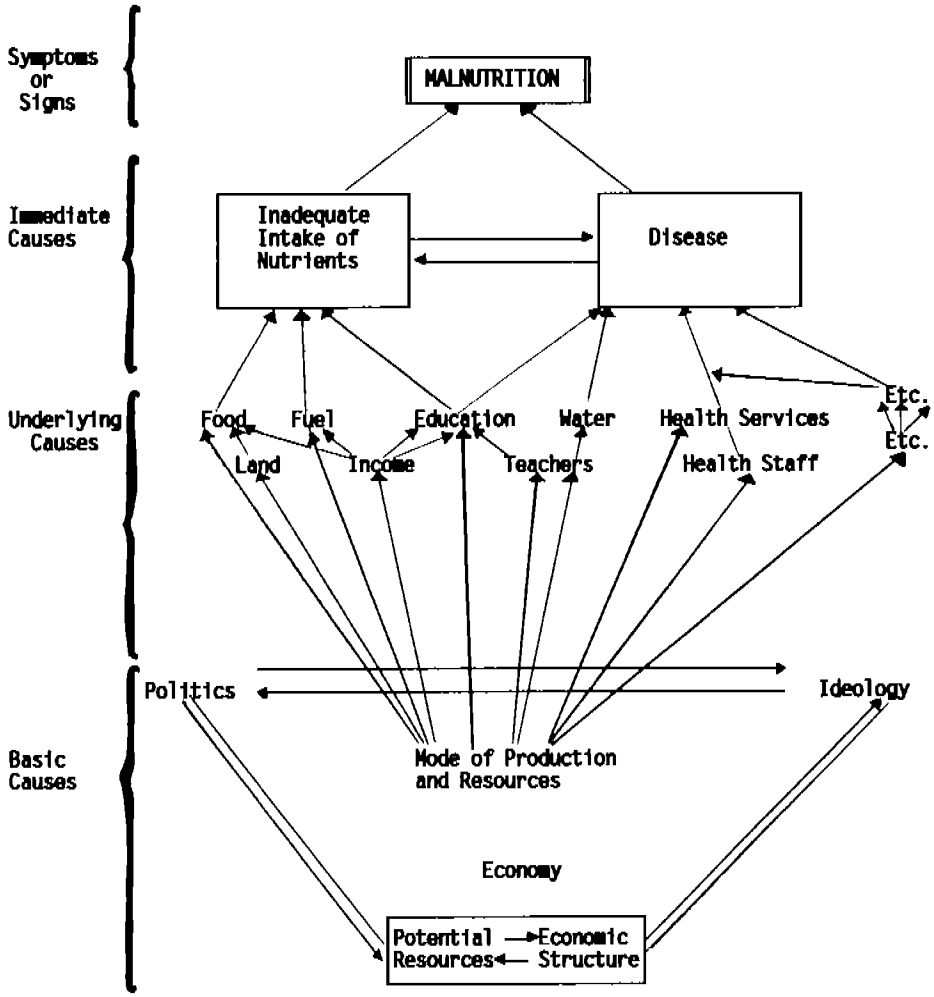


The formal articulation of the assessment, analysis, action and reassessment stages of the cycle underlined the importance of systematic data collection, through regular weighing of children and charting their growth. Breaking down the cycle into

stages also clarified the need to analyse the causes of the problem and take appropriate action. Never before had communities been involved in, or indeed seen the need for, such information. Its currency and immediacy was a powerful factor in galvanizing action.

As important as the triple-A cycle is, its effectiveness increases when used in synergistic association with the **conceptual framework**, a schematic chart that enables villagers to identify the immediate and underlying causes of malnutrition in their community. The conceptual framework has been revised over the years. Those

Figure 2a. Conceptual Framework (original)

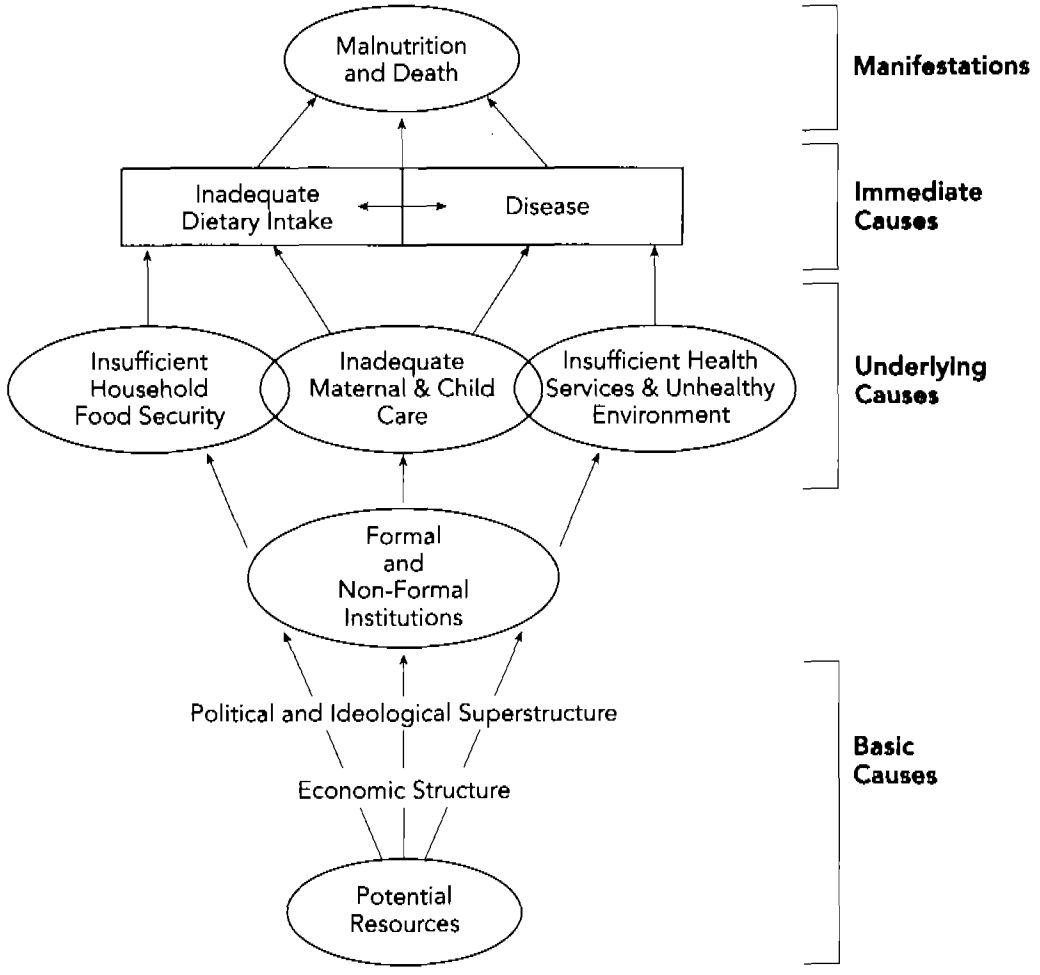


The Causes of Hunger

responsible for designing the programme realized that all causes of malnutrition and their interrelationships could not be captured in one diagram without totally overwhelming the audience. Consequently, the original diagram (figure 2a) was modified and streamlined with the immediate causes and then the underlying causes grouped into three major clusters (figure 2b). Formal and informal institutions were added to the framework as useful resources in solving community nutrition-related problems.

The immediate causes, diet and disease, can be dealt with through delivery of services, such as provision of food and immunization. The underlying causes — insufficient household food security, inadequate maternal and child care, and insufficient health services and an unhealthy environment — require capacity-building through information and education. Basic causes are macrolevel constraints including the basic political and ideological superstructure and economic structure.

Figure 2b. Conceptual Framework (simplified)



Individuals can only hope to influence such basic structures in joint action based on empowerment, community organization and mobilization of resources, and pressure for legislation at the national level.

Use of the conceptual framework enables communities to identify, understand and overcome the problem of nutrition. They also gain self-confidence, internalize information and change behaviour over the long term. Therefore, the improved nutritional status of the under-fives is likely to be sustained. The conceptual framework and triple-A cycle interact and reinforce each other. The former provides the theory, and the latter provides the practice. This has been crucial to the success and sustainability of the effort.

A third tool is **animation**, which evolved out of a number of successful communication strategies and has recently been strengthening and driving the whole social mobilization process. Since the early years in the Iringa programme, communication has always played an important part. In 1983, an effective programme support communication approach was designed and applied. As it was refined and strengthened, the communication component facilitated the rapid expansion of the CSD Programme in the late 1980s. With the more intensive presence of animators at the village level, beginning in 1990 during expansion and as part of the CSD training package, there was greater emphasis placed on dialogue, interaction, and resolution of conflicts and problems within the community.

Through dialogue and observation, trained animators take stock of the potential resources in the community, in particular the human resources, as well as what people believe to be the problems in their community. Animators become a part of the community, learning along with the villagers. Methods used for raising awareness include traditional dances and songs, skits and stories. Such performances promote community organization and help spark dialogue and debate about the situation and possible solutions; in effect, it sets the triple-A cycle in motion and facilitates understanding and use of the conceptual framework.

II. CSD PROGRAMME EXPERIENCE AND ANALYSIS OF THE SOCIAL MOBILIZATION PROCESS

This chapter describes the CSD Programme's objectives and activities, and then dissects the process to show **how** the effort is implemented, so that anyone developing a social mobilization strategy will be aware of some of the implications and what is involved.

We begin by providing an overview of the CSD Programme as it currently exists in Tanzania, reviewing the nutrition/health impact and the process changes in terms of social mobilization and empowerment. To understand the complex but effective structure and management system, we start at the community level and then examine the role of the intermediate ward and district levels, and finally the regional and national levels, as well as how one level interacts and influences the one above and below it. The chapter concludes with a discussion of the role of international agencies, especially UNICEF.

Description of the CSD Programme

Today's CSD Programme is the result of years of trial and error. From its beginnings as a pilot programme in Iringa Region, it has been modified, refined and expanded as new and more effective ways to reach the programme's primary objectives were discovered.

The current CSD Programme consists of a community-based, integrated development effort centred around nutrition, using the triple-A cycle, the conceptual framework and animation to enable communities to generate accurate information, identify problems and improve their situation. The flexibility of the planning process with its very clear commitment to integrated, community-based programming keeps the CSD Programme on course. By treating difficulties as challenges, it is able to solve problems as they are identified.

The CSD Programme has two objectives, which are intimately interrelated. The first is to reduce malnutrition, thereby improving infant and child health status and decreasing child mortality. This is a goal that the entire community can wholeheartedly and enthusiastically support. The second objective is the empowerment of communities, enabling them to gain confidence, act on their own behalf — individually and collectively — and gain greater control over their lives. The latter objective facilitates the sustainability of the first.

Having determined that there is a nutrition problem in the village and collectively agreeing to address it, the community can undertake a number of activities to reduce and eventually eliminate malnutrition. They are grouped into six categories:

- systems development and support (policy and programme communication,

monitoring and evaluation, integrated training and infrastructure support);

- maternal and child health (dispensaries, maternal and child health services, which include family planning, village health worker programmes, training of traditional birth attendants and traditional healers, control of diarrhoeal diseases, immunization, treatment of acute respiratory infections, malaria treatment and control, nutrition rehabilitation, maternity care, and control of micronutrient deficiency disorders);[1]
- water and environmental sanitation;
- household food security (food and nutrition planning, agroforestry, crop promotion, home gardening, small animal husbandry, food processing and preservation, and food preparation);
- child care and development (village child caretaker organizations, child-to-child actions, technology development support and studies); and
- income-generating activities.

Coverage of the UNICEF-assisted CSD Programme is currently estimated to include almost half the population of Tanzania. It is active in 12 out of 20 regions on the mainland and throughout Zanzibar[2]. Only Iringa Region, where the programme started, is covered completely; in all the other regions only some of the districts are included (see figure 3). According to statistics compiled at the end of 1991, a total of 2,022,296 children under five were registered in the CSD Programme. In addition to these UNICEF-assisted operations, other donor agencies and non-governmental organizations are supporting CSD programming efforts. The map on page 14 gives the districts with CSD-related activities and their respective funding organizations.

The four district programmes (two each in Singida and Mara Regions), referred to as nutrition surveillance, are implemented with the assistance of the Tanzania Food and Nutrition Centre and financial support from UNICEF. The approach is similar to the CSD Programme in that it includes a community-based information system, training of village leadership and the provision of training materials for extension officers. They will be expanding into three districts of Tanga Region and two districts of Arusha Region in the next several years.

The World Bank, under a US$47.6 million health and nutrition loan to the Ministry of Health, has taken responsibility for 10 districts in Kigoma, Lindi, Singida and Tabora.[3] The International Fund for Agriculture Development (IFAD) is funding activities in Dodoma, while CSD efforts in Shinyanga are being carried out by a joint United Nations group. The European Economic Community has reportedly been approved to carry out CSD-related activities in three districts. However, their efforts

[1] Breastfeeding is an issue that was not initially recognized but is now considered a vital component.

[2] The programme in Zanzibar is referred to as the Zanzibar Joint Nutrition Support Programme (ZJNSP). It was launched in 1989. Because the structure and operation of the programme is considerably different in Zanzibar, it is not included in the general discussions and data in this CSD case-study. However, there is a short discussion of the Zanzibar programme on page 36.

[3] Discussions with World Bank representatives in Dar es Salaam indicate that they are carrying out their programme through the Ministry of Health. The principal activity is the development of district-level health planning guidelines. The World Bank-funded effort is discussed in greater detail on page 45.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KEY	DISTRICT	DONOR	REGION
1.	Arumeru	SIDA	Arusha
2.	Arusha *	SIDA	Arusha
3.	Babati	SIDA	Arusha
4.	Bagamoyo	UNICEF	Coast
5.	Bariadi	IFAD	Shinyanga
6.	Biharamulo	UNICEF	Kagera
7.	Bukoba Rural	UNICEF	Kagera
8.	Bukoba Urban*	UNICEF	Kagera
9.	Bunda	UNICEF	Mara
10.	Chunya	UNICEF	Mbeya
11.	Dodoma Rural	UNICEF	Dodoma
12.	Dodoma Urban*	UNICEF	Dodoma
13.	Geita	UNICEF	Mwanza
14.	Hai	UNICEF	Kilimanjaro
15.	Hanang	SIDA	Arusha
16.	Handeni	GTZ	Tanga
17.	Igunga	WB	Tabora
18.	Ilala	PI	Dar es Salaam
19.	Ileje	UNICEF	Mbeya
20.	Iramba	WB	Singida
21.	Iringa Rural	JNSP	Iringa
22.	Iringa Urban	JNSP	Iringa
23.	Kahama	WV	Shinyanga
24.	Karagwe	UNICEF	Kagera
25.	Kasulu	WB	Kigoma
26.	Kibaha	UNICEF	Coast
27.	Kibondo	WB	Kigoma
28.	Kigoma Rural	NORAD	Kigoma
29.	Kigoma Urban*	NORAD	Kigoma
30.	Kilombero	UNICEF	Morogoro
31.	Kilosa	UNICEF	Morogoro
32.	Kilwa	WB	Lindi
33.	Kinondoni	PI	Dar es Salaam
34.	Kisarawe	UNICEF	Coast
35.	Kiteto	SIDA	Arusha
36.	Kondoa	IFAD	Dodoma
37.	Korogwe	GTZ	Tanga
38.	Kwimba	UNICEF	Mwanza
39.	Kyela	UNICEF	Mbeya
40.	Lindi Rural	WB	Lindi
41.	Lindi Urban*		Lindi
42.	Liwale	WB	Lindi
43.	Ludewa	JNSP	Iringa
44.	Lushoto	GTZ	Tanga
45.	Mafia	UNICEF	Coast
46.	Magu	UNICEF	Mwanza
47.	Makete	UNICEF	Iringa
48.	Manyoni	UNICEF	Singida
49.	Masasi	UNICEF	Mtwara
50.	Maswa	DUTCH	Shinyanga
51.	Mbeya Rural	UNICEF	Mbeya
52.	Mbeya Urban*	UNICEF	Mbeya
53.	Mbinga	UNICEF	Ruvuma
54.	Mbozi	UNICEF	Mbeya
55.	Mbulu	DUTCH	Arusha
56.	Meatu	UNICEF	Shinyanga
57.	Monduli	SIDA	Arusha
58.	Morogoro Rural	UNICEF	Morogoro
59.	Morogoro Urban*	UNICEF	Morogoro
60.	Moshi Rural		Kilimanjaro
61.	Moshi Urban*		Kilimanjaro
62.	Mpanda	NOR/A	Rukwa
63.	Mpwapwa	SIDA	Dodoma
64.	Mtwara Rural	UNICEF	Mtwara
65.	Mtwara Urban*	UNICEF	Mtwara
66.	Mufindi	JNSP	Iringa
67.	Muheza	GTZ	Tanga
68.	Muleba	UNICEF	Kagera
69.	Musoma Rural	UNICEF	Mara
70.	Musoma Urban*	UNICEF	Mara
71.	Mwanga		Kilimanjaro
72.	Mwanza	UNICEF	Mwanza
73.	Nachigwea	WB	Lindi
74.	Newala	UNICEF	Mtwara
75.	Ngara	UNICEF	Kagera
76.	Ngorongoro	SIDA	Arusha
77.	Njombe	JNSP	Iringa
78.	Nkasi	NOR/A	Rukwa
79.	Nzega	WB	Tabora
80.	Pangani	GTZ	Tanga
81.	Rombo		Kilimanjaro
82.	Rufiji	UNICEF	Coast
83.	Rungwe	UNICEF	Mbeya
84.	Same		Kilimanjaro
85.	Sengerema	UNICEF	Mwanza
86.	Serengeti	UNICEF	Mara
87.	Shinyanga Rural	UNICEF	Shinyanga
88.	Shinyanga Urban*		Shinyanga
89.	Singida Rural	WB	Singida
90.	Singida Urban*	WB	Singida
91.	Songea Rural	UNICEF	Ruvuma
92.	Songea Urban*	UNICEF	Ruvuma
93.	Sumbawanga Rural	NOR/A	Rukwa
94.	Sumbawanga Urban	NOR/A	Rukwa
95.	Tabora Rura		Tabora
96.	Tabora Urban*		Tabora
97.	Tanga*	GTZ	Tanga
98.	Tarime	UNICEF	Mara
99.	Temeke	PI	Dar es Salaam
100.	Tunduru	UNICEF	Ruvuma
101.	Ukerewe	UNICEF	Mwanza
102.	Ulanga	UNICEF	Morogoro
103.	Urambo		Tabora
	Whole of Zanzibar	UNICEF	

WB=World Bank PI= Plan International WV= World Vision NOR/A= Norad/AMREF
*Not shown on map.

will focus primarily on agriculture and economic and infrastructure development. A number of bilateral donors are also involved: GTZ (Germany) in one district in Kilimanjaro and Tanga Regions; NORAD (Norway) in Kigoma and Rukwa Regions; and the Swedish International Development Authority (SIDA) in Mara and Mwanza. Several non-governmental organizations will also play a part: the African Medical and Research Foundation in Rukwa, World Vision in Shinyanga and PLAN (Foster Parents Plan International) in Dar es Salaam. Most of these efforts will be carried out with the technical assistance of UNICEF.

