

PDAAP-903

**INTERNATIONAL NUTRITION COMMUNICATION SERVICE**

**CONSULTANT REPORT SERIES**

IM 36423

**JAMAICA**

**--- February 5 - 20, 1984 ---**

**Evaluation of the Nutrition Education Programme  
Component of the Jamaica Population Project II**

**and**

**Recommendations and strategy for a future  
Nutrition Education Programme Component of  
the Health Management Improvement Project**

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**This project has been conducted under Contract AID/DSAN-C-0209, Office  
of Nutrition, Science and Technology Bureau, United States Agency for  
International Development, Washington, D.C.**

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## PREFACE

INCS had been asked to accomplish three tasks in the Scope of Work for this assignment:

- a) "Review the existing Nutrition Education Programme in Jamaica."
- b) "Evaluate the effectiveness of the Jamaica Ministry of Health Mass Media Nutrition Education campaign of the Jamaica Population Project (II), a World Bank project."
- c) "Design a detailed follow-on mass media nutrition education campaign component of a future Nutrition Education Programme."

With respect to Task c, the consultants were asked to pay particular attention to:

Target Group

Message content and Format

Reach and Frequency of Nutrition messages

Appropriate Media Mix

Message and Materials Development

Monitoring and Evaluation

In addition to the formal Scope of Work, it was made clear to the consultants that the future continuation of the mass media nutrition education campaign would be part of a U.S. AID Health Management Improvement Project, and thus some attention had to be paid to the structure of that project as well.

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I. Executive Summary of the Evaluation

A central conclusion of the "interim evaluation" of the Nutrition Education Programme (JPP II) which was conducted between October 1979 and January 1980 (Haberman, et.al.) was that the weakest part of the programme was the field support (which is believed necessary for any mass media health campaign aimed at changing people's attitudes). With respect to the media campaign itself, the conclusion was that it had been adequately done but that managerial, logistical, and personnel problems resulted in the lack of a successful one-to-one interpersonal component in the field needed to reinforce the campaign. As for overall impact the major conclusion of the evaluation was that the campaign had been most successful in the breastfeeding area in that awareness of the positive aspects of breastfeeding and acceptance of the slogan "The Breast is Best" was now extremely widespread.

The tentative broad conclusion of our evaluation is in some sense the opposite of that of the interim evaluation: We find that the media campaign was not adequately done and that person to person interaction in the field support arena (while it could of course use some improvement) may well have been as good as one could have expected, given real constraints such as personnel ceilings, vehicle problems, and overall funding difficulties. In fact our impression is that at the Community Health Aide (CHA) and Nutrition Assistant (NA) levels the right information is being given and these people are fairly well prepared to reinforce the media messages. Rather the problem seems to be that the

media is not supportive of the efforts of the front line people. They need the support of a truly creative and motivationally oriented media campaign.

Finally we found that the impact of the media campaign was not necessarily as profound as the interim evaluation would have us believe. Our evaluation pointed to the probability that short duration of breastfeeding and interest in the bottle or other improper weaning or supplemental foods is still a serious problem. In short, mere awareness of the positive aspects of breastfeeding is not enough.

We concur with the interim evaluation in recognizing the transportation, supply, time, personnel, and money constraints. We have been made extremely aware that many of these problems still exist. There is no doubt that if the means were available to solve these problems any nutrition education mass media program could be very much improved. We know however that resources were, and will continue to be, limited. Therefore we focused less on these areas and began to look more closely at areas which might be improved without requiring resources which are unrealistic to expect, such as the basic conceptions which underlay the programme.

A major problem with the programme was indeed conceptual, a confusion between "education", "information", "awareness" and "motivation". Research and evaluation were thus affected, as was, of course, the overall message design itself.

- A. An inadequate preparation in terms of basic social research, resulted in some instances in misinterpretations of data, or data which were not sound. Very simply, without solid hypotheses about human behavior, the right questions are often not asked and when that happens, all the data in the world will not lead to usable answers. Behind this problem was not so much a lack of training in research techniques, but a semantic difficulty which we have found in other countries as well. A belief that because one is aiming to get mothers to breastfeed more, or to eat right, one must therefore look only at their attitudes, beliefs and knowledge about breastfeeding and eating. In fact the resistances towards doing the right thing nutritionally often reside in areas tangential to breastfeeding and eating right and hypotheses about these must be generated before valuable research can be performed.
- B. The actual design of the media messages therefore was not based on as good a foundation of data and interpretations as it could have been. A partial result was that the messages also suffered from a semantic problem: The confusion between trying to raise awareness and trying to motivate people to behave differently, the one often being mistaken for the other. While many people we spoke to understood the difference very well, there was less understanding of the gulf that separates the two in terms of how one does one vs. how one does the other. In short, the messages, while designed with good intent and produced very professionally, lacked

inspiration, did not take enough advantage of Jamaican culture, and were not successful in reaching people where they "tick", in such a way as to cause the beginnings of change, that is at deeper psychological levels.

One unfortunate result of the sense that an adequate job had been done with media work is the accompanying feeling that not much more than general awareness can be accomplished by any media campaign. This is, unfortunately, a wide-spread belief but it is nonetheless wrong. In fact, work done in a few other countries in the developing world has begun to demonstrate that social marketing media campaigns may well be the most efficient and cost effective means of changing health behavior. To assume then that the best media can do is the somewhat peripheral role of creating awareness, is at the least, a premature assumption.

Finally the above aspects of the media campaign are tied to a fact of life which is shared by dedicated and well meaning programs in many countries--the lack of an opportunity to become aware of what is being done elsewhere. In the field of social marketing through media there has been pioneering progress in nutrition in a few countries (Brazil and Indonesia being two of them); we found little awareness of this in Jamaica.

II. Executive Summary of Recommendations for a Future Nutrition Programme Strategy

- Change the name of the Programme to National Nutrition Motivation Programme.
- Media component of the Programme should be focused and uninterrupted; a one year long media thrust is recommended.
- Keep the same five target problem areas as the prior programme but refine and hone their definition.
- Aim the programme at the poorest segments of society.
- Experiment parish by parish with sequencing of supporting activities of the Programme at clinic level.
- Reduce print, film and eliminate TV. Confine medium largely to radio spots.
- Baseline, pretesting, and evaluation Research should be oriented towards small, in depth qualitative studies.
- Message focus should be on reassuring mothers and raising their confidence levels.
- Tone and format of messages should be attended to. More use of music, drama and more regular radio series; even 45 second spots should have a dramatic form.
- Greater involvement of Private Sector, particularly food industry.
- Rally greater support among hospital staffs (Doctors, nurses, etc.).

