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Program in International Nutrition

The Proceedings of an International Conference on

COMMUNICATION STRATEGIES TO SUPPORT INFANT AND YOUNG CHILD NUTRITION

July 13-14, 1992
Washington, DC

Sponsored by the International Nutrition Education Division of the Society for Nutrition Education and the Nutrition Communication Project, managed by the Academy for Educational Development for the United States Agency for International Development, Bureau for Research and Development, Office of Nutrition

Edited by: Peggy Koniz-Booher, MPS

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July 13-14, 1992
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Proceedings Edited by: Peggy Koniz-Booher, MPS

Dedicated to the memory of Derrick Jelliffe

Program Chair - Michael Latham

Conference Coordinator - Peggy Koniz-Booher

Program Coordinator - Margaret Burns Parlato

Local Arrangements Coordinator - Cindy Arciaga

The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development

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Program in International Nutrition

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Dr. Michael C. Latham
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FOREWORD

Reading the draft of these Proceedings, just before preparing this Foreword, brought many images to my mind: what a varied group of topics are covered; how diverse are the authors from many disciplines and several countries; what an unusual alliance of persons on the planning committee from international organizations, governments, academia, NGOs and the private sector; and how differently each author chooses to deal with his or her own topic. And yet as I read on, and as I thought back almost 12 months to the exciting days of the conference itself, I was amazed at the harmony and the lack of "dissonance." These are usually words we apply to musical performances.

And that surely is a good analogy. "The International Conference on Communication Strategies to Support Infant and Young Child Nutrition" and these Proceedings are like a well played classical symphony. So many players, women and men, young and old, black and white, yet performing together. A variety of instruments to produce that harmonic sound coming from the strings (are these the educators?), the woodwind (perhaps the communicators), the percussion instruments (let me suggest the implementers). But within each orchestral section so much variety--the strings with melodic violins and the gracious harp. Similarly the educators and the communicators produce different sounds and use a wide variety of methods. And yet with all this there was harmony at this Conference and no "dissonance." How was this achieved?

A great symphonic performance requires more than a good orchestra with fine musical performers in each section. The two other essential ingredients are a good musical score and a talented conductor and musical director. The score for this Conference is the sum of knowledge relating both to communication strategies and to infant and young child nutrition. The decade preceding this conference saw major advances in communication relevant to nutrition as readers will find, for example, in the important papers by William Novelli, Marcia Griffiths, and others in these Proceedings. Similarly we have learned a great deal about appropriate infant feeding as described by Ted Greiner in his "Introductory Remarks" and by others here. So the conference was timely, because it was held in 1992 when there was a solid base of knowledge and exciting new possibilities of improving infant and young child nutrition using various communication strategies.

If the speakers were the skilled instrumental players, and the base of knowledge was the imaginative score for this classical symphony, the final essential requirement for a wonderful performance is a conductor and musical director. And our Leopold Stokowski was Peggy Koniz-Booher. She worked indefatigably to assemble an outstanding group of players; she gently but intelligently helped each of them in preparation for the performance. Also, like any great conductor and musical director, she used all her talents and energy to ensure not only a good performance by each player, but above all a harmonious, exciting overall performance--one which was satisfying and uplifting, and with no "dissonance." Her success deserves wide applause.

These Proceedings, including the presentations by experts from many disciplines, provides a unique set of papers which I believe will be very useful for scholars and practitioners. It is suitable for the university classroom, and for the field. It is Peggy's recording of the symphony she conducted so well in July 1992.

My role in the Conference and in writing this Foreword has been threefold. First, I served as Chairman of the Conference and Program Chair, but was able to leave most of the decisions and work to the Conference Coordinator. Second, working in what is now the International Nutrition Education Division of SNE with Peggy for some 10 years, we have together helped to organize four international conferences. Third, at Cornell University, as well as being Director of the Program in International Nutrition, I serve as Editor of the International Nutrition Monograph Series. I very much welcomed publishing these Proceedings in that Series. I always tell my PhD students, after they complete their research, that research plays no useful role unless the results are published and communicated. A Conference is different, because many people listen to the presentations and discuss them. But publication allows a much wider dissemination, and also puts into the hands of the participants the papers they heard. I am very pleased, therefore, to have this published in our Monograph Series, because the topic is of great relevance to the objectives of our Program, and the Proceedings provide papers that I am certain will be both useful and influence action to improve the nutrition, health, and well being of children worldwide.

Michael C. Latham
June 1993

ACKNOWLEDGMENTS

On behalf of the Society for Nutrition Education and the Nutrition Communication Project, Academy for Educational Development, we would like to kindly acknowledge the major financial and technical contributions made by:

THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT, BUREAU FOR RESEARCH AND DEVELOPMENT, OFFICE OF NUTRITION

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APHA CLEARINGHOUSE ON INFANT FEEDING AND MATERNAL NUTRITION;

INSTITUTE FOR REPRODUCTIVE HEALTH, GEORGETOWN UNIVERSITY;

SWEDISH INTERNATIONAL DEVELOPMENT AUTHORITY;

UNICEF;

WELLSTART INTERNATIONAL;

WORLD HEALTH ORGANIZATION.

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Kristin Cooney for her invaluable collegial editorial assistance;

Cate Harrington for her creativity and expert computer support;

Miriam Labbok, Robert Booher, and Michael Latham for their constant encouragement and moral support;

The entire staff of the NUTRITION COMMUNICATION PROJECT, ACADEMY FOR EDUCATIONAL DEVELOPMENT, especially: Margaret Burns Parlato, for her vision and technical guidance; Cindy Arciaga, for her attention to detail; as well as Claudia Fishman, Valerie Uccellani, Diane Foster, Joelle Chorna, Robert Galinsky, Sarah Marlay, and Jennifer Edwards for their countless contributions;

and

The Conference Planning Committee, Presenters, Chairs and Discussants who donated their valuable time and ideas; and Martha Figueroa, Marjorie Scott van Veen, Ritchie Jacocks, and Doreen Doty for lending a hand when a hand was needed.

CONFERENCE PLANNING COMMITTEE

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Mojdeh Bruss, 1988-1990 Chair INED
Richard Cook, 1991-1992 Chair INED
Hugh Joseph, 1990-1991 Chair INED
Peggy Koniz-Booher, Conference Coordinator and 1992-1994 Chair INED
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Michael Latham, Conference Chair and 1984-1987 SCINE Chair

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Claudia Fishman, Deputy Director, Nutrition Communication Project (Porter/Novelli)
Valerie Uccellani, Program Officer, Nutrition Communication Project

OTHER MEMBERS OF THE 1992 PLANNING COMMITTEE

Susan Anthony, Nutrition Advisor, USAID R&D/N
Helen Armstrong, Training Advisor, UNICEF
Alan Berg, Senior Nutrition Advisor, World Bank
Francesca Bravo, Food and Nutrition Service, USDA
Helen Bratcher, Nutrition Advisor, Catholic Relief Service
Linda Bruce, Training Advisor, Wellstart
Eunyong Chung, Nutrition Advisor, USAID R&D/N
Bibi Essama, Director, EDC WINS Project
Martha Figueroa, Program Officer, Pragma
Gayle Gibbons, Director, APHA Clearinghouse
Ted Greiner, Nutrition Consultant, SIDA
Marcia Griffiths, President, Manoff Group
Miguel Gueri, Nutrition Advisor, PAHO
Marlene Guroff, Food and Nutrition Service, USDA
Barbara Heiser, Board of Directors, La Leche League International
Margaret Kyenkya, Advisor in Infant and Child Feeding, UNICEF
Miriam Labbok, Co-Director, Institute for Reproductive Health
Randa Saadeh, Technical Officer, WHO Geneva
Nina Schlossman, Technical Officer, EDC WINS Project
Carolyn Sharbaugh, Nutrition Specialist, Nat'l Center for Ed. in MCH
Adwoa Steele, Senior Advisor Community Outreach, Wellstart EPB
Virginia Yee, Program Officer, APHA Clearinghouse

CONFERENCE CHAIRS, PRESENTERS AND DISCUSSANTS

Laura Altobelli, Child Survival Program Officer, USAID/Peru*

Jennifer Anderson, President-Elect, Society for Nutrition Education

Molly Anthony, Maternal and Child Health Bureau, United States Department of Health and Human Services*

Susan Anthony, Office of Nutrition, A.I.D

Judy Canahuati, Director of Community Outreach, Wellstart Expanded Breastfeeding Promotion Program

Carmen Casanovas, Board of Directors, Bolivian Pediatric Society, and Member of the Technical Support Committee for Breastfeeding*

Eunyong Chung, Office of Nutrition, A.I.D.

Kristin Cooney, Deputy Director, Breastfeeding and MCH, Institute for Reproductive Health, Georgetown University

Frances Davidson, Office of Nutrition, A.I.D.

Mary Debus, Senior Vice-President and Director of International, Porter/Novelli**

Ruth Elena de Arango, Technical Director, National Commission for the Promotion of Breastfeeding (CONAPLAM), Guatemala*

Gerson da Cunha, Communication Consultant, India*

Claudia Fishman, Account Supervisor, Porter/Novelli, and Deputy Director of the Nutrition Communication Project, AED*

Nancy A. George, Senior Program Officer, Communication Division, IDRC, Kenya*

Gayle Gibbons, Director, APHA Clearinghouse on Infant Feeding and Maternal Nutrition *

Rob Gould, Senior Vice President and Research Director, Porter/Novelli*

Ted Greiner, Consultant, Swedish International Development Association, Sweden*

Marcia Griffiths, President, The Manoff Group*

Abraham Horwitz, Chair, United Nations Administrative Committee on coordination - Subcommittee on Nutrition, and Director Emeritus, PAHO

Catherine Tim Jensen, Consultant, International Conference on Nutrition, FAO

Urban Jonsson, Senior Advisor Nutrition, UNICEF

Pauline Kisanga, Senior Nutritionist, Tanzania Food and Nutrition Centre, Tanzania*

Ann Kittlaus, Director of Communication, Food Research Action Committee (FRAC)*

Peggy Koniz-Booher, Nutrition/Communication Consultant, A.I.D., UNICEF, WHO

CONFERENCE CHAIRS, PRESENTERS AND DISCUSSANTS, CONTINUED

Margaret Kyenkya, Advisor in Infant and Child Feeding, UNICEF*

Miriam Labbok, Associate Professor, Director, Breastfeeding and MCH, Institute for Reproductive Health, Georgetown University

Michael Latham, Director of International Nutrition, Division of Nutritional Sciences, Cornell University, Program Chair

Pam Malebe, National Breastfeeding Coordinator, Kenya*

Manuel Manrique, Director of Communication and Social Mobilization, UNICEF, Mexico*

Irma de Maza, President, La Leche League, Guatemala*

Judiann McNulty, Director of Cooperative Extension Services, University of Wyoming*

Roy Miller, Director of the Center for International Health Information/ISTI*

Maureen Minchin, Vice-President, Australian Lactation Consultants' Association

William Novelli, Chief Operating Officer, CARE*

Chloe O'Gara, Director, Wellstart's Expanded Promotion of Breastfeeding Program

Margaret Parlato, Director of the Nutrition Communication Project, Academy for Educational Development (AED)

Hadi Pratomo, Faculty of Public Health, University of Indonesia and Executive Director of PERINASIA, Indonesia*

Richard Reid, Director of Public Relations, UNICEF, New York*

Bruce Ross-Larson, President of Communication Development Inc.*

Randa Saadeh, Nutrition Program Officer, World Health Organization*

Felicity Savage, Senior Lecturer, Institute of Child Health and WHO Consultant

Janine Schooley, Director, Education Programs Services, Wellstart International

Beverly Spencer, Program Coordinator, La Leche League of Maryland, Delaware and D.C. Inc. Peer Counseling Program*

Maryanne Stone-Jimenez, Director, Child Survival Project, La Leche League, Guatemala*

Tom Tilson, Former Director, Radio Learning Project, EDC, and Vice President and Director of International Basic Education, Academy for Educational Development (AED)*

Valerie Uccellani, Program Officer, Nutrition Communication Project, Academy for Educational Development (AED)*

Cecilia Cabanero Verzosa, Deputy Director of HEALTHCOM, Academy for Educational Development (AED)*

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* Contributing authors

1992 INTERNATIONAL NUTRITION EDUCATION CONFERENCE

COMMUNICATION STRATEGIES TO SUPPORT INFANT AND YOUNG CHILD NUTRITION

8:30am-5:00pm, JULY 13 - 14, 1992
OMNI-SHOREHAM HOTEL, WASHINGTON, DC

Day 1: Monday, July 13, 1992

8:00 **Registration**

9:00 **Welcome**

Michael Latham (Program Chair)
Jennifer Anderson (SNE)
Margaret Parlato (AED)
Richard Seifman (A.I.D.)

9:10 **Introductory Remarks**

Infant and Young Child Nutrition: A Historic Review from a Communication Perspective *Ted Greiner*

9:30 **Keynote Address**

Communication: Untapped Opportunities for Improving Infant and Young Child Nutrition *William Novelli*

10:00 **Plenary Session I: Strategic Planning for Nutrition Communication**
Session Chair -- Chloe O'Gara

Part 1 -- From Research to Creative Concepts

Snapshots of the Planning and Execution of a Media Campaign -- *Mary Debus and Rob Gould*

10:30 **Break/Opening of Exhibits and Posters** (see Appendix B)

11:00 **Plenary Session I: Strategic Planning for Nutrition Communication**

Part 2 -- Beyond Creative Concepts

- Developing a Communication Strategy: Dietary Management of Diarrhea in Peru *Cecilia Cabanero Verzosa*
- Defining Concepts and Strategies for Improving Young Child Feeding Practices: The Experience of the Weaning Project *Marcia Griffiths*

12:15 **Discussion** *Margaret Parlato*

12:30 **Round Table Luncheon** -- Tables designated according to specific themes and hosted by international participants (see Appendix C).

1:45 **Plenary Session II: Strategies for Reaching the Community -- A Look at Concepts, Messages and Media Choice** *Session Chair -- Frances Davidson*

- Bolivia School Radio Project *Tom Tilson and Judiann McNulty*
- Using Oral Tradition in West Africa *Claudia Fishman*
- Using Radio for Community Mobilization -- Experiences in Zimbabwe and Kenya *Nancy A. George*

3:00 **Discussion** *Peggy Koniz-Booher*

3:15 **Break/Exhibits/Posters**

3:45 **Plenary Session III: Strategies for Reaching the Community -- Making the Interpersonal Connection**
Session Chair -- Margaret Kyenkya

- Mother-To-Mother Support Groups: The Peri Urban Model *Maryanne Stone-Jimenez and Irma de Maza*
- Motivating Volunteerism Among Peer Counselors *Beverly Spencer*
- Skill Building in Counseling *Valerie Uccellani*

5:00 **Discussion** *Judy Canahuati*

5:15 **Closing Remarks Day 1** -- *Abraham Horwitz, Program Discussant*

5:25 **Announcements** -- *Michael Latham, Program Chair* (Exhibits and Posters on Display until 6:00)

6:00 **International Reception**

Day 2: Tuesday, July 14, 1992

8:00 **Second Day Only Registration**

9:00 **Introductory Remarks** -- *Michael Latham, Program Chair*

9:10 **Plenary Session IV: Communication Strategies for Supporting Health Care Workers** *Session Chair -- Susan Anthony*

- Developing Complementary Training and Educational Materials in Peru *Laura Altobelli*
- Applications for New Video Technologies -- Experience of the Philippines *Bruce Ross-Larson*
- Building Motivation at the Hospital Level in Indonesia *Hadi Pratomo*
- The Role of Information *Gayle Gibbons*

10:45 **Discussion** *Felicity Savage*

11:00 **Break/Exhibit/Posters/Videos**

11:30 **Plenary Session V: Developing Community-Based Strategies - Using Communications for Social Mobilization** *Session Chair -- Urban Jonsson*

- Targeting Tips -- Brazil *Gerson da Cunha*
- Designing a Media Strategy to End Childhood Hunger *Ann Kittlaus*
- The Iringa Project: Lessons Learned *Roy Miller*

12:45 **Discussion** *Mark Lediard*

1:00 **Round Table Luncheon** -- Tables designated according to specific themes and hosted by international participants (see Appendix C).

2:15 **Plenary Session VI: Developing Communication Strategies in Support of Innocenti and the Baby Friendly Hospital Initiative** *Session Chair -- Randa Saadeh*

- Staging International Events as a Policy Propellant *Richard Reid*
- The Dissemination of Innocenti and the Baby Friendly Hospital Initiative -- Mexico *Manuel Manrique*

3:00 **Break/Exhibits/Posters/Videos**

3:30 **Plenary Session VI: Part 2 - The Innocenti/Baby Friendly Panel**

- Pam Malebe, Kenya
- Maureen Minchin, Austalia
- Carmen Casanovas, Bolivia
- Molly Anthony, USA
- Pauline Kisanga, Tanzania
- Elisabet Helsing, European Community
- Hadi Pratomo, Indonesia
- Ruth Elena de Arango, Guatemala

4:40 **Reflections from the Floor -- The Future Role of Communication to Support Infant and Young Child Nutrition**

4:55 **Closing Announcements** -- *Michael Latham, Program Chair*

5:00 **Official Close of International Conference and Opening of Society for Nutrition Education's 25th Annual Meeting**

SNE ANNUAL MEETING, WEDNESDAY, JULY 15 (SEPARATE REGISTRATION)

10:30 INED-Sponsored **Concurrent Session: Global Nutrition Priorities for the 90s: Implications for Nutrition Education** *Session Chair -- Michael Latham (Ted Greiner, Miguel Gueri, Elizabet Helsing, Urban Jonsson, Randa Saadeh, Richard Seifman)*

1:30 INED-Sponsored **Mini-Session 1: Guidelines for Creating Effective Infant Feeding Materials** *Session Co-Chairs -- Linda Bardfield and Felicity Savage* Using a variety of examples, communication and infant feeding experts will discuss both creative and technical aspects of educational materials related to infant feeding.

INED-Sponsored **Mini-Session 2: Hands-On New Video Technologies** *Session Chair -- Bruce Ross-Larson*

3:30 INED-Sponsored **International Nutrition Education Research Session** *Moderator -- Michael Latham (Stina Almroth, Martha Holley, Rebecka Lundgren, Akbar Ali Khan,)*

5:30 **SNE International Nutrition Education Division Business Meeting**

7:00 INED-Sponsored **Media Viewing Reception** (International Conference participants are invited to this special reception hosted by the Academy for Educational Development at their Washington headquarters.)

WELCOME AND INTRODUCTORY REMARKS

WELCOME

Michael Latham, Program Chairman

Margaret Burns Parlato, Academy for Educational Development

Jennifer Anderson, Society for Nutrition Education

Eunyung Chung, Office of Nutrition, United States
Agency for International Development

Michael Latham: I have been termed "program chair." That is a bit of a misnomer because other people have done all of the work for this conference. But I am very impressed to see who is here with us today. It is truly wonderful to see so many people, so many names, who are very important in the areas of communication and nutrition--people from many different countries. It is exciting to me to see this large gathering of people.

Only eight years ago, in 1984, a very small group of people within the Society of Nutrition Education expressed some dissatisfaction with our society, of which I was a founding member, because its mission seemed to be focused narrowly on nutrition problems only of North America. Very little consideration was being given to other countries in the world, at a time when a great deal was happening that was exciting with regard to nutrition education worldwide.

I was foolish enough to express those thoughts in Philadelphia, and right from the beginning, expressing similar thoughts, was Peggy Koniz-Booher. As a result of us opening our big mouths, we were asked to try to gauge the interest of members of the Society in international nutrition education, and soon after that a Select Committee was formed which became SCINE, and which is now the International Nutrition Education Division of the Society.

Since that time there have been many international activities, and this is the fourth international conference that the group has held. These gatherings are always held at a time just before or after the annual general meeting of the society. The first was held in Washington, DC, in 1986, two years after that fateful Philadelphia gathering. We then met in Hawaii immediately after the SNE had met in California for a conference dealing with problems of nutrition education in the Pacific. In 1988, in Toronto, immediately after the SNE Conference, we held a meeting on dietary guidelines, trying to look at dietary guidelines for different countries, including a consideration of international dietary guidelines. This, today, is the fourth meeting.

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It is really Peggy who should be standing here and not me. Peggy has been with this group and with the movement of international nutrition education within SNE right from the beginning, and for this meeting she has been the organizer, the worker, the ambassador, the fundraiser, the everything. But she also has played an important role for all of the other international meetings that we have held. Peggy is both the coordinator of this international conference and the incoming Chair of the International Nutrition Education Division of SNE--a Division which is being placed in very good hands.

There is a very exciting program that the planning committee has put together. I want to thank you, the speakers, from the bottom of my heart for coming from very many different places, all very busy people, in order to talk at this meeting. But I also want to thank immensely the participants, because the participants are the most important element of any meeting; and I hope that you are going to have a chance to exchange your views with the rest of us here. I would like to mention a brief word about the conference program. I am not going to go over the program, but the topic really is in the title, "Communication Strategies to Support Infant and Young Child Nutrition." I think the title was carefully and well thought out, but despite that, I hear from people from outside that have not been involved in the planning saying, "Is this just a meeting dealing with communication?" I hear another group of people saying, "Is it just a meeting dealing with breastfeeding?" And I hear another group of people saying, "Is this really a conference to discuss the important new issues in relation to infant and young child nutrition?" I do not think it is any one of those things, but rather all of them.