According to the UNICEF 1992-96 country programme, the organization will "continue to advocate with other agencies extension and/or modification of their current support in order to ensure that by the end of 1996 all regions on mainland Tanzania are pursuing effective programmes for women and children."

CSD Programme results to date

Since the CSD Programme has two objectives, one relating to nutrition and health and the other to social mobilization, results are appropriately reviewed separately, even though the objectives are very closely connected.

Nutrition/health impact

a) Participation: Programme participation can be considered from several different perspectives. Here, it will be defined as attendance at Village Health Days and weighing sessions. Of the number of under-fives registered in the programme in 1991, 73.8 per cent attended the weighing sessions; regional attendance ranged from 62.8 per cent in Ruvuma to 89.2 per cent in Shinyanga. More recently, several of the regions report higher participation rates (e.g., Mtwara weighed 96.7 per cent of the registered under-fives in the fourth quarter of 1992).

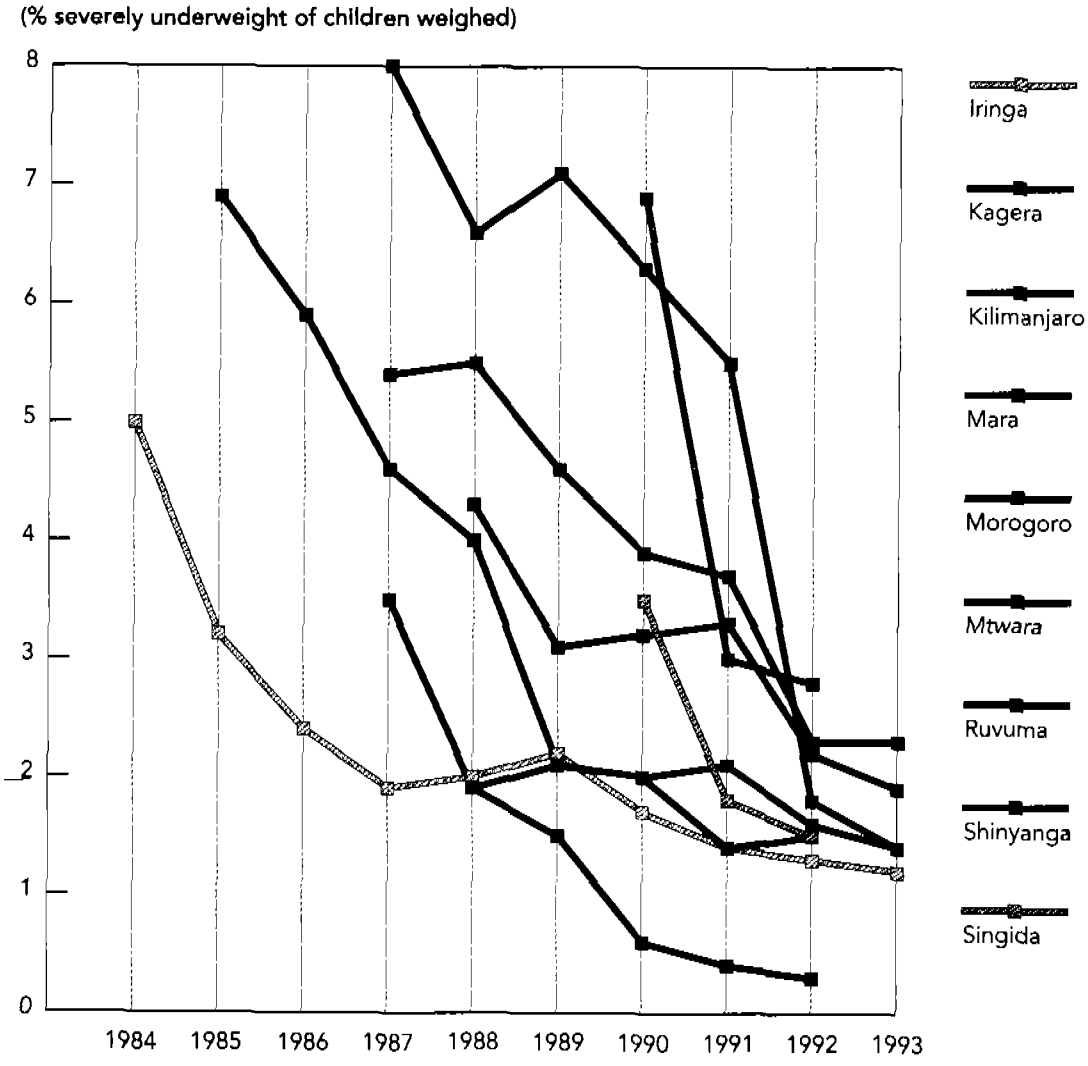
During the early stages of the CSD Programme, nearly all mothers[4] attended, drawn by a combination of films, political 'top-down' mobilization, local social pressure from neighbours and relatives, and intrinsic concern about the health of their children. In many of the most successful villages attendance rates remain high, even when malnutrition has been greatly reduced. Elsewhere, however, only half the parents attend, which may reflect either lower levels of support to village health workers, or a sense of complacency once nutritional levels improve. The registration system was not functioning in some places making it difficult to know who exactly did not attend the Village Health Day. Research conducted in one village in Kilosa District, Morogoro Region (not part of the research for this case-study) in November 1992 found that the same children were missing the weighing sessions each month (Lee, 1992). It appeared that many of the non-attenders were from the lower socio-economic strata. In some cases, villages report a high percentage of children attending the Village Health Days, while in fact the children had been visited in their homes

[4] Attendance rates for men on the weighing/health days was extremely low.

by the village health workers. Although this was not exactly what was intended, the spirit of the programme was certainly satisfied. This is the villagers' way of dealing with outside demands while still achieving their own goals.

b) Malnutrition rates: At the end of 1992, the severe malnutrition rates in the nine mainland regions with three or more years of CSD Programme experience had fallen in some places from as high as 8 and 6.9 per cent to 1.8 and 1.6 per cent (in Mtwara and Kagera). Figure 4 shows the reduction of severe malnutrition in the regions after the introduction of the CSD Programme. The total, severe and moderate malnutrition data for each region for the years it was in the CSD Programme can be found in Annex III.

Figure 4. Impact of CSD Programme
Severe malnutrition among children under five



The reduction in all cases has been dramatic, often with relatively sharp drops in severe malnutrition rates after the first several years of the programme. As of the last quarter of 1992, Kilimanjaro, Kagera and Iringa have shown 91, 77 and 74 per cent reduction in severe malnutrition in the programme areas. This improvement has been sustained.

Mtwara Region is a particularly impressive example. For the region as a whole, it reported an 8 per cent rate of severe malnutrition when the programme was introduced in 1987.[5] Little progress was demonstrated over the next three years. Special attention known as the 'Mtwara initiative' (see page 28), including frequent feeding of children and animation efforts, resulted in a rapid decline in severe malnutrition rates, beginning around 1991, when the rate was reported at 5.5 per cent. At the end of 1992, the rate stood at 1.8 per cent. This represents a 77.5 per cent reduction in severe malnutrition since the CSD Programme was launched in Mtwara six years before. In late 1992, 44 out of 67 villages in Newala District had eliminated severe malnutrition. Such sharp reductions in severe malnutrition rates on such a large scale are very rare in international nutrition programming.

The number of underweight or moderately malnourished children (60 to 80 per cent below standard) has been considerably reduced in all of the nine programme regions. Although it is difficult to compare the respective reductions since the regions have had the CSD Programme for varying amounts of time, the most impressive drop was in Hai District of Kilimanjaro Region which showed a 59 per cent reduction in moderate malnutrition during its five years in the CSD Programme. The downward trend found in all programme regions is particularly significant because as the severely malnourished rates decrease, those children move into the moderately malnourished group, which would therefore be expected to increase. The CSD Programme has not just changed the degree of child malnutrition from severe to moderate but from severe and moderate to mild and normal categories.

At the village level some remarkable improvements in nutritional status can be found. For example, Idamnole of Newala District in Mtwara Region reported in October 1992 that out of 218 children, there were no severely malnourished and only 17 moderately malnourished children. When the CSD Programme began in 1990, Idamnole had 22 cases of severe and 118 cases of moderate malnutrition. Another village in the same district, Nakachela, had 14 cases of severe malnutrition in the late 1980s and by October 1992 had none. This story is repeated in many of the communities that have been part of the CSD Programme.

c) Mortality: The CSD Programme regions collect data on the number of under-five deaths using a population-based registration system. The rates seem to be falling, but UNICEF and the CSD Programme regional coordinators are not confident of the figures. However, there is considerable anecdotal evidence of a reduction in child mortality.

For example, in Utengule in Njombe District of Iringa, the village priest said that before the CSD Programme, eight to ten children under five would be buried each

[5] In March 1990 one district reported a 9.7 per cent rate of severe malnutrition with 62 per cent of under-fives participating. By March 1992 this rate had dropped to 3.3 per cent with 94 per cent participation.

year; now the number is two or three. For the first 10 months of 1992, the village reported that two children had died. Even though it is a village of only 1,136 people, of which 206 are under five, and the data can in no way be considered statistically valid, it does indicate that people are becoming seriously concerned about child deaths and believe that CSD activities can turn things around.

In Mtwara Region, again with a small sample and figures of questionable validity, the under-five mortality rate for the CSD Programme villages during the second quarter of 1992 was calculated at 117 per 1,000 live births[6]. This figure is less than half of the under-five mortality rate of 250 per 1,000 in Mtwara Region (second highest in mainland Tanzania) published in the 1988 census (1985 data).

Figures from individual villages confirm that deaths of children under five have been sharply reduced since the CSD Programme began. In Nakachela, for example, nine children died in 1988, six in 1989, seven in 1990, one in 1991 and two in 1992. Considering the greatly reduced malnutrition rates, the improved health interventions (especially immunization) and increased awareness about proper child nutrition and health practices at the community level, reductions in child mortality rates are not unexpected.

d) Behavioural change: Getting parents to take action based on the information that the health of their children can be improved by eating more and better food has always been a difficult task. In the CSD Programme, villagers see for themselves what more frequent feedings with calorie-dense food can do. They learn to use locally available but underutilized wild nuts and fruits or other foods that make children healthier and stronger. Once the villagers appreciate that previously unhealthy children have become boisterous and active, they become converts. Not only do they themselves change, but they also become convincing promoters of change.

Other behavioural changes based on this new understanding are intra-familial distribution of food and more frequent feeding of young children. Once the importance of food for the growing child was evidenced by the villagers, consumption patterns within the family were altered. In some cases, less food was given to the father so that more nutritious food could be provided to the young children. Increased use of health services by pregnant women and increased immunization coverage for children were also noted in CSD Programme regions.

The greatest challenge in the CSD Programme to date is in the urban centres, which in almost every region report the lowest rates of participation in weighing sessions. The most frequent explanation given is that the governmental and political structure existing in the rural areas does not permeate the urban centres. There is no sense of community, and the all-important registration, follow-up and accountability are more difficult, particularly if the political party structure can no longer be considered a programming asset. Historically, Tanzania has focused on development in rural areas, since over 80 per cent of the population lived in the villages. The cities of Tanzania will require special attention if the programme is to be effective there.

[6] The second quarter of the year is expected to show the worst malnutrition and child mortality rates because it comes during the rainy season when diarrhoea is more prevalent, there are pre-harvest food shortages, and women are busiest with weeding chores.

Nutrition education opposes witchcraft

Superstition is common in Tanzania. It affects every aspect of life. Many people believe that witchcraft causes illness and malnutrition.

A father in Ikelu in Njombe District of Iringa Region of central Tanzania had a malnourished daughter and blamed it on witchcraft. He believed that an enemy had put a curse on the little girl, causing her to be unhealthy, weak and thin.

When the slaughter of animals and visits to a witch-doctor did not improve his daughter's condition, he agreed to try some of the activities suggested by the village health worker. He had his wife prepare a porridge, using cornmeal diluted by germinated millet flour.

The use of this so-called 'power flour' makes the gruel thinner and easier to digest while increasing the calories and the amount of food his daughter could consume. Within a few weeks the young girl was transformed. No longer was she quiet and sullen. Instead she was active, her eyes sparkling and disposition happy. The father could not believe what he saw. Better yet, it had not cost him any more money, and all the food items used were readily available in the village.

It became obvious to the father that witchcraft was not the issue, but rather it was a question of better-quality food and more frequent feeding. He now carries around a plastic bag in his pants pocket. When he sees food in the market that is good for his daughter, be it papaya, oranges, green leafy vegetables or cowpeas, he buys it and puts it in the plastic bag. This once superstitious father has become the village advocate for proper nutrition.

Child to child feeding of 'power flour', Iringa township, 1989.

Process results

With malnutrition and infant/child mortality as the entry point, it is possible to achieve modest results in the short term when food availability is not a major constraint. However, to make significant impact and to sustain that improvement, individual and community action, often requiring changes in behavior patterns, must be brought about through a process of social mobilization which is empowering.

Many of the nutrition/health results discussed above could not have been achieved or sustained without the social mobilization process, which has involved each household of the community in the solution of the nutrition problem in the village.

a) Training and capacity-building: Many institutions participate actively in training, including the Tanzanian Food and Nutrition Centre and the University of Dar es Salaam. The village health workers, traditional birth attendants and traditional healers, the ward, division and district officers and extension workers in agriculture, education, community development, health and women's economic development are all trained in the integrated approach to reducing malnutrition. At the regional and national levels, government and party workers attend orientation seminars on the social mobilization process.

In addition to training in the technical aspects of nutrition and child health, actors at all levels receive orientation on effective social mobilization and involvement of the community. At the village level, the village chairman and the village secretary are oriented in the triple-A cycle and the conceptual framework. It is difficult to measure the effectiveness of the training, but it is clear that leaders and community members in the CSD Programme districts are not only familiar with but also practise what they have learned.

b) Participation: Motivation for participation in programme planning and social mobilization activities ranges along a continuum, from **conviction** (totally active participation based on belief that what the programme espouses is correct) to **compliance** (do what you are told) to **coercion** (cooperate because of some negative incentive, fine or fear of public embarrassment). At the beginning of programme activities in a village, it seems that more coercion and compliance are present; community good outweighs individual practices. As results are demonstrated and positive feedback is received, conviction takes over. The more effective the social mobilization process, the greater the feeling of ownership and conviction, with a correspondingly higher potential for sustained activity.

c) Village-infrastructure relationship: The changes in management and administrative approach mean that there is now a creative mix of 'top-down and bottom-up' participation and decision-making.[7] One of the more subtle yet significant changes to be found in villages having the CSD Programme is the relationship between the villagers and the government infrastructure.

After learning to identify problems, their causes, and feasible solutions, depen-

[7] A 'top-down' approach is sometimes necessary in the beginning to pave the way for 'bottom-up'. A good leader is one who can access the synergism between the two; this ability was characteristic of the best leaders in the Iringa programme.

dency on outside aid is markedly reduced in some villages. The early Iringa Nutrition Programme provided funds for materials to construct local dispensaries or erect brick VIP (ventilated improved pit) latrines. These became known as 'UNICEF latrines' and were in some cases unutilized. However, when community data identify diarrhoea as the principal cause of under-five death and villagers determine that the solution is improved environmental sanitation and the construction of latrines, they devise a way to build them themselves using local materials. They also reduce costs to a minimum by concentrating on just the most effective or core activities.

Another consequence is more rational dialogue between CSD Programme villages and government or donor agencies — no clamour for grants, equipment, buildings or transport. Rather, these communities prefer to show visitors what they have accomplished for themselves. They have a quiet confidence born of experience and the knowledge that they can address and satisfactorily solve many of the immediate problems affecting the well-being of their children.

This is not to say that villagers are totally self-reliant. They still need outsiders for technical advice but they are increasingly knowledgeable about how to gain access to national- and district-level resources for water-pumps, VIP latrines, roads and other infrastructure. They have learned how to demand more attention from high government levels for their local development problems. In some cases, village groups have begun borrowing funds from the bank or an outside agency to start income-generating activities.

This attitude of self-reliance and confidence also changes the way government interacts with the villagers. Because the latter know more about what extension workers do, the government officer no longer feels like he or she is thrusting services upon a reluctant population. In fact, villagers request their technical expertise and assistance.

Analysis of the process

Use of Data

Advocacy, training and discussions about malnutrition result in increased understanding and commitment, but locally gathered data, such as deaths and causes of death, and growth monitoring, allow assessment, reassessment and analysis of situations in specific villages. An effective use of information makes it possible to plan and carry out appropriate action.

To begin with, every person in the village is registered; Annex IV shows a copy of a registration form. Birth and death (with cause of death) are included on the registration form. It is not unusual to see CSD Programme figures posted on the walls of the village secretary's office. The village structure, especially the political party's 10-cell units, guarantees that the registration is highly accurate and complete. Population-based registration is frequently found in private international community-based health and nutrition projects around the world (e.g., Save the Children), but rarely if ever is it effectively implemented in public sector programmes.