- Increase training opportunities that rely on observational visits to model social marketing programmes elsewhere.
- At Health Centre level experiment with new ways to reduce fear of embarrassment among attendees and non-attendees.
- Involve CARIMAC, CFNI and other Jamaican educational, training and Research institutions more centrally in process.

### III. Brief History of the Strategy and Focus of the Nutrition Education Programme

The initial strategy of the Nutrition Education Campaign was thoroughly thought out. Almost every group of opinion leaders in the country which could provide possible avenues of support was listed. It was recognized, correctly, that a health education campaign of any sort must enlist elements from the whole society. Further it was understood that a broad consensus would be needed within the health infrastructure itself and thus a Review Committee was formed. This too was a logical step to take. Finally a logical sense of sequence was understood from the beginning; first a baseline study, then a public relations campaign and a campaign to create awareness among the health infrastructure, then advertising and media production, then pretesting, and finally the mass media campaign itself.

As theory, none of this can be faulted. But as was implied in the interim evaluation done in late 1979, early 1980, putting such a programme into practice is another matter. That has always been so, everywhere. The interim evaluation focused on the reasons why, suggesting that the program was perhaps too ambitious, tackled too much with too few resources. Indeed some of the original goals were far too grandiose, looking back now with hindsight. (e.g. In the original JPP project paper, the total eradication of anemia by 1980 seems now to have been unrealistic). Specifics such as management, personnel, and logistical problems were also cited. These are valid problems.

However, our task is not to rehash the points of the 1979-80 evaluation but to focus on things which it did not focus on. Our intention is to take thoroughly into account present and future constraints, to gauge what we say and recommend against a background of limited resources, personnel shortages and endemic logistical problems. Therefore we concentrate on what could have been done differently and better without adding resources, new personnel or new technology. We focused in short on conceptual difficulties in the programme and these will be the ones which we describe in detail in what follows.

We note however, that we agree completely that improved management, improved logistical support, and more personnel in key areas would clearly lead to a better programme. There is little question about that. But we also note that conception of the programme is more important and is a necessary precondition to successful use of resources. Before discussing the conceptual difficulties there are three specific and concrete areas which fall under the rubric of management/personnel/logistics to which more attention should be paid in a future project.

1. Awareness Preparation At the Hospital Infrastructure Level

If there is one group that needs to be rallied around the core issues in a nutrition education campaign, and without which a campaign can only partially succeed, it is the hospital staff, from doctors to orderlies. These must be rallied around the campaign. This was not successfully done. This is more important than rallying other groups.

[In the Jamaica case, many of the front line NAs and CHAs seem to be quite aware of and in agreement with the goals of the campaign. e.g. A summary of the Hanover parish programme to reduce child malnutrition cites the

key role played by the CHAs in the success of the programme. (See Alderman, et al, 1978).]

2. Rallying of the Nation's Opinion Leaders

Not enough serious attention was paid to the church groups in Jamaica. The church is extremely powerful in Jamaica and while it was listed among the institutions of society which need to be involved in the campaign, more could be done. Secondly, the private sector, particularly the food industry in Jamaica, was not adequately involved. We think the potential pay offs would be great if energy were concentrated on these two groups. More will be said on that in our recommendations section.

3. Training and Preparation of the Nutrition Education Programme Staff

This is the third concrete area which we feel needs a higher concentration of existing resources. We gleaned from our talks with various people involved in the programme that there was a lack of practical training in what we call "Monday Morning Steps". That is to say, the training people were given was not geared to preparing them for what steps to take on the "Monday morning" following the completion of the seminar, workshop or lecture series to which they had been sent. What is needed is training that is practical in nature, rather than training which emphasizes a great deal of theory. The latter has its place, but when resources are limited, a programme like this could have benefitted more from practical oriented training than theoretical training.

Having touched briefly on these three areas we turn now to the main focus of our report: the overall conceptual problems of the programme and our recommendations for a future strategy in nutritional education.

#### IV. Conceptual Confusions

The overall conceptual problem with the programme is one for which no one can or should be blamed. In fact it is one which we have seen elsewhere. Basically it is a semantic confusion which has real consequences for the way in which a program is carried out. There has been, from the beginning, confusion between the concepts: "Education", "Awareness", "Information", and "Motivation". That confusion runs through every aspect of the programme in both its first stage (1978 to 79) and its second stage (1981 to 82). These words (concepts) which appear at first glance to be relatively straightforward, can be rather easily confused. The associations which surround the terms will lead to very different tactics and policies. Even though many people were aware of the need to make clear distinctions among them the confusion still existed.

"Education" tended to reinforce the role of the bureau of Health Education and the media approaches associated with the concept tended to be school-like approaches, the notion being that information needed to be conveyed to the target audience. The term "Awareness" tended to become associated more and more with Advertising and with the Media side of the program, such that many people involved came to believe that media is only good for creating awareness, which is not so. Also many people began to believe that Awareness is a kind of "softening up process" and that after it has been done, one should give "information". "Motivation", when people used the term, was recognized as something one

should be doing, but there seemed to be a dead end here, as if people were hesitant (and justifiably so) about how exactly one could go about motivating people. And so what would often happen is that the conceptual confusion would come full circle and "Motivation" would tend to merge with "information" and with creating "awareness", while it is, in social marketing terms, either of these things.

These confusions led to programmatic difficulties:

A. Research Techniques

Research intended to get at people's knowledge, attitudes and beliefs is always subject to questioning about its validity. This is because social scientists recognize the difficulties inherent in applying science to human thoughts and feelings. Thus, caution should be exercised, as a matter of routine, about drawing broad or firm conclusions from even the best research. We found however that in several of the research instruments used in the course of the Programme, strong conclusions were often drawn based sometimes on little or doubtful data. These conclusions in turn, had real impact on policy decisions. Some examples:

The interim evaluation suggests very broadly that there does not seem to be a need for stimulating positive attitudes towards breastfeeding in Jamaica. It bases this conclusion on the results of two questions. 1) "What do you personally think of breastfeeding?" and 2) "Would you encourage your daughter to breastfeed?" (pp. 42-43). It is well known that direct questions such as these are not the best way to get at true attitudes, for they do not probe underlying psychological or

cultural processes, but only scratch the rational surface of the person. Questions like these appeal to the socially aware and rational side of people and they are almost always likely to result in giving the interviewer what he/she wants. We call these, "motherhood" questions (e.g. "Do you think motherhood is good?" Answer "Yes"). Further, even if one's rational belief about breastfeeding is positive, it does not follow that breastfeeding will retain that positive value at all levels of the person's being. Nor will it ensure that breastfeeding is practiced, or that such positive valuation will be strong enough to resist a perhaps even more positive valuation about the bottle.