It would be very valuable if, by the end of our Conference, we have talked about all of those things and related them all together. It would not have been as valuable to have a meeting that was just on communication strategies. In order to have appropriate communication strategies dealing with infant feeding, I think people have to understand where we are with breastfeeding and with infant feeding in 1992. In order to talk about appropriate strategies for child nutrition, I think we have to know what the current thinking and conceptual framework for dealing with young child nutrition is in 1992. So I believe it is appropriate that we have communication people, people involved in breastfeeding and infant feeding, people who are at the forefront of dealing with child nutrition in the developing world. At an international conference for communication for the control of AIDS you would not want to have only communication people. I think you would want to have the experts on AIDS who state where we are with AIDS in 1992. So this is a meeting of communication people and of experts on infant and young child nutrition, and hopefully the dialogue is going to be between people who come from these different disciplines, so we can work together to improve, through communication, infant and child nutrition.

Before calling on three people to make introductory comments, I want to express my sorrow that Dr. Abraham Horwitz is unable to join us due to a recent accident and illness. He was to have done a summary at the end of day one, today, and at the end of day two, tomorrow. Dr. Horwitz is the Director Emeritus of PAHO, and is a very eminent Chilean who, although retired, is in great demand and very busy with work on international health.

I also want to acknowledge the support from a number of organizations which are listed at the back of your program, but I would like to give a very strong word of thanks to the Office of Nutrition of the United States Agency for International Development for their support, to the Institute for Reproductive Health of Georgetown University, to Wellstart International of Washington and San Diego, to UNICEF Headquarters in New York, to the Swedish International Development Authority in Stockholm, and to the American Public Health Association Clearinghouse on Infant Feeding and Maternal Nutrition. All of these organizations have contributed and have allowed this meeting to go forward.

Finally, you will have seen on your seats an indication that this meeting is going to be taped, and very soon after each talk, and certainly at the end of each day, tapes of what has gone on during the day will be available for you to purchase or order.

It is now my pleasure to introduce three individuals because of the role that they themselves or their organizations have played in this meeting, and the first is Jennifer Anderson, who is the President Elect of the Society for Nutrition Education. She takes over this week as President of our 25-year-old society.

Jennifer Anderson: It is a great pleasure to welcome you here today on behalf of the Society for Nutrition Education and the Board of Directors. I have only come yesterday from Colorado, but I do herald from England. I have great interest in international nutrition education, and hope to speak to many of you about these issue. I am also hoping that many of you will be able to stay for the 25th Anniversary meeting that begins tomorrow evening. We need to develop a vision for SNE for our next 25 years, and it is important to me to have an international perspective. We look at those issues pertaining to nutrition education that affect you and affect us in this country. I personally want to give a very big thanks to Peggy Koniz-Booher. She worked on the Program Committee for me for this meeting and took full responsibility for orchestrating and developing this two-day conference. We all appreciate her efforts.

Unfortunately, I am not going to be able to stay with you for the whole two days. Please come and talk to me about the issues you think are important in nutrition education from where you work, from your perspective, and help us to develop some strategy and some vision about where the society needs to go over the next 25 years. I know you will enjoy these next two days. I am sure it will be full of information, and give you some valuable ideas which we hope you can take with you when you return to your place of employment. Welcome on behalf of SNE, and please enjoy your stay here. Thank you.

Michael Latham: I would like now to introduce Margaret, better known as Peggy, Parlato, who directs the Nutrition Communication Project at the Academy for Educational Development. She has had a long association with communication to improve health and nutrition, and the Academy has been at the forefront of work in social marketing and other efforts to improve nutrition and nutrition education around the world.

Margaret Burns Parlato: We were very pleased to be invited by SNE to join them in planning this workshop. I must say it has been a very unique experience for us. We have been involved in a lot of workshops, but this is really the first conference that has had such an incredible participation from SNE members. I can say that there have been at least 30 people who have been involved from the start last January in planning. The list in your folder is impressive list, with people representing a large number of organizations. What this has allowed us to do with this core planning group is to identify innovative projects around the world. We have had a lot of help in trying to decide how to present new technologies, new approaches, and most of all, with this incredible network we have been able to identify people who are out there doing exciting things. I would like to thank all of the people--many of them in this room--and again, to thank Peggy Koniz-Booher for the role that she has played in organizing this meeting.

Also, I would like to join Michael in thanking A.I.D. and the other donors that have made this meeting possible with their very generous support. It is nice to have an international meeting when there can actually be people from around the world, and that was only possible with support from these agencies. And finally, I would like thank Dr. Chung, who is sitting up here, who is the monitor for the Nutrition Communication Project and has really been behind this effort full tilt, encouraging us to put this meeting together.

Michael Latham: The third person who I am going to call on to talk is Dr. Chung. We had hoped that Dr. Richard Seifman, the Director of the Office of Nutrition of the Agency for International Development could have been here to talk to us. He was unable to do this. We are sorry about that, but we are extremely pleased that Dr. Eunyung Chung, who works in the Office of Nutrition in A.I.D., and who has done a great deal of work in this area, has agreed to say a few words on behalf of A.I.D., which has been a major supporter of this conference.

Eunyung Chung: It certainly is my pleasure to add my welcome to all of you at this International Nutrition Education Conference. I apologize to those of you who wanted to meet our new Office Director, Richard Seifman. I can just say that he is twice as tall as I am, and you would not miss him if he were here.

The Office of Nutrition is very pleased to be participating and supporting this International Nutrition Education Conference through its Nutrition Communication Project because we have recognized for a long time the importance of communication in achieving our development goals. I certainly do not need to convince anyone in this room, I am sure, of the importance of communication in eliminating malnutrition around the world. I believe, however, that the challenge before us now is to make the communication programs more effective and efficient. I really look forward to an exciting exchange of ideas and experiences.

INFANT AND YOUNG CHILD NUTRITION: A HISTORIC REVIEW FROM A COMMUNICATION PERSPECTIVE

INTRODUCTORY REMARKS

Ted Greiner

INTRODUCTION

Most of us have been involved in some kind of work related to infant feeding, particularly in a developing country context. You probably share my feeling that this field of endeavor is entering into a new era, or at least a new phase. But to understand what is happening and how we can best guide this new phase, we need first to clarify some conceptual issues and then to review a few key aspects in the history of breastfeeding programs.

In 1982, the idea was launched that breastfeeding program activity should be designed specifically to achieve different goals related to protection, support, and promotion. Although the idea spread rapidly, the paper introducing it did not[1]. Thus some of the concepts involved have been obscured.

Protection of those good breastfeeding practices that do exist deserves priority nearly everywhere. It makes little sense to focus on increasing breastfeeding in one segment of society even as it declines in another. Protection of what is good is much cheaper than trying to get it back once it has been lost. Protection deserves even greater priority in breastfeeding-friendly cultures where nearly all women breastfeed for longer than a year.

Breastfeeding appears to be natural and even instinctive behavior in traditional societies because learning about it and support of it takes place in subtle ways that are integrated into the culture and at early ages. But breastfeeding requires certain types of skills and knowledge as well as a foundation of support within the family and the society, including what is often referred to as "moral support."

For those of us who are not born into such a traditional breastfeeding-friendly culture, appropriate knowledge and skills need to be learned another way. During the past few decades scientific studies and observations have been codified into what is often now referred to as *lactation management*. This term was chosen in order to attract the attention of the largely male body of physicians whose lack of understanding and interest in breastfeeding has in the past half century only been surpassed by their power over it. Unfortunately the term implies that this power is somehow correct and necessary. But I understand the reason it was chosen--and life is full of risks.

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[1] Greiner T. Infant feeding policy options for governments. Report to the USAID-funded Infant Feeding Study Consortium: Population Council, Cornell University and Columbia University. November 1982.

Where traditional supportive systems no longer function, they must be designed and provided by some other institution in society. In some places voluntary breastfeeding mothers groups play this role and specially trained lactation consultants are being used by formal health services elsewhere. Breastfeeding programs are likely to place high priority on supportive interventions in places where many women do breastfeed for fairly long periods of time but where difficulties are increasing due to rapid cultural change and loss of traditional support systems.

Breastfeeding promotion, that is, programs or campaigns designed to motivate women to breastfeed, is the area in which the mass media are generally expected to play an important role. As I will explain later, in most developing countries, far lower priority should be given to breastfeeding promotion than to the other two approaches.

In general, protective programs depend on government and the infant food industry; supportive strategies place increased responsibility on the health care system, on networks of women, and on employers; while promotive strategies tend to put pressure directly on women themselves.

DISCUSSION

The role of communication

To protect breastfeeding effectively, we must understand how communication technology has been and still is being used to undermine it. We must learn the principles of advertising, promotion, and marketing. We must understand how new innovations diffuse throughout society if we want to hinder the uncontrolled spread of bottle feeding.[2]

Breastfeeding support is too complex an area for the mass media to have much of a role to play. Interpersonal communication channels are the only reasonable ones to use. Naturally teaching materials can play a supporting role.

Breastfeeding promotion often depends heavily on the mass media. Because of their power and of how difficult it is to know how certain messages and media influence women and men in different situations in society, we must proceed with great care and caution here.

Protection

Nearly the entire world now agrees that the capitalist system is the only efficient way to generate wealth. But it is not a perfect system, and already in the 1960s great scientists like

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[2] Greiner T. Regulation and education: strategies for solving the bottle feeding problem. Cornell International Nutrition Monograph Series, No. 4, 1977.

Derrick and Pat Jelliffe and Michael Latham warned about the one sided-effect of capitalism, the spread of bottle feeding into inappropriate settings. Public attention was gained with British War on Want's "The Baby Killer" by Mike Muller and boosted by a libel suit filed by Nestlé against Arbeitsgruppe Dritte Welt for titling its German translation, "Nestlé Kills Babies." In 1978, Senator Edward Kennedy held hearings on the promotion of commercial baby foods in the developing world and put pressure on WHO to do something about it. The process set in motion resulted in the passage of the International Code of Marketing of Breastmilk Substitutes by the World Health Assembly in 1981. Thanks to IBFAN (the International Baby Food Action Network)--its Nestlé boycott and many other activities by its member groups--baby food industry and the Reagan Administration's attempts to kill the Code have failed.

In celebration of the tenth anniversary of the passing of the Code, WHO, with funding from the Netherlands, and some technical support from Sweden, assisted 14 developing and industrialized countries in reviewing their efforts so far to implement the International Code at the national level. A meeting was held in the Hague last October to discuss the findings and make recommendations which were included in Dr. Nakajima's report two months ago to the World Health Assembly.

It is difficult to evaluate the impact of all this effort. But there is no doubt that this very day airwaves around the world are silently reverberating with thousands of advertisements for commercial baby foods that are not taking place. Health center and hospital walls are lacking millions of posters for these products. This is certainly a unique success story in the field of international public health. It is a rare example of the application of ethical standards in the regulation of transnational corporation practices, and of the involvement of "the man on the street" in a global health issue.

Support

Once traditional support systems begin to erode, we know very little about how to repair or strengthen them and tend rather to attempt to replace them. In a few cultures, voluntary breastfeeding women's groups appear to be effective in doing so. The WHO/UNICEF Ten Steps to Successful Breastfeeding suggests that these groups receive formal recognition and cooperation from the health sector.

An approach which may prove promising in other cultures is to provide to local women who have themselves successfully breastfed their children basic training in so-called lactation management. These breastfeeding counselors can then be linked to MCH services and women requiring time-consuming assistance and support for such problems as perceived breastmilk insufficiency can be referred to them.

Lactation management is a new science. It has been developed from a solid but still small base of research, complemented by wisdom gained from observing carefully how successful breastfeeding takes place, often in developing countries, and from learning gradually

over several decades what has worked well in assisting women in industrialized countries to learn to breastfeed. I know of no long-term follow-up studies of the impact and possible side effects of applying lactation management principles in rural settings in developing countries.

Also under the "support" category come the many possible strategies that can be applied in different settings to assist formally and informally employed women to breastfeed optimally. There is still a great deal of need for research and pilot testing. I am convinced that working women themselves are the only source of possible successful strategies tailored to their needs in each national setting. Short-term strategies such as efforts to create breastfeeding-friendly work places must be combined with long-term strategies to create family-friendly cultures. In the mid-1970s, we dreamed of the day when the distribution of free samples of infant formula in hospitals would be considered morally despicable by hospital personnel. It has taken only twenty years to arrive at the threshold of achieving that dream. Perhaps in another two decades long paid parental leaves will be considered a human right and countries not having them will be penalized in international trade agreements for keeping the cost of labor artificially and inhumanely low.

Promotion

There are very few places where the protective and supportive infrastructure is strong enough to justify using scarce resources on promotion of breastfeeding. What is the point of convincing large numbers of women to try breastfeeding when no one they have access to can assist them to do it properly or to solve any problems which arise?

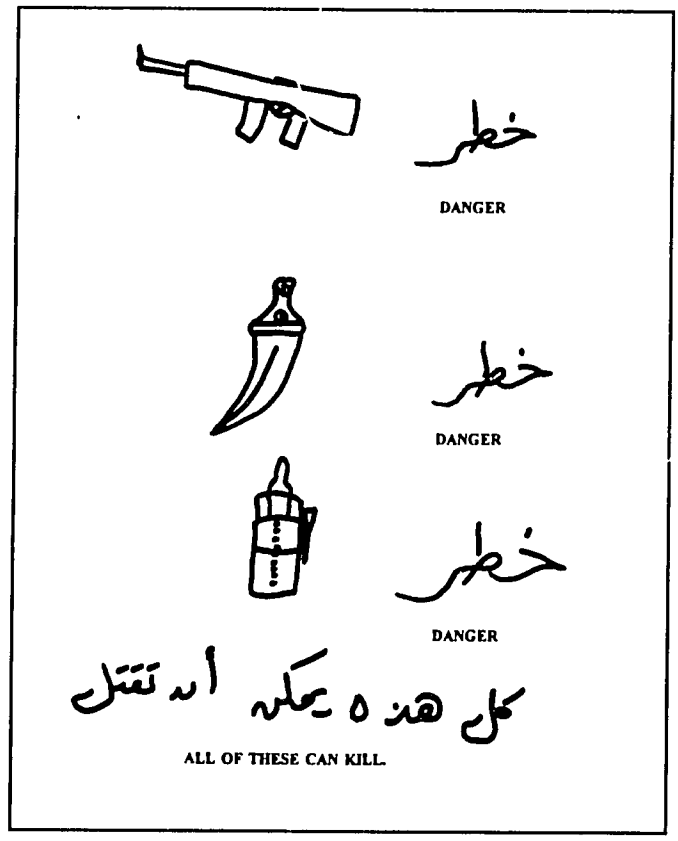
Health officials and professionals who have neglected breastfeeding may experience an almost religious fervor for it once they realize its importance. This may lead to a reflexive emphasis on promotional aspects, which in turn can lead to a backlash among elite women and others in society. Demands are then made that breast and bottle feeding be presented "objectively" or "fairly" as simply two different options. The main objective of infant nutrition communication messages then becomes to "avoid creating guilt" among women who choose to bottle feed.

The only large national breastfeeding program to date started over a decade ago in Brazil by communicating messages designed to convince women of how good it would be to breastfeed. Fortunately, the program included a formative evaluation component adequately strong to reveal that this was a harmful approach. Women already thought breastfeeding was idyllic but did not know how to do it. The thrust of the program then shifted to helping women learn how to realize their dream of breastfeeding.

A breastfeeding program in Yemen found that health workers' first priority was posters promoting breastfeeding which they felt would strengthen them in promoting it among their clients. However, unlike flipcharts, posters convey messages independently of health workers and must be tested more carefully to avoid unexpected side effects. Five posters with varying pictures and written messages were tested and found defective or inadequate in various ways.

Finally the one shown in Figure 1 was developed and appeared promising. It had the desired effect of piquing the curiosity of fathers. "Why does this say bottles are dangerous like weapons?" they would ask. However, even this poster had to be abandoned when it was realized that nonliterate fathers thought the poster was illustrating three items associated with strength and power.

Figure 1



The Yemen program provided another example of the importance of testing and evaluating every component of a breastfeeding program. For many reasons, the Yemeni men designing the program felt it was important to focus messages about breastfeeding on men. In time they were forced to abandon this approach, however. It was simply too difficult to avoid two types of side effects. In one, men who learned how important breastfeeding was for the health of their infants (which in effect belong to the father in traditional Yemeni culture), they threatened to divorce their wives if they did not immediately return to breastfeeding. In another, men attempted to introduce bottles to their wives when they found out about the birth spacing effect of exclusive breastfeeding (husbands even brought bottles home to the wives who didn't already have them).

A better promotional strategy was developed by a Swedish journalist. She managed to place a large photograph of a mother breastfeeding an 18-month-old child in the central Stockholm train station on the front page of the largest newspaper along with the headlines: "Swedish mothers too often being forced to breastfeed in secret." In a country where health workers are worried that breastfeeding fanatics want to force everyone to do it for long periods of time, she emphasized the right of women to breastfeed as long as they want, and where they want, and the duty of society to accept and even support them in doing so.

Health worker training can include all three of these aspects--protection, support and promotion--and can be weighted in one direction or the other depending on the populations to be served. Curricula designed for international or widespread application must place emphasis on protection and suggest that health professionals avoid promoting breastfeeding or at least putting pressure on women to breastfeed. Enabling and empowering strategies should receive priority.

Recent progress

In December 1985 I recall a USAID-financed meeting here in Washington characterized by complaining that there still was no money for breastfeeding and that UNICEF's GOBI (growth monitoring, oral rehydration, breastfeeding, and immunization) strategy should be written with a small "b." Over the next couple of years an informal International Group for Action on Breastfeeding (IGAB) was spearheaded by UNICEF and WHO with substantial support from USAID, mainly via the predecessor of the Georgetown University Institute for Reproductive Health, and with additional support from the Swedish International Development Authority (SIDA). These efforts led to some important technical progress, such as the development of breastfeeding definitions and indicators, and to an increased political commitment embodied in the 1990 Innocenti Declaration.

Now there are millions of dollars available for breastfeeding programs among these and other agencies. While more may be needed, we have turned a corner and must pause to consider this: in the advocacy stage it was okay to "lie" just a bit and say we knew why breastfeeding rates were declining and what to do about it. But now that we have the attention and the money we must take a step back, apply the brakes just a bit, and be sure we do not make large-scale mistakes.

Where to go from here?

Look for example at what has happened with childbirth. For many decades trends in obstetrics were toward increasing levels of intervention, as childbirth was viewed as a virtually pathological process. All women and newborns were subjected to invasive or high-technology procedures assumed to be capable of preventing or protecting against rare problems. Now the trend is toward recognizing that child birth is a natural process which works better when intervention is kept to the minimum required for each individual case. Prevention is not better than cure at any cost!

Now that breastfeeding is receiving increasing attention in the health sector, the danger is that disempowerment of women will take precedence for a generation or two before we learn the similar message that a health worker's role is best confined to passivity except in cultures where maternal breastfeeding incompetence is a proven and common reality (or in individual cases where pathology or serious problems are evident).

No doubt many health workers display great care and gentleness and can assist wonderfully women who need it. But even they should not be asked to show things to women that the women already know. Not every health worker is endowed with kindness and gentleness and I doubt we know how to ensure that all practice it. If lactation management is rapidly integrated into primary health care, what makes us think it will be done with any greater finesse than growth monitoring for example, where we know that after decades of use its potential is rarely being realized?

