

# The First Thousand Most Critical Days Communications Campaign 2013—2014

## Campaign Strategy

**Government of the Republic of Zambia**  
*with support from USAID's Communications Support for Health project*



## I. Background

The Communications Support for Health Project (CSH) aims to strengthen the capacity of the Government of the Republic of Zambia (GRZ) to implement effective health communications activities. Through the USAID initiative *Feed-the-Future*, nutrition and healthy child growth is a critical health area that CSH supports. In the first several years of the project, CSH has assisted the GRZ in developing print materials (posters) that promote key nutrition-related practices (for example, exclusive breastfeeding); national level advocacy print materials (1000 Days promotional handout); and mass media “spots” for radio and television. In 2012, the GRZ intensified its efforts in this area with support from UK-AID, launching scale-up and adaptation plans for Zambia for the First 1000 Most Critical Days Programme, which includes critical, evidence-based services as well as behaviour change communication. Under this partnership lead by the GRZ, CSH joined to support the job of behavior change communications (Cross-cutting Strategic Area 4 in the Three Year Programme 2013-2015) and began work on designing a “First 1000 Most Critical Days” communications campaign with a particular focus on Intervention 2-4 under Strategic Area 2 Priority Interventions.

This paper describes how the CSH project proposes to implement this campaign.

## II. Problem Statement

Child stunting (low height-for-age) is one of the most serious but least addressed health problems in the world, and in Zambia (see Table 1 below). The human and economic costs are enormous, falling hardest on the very poor and on women and children. In Zambia, while rates of stunting have shown some improvement over the past five years, they are still alarmingly high (in rural area almost half of all children are stunted) and are a major factor in preventing maternal and child deaths. It is important to note that research indicates that stunting is not entirely correlated with poverty/household income as rates of stunting cut across all socio-economic classes in Zambia. Likewise stunting is not only affected by feeding practices and diet, it is influenced by factors like maternal health, hygiene practices, exposure to pathogens like aflatoxins and others that inhibit nutrient absorption such as e.coli, and diseases like malaria.

**Table 1: Proportion of Children Stunted (low height-for-age) by Province**

Province	% Stunted
Central	52.7
Copperbelt	43.8
Eastern	49.5
Luapula	56.3
Lusaka	37.2
Northern	49.3
North-western	43.6
Southern	36.3
Western	36.3
Urban	39.0
Rural	47.9

It is now well documented that the process of stunting occurs during the period from conception to two years of age—the first 1000 days. The timing of growth faltering in Zambia follows this trend; 11% of children are born with low birth weight and early in life there is a precipitous drop in height-for-age that continues for the first two years of life.

Additionally, key statistics in Zambia (as per the 2007 DHS household survey) indicate significant challenges on many key indicators influencing stunting:

- Maternal diet is poor in consumption of animal-source food including dairy, and most fruits and vegetables
- Although 90% of children in Zambia are breastfed, only 61% are exclusively breastfed until 6 months
- More than half (63%) of children do not receive an adequate diversity of foods in their diet and almost half (45%) do not eat enough meals for their age
- Although periodic vitamin A supplementation coverage is high (over 90%), vitamin A deficiency is also high, at above 60%
- Only 41% of children under 5 sleep under an insecticide-treated bed-net
- Only 59% of the population has access to improved water sources and only 49% use improved sanitation facilities.

### III. Process

Work on the First 1000 Most Critical Days campaign began in mid-2012 with consultative meetings with all partners working in maternal/reproductive, health, child health and nutrition in the country in order to determine the overall framework for the campaign and the key issues that will be addressed as well as how best to coordinate it with the scale-up of the service delivery aspects of the programme. Formative research and a literature review of existing research were conducted in 2012 before the final strategy for the campaign was developed in early 2013. The programme was officially launched in early April 2013 with an emphasis on work in 14 “phase 1” districts:

**Northwestern Province:**

Zambezi

**Central Province:**

Mumbwa

**Lusaka Province:**

Chongwe

**Northern Province:**

Mbala

Kasama

Kaputa

**Muchinga Province:**

Chinsali

**Eastern Province:**

Lundazi

Chipata

**Western Province:**

Mongu

Sangombo

Kalabo

**Luapula Province:**

Samfya

Mansa

In early 2013, these districts began a gap analysis in the provision of quality services tied to the priority interventions outlined in the government’s First 1,000 Most Critical Days Programme. As resources allow, CSH will support efforts to close the gaps found tied to communications for these interventions at the district level.

CSH is launching this campaign well-into its third year of activity. Therefore, CSH will only be able to directly support activities for 15 months (until September 2014). However, efforts to closely tie all CSH efforts to existing implementation integrated into the overall First 1000 Most Critical Days Programme means that the materials and activities they support will outlive CSH.

#### **IV. Impact**

By its conclusion, the First 1000 Most Critical Days campaign seeks to contribute to the GRZ goal of reducing young child stunting in Zambia from 45% to 30% by 2015.

#### **V. General Behavioral Objectives to support improved nutrition in First 1,000 Days**

Based on a thorough analysis of scientific evidence, current levels of relevant behaviors in Zambia, CSH and partners have selected key behavioral objectives from the First 1,000 Day Programme on which to focus. Positively affecting these behaviors and their sub-behaviors that are feasible to change should translate into an impact on birth weight, dietary intake and a reduced impact from illness episodes, and thus contribute to a reduction in stunting. The broad objectives are:

- To improve amount and variety of food consumed by pregnant and breastfeeding women, particularly the consumption of animal source foods and nutrient-dense vegetables and fruit.
- To improve the effectiveness of breastfeeding, particularly the duration (for the full 6 months) and the quality of exclusive breastfeeding.
- To improve the quality of complementary feeding, as indicated by more mothers preparing and feeding a larger variety of nutrient-dense complementary foods (from family foods) with age-appropriate frequency, food consistency and amount.
- To improve the continuation for feeding during illness and the frequency of feeding and amount of nutrient-dense food given to young children recovering from illness (recuperative feeding).
- To reduce diarrhea frequency and environmental enteropathy through increased handwashing with soap, and actions to keep babies from contacting feces (e.g. safe play areas).

#### **VI. Audience Groups**

The primary audiences for promotion of all of the key behaviors are pregnant women of any age and mothers (or other caregivers) of children under two. Important secondary target audience groups include fathers/male partners and grandmothers, whose support and positive advice is essential. Facility- and community-based health workers and volunteers are also important secondary audiences in that improvements in their counseling and facilitation skills are required if the primary audience is to significantly change its practices in positive ways. Other potentially supportive groups include other family and community members, including Safe Mother Action Groups (SMAGs), traditional leaders, and the community at large.

Although stunting rates are slightly higher in rural areas, all areas will be targeted particularly because a mix of media will be used; mass media are likely to have a higher reach in urban areas, and community-based activities and materials in rural areas.

#### **VII. Summary of Research Findings**

In order to prioritize and provide more specificity on the focus behaviors and to understand the context for promoting them, CSH, in partnership with the NFNC and MOH, conducted a literature review and new formative research to fill in gaps in understanding. The formative study included Trials of Improved Practices (TIPs) in which the mothers' of young children

actually try new, “improved” practices for a trial period and report their reactions. Key findings are summarized below by participant segment.

### **Pregnant women**

**Maternal diet:** All of the pregnant women said that their diet did not normally change from their usual way of eating in terms of buying special foods for themselves. Rather, they buy enough food for the whole family and only if there is money left over will they treat themselves with chips and soda. Women complained about the lack of accessibility and affordability of foods, especially foods such as meat. Most pregnant women report loss of appetite and nausea early in pregnancy, and are concerned for the health of their unborn baby. They also report having cravings and some practice pica or soil eating. Overall pregnant women eat 2 -4 times a day, small amounts lacking in diversity.

**Personal Influencers:** Pregnant women most commonly received information from health personnel, friends, mothers, and elderly community members. Generally, they report husbands being supportive primarily in providing money for food.

**Nutrition decision-making and ability to make dietary changes:** Pregnant women play the key role in deciding what food to prepare for the day. Male partners merely play an advisory role, although they were supportive of the changes the women tried, primarily that their pregnant wife stops eating soil. Affordability and availability of food, either in the community or household, greatly determined whether pregnant women implemented the recommendations. (See below under lactating women for more on food availability).

#### **The most successful recommendations for maternal nutrition included:**

- Increase the frequency of meals (or small meals/snacks): generally women could increase frequency, adding two “meals” whether they were eating twice or three times per day in the beginning.
- Increase iron-rich foods (animal source and nutrient-rich vegetables): Women were able to add or increase bondwe, rape, impwa, katapa, and egg.
- Increase fruit in the diet: the only fruit used was banana
- Stop soil eating: this was tried with just one woman who was successful in greatly reducing the frequency of soil eating by substituting bananas and oranges.