The same evaluation drew positive conclusions about the print ads by asking the field staff whether they liked the ads (p. 83). To determine which printed materials have the greatest reach among the grassroots, again the question was asked of field staff: "Describe your impression of the printed materials". Conclusion - of all the printed material, the posters and brochures have the greatest reach among grassroots people. This conclusion seems to be a function of the fact that the question was asked of staff rather than of grassroots people.

On p. 86 it is reported that mothers were asked "Who showed you the material". Because 24% said nurses and only 3 % said CHAs the study concludes that "Nurses are vital for the distribution of the material". This totally ignores the possibility that the nurses were the only ones who had the material to give and that there is no inherent reason why CHAs would not also be vital for distribution, in fact there is every logical reason to think they would be. Mothers were then asked "Would

you like to take printed material about breastfeeding home?" 93% said yes and 2% said no. From this the conclusion is drawn that printed materials would be an effective means of reaching the mothers, which does not necessarily follow, given the way the question was asked. It also contradicts our field observations.

These are all examples of faulty research. Either the questions asked are too direct to elicit hidden reasons; or the questions asked are signals to the respondent to answer in a certain way, or the questions are addressed to the wrong people. Some further examples:

In the "Report of the Evaluation of the Nutrition Education Materials", designed to determine the usefulness of the support materials (posters, brochures, etc.) the entire survey was aimed at staff only! Not surprisingly, the overall conclusion was that the materials were indeed useful. Staff made some excellent suggestions about improving the print material (e.g. put more emphasis on not using the bottle, make more posters for illiterates; put less information on each brochure) and their comments about usefulness often pointed to some valid things. However, a semantic confusion seems to be inherent in the overall effort such that the main point was lost sight of: The object of the printed material is to communicate to and motivate the client, not to make life more convenient for the staff. As the questions were posed and answers given, it became clearer that the staff was responding to the word "usefulness" in its operational definition as "convenient to use".

In the case of the Baseline Study itself (the original research piece which backed the entire project [1976/77]) there are also several

problems. A central problem was the belief that a very large sample was necessary and so the format was made to fit that need - a questionnaire, short answer format easily codable for the computer. As a result relatively less probing than would have been desired was done. Example: A large part of the survey was devoted to finding out the degree of "exposure" to certain superstitions about breastfeeding. This was extremely thoroughly done, but it relied on respondents filling in the blanks: "Have you heard this? Yes/No". "Do you believe it to be True/False?". We raise the question however, of what use is this information? What does it tell us about how we should design media messages. The data is interesting but that's about it. The problem here may again be a semantic one. The research designers took very literally the assignment to collect data on knowledge, attitudes and beliefs about breastfeeding and other things. Thus they collected such things, but as things rather than as complex cultural and mental structures. Thus we may know that x % of women believe x or y but we have no clue as to how to use this information.

In some instances the data collected were interesting data pointing in the direction of a certain conclusion and yet that conclusion was often not drawn. The baseline survey in several major areas suggests strongly that feelings about the breast being "not enough" either in terms of quantity or quality are the most common reasons why mother bottle feed, or breastfeed only for short period of time. These data point in the direction of some tentative conclusions about psychological feelings of inadequacy and also therefore, in the direction of status

considerations, which may explain the tenacious interest of many in the bottle. This is, in fact, the interpretation that has been made in many other countries with respect to the breast/bottle issue, as well as by other researchers in Jamaica.\* Yet such conclusions were not drawn. Instead the Baseline Study summary report says -

"The claim that advertisements provoke mothers to buy a particular brand is not supported by the data. Neither are other popular claims such as, the seeing of higher class people use a particular brand, or the free samples at the clinics or hospital supported by the data. It is therefore, still unclear how mothers arrive at the decision to choose a particular brand."

However when we look at the data themselves, in this case Table VI on page 13 of the Summary Report of the Baseline Study: "Reasons for choosing particular milk brand", the third most often cited reason from among 14 reasons cited was that they "saw other (high class) people using it". And, if one lumps together five of the stated reasons, which all have to do with hospital samples, advertisements, nurse, doctor, or midwife recommendations of formula brands, then we find that these five together form the second largest set of reasons. Indeed, altogether the 14 reasons give a very clear picture of why mothers choose a particular brand and that is a picture of a very real influence of advertising, hospital staff, and observation of high class people, all of which points to status concern as a likely motivation.

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\* Almroth & Latham, 1982 - reports widespread lack of confidence among Jamaican mothers about quality and quantity of breast milk.

Finally, the focus of the question was a bit tangential in that the concern was to know the reasons for choosing a particular brand. The real issue is why do mothers choose infant formula period, forget about which brand. Had that focus been more clear, and had the questions been more probing and the data been interpreted more carefully, the conclusions drawn would have been altogether different.

V. The Design of the Media Messages

A 1974 paper entitled "Knowledge, Beliefs and Attitudes in Relation to Nutrition Policy in Jamaica" states on page 1 "People will not be ready to change their food habits because they are told why and how to do so." (Murray, et al). There is no simpler way to express the core assumption of social marketing. Yet a large part of the media effort seemed to ignore this fundamental precept. Much of the media work is prescriptive: it simply tells people why and how to change their habits. Not only do such techniques not result in motivation, they often backfire and reinforce the very resistances people have towards change in the first place.

Examples from the Nutrition Education Programme:

A flash card: "While you are pregnant think about the baby's wonderful gift and your responsibility as a mother wanting to give him the best".

This message presumes that prescription will motivate people. It is aimed at pregnant teenagers for the most part and yet it ignores what common sense would tell us is the teenagers plight. In reality she is likely to be worried, feeling insecure, often afraid, at best emotionally up and down about her situation. She may on occasion think of the baby as "a wonderful gift" but more likely than not she is thinking of other things. This kind of message confuses the goal with the message. What

is stated in the message is the goal - Responsibility. But as a message, it is not likely to work since it does not reach the mother where her real concerns lie. It presumes she is an ideal person and since she is not, the message is likely to go above her head so to speak, towards a saintly version of her and, if anything, make her feel even less adequate.

A flash card: "Any kind of worrying can slow down the flow of milk"

This is also prescriptive. It tells you a fact, but the tone is one of warning. It is a blanket statement which can have the opposite effect. It can make a mother who already has much to worry about, even more conscious of her worrying, and in turn can result in making her start to worry about worrying too much.