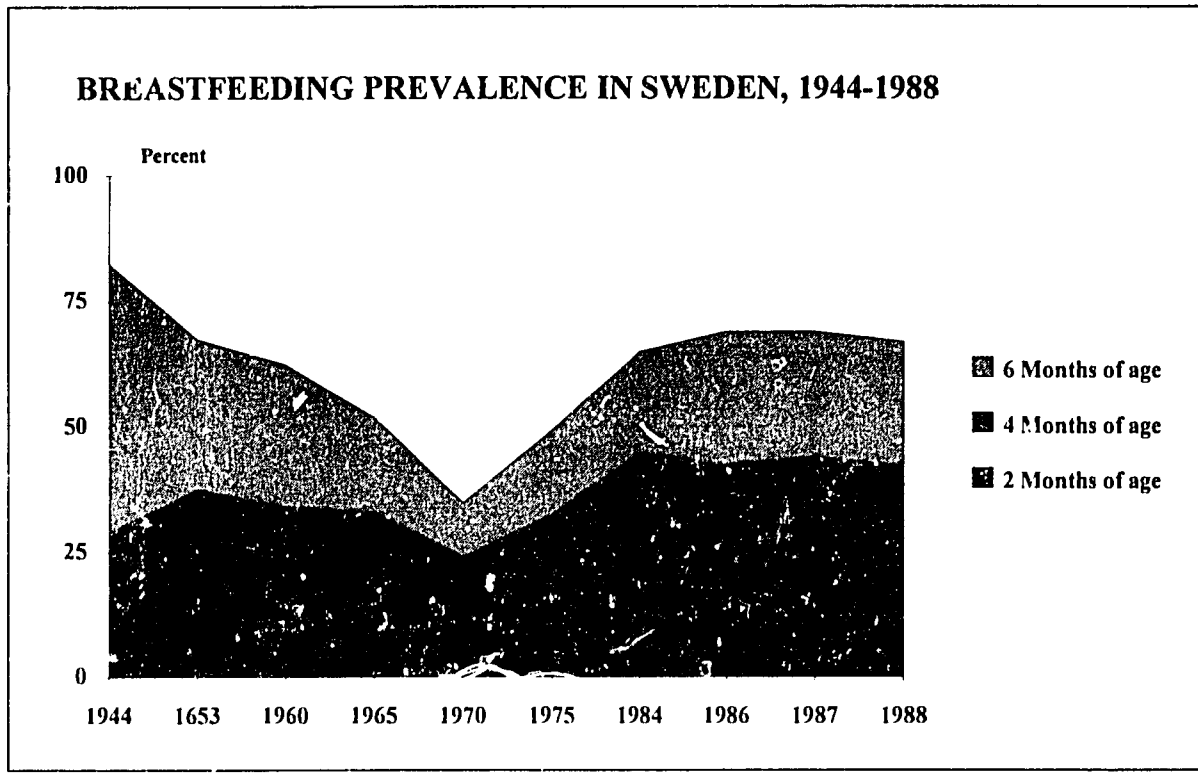
The risk of doing harm is not so great in industrialized areas of the world where little breastfeeding is going on. Even if mistakes are made in the early stages of a breastfeeding program, not much serious disruption is likely to occur. But in poor rural areas the mothers tend to be better at breastfeeding than the better educated, more urbanized health workers with whom they come into contact. Do we really think these health workers can empower and enable their patients to breastfeed even better than they already do? Only when a new generation of health workers (and/or their wives) has itself been enabled and empowered to exclusively breastfeed its babies for six months and to continue for two years and beyond can we be confident that they will be able and motivated to help others do the same.

For example, if rural health workers are asked to demonstrate positioning and latching on to every mother, in return for avoiding problems in a few cases, we may introduce a more Western or linear, logical way of thinking about breastfeeding that robs women of the natural carefree attitude that now ensures that breastfeeding works well in most cases.

Breastfeeding trends from 1944-88 for Sweden (Figure 2) are roughly similar to those that have occurred in the United States and the United Kingdom. Note first the revolutionary change that took place in about 1970. Rarely do national-level curves for any statistic show 90° angles like this. Then look at the other dramatic change that occurred in 1984. It is a change of half the magnitude as that which occurred in 1970, but still unusually large and in the opposite direction.

What was the role of the health professions in the industrialized countries where these trends occurred Did an era of great enlightenment among health professionals occur during the 1960s, leading to dramatically improved promotion and support of breastfeeding? If we interview women who had babies at that time we will find to the contrary, that the change occurred *in spite of* misinformed and discouraging messages about breastfeeding given by health professionals to mothers. We could speculate forever on what might have caused this revolution in infant feeding, but my guess is that the late 1960s was a time of cultural change that empowered many women. Many decided that they would take back control over their

Figure 2



sexual and reproductive functions, among which was breastfeeding. They probably got more useful help from lay women who had successfully breastfed their own children than from health professionals.

More intriguing and germane to my argument is what negative forces could have caused this upward trend to reverse so abruptly in 1984. Did some kind of further deterioration in health worker knowledge and attitudes toward breastfeeding take place from 1970-1984? Here again, we all know that the opposite was the case. A virtual renaissance in interest, knowledge, and positive attitudes toward breastfeeding occurred among health professionals--not to deny that there is plenty of room for improvement, even today.

SUMMARY

Allow me to entertain the admittedly speculative and horrifying thought that maybe the increased involvement of health professionals in breastfeeding is exactly what disempowered women and put an end to the woman-led cultural trend back to breastfeeding that had started 15 years earlier. By the mid-1980s health workers had learned that most women wanted to breastfeed and had received at least some increased knowledge about breastfeeding. They no

longer greeted women's announcements of their intention to breastfeed with doubt or concern (which in the past may have forced a mother to think, "I'm on my own, but I know I can make it anyway"). The response was more likely to be, "Of course you're going to breastfeed for awhile, and I'm going to show you how." Is the health worker's unconscious goal to empower the patient or to increase his or her own power over the patient? When is the last time you, as an educated person, returned from a visit to your doctor feeling empowered?

What I have presented is something of a simplification, a caricature. No doubt I am not quite right. Let us start doing the research to find out what really has and is going on. Let us develop new ways to protect, support, and promote breastfeeding and test these new methods before spreading them.

We know now that most rural women in developing countries do not breastfeed exclusively for very long. We know it is very important that not even water be given to exclusively breastfed infants. Let us have the honesty and humility to admit that we do not know in most settings of how to achieve that kind of ideal breastfeeding pattern. Let us go to the villages and find women who are already closer to the ideal than their sisters, find out why, and see if they can help us learn how to teach the others better practices.

At least let us do no harm.

KEYNOTE ADDRESS

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COMMUNICATION: UNTAPPED OPPORTUNITIES FOR IMPROVING INFANT AND YOUNG CHILD NUTRITION

KEYNOTE ADDRESS

William D. Novelli

INTRODUCTION

Good morning. I am very pleased to have been asked to come here and to share my ideas with you. I see many friends here today, which reminds me that I promised myself when I joined CARE a year and a half ago that I would spend more time among my public health colleagues. I have not exactly lived up to that promise, but today is a good step in that direction.

The focus of this conference is strategic planning for the promotion of optimal infant and young child nutrition. This subject is very important to CARE, not just because of our many programs in this area, but also because we have recently embarked on a thorough review of our entire range of food use strategies. The proceedings of this conference will be useful to us in our analysis and strategic thinking.

I was pleased to see how your planning committee has organized this conference. You have an intriguing mix of presentations and skill-building sessions, with ample time for discussion and debate. My own role is to help set the stage for the conference discussions that will follow. You have an agenda designed to challenge, to teach, to share information, and to broaden your horizons. In thinking about what I might do to help start things off, and in talking to some of you about the state-of-the-art, I developed ***seven observations*** that I would like you to keep in mind and to think about as you work through the stimulating program of the next two days.

These are very difficult times in many parts of the world. As we meet here today, the worst drought imaginable is gripping the countries of southern Africa. The peoples in the Horn of Africa continue to suffer from malnutrition and food shortages. Parts of Eastern Europe, especially fragments of what was once Yugoslavia, are subsisting on relief supplies. Russia and other former Soviet republics are preparing for a winter that will almost surely be worse than the last. And the recent unrest in Los Angeles reminds us that the United States and other western nations have their share of social and health problems.

Yet these are promising times as well. Many of the strategies and programs that will be described at this conference demonstrate that progress is being made in improving health and nutrition. As Dr. Ted Greiner noted earlier this morning, we have come a long way. In my travels to CARE programs, I have visited food-for-work and agricultural projects in

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Honduras, school feeding programs in the Philippines, women's health and income groups in Kenya, and village education programs in Niger, as well as others. I hope soon to visit Elonore Seumo Fosso's CARE program in Cameroon.

You and I know that progress is slow in working with the world's poor, in furthering their efforts to achieve health and social well being. But we also know that there is progress, and that the work you are doing is exciting and meaningful.

DISCUSSION

Let us begin to build on our progress today and tomorrow. I have seven areas of consideration which I call my ***Seven Observations,*** for you, as participants in this conference, to consider when you are planning nutrition communication programming:

1. Targeting
2. Segmentation
3. Strategies for Reaching Policy Makers
4. Supporting Health Care Workers
5. Integration
6. Dare to be Unconventional
7. Simplify

1. Targeting: First, let us rethink the concept of targeting an audience. Targeting is an important, proven communication principle, but one that can be overdone and become ineffective if we accept the idea that only one target is necessary and appropriate. In many cases, nutrition education programs seem to focus almost exclusively on the mother. Instead, our programs need to attempt to understand the influences on this woman and her circumstances, and communicate with other audiences as well, in order to be successful and change behavior.

A mother's information processing and decision making is almost always influenced by others: she does not evaluate alternatives and take action in isolation. Who are the other target audiences of potential? It depends on culture and circumstances, of course, but convincing a pregnant woman to eat more and better may require intervening with her husband, her mother-in-law, her peers, and possibly her children as well.

Midwives and, as appropriate, hospital workers, can encourage mothers to begin breastfeeding during the crucial first few days after birth. Fathers have control over how their children are raised: men often make crucial decisions about food, such as who eats first, what kinds of food to buy, and how much each family member is allowed. Men may actually buy the food themselves or give their wives the money for it, and they often approve the purchase of expensive food like liver, an effective food for night blindness.

I realize that you know about these influences, but my point is that they may not be adequately reflected in our communication plans. Planning around a single audience--mothers--is probably not going to get the job done, because that is simply not the way decision making works.

2. Segmentation: My second observation also has to do with targeting, but this time I would like you to think about target audience segmentation. For whatever reasons--including the difficulty of collecting good data and the cost of tailoring media and interpersonal messages--target audiences in many programs tend to be too broad. "Women of procreational age" is more a universe than a segment. It is not specific enough. People are different. Two women of the same age, same clan, same family size, and living in the same region may have different knowledge levels and different views about weaning, for example.

Later today, you will hear from Claudia Fishman about specific nutrition communication programs in West Africa. Research in that area revealed significant variations in attitudes among villagers within a 100-mile radius. In fact, people in the very same families responded differently to test messages. Audience segmentation requires skillful research, tailored messages, and extra effort. Treating audiences as homogeneous when they are not almost surely will limit program effectiveness. I hope you will be able to give this important segmentation issue some thought as you work through your strategic planning sessions.

3. Strategies for Reaching Policy Makers: Next, I would like to complement you for having a plenary session tomorrow on strategies for reaching policy makers. At CARE, we have come to believe that advocating for policy change is as important as any direct program we can implement among disadvantaged populations. In fact, we have come to refer to policy advocacy as an intervention strategy, since it can clearly affect the health, social, and economic status of the poor. We have identified policy advocacy as one of CARE's six strategies for the 1990s, and have stated this priority as follows: "To have a substantial, measurable impact on policies which empower and improve the living conditions of the world's poor."

I will be interested in the outcome of your deliberations on public policy advocacy. CARE sees advocacy necessary at three levels: first, internationally, on a world stage among multilateral donors and multinational organizations; second, among governments of industrialized nations; and finally, among policy makers in the developing world.

I do not exaggerate when I say that public policy influence and change is a challenge that you, as nutrition educators, must address and must contribute to, if we ever are to have the resources and power to make a meaningful difference in infant and child nutrition.

4. Supporting Health Care Workers: My fourth observation involves your interest in supporting health care workers--call them change agents, distributors, a sales force, intermediaries, or by some other name--these are the people who are essential to our efforts to leverage and extend our work. To take a fairly typical example, CARE has a project in 40

villages of northern Belize where community health workers train young mothers through group discussions, games, videos, and slide shows. These health workers make home visits to help women who are having problems with nursing. The health promoters stress the benefits of breastfeeding, including nutrition and immunity from disease for the baby and delay of pregnancy for the mother. This intervention has resulted in marked increases in breastfeeding in the measured villages.

If we are going to create programs that can be adopted and sustained without our continued, direct presence, we must succeed with motivations, tools, and communication support strategies that keep health workers effective and on the job. Our challenge is, what new ideas can we formulate to make this happen?

5. Integration: Next, I would like to mention a concept that you will find in virtually every communication textbook and every development communication guidebook, but which is exceedingly difficult to apply: the principle of integration. To be most effective, communication tactics, including media, face-to-face interventions, and health professional and health worker channels, must all work together. Each is necessary--perhaps indispensable--to the others. For these tactics to merge, however, it is first necessary to integrate on the basis of common objectives and related strategies. This integration leads to better program quality control, increased message uniformity, and greater synergy for the entire effort.

We all understand the importance of program integration, but often there are circumstances--such as government agencies with responsibilities over different aspects of a program--that impede our progress in this area. How many programs have you seen in which, despite everyone's good intentions and clear understanding, different parts of a public health program did not fit together? I personally have seen it many times. I was once involved in a very large program that had a difficult time integrating the professional, patient, and public education components. This internal integration was as difficult as any external barrier or problem that we faced. We must work hard to overcome fragmentation that causes our programs to end up being less than the sum of their parts.

6. Dare to be Unconventional: Number six on my list for your consideration is to dare to be unconventional. I do not mean to be wild or non-strategic, and I do not mean to be outrageous just for the sake of making some noise and being noticed. What I do mean is to look at research, program plans, reports, and government data with a healthy degree of skepticism. Look for the hidden opportunities that are not obvious at first or even second glance. We all know that statistics and research findings can be interpreted in more ways than one.

Some marketing companies and financial institutions have been very successful by going counter to prevailing trends, by cutting against the grain. In the same way, we as nutrition communicators must learn to look beyond the obvious answers so that we can find new ideas, new concepts, and new strategies.

Perhaps we should add a step in our communication planning process that forces us to stop periodically to look for the unlikely, less conventional way. To borrow from Thoreau, let us "listen closely for a different drummer, and then step to the different music which we hear, however measured or far away." A number of exciting ideas will be presented here today and tomorrow. Look for the unconventional in these presentations, whether in research, strategic thinking, creative message development, or in community outreach.

7. **Simplify:** My seventh and last suggestion is the hardest and perhaps the most important: it is to simplify. The art of simplicity is very difficult to learn and apply, but it is the only way to face the enormous complexities of poverty, malnutrition, and disease. It is estimated that more than a million children die each year because their mothers started breastfeeding too late, stopped too soon, or added unnecessary, unhealthful supplements to their babies' diets. To face complex problems of this magnitude requires programs that are brilliant in their simplicity.

We do not have the resources, the time, or the genius to truly change people's lifestyles and values. Instead, we need elegantly simple means to show how healthful new behaviors fit into and are harmonious with existing, traditional lifestyles. Since budgets are limited, we must focus on answers to a limited number of important questions. Then, step by step, we can complete the picture.

We usually cannot tackle all the barriers to behavior change at one time, so we need to simplify and overcome the barriers one at a time. And, of course, we need to simplify the amount of data we feel obliged to collect. Some years ago I served on an A.I.D. review committee for a major, five-country study on the determinants of infant feeding that was overseen by the Population Council. Much has changed in the ensuing years, but much in the developing world has remained the same. I suspect that portions of that study are relevant today, and would help to simplify current research designs.

SUMMARY

These are my seven observations which I hope you will find useful here at this exciting conference and in your work. To summarize, I discussed the following points:

- the importance of targeting multiple audiences;
- the need for sharper audience segmentation;
- the idea of advocating for public policy change as an intervention strategy;
- the critical nature of the health worker for outreach and sustainable change;
- the principle of integration and its importance to success;
- the dare to be unconventional;
- and finally, the art of simplicity in order to conquer complexity.

I hope these will be a lucky seven for you and I hope that they will be of use in provoking debate and creative thinking as you work through the exciting agenda before you.

It has been ten years now since John Naisbitt wrote and published his book, Megatrends, which boldly claimed that it contained "new directions for transforming our lives." The book became immensely popular in North America, and was also well read and well discussed in Europe. You may recall that this was the book that brought us the very catchy phrase "High Tech/High Touch." This was Naisbitt's clever way of pointing out that when new technology is introduced into a society, there must be a counterbalancing human response, a kind of spiritual or human nature way of dealing with the technology. If this response does not occur, Naisbitt claimed, then the technology is rejected. "High Tech/High Touch" became a very popular phrase among writers, corporate planners, and social change advocates of the day.

It is still a useful idea, and still applies to social and health communication. New ideas and new ways, new foods and clinical procedures, even if relatively low tech, must be connected with a human response--a high touch--if people are going to accept the innovation. Many a technological innovation, from water pumps to windmills, has fallen into disuse, and just plain fallen apart, because it somehow did not connect with the social system, the human ownership that was necessary for its acceptance. This once trendy phrase--"High tech/High touch"--is a useful concept for us to remember today.

What has been forgotten about the Megatrends book is that Naisbitt proclaimed 1982 as a time between eras, a time of parenthesis between past and future. He made predictions, to be sure: for example, that Third World countries would be taking over many industrial tasks--which shows how hazardous it is to forecast the future.

But he turned out to be right in saying that the future would be filled with opportunity. Consider what we have experienced: the end of the Cold War and the destruction of the Berlin Wall; the emergence of new or rather old nations; and the flowering of democracy in many parts of the east and the southern world, including, hopefully, change in South Africa.

Of course, I spoke earlier of drought and war, and it would be inaccurate to paint too optimistic a picture. The dream is still just that--a dream--that everyone have opportunity and access to food, water, shelter, employment, a secure natural environment, basic health care, and education.

But dreams do come true. Many have already come true since Megatrends was written a decade ago. Let us stay with the job. Healthy, well-nourished infants and children can be the key to making it happen. Project by project, conference by conference, child by child, family by family. Please keep up the good work, and have a fruitful two days. Thank you very much.

PLENARY SESSION I: STRATEGIC PLANNING FOR NUTRITION COMMUNICATION

PART 1 - FROM RESEARCH TO CREATIVE CONCEPTS

SNAPSHOTS OF THE PLANNING AND EXECUTION OF A MEDIA CAMPAIGN

Mary Debus and Rob Gould

INTRODUCTION

Of the many health issues communicators are working on today, nutrition is perhaps the most challenging in its complexity. This is true in the United States as well as in developing nations worldwide.

Earlier this morning, listening to Bill Novelli's presentation, we were struck by how many of his **Seven Observations** touch on the most basic and fundamental aspects of program design that we wish to address. We present here the program development process itself as well as the kind of thinking and the challenges and creativity that have to go into that process, in a light that hopefully will clarify further and focus on those worthwhile observations. This paper provides "snapshots" of two Porter/Novelli projects that highlight the enduring nature of those observations as fundamental principles of program design and development.

From these snapshots, we will present several key "lessons learned" for success:

- If possible, start with a national "norm"
- Work as an integrated, cross-agency/client team
- Simplify, simplify, simplify the message
- Operate as publicists, not publishers
- Establish partners to carry the message during and after the life of the project
- Segment the target audience in meaningful ways
- Focus on motivation, not just information
- Harness controversy in a productive manner

DISCUSSION

Snapshot 1: The Food Guide Pyramid

The Food Guide Pyramid has become a common presence throughout the United States, both from a public and a commercial perspective.

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In 1989, Porter/Novelli, under a contract with USDA, began work on an updated nutritional guidelines brochure. One illustration in that brochure--the pyramid depicted above--was to become eventually both a breakthrough in nutrition communication and a major controversy within the nation. This pyramid will be our symbol for the future. It will help to set a new standard for eating habits in America. But its birth as a stand-alone kind of design was largely unintentional. This is how the process began.

In 1980, a small but important document was published: ***The Dietary Guidelines for Americans***. This slim booklet was a landmark precisely because it represented a national consensus on nutrition guidelines, and consensus is often a catalyst for action. In the few years that followed the publication of the ***Dietary Guidelines***, U.S. consumers were targeted with more nutritional messages from more sources than ever before: they saw advertising stressing the importance of fiber, magazine articles and talk shows advocating healthy diets, and new low fat, high fiber products lining supermarket shelves.

The result was the American public became aware of many isolated nutritional message points. For example, the Cholesterol Awareness Surveys conducted by the Food and Drug Administration and the National Heart, Lung and Blood Institute showed that American's concerns about fat in their diets increased significantly during the 1980s. For a public once largely aware of mostly calories and vitamins as nutritional concerns, this trend alone

represents a major increase in consumer awareness of an important nutritional issue. But a problem continued to exist: many of the nutritional messages conveyed since 1980 were fragmented, incomplete, or even contradictory. Consumers were left somewhat confused. For example, the same surveys also showed that consumers were confused about what fat was, where it was found, and what the difference was between fat and cholesterol. Consumers still needed a single, uniform context regarding nutrition and food guidelines for consumers. Therefore Porter/Novelli, under contract with USDA, began work on the updated nutritional guidelines brochure.

When addressing any kind of creative approach or format, Porter/Novelli attempts to rely on lessons learned from the past--as hopefully all social marketers and communicators do. Previous research has shown that consumers respond favorably to information presented in a magazine format--short segments, multiple inserts, visuals, and graphic illustrations. As an operating philosophy, Porter/Novelli generally organizes a communication task like that of a magazine, forming a team which works together as a single, integrated unit throughout the life of the project.

Such a team was formed for the USDA project: from USDA came the nutritionists, or the policy makers, the content specialists, and the writers. From Porter/Novelli the team members were the research people and the designers, or the "creatives." This team was established to work together, side by side in the same room, through the various stages and tasks to develop the materials.

