



**PROTEIN-CALORIE ADVISORY GROUP (PAG) OF THE UNITED NATIONS SYSTEM
GROUPE CONSULTATIF DES ORGANISMES DES NATIONS UNIES SUR LES PROTÉINES ET LES CALORIES (PAG)
GRUPO ASESOR DEL SISTEMA DE LAS NACIONES UNIDAS SOBRE PROTEINAS Y CALORIAS (GAP)**

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MASS COMMUNICATIONS IN NUTRITION IMPROVEMENT

A guideline for formulating operational strategies



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CASE HISTORIES IN MASS COMMUNICATION

I. BALAHAR - THE INDIAN CHILDREN'S FOOD

(A Case Study in Communications To Promote Better Nutrition)
Sylvester daCunha*

A few years ago, a severe famine overtook Bihar, a state in Eastern India with a population of around 50 million. It was feared that some three to four million rural poor were at risk of starvation. The Government of India, as well as international aid and voluntary agencies rushed in to avert what threatened to be a catastrophe of monumental proportions. Toward the end of the famine, the Government introduced a mixture called "Balahar", which translated means "children's food".

Objective

The US Agency for International Development (USAID) commissioned an advertising agency to design a communications campaign to create awareness of and demand for Balahar after famine conditions had disappeared. The intention was to so package, price, and retail Balahar as to win continuing acceptance among those who were in nutritional need of it.

* Managing Director, daCunha Pillai Associates Private, Ltd. Elysium Mansion, Walton Road, Bombay 1, India.

V. THE INCAPARINA PROJECT

Susana J. Icaza^{*}

Incaparina is a vegetable mixture with a nutritive value equivalent to that of cow's milk and with physical properties that make it an adequate food for infant feeding purposes. It has played a very important role in alleviating the protein lack in Guatemala, as well as other underdeveloped countries. The name is from harina, the Spanish word for flour, and means literally "INCAP flour". More technically, it is called INCAP Vegetable Mixture-9, developed in 1958.

Many factors had to be considered in the development of this new food; adequate quantities and quality of its components; ease of manufacture, transportation, marketing and preservation and low cost. It had to be nontoxic, and its nutritive value resistant to damage. It was necessary that its flavor and physical characteristics be in accordance with the dietary patterns of the population. It had to be easy to prepare and feed to children.

Data relating to all these factors were collected and at hand before work for the development of this new food was undertaken. The project was supported by funds from different sources, usually granted for a specific phase of the study. The new food obtained support from governmental authorities, particularly public health personnel. These workers recommended Incaparina to mothers of preschool-age children who attend the various clinics.

In its initial phase, acceptability tests were run in a community where an integrated health center was functioning adequately, and where acceptance of the health programs by the community members was evident. Demonstrations by a nutritionist to a group of mothers initiated the acceptability trials, and personnel were assigned to pay home visits and keep daily records for a period of three months on the amount of Incaparina

* Director, School of Nutrition, Center for Advanced Studies in Nutrition and Food Sciences (CESNA), University of San Carlos de Guatemala/ Institute of Nutrition of Central America and Panamá (INCAP), Guatemala, Guatemala, C.A.

ingested by every child in the home. These visits permitted collection of more data concerning local dietary patterns; types of dishes that could be prepared with Incaparina; possible frequency of its consumption and the members of the family who would consume it; their reaction to the product; the potential demand and the most desirable promotional approach.

The next step was an attempt to duplicate the first test in a group of representative communities. This was preceded by a nationwide, publicized press conference by the Ministry of Health, which informed the people about the benefits of this new product. A group of demonstrators was trained by a nutritionist and equipped with foods specially prepared with Incaparina. Information was given to community groups and the product was placed for sale in local stores. This promotion campaign was fully supported by the health center doctors and nurses in their regular work. Acceptance was high, and an initial period of inflated "curiosity" purchase started, followed by more stable sales.

The product then entered its third phase, introduction on a national scale. The new food was made available in local stores and efforts to reach the target audience began. Mass communication media and materials used for this purpose included posters, newspapers, radio and television commercials, food demonstrations, and group discussions. Messages were selected and tested prior to developing the materials and were used all over the country. Local demonstrations were given by health workers or food demonstrators in a combined effort to reach all the mother groups in each town where Incaparina was introduced. The demonstrations included a description of the properties of the product, a task in which demonstrators used flip charts and prepared a sample of Incaparina in atole (gruel) form, which was tasted by all who watched. Other demonstrations were conducted for religious groups, schools, and agricultural extension workers. If electricity was not available, panel vehicles were equipped with a generator and demonstrations were offered at night in the main plaza of the town. A color film showing the effects of malnutrition was projected before or after the demonstration. In some instances, these activities were attended by as many as a thousand persons.

Evaluation studies were then designed. From 1959 to 1964 a study of three villages in which Incaparina was used as a food supplement in the diet of preschool-age children was conducted. It showed a drop in the overall incidence of diseases. Comparative surveys on diffusion of the innovation carried out in 1962 and 1963 in the same rural and suburban communities showed that the percentage of people who were not aware of the product's

existence decreased from 69 per cent in 1962, to 16 per cent in 1963. During 1963, 64 per cent of the families in the sample who had children under one year of age, were feeding them Incaparina. This percentage was higher in families with children one to two years old (89%), and reached 91 per cent in those whose children were two to five years of age. The percentage was lower among the older groups. Forty-three per cent of the people interviewed in 1968 said they had learned about Incaparina from personal contacts, 35 per cent through the radio, and 14 per cent by nonpersonal contacts, especially at the local store. It is worth pointing out that, in 1962, those who learned about Incaparina through the radio represented only 14 per cent.

Another study carried out in 1968 concentrated on the marketing aspects of the product, and included families from all over the country. A total of 1,246 families were interviewed, and it was found that 84 per cent had some knowledge of Incaparina, a percentage that varied according to geographical area. The main sources of information on Incaparina were: radio, 33 per cent; local stores, 22 per cent; neighbors, 11 per cent; and health centers, 9 per cent. Only 29 per cent of the families with a monthly income under US\$20 consumed Incaparina. This percentage rose to 61 per cent when the monthly income was from \$21 to \$100, and reached 76 per cent when income was higher.

Today, Incaparina continues to be sold in Guatemala, and the commercial enterprise in charge of its production had to enlarge its plant in order to satisfy the increasing demand. Unfortunately, the world economic crisis has made it necessary to increase the price, due to higher costs of the ingredients. This increase places Incaparina a little beyond the purchasing power of the people who need it most - the underprivileged. However, in 1975, the Guatemalan National Health Department decided to subsidize the product, offering Incaparina at a lower price to those mothers who attend the well-baby clinics. Although still in its initial stage, the project may well be successful and beneficial.