Food Group Posters: These posters are another example of forgetting the audience and confusing education with motivation. They proceed from what Nutrition Scientists know about food. They should rather proceed from what Jamaican mothers and fathers know about food and take Jamaican culture into account. The focus should not be on making Jamaicans into a mass of amateur nutritionists but on finding ways to adapt what the scientists know about nutrition to what Jamaicans know and believe about food. The key to that is to understand what the people mean by "food". Anthropologists have for years understood that food categories differ sharply from people to people and that what we think of as "food" may not be what someone else thinks. These posters are likely to have little effect because, in short, they are trying to teach science to the people

and in so doing are too complex and too far removed from their daily concerns.

The 1983 Calendar: This is a good example of a message approach that is purely prescriptive. It is a series of "Do this, do that, don't do that". But more importantly the calendar may be passing along a hidden message to the elderly which many of them may not want to hear. The keywords like "Older", "Loss of Smell and Taste", "Constipation", "Losing your Teeth" may well be asking old people to accept that they are old people, something many of them may not want to do. For such individuals, the advice may be rejected because the person may say to himself "Well they are certainly not talking to me. I'm not like that."

The Slogan: "Only the Breast is Good Enough" Everyone has praised this slogan but in fact it has not been thoroughly evaluated for its impact, and may not be an appropriate slogan. If inadequacy and lack of confidence are the key reasons why mothers take up the bottle or breastfeed for short periods of time, then one must deal with that in the messages. The slogan "Only the Breast is Good Enough" may ironically reinforce the underlying feeling of inadequacy in that it may suggest to the mother that while this may be true for others, it didn't seem to be true for her, and she may seem more isolated than ever. She may say: "The breast milk of other mothers is good enough but mine is not". In other words, she may be prompted to wonder why, if what the slogan says is so, her breast milk was not good enough. The slogan is not talking to

her and it does not address her insecurity nor give her any reassurance - which may be what she needs.

Radio spots: Many of the spots are lectures and contain too much information. Some of the spots are rather alarming or scary. The gastroenteritis series, for example, tells the mother melodramatically: "Your child may have CASTROENTERITIS!! You'd better get him to a hospital or clinic quickly. It could be serious." Not only does this have the potential to truly scare the mother, but it reinforces her sense that she is not adequate to the task of caring for her children by herself. One underlying message is the need for experts. There is nothing in the message at all which is supportive of the mother or which deals with the realities of the situation, such as the possibility that she may not be able to get to a clinic.

In another radio spot, Cynthia worries about "long breasts". The nurse says "It's not true. I'll explain this when we get together with the other ladies." The listener receives no further information about why it's not true and again no attempt is made to get at deeper reasons why mothers may be reluctant to accept the breast only or to breastfeed for longer period of time.

The slogan: "Eat Right for the Baby" Here the word "Your" is left out. At the very least the slogans must address persons in a personal way.

In another of the radio spots a lecture is given on protein, fat and milk, and how one can shop wisely for these things. The spot ends on this note: "Interesting isn't it? That's why we always have to be smart shoppers." This spot illustrates three problems. First, it uses a lecture tone similar to one he/she might have heard in school. Second, it attempts to fool the listener. For it is unlikely that listeners will find the information "interesting" and to say to the listener "interesting isn't it" is to risk patronizing the listener. But these are less important than the fact that the spot does not deal with realities. There are many reasons why people do not shop smartly, and the least important of them is probably lack of information. The more likely reasons; the ones with real motivating power are economic ones, the effect of advertising, and the need for prestige, status and so forth. These need to be addressed. At present they are not being addressed.

The social marketing field is relatively new and there is an enormous amount to be still learned about motivating people for health and social goals through the use of the media. But certain common pitfalls have been identified. Some message types which would seem to be ineffective in this type of campaign are:

- messages which use scare tactics
- messages which reinforce existing inadequacies or insecurities
- messages which lecture or sound too much like school
- messages which are too technical, and which use a kind of "we-know-better-than you" tone.

- messages which remind people of what they may know rationally but don't always want to face (such as guilt-inducing messages) which often results in a repeat of the same behavior (e.g. Anti-smoking messages)
- messages which tell people they are wrong
- messages which in effect lie to people (e.g. "Skimmed milk is quite delicious" when most people do not think it is delicious at all)

Message approaches which have been found to be generally more effective in motivating people to change are ones which create a bridge to people's underlying emotional/cultural/psychological state - messages which reach them in such a way that a kind of psychological light goes on inside the person, something one could call an "A Ha!" experience.

Examples are:

- messages which sympathize with people or empathize with their often hidden doubts
- messages which give people permission to do new things in ways which assuage their concerns about status or prestige
- messages which jog peoples memories about good things in their lives
- messages which are often indirect
- messages which appeal to humor
- messages which proceed from what people know.

**VI. The Potential for Adapting Jamaican Food Practices to a Future Programme**

**Nutrition and Cultural Food Practices**

The Jamaican food lifestyle revolves around a basic love for food and includes such exotic dishes as ackee and codfish, stew peas and rice, meat patties, and curried goat. Every Jamaican can prepare such a meal if there is enough money and/or food products available. This is the problem.

Recent attempts by the nutrition education campaign to educate the Jamaican population about proper eating habits/breastfeeding habits does not appear to take into consideration the "model" foods or meals which Jamaicans esteem in their minds but no longer can afford. Rural and Urban Jamaicans alike are finding it tough to make ends meet. In spite of such economic constraints, most Jamaicans are still trying to live "like the Joneses" and as they struggle to achieve their status level, bitter reminders of the inability to prepare a 'proper' meal which includes meat, rice, and other luxury items constantly faces them.

As a result of hard times, it is now more important than ever to reassure families and mothers that they can provide adequate food, or adequate breast milk for their children. Reassurance, masked in the disguise of special foods for "at risk" or target populations, and coupled with a marketing strategy aimed at making the mother/family feel more confident, could reinforce the strong pride that exists in Jamaica.

The following section, therefore, approaches the nutritional and cultural food practices that exist now in rural areas of Jamaica and suggests ways of building up the confidence of families through innovative ways of looking at the role of traditional and new food products.

### Jamaican Meal Patterns

The "ideal" meal pattern of three meals a day does not really exist in most Jamaican households. In the rural areas, most Jamaicans will consume a hot beverage in the early morning (bush tea, coffee, cocoa) and maybe have a piece of bread/biscuit. In some households, porridge is prepared from cornmeal or bananas and this might supply the food for both the morning meal and the midday meal. One large meal is prepared daily, called the 'family pot' meal and every member of the household will partake of it.