It is important to note that such teamwork represents a departure from the typical "hand-off" approach used in many government programs. In the typical approach, the policy maker might synthesize important new, scientific research and establish the findings as guidelines or policies to be followed. The policy maker then might hand off these policy dictates to a content specialist who would decide which information needed to be included in the messages intended for the public.

At this point, the content specialist would prepare a precise, accurate, and complete content statement which would be given to a writer to transform into some smooth, attractive, and perhaps consumer-oriented language. Once the writer had accomplished that task and reduced a long document to a more concise form, the writer would turn the work over to a designer in order to make it visually attractive, who then in turn--after extensive review--may give the work to production.

The difficulty inherent in this process is that every person has only one job, and it is not the same job. Each person has a different goal, a different agenda, and a different viewpoint. The policy maker is committed to sound policy, the content specialist to accurate content, the writer to good writing, the designer to good design; but no one in the process has the ultimate job of communicating.

Therefore, teamwork, as the first of the key principles, results in a very special kind of side-by-side interaction that we feel is an essential ingredient for success. Some of the keys that we have found important to forming successful teams include the following: (1) keep the team small and manageable--it is not a committee; (2) have clearly defined roles that are respected by other members of the team; (3) have a policy decision maker on the team to advocate for the product at the appropriate level and through the appropriate channels; and (4) depending on the task involved, the team also may include content specialists, writers, designers, and a research person who would represent the consumer.

A key challenge to the Porter/Novelli team was the development of one particular **infograph** for the brochure. The message to be conveyed by this graphic device was complex: it was to include guidance about moderation and serving size, balance and variety among food groups, and even the presence of sugar and fat naturally occurring and added in foods. It was essential to simplify the message.

Simplification is the second of the key principles and is a necessary task at the heart of every communication effort. Experience has shown that it is not only the lower socioeconomic consumer that requires simplified messages, or minority groups, or the less educated. Simple messages work best for all ages, all ethnic and income groups--even for the better educated.

Working side by side, the team began testing concepts in focus groups. Old symbols, such as the food wheel, were explored, as well as multiple geometric shapes, such as circles and steps. As the team observed focus groups and listened directly to consumers discussing the proposed symbol, the **Food Guide Pyramid** literally "drew itself" in the minds of the team members. The result was one symbol which clearly depicted the multiple messages and which had tremendous flexibility and potential for extended uses.

Then came the controversy. The illustration clearly presented the notion of "proportionality"--how much of each food group should be eaten each day to maintain a healthy diet--but some feared that it communicated that some food groups were "better" than others. Considerable additional consumer research was needed to allay those fears. Although the research resulted in only minor changes to the pyramid, it was the subject of a great deal of media attention that actually helped to explain and validate the pyramid itself. And, importantly, it fostered consensus among key influential individuals throughout the nation. Stories such as the following example appeared on virtually every U.S. television network and reached millions of people:

> *"In the beginning, or at least in the late 1940s, there was the food wheel, when the Department of Agriculture thought the American family looked like this and ought to eat food that looked like this. But people look at food differently these days, so the Department reinvented the wheel and turned it into the pyramid--The Food Guide Pyramid--built like the originals from the bottom up. Cereal products at the foundation of the diet, vegetables and fruits next, dairy, meat*

and fish on top of them, and fats, oils and sweets, the smallest piece at the peak. The Department spent $855,000 to improve its pyramid. It tried pie charts, shopping cart charts, triangle charts, bold charts, color bold charts, but it kept coming back to the pyramid, and this time everybody seemed to like it...What this move symbolizes is they're changing and turning the corner to listen to the public health needs of consumers."

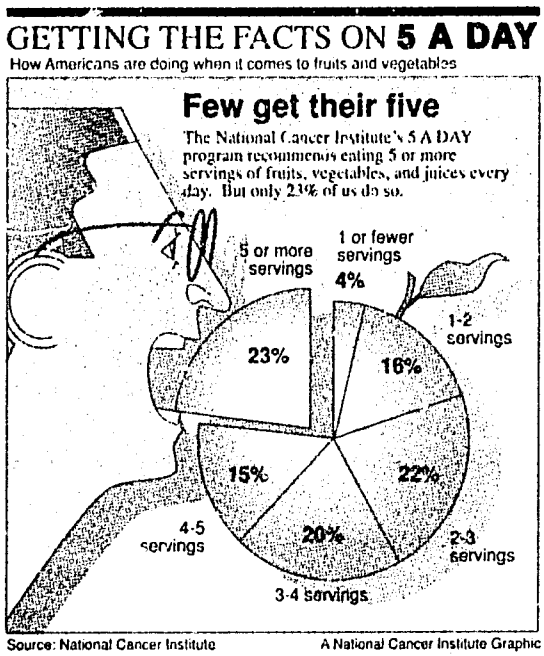
At this point, the Food Guide Pyramid stands as the new norm for American nutritional guidelines. The media attention surrounding the development of this **info-graph** was itself an unplanned asset in the communication process, making the pyramid better known and better understood by millions of Americans.

More importantly, the pyramid does not end here. The appeal of such a symbol is in its extended application. For example, it will be introduced into the school system in 1992 through textbooks and other programs. The food industry is considering its use in new package designs in 1993. It is being considered for use as part of the new U.S. food labeling system, and other government programs--such as the Women, Infants and Children Program (WIC), and the Department of Health and Human Services--will adopt it.

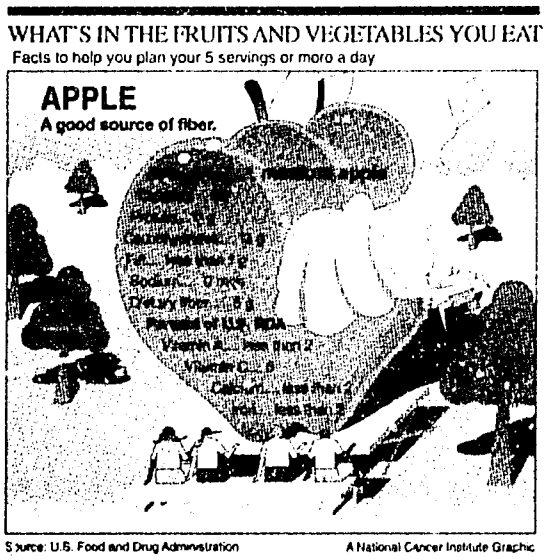
Snapshot 2: The "Five A Day" Project

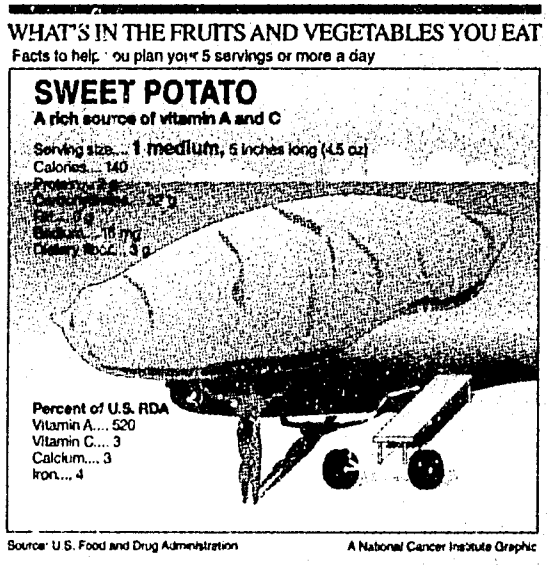
Source: National Cancer Institute A National Cancer Institute Graphic

As successful as the pyramid has been to date, it still provides consumers only with <u>information</u>. We know that our third key principle to success in communication is that motivation--not just information--is needed to effect change. Still in its infancy, the "Five A Day" program can be seen as the door to the pyramid. This is the first project that looks at a single level of the pyramid, simplifying the message even further and specifying an action step: eat at least five servings of fruit and vegetables daily. The focus on this level of the pyramid is twofold: first, it follows the revelation of new scientific data that 35 percent of the nation's cancer death may be related to diet. Secondly, research has shown that from a consumer's point of view, the fruit and vegetable layer of the pyramid may be the most easily accessible. The Five A Day program presents a positive ("do") action rather than a negative ("do not") message. The message has immediacy--the consumer can do it today--and it is an action to which consumers are predisposed: they like to eat fruits and vegetables and, more importantly, they feel more confident that they can accomplish this action.



Presently few Americans are getting their five a day. The baseline research findings indicate that only 23 percent of Americans are eating the recommended five servings of fruits and vegetables daily. Women are eating more fruits and vegetables than men--a noteworthy finding given that men consume more calories. Ultimately, however, neither group is achieving the recommended minimum. Older Americans consume more fruits and vegetables than any other groups, but even those who are doing their best still fall short of the recommended five. Finally, only eight percent of Americans think that they should consume five servings of fruits and vegetables daily for better health. Sixty-six percent believe that less than two servings is sufficient. Perhaps one of the most interesting findings is that those who believe they should eat more fruits and vegetables do so. This is not consistent with the usual knowledge-behavior gap characteristic of so many health communication programs.





The finding that beliefs are indeed correlated with action combined with the low level of existing beliefs argues strongly for an aggressive and widespread awareness campaign. For the Five a Day program, the first phase emphasizes the importance of mass media in repeating the message. What does this emphasis mean in action? It clearly is not possible financially for the National Cancer Institute to produce 240 million information packets, one for every

American. The Five A Day program follows another of the important communication guidelines: operate as publicists, not publishers.

In essence, this principle guides us to work through intermediaries, such as the press, news media, and private industry to carry the message. For example, we launched the Five A Day program with a national press conference featuring important individuals such as Secretary of Health Sullivan to emphasize the importance that government is placing on the program. The press conference included the provision of a Five A Day reference kit, which will also be provided to all major newspapers' food and health writers. This kit contains a variety of information from which writers can prepare articles. In addition, a food newsletter for smaller newspapers has been launched, providing quarterly editions that include stories and story ideas which health and food writers can lift directly. Writers even have access to a diskette containing info-graphs in four colors which can be used by the writers in their own publications.

Finally, Olympic swimming champion Matt Biandi served as the kickoff spokesperson for the program. A video news release was provided to hundreds of television stations and reached millions of Americans with the following message[1]:

> *"At 26, once retired Matt Biandi could be considered over the hill. It does not look like it and he is not. He is the fastest man in the world in the 100 meter freestyle and he hopes to prove it once again in Barcelona this month. Despite his rigorous training schedule, Biandi is also taking time this summer to lend a hand to a National Cancer Institute campaign. It is called Five A Day For Better Health, and it is designed to get us all to eat at least five fruits and vegetables a day.*
>
> *'Something that my mom did for us that was really great is to get us in the habit to eat good food. She was very good about not having sweets around and always a big bowl of fruits by the door...that when we came and went, if we wanted a snack, we would always go to the bowl of fruits. Moms have a way of being right most of the time.'*
>
> *A new national survey for the Five A Day program shows that only 8 percent know that we should eat five servings of fruits and vegetables a day. A whopping 92 percent thinks four servings or less will do. But the National Cancer Institute says five is the minimum and even if you are not an Olympic athlete, you stand to gain a lot if you eat more fruits and vegetables.*
>
> *You can lower your chances of getting cancer by eating five or more fruits and vegetables a day. We have proven that again and again in over 100 studies.*

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[1] Video news release edited slightly for this presentation.

The folks who deliver fruits and vegetables to the consumer, are also doing their part to deliver the five a day message. At any one of 25,000 supermarkets throughout the United States you will be able to find good practical advice on how to increase your consumption of five fruits and vegetables per day.

For Matt Biandi the short-term goal is a seventh gold medal to wear when he returns from Barcelona. For the longer term, he is spreading the word about Five A Day.

'That is something I believe in, that is something I practice personally. I think it is a very good message for people to eat properly and to eat lots of fruits and vegetables in their diet.'"

This videotaped consumer message highlights another important ingredient to communication program success: forge partnerships--like the partnerships with industry that will bring the Five A Day message to consumers in almost 30,000 retail stores. Such partnerships with the commercial sector not only stretch program dollars but often help to sustain the message after the initial program ends. The Produce Foundation for Better Health is the commercial sector group which will handle the cost of production and also the placement of those Five A Day brochures and other messages right in the produce section of local grocery stores. This will provide consumers with consistent information and reminders exactly at a time they are closest to making food purchase decisions. A news clip with Dr. Bernadette Healy, the Director of the National Institutes of Health, helps explain NIH's thoughts about this partnership[2]:

" 'Dr. Healy, you are doing this in partnership with the fruit and produce industries, right? '

'That is correct.'

'Do you get edgy when a very respected health organization like NCI gets involved with private industry?'

'Well, I know this is all about partnerships. I must tell you that this particular program was initially done in partnership with a California public health office. Now we are in partnership with industry because that is the only way to touch every American. After all, we don't make food, we don't sell food, we have to touch the point of purchase, we have to touch the grocery stores, we have to work in partnership in terms of transferring powerful information to people who make the food and sell them to the consumer. Our goal is to use science to decrease the risk of death and disability in this country and we cannot do it by

[2] News clip edited slightly for this presentation.

sitting in an ivory tower making great discoveries and not touching the population at large. In partnership with the food industry we are able to influence what they do, influence what they say. So we think it is the best of all kinds of partnerships.'

'Alright, Dr. Bernadette Healy, I appreciate your being here. The program starts today: The National Cancer Institute Program Five A Day to get people to eat more fruits and vegetables. I should mention, you held up those pamphlets, the next time people visit their grocery store, they should keep their eyes open for those pamphlets because they are going to be distributed widely--the Five A Day pamphlets on how to eat more fruits and vegetables...' "

In undertaking this program, it was important to understand that changing dietary habits that are deeply ingrained in culture is a great challenge. In order to bring about changes in behavior, we need to provide consumers with not only needed knowledge about what to do and motivation for why to do it, but also with the skills necessary to make the change. To craft impactful approaches to the Five A Day message, both the motivation for the consumption of fruit and vegetables as well as barriers are being carefully researched. Many practical barriers have been identified: (1) consumers think that fruits and vegetables leave too many pits and peels everywhere and are just too messy to eat; (2) consumers feel that preparing fruits and vegetables means a lot of peeling and slicing and dicing--just too much work; and (3) a number of consumers feel simply that it is easier to eat a candy bar for a snack then to search for a fruit and vegetable snack as an alternative. Practical skills that help overcome barriers such as these to fruit and vegetable consumption can be developed and presented to consumers in the form of skill sheets or through other media. Stories have appeared in newspapers and on television using this approach. For example, the following is an interview with Sharon Olmy, from the Washington Times, to illustrate the approach[3]:

" 'How are we getting five helpings a day?'

'You are going to get rid of those jelly beans back on the counter back there, and you are going to replace them with some dried fruit. Some raisins, perhaps. For breakfast, it is a glass of orange juice, even a small glass of orange juice counts as a serving here, some strawberries perhaps on your bran cereal. Now this is not going to be fruit with sweet yoghurt already in it. This is going to be yoghurt with fresh fruit on top of it. Then some salad for lunch, something like even half a baked potato and a quarter of cup of peas counts as your five vegetables a day. I think, we just need to be aware that we need to get the junk out of our systems, our bodies need to last a lifetime. We have got to put good fuel into them and when we put inferior fuel in, our bodies start knocking. You know that.'

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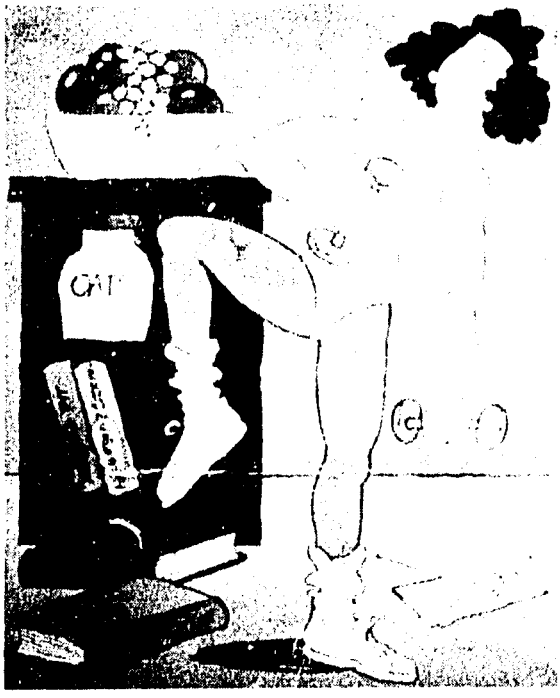
[3] Interview edited slightly for this presentation.

'What about kids? Every mother, every parent complains about the stuff that kids are eating. How are we going to get them to get five servings a day?'

'We are going to have to help them on that. You can put raisins in the freezer, you can keep green grapes in the freezer, kids love them as a sort of sweet snack. Dried fruits in their lunch box, sometimes fill a thermos with a ice cubes and carrot sticks and some celery sticks, cucumbers or whatever. Things cut with crinkled edges. Eat peas raw, kids like them better than cooked. They have usually some vegetables that they are into at any time that they are happy to eat. And I think in time you can do that, smaller portions but five a day for kids too. You have to be the watch dog.' "

As Bill Novelli presented, all of us are not alike--and certainly all Americans are not alike. A critical mandate for any social marketing effort is meaningful audience segmentation and targeting. Clearly the behavior, attitudes, relevant barriers and skills will be different among different groups of Americans. As the Five A Day program moves away from this first general awareness phase, we will be faced with tough choices regarding segmentation and targeting. Targeted media and tailored messages will be used in the second phase of the project.

Although the segmentation research is still underway, some exploratory ideas can be presented. As with most programs, ideas for audience segmentation vary considerably according to age, race, sex, education, and the psychological outlook of the consumer. The following descriptions discuss the potential targets of the second phase of the program.



1. Health Achievers: This group represents 30 percent of the American population and they are the largest cluster. They are young-more than half are 25 to 44--and compared to all groups they are the most educated. They are open to learning about diet and cancer and report that they are knowledgeable and confident in that knowledge. They lead very healthy lifestyles and tend to eat better than any other groups and to exercise. Surprisingly, however, health achievers are almost overachievers. They cannot seem to convince themselves that their bodies are really in great shape and they tend to see themselves as somewhat more vulnerable to getting cancer than their counterparts.

2. Naive Optimists: This segment represents 21 percent of the population and is demographically quite similar to the health achievers: in the higher income bracket, they have more kids under 13, more are married, and so forth. Their cancer and health outlook is totally different than the achievers, however: on the one hand, they admit on being quite confused on issues about cancer, diet, and general health. However, although they are confident that they are already in good shape, they are not doing the things to earn that confidence: they are unlikely to exercise, they have sedentary leisure pursuits, and they generally eat unhealthy foods. In a word, the naive optimists are young people living the line "ignorance is bliss."

Comparing these first two groups demonstrates the power of this kind of segmentation to go beyond what simple demographic breakdowns might show. In fact, to do justice to the richness of all the profiles goes well beyond the boundaries of this paper.

3. Recalcitrants: This group represents 26 percent of the American population. Though this middle-aged group knows that they should be concerned about health and nutrition issues, they are "too busy" with other things. The most cancer fatalistic group, they are not as willing as other groups to make health related changes and they do not listen to health information.

4. Vulnerable Procrastinators: This group represents only eight percent of the population. They are the oldest group. They feel quite vulnerable to cancer. They lack confidence in their health, but they are taking very few steps to actually improve their current health status. Many are true procrastinators and say that they are simply putting off changes which might help their health.

5. Isolated and Confused: The isolated and confused represent only four percent of the population. They are lower socioeconomic status and represent a relatively high number of minorities. This group is not very well integrated into traditional medical services and tends to be highly misinformed and confused about health issues. Their dietary habits are poor; however, on a more positive note, they are usually willing to make health related changes.

6. Receptives: Receptives, representing only eight percent of the population, are somewhat like the isolated and confused demographically. They exhibit a paradoxical mix of attitudes and behaviors. On the one hand, they rate their health knowledge and attentiveness as low, but on the other hand they report that they are taking a number of steps to improve their health. They are hard to reach, but they are receptive to change.

SUMMARY

There are six basic ways to develop and implement a successful nutrition communication program, which have been demonstrated through this paper:

1. Teamwork: Teamwork is not a "hand-off" process, but professionals working and interacting as a single unit. We should keep in mind that a research person should be included in our team, to keep us in touch with our target audience. A policy decision maker on the team helps us to streamline our process.

2. Simplify The Message: Less is more when communicating with consumers. The message needs to be easy to understand and when appropriate, easy to translate into action.

3. Motivate, Not Just Inform: Programs should strive to motivate, not just inform, the consumer. When attempting to overcome longstanding cultural norms such as eating habits, consumers will need compelling reasons to change.

4. Operate As Publicists, Not As Publishers: In every setting intermediaries can be found to add a significant multiplier effect to the program's message. Here in the U.S. informing the news media is a way to ultimately inform millions of Americans, but other intermediaries--associations, community groups, educators, churches, physicians and many others--can carry the message.