#### **Less successful trials included:**

- IFA supplementation—but numbers were insufficient to draw more generalized conclusions
- Increasing fruit and vegetable consumption significantly

### **Lactating Women (with infants 0 -23 months)**

**Diet:** Generally, mothers do not adjust their diets for breastfeeding, although some reported increasing their solid and liquid intake and focusing on a “balanced” diet with vegetables and animal-source foods. A few mothers mentioned improving their fluid intake, especially of milk or maheu, and breast milk production. A few mothers had extremely low food intakes—two meals a day of nshima and greens, or nshima and beans or porridge. And, there were several mothers who had not

eaten any animal source foods. There are few food taboos mentioned, although among those foods thought to inhibit breast milk production was okra.

**Nutrition decision-making, food availability and ability to make dietary changes:** Overall, mothers played the most significant role in deciding on the food prepared for the family, with support, usually monetary, from their husbands. A few husbands will purchase foods like milk when asked.

**Applicable to the entire summary**

**What women had to say about food availability:**

Food availability appears to have a notable influence on the ability of mothers to implement recommendations. In the urban areas mothers talked about increased prices for foods in the rainy season, like mealie meal while mothers in the rural areas mentioned increased prices and scarcity. Mothers tend to try to dry foods to preserve them for the rainy season. Mothers emphasized the lack of food in the rainy season except for greens that are abundant and discussed ways they dry food to preserve it. Mothers reported skipping meals or eating less in both urban and rural settings during times of shortage and when prices rise. They also said that in extreme cases they feed only the children. Because the sample for the study came from urban and rural areas many of the families had home gardens with maize, beans, groundnuts and green vegetables. Animals are also kept in the rural areas—the large ones as security to be sold if the family needs a large amount of money and the small ones for home consumption. “Wild” animals are also mentioned such as field mice. Of interest is the point that mothers expressed surprise to know that local/traditional foods were good, in fact better, than many packaged foods. They recognized that they were cheaper, but did not recognize their nutritional/health value. For example, the fact that cowpeas have good nutrition value was surprising.

**The most common recommendations for maternal nutrition included:**

- Increase servings of fruits and vegetables: women were able to increase particularly the amount of green vegetables, adding several tablespoons of cowpea leaves and pumpkin leaves. The only fruit that was added by women was banana.
- Increase servings of beans and groundnuts: Several women were able to do this, one adding a combination of beans with groundnuts and another, beans with minced meat.
- Increase animal source foods: This recommendation was offered primarily to women in the urban areas. Eggs, fish and/or kapenta and chicken seemed to be what women could add.
- Increase the number of meals and amount of food per meal: This recommendation was offered to women in the rural areas. It appeared that women with low intakes could increase two meals and some an additional snack. The meals tended to be nshima with relish and some added porridge and a banana as snacks. Animal source foods tended to be limited to several times a week rather than daily.

Less successful trials included adding snacks: only one mother added a snack each day.

**Infants 0-5 months old**

**Breastfeeding and the introduction of supplements :** Knowledge of the importance of breastfeeding and even particular aspects of breastfeeding was high. All mothers but one were breastfeeding their

infants. The one that was not was a field worker and could not be with her child. She started with formula, but switched to cow's milk offered in a bottle. The majority of mothers with infants under 4 months are exclusively breastfeeding, with an average of 11 feeds per day usually based on the demand of the child, although a couple of mothers reported having a schedule because their children slept a lot. Mothers also reported being influenced in their breastfeeding frequency by the amount of work they have to do, saying that some days they "starve" their babies because they are too busy or have to go away for long periods. Mothers with infants 4 and 5 months old tend to have started supplementing their breast milk with watery porridge, Maheu Super Shake, water and/or juice. While breastfeeding frequency remains high, all mothers were breastfeeding for limited duration (not emptying the breast) even if they were feeding from both breasts, although some were not. On average, these mothers plan to breastfeed for 19 months.

**Practices related to child illness:** Breastfeeding mothers reported a variety of practices when their infants have been ill (several reported episodes of flu, no one reported diarrhoea). The practices included breastfeeding slightly more frequently to offering less breast milk so their children could sleep. One mother said that she forced her child to take breast milk.

Mothers equate child growth and development with the absence of illness and with weight gain, achieving developmental milestones and happiness. Generally, these mothers knew that diarrhoea was caused by unclean water and not washing hands, but several also reported that diarrhoea in young children could be caused by teething.

**Personal influencers and common beliefs:** Overall, mothers feel in control of their infant's well-being. It was rare that a mother felt fatalistic about her child's development because of poverty. The beliefs and behaviours of mothers appear to be influenced by a range of other individuals. Commonly the health clinic staff are listened to and seem to be respected. They have influenced many mothers to use colostrum. Most mothers believe that breast milk is the best nutritional option for their children. Those who introduced a supplement like watery porridge or juice were influenced by the grandmothers of the child or neighbours/sisters. Other foods/drinks are offered because the child was "crying a lot" and the prevailing opinion is that the baby is hungry and the breast milk is not satisfying the child. However, supplementary foods seem to be started and stopped depending on the child's likes and dislikes. Mothers also said they do things based on their experiences with their older children.

**The most common and successful trials for improving breastfeeding practices included:**

- Improve positioning for breastfeeding: Mothers did this with pleasure because it made breastfeeding better.
- Use and empty both breasts and increase length of breastfeeds: Mothers reported noticing a big difference in milk production and felt that their child was much happier and was getting more breast milk. They felt this would help them keep their baby healthier.

Other successful, but less frequent trials were:

- Stop giving water or watery porridge and increase the frequency of breastfeeding: those who tried with the exception of one mother were successful and like the practice, again

because they thought the health of their baby was better and they could tell they had more breast milk.

Most of their families were very supportive, and the mothers said that they would use their stories as a means to recommend these practices to friends, neighbours, and family members.

### **Infants 6-8 months old**

**Breastfeeding:** All of the mothers were still nursing, although a few had decreased the frequency significantly, but most continued with an average of nine and as many as 13 feeds per day. Duration of the feed and the use of just one breast at a feeding increased over the group of younger infants. The average duration was 10 minutes per feed and a significant number used just one breast per feed. Many more women nurse on a fixed schedule (about half) as compared to mothers with children aged 0–5 months. Those on a schedule were trying to accommodate the introduction foods, while those feeding on demand said their breasts got full or they needed to comfort the child when he or she cried. On average, mothers planned to breastfeed for 20 months.

**Complementary feeding:** All but one mother provided their children with solid meals, but that mother was supplementing breast milk with water. In general mothers knew to start porridge at 6 months and did so, offering a mealie meal or cassava flour “light” (watery) porridge. When first introducing foods a few mothers added ground nuts to the porridge. Other first foods included milk, nshima, egg, bean soup, juice and chibwantu. As the infant gets slightly older thicker porridge with ground nuts, nshima, bean or kapenta soup (mostly the water) potatoes and fish become more common. Most meals are boiled. On average, mothers gave their children three meals a day, but this varied from 2 – 5. Many children eat with either their mother or the entire family from a shared plate and drank from a shared cup. Few families had special spoons, cups or plates for the young child. The mother fed the child with her spoon or with her hand. A few children were left on their own.

**Practices related to illness:** The majority of mothers reported that they had been to the health clinic monthly since their child was born. They also reported a fairly high rate of illness, on average 5 illness episodes since birth (flu, cough, diarrhoea and malaria). One quarter of the mothers said their child had poor appetite on a regular basis and was failing to gain, or losing weight. Mothers either offered less food to their sick child because of loss of appetite or they tried to force-feed the child so that there would be food in the stomach for the medicine and so the child would not become sicker. A few mother mentioned breastfeeding more to prevent dehydration.

**Personal influencers and common beliefs:** The beliefs and behaviours of mothers appear to be influenced by a range of other individuals, but most commonly by the health clinic staff who they trust. They also learn from those around them, the grandmothers of the child and women at their church and the neighbourhood health committees. They also learn from their experience with their older children.

Mothers said they selected foods to offer because they thought they were nutritious, but few thought that a child could eat mashed vegetables or fruits and not mashed meat for fear they might not be able to swallow or the foods would be bad for their intestines, making them sick, particularly

with diarrhoea. A few mothers also feel that children need to drink water following their food to clean the mouth and help the food travel to the stomach. Mothers also decided what to give based on the child's preference which is when mothers mentioned buying sugary drinks for the child. Also, they based food decisions on availability which is why porridge is so popular: even with groundnuts, it is always available. The mother who had not started foods yet was afraid to do so because she didn't have money for food.

Although most mothers believe they can protect their child's well-being, the number who express some fatalism increases over the mothers of the younger infants. Mothers become sceptical because they feel they cannot prevent disease, a part of growing up and something they see as being all around them. They view health as the absence of illness and the ability of the child to gain weight, have a good activity level and appetite.