The registration system makes possible effective follow-up on non-participating or malnourished children. A special follow-up form has been devised to facilitate this process (Annex V). In addition to a longitudinal record of the child's nutritional status, immunization status is maintained on the follow-up form. If the child does not show up at the monthly Village Health Day or is not immunized and should be, someone will call on the family to find out why. The village health workers, village and 10-cell leaders or even neighbours are there to remind, encourage and sometimes pressure delinquent parents.

Growth monitoring is the moving force of the CSD Programme. Nutrition is an abstract concept unless it is linked to the health status of specific children in real communities. Under-five weighing and growth cards (Annex VI) are used initially to assess the needs of the village. By comparing the number of children in the normal range (green) with those with moderate malnutrition (grey) or with severe malnutrition (red), the villagers get a clear picture of the state of their under-five population.

The CSD Programme data help villages prioritize. Not everything can be achieved at once, so the most needy are targeted first, usually the severely malnourished. To begin with, the CSD Programme has a curative orientation towards children that are in greatest danger. The first step is to increase frequency of feedings with high-energy foods. A child in the red zone, or a 'red child' in CSD jargon, is then accorded special attention such as extra weighings (often weekly), special education sessions with the mother, assistance in preparing the proper nutritious food, and attendance at the village feeding or rehabilitation centre.

Once the number of severely malnourished is greatly reduced, the community adopts a preventive mode and shifts its attention to those in the grey zone. CSD Programme villages target 'weak households', where there is malnutrition and limited means to solve the problem. These may be simply poor households which have little or no way of supporting themselves, often households headed by women who are divorced or widowed. The village assists with food, either from the community plot or from community donations. One community in Hai District loaned a poor widow a bag of maize seeds and pesticides, after it was discovered her children were malnourished, so that she could plant her field and become self-reliant.

The information system is a good example of built-in evaluation. Village leaders and village health workers are expected to use the data directly for continuous reviews of performance, without having to send it up to the next level and await feedback. The community itself knows on the Village Health Day what percentage of the under-fives participated in the weighing session and how many of them were in the green, grey and red zones. They have this information for previous months, making it easy to determine progress. This provides either positive reinforcement or the incentive to work harder.

All programme management at the ward and district level is based on the data received from the village. Figures reporting high programme participation and low severe malnutrition rates might be automatically suspect, particularly where pressure is being exerted for positive results. However, there have been few reports of this happening, primarily because there are so many checks and double-checks in the system. With connections right down to the 10-cell level, it is very difficult to miss a

birth or a death. Tracking of vital events is reinforced by the village council, the village health workers, traditional birth attendants and traditional healers. Hence, the vital statistics and participation and malnutrition rates reported have a high degree of reliability.

Capacity-building

Training, utilizing the triple-A cycle, conceptual framework and animation, is a vital part of human resource development, which in turn was crucial to the success of the CSD Programme. This critical period of preparation was described by the CSD Coordinator of Mtwara Region as "building the mental infrastructure," the foundation upon which social mobilization, empowerment and malnutrition reduction are based.

Prior to initiating CSD Programme activities in a village, extensive training and orientation of key actors in the village takes place. A strong village health committee is absolutely essential for the process to function in a systematic way. First, the village chairman, secretary and health committee learn about the purpose and methodologies of the triple-A cycle and conceptual framework. At the same time, the roles and responsibilities of the community and its leaders are discussed. These training sessions are usually conducted close to the village, often at the ward level, by specially trained trainers who are most often district extension workers.

Villagers cited education and training as the most important and appreciated aspect of the programme. Besides information, there is an opportunity for dialogue, application and feedback. The training phase can take up to three to four months. Timing and coordination are a logistic feat. For example, the training of the 10-cell leaders, the village health workers and village health committee members must be concurrent so that they are all prepared to conduct the registration of the villagers.

Having received the orientation, the health committee of the village council selects two village health workers, one male and one female. These village workers receive two months of training. The village health workers are critical to the success of the CSD Programme since they carry out the Village Health Days and are the link to the broader health services.

In a majority of villages, village health workers are compensated by their communities. The amount varies widely, but there may be extra benefits, such as fertilizers or pesticides for their fields, help with farming their land and exemption from the customary volunteer work in the community. In four of the 14 villages included in this case-study, the village health workers received no monetary remuneration. The lack of pay has varying effects on village health workers' performance; in some cases, they do only the minimum, while in others they continue to work effectively.

Overall, there appears to be an extraordinarily high level of motivation among the village health workers, with little drop-out except through attrition (e.g., marriage, or moving out of the village). It seems that the selection of village health workers has been excellent, attributed to effective orientation of the village health committees when the programme is introduced.

The commitment of a few village health workers is demonstrated by their willingness to buy food for the feeding centre and kerosene for sterilization of immunization syringes from their own resources. Motivating factors include prestige, a feeling of responsibility to the children of the village, and a sense of satisfaction in working for the good of the community.

The traditional birth attendants are trained in hygienic birth practices and antenatal care. The traditional healers are oriented as to the objectives of the CSD Programme and asked to be 'strategic allies' in that they are respected members of the community. Feeding centre and day-care centre attendants are also trained if the village has such facilities. The community compensates these attendants either by raising the money from individual households or from common village revenues.

Integration

The triple-A cycle and conceptual framework address food and health care issues, and show the three levels of causes — immediate, underlying and basic. The number of possible interventions is large. The specific activities the villagers choose to propose and adopt is based on their own analysis of their particular situation. Some possibilities are directly related to food and nutrient intake, such as feeding and rehabilitation centres, food availability and nutrition education on nutrient-dense foods and proper breastfeeding. Other measures are more indirectly related, but still affect the nutritional status of the child, such as immunization, treatment of acute respiratory infections, and improved water sources. Still other interventions address underlying causes of malnutrition, such as income generation and labour-saving technologies. Wheelbarrows reduce the time women spend hauling wood, and improved stoves reduce the amount of wood required; both give women more time for their children.

CSD Programme-related activities in Ikelu Village

Health/nutrition education — The village has promoted the message to 'feed family better'. After learning about the needs of various members of the family, they now retain more for their own consumption rather than selling it. In the first half of 1992, no 'red' (severely malnourished) cases were identified.

Household food security — The village council suggested that each family cultivate at least five acres. All 10-cell leaders form committees to ensure that each family stores enough food. They use a formula of three bags of maize per person for one year. Families are not supposed to sell food unless they have enough for themselves. Villagers are building improved storage bins to reduce post-harvest losses; 49 out a target of 150 have been constructed.

Care for pregnant women — Women who are more than six months pregnant are exempted from village labour until three months after delivery. The village government directs husbands to assist their pregnant wives in husking and grinding the corn, hauling the water and cooking.

Environmental sanitation — The village population was encouraged to build better houses. The newer houses being built in the community are larger and have windows as well as nearby latrines. Neighbours are competing with each other.

Clean water — Women have to walk more than one kilometre to a spring. They tried making shallow wells and boiling the water, but this takes precious time away from women's other chores. Moreover, it uses scarce fuel and the water "loses its taste."

Waste disposal — The village council promoted the idea of building garbage disposal pits, but few have done it.

Women's economic activities — With funding from the Tanzanian Women's Union (*Umoja wa Wanawake Tanzania*), they started pottery, weaving and knitting projects. The women now want a loan to purchase an ox-drawn plough. Seminars on management have been helpful.

Forestry — The village council has encouraged every family to plant trees for firewood and fruit; 58,000 seedlings were requested from Project Concern.

The CSD Programme includes income-generating activities to resolve the question of long-term food availability. Most of the economic activities supported by the CSD Programme at the village level such as maize husking and milling machines, and sunflower-seed oil presses are developed and carried out by women's groups.

Some women's income-generating groups are having a difficult time repaying their loans because of mechanical problems or a changed business environment (e.g., electrification of the village after receiving a diesel engine or increased competition from a new and cheaper electric milling operation). In Hai District, the formation of a women's economic group led to community conflict over land and funds. But the women have in most cases learned how to organize themselves on their own behalf, and to lobby for support from village governments. These operations are supported by revolving funds from UNICEF administered through a local bank, and by government sources. The women learn how to develop proposals and work with banks. The projects serve the dual purpose of increasing women's income and reducing their workload. A maize milling machine, for instance, reduces the hours spent in husking and milling the family's maize and frees more time for caring for and feeding infants.

Noronga women's group

In 1983, women began to meet together under the leadership of a primary school teacher to try and solve the problem of cooking-oil shortages. They decided to keep dairy cattle in order to get ghee for cooking and milk for their children.

Three hundred and fifty women joined the local project with individual contributions and received technical assistance from the Tanzanian Small Industries Development Organization. Most members were farmers; one fourth were businesswomen.

Later, with donor support, the group diversified into the production and sale of milk and yoghurt in Moshi town. They established a small-scale dairy-processing industry, bought

two vehicles for transporting their products and branched out into other activities.

Individual members now earn an average monthly income equivalent to top government civil servants. The group set up its own savings and loan scheme. Many members have been trained in dairy cow husbandry at a local agricultural training institute.

Especially significant, they have successfully redefined gender roles in dairy production; women own their own dairy cows, milk the cows themselves and control the earnings from the dairy products. Men have provided concrete support, helping to construct buildings, maintaining the vehicles and providing advice when requested.

Empowerment

Empowerment enables people to understand the reality of their environment, analyse and act upon the factors that shape their environment. It is a process that promotes participation of people, organizations and communities towards a goal of increased individual and community control to change the conditions that create or reinforce their problems. In the CSD Programme an empowering process has contributed to the achievement of significant results.

Instead of starting with a set of messages developed by experts outside the village, the CSD Programme involves the population in the process. Those who will be involved in programme activities reach a consensus as to what must be done to combat malnutrition. Since there was broad participation in identifying the problem and potential solutions, the community feels ownership of process, internalizes new information and carries out programme activities together.

Results at the monthly Village Health Days and weighing sessions are soon apparent. As the parents of malnourished children follow improved feeding practices and the promised changes occur, converts are gained. Or, as the old cliché says, "Nothing succeeds like success." Villagers are then much more likely to try other new ideas and practices recommended in the CSD Programme.

In the early phase of the Iringa Nutrition Programme, the empowerment approach focused primarily on training. As the CSD Programme evolved in the latter half of the 1980s and as the strategy was replicated in other regions, frustration developed in some places where there was resistance to change and results were slow in coming or mediocre in impact. It was necessary to introduce an approach that made the training more meaningful and effective and enabled communities to take action.

Animation

Animation was recognized as an extremely effective tool in the early 1990s. It grew and evolved out of the programme's communication strategy. Much of the recent success that has been achieved in terms of social mobilization can be attributed to animation.

First, a month is spent gathering socio-economic data in the village to obtain a comprehensive picture of the situation. Information, gathered collectively through conversations, interactions, interviews with key people and observation, includes

sources of livelihood, extent of poverty, resource availability and utilization, different groups, infrastructure, development efforts initiated by the villagers or their leaders, nature of leadership, conflicts and other issues.

To encourage the community to participate, animation then brings in activities such as role-playing, case-studies and stories, traditional songs, poetry, dance and games to give villagers the opportunity to express themselves, communicate their concerns and experience the analysis/planning exercise firsthand. Community members might act out a typical scene at home where a husband provides little support to the wife in caring for the children. The use of role-playing objectifies the problem, but makes the need for change apparent to everyone. Through dialogue, the animator guides the villagers to see the actual causes; the conceptual framework provides a useful tool in this activity. There is no blueprint advocated for all. Each village determines the specific activities and approach for its own situation.

The Mtwara Initiative

After several years of CSD Programme activity, malnutrition rates in the programme areas, which started at around 8 per cent, had stagnated at 6–7 per cent. The Regional CSD Coordinator was frustrated. At a CSD Programme meeting to discuss programme performance in Morogoro in late 1989, he heard about animation, which had been found useful in mobilizing communities elsewhere in Tanzania. Together with the National Coordination Committee, he arranged to have experienced social mobilizers/animators come to Mtwara from Iringa, Morogoro and Kagera Regions.

Each animator stayed for three months in the ward or village to which he or she was assigned. There was a high degree of cooperation among party and government officials in the initiative. To sustain the effort, internal animators, often the community development workers, were trained and temporarily transferred to poorly performing villages or wards.

This effective mobilization resulted in families feeding their children three times a day, which markedly improved their nutrition.

Some of the songs that were produced and performed locally in support of the CSD Programme are worth noting. One was the result of the animator encouraging participants to express their feelings about major issues concerning the unfair division of labour:

A husband who only brings forth
children, but does not know how to
bring them up is a big shame. See this
one; there is this child and then this and
another one in the mother's stomach.

The song is accompanied by a local dance and everyone sings the chorus and claps.

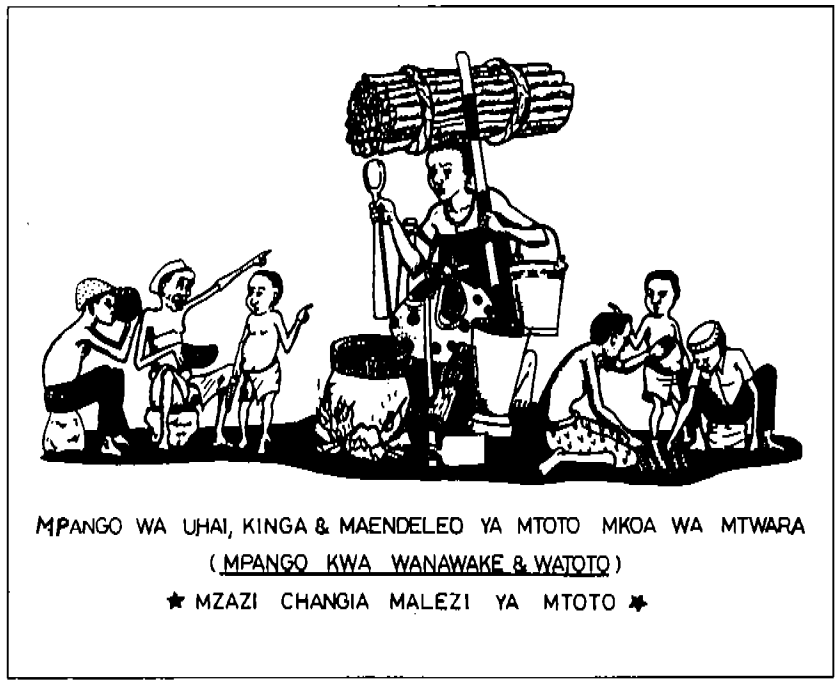
Another group deals with water or the poor service at the nearby dispensary. One skit combines drama, dance and mime.

We citizens of Newala District.
We have problems that face us.
We ask that these problems be solved.
The first one is that of water we need to
be supplied with.
And then that of drugs at the hospital —
how are we to look after the child
if these basic services we don't get?
The problem is corruption, we have
discovered.

The accompanying skit, performed in the local language (Makonde), tells of a farmer who returns home to find his son sick with acute stomach pain. He and his wife take him

to the dispensary. The doctor is late, causing them to wait a long time. When he finally arrives, the doctor demands a bribe to treat the child. When he returns home, the father reports this to the police. The physician is arrested and sentenced to 15 years in prison for corruption.

Discussion following the performances led to agreement that these were common and serious problems. Other problems were raised, including the broken village milling machine, which was adding to the time women must spend preparing flour, resulting in less time to care for the children, thus hindering their development. The villagers decided that they had to take action themselves. "If we depend on assistance to fall down from heaven or from the government, we will never solve our problems." They used the money from the sale of crops from the community plot to repair the milling machine. — *Source: Mlama (1989)*



This drawing was done by a local artist in Mtwara and was used as the cover for the region's CSD Programme reports during 1993. It shows the hard life of a village woman and her many tasks. Men are seen drinking and gambling. The cover emphasizes that both parents should contribute to child care.

The animation aspect is open ended, meaning that it is not initiated with any preconceived solutions. There are well-established programme objectives with guidelines and a framework for villagers and staff to follow, but the activities carried out to achieve those ends are flexible, depending on local analysis of community problems, conflicts and needs.

In animation, all participants must have a way to contribute and feel that the results are theirs. Increased awareness inspires individuals and communities to take action once they see that the problem is their own that they have both the responsibility and means to do something about it. Animators must begin slowly, not raising expectations too high at the outset. As the community becomes more confident and empowered, they will be able to tackle more difficult problems, even some of the conceptual framework's basic causes for malnutrition and underdevelopment.

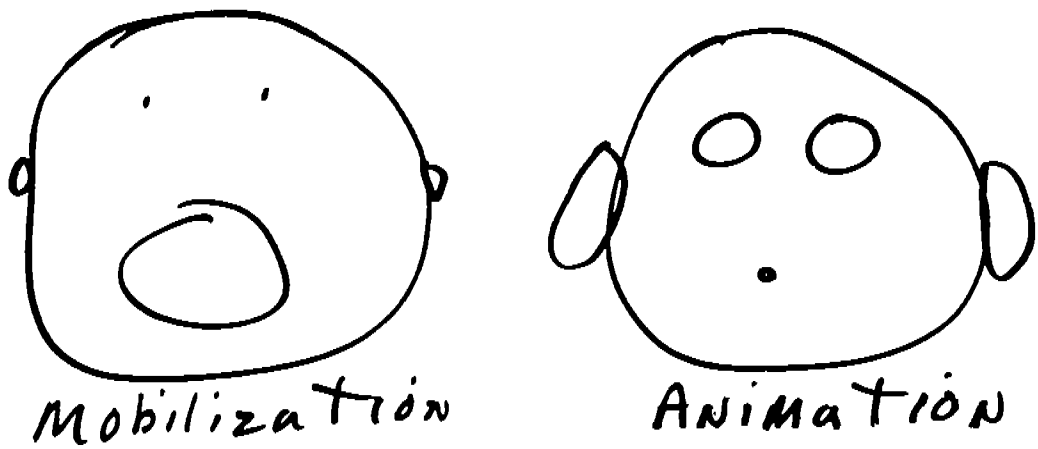
Figure 5 shows how the CSD Programme trainers differentiate between a mobilizer and an animator. The one on the left is the mobilizer, with a huge mouth and small eyes and ears. He or she speaks constantly and loudly, rarely using eyes or ears to observe and listen to the villagers and their problems. In contrast, animators have tiny mouths. They observe and listen with their oversized eyes and ears, helping the villagers in the process of identifying underlying problems and potential solutions. When they do talk, they are usually asking questions, such as "How?", "Who?" and "Why?".