5. Create Partnerships: This step relates to the fourth point. We should attempt to develop partnerships that will exist both during the program and after it ends. Partnerships

such as that with commercial industry can be a vital way of increasing program reach and impact. In any successful partnership, all partners get something of value from the relationship.

6. Segmentation: A specific group or groups should be selected at each stage of the social marketing process. This process will result in meaningful segmentation.

These two snapshots of nutrition media campaigns--The Food Guide Pyramid and the Five a Day Program--can serve as useful examples of how to meet some of the challenges we all face in our work.

PLENARY SESSION I:

STRATEGIC PLANNING FOR NUTRITION COMMUNICATION

PART II - BEYOND CREATIVE CONCEPTS

BEYOND CREATIVE CONCEPTS: THE DIETARY MANAGEMENT OF DIARRHEA PROJECT

Cecilia Cabanero Verzosa and Kenneth H. Brown[1]

INTRODUCTION

This paper presents the process of translating message ideas and concepts into program action at the field level. Messages must reach target groups: the messages incite these groups to take action; and in this particular case the action must result in a nutritional benefit to the child who is nutritionally at risk. This process of translating concepts to action is guided by a strategy, which is a plan, outline, or approach that requires making decisions to achieve certain predetermined objectives.

To illustrate this process, this paper presents the Dietary Management of Diarrhea (DMD) project as a case study to demonstrate how a nutritionist and a communicator reached decisions that guided the design of a nutrition education intervention in Peru. A key to the success of this project was the joint decision making process, which meant that all of the DMD team members spoke with one voice as the intervention was designed and implemented.

This paper describes the four key decisions in developing a nutrition education intervention; provides research data; presents the DMD teamwork decisions and intervention outcomes; and highlights the research findings that led to these decisions. The outcomes are summarized in terms of knowledge, trial, and adoption of the new food promoted.

DISCUSSION

Background

The DMD Project was a four-year project supported by the U.S. Agency for International Development's Office of Nutrition and USAID/Lima. It was implemented by The Johns Hopkins University and the Academy for Educational Development in Peru and Nigeria. The overall DMD project objective was to ameliorate adverse nutritional consequences of diarrhea; we had to decide, therefore, whether we were concerned primarily about practices during and after diarrhea or with weaning practices--or both.

At the time of project start-up, the nutritional status of children was poor in the intervention site, Callejon de Huaylas, a valley consisting of about 20,000 households. This

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[1] This paper was prepared jointly with Kenneth Brown, Director of Programs, International Nutrition, University of California, Davis.

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valley had both urban centers and rural communities. Sixty percent of the population spoke Spanish and 30 percent spoke Quechua, while the remaining 10 percent spoke both languages. Most of the people relied on agriculture for their livelihood. The major crops were wheat, potatoes, maize, and vegetables.

Growth stunting was identified as a problem in this site. The problem was more pronounced in the rural areas, where at age 18-23 months, 70 percent of the children less than 6 years of age were stunted compared to 42 percent of urban children. Regardless of these facts, qualitative research results indicated that mothers were not aware of the problem of stunting. Rather, they were concerned about the child getting weak and thin from diarrhea.

Nutritionists involved in the project concluded after early analysis that the main nutritional issue was inadequate energy/protein intake and the ideal intervention would therefore be to promote a nutritious weaning food. The project team had made an initial assumption that mothers were withholding food; however, the data showed that mothers were feeding actively during diarrhea episodes but that the child lost appetite. Thus, the energy intake during diarrhea, during convalescence, and after recovery remained almost the same. The nutritional problem was that these levels of energy intake were low compared to the theoretical requirements. Breastfeeding was universally initiated but practices declined faster in urban areas compared to rural areas across age groups of 6 months to 23 months.

In terms of channels of communication to which the program would have access, radio was available to both urban and rural groups. Access to print materials was limited to urban areas and problematic because literacy levels were low, particularly among women. Face-to-face communication was possible at the market place and through the Mother's Clubs. About 80 percent of the mothers and fathers in the population traveled to the market once a week; and mothers visited the Mother's Clubs to obtain food donations. The National Nutrition Survey (ENSSA) reported that although few families consulted health professionals when their children had diarrhea, health professionals influenced general treatment practices.

The Decision Making Process

The nutritionist and the communicator had four key decisions to make to develop a complete "picture" of a nutrition behavior change intervention. These decisions centered on four questions, namely:

1. *Who is the target consumer of the food or who is the target audience for our communication?*

2. *What is the product?*

3. *What is the message?*

4. *What are the channels of communication?*

1. Target Consumer: The first question, "Who is the target consumer?" meant that the team had to decide who was the consumer of the DMD product. The ultimate consumer of the food, or the beneficiary, was the child, but that the child's caretaker--usually the mother--was the target audience for the communication program since it was she who determined which foods the child consumed. The target audience could also be identified as the user, the provider, or the influencer. The health workers in Peru were an important secondary audience for the intervention since they influenced treatment of diarrhea.

2. The Product: The second question was "What is the product?" The term "product" is defined as an offering that is exchanged with the end user for a price. The key word is "exchange." The concept of "price" is not limited to a monetary value: it can involve an opportunity cost; a loss of status; a loss of time (when a mother has to spend more time preparing a new food); fear or anxiety (because it requires her to make certain changes in the way she buys food and prepares and feeds it to her child); or a psychological price such as a fear of change. "Price" can also refer to the time that the mother needs to prepare and feed the new food. In thinking about the concept of price, we ask two questions: (1) How much will the "product" cost the consumer? (2) Is the cost a fair exchange for the product?

Products can fall into a continuum--from the tangible to the intangible. An example of a tangible product would be condoms or weaning food. A tangible service provided may be a medical exam. The product also may be a practice--such as breastfeeding. An idea, such as the concept of being a good neighbor, can also be considered a "product," though it is intangible. A tangible product involves all of the senses--it can be seen, touched, smelled, heard. An intangible product can be a "practice." A "practice" can be considered a "product" when you want people to start doing something--such as to feed a new weaning food; or to stop doing something--such as to stop giving infant formula (such as Dr. Greiner mentioned in his presentation); or to switch to something--such as to switch from feeding children a watery cereal pap to a more nutritious weaning food.

3. The Message: The third question, "What is the message?" refers to the messages about the nature of the product. Who is it for? What is the product for? How does it compare to other products in the same product category?

4. Communication Mix: To answer the fourth question, "What mix of channels of communication will be used?" one must determine whether print, radio, television, or interpersonal communication channels will be used in the communication program. This decision is based on the following considerations: affordability, audience reach, and effectiveness of a particular channel in achieving the communication objective. The choice of the media mix depends on the resources available, such as money, people, production capabilities, infrastructure, and efficiency considerations. We can ask several questions to determine our media mix: how many people will be reached? How quickly and easily will they be reached? Is it too much? (Is the media mix going to reach people outside our designated target audience?) There are also timing considerations: we want to reach our target

audience when they are most receptive, when they are close to the decision, and when they are easy to reach.

The nutritionist and the communicator have complementary and supportive roles to play throughout the design and implementation of interventions aimed at changing nutrition-related behavior. Let us see how the nutritionist and the communicator reached joint decisions on two of the four questions concerning the DMD intervention.

The DMD Target Audience

The first key decision the project had to make was to determine the target audience. The nutritionist and the communicator focused on different aspects of this issue. The nutritionist wanted to address the following audience: (1) the consumer/target audience which was the most malnourished; and (2) the people likely to be least accessible to the health system for a number of reasons: they were from low income groups (probably from urban areas or rural poor), were semiliterate, and were geographically hard-to-reach (either rural or urban poor).

The communicator agreed that it was a good idea to reach the most malnourished sectors but cautioned that these groups may not be the first target audience: they may not be the most ready to adopt a new behavior and may not be as accessible to the program as other segments of the population. Target audiences might occur at different parts of a behavior change continuum. Some audiences might be unaware of a problem and therefore are least likely to change. Others may be knowledgeable about the problem and actively seek solutions to the problem, and are motivated to change. It is important to note the limitations of the DMD Project when considering these questions: the project budget was only U.S. $15,000 for local costs of the communication campaign, and we had only 90 days to introduce the new food. Ideally, the target audience for a 90-day introductory campaign should be those who are accessible and ready to change dietary practices.

The communicator therefore felt that the following characteristics of the audience were important: (1) they should be accessible through channels of communication that the project can afford to sustain; (2) the group should be innovative and ready to change behavior (for example, if mothers are not aware of stunting as a problem, telling them that this new food will promote growth will not encourage adoption--the solution does not solve the consumer's problem; however, cuing the behavior change to a problem mothers recognize, such as the

child becoming weak and thin due to diarrhea, would be more convincing); (3) the target audience might have some primary education; and (4) the group would have some resources to obtain nutritious foods.

How did the nutritionist and the communicator choose the target audience? Although stunting was a nutritional problem, it appeared that a 90-day campaign could not use stunting as a "hook" to get the mother's attention. The campaign had to start with a problem that the mothers recognized, which was diarrhea. Thus the joint decision of the nutritionist and the communicator was that they would have to reach the following target audience/consumer: (1) low-income mothers from urban and rural areas with children less than three years of age; and (2) mothers of children with diarrhea. This second characteristic had implications on the choice of the product, which is explained below.

The DMD Project

The second decision had to deal with the nature of the product offered. How was the project positioned in the mother's mind? The idea is to position the product clearly and competitively. The nutritionist felt that the product should be a weaning food, to be fed daily (not meant only for diarrhea); should be nutritionally adequate; and that we should promote a new weaning food, as well as encourage other dietary practices such as giving other foods and liquids, in addition to promoting exclusive breastfeeding up to 4-6 months and continued breastfeeding during diarrhea.

Although the communicator supported such product definitions, there were other product characteristics that the communicator wanted. The communicator felt that mothers must perceive the new product as being superior to "competing" foods which were currently being given; that the product must taste good to both mother and child; and the food must be of acceptable consistency, form, color, and smell. In addition, the communicator stressed the following: ingredients for the food should be affordable and available at home, easy to prepare and store; and ideally, the new food would not involve changes in mode or frequency of feeding, or serving size, all of which would involve more time in educating the mother. To be easy for mothers to adopt, the food ideally would involve merely a switch to a more nutritious alternative.

The team identified four product options to increase nutrient intake: (1) develop a new weaning food or diarrhea food; (2) fortify the traditional recipe; (3) increase feeding frequency; or (4) increase serving size. Finally, the nutritionist and the communicator agreed that the produce would be a diarrhea food with an acceptable taste, made from ingredients readily available in the market, that was nutritionally superior to traditional food. In addition, the diarrhea food would involve a short preparation time (competitive with the time it takes to prepare other foods that the mother was currently feeding, like soups or cereals), and would be low cost. A traditional food called ***sanco*** was selected to be fortified and was called ***sanquito*** (to mean ***sanco*** for a child).

This dialogue between the nutritionist and the communicator reinforced the value of research in making key decisions about the intervention: research tested whether or not this food was nutritionally adequate and could be given to children with diarrhea, and recipe trials held with mothers confirmed whether mothers could prepare the new recipe and whether they found it acceptable for children with diarrhea. The DMD team conducted different types of research, from community based research to help understand feeding practices during and after diarrhea; to clinical trials to evaluate the candidate recipes; to communication research to determine whether we could change feeding practices and whether the mothers could understand the messages. Based on the results of the research, the team confirmed that a campaign based on information would be most effective.

The project intervention design would have been very different if the team had based the decisions on the initial assumptions about feeding during diarrhea. The assumption, for example, was that traditional food preparations with adequate nutrient density are not available for children of weaning age. DMD research revealed that there are traditional preparations, like ***sanco*** which can be prepared simply from local ingredients and used as high density, well accepted weaning foods. The second assumption was that cultural beliefs limit foods that could be fed during diarrhea: potatoes were described as "heavy" and inappropriate for use during diarrhea. DMD research showed that there are processing techniques and food mixtures that can be identified to avoid these taboos. In the case of potatoes, if mothers mash the potatoes, or mix them with a little oil, they become acceptable for feeding to the child with diarrhea. The third assumption was that mothers withheld food from children during diarrhea. The DMD team found that mothers fed more actively, but the problem was that children's appetites were decreased.

The DMD Intervention

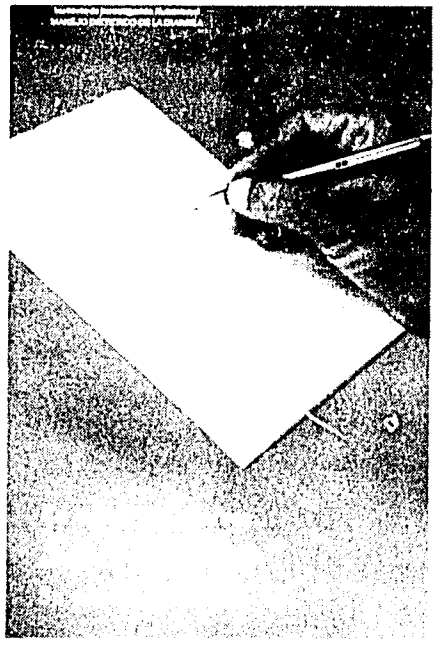
The resulting intervention design had the following objectives: (1) to generate awareness and interest in ***sanquito*** among 20,000 households in the Callejon de Huaylas; (2) to encourage product trial among mothers through cooking demonstrations. The goal was to encourage at least 20 percent of the households to try the product. It initially was hypothesized that only 5 percent of the mothers would adopt the product. "Adoption" was defined as mothers who tried ***sanquito*** at least once and who intended to use it for the next episode of diarrhea.

These communication objectives were to be achieved through a 90-day product introduction scheme using mass media and face-to-face channels of communication. The targeted action to be taken by mothers was that, during diarrhea, they must continue breastfeeding, give ***sanquito***, and give other fluids. The mother was also asked to give ***sanquito*** for one week after the diarrhea together with other foods.

The messages given during the campaign were as follows. We started by defining the problem and then identifying a solution: Why ***sanquito***? It strengthens the child, and prevents

additional weight loss; the combination of peas and wheat flour in ***sanquito*** produces a superior product; and then we focused on promoting an appropriate feeding regimen.

The communication program used a combination of communication channels to reach mothers as well as health professionals, who were an important secondary audience. Print materials for physicians included prescription pads and pamphlets, as well as a poster advertising ***sanquito***.



A flipchart was developed to be used in teaching mothers at the Mother's Clubs, and a calendar poster featured a nationally known folk singer who became a spokesperson for the DMD Project. Many materials were developed for health workers. Health worker training programs were provided as well.

The radio materials included a radio song which taught the recipe and cooking process for ***sanquito***; a public service announcement including the locations of the Mother's Clubs where cooking demonstrations were being held; testimonials from mothers who used ***sanquito*** early on; and a radio drama series, to dramatize the problem of diarrhea and feeding children during diarrhea.

Face-to-face communication took place at the Mother's Clubs and during physician-to-mother consultations. To teach Mother's Club leaders, cooking demonstrations were held in about 50 Mother's Clubs and during market day demonstrations. Furthermore, to encourage physicians to promote the DMD food, the project held three workshops for physicians. A DMD physician also made several follow-up visits to talk to the local physicians, one-on one, about the benefits of ***sanquito***.

SUMMARY

Lessons Learned

What did we learn about the intervention? The nutritionists and the communicators were primarily interested in the levels of knowledge, trial, and adoption we were able to obtain after a 90-day communication program. Three evaluation criteria were defined to determine the success of the intervention. "Knowledge" was defined as mothers who had heard about a new food for children with diarrhea and were able to identify that food as ***sanquito***. "Product trial" occurred when the mother tried cooking ***sanquito*** at least once, either at the Mother's Club or at home. "Adoption" was defined as the mother had cooked ***sanquito*** at least once and indicated that she would use it again for diarrhea in the future.

The rates of knowledge and adoption of ***sanquito*** exceeded the goals of the intervention. Results showed that 82 percent of the mothers had knowledge of ***sanquito***, 16 percent had ever tried the product and 12 percent planned to use it in the future.

Among those who knew about ***sanquito*** and who tried it at home (N=79), 97.5 percent said they will use it in the future. The rate of adoption was lower among those who knew about ***sanquito*** but who tried it in the Mother's Club, rather than at home. Among this group (N= 102), only 75.5 percent reported that they intended to use ***sanquito*** again.

Adoption rates were also dependent on whether or not radio was a source of knowledge. The communication plan was to use radio primarily to generate awareness about the new food, while actual teaching of the cooking process was done through cooking demonstrations at the Mother's Clubs and the public markets. As was found for trial, those who heard of ***sanquito***

only through the radio had the lowest adoption rates. The highest rates were for those who heard through radio plus another source. Radio, however, reached the greatest number of people at 87 percent. Mothers' Clubs/cooking demonstrations reached 25 percent of the households in the intervention site; followed by print materials (19 percent); friends (16 percent) and by the doctor/nurse (5 percent). Mothers learned the DMD Project message well: ninety-four percent of the mothers who had heard of ***sanquito*** knew that it was to be used for children with diarrhea.

The nutritionist and the communicator have complementary and supportive roles to play in the design and implementation of interventions aimed at changing nutrition-related behavior. Using marketing terms, the nutritionist is the "product" specialist. He or she must ensure that the product will provide nutritional benefits to the consumer.

The communicator brings in the consumer perspective in the project's decision making process. The communicator ensures that the consumer is at the center of key decisions made about the intervention, such as the choice of the product, the consumer benefit to be promoted, or the communication channels to be used. This partnership is necessary to develop and implement nutrition behavior change interventions. By working together, the nutritionist and the communicator will be able to serve the consumer: the mother with a child who is nutritionally at risk.

DEFINING CONCEPTS AND STRATEGIES FOR IMPROVING YOUNG CHILD FEEDING PRACTICES: THE EXPERIENCE OF THE WEANING PROJECT

Marcia Griffiths

INTRODUCTION

This paper presents a variety of projects from the Weaning Project countries and draws some specific lessons learned from these sites--Cameroon, Ecuador, Indonesia, Swaziland, and Zaire--as well as provides a bit more of a framework for nutrition behavior change. I hope that this presentation will add to rather than repeat the framework for nutrition behavior change that previous presentations have outlined.

When we are not directly involved in a project and are presented with materials like those that Caby Verzosa shared with us from Peru, many of us often comment on the material's aesthetic qualities, or we try to judge whether or not they are technically accurate, nutritionally sound, or we comment from the particular perspective or sector that we represent. As we know, however, these are not really the questions to ask. The questions should really be: Why was the material developed? Why were the specific concepts represented in the material stressed? Why was a particular medium chosen over another? Who is the material for? It is very important to remember that the product of our work as nutrition educators is not just the materials we develop; more importantly, it is the <u>changes in behavior</u> and <u>in nutritional status</u> that we seek.

DISCUSSION

Over the last ten years, the way we approach nutrition education has changed. Ten years ago, a given nutrition education effort would have been primarily determined by nutritionists, stressing concepts that they felt should be stressed, the audiences that they felt were important to reach, and the media that they felt were most appropriate or popular at a given moment in time or in a given country. Around 1983, however, the government of Indonesia presented the results of the Nutrition Communication and Behavior Change Project. This project demonstrated that by applying social marketing principles to nutrition education not only could nutrition related practices be improved but also changes in the nutritional status of children could be achieved. These results prompted Alan Berg, in <u>Malnutrition, What Can Be Done</u>, to applaud the effort of the Indonesian government and to point out that this was the first time that a quantifiable change in nutritional status had been measured as a result of an educational intervention.

When we examine the lessons learned from that project, we see that (1) the focus was on changing behavior, not just on supplying nutrition information; and (2) the changes in

behavior that were sought were responsive to audience needs. They grew out of very thorough audience research and were not based on a nutritionist's perceptions of the needs of a given audience. Third, the solutions needed to be creative. Many people at this conference have already emphasized creativity, so I will not dwell on it here other than to say that it has been a very important--although elusive--element of every successful project that I have seen. A fourth critical lesson of the Indonesia project was that the development of a comprehensive strategy is essential. The various activities in Indonesia were not ad hoc in nature. A basic strategy was designed and executed over the course of several years.

These four principles, or lessons learned, have been applied now in a number of programs, including the Weaning Project, a five-country, five-year project supported by the Office of Nutrition of the Agency for International Development. At a country level, the Weaning Project formed partnerships either with UNICEF, CARE, or with USAID missions, and always with either a Ministry of Health, a Ministry of Agriculture, or a Ministry of Community Development. The Weaning Project's challenge was behavior change. We were looking for low cost, nutritionally sound, and sustainable solutions. In doing so, potential beneficiaries were constantly consulted throughout both project development and implementation. The concepts promoted by the project were defined and refined by the audience. A very elaborate, qualitative research protocol was used at the outset.

The Assessment Methodology

The assessment methodology or protocol used in the Weaning Project, refined over the course of the project, had the following characteristics:

- It was highly qualitative. It included sections on parents' aspirations for their children, on expectations for child development and on maternal self-confidence, in addition to a step that involved actual trials of certain recommendations by families.

- It called for a small sample. Even for a national program--for example, in Ecuador or Ghana--no more than about 150 families were represented in the research sample, and of those, only about 50 participated in-depth.