Although many mothers know that diarrhoea is caused by unclean hands and home, they also believe there are other causes such as teething, exposure to fertilizers, and to the sun (which can cause the mother's breast milk to sour and the child to get sick).

Mothers also view the burden of their daily chores to be one of the reasons that they may not feed their child as needed. They are just too busy some days.

**The most common recommendations for improving child feeding practices included:**

- Use and empty both breasts and increase length of breastfeeds: this recommendation was made to virtually all mothers and they were all able to do it and mentioned the increased amount of milk they felt they had for their infant.
- Increase servings of mashed animal source foods and beans: Half the mothers requested to try were able to add or increase the amount of beans, kapenta or fish they gave. The switch seems to have been from offering fish or bean soup to the beans or the fish flesh. Others said they could not afford these foods.
- Increase servings of mashed fruits and vegetables: Fewer than half the mother followed through with this recommendation. Those that did added banana, and rape or chibwaba to the child's food. Others said they did not have access to vegetables or fruit; these were primarily urban mothers.
- Thicken the porridge with groundnuts: All mothers but one (she had no groundnuts at the time) who were introduced to this idea followed through.
- Offer the infant's food in a separate bowl or plate: All mothers who were asked to try this found a separate container to separate the child's food.
- Increase the amount of food per meal to 250 ml.: This trial was only successful with the rural mothers; none of the urban followed through. The mothers increased the amount of nshima.

Other successful, but less frequent trials were:

- Start giving food: the one mother who had not started food gave nshima with broth twice a day and 325 ml of porridge with groundnut flour once.

- Increase the number of meals/snacks: although mothers were feeding frequently enough a few were asked to increase frequency and they could add an additional feeding per day—averaging 4 – 5 feedings
- Stop sugary, non-nutritious foods: the few rural mothers who were asked to try this were successful while only one of two mothers in the urban area stopped, the other continued with Super Shake.
- Stop force-feeding: The urban mother doing this stopped.

Many said that they could see increases in their breast milk supply, their children's appetite, and their children's activity level. Most of their families were very supportive, and the mothers said that they would use their stories as a means to recommend these practices to friends, neighbours, and family members. The idea of improved breastfeeding technique and a separate plate for the child were particularly well received and women expressed a desire to share based on the results they saw and the importance they gave to knowing how much the child was actually eating.

### **Infants 9-11 months old**

**Breastfeeding:** Two mothers had weaned their babies: one because she was pregnant and the other due to work. Other mothers were still breastfeeding their children; frequency ranged greatly from 5-15 times per day, on demand, but of short duration and from one breast. Breastfeeding becomes a pacifier and less a food source.

**Complementary feeding:** All children were receiving food. However, the type of food was not substantially different from that fed to those first learning to eat; children are still receiving a watery porridge or *nshima* with soup or the water of other items cooked for the family. They are not receiving vegetables or animal source foods mashed or shredded in their food. They seem to be fed an adequate number of times per day: 3-4, but they are not supervised adequately during a meal. While they often have their own plate, they are left to eat on their own or with older siblings. If the child loses interest in eating, the mother assumes the child isn't hungry.

**Practices related to child illness:** All mothers reported taking their children regularly (monthly) to the health centre. They define a healthy child as one who eats well and plays happily. All children had at least one episode of illness since birth and mothers reported that they all lost appetite during illness. Mothers generally increased the frequency of breastfeeding or liquids and a few force fed their child. Two mothers knew their child was not eating well and was losing weight. They were particularly eager for advice.

Although mothers recognize that diarrhoea is caused by poor hygiene they do not relate their child's episodes of diarrhoea with their own practices, but instead talk about the diarrhoea being caused by teething, a change in climate or the child eating dirt.

**Personal influencers and common beliefs:** Mothers are primarily responsible for what food is cooked and prepared for the family. They are the key decision makers in providing balanced nutrition to their children. The mothers seem to have high regard for the advice of the clinic

personnel and it seems to be the main source of information apart from friends and family. Mothers did not identify any community groups that they attended for advice.

They feel that a certain times of the year food availability is a problem and confirm that meals are smaller and often less frequent.

**The most common trials for improving child feeding practices included:**

- Increase length of breastfeeds for longer periods and empty both breasts: All mothers requested to do this could. The mothers receiving this recommendation are primarily in the rural area.
- Feed the baby thick porridge mixed with groundnut flour: All mothers were able to do this. The mothers ricing this advice were primarily in the urban area.
- Increase the number of servings of fruits and vegetables: Only a few trials were done and among the few trials one mother could not follow through.
- Increase the number of meals daily, to at least three main meals: Every mother not already doing this was able to do it.
- Increase the number of servings of animal source foods such as eggs, meat, and fish: The few mothers asked to give their child an egg, with the exception of one mother could do so. Those asked to offer fish or meat gave chicken or fish and one mother could only do it twice a week, not every day.
- Mash the baby's food: All mothers reminded to do this were able to mash the nshima or potato or other foods.
- Feed the foods prepared for the family: A few mothers were asked to use family foods and did so.

All of the mothers were receptive to the nutrition recommendations that were offered, although a few of the mothers were doubtful that financially they could implement these new practices because it required additional foods. Several of the women who were asked to increase breastfeeding time mentioned that they noticed immediate changes in their baby's temper; the child was happier and less fussy. Many of the mothers expressed that they received positive support from their husband, male partner and family members and were highly motivated that they would recommend the new practices to other family members, friends and neighbors.

**Mothers of children 12-23 months old**

**Breastfeeding:** Most of the mothers were still breastfeeding their children. A quarter of the mothers with children in this age range had stopped breastfeeding. Two had done so around 6 months because of fear of transmitting their HIV to their child. The rest had weaned their child between about 17 and 20 months of age for a variety of reasons: pregnancy, illness on the part of the child, illness on part of the mother, and because it was a family tradition to wean at a particular age. The children who were still breastfeeding used breast milk as a snack. The duration of the feeds were 2 – 5 minutes, on one breast and usually terminated by the child.

**Feeding:** Children began eating the regular family food (nshima with relish), with the family. However, they do not, generally give up porridge, and often porridge makes up 2 of their three plus meals. Even at this age nshima or sweet potato (cut into small pieces) is given more often with just the soup of the bean or kapenta than the food form the soup itself. Children are fed on a schedule of

the family's regular three meals, but also when the child seems hungry and cries for food. Many of the foods given when the child is crying or as snacks are packaged foods. This is especially true in the urban areas. Mothers usually feed the child porridge, but the child is often on his/her own to eat their nshima. The child's food is seldom separated from the family so quantities are difficult to gauge. Eating together helps the child learn to share and represents the oneness and love of family. Mothers say they watch to be sure the child is full and they know this when the child loses interest in the food.

**Practices related to child illness:** All children had had multiple illness episodes, the most common, cough, malaria and diarrhoea. Mothers view this type of illness pattern part of growing up, and diarrhoea as part of the teething process, or cause by the child playing in the dirt or eating leftover/spoiled food. They don't think they can do much to prevent it, but they do take their child to the health clinic.

Mothers report that when their child is ill and has lost his/her appetite they stop solid foods and increase breastfeeds or switch to watery porridge, Maheu or fizzy drinks. Mothers report buying Super Shake for their ill child. A few mothers mentioned force feeding their ill child, while others felt this could result in vomiting.

**Personal influencers and common beliefs:** Mothers predominately relied on health clinic staff to provide information on nutrition during ANC and under 5 appointments; they report there are no community groups to discuss child health and nutrition. Mothers decided what to cook for the day; the decision on what to buy was influenced by the desire to achieve food variety for the family and to buy food that would be enough for the entire household. Mothers know that breastfeeding is best for the child under two and that malnutrition can be brought on by weaning too early. They also worry that they cannot provide the appropriate nutritious food for their child and so they want to keep breastfeeding. Many mothers recognized that some children just lack appetite and that this is a difficult situation to overcome. They often switch to non-nutritious foods and drinks just to get something into the child. Very few food taboos were mentioned.

**The most common recommendations for improving child feeding practices included:**

- Switch from giving the child the soup with nshima and offer the food adequately mashed or chopped into sizeable pieces for children to be able to eat: About three quarters of the mothers who tried to do this—give the child some of food with the relish-- were able to do it. They gave beans, fresh fish and chicken.
- Increase the amount of fruit and vegetables offered: All mothers were able to do this. They tended to add bananas and oranges and to increase the amount of green vegetable or to offer different ones or twice in one day.
- Stop giving non-nutritive foods as snacks (e.g., jiggies, biscuits, Super shake Mahew, Freez-it): All mothers in both urban and rural areas were able to do this. They did by substituting banana, orange, natural yogurt and sweet beer (munkoyo). A few mothers didn't want to try they said their child was too used to these foods and it would be a problem.

Less frequently offered recommendations:

- Increase the amount of food to at least 250 ml/meal: Two of five mothers could not do this. Those that did, some barely gave the 250 ml while others increase significantly.
- Serve the child food in a separate plate: All mothers were able to accomplish this.