When one examines this pattern of eating, it appears that Jamaicans eat three times a day. This, in fact, is not how Jamaicans view their meal pattern. This is partly due to how Jamaicans define 'food'. After talking to some men and women in rural areas and listening to their dietary recall of a typical day, it appeared that these Jamaicans defined 'food' as a cooked meal. Uncooked foods are not classified as food. Based on this view many Jamaicans do not have a three meal food pattern, but instead, a two meal food pattern.

Webster's New Collegiate Dictionary defines food as "something that nourishes, sustains, and supplies." A meal is defined as "the portion of food taken at one time to satisfy appetite." These two academic definitions seem to also correspond with the Jamaican approach to cooked food in how they view porridge/pudding or a family pot meal. Any uncooked food is regarded as a snack and less significant. Webster's definition of a snack is "food eaten between regular meals." Given these definitions and the lack of a more appropriate Jamaican term which could apply to uncooked foods, it appears that the "typical" food/meal pattern for Jamaica is two cooked meals and one or more snacks (uncooked foods).

Our visits to the rural areas did in actuality, show that the family pot meal was a "meal" in its real connotation. It contained a variety of foods and appeared to provide adequate quantities of protein, carbohydrate, fat, minerals, and vitamins. In general, the family pot meal appears fairly well balanced considering the economic constraints being placed on families nowadays.

This eating pattern of two cooked meals a day does not conform well to information or education efforts which are now following the "ideal" food consumption pattern of three meals a day. If this is indeed the cultural or "real" food pattern, then the question must be asked, "How can we work with this system?"

One way of working with this food pattern is to approach uncooked foods differently than cooked foods. It appears that Jamaicans view them differently and apply different status criteria to each of them. A cooked food seems to have more status than an uncooked food. In fact,

one CHA related a story about how she visited a home and the mother said "I have nothing to feed my child", but in the corner of the house were some bananas. The mother did not consider the bananas as 'food' and even though the child was crying from hunger and the mother was upset, felt embarrassed and probably felt inadequate as a mother, it seems it never occurred to her to give the child bananas. Of course the CHA offered the mother the practical advice of feeding the child the bananas and soon the child stopped crying.

According to the mother's definition of proper 'food', she did not really have the ingredients to cook the bananas and provide the child with a meal.

Food in addition to being cooked, must also contain certain elements in order to be classified as 'food'. One nutrition assistant related a story of when she visited a rural family and found that they only had peas and rice to cook with. She suggested that they cook stew peas and rice, but they laughed and said "How can we cook stew peas and rice without meat?" "It isn't food/meal unless it has meat." Though most rural families do not buy much meat, the meal must have even the most insignificant little piece of meat (for flavoring, they say) in order to be considered food.

Underlying the belief that they must have meat, may actually be the feeling of status -- only the poorest of the poor would eat stew peas and rice without meat. Suggestions that families eat stew peas and rice without meat may, unintentionally, embarrass the family by suggesting that they are in the same status class of the poorest of poor. As a result, families/mothers may have their confidence degraded even further and their feeling of inadequacy exacerbated.

It is this type of information that is needed when developing a nutrition education campaign. If mothers continually believe that uncooked food is not food and, therefore, believe they are inadequate providers because they cannot provide cooked foods three times a day, then any reference or suggestion by health personnel that mothers give items such as uncooked bananas, plain bread/biscuits, lemonade, etc. reinforces the mothers belief that she is inadequate. If she was a 'good' mother, she would be able to provide cooked meals/foods i.e. status foods all of the time.

With the proper research, the nutrition education campaign can tackle this concept of cooked/uncooked foods and status foods/poor people's foods. A new mass media campaign -- while addressing the overall issue of confidence in women -- can build a positive image of the use of uncooked foods as "special" foods which have an important role in the development of each family member.

### Weaning Practices

The traditional weaning patterns appear to be closely linked with the Jamaican concept of cooked and uncooked food. Information not gleaned from the baseline survey but gathered through personal communication with health personnel and Jamaican mothers, indicates that weaning foods, other than cooked porridges, puddings, and food taken from the family pot, are not considered "food". One nutrition assistant stated "Jamaican mothers do not consider it 'food' unless it is cooked".

This, therefore, indicates that advice given by CHA's or other health staff persons regarding weaning foods is taken in the context of whether the food is cooked or not.

A mother's feeling of adequacy stems from her ability to provide food in the form of a cooked dish. Even if the mother is providing some uncooked items in addition to the family pot meal, she only views the cooked meals as food. It appears that many mothers feel embarrassed that they only give one or two cooked meals per day, where, in fact, they should feel proud because they are often providing a variety of difference food items, some cooked and some uncooked or plain (e.g. fruit, biscuits).

Taking this cultural approach to nutrition education, any advice given to mothers or families should focus on strengthening the concept of both uncooked and cooked foods as having special functions in the development of a child. Special weaning foods should be researched and promoted in an appealing status-oriented way. New recipes could be developed, and certain uncooked foods could be touted as super foods thereby helping families make the transition from cooked foods as status foods to uncooked foods also sometimes being status foods.

Several nutrition assistants have mentioned that mothers like to give their children sweet weaning foods. An example of this is the current practice of preparing cornmeal porridge with milk and sugar. Another example is pudding. More experimentation should be done in developing additional cooked weaning foods. Since new cooked weaning foods would fall in the category of 'food' their acceptance should be

easier. One suggestion would be to teach mothers how to make tapioca pudding from locally available cassava, powdered milk, sugar, and egg.

### "Super" Foods

Within most cultures there are special foods that seem to be more important or hold a special place within the society. One such food in Jamaica is the Irish potato or "Irish" as it is commonly referred to. The Irish potato was constantly mentioned as a "super" food by Jamaicans at every social level and it has developed into a revered baby food. Even the literature (CFNI, 1983) notes that Irish potatoes are a highly esteemed staple. Currently, Irish potatoes sell for \$2.40/pound while yams sell for \$1.00/pound.

Irish potatoes are bought by the lowest of the low income population for several reasons:

1. easy to prepare (boiled and mashed with butter/margarine)
2. loved by children/infants
3. status (believed to be better than yams or other staples)

The over-riding decision making factor for buying Irish potatoes is status. This was confirmed by personnel at all levels of the health system, from CHA's to nutrition policy planners in the administration of the Ministry of Health. Nutrition assistants and CHA's, as well as midwives, have tried to convince families to buy other less expensive

foods. Health personnel need to understand the psychological reasons why people prefer Irish and use this information to either 1) decrease the importance of Irish potatoes in the diet, and/or 2) increase the importance/appeal and acceptance of other less costly indigenous food items.