- It was in-depth. Time was spent not in talking to a great number of people, but in talking to a small number of people in detail--while observing them prepare food and feed their children--discussing and constantly asking why.

- It was rapid, at least by some definitions. In the first countries, where it was implemented in pilot regions, the process took a year. Later, the time was reduced to six months for a national assessment.

- Its implementation required minimum technical assistance, although it did require a principal investigator with knowledge of qualitative research and child feeding issues.

The first step in the process was always problem identification. We used this to find critical problems impeding proper feeding and care of children and to identify resources to solve them. We used focus group discussions, employing, for example, a technique involving the use of photographs of various types of women in order to focus the discussion on mothers' perceptions of what it means to be a good mother and to care for children well. Focus groups were also held with men--in many cases policy makers--from a variety of groups. In-depth individual interviews were conducted in homes, often while sharing daily chores with the mother. There was then a regrouping and analysis time when we tried to determine a nutritional benefit or harm of current practices and identified possible modifications in practices and rationales for them. A comparison was made between an "ideal" practice and the "real" practice. Possible behavior change goals were identified based on this process.

Focus groups were held with men from a variety of groups in Swaziland.

In-depth individual interviews were conducted with women in their homes.

The methods involved structuring case histories, reviewing and synthesizing what we had learned. Many people were consulted until the project team, along with nurses, doctors, and families involved, felt that they had come up with a list of potential recommendations. We then returned to the field for what is called <u>intervention</u> or <u>concept</u> testing where we determined the potential for retaining or changing practices. At this point in the process, we tried to clarify motivations for change. This involved very specific household trials with mothers, such as adding green leafy vegetables to a porridge in Indonesia--actually cooking with her and feeding her child to see how the child liked the food and how the mother liked the food. The mother was then asked if she would continue to make the food over the next week or two. We then returned to the household to find out whether she had or had not, what

she liked or did not like about the food, and what she had changed. Often, additional focus groups were then held.

This formative research process was implemented in every case by local groups representing either our direct project counterparts, either people in the Ministry of Health, or people hired from a local market research company. The process was streamlined over its application in five countries and now basically takes about five months to complete. It is relatively inexpensive, costing between $12,000 and $35,000.

Common Themes for Program Strategy Formulation

Research findings were reviewed and synthesized, providing new insights.

In every country, the assessment methodology yielded a wealth of information that provided new insights into infant feeding practices and indicated concrete actions to be taken to improve infant feeding-related behaviors. Even though results are generally most meaningful in their country context, the following synthesis of some of the salient findings from the assessments may be useful. These insights appear to be broadly applicable since they emerged from assessments that were carried out in a variety of contexts ranging from the isolated, poor areas of the extreme north province of Cameroon and in Ghana, to the semi-urban areas of Swaziland and Indonesia, to the heavily urban areas of Ecuador and Zaire. Based on the assessments that were conducted, the following general recommendations can be made:

- *Find a balance between food and practices.* The focus on practices made it abundantly clear that unless breastfeeding techniques and weaning practices are addressed, any food will have minimal impact. For example, just promoting "breast is best" is not useful when what women need to practice is more frequent breastfeeding.

- *Target changes in practices.* There are a number of practices (consistency of food, frequency of feeding, nutrient density, quantity, hygiene, patience, and persistence). These can all be included in a program when they are considered priority for the needs of different aged children. Generally, the following priorities held across cultures: (1) 4-6 months: introduction of a food; concept of consistency--a semi-solid, reducing water content; (2) 7-12 months: feeding frequency and food variety--use of family foods; (3) 13-24 months: feeding

frequency and food quantity--family foods plus snacks; and (4) 7-24 months: need to supervise eating and to be patient and persistent.

- *Do not ignore the first days of life.* This concept is better recognized today than five years ago. Bad practices begin with prelacteal feeding--there was virtually no exclusive breastfeeding in any culture. In addition to traditional and non-traditional prelacteal foods, there is an increasing tendency to introduce foods early to "accustom the child to food," often because the mother must return to work.

- *Expect the worst characteristics of the daily feeding pattern in feeding during and immediately following illness.* This area presents a big challenge. If mothers allow children to determine their own feeding pattern, they will do it more so during illness. If mothers give only a small amount of food regularly, they will reduce the quantity even more so during illness. However, mothers generally continue breastfeeding and do not withhold food because they think they should, but because the child "just won't eat." Patience and persistence are already well recognized as characteristics of feeding the sick child, but are not always practiced. In addition, there is no concept or practice of recuperative feeding in any culture.

- *Recognize the extent to which families can do more for themselves.* The household trials gave a realistic picture of where poverty and/or lack of coping skills were so significant that the mother, family unit, and community could not change their practices enough to have significant nutritional impact. For example, in a district in East Java, Indonesia, almost all families (90 percent or more) could and would do a lot to improve their practices related to young child feeding. However, in Ghana and parts of Swaziland, the picture was not as optimistic: closer to 20 percent of the families had a serious shortfall in resources. Families in the Extreme North Province of Cameroon and the high Sierra of Ecuador appeared to have an even worse shortfall.

  Undertaking this type of assessment allows planners to know what to expect if no additional food or economic assistance is given, and it allows for that assistance to be better targeted to where it is needed.

  Of great importance, and what emerged resoundingly from all assessments, was that the majority of families could and would do more to improve conditions for their children. Enabling people to optimize their resources and current feeding patterns should become the priority.

- *Distinguish the nature of "resistances" to change.* Both "environmental" and "attitudinal" resistances were identified. Environmental resistances included unavailability of certain foods and lack of feeding utensils. However, the most

important environmental barrier in each country was misinformation about child feeding by health care professionals.

"Attitudinal" barriers included such ideas as the inability of children to swallow or digest particular foods or preparations. Two key resistances commonly were seen:

(1) *Maternal self-confidence.* A woman's low social status and her feeling that she exists to serve her family often means that she feels powerless in the face of resistance from her child.

(2) *Perception of time.* Having time was not related so much to real "busy-ness" or hard labor as to perception of "busy-ness" and tiredness.

- *Pinpoint motivators or enabling factors*, i.e., "If my husband told me"; "If I just understood." "If I had a measuring cup or plate"; "If the food is well cooked, then my child could digest it." Two key facilitating factors commonly seen were:

  (1) *The significant role of fathers.* Fathers seem to be playing and seem willing to have a larger role related to child feeding than anticipated. Their contribution previously has been undervalued. Fathers could do more, particularly when it comes to the purchase of "special" calorie-dense foods for young children.

  (2) *Food vendors and owners of small food shops or stalls.* These individuals have the potential to disseminate information about young child feeding, especially related to food purchases. These people are often one of the most stable and abundant potential "sales forces" in the community and in most instances are credible sources of information on food-related topics.

- *Learn where the differences and similarities are across cultures,* i.e., what behaviors and concepts are similar and can be promoted nationally and which behaviors require regional or even more local adoption. Some examples are whether programs should be different or similar for highland and coastal Ecuador, Java and Lombok in Indonesia, religious groups in the Extreme North Province of Cameroon, or the north and south of Ghana. Too often, people are quick to rule out national-level programs because of perceived or real regional differences. However, many of the feeding problems are similar: it is the solutions that may or may not be the same. Often, it is the expression of the solution that must vary, but not the concept. These variations can be handled in a national program as long as there is strong regional, district, and village participation.

Once key concepts were clarified and we took all these lessons from the research, the strategies almost formulated themselves. There is often a dread of sitting down to formulate a strategy, but if we spend time with the research results, the strategies will become very clear. The stategies are dictated by the research findings, by what people in the communities are saying.

Strategy Framework for Behavior Change

As key concepts and behaviors are clarified by assessments, the required strategies easily are formulated. By comparing ideal and real behaviors, and what families indicated they can and will change, and then by examining resistances and enabling factors, planners can lay out the strategy or road map for how to achieve the behavior changes, whether they are increasing the frequency of feeding; adding malt to the child's porridge; or having men stop purchasing infant formula.

In the Weaning Project, although no template was provided for program strategy formulation, each country defined similar areas requiring attention. While the project teams organized the information from the assessments, the overall strategies were designed at workshops with program managers and policy makers representing key programs related to child health and nutrition. These workshops were successful in heightening awareness of young child feeding problems and in achieving a commitment to action, even if only a skeleton program.

The framework that commonly emerged contained the following areas for action: (1) legislation/regulation; (2) training; (3) communication, focusing on practices; (4) food product or ingredient; and (5) "other," which could include child care, sanitation, bowl to measure food quantities. Examples of country project activities under each category show that although the framework was consistent across projects, the activities varied within the categories.

1. **Legislation**: In Ecuador and Swaziland, because the widespread availability of milks and formulas was a deterrent to optimal breastfeeding, importance was placed on making into law the Code for the Marketing of Breast Milk Substitutes. But in Cameroon, given the remoteness and small size of the project area in the Extreme North Province, focusing on legislation did not make much sense.

2. **Training**: In many countries, there were ongoing, large, pre-service and in-service training schemes with which the project tried to coordinate. However, the need for special training efforts emerged clearly from the research and from discussions with managers of ongoing training programs. Examples of The Weaning Project special training efforts were:

   - In Indonesia, a short course on child feeding for representatives of the national women's association was held because of their role in community programs;

- An orientation was also planned and conducted for selected small shop owners in Indonesia because they are convenient, are visited frequently, and often give or could give advice on child feeding;

- In Cameroon, an orientation on child feeding for community development (not health) workers was held because they are the most frequent visitors to distant villages in the extreme north;

- In Swaziland, an in-service training for nurses was held because they are well respected and convey much misinformation on child feeding; and

- Extensive training on counseling techniques for all project and all medical personnel was an important element in each country because they were seen as important sellers of the "product" (optimal weaning practices) and they need the skills to be good spokespeople.

3. **Communication**: Each program included two aspects--promotion of the project and its products and education on basic practices.

The major challenge that confronted the planners of the communication component was how to get out the message about the specific behavior changes in a manner that was precise and targeted to the person in need at a time when he or she needed it.

Communication strategy planning began with decisions on audience. Generally, the primary audience was mothers and principal caretakers because they are the ones who prepare the food and feed the children. However, the secondary audience of influencers (fathers, children's grandmothers, other family members) were considered virtually as important as the primary audience. The tertiary audience were those influencers one step removed from the family--key community leaders, health care workers (both traditional and non-traditional), and vendors of prepared or special ingredients for young children's food. Communications for this tertiary audience should not be confused with training. Although influencers often were also oriented or trained, a segment of the communication program was developed especially for them.

Critical to the success of the communication effort is segmentation within the audiences. For example, among mothers and families it was recognized that the concerns and practices of mothers with newborn infants are much different from those of mothers with children in the second year of life. Therefore, using the research results, the audience of mothers was segmented according to their infants' ages.

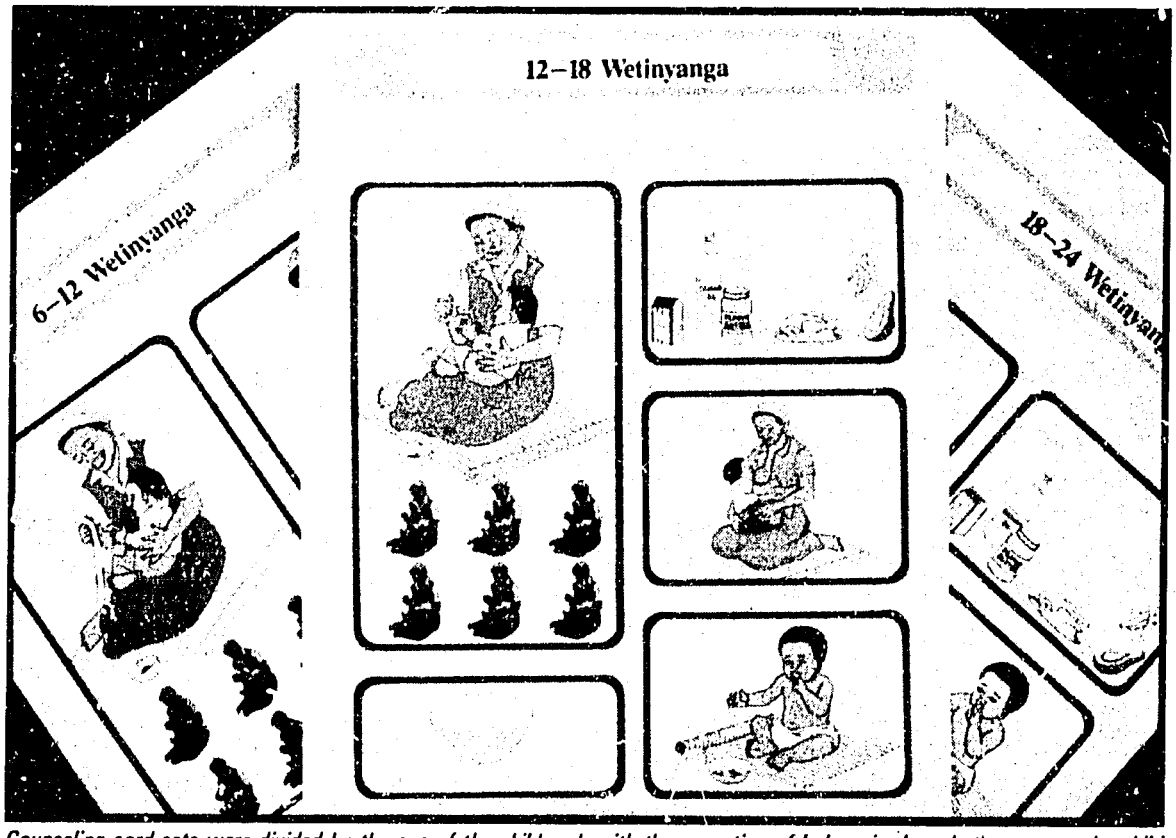
The goals of the media strategy were to reach: (1) parents of young children and families with limited resources, either at home or elsewhere, with messages that focus on specific behavior changes; and (2) other family members and members of society with more general messages on enhancing the importance of child feeding and on a few

more generic principles. The media used varied tremendously--from the Cameroon project that relied exclusively on community workers, to Ecuador, where mass media (radio and television) played a major role.

The materials that were created also varied greatly depending on local creative talent and budget. The following is a brief overview of the types of materials created, divided into two categories--those focusing on specific behavior changes and those focusing on the image of young child feeding, general principles, and project promotion:

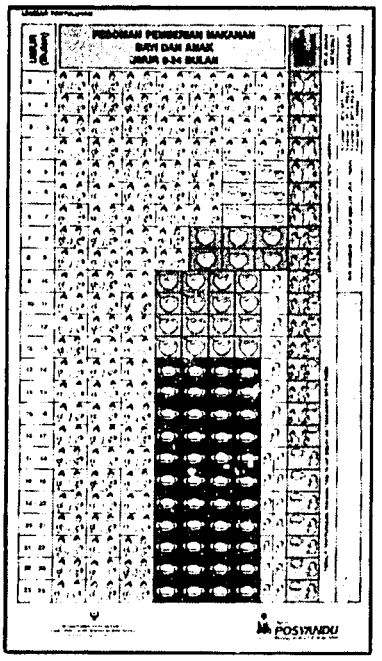
1. Focus on specific behavior changes.

- *Sets of counseling cards to aid village or health workers target their messages* were developed in every project. Cards, such as those shown below, were designed to be used primarily with a growth monitoring program.

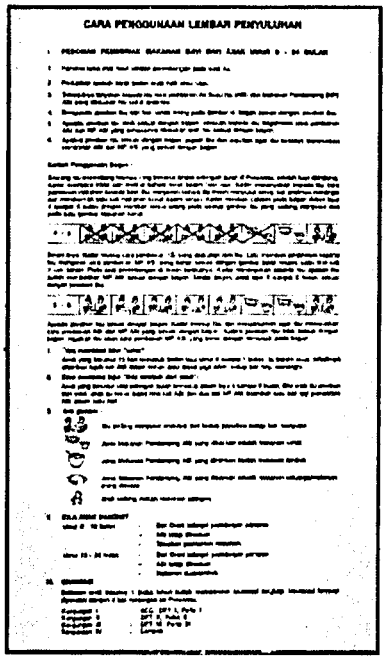


Counseling card sets were divided by the age of the child and, with the exception of Indonesia, by whether or not the child was healthy, sick, or not growing properly.

- *Reminder sheets for the family and health worker* are used in counseling but remain with the family. In Cameroon, they were mimeographed copies of the counseling card. In Indonesia, the reminder sheet was more elaborate, containing the entire framework for feeding by month and serving as a checklist for the community worker at the growth monitoring session. It was kept by the mother in between visits, folded in the growth chart.



The front of the Indonesian reminder sheet containing a visual framework for feeding by mouth.



The back of the reminder sheet contains additional written reminders, including an immunization schedule.

- *Radio spots and cassettes were made on key behavior changes.* Radio spots were used in Swaziland, Ecuador, and to a limited extent, in Indonesia. Generally, they were in a dialogue format. In Indonesia, a standard character, Ibu Gizi (Mrs. Nutrition) was created to be the voice of wisdom and she would informally counsel young mothers. Two mothers conversed in all of the Ecuador spots. The dialogues for radio in Indonesia were also put on cassette and were played at weighing sessions at village meetings.

- *Posters* were prepared by all projects except Swaziland. In each case, posters were used for specific purposes. For example, the posters created in Ecuador were for (1) maternity hospitals, reminding women about early initiation and on-demand breastfeeding; and (2) health centers and doctors' offices, advising families to feed sick and recuperating children.

The poster developed for hospitals in Ecuador encouraged early initiation.

Food demonstrations were held in Indonesia.

- *Food demonstrations and demonstration guides* were prepared in most projects. The Indonesia and Ecuador projects were the only ones to prepare formal recipe-type guides.

2. <u>Focus on the image of young child feeding, general principles, and project promotion.</u>

- *Name, logo and song*: Local names for each project were selected, plus logos in Indonesia and Swaziland. In every country but Cameroon (where no audio materials were prepared), a project song was created.

  In Indonesia, the logo was a replication of the one developed previously by Manoff International, and in Swaziland, the three-legged pot that symbolizes the Swazi staple food--corn porridge--was used.

  The project music was all original. In Indonesia, the song was an uplifting, marching-type song, the words sung by a children's chorus. In Swaziland, the song used a traditional music form, the Umboloho, sung by a small male group of singers. In Ecuador, two songs were recorded: a lullaby about breastfeeding, and a rhyming song about infant feeding through the first two years of life.

- *Television* was used only in Ecuador. There was a documentary on the importance of child feeding and proper practices at various ages. From the documentary, video clips were made.

- *Flipcharts* were developed in Cameroon and Swaziland. In both settings, there was a need for an educational materials that were simple and versatile. In Swaziland, the flipchart was used by all community-based agencies, including *tingkundtla*, the traditional Swazi government system. Flipcharts in both the Swazi and Cameroonian projects stressed the actions of men, because women complained of their lack of support, and men themselves said they could pay more attention to child feeding and use family resources more wisely.

- *Cassettes* prepared in Swaziland and Indonesia discussed infant feeding generally, particularly family and community behavior. The tapes in Swaziland were made to be used in *shibens*, gathering places of men. In Indonesia, the cassettes made for the community-at-large were done in dialogue form with *Ibu Gizi* (Mrs. Nutrition) as the spokesperson, the one who could solve child feeding dilemmas. These dialogues were interspersed with popular songs. These cassettes were played at community gatherings.

- *Other items*, such as a supplement in the Sunday edition of the most widely read newspaper and a special book for parents with a newborn, were developed in Ecuador. A play on child feeding and the role of the father was written and produced in Swaziland.

4. **Food product or ingredient**: Emphasis was given to the greatest need: how to improve the common homemade food(s).

- In Indonesia, rice porridge was used as a basis--rice rather than rice flour was stressed plus the addition of common (every day, household ingredients) like *tahu*, green leaves, and a source of fat. The recipe was flexible to accommodate a variety of possibilities--examples were given using already cooked foods and raw foods to be cooked. The name Nasi Tim Bayi was chosen to identify this good infant food because it conveyed that it was soft rice mixed with other ingredients <u>for the baby</u>.

- In Cameroon, the problem was that *bouille* given to children was not calorically dense. Enriched *bouille* was promoted--made thicker with the addition of milk, egg, or peanut paste. For older children, the use of the adult food required much convincing and proper preparation before it would be considered for a child.

- In Swaziland, the key problem was that mothers felt the family's corn porridge was too thick for the child to swallow and digest so they diluted it tremendously. Therefore, malt was introduced to thin the thick porridge without reducing its caloric density. Otherwise, traditional Swazi foods were promoted.

- In Ecuador, in the highlands, the caloric and nutrient-poor regular diet did not lend itself to minor modification. The project promoted a special *machica* called *fuersan*--a toasted legume and grain mixture that is traditional but usually not for children. For other areas, regular family food (semisolid) was promoted, usually based on rice or noodles and emphasizing the semi-solid, not the water or soup.