- Lengthen the duration of the breastfeeds: All of the mothers offered this recommendation were able to do this.
- Increase the frequency of meals and snack to 3 meals and 2 snacks per day: Half the mothers who received this recommendation could not follow through, but several of these increased feeding frequency from twice a day to 4 times a day. The reason some gave for not doing this practice was because of lack of money.
- Thicken the child's porridge with groundnut flour or other nutritious foods: All mothers could do this; adding groundnut flour and in one instance oil and sugar as well.
- Monitor the child while he/she eats: All three mothers who were asked to pay more attention to their child at meal time were able to do this.
- Increase servings of animal source foods: Egg and kapenta were the foods of choice.

Most of the mothers accepted, tried, and adopted the recommended practices. The mothers were motivated to try the practices because of the promise of good health, especially for their children, if they improved their feeding practices. After trying, mothers were able to see improvements in their children's health, increases in appetite, and increases in their children's activity levels. Mothers received support to practise the recommendations from their male partners, mothers, mothers-in-law, and sisters. They said they would recommend these practices to their friends, neighbours, and family members.

### **Caregiver Hygiene Practices**

In all homes caregivers practised poor hygiene, including drinking unsafe water and not washing hands with soap before handling food, eating themselves or feeding their young children. The lack of safe drinking water includes the lack of treatment (boiling or chlorination) and poor storage. Some families have piped water and they assume that it has been treated at the source. Those who get their water from a well or bore hole say boiling takes too much time and chlorination is too expensive. Generally, hands are not washed, but when they are, especially for children they are washed in a pan of water used by everyone.

### **The most common recommendations for improving hygiene practices:**

- Wash hands before feeding the child and after using the toilet: Almost all mothers said they were washing their hands before eating or feeding the child: of the few who didn't change practice the majority were in the urban area.
- Boil or chlorinate water for drinking; almost all mothers said they were doing this for the drinking water; of the few who didn't follow through the majority were in the urban area and said that chlorine was too expensive and it is too difficult to boil water.
- Cover or store the water in a narrow necked container: Almost all mothers could practice this, many buying a new water storage container.

### **Fathers of Children Aged 0–23 Months or Partners of Pregnant Women**

**Breastfeeding:** Most fathers and male partners of pregnant women are aware of the importance and benefits of breastfeeding. Male partners overwhelmingly support breastfeeding efforts and seem to know that breast feeding alone should be done for the first 6 months. When their wives offer food earlier they say they are influenced by other women in the village. The men do not articulate a role for themselves in supporting their wives.

**Maternal diet:** Fathers and male partners see themselves as the primary income providers. Their role is to make sure that a pregnant woman or breastfeeding mother has money to buy food. They

understand the need to have access to a variety of foods and many, although not all seemed to know what the most nutritious foods are, frequently mentioning animal source foods and vegetables.

**Common beliefs about maternal and child nutrition:** Men said they learn about health and nutrition from the clinic, the church and family members. Common behaviours that fathers or partners of pregnant women have learnt include the exclusive breastfeeding, introducing solids foods at 6 months, and preventing illness and diseases by maintaining good hygiene practices. However, some fathers and male partners showed a lack of knowledge about proper infant feeding and hygiene practices. They primarily rely on what they and their wife/partner learn from their local health clinics about proper feeding practices. Men were eager for advice on child care and feeding.

**Factors that influence the feeding practices for infants and children:** Male partners are very concerned about providing enough money for proper nutrition. Only a few spoke out about helping around the house. They are cognisant that women adopt feeding practices from elderly women, mothers-in-law, and other women in the community. They stressed that there is a need for outreach and education on proper nutrition practices for both pregnant women and infants.

#### **Grandmothers of Children Aged 0–23 Months/Elderly Women**

**Breastfeeding:** Grandmothers and elderly women provide advice on breastfeeding. The majority are aware of the benefits of exclusive breastfeeding, including offering colostrum, and encourage their daughters or young mothers to breastfeed their babies for a period of 18–24 months. Overall, these women continue to play a key role in making sure that pregnant women and young mothers know how to properly breastfeed their babies.

**Maternal diet:** The mothers and mothers-in-law have strong opinions about what pregnant and lactating women should eat for better birth outcomes and to produce more milk and they are not afraid to share their ideas.

**Child nutrition:** Overall, grandmothers and elderly women play a significant role in deciding the kinds of food that are prepared, cooked, and consumed in a household. Most of the women stated that a child is first introduced to other foods and liquids at 6 months of age, and they consider that a child's diet does gradually change as he or she gets older. Most women are advising their daughters or young mothers on the types of food to give their babies. However, these women while able to provide good advice on breastfeeding had much less than ideal advice on complementary feeding.

**Hygiene and illness:** The majority of the women explained that they are aware of how hygiene affects a child's health. Many of these women stated that they are teaching their daughters and young mothers on the importance of proper hygiene. But, these older women do not feel responsible for the preventive aspect of the child's health. This rests more with the mother. However, when the child is sick the grandmothers are full of advice. In general their suggestions on what to do in the case of poor appetite and illness is well informed, although several mentioned changing to a liquid diet, including offering tea.

### **VIII. Behavioral Analysis and Specific Behavior Change Objectives for the First 1000 Critical Days Campaign**

These specific behaviors were chosen through a systematic process based on:

- 1) A review of existing studies and other documents that set the stage for the general objectives;
- 2) A formative research study undertaken by CSH and partners in 2012; and

3) A series of analyses carried out at a multi-agency workshop held January 28-31, 2013 at which participants prioritized 29 major behavioral objectives related to improving maternal and young child nutrition and related practices during the critical first 1000 days. They looked at current practices, barriers, and facilitating factors and identified specific, feasible behavior changes and strategies to promote and facilitate the priority practices. Following is a summary of the specific recommendations that resulted for each of the general objectives identified prior to the formative research.

**1. Improve amount and variety of food consumed by pregnant women, particularly the consumption of animal source foods and nutrient-dense vegetables and fruit.**

- Eat more high-value foods (nutrient-rich): Take an extra portion of vegetable relish; add an egg, small piece of fish, chicken, liver, mice, caterpillars, or kapenta each day
- Eat three meals per day. (If feel full or nauseous, eat less quantity, but more frequently, 4-5 times/ day)
- Add a small “extra meal” or snack each day: a banana, an orange, or even leftover beans and nshima
- Stop soil eating by substituting a small snack.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Idea and benefit of altering buying, cooking or eating pattern for pregnancy not well understood.</li> <li>2. Local foods are not the high value foods— soft drinks and chips are the “treat”</li> <li>3. Women do not feel well early in pregnancy</li> <li>4. Feel there is not enough food or money to implement recommendations</li> </ol>	<ol style="list-style-type: none"> <li>1. Family members are supportive, but are passive.</li> <li>2. Willingness in general to try new diets, but need specific—reassurance they can—within means</li> <li>3. Concern about pica</li> </ol>

**2. Improve amount and variety of food consumed by lactating women, particularly the consumption of animal source foods and nutrient-dense vegetables and fruit.**

- Eat more--four meals each day.
- Eat more high-value foods (nutrient-rich):
  - Take an extra portion of vegetable or bean relish with each meal;
  - Add an egg, small piece of fish, chicken, liver, mice, caterpillars, or kapenta each day.
- Eat fruit: a banana or orange or other fruit in season.
- Drink more: water, fruit juice

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Idea of altering buying, cooking or eating pattern during the breastfeeding period is not well understood.</li> <li>2. Local foods and drinks are not the high value—purchases of maheu and boxed juices.</li> <li>3. Feel there is not enough food or money to implement</li> </ol>	<ol style="list-style-type: none"> <li>1. Family members are supportive, but are passive. (Some father known to purchase milk for woman)</li> <li>2. Willingness in general to try new diets, but need specific—reassurance they can—within means</li> <li>3. Concern about ability to produce enough breast milk</li> <li>4. Food taboos are minimal</li> </ol>

recommendations	
-----------------	--

**3. Improve the ability to exclusively breastfeeding for a full 6 months by improving the quality of exclusive breastfeeding.**

- Improve positioning for breastfeeding; sit and place the baby in front with good attachment.
- Increase length of feeding sessions: empty both breasts each time.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Mothers feel they do not have the time to breastfeed for a sufficient duration.</li> <li>2. Local foods and drinks are not the high value—purchases of maheu and boxed juices.</li> <li>3. Concern about ability to produce enough breast milk to satisfy baby especially after the baby is 3-4 months.</li> <li>4. Mother and grandmother feel that child crying/fussiness is a sign of hunger and dis-satisfaction on part of baby and the tendency is to begin porridge.</li> </ol>	<ol style="list-style-type: none"> <li>1. Overwhelming acceptance of and intention to exclusively breastfed as the best for the baby</li> <li>2. Breastfeeding frequency is good, unless the mother is very busy in the field.</li> <li>3. Family members are generally supportive, but are passive (don't help with chores to allow mother more time).</li> <li>4. Mothers immediately noticed an improvement in their breast milk production and the baby's "satisfaction" when they fed for more time per session.</li> </ol>