The role of the animator is that of transformative leadership, which is both complex and crucial. An animator's responsibilities include the following:

- to engage villagers in dialogue and cooperate with them in collecting and analysing basic socio-economic data in order to better understand their real situation;
- to identify different socio-economic groups in the villages and stimulate these groups to investigate their needs and problems of concern to them;
- to assist people in exploring possibilities for changing their reality and enhancing their opportunities for improvement of welfare through their own resources;
- to assist people in translating perceived possibilities into action programmes, mobilizing required resources and involving the necessary local organizational mechanisms to carry out the actions required; and
- to link animated groups with one another and with appropriate institutions for effective operation of development activities.

To be successful, the animator must identify and work as one with the community. Existing extension agents are considered potentially effective animators since they normally reside in the villages, understand the prevailing problems and can better stimulate interaction between the indigenous system and institutions. Criteria for selection include commitment, demonstrated devotion to people, communication skills and initiative.

Figure 5. Mobilization versus Animation



What follows is a shortened version of a case-study produced in Hai District by community-based researchers in order to objectify local conflict between two groups of women, and between 'ordinary' women and a district-level leader. It was deliberately set in another area so the participants would not initially realize they were talking about themselves. The case-study stimulated debate and analysis on gender and class issues, opening up communication among all the actors involved about future steps to resolve the conflict.

Case-study: Nkabeba and Kekue

Two families lived side by side in a village, as if they were blood relatives. The fathers were close friends, who helped each other whenever they had problems and enjoyed the good times together, too. Their children, Nkabeba and Kekue, grew up together, shared meals, and all went to the same local school.

Nkabeba and Kekue were both clever women, but only Nkabeba was lucky enough to get more education. After secondary school, she trained as a land surveyor and was employed by the Lands Department in Kilimanjaro Region.

In spite of her low salary, Nkabeba lived well; we all know how land surveyors earn extra 'allowances' from the many people in search of land. She married a doctor named Lelo. They bought a farm in Kimashuku Village, built a house, and in no time had three children.

Kekue stayed home and helped her parents on the farm after completing grade school. When her father died, however, Kekue's brothers insisted she leave, so they could take over the farm themselves, 'according to tradition'. She married an older widow named Ndeyanka, who had six children. Ndeyanka lived and farmed in Kimashuku Village, the same place where Nkabeba and her husband lived.

Although old childhood 'sisters', Nkabeba and Kekue now hardly saw one another. Nkabeba spent all day in Moshi Town, because of work, and her children went to city schools. The only villagers she bothered to be friendly with were other 'big' people.

Kekue and Ndeyanka before too long had two more children of their own. Ndeyanka admired his wife's hard work and initiative, and helped her establish small trading in the village. She also became a leader of a local women's group.

Many of the village women began to work together to set up small economic groups, so they could earn more income and get access to external support. They began a cooperative maize farm, and used the proceeds to build a structure for a maize milling machine.

But one day a government official came with a gang of people from district headquarters and claimed their farm as his land. When the women challenged him, he showed them his title deed from the Lands Department, signed by none other than Nkabeba herself!

One example of how animation has led to the improvement of the quality of life involves youth employment. A community was having problems with a large number of their adolescents who had finished school and were unemployed. Traditionally, young men work on their families' land without pay. After a discussion of the problem,

the community decided to give an acre of land from the village's multi-acre plot to individual youths. It was their land to cultivate, and they were allowed to keep the profits. Not only was village agricultural production increased, but also the young men of the community were gainfully employed; thus, they became a productive force in the village.

Another instance that directly affected the health and nutrition status of the under-five population involved water supply. The village water taps had been dry for several months. As a result, mothers had to trek a mile to a spring and haul the water back to their houses. This put an extra time-consuming burden on already overworked women, at the same time reducing the amount of water available to their families. The villagers were concerned about the high incidence of diarrhoea, particularly among the under-five group. Through the animation process, the community was able to identify the problem and work together to restore the flow of water.

The villagers have proved to themselves that they can overcome a serious problem and in the process improve their lives and the lives of their children. The empowerment process through animation raises the probability that the CSD Programme changes will be sustained over time. As the village chairman of Idamnole said, "This programme has liberated my people; we will never go back."

Government policy versus community willingness

The demand for medicines in the villages is very high. Several CSD Programme villages wanted to initiate a revolving drug fund in their communities. In fact, several years ago Rambo District in Kilimanjaro Region reportedly launched such a scheme on its own. In reality, since the government facilities so often ran out of stock, people were already purchasing drugs at local pharmacies. When a child is sick, the money will usually be found somehow.

However, cost-recovery schemes for drugs are prohibited by current central government statutes which say that health care and drugs are a government responsibility and must be provided without charge. Dar es Salaam policy makers are discussing this matter and are expected to change the provision in the near future. In the meantime, the CSD Programme villages are out in front of the official policy. This is confusing to villages that have always been encouraged to be self-reliant. In the case of drugs, they are being told "not yet."

Focus on women and gender issues

Gender oppression remains a major constraint that blocks efforts to improve the situation of women and children. It is possible to convince mothers that their children require food more frequently, but how to achieve it is a problem. Mothers are beset by a thousand and one responsibilities and find it difficult, if not impossible, to rush home every couple of hours to feed their children. The most common gender-linked

themes are the unequal division of labour, control of resources such as land, and control over the proceeds of women's work. The issue of women's overwork is most common, and it causes the lowest degree of conflict.

A significant step has been taken by raising gender issues in people's consciousness and changing normative male behaviour. In the villages studied, men were beginning to share the workload at home. There were increased income-generating opportunities for women, and sanctions against irresponsible men. CSD Programme village governments typically exempt pregnant women from field work and legislate the responsibility to husbands. If the husband misuses household resources — for instance, selling maize stocks to gamble or buy beer — he may be fined for breaking a village by-law. The women are better able to care for their children when they receive increased support from other members of the family, especially the husband.

Cooperation between parents — *Ushirikiano wa Wazazi*

There is a widely held belief in a Kilosa District village that a child should not be breastfed if the mother is pregnant with another child, since the mother's breastmilk will be 'spoiled' by the pregnancy, and the infant will get diarrhoea and fever and become weak. As a result, mothers try to avoid a second pregnancy while nursing. However, where family planning methods are not accepted, avoiding pregnancy means avoiding sexual relations, which can create problems with the husband who has a right (*unyumba*) to these relations.

Some women spoke with bitterness of frequent childbirth against their wishes because of *unyumba*. Sexual abstinence while the child is nursing entails the father's consent. 'Father's cooperation in child-rearing' connotes not only providing clothes and food, and giving permission for the child to attend the clinic, but also allowing adequate time for nursing.

During this time, the father may seek other women for sexual satisfaction, which diverts resources outside the household. If the child falls ill, the father may accuse the mother of having an affair herself. Then, because he claims the illness is not his fault, he will not help care for the child. Women say that the men feel the only way to ensure a wife's fidelity is to keep her pregnant. This may explain the lengths to which some women go to conceal the use of contraception from their husbands. — *Source: Lee and Kidunda (1993).*

During a workshop in Shiri Njoro (Hai), participants concluded that while in most homes women work harder than men, changes were taking place and signs of positive work-sharing and joint decision-making needed to be more acknowledged. Even a debate on the issue is a sign of progress and perhaps more progressive than attitudes among civil servants and higher-educated groups. Many male CSD Programme staff, particularly at national and district levels, seemed ambivalent about the subject of gender disparity.

Women's participation in local government is apparent in those CSD Programme villages most successful in social mobilization. Members of one district

council in Hai declared that a certain proportion of committee and village government members should be women. One of the explanations given for the success of the CSD Programme was the increased opportunity for and the actual participation of women in decision-making, including village health committees and households.

The following true story was developed as a case study to stimulate discussion of gender issues in a workshop.

Dispossessing women

Kaanade and her brother Tetera are children of Isava and Leia in Hai District. Their father died when they were teenagers, but they had enough wealth in terms of developed land to grow coffee, maize and beans. Before Leia died, she made sure that Kannade, the only girl and now a widow, was allocated a share of the family property, as she had done for her sons. Although Kannade had three sons, she had returned home when her husband died because she had been banished from her husband's property by her in-laws.

Kannade farmed the land allocated to her by her mother. When her mother died the youngest brother, Tetera, inherited the farm that had the family house where Kannade lived. Soon after their mother's death, Tetera started causing problems and asking, "Since when did a woman inherit family property in Chagga tradition?"

Tetera summoned a few of his confidants in the Masamana clan to discuss the issue, and they unanimously agreed that Kannade must give up her farm and get out of the Masamana clan. Having made the decision, they left the meeting boasting, "We have come from a meeting where we have abolished women's rule in Masamana!"

Kannade was destitute and forced to beg from other relatives and friends for survival. Eventually she settled in a rented room where she set up a small business in trade.

Organization and management

The social mobilization process has worked especially well in Tanzania because of the active involvement and participation of the Tanzanian Government, including a supportive and legitimizing ideology. Just as important is the existence of government and party structures that create channels for service delivery, communication and mobilization all the way down to the local level and back up again. There are also development committees at every level. Analysing who does what at each level and how they interact with one another and with international agencies will identify the management aspects that make the programme work successfully.

Community level

Programme activities are carried out at family, neighbourhood and village levels. This is where the population is mobilized to assess the nutritional status of their children,

identify the causes and adopt practices to improve the situation.

Village government consists of the village council with an elected chairman (a party member) at its head and a village secretary (until recently, a party staff person under the District Executive Director's Office)[8]. The village council members are well versed in the CSD Programme approach and frequently assist in achieving programme objectives. For example, in Nakachela in Newala District, the 14 severely malnourished under-fives originally identified were divided up among the village council members who were made responsible for their nutritional improvement. Now the village has no children in the 'red' zone.

The village government has the right to establish and collect levies from every able-bodied villager over the age of 18. Twenty per cent of the amount collected is returned to the village; the remainder is retained at the district level to fund local development activities. In addition, village governments can and do set levies to support village projects[9]. Most villages in Njombe, for instance, collect money each month for the health fund, to pay village health workers and day-care attendants. The village government might also levy each household a quantity of food to be used in the community's feeding post.

Many CSD Programme villages have adopted by-laws in support of CSD programme objectives. When men spend their time drinking *pombe* rather than helping their wives, they also waste the family's scarce resources, leaving less money for high-calorie foods for the children. To combat this problem, many CSD Programme villages have passed by-laws governing the hours that local bars can operate. Other villages fine mothers of children under five who do not get their children immunized on time, or who are caught drinking after six in the evening.

The CCM (*Chama cha Mapinduzi*) Party structure, which parallels the government structure, has been vital to the success of the CSD Programme. Even though Tanzania was a single-party state until mid-1992, there has always been competition for party posts. This provides some measure of democratic accountability and choice, since there are differences of opinion among party members. The party 10-cell leaders are elected by the member households; typically they are effective and respected neighbourhood leaders. In the CSD Programme, they ensure that children participate in the weighings and that the parents of malnourished children do what is necessary to move towards and into the 'green' zone on the growth cards.

As of July 1992, Tanzania is no longer a single-party state. Political pluralism and multiparty democracy have been introduced in preparation for elections in 1995. It is uncertain what impact the multiparty system will have on Tanzania in general or on the CSD Programme in particular. While some officials are worried, others are optimistic, saying that the CCM Party will continue to control a large portion of the more conservative rural areas for some years to come. Hence, they believe there will

[8] The village secretary is soon to be replaced by a village officer who is to play more of a development role.

[9] Many residents in Hai are not willing to pay the development levy. They feel the central government is not returning the benefits derived from their taxes and labour; instead, they are asked to pay more through cost-sharing. However, many villagers do make regular contributions to the village health fund, and/or support day-care attendants, because of direct benefits they enjoy.

be little change. Moreover, they add that no party would or could oppose the CSD Programme; all political parties can be expected strongly to endorse and support a programme that responds to the needs of children and mothers.

Social pressure is often employed to obtain villagers' cooperation. With the support of the village government, community members are likely to show up at the door of a family that has not contributed to the village feeding centre and demand food. A strong incentive for attending weighing sessions, immunizing children or giving extra food to a severely malnourished child is the embarrassment of receiving a visit from the 10-cell leader and being called before the village council.

Strong village leadership is essential for an effective CSD Programme. An internal evaluation in 1986 revealed that the key characteristic of a progressive village was dynamic, younger and often female leadership.

One village in Njombe District had three village chairmen within three years. The CSD Programme limped along; the village health worker, who was not being compensated, was only showing up at Village Health Days. The registration system was in complete disarray, with reports showing 520 children under five. A new chairman was recently elected and within the first month had paid the village health worker to get his cooperation in organizing the re-registration exercise. A new registration established the number of under-fives to be 206.

However, even with weak leadership and poor programme management, the number of infant/child deaths in the village had dropped sharply since the programme started. The community apparently had participated, and villagers were practising good health and nutrition. Weighing had been continued regularly with the help of the local dispensary, and immunization had been carried out on schedule.

CSD programming in Zanzibar

The Zanzibar Joint Nutrition Support Programme (ZJNSP) has been operating since 1989, but has not reached the same level of effectiveness in Zanzibar that it has on the mainland. While the effort has demonstrated some nutrition impact among participants, attendance at weighing sessions has only been 60 to 70 per cent.

The administrative structure in the rural areas is centred around the branch level, which has several disadvantages for CSD programme implementation. First, the branch administration is tied to the CCM Party, which is not overly popular in Zanzibar. Second, it covers a larger population, often 5,000–6,000 people in each combined unit, making it impossible for the programme to duplicate the intensity found in the CSD Programme on the mainland. With a catchment area that may contain over 500 children under five, the mothers have to walk some distance and also have to undergo a lengthy wait for the child to be weighed.

In the recent annual review, the need to identify some intermediate structural level of operations was seen as a priority issue. The possibility of using the existing *shehia* as a programming unit was considered. The *shehia* is at the same level as the branch, but it is headed by a *shea*, a traditional position of leadership dating back to early this century. There is a government community development officer at the *shehia* level as well.

Under the *shehia* are neighbourhoods, which are headed by traditional leaders referred to as *mzee wa mta*. This would provide ZJNSP with a manageable unit to interact and link with the 10-cell units.

Effective decentralization has yet to be realized in Zanzibar, partly because of this lack of structure. Another possible reason is the island is small, the villages are close to the centre and consequently central authorities take part in local affairs. Moreover, the customs and culture of Zanzibar are different. More research on its history and political background is required to design an appropriate approach to the implementation and management of a community-based programme.

Intermediate level (ward and district)

As important as village operations are to the success of the CSD Programme, they could not function effectively without the support of the intermediate level. During the start-up phase, government and party apparatus at the ward and district levels provide technical assistance and ongoing supervision of programme activities.

a) Multisectoral/integrated programming: The CSD Programme could logically have been carried out as a health sector scheme with nutrition and primary health care as its focus and under-five mortality reduction as its objective. However, it would not be nearly as effective since health does not have the authority to direct the other sectors laterally. Health is only one of many sectors involved in the operation. The health personnel are usually from the nearby dispensary and are involved mainly in the Village Health Days.

Both the ward and district levels have CSD Programme implementation teams including party leadership and extension workers from agriculture, education, community development, women's economic activities, planning, health and forestry. After training, the implementation teams are fully conversant with all aspects and all sectors of the CSD Programme. Above all, they are important sources of technical assistance.

The only way for effective integration to take place is by horizontalization of the structure at the programming level. The vertical lines of authority are broken down at the district level where the District Executive Director (DED), the highest level development officer in the

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Mother and child health (MCH) services at a regional hospital.

district, is given control over the various line and sector agencies. He also serves as the head of the CSD Programme implementation team. A CSD coordinator is appointed in the district Planning Office which comes directly under the DED and above the other line offices. He or she may come from any of the other line agencies, but is seconded to Planning to catalyse and coordinate participation of other sectoral officers. In this way, effective multisectoral programming becomes a reality.

Masasi's *Onjama* Campaign to Increase Food Production

Captain Mwambi, the District Commissioner in Masasi District of Mtwara Region, described with great enthusiasm and pride what his district had accomplished in 1988-89. He refers to it as *Onjama*, a word made up from the first letters of the Swahili words *Ondoa Njaa Masasi* or 'hunger eradication in Masasi'.

When he assumed his position in 1988, Capt. Mwambi found a desperate situation. The district was suffering from a severe drought; only 25,000 tons of maize were produced as against a minimum requirement of 60,000 tons. The CSD Programme was in its infancy in the district, and it was clear that if malnutrition was to be eliminated, the district must provide sufficient food.

Capt. Mwambi conducted a situation analysis of the agricultural sector and discovered several reasons for the low production. First, the farmers were practising primitive farming, using only small traditional hoes. Second, they were not using fertilizers and pesticides. In addition, they did not till the land. Finally, more drought-resistant crops like cassava and sweet potatoes had to be planted.

Capt. Mwambi mounted an intensive, military-like campaign that mobilized both the government and party infrastructure. He started by passing a by-law directing that every able-bodied person must cultivate one acre of drought-resistant crops; this was later raised to two acres. Close supervision was provided by the extension workers and the 10-cell leaders, assuring that the farmers were trained and that they carried out the programme. Regular review meetings were held to report on the progress being made under *Onjama*.

A cultivation target was established at 122,000 acres; 99,000 acres were realized. In the first year, production rose to 90,000 tons, giving the district a 30,000-ton surplus. But despite this tremendous increase in production, the malnutrition rates did not drop significantly.

Capt. Mwambi then realized that food alone was not sufficient to improve the situation. Changing behaviours, such as more frequent feeding with high-density foods and reduced workloads for mothers, takes more than a military campaign. He has now become one of the strongest supporters and proponents of the CSD Programme's multisectoral and social mobilization approach in the region.

Those who are familiar with other developing country settings are surprised to see the level of activity of Tanzanian government extension workers involved in the CSD Programme. The difference is that they, too, have been empowered. Development literature stresses the need to empower community members, but rarely talks of

the extension staff. However, if adequate support and supervision is to be applied to village-level activities, the attitudes and morale of government workers must also change.