One suggestion for increasing the appeal of less popular or less "status" foods is to combine in a new recipe a small amount of Irish potato with a larger amount of yam, or some other staple, prepare it in an "exciting" manner and call it a "special" baby food. This type of adventure requires a creative mind and adequate research into the cultural food beliefs and preferences, but a successful weaning food could be achieved.

#### Food Habits during Pregnancy and Lactation

It is a well known fact that the nutritional status of the pregnant woman directly affects the health status of the fetus and newborn child. There are increased caloric and nutrient needs during pregnancy and lactation and any efforts to motivate a woman to consume an adequate diet during both of these two periods should result in better health for both she and her child.

Traditional approaches to educating a woman about the food groups is not usually effective in motivating her to choose nutritionally sound foods or meals. One approach that may be more effective in gaining the attention of pregnant and lactating women would be to work with their cravings.

Data from research done by the Tropical Metabolism and Research Unit (TMRU) indicate that pregnant women have an increased thirst for ice, fluids, milk and fruit juices. (Murray, et al, 1974). In addition, they also have an increased desire for sour or salty foods. These desires appear around the world in pregnant populations and are a physiological response to the state of pregnancy. It is unusual, however, that in Jamaica there appears to be a culturally determined craving for green fruit (Landaman and Hall, 1983). Coupled with the data that 47% of the pregnant women indulge in their cravings, it appears that the goal of educating pregnant and lactating women about nutrition could be done through avenues which would address these cravings in an appealing manner. Additional cultural research could reveal appropriate data concerning the creation of nutritious appealing products that would:

1. improve the nutritional quality of the pregnant/lactating woman's diet,
2. satisfy the physiological cravings,
3. satisfy the culturally determined cravings,
4. be easily obtainable by everyone, and
5. appeal to each person's status concept.

One such example would be a product similar to an "Orange Julius" or "Lime Julius" drink available in the U.S. A Lime Julius contains lime juice, sugar, water, powdered milk, and sometimes a raw egg. The combination produces a frothy (from the milk powder) drink which is similar to a milkshake, although not as heavy. A "Lime Julius" would

appear to fit quite naturally into the Jamaican culture and have the appealing ingredients that Jamaican pregnant and lactating women crave. This type of product, after it has been pretested to determine threshold levels of the ingredients, could be given a special name and marketed as a product that women could make at home or purchase.

One likely avenue for preparation and distribution of this special product could be through Child Welfare Clinics. It was observed during our field visits that soda (Pepsi, Ting, etc.) and sweet crackers are being sold at the Clinics. These commercial products now available at the clinics could be replaced by this new lime drink thereby propitiously affecting the nutritional quality of the women's diet.

### Food Superstitions

Many of the food superstitions that were mentioned by Murray, et al (1974) and reported in "Nutrition Notes, Young Child's Feeding" can be substantiated or reasoned out to a point where they do not appear to be superstitious at all. Peas are often avoided because they cause flatulence and cocoa may be thought to rot bones/teeth either due to the additional sugar which might be added when drinking it in a beverage or due to the oxalic acid content which affects calcium absorption. In any case, most food superstitions can be worked with if realistic recommendations can be made regarding its validity or invalidity.

One example of working with a superstition would be trying to reduce the resistance to feeding a small child eggs. Often eggs are viewed as bad and cause children to stutter, etc. One way to go around

this superstition is to agree with the mother/grandmother but at the same point state that it is only the white portion of the egg which is bad, the yold is good (it also contains a good source of iron). Over time, people will eventually begin eating the entire egg, but it is first necessary to start out small, to start out with the real, not the ideal, and realize that over time, the entire egg will soon be viewed as good.

One common superstition in Jamaica is that liver will make the tongue heavy. As a result, liver is not always given to children. Considering the high incidence of anemia in preschool children, it would be advantageous to find a way to work with this superstition. One such way might be to tell the family that yes, indeed, liver is bad if it is given in large quantities. If small amounts of liver are given this will not make a heavy tongue. Liver is now quite expensive in the rural areas, therefore suggestions that small amounts of liver be given to children once a year may provide a realistic and manageable suggestion that can be acted upon by almost every rural family.

Superstitions are real to most rural families. If they are approached and suggestions made regarding their reality, they will often disappear over a period of time.

**VII. Recommendations for strategy in a new National Nutrition Education Campaign**

**A. Semantics**

Semantics, being in our opinion very important, we recommend a small but significant change. The programme should henceforth be called the National Nutrition Motivation Programme.

**B. Duration and Continuity**

There is one logistical aspect of the past programme which does need to be remedied in any future program and that is continuity of duration. It is more important to have a small scale campaign that continues steadily over a long period of time than a campaign which tries to cover everything, and reach everywhere, and last only 6 to 8 months.

**C. Program Thrusts**

The original programme aimed at five basic target problems: Breastfeeding, Pregnant Mothers' Nutritional Needs, Anemia, Weaning Foods, and Clinic Attendance. There is no conclusive evidence that the original programme sufficiently solved any single one of these problems to the point where it could be eliminated. Our field work suggests strongly that the five original target problems should be

continued in a new program, but that a more finely honed definition of each one be worked out. For example, the CHAs, NAs, and Nutrition and Dietetics Division Staff seem to be in agreement that the key problem with breastfeeding is duration of breastfeeding and its exclusivity. The weaning foods problem, for example, may have much to do with concepts of what is "food" and what is not "food". Clinic attendance, many seem to agree, seems to have much to do with fears of embarrassment. Such honing of the definition of the target problems will help in designing messages and supporting training. Finally, we strongly recommend that an attempt be made to link all five problems together in terms of a single unifying underlying problem. Our initial hypothesis is that such a unifying problem is the sense of inadequacy, the lack of confidence of poorer mothers, propelled by a status considerations (both awareness of their low status as well as aspirations for higher status) and fueled by problems of modernization and development which are now considered to be classic ones world wide. If such a single construct is found to underlie all five areas at some level, then a single media strategy may be able to have a motivational impact on all five.

D. Target Group

Given the necessity of making hard choices and setting priorities, we would recommend an acceptance of the fact that for

the foreseeable future; the focus should not be on all population groups. The middle class mother is not generally suffering from nutritional problems with her children. She may be bottle feeding, but if it is because she is working then we may perhaps have to "allow her" to continue. The most efficient use of resources would be to aim the campaign at the largest problem group - the group where we see the most serious cases of malnutrition - the poor, teenage mothers, rural populations, illiterates.