**4. Improve the quality of complementary feeding, as indicated by more mothers preparing and feeding a larger variety of nutrient-dense complementary foods (from family foods) with age-appropriate frequency, food consistency and amount.**

Infants 6-8 months:

- At six months introduce the baby to soft, thick "enriched" porridge and mashed nutrient-rich foods, (not "light" porridge or the soup from beans and vegetables).
  - enrich the soft, thick porridge by adding groundnut flour or mashed beans or pounded kapenta, caterpilla or milk/sour milk, mashed boiled egg.
  - mashed orange-flesh sweet potatoes with one of the above
- Provide the food in a separate plate or cup.
- Be patient when helping the child learn to eat.
- Offer food twice a day.
- Continue full breastfeeding—taking time to breastfed; emptying both breasts at each session.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Mothers feel they do not have the time to sit and feed/breastfeed the child for a sufficient duration.</li> <li>2. Caregivers believe children cannot "eat" vegetables and other foods because they don't have teeth and they need to have foods that are easy to digest.</li> </ol>	<ol style="list-style-type: none"> <li>1. Family members are generally supportive, but are passive (don't help with chores to allow mother more time).</li> <li>2. Mothers want their children to be content—less crying and more playing and sleeping.</li> <li>3. Mothers immediately noticed an</li> </ol>

<ol style="list-style-type: none"> <li>3. No concept of watery porridge or soups not having nutrients.</li> <li>4. Cultural value in child learning to share food with the rest of the family.</li> <li>5. High value foods for children of this age unknown.</li> </ol>	<p>improvement in their breast milk production and the baby’s “satisfaction” when they fed for more time per session.</p>
--	---

Infants 9-11 months old

- Offer foods cooked for the family, but in small pieces or mashed. (Porridge and (cooking water) soups should not be the main food and the porridge should be thick and enriched).
  - Offer a variety of foods adding nutrient-rich foods each day (the quantity is not large and can be obtained from household foods for the small child): each day the child needs vegetables and a serving of the following: either milk/sour milk, egg, kapenta, chicken, liver, fresh fish.
  - Offer other nutrient rich foods found locally (there is no need to buy packaged foods): orange fleshed sweet potato, beans, groundnuts, avocado, banana, paw-paw and other fruits.
- Feed the child 3 times a day ensuring that the child eats 150 ml – 200 ml as he/she gets bigger. Offer a snack like a banana, oranges, or sweet potatoes with groundnuts, pumpkins or leftover nshima with beans . (Do not let the child get accustomed to purchased “treats”.)
- Sit with the child to help him/her eat out of their own plate. Be patient and help the child finish his/her food. Fussy eater requires more patience/force feeding will not help. Continue full breastfeeding—taking time to breastfeeding emptying both breasts at each session.
- Continue full breastfeeding—taking time to breastfed; emptying both breasts at each session.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Mothers feel they do not have the time to breastfeed for a sufficient duration and spend time feeding their child.</li> <li>2. Local foods and drinks are not perceived as the best; rather packaged foods are—convenience becomes value.</li> <li>3. Belief that child is not ready to “eat” because teeth are not in.</li> <li>4. High cultural value placed on sharing food and perception that older siblings can “supervise” feeding session.</li> <li>5. Perception that don’t have the food or the money for proper feeding.</li> </ol>	<ol style="list-style-type: none"> <li>1. There is a strong desire to learn how to keep the child healthy and growing. A seemingly high confidence level in what is said at the health facility.</li> <li>2. Feeding frequency is good--Eating three times a day, especially for children, seems a norm.</li> <li>3. Willingness to try new practices if mother thinks she can afford it/has the food.</li> </ol>

12 – 23 month old children

- Offer **all** foods cooked for the family. (Porridge and cooking water (soups) should not be the main food and even porridge should be thick and enriched).

- Offer a variety of foods (the quantity is not large and can be obtained for the small child): each day the child needs vegetables and a serving of the following: either milk/sour milk, egg, kapenta, chicken, liver, fresh fish or other animal meat eaten by the family—field mice, caterpillars.
- Offer other nutrient rich foods found locally (there is no need to buy packaged foods): orange fleshed sweet potato, orange pumpkin, beans, groundnuts, avocado, banana, paw-paw and other fruits.
- Feed the child 3 meals a day ensuring that the child eats 250 ml as he/she gets bigger. (The child’s stomach needs this amount).
- Offer one or two snacks during the day like a banana or leftover nshima with beans . Replace “low value” snacks like chips and jiggies, super shake with fruit, avocado, groundnuts, enriched porridge.
- Sit with the child to help him/her eat out of their own plate. Be patient and help the child finish his/her food. Fussy eater requires more patience/force feeding will not help. Continue full breastfeeding—taking time to breastfeeding emptying both breasts at each session.
- If the child is a “fussy eater” ask for help feeding: the grandmother, father or other adult family member.
- Continue breastfeeding—taking time to breastfed emptying both breasts at each session.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Perception that don’t have the food or the money for proper feeding even though they might buy “treats”.</li> <li>2. No practice of buying with one or two family members in mind—think of the entire family.</li> <li>3. Mothers feel they do not have the time to breastfeed for a sufficient duration and spend time feeding their child.</li> <li>4. Local foods and drinks are not perceived as the best; rather packaged foods are—convenience becomes value.</li> <li>5. High cultural value placed on sharing food and perception that older siblings can “supervise” feeding session.</li> </ol>	<ol style="list-style-type: none"> <li>1. There is a strong desire to learn how to keep the child healthy and growing. A seemingly high confidence level in what is said at the health facility.</li> <li>2. Feeding frequency is good--Eating three times a day, especially for children, seems a norm.</li> <li>3. Willingness to try new practices if mother thinks she can afford it/has the food. Liked idea of substituting family food for purchased snacks. Family is prepared if doesn’t have money for “treats”.</li> </ol>

5. Improve the continuation for feeding during illness and the frequency of feeding and amount of nutrient-dense food given to young children recovering from illness (recuperative feeding).
  - Increase breastfeeding frequency during illness episodes.
  - Continue feeding normal food if possible or switch to soft foods like porridge with groundnut flour or sour milk or mashed banana.
  - When the child recovers feed him/her an extra portion for food with meals-- **and special** “recovery foods” each day for at least a week. These foods are: avocado, egg, groundnuts, enriched porridge with oil added.

- If the child is a fussy eater following the illness be patient. Offer porridge that is sweet-sour: made with sugar and with some lemon added, this may be appealing to the child who has lost his/her appetite.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Frequent illness thought part of growing up.</li> <li>2. No concept of a recuperative period following illness.</li> <li>3. Believe continued feeding during illness will worsen the illness.</li> <li>4. Grandmothers full of advice, but often erroneous.</li> </ol>	<ol style="list-style-type: none"> <li>1. Concern for child getting weak.</li> <li>2. Many are aware that feeding should continue, although modified.</li> </ol>

4. Reduce diarrhea frequency and environmental enteropathy through increased handwashing with soap, and actions to keep babies from contacting feces (e.g. safe play areas).
  - Wash hands before eating, breastfeeding the baby or feeding the baby.
  - Wash baby’s/child’s hands before eating.
  - Wash hands with soap or ash and run water over hands (don’t use the same water others use). Create designated handwashing stations to make the practice easy.
  - Boil or treat water that is used for the baby/young child.
  - Keep the baby from feces that may have spread on the ground—put a mat down and keep a play space. Keep the child away from animals and dirt while eating.

Key Barriers	Key Facilitators
<ol style="list-style-type: none"> <li>1. Perception that diarrhea and illness in young children is inevitable.</li> <li>2. Perception that diarrhea is caused by teething.</li> <li>3. Belief that water available from a tube has been treated.</li> <li>4. Lack of resources for water treatment: cost of chlorine and time and fuel for boiling.</li> </ol>	<ol style="list-style-type: none"> <li>1. Families cover food that is cooked and “stored”.</li> </ol>

## IX. Communication Objectives

Based on the behavioral analysis, the campaign will aim to address the identified barriers, leverage the facilitating factors to create a supportive, enabling social environment for change by communicating the following:

1. Create a belief that the best start in life for a child begins with support of the pregnant woman and continues with proactive family action through the child’s first 2 years of life. Prevention of irreversible “stunting”—growth, mental and physical development.
2. Improve women’s sense of self-efficacy in terms of their ability to take small actions to protect themselves and their baby: eating more nutrient-rich foods with each meal; asking for help during the breastfeeding period; knowing the care their baby/young child needs and persisting with children even if they are fussy eaters, feeling that it is feasible to improve feeding within what they already have available in the household.