As a result of the orientation and training outreach workers receive on the triple-A cycle and conceptual framework, the CSD Programme links the extension workers to the villagers in a meaningful way. As the community assesses its situation, problems and possible action, it becomes more receptive to the technical assistance and resources commanded by government workers, and this in turn stimulates the extension workers to visit the communities.

The programme is described as 'bottom-centred' planning and development, as opposed to 'bottom-up', where plans always have to go up to the ward, district or regional level to be consolidated before being sent back down with possible changes from above. Here, plans are both formulated and carried out at the local level, which makes the programme real and immediate to all concerned. In this way, the extension workers at the ward and district levels have substantial responsibility. The bottom-up aspect still exists in such cases as water systems or health services, which require technical expertise or materials from outside the village. There are also requests from villages for such inputs as materials, forms and training. But in general, the orientation is towards greater self-reliance ('We can do this by ourselves if you make minimal inputs of equipment or skills that we do not possess').

b) Decentralized structure: A succinct description of decentralization is that it allows more to be achieved with less. Decentralization requires participation, which brings sustainability. While most governments agree that it is beneficial and claim to be pursuing it, rarely does one find effective decentralization.

If the emphasis is on community-based and community-involved programming, the structure must permit the same. Both government and party are decentralized on paper, but there is constant tension between the centre and the regions and districts, especially in a time of increasingly scarce resources. Districts must often balance demands from both above and below. The situation is similar to that of the struggle between top-down and community-based development.

The most important indicator of decentralization is control over resources. The district can also raise funds by means of levies and by-laws, thereby covering a portion of the cost of supporting and supervising development activities. Raising funds is frequently a problem when resources are so scarce at the local level, and there is sometimes conflict over the control of resources between CSD team members and other top district officials. The high motivation and built-in accountability of the CSD Programme make it more difficult for other government staff to use vehicles and other assets outside of official business, which also increases tension. But at least there has been some devolution of power to local authorities.

c) Information system: The CSD Programme coordinators and ward secretaries review quarterly data sent in by the villages. They identify which places have low participation rates or high numbers of severely malnourished children. This is known as 'management by exception'. Instead of requesting that huge amounts of data be sent, the programme supervisor visits the 'weak' village or ward and determines the nature and causes of the problem through interviews, observation and review of

records. Thus, there is immediate and personal follow-up and feedback on the data that have been presented.

The data are the source of considerable competition. A village wants to be the first in the ward to eradicate severe malnutrition. A ward attempts to attain the highest participation rate in the district. The CSD Programme coordinators encourage this competition, frequently telling one village what others have achieved. In both Mtwara and Hai, annual prizes are given to the best-performing villages, in terms of child nutritional status and other indicators. A public meeting is held with top government leaders, where the prizes are presented to village leaders. This encourages villagers to work harder on CSD Programme activities.

Regional and national levels

Government bureaucracy is typically described as 'procedure-oriented', as opposed to private-sector groups, such as non-governmental organizations, that are oriented more towards results. But in the case of the CSD Programme, the Government has shown that it can function in a result-oriented manner. It is as if it has instituted the 'management by objective' principle in the CSD Programme. Its planning process is dynamic and evolving; if one approach does not produce results, then something else is tried, based on the triple-A process of assessment, analysis, action and reassessment.

a) Political commitment: Political will is supposed to be the sine qua non of successful development efforts. From the beginning, the CSD Programme has received support from the highest levels, including that of former President Nyerere and the last several Prime Ministers. The ideology endorsing health, rural development and a people-centred approach was compatible with the CSD Programme and UNICEF goals and values. In addition, the programme has enjoyed the backing of the CCM Party, which saw that it could but gain support by actively campaigning in favour of improving the lives of mothers and children.

Quotations from President Nyerere's speeches

Address to UNICEF Pan-African Committee of Artists and Intellectuals for Children (Bamako, July 1989)

"Africa has no future... if we do not take care of our children.... There is no room for protocol or red tape or personal pride when the life of a child is at stake.... Governments have a responsibility to help the people to understand and help them to convert that understanding to action.... The key is: keep the systems simple and involve the women.... The one thing all history teaches is that people have to act for themselves and in their own interest.... The people know their own needs; once convinced that these can be overcome by their own efforts, they will make these efforts. What they need now is knowledge, self-confidence and sometimes skills or very small amounts of money."

Speech on Decentralization (Mwalimu, 1972)

"The purpose of both the Arusha Declaration and of Mwongozo was to give the people power over their own lives and their own development.... The planning and control of development in this country must be exercised at the local level.... It is difficult for local people to respond with enthusiasm to a call for development work which may be to their benefit, but which has been decided upon and planned by an authority hundreds of miles away."

Statement on Development/Self-reliance

"People cannot be developed; they can only develop themselves. For while it is possible for an outsider to build a man's house, an outsider cannot give the man pride and self-confidence in himself as a human being. Those things a man has to create in himself by his own actions. He develops himself by what he does... by making his own decisions, by increasing his understanding of what he is doing and why, by his own full participation."

All Prime Ministers of Tanzania have participated in the CSD Programme in a variety of high-profile ways. The late Prime Minister Edward Sokoine took part in the inauguration of the original Iringa Nutrition Programme in 1983. When the Morogoro CSD Programme was launched in 1991, the Prime Minister was on hand. In addition, the Prime Minister wrote the foreword to the National Meeting on Child Survival and Development, the Tanzanian position for the World Summit for Children.

An article on the inauguration of the nutrition pilot programme in Iringa, held at the Samora Machel Stadium on 3 December 1983, appeared in the *Daily News* on 4 December 1983. It quoted Prime Minister Sokoine's speech, which called on Tanzanians to give top priority to child health because to ignore children's problems was to endanger the nation. He stressed the need for mothers to breastfeed their children and for villages to provide day-care facilities that would allow mothers enough time to participate in economic activities.

The grim statistics concerning child health in Tanzania were reviewed by the Prime Minister that day. He said that 60 per cent of the country's children were affected by diseases resulting from or exacerbated by malnutrition. The programme being inaugurated was intended to increase the knowledge of the communities served concerning health, nutrition, education, agriculture, water and sanitation, and at the same time improve their access to an integrated package of services.

The Executive Director of UNICEF, James P. Grant, also spoke at the inauguration. As a financial supporter of the Iringa Nutrition Programme, UNICEF hoped that Tanzania would utilize the experience gained in literacy and universal primary education campaigns to help the Iringa programme achieve success. WHO was represented by Dr. Franklin Albert, from the regional headquarters in Brazzaville (Congo); he stressed that the fight against malnutrition in Africa was vitally important considering the continent's 15 per cent drop in food output during the 1970s.

Another article in the *Daily News*, dated 27 February 1984, refers to malnutrition

as the largest killer of under-fives the world over. It quotes UNICEF figures that report 15 million child deaths every year in the developing world, including 50,000 under-fives in Tanzania. It went on to quote the Director of the Tanzania Food and Nutrition Centre, who said nutrition workers could not cure the problem by themselves. Because malnutrition was the result of a number of immediate and contributory causes, it required the multisectoral approach that was going to be adopted in the nutrition support project recently launched in Iringa Region.

b) Structure: The further one gets from the programming level, the less technical and operational input and supervision are found, and the more policy direction and oversight are required. The higher levels of administration performed an especially important part in the initial phase of the programme when advocacy was required to get the needed support. The National Coordinating Committee coordinates CSD Programme activities and actors at the national level, encompassing the various government sectors and the donor agencies. There is an annual programme review meeting where all sectors, donors and regions meet to discuss CSD Programme activities during the previous year and plan for the future.

The role of the region includes supervision, coordination, materials/supplies, logistic management and support.[10] Funds are sent directly from the centre to the districts to ensure that the regions do not allocate part of the funds to other activities.

c) Publicity: Regional journalists and representatives from the radio, news agency and news magazines are well briefed on the CSD Programme, and a journalist from the regional press is always present at the annual regional CSD Programme reviews. Newspapers carry articles that promote specific interventions. A series of three articles on impregnated mosquito nets, referring to them as "magic nets," described how villagers found them very useful in preventing malaria in the under-fives and pregnant women. During the eight years between August 1984 and August 1992, at least 464 articles relating to the CSD Programme or associated health and nutrition issues were published in the English-language *Daily News* and Swahili Uhuru press.[11] These articles made liberal use of data from the CSD Programme information system.

Some of the regions have their own publications with trained village correspondents. The best known was *Nipe Habari* in Iringa. It included stories on nutrition-related problems and on specific CSD Programme activities in some Iringa communities. It was sold for a few shillings but was not able to recover its production costs. Its progressive editor died in 1988, and the periodical has not been published since. However, people still remember it as an important programme component, and steps are being taken to revive publication. Hai District's CSD Programme newsletter (*Uhai wa Watoto wa Hai*) is still being published quarterly.

[10] Because Hai District is the only district of Kilimanjaro Region participating in the CSD Programme, there is no need for a regional coordinator. This will change as soon as a second district joins the programme.

[11] If reporters distort or misrepresent what is taking place, press coverage can boomerang, with devastating results at the local level. In one case in Hai, a reporter chose to highlight the drinking problem, whereas in reality the village was one of the best-performing villages according to CSD Programme indicators. Local people were incensed. A public meeting was subsequently held to reaffirm the village's successes without dismissing the need to reconsider local drinking habits.

In addition to the print media, several films were produced and distributed for the express purpose of mobilizing the decision and policy makers, the regional, district and ward government and party officials as well as the extension workers and the community members themselves. The first one, 'Hidden Hunger', was a very effective way to introduce the programme to a village and its leaders.

'Hidden Hunger' (*Utapia-mlo Ulloflchika*)

The 25-minute film in Swahili opens with a funeral procession, villagers following behind a father carrying the small, lifeless, shrouded body of a child. It cuts to a household in the village and tells the story of Asina, a wife and mother whose young child is sick. The story portrays her many tasks, such as working in the field, collecting firewood and fetching water from some distance. Because of this heavy workload, the mother cannot devote enough time to the care of her children.

Meanwhile, her husband is drinking *pombe* with his friends at a local bar. The narrator explains that this drinking has several negative results. For one, he could be helping his wife so that she could spend more time on child care. Second, the cost of the liquor means that already scarce resources will be further depleted, leaving less food for the family and its vulnerable members under five.

A neighbour and friend of Asina is pregnant but still has to work hard in her family's plot. The point is made that too much hard labour by the woman can have a negative effect on the newborn.

The film shows the result of under-fives not receiving enough food, food of poor quality or food not properly prepared. Listless and weak children are more susceptible to infection because malnutrition lowers their resistance. The film explains how to recognize malnutrition, the 'hidden hunger'.

At the conclusion, there is a village meeting where a visitor from the regional capital talks about how to reduce malnutrition. While the villagers want a clinic, the government worker informs them that a clinic will not solve the underlying problems causing malnutrition. They need an integrated approach to deal with the problems underlying malnutrition, thereby removing the cause for the death of the child shown in the opening scene of the film.

The strongest publicity came from the success and momentum of the CSD Programme itself. As nearby districts, divisions and wards observed or heard about results, they requested that the programme be started in their areas. In many cases, the local population started CSD Programme activities on their own with little outside assistance. This was possibly the best endorsement of public support and commitment that a programme could have.

The quarterly meetings provide the opportunity to recharge people's enthusiasm. This, coupled with the continued press coverage and participation by the local and national leaders, constantly reinforces everyone's support.

d) Institutional and individual involvement: The CSD Programme has received broad support from a number of national organizations and institutions, and from

local consultants. The Tanzanian Food and Nutrition Centre developed the conceptual framework and the community-based approach, and initiated the Iringa nutrition surveillance pilot programme in the late 1970s. The Centre still plays a significant part in the CSD Programme, especially in nutrition surveillance and in developing and researching nutrition-related questions. It developed the Food and Nutrition Policy which will influence the nutrition and health status of mothers and children in Tanzania for years to come.

The universities of the country have also been involved. Of particular note are the Institute of Development Studies and the Departments of Theatre Arts, Economics, and Political Science at the University of Dar es Salaam, and Muhimbili College of Health Sciences. Local consultants have made valuable contributions to the success of the CSD Programme, and the international consultants had extensive experience in Tanzania through action and policy-oriented research and training. UNICEF's hiring of many of the above contributors, as well as Tanzanians who previously worked for the Government and were instrumental in the creation of the CSD Programme, has increased organizational commitment, provided continuity and allowed for gradual, incremental development.

e) Commitment of resources: The annual cost of initiating CSD Programme activities in a new district in the early 1990s is mostly taken up by the training of the village and government officials. An estimated two thirds of operating or recurrent costs is borne by the community. Another fifth is covered by the district, while the region pays only about a sixth. The national level has had a very small input, barely 1 per cent, but regional and even national contributions are growing. For example, in 1992, the central Government allotted almost TShs 70 million (US$299,000) directly to districts in support of the CSD Programme, stipulating that the funds could not be diverted for any other purpose.

International agencies

Although largely a Tanzanian effort, international agencies have provided a large portion of the programme's start-up cost. UNICEF collaborates closely with other international donor agencies operating in Tanzania, including multilateral agencies (World Bank), bilateral agencies (Germany, the Netherlands, Norway and Sweden), and non-governmental organizations (African Medical and Research Foundation, PLAN and World Vision). Several of the donors, specifically Norway and Sweden, programme some funds through UNICEF. All donors are invited to participate in the CSD National Coordination Committee meetings in order to facilitate expansion and replication of the programme.

UNICEF contributions consist of materials and technical expertise. Material inputs have primarily been vehicles, drug kits, and funding for training. The vehicles go to different agencies with broad-based development responsibilities, so they will have an impact over and above the CSD Programme. Almost half the vehicles provided come through a reimbursable procurement scheme. UNICEF makes the purchase in foreign currency, and the Government reimburses the agency in local currency. Districts are responsible for purchasing fuel from their own funds. In Njombe, for

instance, 10 vehicles have been allocated among the CSD Programme coordinator, immunization activities, women's economic activities, sanitation, water, a multi-purpose training centre and health centres. The district also received 33 motorcycles, 25 for the ward secretaries, seven for the division secretaries, and one for sanitation activities. Finally, there are 220 bicycles, two for every village (one each for the male and female health workers). UNICEF provides the village health workers with drug kits each quarter. The villagers place a high value on these medicines, and attendance at Village Health Days is said to suffer when drug supplies are exhausted.

UNICEF support has enabled a team of experts to attend training workshops and seminars; these experts in turn trained district teams, who then worked with others at the village level. Allowances from UNICEF have allowed national consultants to concentrate full-time on technical assistance and research. Participants in training sessions receive a per diem or meal allowance from UNICEF. In some cases, the per diem is viewed as an incentive to motivate officials and extension workers to support the CSD Programme effort. During a five-day training, they can earn more than their monthly salary. The rates paid, however, are according to government scales.

UNICEF has played a major role in advocacy and building mass support for the CSD Programme through frequent meetings, site visits, research/outsider interest, publicity, briefings, newspaper articles and film production. UNICEF has generously supported seminars and briefings for journalists at the national level. Important government and party policy and decision makers are made fully aware of what the CSD Programme is accomplishing. One effective means of ensuring support at the top level is including high-level officials in the periodic 'study tours' of a CSD Programme region. These week-long tours give officials the opportunity to see for themselves what is being done in the villages, something which is impossible to capture in articles, or on film or video. In addition, many officials and representatives of the media attend the annual review meetings.

World Bank-supported districts

The World Bank is funding a Health and Nutrition Project (1990-96) in 10 districts in four regions (Kigoma, Lindi, Singida, Tabora). The National Coordination Committee members described the World Bank effort as a health programme. Approximately 15 per cent of the US$47.6 million loan will be devoted to women's and children's health, concentrating on the 10 districts.

Among the issues raised was the structure through which the activities will be implemented. Its counterpart is the Ministry of Health, but it is also collaborating with the Ministry of Local Governments. There is some concern over the ability of the Ministry of Health to coordinate and implement an integrated community-based approach.

UNICEF is assisting the project by training district staff in animation. Recently the project implementing team adopted the conceptual framework for use in the World Bank-supported districts.

Within the next three years, the programme will extend to the remainder of Tanzania, with generous financial support from UNICEF. The 1992-97 country programme allocates a total of over US$37 million to support the existing CSD Programme and the new areas. A large portion of this amount covers start-up costs, mostly used in the training of village and government officials.

A complex effort involving significant community participation requires a considerable time investment. The process of development and implementation cannot be rushed. UNICEF will in fact be devoting more than a dozen years (from 1983 until 1996) to funding this programme.

Sustainability and future directions

The October National Report Workshop on the social mobilization case-study adopted the following concept of sustainability: empowerment of the community and disempowered groups to act on their own behalf, to generate local resources and access resources from higher levels, and to increase their control over resources at all levels. Sustainability has been an important consideration throughout the life of the programme. It has two aspects: one is financial, associated with funding CSD Programme activities in the future; the other deals with process of maintaining the systems and structures that enable the programme to achieve its considerable impact.

Financial sustainability

The real question of financial sustainability is not whether UNICEF will withdraw its support or if internal resources will be utilized. Rather, it depends on whether or not funds or a combination of funds will be available or be allocated to allow the programme to be implemented effectively.

The cost of operating the CSD Programme has been dramatically reduced. In the late 1980s, UNICEF estimated the annual recurrent cost of operating the CSD Programme to be US$2.55 per child, as opposed to US$12–US$17 in the early days of the Iringa Nutrition Programme. Two thirds of current programme costs are already being absorbed at the local level in the form of community and household contributions to feeding centres and remuneration of village health workers and traditional birth attendants. Local government has released many district and ward-level staff to participate full-time in the CSD Programme on government salary.

In more recently added regions, much less UNICEF support is being provided. For example, in Singida, vehicles for the programme are provided on the basis of 'reimbursable procurement', which means that the region must repay the cost of the vehicle over five years into what amounts to a revolving fund. The UNICEF annual input into the region will be in the range of US$200,000 over the next five years, a little over a US$1 per child under five (for an estimated 165,000 children).

Every year Tanzania receives over one billion dollars in foreign assistance. An estimated 20 per cent of this amount is allocated for the social sector. Even if one were to allow for every contingency and budget US$5 per child for recurrent costs, the total

amount required to cover all under-fives in Tanzania would be US$20 million a year, or only about 10 per cent of the foreign assistance funding available for social sector programming each year — a small amount considering the large impact. It should not be difficult to generate this level of funding on an ongoing basis. Donors are eager to support and claim credit for successful social sector programmes.