E. Programme Sequence

An approach which has been suggested is that of focussing the programme not only on one level of the population but also on one geographic area at a time. A possible application of this idea might be to mount a nationwide media campaign but do intensive field support, parish by parish, say for 2 months at a time. This would enable maximum use of vehicles and headquarters personnel.

F. Medium

The print media could be reduced - fewer newspaper ads, fewer brochures, fewer small pieces. These last are relatively inefficient. The main focus should be on the radio message. Television is out of the question. Film is also too costly and time consuming. The radio reaches by far the largest segment of

the population and has for the short term future the highest potential for success. Two print areas are recommended for support of the radio campaign: posters and calendars. The posters are for clinic use. Calendars have high potential for home use but we recognize printing costs here as a limitation.

G. Method

Research is often a term which puts many people off in the development field. They think it must cost money to be valuable and/or they think it is of questionable value, not necessary at all.

Research can be relatively inexpensive if there is a firm control of the purpose of the research. In the case of a nutrition motivation campaign using media, the focus of research should be not on merely generating a lot of interesting data on people's knowledge, attitudes and beliefs about food, or breastfeeding, but quite specifically on generating some answers to the question: Why do people do X or why don't people do Y? This more dynamic approach to research can result in lower research costs. Specifically we want to locate the points of resistance to the recommended nutritional changes. We want to locate those points at all levels, not merely the economic or rational reasons why people behave but the underlying psychological and socio-cultural reasons. These usually cannot be reached by simply asking the

question: "Why do you do this (breastfeed, bottle feed, not use cup and spoon, not eat banana, eat Irish potato, etc)".

This kind of research must begin with some hypotheses - that is, some guesses about what the answers might be. We can guess, for example, by looking at what has been found out elsewhere, that status, prestige, need for self esteem, and their opposites: lack of status, lack of self esteem, lack of confidence, are very powerful forces behind people's choices about things, whether about foods or about health practices. Questionnaires with large samples are an inefficient method to get such answers. They cost a lot and by their nature, only ask for short and superficial answers. Thus, when the baseline survey asked people to answer the question "Why did you stop breastfeeding?" It only probes the surface. The answer often came back: "Baby didn't like it." "Baby wanted bottle." "Breast milk wasn't good enough." "Breast milk wasn't enough."

Here is where one needs to probe more. Armed with an hypothesis like the one proposed above, we would conclude that the key here may well be lack of confidence. By probing further one might arrive at deeper levels. Why the lack of confidence (expressed by "not enough") that is behind it? Perhaps a sense of low status. Perhaps an awareness of the tendency of the higher classes, the rich folk, to not breastfeed.

A small research program can be designed, at low cost, which will get at the points of resistance and the underlying reasons for

doing things. Qualitative rather than quantitative research, using techniques such as open ended in-depth interviewing, participant observation and some projective testing can be done by a small group of 4 to 6 interviewers with a representative sample of as few as 100 to 200 people nationwide, in a period of 3 or 4 weeks. This has been successfully done elsewhere.

#### H. Overall Media Message Focus

If the hypotheses about confidence/status can be further demonstrated through additional research, then the appropriate overall message focus should be to restore that confidence. The approach should be sympathetic, empathetic, and reassuring. It can even address the issue head on as in: "You can do it, we know you can do it. You are our national pride." "When you breastfeed your baby, we applaud." Posters could show a crowd applauding a breastfeeding mother.

#### I. Message Design

McLuhan said that the medium is the message, by which he meant that the means of carrying the message in itself conveys something to the receiver of the message. An aura can be created by the means. For examples, billboards, often used to advertise particularly famous commercial products or services (like airlines

for example) acquire a power because of that kind of use. Thus when a large billboard carries a health message the health message can be imbued with a bit of that leftover power.

The medium also has to do with the format and tone of the message. If the message sounds like school, then the reaction to it may well be the reaction people have to school. We would recommend that health messages in Jamaica take advantage of Jamaican cultural predilections which may have motivation power, such as: humor, music and drama. These would have to be carefully pretested.

Testimonials are an excellent way of adding power to the message. Using famous cricket players or singers to be the speakers or singers of messages is extremely effective, not just in raising awareness but in motivating change.

#### J. New Ideas for Experimentation

1. A small experiment with Radio Listening Groups may be tried. These have been used elsewhere (Kenya for example). The technique is simple: A CHA might gather a group of local mothers to listen together to a radio program on nutrition or breastfeeding. The drama keeps the audience involved, and the CHA or NA is present to reinforce the program after it is over. This should not be tried nationwide, but initially only experimentally, in pilot form, then perhaps parish by parish.

2. The private sector, the food industry in particular (one segment of the opinion leaders in the country was not strongly included in the original effort) should now be included in a much bigger way. We learned, for example of a monthly meeting of the Food Group within the structure of the Jamaica Manufacturers Association. The food group might be amenable to having some role in a new nutrition motivation programme. One possibility is to piggy-back messages on their already planned advertising. A second one is to join with the food group in designing new products which would be both nutritionally sound and fit within poorer peoples' food conceptions and means. At the very least it would cost nothing for someone from the Nutrition Motivation Programme to attend the monthly meeting of the Food Group.

K. Support at Hospital Level

By far the most critical area needed in any nutrition motivation programme is the support of the key medical infrastructure in the country, not the community based people like the CHAs and NAs but the hospital people, the doctors and nurses who have first contact with the new mother and who are widely respected. They must be involved in a total way. Without their rallying around the issue of breastfeeding, without them involved in accepting certain aspects of local diet and being realistic about

these, without them understanding the economic and other constraints in people's nutrition choices (including people's deeper psychological motivations) there can only be stultified progress.

Successful rallying of the hospital staff level has been done in other countries. In addition to sending key Nutrition Division people to look at those models we recommend also that some training money be spent on seminars and workshops and that key government individuals, the Prime Minister, the Minister of Health, be the nominal backers of these seminars in order to give greater legitimacy to the effort.

L. Training of Nutrition Division and Bureau of Health Education Staff

Nutritionists and Health Educators can become adept at innovative and motivational message and media work. They can be trained in the practical aspects of preparatory research and motivational message design. They do not need to feel, as some do, that only highly paid consultants and communications experts can do this kind of work. Much of the talent of communications people lies in an ability to put oneself in the shoes of the target audience.

We recommend, as a first step in this direction, that senior Nutrition Division staff and perhaps Bureau of Health Education staff conduct observation visits to that country or countries which

have demonstrated success in health motivational programmes using media. Such visits would enable these people to see what can be done, how it can be done and generally stimulate an openness to the possibilities of social marketing. Given limited training funds such visits might be more productive than traditional U.S.-based academic training in communications.