3. Improve inter-family dialogue and in particular specific, positive male roles about protecting the baby / young child in with specific activities: bringing home particular foods for the pregnant woman/lactating woman; supporting and helping the mother with chores so that she can take time to breastfeed particularly during the baby's first 6 months; bring home nutrient rich foods for the young child's diet; help with babies who are fussy eaters.
4. Create an attitude shift and build a sense of responsibility on the part of health worker to support and facilitate caregivers/families in seeking care and following through on critical recommendations during the first 1,000 days: You are a mother/father like the caregiver, recognize that they have come and want help; they need help making changes, not just information.
5. Create a sense of responsibility within communities for their women and children during this period.
6. Reposition locally available foods and traditional ways of growing and preserving foods as the healthiest, best option for families. Dispel the idea that more or better food equates with packaged, purchased foods. Possibly create "star/value" foods.
7. Build the link between poor hygiene and sanitation and poor child growth and health and impart confidence that it is possible to reduce the incidence of child illness (dispel the fatalism that frequent illness is part of childhood): handwashing at key times like before eating of feeding the baby; safe disposal of feces and create a space for small infants to play on the ground away from animal and/or human waste are the cause of much illness—not teething.
8. Build the concept and recognition of the "recuperative feeding window" for children following an illness. This is a time when fathers can buy "special" foods—avocado, groundnut paste...Grandmothers can help feed the child who needs more attention during recuperation. This is a new concept and one that could involve other family members.

## **X. Activities and Communications Products**

In building a communication program that will address the required behavior and social change objectives and the need for the campaign activities to easily integrate with on-going health sector action and those of other sectors such as agriculture, the proposed communications activities are organized in 4 groupings. At least in the near future, their initiation has been proposed as stand-alone (the mass media) and in an integrated fashion with on-going safe motherhood and malaria communication programming.

- **(1) Mass Media (national TV and radio and community radio)**

A small set of critical social and behavior change products will be designed and aired on all national television and national and 20 community radio stations for a period of 6-8 months.

- Social change/ awareness creation: This will likely include 1-2 social change/awareness creating television commercials promoting the concept of the 1000 critical days and urging families to talk to health workers about how to give their children the very "best start to life".
- Behavior change: Revision and official translation into 7 local languages of a 13-part radio series (*Bushes that Grow...*) produced as part of a previous USAID project called IYCN (Infant and Young Child Nutrition) and production of 5 radio adverts in 7 languages reinforcing specific aspects of the campaign including 1) quality of maternal diet, 2) quality of breastfeeding, 3) importance of local foods in a healthy diet for children over 6 months, 4) importance and process of recuperative feeding after a child has been sick and 5) link between hygiene practices and healthy children.

- **(2) Interpersonal /Community group discussion and action meetings and Interpersonal / Individual counseling through a network of Civil Society Organizations in 8 districts**  
In 2012, CSH engaged 5 CSOs to work in 8 districts (Kaoma, Mongu, Samfya, Mansa, Mpulungu, Kasama, Chipata and Chadiza) on implementation of a community-based programme called STOP Malaria Champion Communities. These CSOs are well-positioned to begin integrating work on nutrition into their program using a set of communications tools provided by CSH/the First 1000 Most Critical Days campaign. The community and household level activities to be carried out by these CSOs will include:
  - Creating community gardens and holding monthly cooking and food preservation demonstrations using new, healthy but feasible recipes
  - Holding weekly radio listener groups for the *Bushes that Grow* series using the series recorded in the appropriate local language and a corresponding discussion guide
  - Working individually with families who have pregnant women or children under 2 using existing GRZ/UNICEF counseling cards, a CSH-developed child-growth reminder tool on the critical campaign issues (maternal diet, quality of breastfeeding, use of locally available foods, hygiene and sanitation, recuperative feeding), a plastic “child feeding bowl” using colors to indicate appropriate amounts for each appropriate age
  - Strengthen referrals to the health center for children who are acutely ill or have been chronically ill for the previous month or have signs of malnutrition

These activities would be appropriate for organizations that work with family members in a group setting. CSH will supply recordings of the radio series above so community agents can hold weekly radio listener groups for the *Bushes that Grow* series using those recorded in the appropriate local language and a corresponding discussion guide. Guides for potential group activities such as breastfeeding, cooking or food preservation demonstrations, especially with nutrient-rich local foods, and discussions on how to sell some produce but save/preserve others for family use will accompany.

- **(3) provision of technical assistance and materials to other USAID and NGO partners**  
CSH will support partners with sets of materials for use in community-based programming. These partners/programs are currently implementing activities through health or other extension workers who interact with families or caregivers on an individual basis. Examples of these agencies include GRZ and their partners in nutrition (working across the country) and USAID’s Feed-the-Future and health partners (clustered in Eastern Province), particularly:
  - ZISSP
  - MAWA
  - CHAZ
  - World Vision
  - IBFAN
  - JICA
  - ZAMNACS
  - CIP
  - ZARI

The specific packets of materials to enhance the work these organizations are doing will include copies of the 1,000 Days child healthy growth reminder card, reprints of the agreed upon Community Counselling Cards, and a plastic “child feeding bowl” that indicates appropriate amounts for each age grouping.

Distribution of these materials to the partners will be tracked, but use of the materials will depend on the particular partner reporting use to CSH.

Meetings with each of these partners have been held and most are collaborating on the development of these products. A summary of many partners' activities related to topics within the first 1,000 Days programming is found in Annex 2.

- **(4) Support to district MOH nutritionists with capacity building/input to program scale up and IEC and other materials**

To support the need to increase action at the district level, the Ministry of Health and the National Food and Nutrition I commission have established district-level nutritionists. The CSH-supported 1,000 Days campaign will directly support these nutritionists in the 14 phase-one districts by:

- providing technical assistance to the planning and scale-up of service delivery, and
- providing IEC/BCC materials to be used in district clinics, at well-child visits, at growth-monitoring/promotion outreach activities and at community or district events.

These materials will include those mentioned above as well as a selection of 3 new posters for distribution to clinics to remind clinic workers on the steps to good counseling, with a goal of promoting quality/effectiveness of breastfeeding and complementary feeding.

#### **Summary of materials to support activities:**

##### Mass Media:

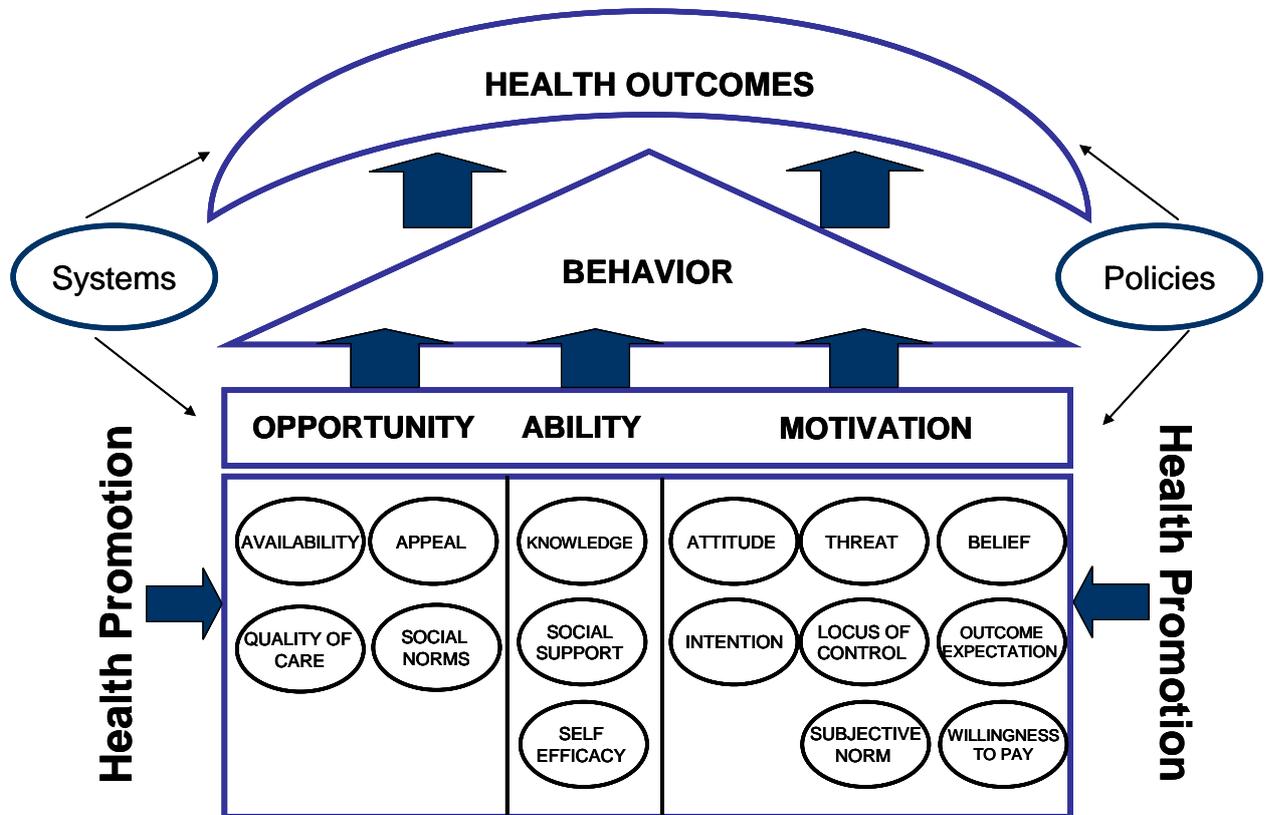
- 5 new radio "adverts" and 2-3 new TV adverts
- Adaptation/expansion/translation of IYCN project "Bushes that Grow" radio drama programme and the transfer to discs for use in groups.