Of course, the Government must first agree to allocate the foreign aid to the scheme. There are numerous competing demands for resources in Tanzania, and the CSD Programme must be given a high enough priority to receive funding. However, given the Government's commitment to the programme to date, this does not appear to be a concern.

Sustaining the process

Some people are concerned that a cessation of UNICEF's promotion efforts and technical inputs, such as IEC (Information, Education, Communication) and tracking of child survival data, could be detrimental. Others think that the programme is so well established that the management systems have been institutionalized. The registration, follow-up and information systems and the quarterly meetings of the implementation teams at the various levels are now taken for granted in CSD Programme districts and regions. However, some of the problems that might be expected to arise in a more mature programme like Iringa are described below.

Sustaining a mature CSD Programme: The case of Iringa Region

The Iringa CSD Programme is now eight years old. In recent years, the programme has gone through, in the words of the regional authorities, a "period of laxity." At the September 1992 annual review meeting in Iringa, the performance of mid-1991 (end of the second quarter) and mid-1992 were compared. Only 52.4 per cent of under-five children were weighed in June 1991. Local residents said the figure was low because medicine had not been supplied during that period, and most village health workers were without drugs. A year later, the rate was back up to over 75 per cent.

A national demographic and health survey was conducted in mid-1991 and found that only 71.3 per cent of children between 12 and 23 months were fully immunized. This was discouraging because in 1988 Tanzania was the first country in sub-Saharan Africa to attain universal immunization coverage. In the recent figures, Iringa had a rate considerably below the national average and fifth lowest in the country, 61.5 per cent.[12]

The registration system has not been maintained in Iringa Region, so weighing participation is based on census projections. At the annual review, the district coordinators were instructed to re-register all the villages.

The participation rates of a mature CSD Programme do not show who is and who is not participating — the better-off families, the poorest or a random selection. In a mature programme with low rates of severe malnutrition, low participation rates might be expected because people feel little need to attend weighing sessions.

Despite these problems, severe malnutrition rates continue to decline, with 1.3 per cent

of the under-fives in the 'red' category. Another 33.2 per cent of the target population is reported to be in the 'grey' category. Given the uncertainty as to the accuracy of the denominator and questions about exactly who is participating, it is difficult to know precisely what these figures mean. However, malnutrition rates did not increase dramatically when the programme's management began to slacken. This is an encouraging sign that households have internalized the lessons of the experience in the form of improved basic nutrition and health understanding and practice.

[12] The national expanded programme on immunization (EPI) coverage survey, published in January 1992, gives very different figures. The survey was carried out at approximately the same time as the demographic and health survey, but the sample size was only about half the size. The national coverage figure is given as 61.1 per cent, and the figure for Iringa in this case is 71.9 per cent, tied for second place among the 20 regions.

After malnutrition is controlled

There is the prospect that because the CSD Programme has been so effective in reducing malnutrition and under-five mortality some will believe the programme's primary objective has been met. While this does not mean that malnutrition will be totally eliminated, it is highly possible, even probable, that nutritional status and child mortality may no longer serve as an effective motivating or driving force for the programme. Some people are beginning to consider where the CSD Programme can go after significantly reducing malnutrition.

Also to be taken into consideration is the fact that the context has changed, and that a number of new factors which were not present during the period of growth and expansion could affect sustainability. There will be changes in the political system as multiparty democracy challenges the monopoly of the ruling CCM Party. Donor fatigue, structural adjustment and economic liberalization raise questions about available resources. The AIDS epidemic and the increased number of street children are new factors that must be addressed.

As the malnutrition problem becomes less severe in CSD Programme areas, new concerns are identified and handled in a similar manner. The conceptual framework is particularly sensitive and conducive to identifying issues of women's health. For example, in Mtwara Region, information on pregnant women is now being collected at the suggestion of a village woman. This is a way to ensure that mothers practise good nutrition during pregnancy, thus reducing the incidence of low-birth-weight babies.

With the reported increase in maternal mortality rates, there is also a need specifically to address women's health issues and concerns other than those related to pregnancy and childbirth. In Hai, women used to be criticized for "eating all the time," meaning they were lazy. Now CSD villages are realizing mothers need good nourishment, too. Mothers are demanding a larger share of resources for their children and themselves.

The regional CSD Programme coordinator in Mtwara is considering reporting the percentage of school-age children attending primary school by tracking children through the registration system. Tanzania has had very high literacy rates and

Village members performing 'ngoma' — communication through song and dance.

traditionally had high attendance rates in primary schools; however, the figures have dropped substantially in recent years. National data indicate that only 12 per cent of the seven-year-olds are enrolled in school. A considerably higher percentage eventually enters at a later age, but most have dropped out by the time they become economically active in the early teen years. Thus, if a child enters school at 10 and drops out at 14, he or she has received only four years of education, barely enough to become functionally literate. If enrolled at 7, the child may still drop out at 14, but he or she will have had have seven years of education and be both literate and numerate.

The challenge now is education that involves communities in its direction and management. Indeed, educators and communities in a number of areas are already exploring possibilities. Educators have recognized that community involvement will mean better retention rates, sharing of administrative burdens and reinforcement of the learning process; communities are electing to use their experience of self-management to build that learning perspective into their children's education.

The impulses underpinning such developments manifest a widespread determination among participating Tanzanian communities not only to safeguard the achievements of the CSD programme but also to preserve the dynamic on which the programme is based — so that those achievements can become a springboard to an enduring and expanding development future.

III. BACKGROUND — HISTORY AND CONTEXT

To fully understand and appreciate the success of the Tanzanian CSD Programme, it is essential to see it in context. The dramatic large-scale reduction in the levels of severe malnutrition brought about by the CSD Programme in Tanzania is among the very few nutrition success stories in the developing world in the recent past, others being Thailand, Indonesia and Tamil Nadu in India. This chapter begins by reviewing the health and nutrition status of the CSD Programme target population, the under-fives and their mothers. The programme is then placed in the context of the difficult economic conditions. Equally important is the political and cultural environment, with its rich and supportive development history. The chapter concludes with a review of the early years of integrated nutrition programming in Tanzania that evolved into the CSD Programme.

Health and nutrition status

The mortality and malnutrition rates among infants and young children in mainland Tanzania and the islands of Zanzibar are high. It is estimated that approximately 200,000 children under five die every year. Between the late 1970s and the 1988 census (based on 1985 data), the under-five mortality rate was reduced from approximately 225 per 1,000 live births to slightly under 200. The more recent demographic health survey, based on 1991 data, reports a figure of approximately 160 per 1,000. Infant mortality rates have also dropped, from about 130 per 1,000 live births in the 1978 census, to approximately 115 in the 1988 census (100 per 1000 in the demographic health survey).

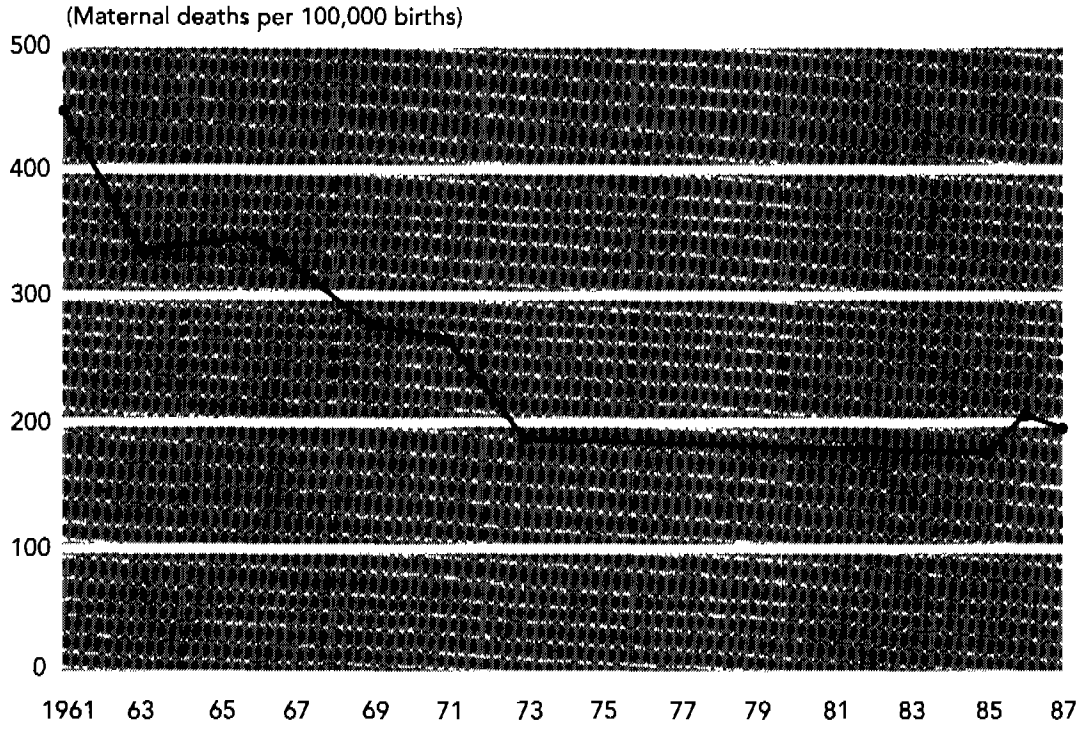
The figures on malnutrition among the under-five population of Tanzania are equally disturbing. In the late 1980s, it was estimated that half of all children in this age group were undernourished (less than 80 per cent of standard weight for age). Six to seven per cent of the under-fives (in a few cases as high as 10 per cent), or nearly 300,000 children, were classified as severely malnourished (below 60 per cent of standard). The latter are nine times more likely to die from infectious diseases than their better-nourished contemporaries.

Maternal mortality rates are still high, although there was a decrease from independence until the mid-1980s. Twelve years after Tanzania's independence (1973), the figure had dropped from 450 (1961) to 200 per 100,000 live births, a reduction of 250 per 100,000. As figure 6 shows, however, the sharp decline of the 1960s and early 1970s slowed and eventually levelled out in the 1980s. More recently a rise in maternal mortality was recorded. The current rates are between 200 and 400 per 100,000 births, according to estimates from health centres, dispensaries and hospitals.

Maternal and child morbidity and mortality remained high despite favourable

ideology and policies. Medical services were rapidly expanded to rural areas after independence. The Government adopted a progressive health policy in the late 1960s that emphasized preventive health care. Village dispensaries and maternal and child health clinics provided immunization services and other primary health care services, as well as curative medicine. In the early 1980s 'barefoot doctors' or village health workers were trained and supported by their village governments throughout the country. The trial was not successful and was replaced by the integrated approach that was tested and implemented in Iringa and the CSD Programme.

Figure 6. Trends in maternal mortality rates in mainland Tanzania



Source: M. Mandara and G. Msamanga "Maternal Mortality Estimates and the Trend in Mainland Tanzania", Faculty of Medicine, University of Dar es Salaam.
Note: Data for the period 1975–1984 are not available.

The 1980s witnessed deteriorating conditions in hospitals and a breakdown of referral systems in urban and rural areas. Lack of transport often meant that women and children in critical condition could not get to hospitals or arrived weak and at high risk. Once they arrived, emergency blood transfusions and other treatment could not be given because of shortages of drugs and equipment. Prescribed drugs were

unavailable at dispensaries. Budgetary support of national health policies was cut from 7 per cent in 1979 to 4 per cent by 1987.

Child survival begins with safe motherhood. The root causes of under-five and maternal mortality begin with the mother who is malnourished. Her food has low nutritional value, and there is not enough of it. Too many children, too closely spaced, with continuing heavy workloads during pregnancy, seriously weaken mothers and result in low-birth-weight, high-risk babies.

At a minimum, safe motherhood requires better nutrition and food security, adequate ante-, intra- and postnatal care, sufficient health services, a healthy environment, and formal and non-formal institutions prioritizing women in allocation of and access to resources. In Tanzania, only about 46 per cent of births take place in health facilities, especially in rural areas. Both mothers and health care workers need to deepen their understanding of the maternity process and all the high-risk factors, within a system of participatory community maternal care.

Vitamin, iodine and iron deficiencies also take their toll on women and children, the most vulnerable groups. Breastfeeding mothers in urban areas often cannot leave work to feed their infants frequently enough, either because there is no transport or employers do not allow it. Infants are often weaned incorrectly. Malnourished children typically suffer heavy infection rates, while diarrhoea, malaria and respiratory infections worsen nutritional status. Child survival and development require a viable strategy for improved nutrition, immunizations and functioning preventive health care facilities.

The issue of food security has only been recognized recently, and there was no national food policy until 1991. Too much emphasis has been on cash crops for export. Agricultural practices for much of the country have remained small scale, using primitive technology. In the most populous areas, land shortages lead to insufficient cultivation of food crops, and up to 30 per cent of the harvest is lost because of poor storage facilities. A substantial amount is also sold for cash or used for such purposes as the brewing of beer. Strategic food reserves are only a recent phenomenon.

During the first half of the 1980s, the agricultural sector lacked adequate resources to buy fertilizers and pesticides or install irrigation and storage facilities. There were also laws which prohibited movement of food across regions. Most of the water supply systems established in the early 1970s had broken down due to lack of maintenance. This led to greater burdens for women, who had to travel farther to find water and thus had less time for their children. Meanwhile, the declining environmental sanitation conditions and other factors increased rates of malaria infection and parasitic infestations.

Economic setting

Many of these health and nutrition problems can be traced directly to the macroeconomic situation. In the mid-1970s, drought forced the country to import a huge amount of food, and oil prices suddenly quadrupled. Between 1977 and 1980,

foreign exchange holdings declined 95 per cent. At the same time, the terms of trade became highly unfavourable for Tanzania. For example, the country paid over 20 per cent more for iron and steel imports while prices of coffee and cotton, Tanzania's major exports, fluctuated downward. Growth in the gross domestic product (GDP) fell from over 5 per cent a year during the first half of the 1970s to less than 2 per cent a year between 1977 and 1986. An additional problem was the border confrontation with Idi Amin in neighbouring Uganda which consumed scarce national resources.

Manufacturing output fell with shortages of imported spare parts, fuel, electricity and water. Exports dropped by almost a third, from US$546 million in 1979 to US$369 in 1984. Meanwhile, interest on the external debt rose over 45-fold in a five-year period, from US$4 million in 1980 to US$183 million in 1985. By 1987, the total outstanding debt stood at almost US$5 billion, one and a half times the value of GDP. In the late 1980s, the Government allocated over 30 per cent of its budget for public debt obligations.

In 1984, the Tanzanian shilling was devalued and the subsidy removed on the consumer price of maize, the staple food. A few years later, agricultural producer prices were increased and the currency further devalued. Agriculture played an ever-greater role in Tanzania's economy, 62 per cent of GDP in 1989 compared to 43 per cent in 1980.

The impact of the macroeconomic situation was felt directly at the household level. The scarcity of resources affected government allocations for social services. The quality of health services deteriorated, with few drugs and medical supplies available. The International Labour Organisation estimated that between 1979 and 1984, rural household incomes fell by 13 per cent in real terms. Average non-agricultural wages decreased as farmers shifted to more profitable cash crops. Inflation rates were around 30 per cent.

During the latter half of the 1980s and early 1990s, the economic situation did not improve even though the economy was recently liberalized to permit more free-market enterprise. The disastrous economic situation in a country with such scarce resources makes the achievements of the Iringa Nutrition Programme and CSD Programme all the more impressive.

Political and cultural environment

The Tanzanian macropolicy context will be described in this section, including an outline of the cultural environment and political structure.

National culture and political integration

Tanzania has a rich ethnic mix, but this has not been a source of strife, as it is in many African countries. Since independence, there has been a deliberate policy of integration in the schools, health care services, housing and social gatherings. Traditional tribal authorities were abolished and replaced by village and ward development committees.

Freedom of religion was built into the state and party constitutions in order to pre-empt any conflicts and also to facilitate joint schools and health care facilities, mixed residential areas and national unity. It brought peace and tranquillity to the country, built a strong nationalist feeling and a sense of belonging, and was helpful in promoting joint development activities.

Recently though, with the advent of multiparty democracy and widening economic disparities, friction between ethnic, religious and socio-economic groups has been surfacing. People are realigning themselves according to their birthplace, and this is influencing politics. The mass media often carry editorials urging people to desist from religious divisions and sectarianism. Religion and ethnicity are becoming negative factors in social relations in Tanzania despite legislation and policies to the contrary.

Another important aspect of the national political and cultural integration effort has been the widespread use of a single language. Swahili is spoken even in the remotest villages of Tanzania, and this has facilitated community participation and movement around the country.

Arusha Declaration

The First Five Year Plan (1964-69) was frustrated by serious misunderstandings with and a lack of support from Western countries, especially the United Kingdom and the former West Germany. With the Arusha Declaration in 1967, Tanzania denounced dependency, turned inward and promoted self-reliance. The village became the centre of development organization and resource mobilization. The emphasis on self-reliance targeted human resources as the primary motivating force for development and self-emancipation. Villagers organized themselves to build schools, dispensaries, roads and even houses for each other, dig trenches for water-pipes, and start communal farms.

The Arusha Declaration also made popular decision-making its *modus operandi.* The leadership over the last several decades has recognized that the people have something to contribute, and the ruling CCM Party claimed to be rooted in the masses.

The Arusha Declaration was a major policy shift, originating from the top government leadership of the country, but actions often differed from policy statements. The control of the nation's economy was supposed to be placed in the hands of the people, but in fact it was given to the bureaucracy. The banks, industries, estates and factories were all nationalized, and government took control of land and other natural resources.

Although people were asked to plan, the central Government maintained control over funds. This gave it leverage over planning and implementation. Each ministry continued to give orders through its officer in the regions, while those closest to the problems had the least power. Despite nationwide demonstrations to support the Arusha Declaration in the late 1960s, by the early 1970s most workplaces remained under central bureaucratic control. The progressive top leadership, which was genuinely committed to rural development, set out to address this issue.