In addition, workshops for Nutrition Division staff and Bureau of Health Education staff could be instituted which would examine the state of the art in advertising design and show the possibilities of "fertilization" from the commercial to the social arena.

M. Health Centre Operations

We recommend that workshops be conducted to expose Nutrition Assistants, CHAs, nurses and midwives in Jamaica to the new emphases of a new Nutrition Motivation Programme. They do not need more instruction about what mothers need to hear but more instruction about how mothers need to hear it; ways to make their home visits and the visits of mothers who come to the clinics more comfortable psychologically.

Our health centre visits indicated a tendency on the part of staff to talk down to mothers, to "rough" them verbally (with phrases like "You know you shouldn't be doing that." or "We told you many times not to do that." or "We are not pleased when we see

that." etc.) Some CHAs and NAs told us that they know that some mothers do not like to come to clinic because they feel they might be "roughed" or because they are embarrassed if they have low weight babies. In addition, the mothers seem to be motivated to attend or, in turn, to be reluctant to attend depending on whether they have nice clothes for the babies to wear.

These kinds of problems can be ameliorated by involving the CHAs, Midwives, PHNs, NAs in a workshop or series of workshops which would aim at getting their ideas as to how to experiment with solutions. Some suggestions which CHAs and NAs made to us were:

- Make the home visit more physically dynamic. Do not just sit or stand in one room with the mother. Go outside with her, touch the child more, etc.
- Make it a rule that babies should only be dressed simply to attend clinic. Tell mothers this is so the dressing and undressing can be done more quickly.
- Have a clinic day once a month when only low weight babies attend.
- Generally try not to shame the mother.

**N. Involvement of Jamaican Research and Training Institutions**

Finally we propose that existing Jamaican research and higher education institutions be brought more centrally into the social marketing process, as opposed to merely serving in an advisory or, in some cases, a subcontracting capacity.

We had meetings with key people from both CARIMAC and CFNI and read some of the work done by the Tropical Metabolism Research Unit and the Scientific Research Council. There are clearly very solid resources in Jamaica which could be tied in more regularly to any health motivational program, and certainly to a nutrition motivation programme. Both CFNI and CARIMAC have individuals on their staffs who are committed to innovation in social marketing.

We note, as an example of what could be done, the existence at CARIMAC of a four week summer module program which could be easily adapted to focus on techniques of social marketing, both the preparatory research techniques which are special to social marketing (namely qualitative, in-depth research) and the media design work. As the UWI and some of its units serve many nations in the area, a future program in social marketing could eventually evolve which would serve the entire region.

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The mothers and children whom we visited during our field trips to Morant Bay and Lawrence Tavern Child Welfare Clinics.

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**B. ITEMS READ/RECEIVED BY NUTRITION DIVISION/MOH**

**I. Materials Used in Nutrition Education/Communication Campaign**

1. Posters
2. Brochures
3. Calendars,
4. "Carlens" (film)
5. Book cover
6. Game
7. 45 second and 5 minute nutrition education radio spots (heard at Dunlop, Corbin, Compton)

**II. Reports**

1. "Nutrition Notes, Young Child's Feeding"
2. "Nutrition Education and Training Programme"
3. "World Bank Population Project, Jamaica II Nutrition Education/Communication Mass Media Campaign"

**C. NUTRITION AND DIETETICS DIVISION -- FILES 1979 - 1982**

- A) Radio scripts
- B) Correspondence
- C) Meetings
- D) Notes

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## WHAT IS INCS?

INCS is a consortium of educational, medical, marketing, and social service institutions which provides technical support for nutrition education/communication activities in the Third World. Founding institutions include Education Development Center, Manoff International, Save the Children Federation, the Harvard School of Public Health, the School of Public Health at the University of California at Los Angeles, and La Leche League International. Other institutions which have been professionally associated with INCS include Yayasan Indonesia Sejahtera (Indonesia), the Department of Paediatrics of the University of Colombo (Sri Lanka), the Department of Paediatrics of the University of Nairobi (Kenya), and CORSANU (Guatemala).

## WHAT DOES INCS DO?

INCS provides technical assistance to nutrition/nutrition education projects. It responds to requests from government ministries, international agencies, and non-governmental organizations. INCS also produces reference materials for projects in the field, such as country nutrition data profiles and catalogues of exemplary nutrition education materials (see our publications list below).

## EXAMPLES OF INCS ACTIVITIES

- Maternal and infant nutrition workshops for health professionals (Fiji, Kenya, Sierra Leone, Colombia, Panama, Costa Rica, Indonesia, Nepal);
- the design of national nutrition education campaigns (Congo, Indonesia, Burma);
- the design of surveys to assess the determinants of infant feeding (Cameroon, Bolivia, Congo, El Salvador);
- primary and secondary school curriculum development (Bolivia, Honduras);
- medical school curriculum development (Costa Rica);
- training of field workers in nutrition (Honduras);
- workshops in participatory approaches to nutrition education (Guatemala, Philippines);
- The First Asian Household Nutrition Appropriate Technology Conference (Sri Lanka);
- evaluations (Chile, Jamaica, Costa Rica, Zaire);
- materials development workshops (Peru, Sierra Leone).

## **EXAMPLES OF INCS PUBLICATIONS**

- **Maternal and Infant Nutrition Reviews:** profiles of mother and child nutrition status, beliefs and practices, programs and policies in 31 Third World countries;
- **Nutrition Training Manual Catalogue:** a guide to more than 100 of the best training manuals in nutrition that have been developed for use in developing countries;
- **A Breastfeeding Counselor's Curriculum** (in conjunction with the CALMA project in El Salvador);
- **A Manual on Participatory Approaches to Nutrition Education** (to be published in conjunction with Save the Children Federation);
- **Proceedings of the First Asian Household Nutrition Appropriate Technology Conference** (in conjunction with UNICEF);
- **A Nutrition Education Compendium** (to be published in 1982);
- **INCS Consultant Reports** from over 23 countries;
- **An Anthropological Approach to Nutrition Education:** a concept paper by Mark and Mimi Nichter.

## **WHO SUPPORTS INCS?**

To date, INCS has been supported mainly through a four-year contract from the United States Agency for International Development. Additional funding has been supplied by UNICEF.

## **WHO ADMINISTERS INCS?**

The INCS consortium is coordinated by Education Development Center, Inc. (EDC), a non-profit organization with twenty years experience in the administration of international educational projects. Manoff International and Save the Children Federation share with EDC responsibility for project administration.

## **FOR FURTHER INFORMATION CONTACT:**

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