##### Interpersonal:

- Radio discussion guide for use with mothers' groups
- Reprint modified IYCN/UNICEF counseling cards including 2-3 new counseling cards for inclusion on package emphasizing environmental hygiene and local foods/recipes
- User-friendly/pictorial reminder tool for mothers/families on information necessary for health child growth at each age—"Healthy Growth Reminder Tool"
- Plastic, feeding bowls with appropriate quantity and reminders of quality
- 3 new posters emphasizing key messages/elements of the campaign for use in clinics

**Appendix 1:**

This model depicts the theory of behavior change upon which this campaign is predicated. It was originally developed by Population Services International, but has been adapted by the Manoff Group and CSH to better reflect the inputs of health promotion specifically.



## **Annex 2: Partner Matrix**

### **World vision**

CHILD HEALTH NOW CAMPAIGN.

World Vision is not directly involvement in the 1000 most days program. At the moment world vision is in the process of designing a Child Health Now campaign that will focus on maternal and child health. It is a global advocacy campaign that works to save the children dying from preventable diseases and malnutrition. Preventable diseases include diarrhea, pneumonia, HIV/AIDS, measles, malaria and neonatal complications. It also aims at preventing mortality during pregnancy or child birth. This campaign will be implemented in Mbala, Kasama, Mumbwa and Kaoma and will work engage and collaborate with Government and other Civil Society Organizations and the private sector. The campaign will use an approach called the citizens Voice action that aims at building local empowerment for ownership of program)and will work hand in hand with the water sanitation and hygiene project (WASH), maternal and child health projects, HIV/AIDS and food security and livelihoods projects found in the catchment areas.

The campaign has five impact goals and these are:

- Health systems- government ensure equitable access to quality health services to effectively address maternal, newborn and child health
- More money for health- ensure adequate long term predictable funding for maternal newborn and child health
- Accountability – develop national and global accountability frameworks with the involvement of empowered communities
- Barriers- eliminate barriers (financial, social, cultural geographic) to health in the poorest and most marginalized families and communities.
- Disease and malnutrition- prevent diseases and malnutrition in children through addressing the social determinants of health.

A design workshop was held in January this year.

Among the communication products that the project may eventually develop will include

- Posters
- Radio programs
- Documentary
- Bill boards
- Leaflets and brochures

These will have messages on maternal health, child health including nutrition.The project will need technical support to develop these products. It is with hope that CSH can work with this project to come up with products of interest that can cover the needs of both projects.

## Summary

organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
World Vision	Child health Now campaign- Maternal and child health and not linked to the 1000 most critical days program- its aim is to reduce mortality	- Production to start in April	Design materials such as posters, leaflets, documentaries, brochures, radio and TV programs on child health, hygiene and nutrition	Share costs on materials that are of interest to both parties  CSH to offer technical assistance in design the materials	Activities are coordinated by a District Development facilitator.  He trains community volunteers who implement the activities.  The project has plans of using famous traditional leaders as change champions

## IBFAN

It stands for International Baby Food Action Network funded by SADDC -HIV. It focuses mostly on IYCF operating at both community and health facility levels. Capacity building through training is conducted for Community health workers and health providers at clinic level. The project activities are implemented in Lusaka and Kabwe districts. In Lusaka the project is operating at all the Lusaka health facilities. The project plans to scale up to Chongwe district very soon.

The trainings are conducted at two levels using two packages for community volunteers and health providers. A Training of trainer is conducted for the health workers in IYCF and then these in turn, train the community volunteers in community IYCF

After community trainings, the volunteers are told to form mother support groups and these groups do the following activities;

- Give health education at the clinics during ANC, GMP, labor and outpatient
- Conduct cooking demonstrations
- Counsel mothers

Activities by health providers

- Counsel mothers on child feeding and care from health facility
- Conduct health education at facility level

Activities by community health workers

- IYCF counseling
- Conduct community based growth monitoring and promotion
- Conduct cooking demonstrations
- Promote small nutrition gardening to support the cooking demonstrations
- Identify malnourished children, moderate and severe malnourished are referred to higher level for management.

At the moment, IBFAN has no IEC/BCC materials. Use what is available at NFNC,

Suggested IEC/BCC materials

- IYCF take home training packages
- Special feeding reminders in form of clocks for children from birth up to 2 years
- Posters with plain messages for health centers and shops, leaflets for mothers to take home on code of marketing of breast milk substitutes.
- Standardized measurement bowls or cups for feeding children
- Recipe books to be made according to regions and simplified
- Feeding in the context of HIV???????

Organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
IBFAN	Infant and young child feeding. this include initiation of breastfeeding, exclusive breastfeeding and complementar	<ul style="list-style-type: none"> <li>- Depend mainly on materials from NFNC and MOH. They use the following;</li> <li>- IYCF take home training packages</li> <li>- Counseling cards</li> </ul>	<ul style="list-style-type: none"> <li>• More take home materials for participants</li> <li>• More counseling cards are needed for the volunteers</li> <li>• Feeding reminders for children from birth to 24 months</li> </ul>	<ul style="list-style-type: none"> <li>• Offer technical input into designing some products</li> <li>• Help with the implementation or distribution of products</li> </ul>	<p>The project activities are implemented by the mother support groups and community health workers</p> <p>Work closely with the health</p>

	y feeding for children from 6 to 24 months	- Posters and leaflets on child feeding	<ul style="list-style-type: none"> <li>• Standardized measuring bowls and spoons for feeding children and to be used during demonstrations</li> <li>• Posters with clear messages</li> <li>• Regionalize the recipe books and have them translated.</li> </ul>		providers at the health facilities
--	--	---	--	--	------------------------------------

### JICA- CHILD HEALTH PROJECT

JICA's child health project is not directly linked to the 1000 most days campaign although it carries out some activities in the 1000 package. This project is implemented in Lusaka, Kabwe and Ndola districts. In each district the project covers to two health facilities and two communities. Under this project the following activities are carried out:

- Community Integrated Management of Childhood Illnesses (IMCI and this covers most of the child health activities)
- Nutrition – comprising of IYCF activities and community growth monitoring and promotion
- Environmental health that deals with hygiene, water and sanitation.
- Income generating activities

### Implementation structure

The project uses the GRZ training materials and guidelines and the implementation structure starts at MOH/ MCDMCH, province, district, community volunteers and the community.

Under the IMCI approach, a Training of Trainer is usually conducted for the district level staffs (clinic staff) who in turn train the community volunteers. The main aim is to effectively do the case management of childhood illnesses and these being diarrhea, malaria, pneumonia and HIV/AIDS

**IEC materials**

Under IMCI, the project uses existing IMCI training manuals and charts. – Flip charts, GMP flow charts, banners. These are printed with the help of CARE international.

**IYCF-**

This project aims at preventing malnutrition in children. The materials used are the counseling cards obtained from NFNC. The cards are of two types, the small ones for individual counseling and the big flip charts for group counseling. However there is need for posters to be used during group discussions. GMP- there are no updated IEC materials for GMP. The main aim of the GMP activities is to check the growth of children, prevent diseases like diarrhea, malaria and pneumonia and link nutrition to growth and good health of children. There is need for more materials on hygiene especially for hand washing.

Health Education- this is seen as an effective way of giving and sharing information to the community. However the traditional way of giving the vital information has been too traditional and usually mothers don't like to waste time. Better ways of doing this should be done. For example, to give leaflets or brochures of different health topics to the mothers attending health education sessions.

The other way is to produce videos or documentaries to show really scenarios in child health and nutrition. In urban areas these videos or documentaries can be shown using TVs in health centers while in urban areas mobile vans can be used. Discussions can then follow after the shows. Have documentaries that can connect nutrition to growth, disease and malnutrition, etc.