5. Other activities:

- In Swaziland, a key complaint of working women was the poor nutritional care offered by child caretakers. Therefore, the project sought to upgrade the knowledge of existing day care providers. The project also encouraged the creation of more day care centers.

- Also in Swaziland, food hygiene was consistently blamed for childhood illness. Often mothers felt the food itself caused the illness. Hygiene became a priority. A food preparation unit was added to the hygiene education materials being developed in another project, and all child feeding materials contained key advice on hygiene.

- Because of mothers' lack of the concept of food quantity in both Swaziland and Ecuador, the manufacture of calibrated child feeding bowls to measure food quantities against the necessary intake per meal was proposed.

SUMMARY

The Weaning Project was evaluated formally in two countries. The project in Indonesia replicated the results of the earlier nutrition communication and behavior change project: that is, the changes in behavior brought about by the program were so significant as to cause major shifts in the nutritional status of the children. An evaluation in Cameroon also showed major changes in practices.

Materials promoting improved child feeding practices do and should vary in different settings. There is no template for them. However, the process of making decisions about them is becoming more standardized, and we know enough now to promote a strategy matrix about improving young child feeding (Figure 1).

Figure 1

STRATEGY Improved Young Child Feeding Practices				
COMMUNICATIONS	TRAINING	FOOD	LEGISLATION/ REGULATION	OTHER
Public information: general concepts, demand creation, prestige	On-the-job: concepts and communication skills (prior to launch)	Special food made from family pot	Hospital procedures	Products: -feeding bowl -grinders
Education: counseling, group sessions, demonstrations, link with growth monitoring	On-the-job: technical & communications (routine monitoring)	Special ingredients or technologies -malt -fermentation	Breastmilk supplements	Child care
Other: point of purchase	Formal training: curriculum revision	Commercial food -dry ingredients -prepared	Labor laws related to women	Sanitation

At this point in time, if asked by a minister of health what can be done to improve young child feeding, we no longer have to say that it is a mystery or that it is too complex. We now have some answers. We have learned, for example, that when a situation is examined systematically, when decisions are taken with the project beneficiaries, when a strategy grows from good formative research and is developed into a cohesive program that is culturally sensitive and specific to the situation, we can make a difference for the nutritional status of children.

PLENARY SESSION II:

STRATEGIES FOR REACHING THE COMMUNITY -- A LOOK AT CONCEPTS, MESSAGES, AND MEDIA CHOICE

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BOLIVIA SCHOOL RADIO PROJECT

Tom Tilson and Judiann McNulty

INTRODUCTION

It is a pleasure to be here this afternoon with you. The program that Judiann McNulty and I discuss in this paper has a very special focus: its aim is to try to alter the food knowledge, attitudes, and behavior among school age children through the principal medium of radio lessons presented in classrooms.

These lessons have a long and interesting history, dating back almost twenty years, when, in the mid 1970s, A.I.D., with Stanford University, developed the first of what has now become a complete series of radio programs for teaching children in school. The program began in Nicaragua in 1974 with mathematics programs for young children, and since then it has spread to other parts of the world and to other subjects. There are now radio programs of this type--and I will discuss what I mean by "this type" later in this paper--in Africa, Asia, and Latin America, teaching not only mathematics, but English as a Second Language, Spanish as a Second Language, environmental education, science, and health. These programs have been funded by A.I.D. with other funders occasionally participating as well.

In Bolivia, the work began in 1987 on a mathematics program, with the intent of finding a way to assist the teachers in improving the instruction of mathematics in the early primary school grades. The program consists of a special form of school broadcast or school radio, but it has several unique design characteristics. A great deal of baseline data is collected, and later in this paper we discuss the very careful formative evaluation in the health area.

When we enter a classroom where this type of instruction is taking place, we see a great deal of student participation; because of this participation, although the program uses a conventional one-way radio, the term ***interactive radio instruction*** has evolved and is the name by which this instruction commonly is known. In a typical example of the classroom situation, we would see perhaps a third grade class. The students listen to daily half-hour lessons on a given subject, such as, in mathematics, the difference between numerical units.

The idea of teaching by radio at first met with skepticism. I began working on a project with Stanford in Nicaragua, when people told us we were crazy if we believed that we could teach young children mathematics by radio. Of course, the image these people had was that of young children sitting back passively with the radio talking "at" them. The reality is a far cry from the image. Another commonly held myth was that we could not attempt to have a lesson of more than ten minutes long because children's attention spans are no longer than that. In reality, all of the thirty-minute programs are very effective. In fact, in the Dominican

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Republic, the program added an additional thirty minutes of language teaching, so the radio programs run for a full hour. The children still seem to remain interested during that time, provided they are actively involved and that activities change every few minutes.

The growth of the program has been impressive since its inception in Bolivia. The programs have moved from the second grade all the way up to the fifth grade, and is being broadcast in Bolivia to seven of the nine departments of the country to approximately 100,000 children as of 1992. In 1989, we decided to examine whether the radio teaching technology might be used to teach health education. In Bolivia, there is an enormous need for health education, and in the rural schools in particular, little or no health is taught. Statistics have demonstrated that a great deal of work needs to be done in this area. Infant mortality has decreased enormously in the country from pre-1976, with the last data available from 1989, but the rates are still high: it went from 169 per 1,000 down to 96 per 1,000. Diarrheal disease and its resulting dehydration is the leading cause of death in children under five. Forty percent of the population may not have had a full set of immunizations. At any one time, 28 percent of the children have some diarrhea, with malnutrition as a contributing factor, as well.

With the experience of the radio learning program, a trained team, and a tremendous need for health education in the country, A.I.D. funded a pilot project in 1989 with Judiann McNulty as the Resident Director. Early in 1992, a full-scale project began to extend the initial work in diarrheal disease to a whole series of modules for fourth, fifth, and sixth grades as well as primary school. We will move now to a discussion, presented by Dr. McNulty, of the pilot activity and the many interesting activities that have resulted from the initial work.

DISCUSSION

The experience of being Resident Director for the Bolivia project may represent the most exciting and challenging work with the most potential of any health education intervention in which I have been involved. In preparation for implementing the pilot project, we looked at the three main reasons for targeting children with health and nutrition education.

Reasons for health and nutrition programs

The first of these reasons is that **children are very open to new ideas**. Everything in their world is new for eight-year-old children: what they learn at school, what they learn about the world around them, what they learn at home with their parents. Children are very teachable. They are willing to learn and they will, particularly in developing countries, accept ideas that are totally foreign to their culture; whereas parents or older adults, as we have seen in adult education programs, can be resistant to change. With children, the fact that they are going to school and their parents never did, alone, is one difference that makes them open to change. Their parents still may not know that the world is round, nor how to read and write, but the child is expected to learn these things. Why should these children not learn health and nutrition as well?

The second reason that teaching children is important in developing countries is that these **children usually assume major responsibility for their siblings and for household chores**. This fact is particularly relevant in areas where families are forced to migrate, or in the case of Bolivia, large numbers of parents are migrating to one region of the country to work, leaving ten- or twelve-year-old children in charge of the household while the parents are gone during the week. On a smaller scale, the mother and father both may be in the field for twelve hours a day. And again, an eight- or nine-year-old is in charge of an infant or a toddler. These children have responsibilities that affect health behavior or the health of the younger siblings. In addition, our third reason is that, when we look at population in the developing world--and this fact is changing somewhat--**in general they marry very young**. When we see teach ten-year-olds, **within five or six years, these children may be parents themselves**; therefore, when we can expose them to health and nutrition concepts before they themselves are parents and settled with other responsibilities and concerns, we may plant some ideas that will carry on.

Goal and Description of the Program

Our goal with the Bolivian health radio project is to teach children to improve health practices over which they themselves have control either for themselves or for younger family members. We are not attempting to have children change the world. Obviously, they cannot do anything about the lack of potable water in their community or cannot be expected to influence drastically the way their parents think. They may have some influence, but for the most part we are only attempting to present them with skills that they need to make changes in their own individual lives or those of their younger siblings or the household chores over which they have responsibility. At the same time, we do try to create an awareness of the larger issues that impact their health, such as the existence of potable water. We help these children realize that they do have the right to expect services, to work together as a community to bring about change, but not that they themselves, as individual children, could change these issues.

The radio projects are about ten weeks long, depending on the grade level: some grade levels are six weeks long. The pilot was a ten-week unit with one lesson a week. The lesson itself is 25 minutes long and is followed by a 25-minute post-broadcast class activity. The lessons include a variety of activities. We use songs and rhythms, and at time physical movement, such as having the children raise their arms or stand up or move to the front of the classroom. While some cases involve role playing, there is always a story with accompanying questions and answers. The children are very involved, which is why we refer to the program as interactive radio. Contents that we need children to memorize, such as the formula for oral rehydration therapy, are taught in songs, repeated over and over to help them remember. Stories are the most appealing of any aspect of the program. Here we deviated from the standard interactive radio format and made the stories take up from three to five minutes in each lesson. It did not matter; they liked to hear about a "monster microbe" as much as they liked to hear about situations that were similar to their daily lives. Therefore, we used the stories to emphasize the key points that we wanted learned from a lesson.

Bolivian children involved in a radio lesson

Bolivian teachers learning how to make oral rehydration solution

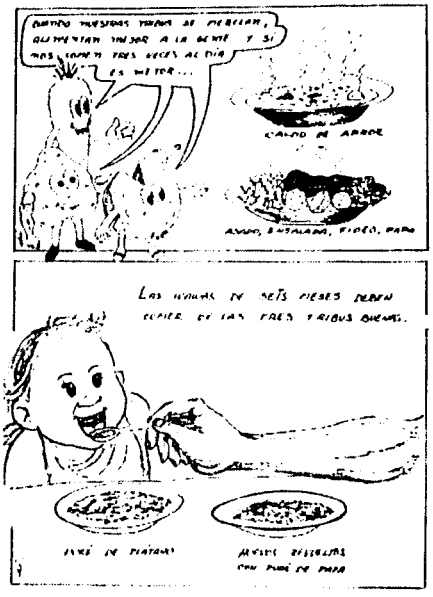
Again, lessons of about 25 minutes long are followed by a post-broadcast activity. The teachers receive a flyer in advance, or in a formal program, a booklet, which illustrates to them what they are supposed to do to get ready for the lesson and the post-broadcast activity. There is one of these for each lesson. It might say, for example, "Teacher, before the lesson you need to have a one liter bottle on the desk in front of the class, so that the students can see it." Or, "You may have to have a bucket of water outside the door." The instructions will tell the teachers specifically what to do. If they need to prepare something after class, such as a filter for water, the instructions provide a complete list of materials, step-by-step instructions, and advice to practice the process once before the lesson so that they will be able to demonstrate appropriately. Getting the teachers involved and cooperating in these lessons has been one of the most difficult aspects of the program. Teachers get much more excited about the program as they begin to understand that they have an important role in the lessons. We must reassure then that they are not being replaced as teachers, but that the radio lessons are supplemental to their own teaching. We help the teachers to prepare and to use the radio as a teaching aid.

Dissemination and Access

In terms of dissemination of the program, the pilot program was distributed on cassette tapes to commercial radio stations where we actually paid for air time. The program is now going national, so the distribution system will be somewhat less complex and there is some hope of a national public radio station being built in Bolivia in the near future which would facilitate transmission. Even with the current, more complex dissemination system, the program is active in seven of the nine provinces, which is significant.

Teachers need know only what time to turn the radio on to use the program. For example, the pilot fifth grade health was at 11:00 am on Wednesdays. Teachers who are not in the official pilot testing at this point hear by word of mouth from other teachers that the program is on the air and can turn it on and use the lessons--although they do not have the

backup of the teaching materials. Because of this access, more people are actually being targeted and are able to take advantage of the programs. Parents also have access to that knowledge simply by asking their children at what time the programs are on and they too can tune in and hear and learn what their children are learning at school.



Sample pages from teachers' booklet

Formative Research

One of the major emphases of the program was on formative research, and, as Marcia Griffiths presented, it is extremely critical to spend a large amount of time and effort on formative research. The lessons have to be culturally appropriate--not only how the general culture lives--but how children live within that culture. We did extensive anthropological studies and qualitative research to try to determine as much as possible about the actual lifestyles of the target audiences. We noted some differences between what existing anthropological studies showed about the culture and lifestyle and what we actually uncovered during our research. For example, we found some discrepancies between what parents reported and what children reported on the same questions: when we asked parents what their children knew about the spread of disease, they responded that their children knew nothing about microbes and bacteria. Yet, when we asked the children the same question, they were able to tell us about microbes.

Another area of discrepancy in responses was household responsibilities. We asked parents what tasks they had their nine-year-old or ten-year-old children doing in the household, and we were provided with a very limited list of responsibilities which were usually carried out under parental supervision. In focus group activities with the children themselves, where we used various tools, such as puppets to get responses from the children, we found that

children often were responsible for the running of the entire household for days at a time. We also discovered that we had to recognize the vocabulary that children use: for example, they commonly referred to diarrhea with the word ***kaka***. In Bolivia, which is a very large country, we also had to recognize that we would have to standardize vocabulary used between the different regions, which has posed a very great challenge.

At the same time we realized that the lessons have to be generic enough to be understood by children who live in very diverse environments: from the urban slums of La Paz, to remote mountain villages, to the Amazon basin, to the high mountains where there are no trees. As other presenters at this conference have noted, our challenge was to begin to **target** our audiences appropriately. One of the upcoming lessons will be on disease transmission in the Amazon, so we are talking about malaria and yellow fever; while in the highlands we will need to talk about other diseases, such as tuberculosis.

We conducted a formal evaluation of the pretest and post-test and discovered significant changes in knowledge. There were about 450 children from ten different schools involved in the testing, and overall scores between the tests were improved about 20 percent. However, on specific questions that were of great interest to us in developing our lessons, the changes were more dramatic: for example, on the question of how much liquid a child with diarrhea should have in one day, pretesting showed that only 75 children knew the correct response, while in the post-test, 363 children could tell us that a child with diarrhea needed a liter of liquid a day. On the pretest, only five children knew how to prepare oral rehydration salts (ORS), which was not a poor result considering that we were starting from ground zero. On the post-test, however, 338 of the children could write out the preparation procedure for ORS. On another question--symptoms of diarrhea--only fourteen children could list the symptoms on the pretest, while on the post-test, 327 children could provide one or more symptoms of dehydration.

The project is now expanding to the preparation of units for each one of the third grade levels. For the third grade, we are starting, at an opportune time, with cholera, and then will advance to personal hygiene, dental health, respiratory infections, and the importance of immunizations. These diseases will all be covered in six-week or shorter units. In the fourth grade, in the unit on diarrhea, we are in the process of revising the initial module. We are also discussing transmissible diseases, such as malaria, tuberculosis, and yellow fever, depending on where the target children live. Accidents and first aid are important subjects for children worldwide of this age group as well. For the fifth grade we have a very long center unit first on nutrition for the children themselves and then on infant feeding practices. We also have a unit on environmental health; and the final unit will be on self-esteem and decision making related to drugs, alcohol, and sex.

SUMMARY

We look forward to continuing this important project because it is extremely effective in bringing about changes. We have been documenting some of these changes through follow up with parents to find out which information has been shared at home. We have seen that information definitely has been transmitted to the home, and that children themselves are practicing better behaviors in hygiene, even after only a short pilot unit. Some of the key lessons learned from this project include the following:

1. Formative research is critical to acceptance and to success in bringing about behavioral change. This research must focus on the lifestyles of the children and include children as informants.

2. While the general educational units must use vocabulary and life experiences generic to the whole country, specific units can be regionalized to be broadcast in a limited area.

3. Getting the teachers involved and cooperating in the lessons has been one of the biggest challenges. While they are enthusiastic about the radio as a teaching aid, many either perceive their role as totally passive, or conversely, they feel threatened that they are being replaced. Since their participation is crucial, teachers need an adequate orientation to the purpose of the program and their role in it.

4. Teachers who are familiar with the abilities, lifestyle, and sophistication level of the target children need to be involved in curriculum development and lesson writing. In our enthusiasm as health educators and script writers, we found it was all to easy to overload the lessons with too many concepts.

USING AFRICAN ORAL TRADITION TO BRIDGE THE CREATIVE GAP

Claudia Fishman

INTRODUCTION

The Nutrition Communication Project and its Primary Goal

The Nutrition Communication Project, a program of the United States Agency for International Development, Office of Nutrition, managed by the Academy for Educational Development, has been active in Burkina Faso, Mali, and Niger since 1988. In Niger, the Nutrition Communication Project has completed a successful pilot project and is awaiting promised funds for expansion, while in Mali and Burkina Faso, we are implementing scaled-up activities involving the collaboration of the government health and education ministries, private voluntary agencies (e.g., CARE, Helen Keller International), and UNICEF.

In Burkina Faso and Mali, the USAID field Mission considers the Nutrition Communication Project to be USAID's primary bilateral activity in nutrition, complementing programs funded by other bilateral agencies, FAO, UNICEF, and the World Bank. Stated very practically, the Nutrition Communication Project shares the USAID Mission's goal of measurably reducing malnutrition rates for children under five years of age in areas where the program is active. We hope to do this by using communication in any form (individual, group, mass) to affect family and community centered, nutrition-related behaviors.

Research to Creative Strategy--The Grand Canyon

The Nutrition Communication Project uses a strategic approach to communication derived from social marketing[1]. A combination of in-depth and survey research tools are used to develop and test messages which form the basis for group training and interpersonal or mass communication campaigns. There is a growing literature on how to do *focus groups*[2] or *Knowledge, Attitude, and Practice (KAP)* surveys, and reports from such endeavors are available from most programs, including our own. The research phases generally go smoothly: data is collected, transcribed, and analyzed. At this stage, many programs "overcook" their data, boiling down their rich findings to the bare bones of a "communication strategy."

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[1] See Debus & Gould, Verzosa and Griffiths papers, this volume, for more examples of social marketing.

[2] For example, see M. Debus, *Handbook for Excellence in Focus Group Research*, HEALTHCOM, Academy for Educational Development, 1990.

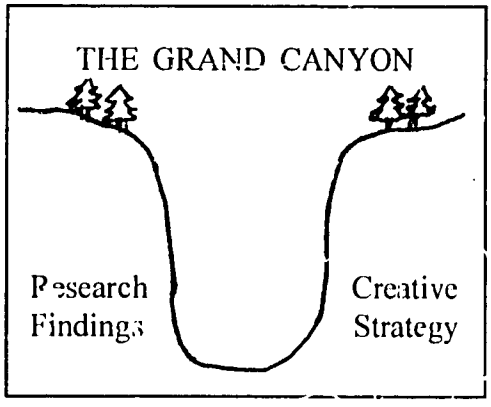
The example below is a piece resulting from one of our early "strategy development exercises":

Target Group	Objective	Specific Behavior	Message Theme	Media
Pregnant Women	Increase consumption of fruits & vegetables	Snack on carrots or fruits in the market place	Give in to your cravings, it is the baby inside who needs these foods	Health worker cards Market game/posters
Men	Increase financial involvement in food purchased for women & children	Buy liver for pregnant wife and young kids	A small investment in the future	Men's group hand-outs Radio Market place materials

The result of the typical strategy development workshop is a plan with target audiences, action objectives, themes, and media. It is usually after all the contributing health and nutrition experts have left the room that the project management team faces the impossible task of translating a frankly boring document into an exciting communication program.

Strategy development workshop

This moment is what we have learned to call the "Creative Gap," and in this case, it really is a Grand Canyon.



In thinking about how to get across the Grand Canyon, our first inclination might be to use an airplane or helicopter--but, if we want to avoid crashing and burning, the most appropriate means is probably a burro and a local guide.

Local guides and burros represent a **process for finding a solution to a problem that is appropriate to the context**. In this paper, we will discuss our experience using "story telling and drama," two forms of expression that are integral parts of many African societies, not only as end communication media, but as a means for finding solutions--i.e., as part of the strategic process.

Amateur role playing

We believe that strategy development itself is not only more fun, but actually more effective, when (1) amateur role playing (for example, by health workers) or expert acting is part of research planning and interpretation, and (2) dramatic interpretation is part of message pretesting. Finally, in our west African experience, we find (3) creation of a "dramatic story line" to be the most logical means of tying a communication campaign together. Effective creative interpretation requires a different approach to formative research, which if given weight equal to "nutrition data collection," will enable program managers to avoid the Grand Canyon in the first place.

DISCUSSION

Dramatic Interpretation in Research

Research Planning

Communication programs that aim to affect human behavior cannot be developed without really looking and listening to the people who are the intended audience for the campaign. "Brainstorming sessions" with field personnel (not headquarters staff) are a good first step to identifying potential target audiences and where each audience is "blocked" in terms of adopting the behavior under consideration.[3] What we have found is that rather than the American version of "brainstorming" where everyone suggests ideas verbally, community based field staff contribute valuable insights more readily through role playing.

In the strategy example above, in order for women to eat more fruits and vegetables during pregnancy, most people will first need to see "not doing so" as a problem that requires a solution. Some, but not all, women will need physical obstacles removed, such as having more money or access to garden produce. Others might be constrained by a lack of appropriate skills and confidence to accept a new behavior. Men might be chiefly "blocked" by a lack of appropriate concern about the issue.