Decentralization

Decentralization legislation was first enacted in 1972, although the Constitution was not amended until the mid-1980s. The existing system whereby each ministry had its own officer at the regional and district levels was abolished, giving local authorities more freedom and control over decisions and actions having local impact. The same policy also directed that villagers use their own initiative and resources to find solutions to problems.

Figure 7 shows graphically a simplified administrative structure of central and local government, paralleled by the CCM political party. Each level's development team consisted of planning, financial and personnel officers, together with eight functional officers responsible for agriculture, community development, education, health, industries, land development, natural resources and water. The district development councils were responsible for interfacing with local populations, ensuring they had a say in their own development. The functional officers were responsible to the District Development Director or Regional Development Director, who in turn was subject to policy direction from both Dar es Salaam and from the people via the development councils and committees.

By merging the local and central governments, Dar es Salaam ostensibly brought itself closer to the people; however, some would argue that it actually increased central control rather than devolving power to the local authorities. Regional and district administrations were supposed to be advised by locally elected committees. However, elections were never held, and the committees soon ceased to have influence.

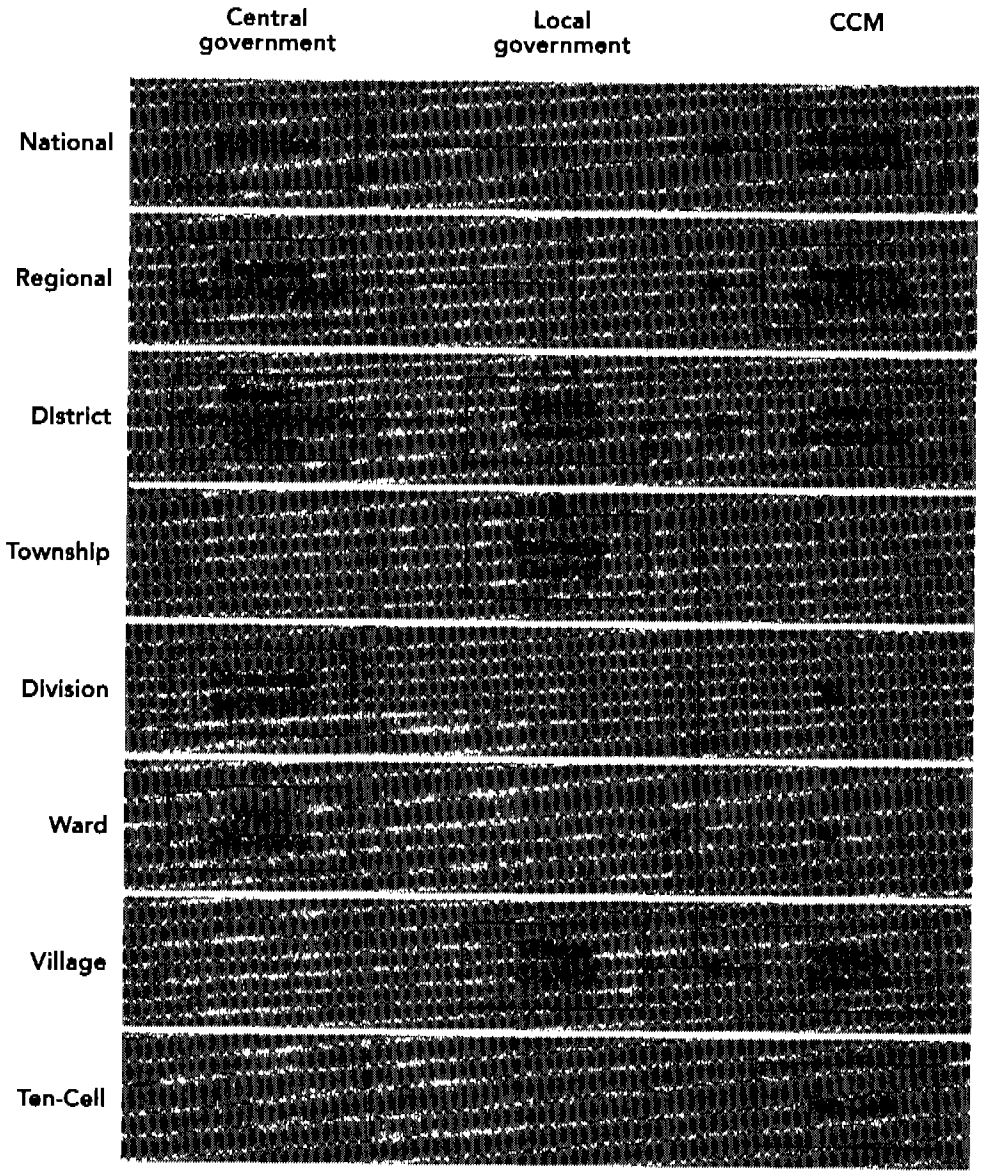
In addition, local development institutions were never authorized to generate their own revenues. As a result, they remained dependent on the national budget. With funds disbursed centrally, planning and implementation were typically initiated and carried out by district bureaucrats, with considerable red tape and frequent delays in disbursements. This seriously disrupted the provision of social services and increased frustration among the population.

Throughout the 1970s and early 1980s, decentralization meant little more than delegation of administrative authority to the regional and district bureaucracy. People felt they were contributing their resources and receiving only unfulfilled promises in return. In fact, resources and revenues dwindled because people in the rural areas either did not plant cash crops as expected or they diversified to grow fast-moving food crops. An alternative arrangement was needed which responded to local needs.

The emerging organizational structure and local government

The central Government introduced local governments in 1984 to stand between themselves and the frustrated villagers whose demands it could not meet. Local governments could raise revenue, use some of it for local development activities, and send the rest to the central Government. The system would bring villagers together

Figure 7. Current administrative structure of government and party



Source: Semboja et al. Handbook on District-level Administration in Tanzania, p. 6.

under their own leadership and give them the autonomy and power to make decisions on the use of their own resources.

The regional and district development committees became the principal links between village councils and central Government. The district council had the authority to raise funds through taxation and plan how to spend them. Members were elected by the villagers, providing the formal basis for democracy, local governance and increased control over their own destiny. However, local authority decisions still had to be in line with national policies emanating from Dar es Salaam. Local financial constraints made it necessary for the districts to seek support from the central Government; with the money came more regulation and less autonomy.

Figure 8: Difference between decentralization and local governments

Locally elected decision making body	No	Yes
Staff accountable to:	Central government	District Council
Head of administration	District Development Director	District Executive Director
Power to tax	No	Yes
Own budget	No*	Yes
Own staff	No**	Yes

*Part of Regional Development Director's budget.

**Part of central government service.

The ward development committee had several functions:

- **bottom-up** — collate, coordinate and forward village council plans, requests and opinions to the district council for consideration, approval and funding.
- **top-down** — coordinate and supervise district council activities and forward information from district council to the village councils.
- **on their own** — propose development projects for the ward or enact by-laws for villages and initiate, coordinate and implement self-help activities in the ward.

Villagers elected between 17 and 25 council members every three years, who were supposed to meet monthly and enforce by-laws that generated funds. The effectiveness of this system in support of development objectives depended on how well mobilized and empowered the villagers were.

Party structure and mobilization

Both the Tanganyika African National Union (TANU) and later the *Chama cha Mapinduzi* (CCM) political parties issued guidelines discouraging top-down, bureaucratic decision-making and promoting popular participation. Their organizational structure reached down to the household level, enabling them to contribute significantly to development efforts.

The cell consisting of 10 households is the basic component of the party structure. Each cell elects a leader and holds periodic meetings to plan development activities. The mobilizing role of the party is most effective when party leaders also serve as government officers, as often happens. One example is the intensive national adult education campaign that achieved and has maintained adult literacy rates above 65 per cent, with heavy party support and participation.

In the last several decades, the party has been supportive of child health-related issues. In the early 1970s, a TANU conference directive advocated the extension of health care services to the rural areas. In 1987, CCM issued a national policy on the care and raising of children and youth, providing detailed guidelines on the care of pregnant women, newborns and young children, as well as community-based day-care centres. The party has a programme emphasizing maternal and child health care through the year 2002.

Evolution of the CSD Programme

Tanzania's history and political and intellectual climate provided a fertile foundation for the CSD Programme and helped shape its theoretical underpinnings. In the late 1960s and 1970s, there were numerous discussions in the university and development community regarding participatory research and development. The development of adult education programmes, the development of the Tanzania Food and Nutrition Centre along with a food and nutrition policy and pilot nutrition activities, and joint government/UNICEF activities under the Basic Services Programme and Iringa Nutrition Programme all led to the present CSD Programme. Other precursors include non-governmental organization initiatives, animation training in agricultural colleges, and pilot projects in village-level planning that have collectively influenced the framework, objectives and methodology of the CSD Programme today.

Early experiences in participatory development

After the Arusha Declaration in 1967, during a period of high enthusiasm for socialism in Tanzania, the faculty at the University of Dar es Salaam and others began developing participatory research as a tool for self-reliance. Participatory research is an approach of social investigation with the active participation of the target group in the entire research process, a means of taking action for development, and an educational process of mobilization for development. The process of promoting participation and self-reliance depends heavily on the extent to which people become

aware of their current situation, as well as potential options and alternatives, and critically examine the root causes. This process, termed 'conscientization' by Paulo Freire in 1968, is considered a core element of participatory development.

The Institute of Adult Education and the adult literacy campaign also began to examine alternative participatory education experiences based on ideas developed by Freire and others. The Education for Self-reliance approach started with the experiences and knowledge that one possesses and, through a process of reflection and analysis, taught how to develop critical thinking skills in order to discover strategies for change.

In the 1970s, some of the early practitioners of participatory research included the Christian Council of Tanzania, an indigenous organization whose activities included setting up a vocational training programme based on local priorities, and the Jipemoyo Project of the Ministry of Culture, which conducted multisectoral participatory research in Bagamoyo. Both organizations developed conceptual frameworks with villagers, focusing on the root causes of poverty and raising specific issues concerning class differences, gender and ethnicity.

The Agricultural Revolution around 1973-74 included training community development agents in participatory methods and animation. The Training for Rural Development College in Ruaha, Iringa investigated empowerment issues with the extension agents. The Ministry of Community Development used a participatory approach to village-based assessment and planning. Mass radio campaigns emphasized a village-level planning process.

In 1978, a workshop on research methodology brought together members of the University of Dar es Salaam, the Christian Council of Tanzania, the Ministry of Culture and others, from which both the African and the Tanzanian Participatory Research Networks were created. Popular theatre was incorporated into participatory research around this same period.

The Planning for Rural Development at Village Level Project was conceived in 1979 and established in the Institute of Rural Development Planning in Dodoma in 1984. The project's overall goal was to test a replicable methodology for the promotion of participatory, self-sustaining, rural development initiatives in 30 Tanzanian villages. Although by 1986 ideas about participatory, action-oriented research methodologies were crystallizing, villagers were not yet fully engaged in the process. Extension agents were re-oriented and trained in animation techniques to stimulate and catalyse participatory development at the grass-roots level.

The Institute for Development Studies at the University of Dar es Salaam formed study groups on rural development, women, labour and health, with wide participation from non-university people. Their analyses concentrated on the multisectoral nature of health and development, gender issues and the influences of the political and economic environments. There was considerable cross-fertilization of ideas through consultative visits, debates and reports. The recognized needs for grass-roots participation in planning and for linking development to issues of redistribution of resources and justice were legitimized by the supportive ideological environment following the Arusha Declaration.

Tanzania Food and Nutrition Centre

The Tanzania Food and Nutrition Centre (TFNC), established in 1973, has from its inception recognized the multiple causes of malnutrition and stressed the need for an integrated approach to the problem. Its first director and staff, some of whom participated in the debates described earlier, were convinced that a new agricultural policy was required putting food before export crops, and that change should build on people's knowledge of farming and technology. The TFNC Board of Directors represented the Ministries of Health, Agriculture and Education as well as the Prime Minister's Office, the Party and the Parliament.

Through years of developing approaches and testing the feasibility of various nutrition development alternatives, TFNC developed a conceptual framework that facilitated the identification of important factors and causes relating to malnutrition and underdevelopment. In the broadest sense, malnutrition is caused by unequal access to basic resources or services, which in turn stems from historical, economic, political, ecological and cultural factors at different levels of society. The actions required to reduce malnutrition are ultimately a compromise between attacking the major causes and selecting those measures that are feasible to change. Planners must therefore use a broad interdisciplinary approach as they work hand in hand with villagers to formulate problems and analyse the causes of malnutrition.

TFNC was also responsible for the development of the Food and Nutrition Policy, which was drafted in 1980, evolved and refined over a period of 10 years, and finally passed in 1991. The Iringa Nutrition Programme, through the Joint Nutrition Support Programme in 1984, provided an opportunity to put the policy into practice. The regional officers had already been exposed to the idea of a nutrition information system and multisectoral planning. TFNC posted one of its staff in Iringa to help set up the system and provide technical assistance.

Government of Tanzania and UNICEF

Tanzania's development policy after the Arusha Declaration of 1967 emphasized the rural areas. Thus, from 1972 to 1982, health resources were used to expand rural health facilities and train paramedical personnel. The Basic Services Programme was set up to improve coverage in rural areas, assist a process of social development and provide some key health services.

The UNICEF-assisted Basic Services Programme covered four previously neglected southern regions — Iringa, Morogoro, Mtwara and Ruvuma. This assistance, directed to village 'clusters', targeted the provision of water as the core activity, plus construction of health facilities and better housing, nutrition, basic education, day care and income-generating activities.

After a decade of working closely with UNICEF, the Government of Tanzania continues to be in the vanguard of the child survival and development initiative. Following the World Summit for Children, President Mwinyi held a National Summit on the Survival, Protection and Development of Children in June 1991. The National Assembly adopted the global goals for children and the community-based strategy that

uses nutrition as the entry point and growth monitoring information as the key indicator for managing the assessment/analysis/action process. Furthermore, the members of the National Assembly became permanent members of the ward development committee in their respective constituencies to facilitate closer monitoring of the CSD Programme.

The annual Day of the African Child (16 June) has been named the National Day of the Child in Tanzania. Successes and failures of the National Plan of Action for the Survival, Protection and Development of Children have become political issues, and there is increasing awareness and demand for nutrition information at different levels of public administration and development planning.

Joint Nutrition Support Programme

The Director-General of WHO and the Executive Director of UNICEF initiated the idea of developing joint support for the improvement of nutrition programmes in November 1980. In May 1982, following the UNICEF Executive Board's approval, a global grant from the Italian Government of over US$85 million made it possible to launch activities in the three countries initially selected to participate. Tanzania was chosen because of its reputation for work in nutrition, the priority given to nutrition in the Government's development plans, and the Government's preparedness to implement a large-scale nutrition effort.

In 1982, the new Representative for UNICEF in Tanzania, who had worked for the TFNC in the 1970s, organized a briefing for representatives from the Prime Minister's Office, Ministries of Health and Social Welfare, TFNC, Bureau of Statistics, Institute of Resource Assessment, the Swedish International Development Agency, and the Italian and Dutch embassies. An Ad Hoc Planning Committee, chaired by the representative from the Prime Minister's Office, was established to prepare a programme proposal, select an appropriate site and formulate a preliminary budget. The decision to have the Prime Minister's Office assume responsibility assured that the programme received the high-level attention it needed.

Iringa Region was selected for a number of reasons. To begin with, recent TFNC nutrition surveys there showed a high prevalence of malnutrition, so there was a sense of emergency. In addition, the region contained a range of agro-economic and ecological zones typical of other areas of Tanzania which could facilitate replicability. The region's institutional infrastructure for training and nutrition work was comparatively well developed, and TFNC had already established collaboration with the region. Finally, the Basic Services Programme was also present. Iringa regional authorities proposed further concentration of the programme to seven divisions within the six districts, covering 168 villages, accounting for approximately 25 per cent of the region's total population.

The Ad Hoc Planning Committee expanded to include the relevant functional officers of the Regional Development Director in Iringa, and in October 1982 a proposal was completed for the Global Steering Committee and the Italian Government. The proposal identified priority activities such as family/village food production and conservation, young child food consumption, health sector activities, and

support of household and village activities by national and regional institutions, but did not include a conceptual framework or a monitoring component. The proposal was approved and allocated US$5.7 million for five years. The Ad Hoc Planning Committee was transformed into a National Steering Committee and included WHO and UNICEF representatives.

At the first meeting in February 1983, the National Steering Committee established a Project Preparatory Team with five full-time members (four seconded from the Government and one consultant living in Iringa) representing the following fields: human nutrition and food science, primary health care, community development, agriculture/livestock and nutrition education, and economics/planning and rural sociology. Task forces were set up to develop a plan of action and consider programme priorities within each of the various sectors: conceptual development, situation analysis, health, agricultural production, nutrition planning, weaning foods, technology development support, child development services, education and training, communications, and water and sanitation.

The plan of action, approved in July 1983, substantially modified the first proposal by introducing an explicit conceptual framework to focus on key nutritional factors and suggest a process of assessment. The triple-A cycle was introduced at all levels where there was some command of resources, to provide a graphic and flexible mechanism for modifying or redirecting the programme according to need and in response to received data.

The 220-page plan outlined 11 projects and 38 sub-projects, including support to the health sector through construction and renovation of dispensaries and staff homes, environmental health hazard control, education and training, child care and development, technology development support, household food security, food preparation, communications, monitoring and evaluation, research and management.

The Iringa Nutrition Programme was launched in December 1983, by the Prime Minister, the late Edward Sokoine, and was attended by thousands of people from the region as well as the Executive Director of UNICEF, James P. Grant. Preparation for the event at Iringa stadium, involving communities and leaders from all levels, increased government awareness and commitment to the programme. The activities of the day included announcement of the winners of the song and dance competitions containing nutrition and health messages, demonstration of high-density food preparation, and an enthusiastic hour-long speech by the Prime Minister.

The first year of implementation (1984) was the 'Year of Mobilization'. Systematic campaigns were then launched in each of the 168 villages. The film *Hidden Hunger* was shown the evening before the Village Health Day during which all children were weighed. Education was given about immunization and oral rehydration therapy, and the growth monitoring system was explained. More than 1,000 leaders were trained for three days in preparation for these campaigns.