**Exclusive breastfeeding**

Most mothers agree that they exclusively breastfeed their children but the problem has been the quality. Therefore there is need to have materials talking about the improved practices on exclusive breastfeeding. Posters, brochures, leaflets are available. There was a radio drama series by PATH which can be worked on and be aired

**Complementary feeding**

Generally, most mothers don't see the immediate effect of poor nutrition on the growth of the children. In addition to this, mothers don't understand the growth curve of their children. Sometimes mothers are ignorant of how to feed their children, while others lack food. There is need to educate people on how to feed their babies with right foods, good variety, and right quantity.

Cooking demonstrations are mostly done in the community and sometimes there is no food donated by the community. Health centers should conduct cooking demonstrations too especially if they make budgets at that level. Recipe books are limited and not regionalized. They don't reach the mothers who in turn can use them to discuss with their husbands what food to buy for the children. It is better to also come up with simplified recipe leaflets for the mothers to take home after a cookery demonstration.

Hygiene – JICA does not have any IEC materials produced from their office. Instead they depend on what MOH has. At the moment they are using the leaflet designed by CIDRZ on diarrhea prevention and treatment.

Collaboration with CSH

The project is winding up in March next year and has no budget allocation to develop IEC/BCC materials. However JICA is willing to print or help with the airing only if the request is passed to JICA headquarters and passed through MOH.

Organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
JICA Child Health Project	Community IMCI activities IYCF and GMP activities Hygiene promotion activities Income generation activities	Community IMCI booklets, flip charts, GMP flow charts IYCF Counseling cards MOH posters, leaflets Diarrhea brochures Recipe books	Design materials such as posters, leaflets, documentaries, brochures, radio and TV programs on child health, hygiene and nutrition, Simple recipe leaflets for mothers Translate these leaflets Produce videos or documentaries showing common health problems/ scenarios and show at facilities and in communities	JICA can assist in printing and airing only if the request is made to JICA headquarters through MOH.  However JICA needs to be involved in the process. The CHWs on the ground can also help in the implementation and distribution of materials	Project activities are implemented by the health facility staff and community volunteers- CHWs and NHCs

### CHAZ

CHAZ is implementing a new community-based maternal newborn care and child health project. This project is supposed to cover national wide, however to start with, they are focusing at four districts namely Mungwi, Luwingu, Samfya and chienge where the needs are greatest. The activities are community based and are equity based. The target for this project include pregnant women, new born babies and children up to five years of age

The project uses the integrated Community Case Management package that is delivered through an enhanced district-wide community health program linked to health facilities and Neighborhood Health Committees (NHCs), CHWs and consistent with Ministry of Health (MOH) plans and policies.

Maternal health activities include the following:

- Training of community health workers to identify and help pregnant women to access ANC visits, acquire IPT
- Promote sleeping under treated ITNs
- Encourage pregnant women get the tetanus vaccine
- Encourage pregnant women to deliver at health facilities.

Newborn activities include all activities after the baby is born, such as initiation of breastfeeding, BCG immunization, care of the code etc. CHWs are trained in identifying danger signs in new born babies

Child health activities

- Integrate community case management (ICCM) of the four common child hood illnesses- malaria, diarrhea, pneumonia and severe malnutrition. These include teaching the community on how to identify signs and symptoms of childhood illnesses, management of illnesses, feeding of sick children at home

### IEC materials

**No yet developed. The project plans to start producing IEC materials very soon**

organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
CHAZ	Community based Maternal newborn and child health project.  This is not directly linked to the 1000 most critical days campaign but has similar activities.	<ul style="list-style-type: none"> <li>- No materials available.</li> <li>- Production to start soon</li> </ul>	<ul style="list-style-type: none"> <li>- Design materials such as posters, leaflets, brochures, radio jingles using community radio stations focusing on issues surrounding the pregnant women,</li> </ul>	<p>Share costs on development of materials that are of interest to both parties.</p> <p>CHAZ is willing to partner with CSH to produce these materials</p>	<ul style="list-style-type: none"> <li>- Project activities are implemented by the community volunteers mostly the CHWS who work hand in hand with the health center staff</li> </ul>

	Target is from conception, birth and up five years for children		new born and children up to five years of age		
--	---	--	---	--	--

### Zambia CSO-SUN

It brings together civil society organizations to increase understanding about the crisis of under nutrition. The focus is on the 1000 most critical days “window of opportunity”, from conception until the child is 2 years old. They mobilize, coordinate and build capacity of the civil society in Zambia for an effective civil society led SUN/1000 Days campaign

CSO-SUN works in setting up a strong sustainable and influential civil society alliance to support the implementation of the National Food and Nutrition Commission Strategy plan. It is also part of the global scaling up nutrition movement working in 33 countries across the world to tackle under nutrition.

organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
CSO-SUN	<ul style="list-style-type: none"> <li>- Efforts are focused on the 1000 Most Critical Days program.</li> <li>- Facilitate civil society to influence national efforts through pressure by media as well as having dialogue with stakeholders like government, donors, and private sector to contribute to improved leadership and accountability towards the national</li> </ul>	<ul style="list-style-type: none"> <li>- Banners</li> <li>- Leaflets and poppers</li> <li>- Newspaper articles</li> </ul>	<ul style="list-style-type: none"> <li>- Design materials such as posters, billboards, radio and TV drama series</li> <li>- Want to form a committee with MPS to look at nutrition issues in the country</li> </ul>	<ul style="list-style-type: none"> <li>- Would need technical and financial support to produce the materials.</li> <li>- very much willing to work with CSH to produce the materials</li> </ul>	Work with other CSO in the country

	1000 days movement				
--	--------------------	--	--	--	--

### ZISSP

ZISSP operates in 27 districts of Zambia and works with MOH, NFNC and MOCDMCH. The activities done in the child health and nutrition units are targeting the 1000 most critical days program. Activities under these units include the following

- Promotion of immunization
- Growth monitoring and promotion
- Adolescent and maternal nutrition promotion.
- IYCF activities
- Capacity building programs inform of trainings in IYCF.

### Trainings

Trainings start at a higher level in IYCF for Provincial and District staff. The team leader in these trainers is usually the Provincial nutritionist who makes sure that logistics are put in place. The mass trainers then conduct TOT where district trainers are the main participants for these workshops. The District trainers then train the facility health workers and supervisors who in turn train the community volunteers called the child health promoters.

### IEC/BCC materials available

The available IEC/BCC materials available include the following:

- Job aids like recipe books
- Posters
- Counseling cards for clinicians and community volunteers
- Posters on ten steps to successful breastfeeding

This year the organization is planning on supporting activities around Baby friendly initiatives. The poster “ ten steps to successful breastfeeding needs to be reviewed.

ZISSP has been planned to develop materials such as brochures for the mothers to take home on feeding of children and micro nutrient supplementation. ZISSP has supplied has supplied scales, gum boots, umbrellas T/shirts, bags and community registers to the community volunteers. There is a heap of material at NFNC that were developed by NFNC, ZISSP and partners but were not procured in good faith. They were rejected by ZISSP Role of Child health promoters include the following:

- Conduct Growth monitoring and promotion in the community

- Offer health education
- Conduct counselling of mothers
- Identify children that are malnourished or sick and refer these to the clinic
- Make follow up visits to children in the community
- Conduct cooking demonstrations in the community
- Participate in the child health and breastfeeding weeks

Summary of activities

Organization	Project activities	Available IEC/BCC materials	Areas of interest (IEC/BCC materials)	Areas of collaboration	Implementation structure
ZISSP	Child health and nutrition activities. ( revise policy document of role of NFNC in general, develop packages for nutrition guidelines to operationalize the 1000 most critical days, offer capacity building trainings comprising of infant and young child feeding and GMP	Job aids including recipe books, posters on infant feeding, counseling cards for both clinicians and community volunteers, posters on tens steps to successful breastfeeding,	Flyers and brochures for mothers to carry home, posters on the 13 steps to successful breastfeeding, standardized feeding bowls for children. Child feeding remainder. Materials that were designed but not finalized- 3 posters on <ul style="list-style-type: none"> <li>• key practices on complimentary feeding</li> <li>• nutrition during pregnancy</li> <li>• 10 steps to successful breastfeeding</li> </ul> <b>Brochures</b> <ul style="list-style-type: none"> <li>• Breastfeeding in the context of HIV</li> <li>• Breast conditions</li> </ul>	<ul style="list-style-type: none"> <li>- ZISSP is ready to offer their technical input during development of materials</li> <li>- Their community volunteers as well the health providers to be involved in distribution and implement IEC/BCC materials</li> </ul>	Structure starts mostly at district level then goes down to health facility level and community level. Activities are implemented in the community by the child health promoters. Implemented activities include maternal and infant and young child feeding

			<ul style="list-style-type: none"><li>• Early initiation of breastfeeding</li><li>• Healthy eating</li><li>• The 1000 most critical days.</li></ul> Reproduced the following : <ul style="list-style-type: none"><li>• Complimentary feeding</li><li>• Nutrition during pregnancy</li><li>• Exclusive breastfeeding</li></ul>		
--	--	--	---	--	--