Two major changes to the conceptual framework occurred in 1985. The conditions necessary for adequate dietary intake and control of diseases were grouped into three clusters: adequate household food security, adequate child care, and adequate health services. This led to new priorities including energy-dense foods, more frequent feeding, and reduction of women's workload. Finally, formal and

informal institutions were identified as resources to accelerate the triple-A process.

A variety of activities in different combinations started in the villages. By March 1986, the programme had renovated 14 dispensaries, built eight new ones along with staff houses, completed six multi-purpose training centres intended for community development training, created day-care centres, installed water systems and constructed latrines. The communities contributed some materials and labour. Almost 3,700 village workers were trained in Iringa under the programme, including:

1,240 village health committee members
340 village health workers
200 villagers in afforestation and agroforestry
220 villagers in crop promotion
226 trained in day-care centre organization
600 day-care attendants
250 traditional birth attendants and healers
610 village artisans.

After the success of social mobilization for nutrition and child survival in Iringa, a workshop was held in March 1987 to define the key elements in this process and the role played by national and local party and government structures and other mobilizing agents as well as external agencies. Participants concluded that the most important elements were advocacy, information/communication, training/education, provision of key services, mobilizing agents and strategic allies, social organizations and relations, and analysis and programming for social mobilization.

In 1987, the programme was decentralized, district implementation teams were strengthened, and the management committee was replaced by a Programme Support Team. The sub-projects and activities were regrouped into five programmes (systems development and support, maternal and child health, water and environmental sanitation, household food security, and child care and development) and a new programme (income-generating activities) was added.

The Iringa Nutrition Programme was also expanded to cover the whole region, adding 450 new villages. As a result, Iringa reached 80 per cent immunization coverage very quickly, the highest in Tanzania. The expansion was achieved in just four months at a cost of US$5 per child compared with US$12 per child per year in the original programme areas. In 1988, the evaluation showed that the Iringa Nutrition Programme had reduced severe malnutrition from 6.3 per cent (second quarter 1984) to 1.7 per cent (second quarter 1988), and moderate malnutrition had decreased from about 50 per cent to 37 per cent.

By 1984, other regions requested the programme in their villages. Kagera Region initiated the programme in two districts with the help of UNICEF funds in 1985. Shinyanga Region in 1984-85 and also Hai district in Kilimanjaro Region in 1986 started small versions of similar programmes. The first major expansion took place with the new UNICEF country support programme for 1987-91. In addition to Iringa, Kagera, Shinyanga and Hai, the Basic Services Programmes in Mtwara, Ruvuma and Morogoro Regions adopted the Iringa approach. It had become evident that this approach was not confined to nutrition objectives but provided a comprehensive strategy to address the problems of child survival and development.

IV. LESSONS LEARNED

After almost a decade of experience with the CSD Programme, it is appropriate to attempt to identify the lessons learned. Anyone interested in adopting a similar strategy elsewhere in Tanzania or in other countries should be aware of the critical factors that lead to success, both in terms of nutrition/health status and the social mobilization process. The approach has been compared to a complex and sophisticated machine with a thousand moving parts, all of which are important if it is to operate at optimal efficiency. However, there are some major parts of the CSD Programme machine which are more important than others and which, if missing or broken, can prevent it from operating at all. From its earliest days, attention to process established the proper atmosphere; constant analysis, feedback, re-evaluation and adaptation permit the programme to perform with optimal effectiveness.

Ask a roomful of experts to identify the most salient points to remember when implementing a CSD programme and each is likely to focus on his or her personal interest, field of expertise, and bias. What follows is a brief discussion of a dozen points extracted from the case-study that appear crucial to the success of the effort.

1. **Goal**: It is important for the programme objective to be a top priority of the communities involved and to receive universal support. The reduction of malnutrition and infant/child death is of immediate concern to villagers and a goal that all can join forces to achieve.

2. **Tools**: The triple-A cycle and conceptual framework have been instrumental in presenting to the community, its leaders and officials the core activities of the programme. These tools enable the programme participants to identify problems and their causes so that effective strategies can be developed to reach the common objective. The approach and information presented in this manner are not new; however, the ideas have been systematized and graphically presented so that all levels can comprehend, adopt and practise them. By exposing everyone to these tools, all participants interact on a more equal basis.

3. **Use of data**: The core of the CSD Programme is its nutrition data, particularly the number of severely malnourished children. The initial assessment of nutritional status in the village prompts community action and the regular reports on nutritional status encourage participation and achievement of programme objectives.

4. **Focus on process**: The CSD Programme has a clearly defined process objective. Social mobilization is a goal to be pursued simultaneously with the nutrition/health objective and is considered equally important. It is not only a means to an end but also an end in itself.

5. **Empowerment/animation**: Empowerment is the cornerstone of the social mobilization process, and animation is the most effective way to empower and mobilize the community. The process not only sustains the nutrition/health improvements, but also changes the way that the community and individuals view the world and their place in it. With increased self-esteem and confidence, they are willing and

able to challenge injustice, act on their own initiative, and improve their situations.

6. **Integration**: The CSD Programme is a truly multisectoral effort. The problem of malnutrition is approached from a number of different directions, including agricultural productivity, women's issues, income generation, and water supply. The conceptual framework facilitates the multisectoral approach by pointing out the immediate, underlying and basic causes of malnutrition.

7. **Structure**: Two structural aspects have enabled the CSD Programme to achieve its objectives. A community-based strategy must have a congruent structure, in this case decentralization. Although tensions and struggle with the centre are present, a degree of decentralization does exist and permits the local level to generate and control funds. It also allows for local management and more flexible support, responding to local problems and issues as they arise. The second aspect concerns administrative responsibility. The Planning Office's supraministerial position, with representatives down to the local level, gives it the authority and capacity to bring the sectoral agencies together to coordinate nutrition and development efforts.

8. **Capacity-building**: Nutrition and social mobilization training is extensive. All levels involved in the programme attend orientation and training sessions and workshops. This is true for the village leaders and workers (village health workers and traditional birth attendants), the ward, district and regional officials and party leaders, and decision/policy makers at the national level. Human resource development has made it possible not only to achieve massive reduction of malnutrition, but it has also been responsible for changing behaviours and empowering community members.

9. **Supporting ideology**: Although there is a constant tension between forces favouring centralization and those supporting decentralization, there is a long-standing ideology in Tanzania that espouses people-centred and self-reliant development and is fully supported by political and intellectual roots.

10. **Advocacy**: UNICEF's active promotion of the CSD Programme and its engagement of key allies at all levels, especially among the policy/decision makers, have been important in building a critical mass of support. The advocacy activities include newspaper publicity, videos, workshops and seminars, and tours.

11. **Affordability**: No programme, no matter how effective, can expand without sufficient financing. In this programme, a concerted effort has been made to minimize costs. With the community providing a substantial portion of the operating costs and not depending on funds from the central Government, the programme has a good chance of being sustained. Donor funds are required to cover the costs of expansion (equipment, vehicles, training). Recurrent donor costs are restricted primarily to drug kits and amortization of vehicles. The cost of sustaining the programme is reasonable (from US$3–$5 per child per year) and could be met for the foreseeable future by allocating a small portion of funds provided for the social sector.

12. **Time**: The CSD Programme has been successful because it was able to develop over an extended period of time. In the 15 years since the Iringa Nutrition Programme was introduced, much has been learned and fed back into the improvement of the programme. Moreover, pressure for results in the observable and measurable nutrition indicators has not been allowed to distract programme managers from the harder-to-measure but crucial social mobilization process objectives.

Annex I — Research process

Organization

Two research groups developed this case-study: a national team that concentrated on districts and villages, coordinated by a local researcher, whose approach was reflective and action-oriented, using participatory methodologies; and a team organized by UNICEF New York, led by an international consultant, that concentrated on the regional, national and international issues and the management structure of the CSD Programme.

The national research team consisted of five researchers and three district teams, each made up of one resource person and one district researcher. In addition, 29 village researchers/animators were selected (one man and one woman already based in each village) from trained animators, ward-level extension staff and primary school teachers. They were trained in the research process, and their responsibilities included writing the village workshop reports and conducting the individual interviews. Villagers not only participated in the research, but also welcomed the researchers into their communities and homes for the six weeks of field research and helped to organize workshops and other research activities.

Methodology

To begin with, the large volume of articles, papers and reports produced over the last 15 years were reviewed (Annex II). Open-ended interviews were conducted with UNICEF staff, and at the district, regional and national levels, interviews were conducted with individuals and officials who were knowledgeable about and involved in the programme. These included members of the Government, the party, the press, the academic community, and international agencies in Dar es Salaam.

The research methodology used in the district and village research was participatory, combining workshops, interviews (structured and unstructured), participant observation, and life histories, each providing opportunities for reflection on the CSD Programme. Workshops included orientation, brainstorming and planning workshops, district and village history workshops, and national, district and village briefing/report workshops. The workshops proved to be the most effective way to encourage interaction, uncover issues of conflict, analyse the causes, and propose strategies for action. Researchers participated in meetings at different levels, training sessions and Village Health Days.

Researchers carried out structured and unstructured interviews at the district/ward/village levels with CSD Programme coordinators, government officials, village leaders, village health workers and traditional birth attendants, women's groups and parents. A total of 1,072 people were interviewed, including community leaders and parents of children with a range of nutritional statuses, from well-nourished to severely malnourished. Many questions were open-ended and complex so that the interviews became extended discussions.

Research locations

Field research was conducted in three districts in three different regions. The regions were chosen so as to represent the most mature CSD Programme (Iringa, where the approach was first introduced late 1983), one more recent programme (Kilimanjaro, in the more developed northern section), and a region that started the programme in late 1987 (Mtwara, in the less developed southern part of the country) and where animation approaches were developed. One district in each region was selected for intensive study: Njombe, Hai and Newala, respectively.

Four villages were chosen in each district, two where the CSD Programme was considered to be working well and two more that had experienced or were experiencing difficulties. The villages represented a variety of socio-economic conditions, ethnic diversity, income levels, degree of urbanization, and accessibility to infrastructure and communications.

Background on districts

Hai District in Kilimanjaro region is one of the most advanced areas of the country in terms of economic and social development. Situated in the northern highlands, the area has received special attention in the past because of the presence of colonial coffee farmers and missionaries. Its strong resource base includes universal primary school attendance rates, the highest rate of secondary education in the nation, dominance of local people in government service and business, and a well-developed infrastructure of electricity, transportation, health and agricultural services.

Incomes tend to be high on average although social differentiation is wide. Local growers produce coffee as the main export. Severe land scarcity forces young people to migrate to towns or other parts of the country to seek employment or land. Many people engage in beer brewing, trade or casual labour to supplement farming.

Njombe District in Iringa Region is part of the southern highlands and is between Hai and Newala in its level of economic development. Local and migrant workers are hired seasonally on the sugar, tea, sisal and wattle plantations. Small farmers have problems with access to cash, markets and the agricultural inputs needed to sustain their farms.

Mtwara Region, in the south bordering on Mozambique, remains one of the least developed in the country in allocation of human and monetary resources from the Government and donors. Permanent roads do not exist in many parts of Newala District, and the marketing infrastructure is poor. Cashews are the major cash crop in the southern part of the district. The north has remained dependent largely on subsistence farming, given the lack of markets. Newala also has a severe water problem, largely because of its high plateau location but this problem is made worse by government neglect.

Infant and under-five mortality rates in 1985 for Kilimanjaro were 67 and 104, Iringa 130 and 220, Mtwara 138 and 233 respectively, compared to the national average of 115 and 191.

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Annex III — Nutritional status in regions with CSD Programme Annual summary

Total malnutrition

Iringa	49.0	42.9	40.0	38.5	37.1	38.2	37.5	35.9	34.1	34.6
Kagera		42.6	49.1	40.2	37.4	32.5	31.5	35.7	30.9	28.0
Kilimanjaro				34.2	28.3	20.4	16.1	13.6	12.8	NA
Mara							39.1	29.9	25.9	NA
Morogoro					44.6	39.3	41.9	39.8	37.0	35.7
Mtwara				54.9	50.2	53.6	49.7	46.9	37.3	37.5
Ruvuma				51.3	49.8	45.5	43.4	38.1	31.6	31.7
Shinyanga					22.7	34.1	29.2	28.2	30.9	NA
Singida							38.1	33.3	35.2	NA

Severe malnutrition

Iringa	5.0	3.2	2.4	1.9	2.0	2.2	1.7	1.4	1.3	1.2
Kagera		6.9	5.9	4.6	4.0	2.1	2.0	2.1	1.6	1.4
Kilimanjaro				3.5	1.9	1.5	0.6	0.4	0.3	NA
Mara							6.9	3.0	2.8	NA
Morogoro					4.3	3.1	3.2	3.3	2.2	1.9
Mtwara				8.0	6.6	7.1	6.3	5.5	1.8	1.4
Ruvuma				5.4	5.5	4.6	3.9	3.7	2.3	2.3
Shinyanga					1.9	2.1	2.0	1.4	1.5	NA
Singida							3.5	1.8	1.5	NA

Moderate malnutrition

Iringa	44.0	39.7	37.6	36.6	35.0	36.0	35.8	34.5	32.8	33.4
Kagera		35.7	43.2	35.6	33.4	30.4	29.5	33.6	29.3	26.6
Kilimanjaro				30.7	26.5	18.9	15.4	13.2	12.5	NA
Mara							32.2	27.0	23.1	NA
Morogoro					40.2	36.2	38.6	36.5	34.8	33.8
Mtwara				46.9	43.6	46.6	43.4	41.4	35.5	36.1
Ruvuma				45.8	44.3	41.0	39.5	34.4	29.3	29.4
Shinyanga					20.8	32.1	27.2	26.8	29.4	NA
Singida							34.6	31.5	33.7	NA

Annex IV — Village registration form

Village Registration Form

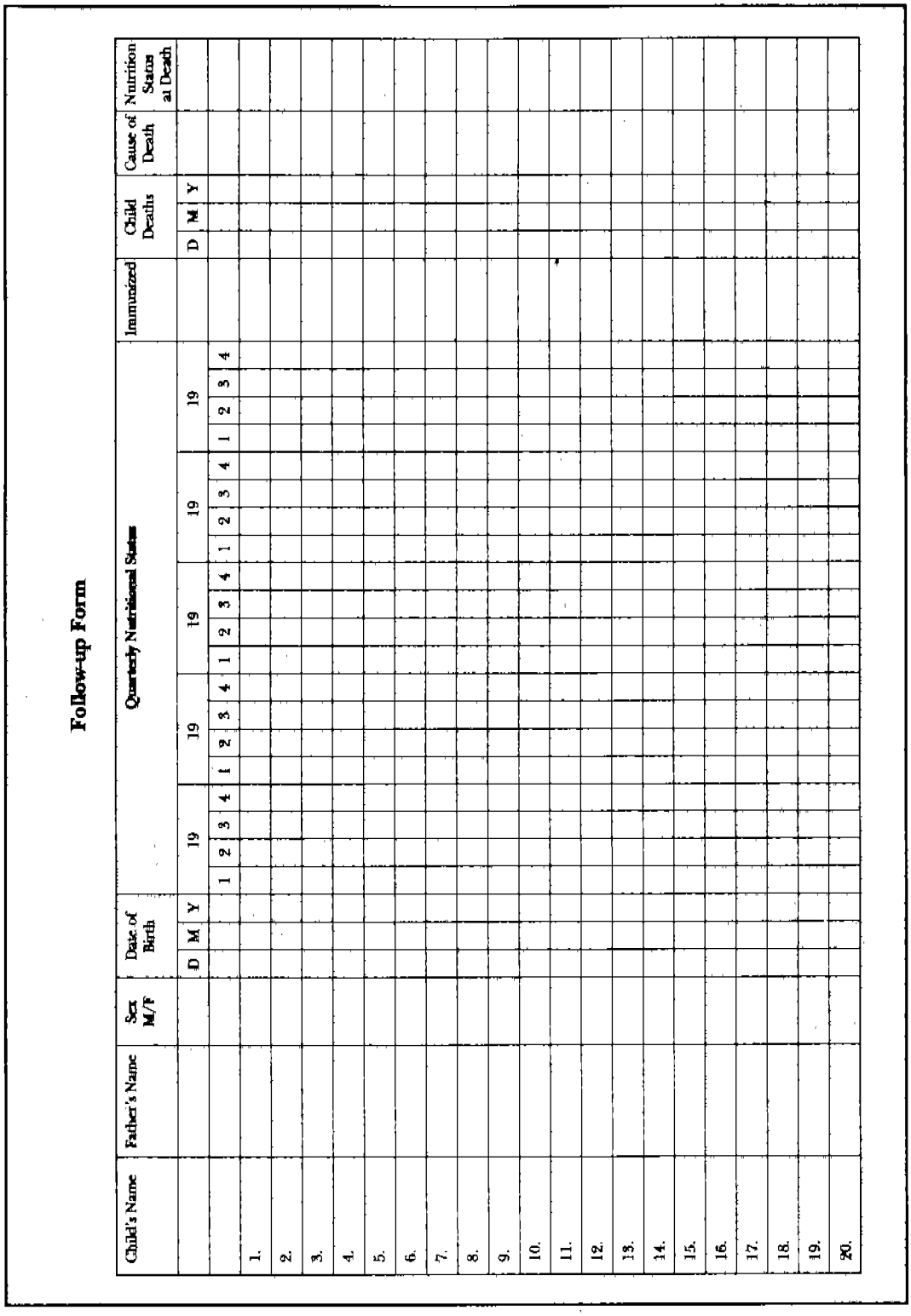
Form No. 1B

Name of the Ten Cell Leader

Household No.

1	2		3	4	5	6	7	8	9
	Sex		Date of Birth			Any deaths in the household			Cause of Death
Names of all Household members beginning with the head of household	Female	Male	Day	Month	Year	Day	Month	Year	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									
17.									
18.									
19.									
20.									

Annex V — Follow-up form



Follow-up Form

Child's Name	Father's Name	Sex M/F	Date of Birth			Quarterly Nutritional Status																Immunized	Child Deaths			Cause of Death	Nutrition Status at Death
			D	M	Y	1	2	19	3	4	1	2	19	3	4	1	2	19	3	4	1	2	19	3	4		D	M	Y		
1.																														
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Annex VI — Growth chart