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[3] Participative training leader, Lyra Srinivasan, describes a "resistance to change continuum" which can be described as 1) total lack of awareness of the problem; 2) lack of concern: 3) concern but lack of knowledge of what to do; 4) know what to do but not empowered to take first step; 5) take first step but not ready to continue; 6) adopt behavior and ready to convince others. See L. Srinivasan, Tools for Community Participation, PROWESS/UNDP, 1990.

These preliminary behavioral issues could be collected during a rapid ethnographic phase of research--this was our first step in both the Mali and Burkina Faso programs. But information from these and comparable studies currently exists to suggest the potential "blocking behaviors," that future efforts might be able to start from this point of departure.[4] Community based field staff could then be asked to "role play" scenes in which they have observed or could imagine how the behavior would be played out in a family or community context. Characters and situations emerging from the scenes can then be explored, using rapid qualitative research, for validity in the community. The goal of this "pre-research" role-playing is not to eliminate in-depth research, but to focus it on real behavioral issues and more tightly defined target audiences.

Selecting the correct target audience or audience to achieve objectives is rarely a simple decision and many programs tend to overgeneralize. Consider the following examples for a program designed to improve weaning practices:

Typical General Target Audience	More Defined Target Audience
Women of Procreational Age	First-time mothers (15-20) who come to health post and seem willing to try advice
	Experienced mothers who have had at least two children die in the past five years following bouts of illness, particularly diarrhea
	Periurban women (20-35) who have tried one new weaning product but stopped due to price constraints.
Fathers	First-time fathers who obey everything their elder brother or father tells them to do--seeking approval of the older generation and hoping to eventually be seen as a "chef de famille"
	Confident "chefs de famille" who are consulted for their wisdom and experience. Have lost several children (from multiple wives) due to illness and complications related to malnutrition

[4] The Nutrition Communication Project and the Weaning Project are two resources, as is the nutritional anthropological literature.

A very popular, and highly recommended, form of qualitative research is focus group interviews. In defining groups to be interviewed, smaller groups of persons sharing a few behavioral characteristics (such as those illustrated above) will provide much more meaningful information than larger groups with people merely sharing demographic characteristics. Again, defining characteristics can emerge from brainstorming or role playing sessions with field based staff.

Sample illustrations from flipchart developed in Burkina Faso

Research Interpretation

Two important tools guide translation of research findings into creative strategy development. The first is an analytical "Creative Brief" which summarizes key research findings related to the specific behaviors to be addressed by the communications campaign. The other is actual tapes or transcripts from in-depth or focus group interviews.

Compare the two forms of information below:

Burkina Faso Creative Brief
Data from KAP survey (n=640)

To the extent that malnutrition is recognized, it is perceived to be an illness that a child gets from drinking breastmilk that has gone bad/is no longer nourishing because his mother has become pregnant too soon.

Women were asked about the correct age to begin introducing other foods to the child: 10% said before four months, 48% said between 4-6 months and 43% said after 6 months.

Older women are more in favor of delaying the introduction of complementary foods until 6 - 7 months, while young women, who have been talking to health workers or doctors, who advocate earlier introduction of foods 2-4 months.

Nutrition Communication Project Creative Brief, 1992.

Niger In-depth interview on weaning

Balira: I want to forbid her the breast, Nana, she's old enough?

Nana: How old is she?

Balira: One year and 10 months.

Nana: Why do you want to take her off the breast now?

Balira: This nursing that she does, she grabs the breast to drink; she grabs the breast to drink. You know now I don't have any breast milk, I have less milk than I used to.

Nana: Have you been sick?

Balira: I'm fine!

Nana: Is she well?

Balira: There is nothing wrong with her. She eats everything. You see just now she drank *fura* and she ate *tuwo*.

Nana: Does it seem to you as though she is tired of breast feeding?

Balira: No, she isn't tired of breastfeeding, that's the problem. I feel pity for her because she wants the breast. At the same time, her sucking wears me out; she wants to nurse all the time. You know, I feel I shouldn't take her off the breast because I'm afraid she'll get skinny.

Nana: I'm afraid of that too because you don't have all different kinds of food in your house.

Balira: We don't. We just have fura. That's why I'm afraid to take her off the breast - because we don't have different kinds of foods that I could giver her to make her grow big. Get skinny is what she will do....

Nancy Keith, *Young Child Feeding, Weaning and Diarrheal Illness. Part I: Ethnographic Study PRITECH, 1991*

While summarized "findings" from the research help focus our program objectives, they do little to get creative juices flowing. We find that it is best to let the program managers devise more focused program objectives from the research findings, but bring in a creative team comprised of amateur or professional actors to develop the creative approach based on the richer, qualitative findings.

In essence, each person in the group reviews the written objectives, stated as specifically as possible, and listens to the tapes or reads verbatim transcripts from focus groups. We have found in our programs that actually listening to the tapes results in a more effective creative process. What emerges from this interpretive activity is more than just a sterile concept or a number, but real people who tell us something about their lives.

Creative and program management teams can usually develop a number of little dialogues or scenes which still need further refinement before final creative products emerge for pretesting. In Burkina Faso, NCP was fortunate in having the early collaboration of the Atelier Theatre Burkinabe (ATB), the country's preeminent Forum Theatre Troupe, which has broken ground in using forum theatre as a tool of development.[5] The ATB became a key partner for the Ministry of Health, acting and eventually scripting a play that emphasized the primary themes uncovered by the focus group research. We are continuing to work with a University theatre group and its director in development of a radio program. In Mali we have worked with a University-based Theatre group.

Dramatic Interpretation in Pretesting

"On a scale of one to five, how likely are you to buy your pregnant wife a brochette of liver, Mr. rural villager? Now, if I show you this poster, does your opinion change?"

This is obviously a spurious example, but much pretesting of concepts and materials results in little more than "half of the target audience said they were likely or very likely to perform the intended behavior" and "over 80 percent said they 'understood the message' and 'liked the poster' (but you have to tie the woman's scarf in the front/back of her head)." With results such as these, most managers feel confident that with a few cosmetic changes, their print materials are ready to go. While it seems like more fun (and thus violating the unwritten

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[5] See Joy Morrison, "On the Road with the ATB", *Development Communication Reports*, 1991.

law of research that it cannot be entertaining), our dramatic and participative approach to pretesting probably results in a greater proportion of material being "sent back to the drawing board" or recording studio than traditional ranking or other quantitative exercises. (In the final stages, we have exposed materials to significant samples of the target audience, but caution that in our experience, most rural, nonliterate people are most comfortable giving everything an average grade (i.e., a "3" on a scale of "1 to 5").

In Niger, we trained local "village animation teams" to perform skits incorporating the key messages of our communication strategy--as this was a tiny pilot project, we used this as our final communication method as well. In Burkina Faso where we eventually had to reach eight provinces and approximately one million people, the ATB developed a full-length play which was captured on slides and pretested by having government health workers provide the "voice-over" for the characters.

It is difficult for many people, including rural villagers, to express their opinions on theoretical or abstract ideas on subjects they are not particularly concerned about, such as maternal and child nutrition. However, by acting out a "real life situation," we have found people to be outspoken about 1) how they disagree or agree with what the characters did in the situation, and 2) what they would say or do in the character's place.

For example, in our original story line for Burkina Faso, we have a tale of two families.

What we found out in our initial pretesting was that the protagonist in our story was "too good to be true" or that a "real man"--a man in their community--would never share much of his own food with the rest of his family, but would shell out pocket money or buy things and bring them home. They also suggested that only someone "who was really from the bush" (their words) would behave as badly as our antagonist. They were happy to act out what should be done and said instead. In response to the village level response, new slides were shot and the play was adjusted to make it as convincing and life-like as possible.

Dramatic Interpretation as Media

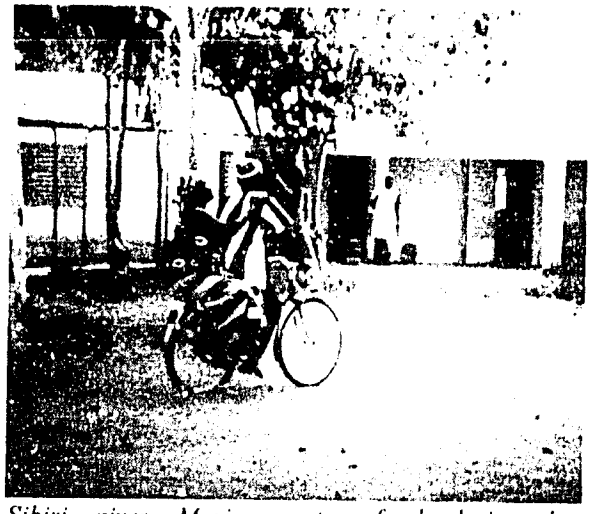
Once we have a strong story line, we use it to tie together the elements (tactics) of our communication strategy, including community mobilization, actual drama, radio, and print media.

In Niger, we worked with community mobilizers, agricultural agents, teachers, and health workers to train village animation committees. The agents explain the role play ideas to an assembled village who then take on various parts. One very effective skit was performed by village men playing the roles of wives trying to convince their husbands of their nutritional needs during pregnancy.

Another story depicted men deciding it was profitable to plant green vegetables off-season so that everyone could eat and sell them. In another role play (illustrated below), a man represented the "typical" health worker at his post while other men acted as women waiting to see the health worker. The men found these representations of what women encounter performed by other men in the community to be very moving. Cross-gender role playing is not always done, but in this part of Niger, where the social ideal is to cloister women, it was both socially necessary and particularly effective. As this was a small scale effort, our "communication interventions" consisted of the dramatic guidelines, training the corps of village animation directors, and training of the village animation committees who performed the local events. In the evaluation of the project, we found that villagers did initiate gardening activities and purchased more liver for women and children, which were the behavioral foci of the campaign.

However, the labor-intensive method was considered better suited to small scale projects, such as those managed by private voluntary organizations, and not the Ministry of Health.

In a scaled-up activity in Burkina Faso, the Atelier Theatre Burkinabe created four characters who would become the "Deux Familles Burkinabe": Sibiri and his wife, Mariam--who generally follow health center advice--and Bouriema, who is a selfish and uncaring man, and his mistreated wife, Téné.



Sibiri gives Mariam extra food during her pregnancy, and provides a lift on his bicycle when she goes to deliver her baby.

Téné works too hard during her pregnancy and does not eat anything but plain to.

Mariam gives birth to a healthy baby while Téné's children are just steps away from dying from illness and malnutrition. Sibiri listens to the good advice from the village elders, who eventually also manage to convince Téné's husband to improve his attitude and support his wife. Ultimately, all of the characters are "on the road to health."

The Nutrition Communication Program has adapted this story line for several media. The original slide show, accompanied by a dramatic voice-over, is now used to train community health and agricultural agents in the key themes that the MOH want to emphasize in maternal and child health and nutrition.

The series was also transformed into two printed flipcharts for use in community centers and by outreach workers. Production time for the bi-color flipcharts was cut to a fraction by having artists draw directly from the projected slides. Community workers use the flipcharts to tell stories about the "Two Families" themselves. Again, villagers are encouraged to participate in a story and respond with what they would say in the place of the characters.

Flipchart covers from Burkina Faso

A central motif of the story line is man's involvement in the health of his wife (wives) and children. A health center poste · recreating a pivotal scene asks: "Sibiri, what do you do to make sure your family is so healthy?" The poster is designed so that even non-literate people can see that Sibiri is doing something extra for his family.

The original script, which was dense in terms of numbers of behaviors it contained, was broken into 16 single-issue dramatic episodes for radio broadcast. The drama will be broadcast once weekly in the two principal national languages. Prior to broadcasting, health workers in government health centers were trained in the interpersonal counseling techniques that are modeled by the health worker appearing in the radio program. Finally, a sticker book with nine key prenatal and infant feeding practices will be distributed by health centers to motivate mothers to demonstrate the various behaviors being promoted.

SUMMARY

African societies have been communicating important social lessons for generations through proverbs, anecdotes, stories, songs, and dance. Health communication strategies will be more sensitive to how the people incorporate new information into their lives if narratives play a pivotal role in strategy development.

The whole really is greater than the sum of the parts: from what we have learned from our experiences to date, an African approach is to create the whole first. In other words, develop the dramatic story line, rather than a series of messages, first. In this manner, "messages" almost literally "fall out of the characters' mouths" rather than being scratched out of an arid research report.

While outside consultants, such as ourselves, may be able to help local management teams strategize, African creative experts need to be involved from the beginning. These experts will prevent wasted research efforts that just collect data on people's "nutrition-related knowledge, attitudes, and practices" and help us find out something about their lives, wants, and needs. Community based agents also have many excellent ideas and can be incredibly creative with improvising skits based on their experiences in the field.

Planning for creativity from the beginning, and involving local creative talent before the research is implemented, will ensure that we never end up at the top of the Grand Canyon again searching for some "high tech" way to get across.

USING RADIO FOR COMMUNITY MOBILIZATION EXPERIENCES IN ZIMBABWE AND KENYA

Nancy George

> ...in dealing with communication problems...There are no permanent formulas... the resonance principle suggests that the starting point for understanding and creating communication *lies in examining the communication environment you are living in at this moment*...(emphasis added) (Schwartz, 1974: pp. 160-161)

INTRODUCTION

The subject of this conference, reflected in its title, **"Communication Strategies to Support Infant and Young Child Nutrition,"** is built on an important assumption: the assumption that there is a variety of communication strategies, some more valuable than others, which can be employed to transfer information from the "experts" to those who need that information in order to feed their children adequately and/or better.

That a conference with this focus is being mounted under the aegis of nutrition educators and nutritionists rather than communicators is evidence of a shift in thinking by the education and development communities. Until recently, those involved in development communication and development support communication tended to be derided as technocrats or, even worse, simply ignored: those actively involved in development considered the content of their messages more important than the means of delivering them, believing--incorrectly--that if one can generate useful subject-related information, those who can benefit from it will use it. That belief could be supported *only if those who can benefit from the information are aware of its existence.*

Until recently, development researchers and practitioners have considered the ingredients which constitute communication strategies or processes as addenda to the development content, whether it be related to water and sanitation practices, improved farming practices, primary health care, or infant and young child nutrition. For those familiar with the cultural milieu of North America or Western Europe, communication of development information appears simple because of the ubiquity and pervasiveness of the preeminent mass media--print, radio, and television.

Approaching the communication process from the perspective of communication researchers, however, makes the apparently simple considerably more complex. The perception of the value of the mass media in the development process has changed markedly with the evolution of radically different development paradigms. In the late 1950s and early 1960s, the

early media advocates, who optimistically--or arrogantly, according to scholars like Melkote (1991)-- believed that development and modernization were synonymous, claimed that the mass media were dominant and powerful influences on their audiences, and, therefore, could be effectively employed to deliver development information to passive audiences who would be stimulated to implement positive developmental actions and/or changes in community behavior patterned on modern western societies (e.g. Berlo, 1960; Lerner, 1958; Schramm, 1964).

The technocrats' optimism about the power of the media to make development easy was constructed on an assumption related to the mode of delivery: because the media *can* deliver information, audiences *want* to receive it. Because the signals of the big, urban-centered media could reach large audiences, they could be used to diffuse innovations and development information easily and effectively to passive (and, it was assumed, receptive) audiences, who, the advocates believed, would readily absorb what the media delivered.

Melkote (1991) sums up the perceptions of the power of the mass media in the world of development in the 1950s and 1960s as follows:

> The mass media were thought to have a powerful, uniform and direct influence on individuals... The strength of the mass media lay in their one-way, top-down and simultaneous and wide dissemination. And since the elites in every nation were required to modernize others in the population, the control of the prestigious mass media by them served their economic and political interests... [The mass media] were considered as *magic multipliers* of development benefits in Third World nations. Administrators, researchers, and field workers sincerely believed in the great power of the mass media as harbingers of modernizing influences... (p. 87) (emphasis added in the original).

In the past 20 years, however, these theories have changed dramatically. By the 1970s, there were major shifts in the traditional communication, education, and development paradigms. In the development field, there was a general denigration of the assumptions underpinning the dominant development paradigm and the advancement of a "self-development" paradigm. Development was no longer assumed to be a "packaged" commodity which could be delivered to passive recipients. As early as 1971, Havelock (1971) broached the concept of a problem-solving model for community development, focusing on communities' diagnosis of their problems and identification of potential solutions to them. Similarly, the "experts" began saying that for communication to be effective, it had to be two-way, not top-down, and lateral as well as vertical.

These theories of development and communication are, indeed, congruent with the shifts in educational theory of the 1970s. If one accepts that development is basically and primarily an *educational* process, and that communication is an integral component of both education and development, the complementary shift in the paradigms of all three fields was predictable. The communication strategy selected is the significant ingredient in the teaching/learning experience which can facilitate or obstruct the learning experience. And just as educators, through the

increasing ascendancy of Jean Piaget's (1935) ideas in the 1960s and early 1970s (see, for example, Duckworth, 1964; Barth, 1972, Kamii, 1974) and Paulo Friere's (1970) adult learning philosophy, became increasingly aware of the value of the learners' active involvement in the learning process (no matter what their age), so development agents and communicators have become increasingly aware of the imperative of community participation in the development process.

The evolution in thinking about the nature of communication within the development process is the necessary underpinning for the discussion contained in this paper.

DISCUSSION

Appropriate Media and Community Development

Current development philosophy argues that any attempts at development must begin with those who need the "development," rather than with the elites or outsiders who define a community's problems in a contextual vacuum. Media, within the concept of self-development, need to be both appropriate and relevant. Interestingly, not all of the useful examples of appropriate media deployment in the self-development paradigm originated in the Third World. Indeed, both of the examples cited here have come from Canada: an industrial country where the vastness of the land and its comparatively small population have continually challenged communication strategies for reaching the more isolated communities within its borders.

The Radio Farm Forum model, which was widely proliferated in Africa, India, and Latin America during the 1970s, was patterned after an extremely popular and long-lived Canadian radio series which began in the early 1950s, entitled *Farm Forum*. Targeted to isolated Canadian farming communities, the series was broadcast across the country each week on the national Canadian Broadcasting Corporation (CBC) network. The *Farm Forum* format encouraged the members of isolated farming communities, some originally with little access to radio, to gather at one farmer's house each week to listen to the program, and then, following the broadcast, to discuss the program content and any other related farming issues with their neighbors. Listeners were encouraged to write in to the program with questions, problems, and ideas stimulated by the broadcast, and these listeners' contributions formed part of subsequent programs. In many cases, especially in the later years of the series, the farmers' groups who had contacted the program producers with ideas or suggestions were called during the broadcast to make their contributions to their peers across the country.

In the late 1960s and early 1970s the National Film Board (NFB) of Canada, whose mandate was "...to provoke social change through the use of video and film" (Burnett, 1991: 54), developed a series called *Challenge for Change*. The most famous of the CFC series was produced in the community of Fogo Island, Newfoundland.

> As the producer Colin Low said at the time, he wanted to recount the history of the people living there in their own words. He felt that what they had to say was more important than what he could put together as an outsider... he interviewed them... and he did his best to put the people at ease. He never shot without permission, and he gave the interviewees the chance to view the footage and remove whatever disturbed them...[He used an] interactive approach [which] created more and more discursive spaces in which the local people could not only examine what the filmmakers were doing but also question their own orientation and direction. It is generally agreed that Fogo Island changed after the work of Low and his partners (Burnett, 1991: 55).

Initially, the camera crew had come to Fogo Island to document the decline of the community in face of the loss of their fishing industry. However, confronted with a community whose members were reluctant to express themselves on camera before a "professional" crew, the producer persuaded the residents to use the video camera and recorder to document their lives and problems themselves. Stimulated by viewing the videotape document which resulted, the community collectively decided on a plan of action to rebuild their village and obtained assistance from the government to do so. So successful was the outcome of this experience on Fogo Island, that its replication in other communities has become known as "the Fogo process" (Schramm, 1977).

Although small format video, building on the lessons from the Fogo Island demonstration of its usefulness for communities to document their own problems, has recently become an extremely useful community development tool (Thede and Ambrosi, 1991), video is more expensive and far less pervasive than radio in Eastern and Southern Africa; therefore, this paper will confine itself to discussion of two ongoing social mobilization[1] projects which are attempting to democratize selected programming aired on the nationally-broadcast radio networks in Kenya and Zimbabwe to increase that medium's contribution to community development.

Since the advent of the transistor, radio has become a familiar medium in even the most remote African village. And placing the radio cassette recorder within easy reach of rural villagers can produce results not unlike the synergistic experience of the Fogo Islanders.

During the 1970s, under the aegis of international nongovernmental organizations (NGOs) and community development groups, a number of donors (most notably, the Canadian International Development Agency and the Friedrich Ebert Foundation) funded experiments in the adaptation of the Radio *Farm Forum* model in a variety of developing countries in Africa, India, and Latin America. However, without exception, these experiments died out with the

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[1] Social mobilization is a term used extensively be UNICEF to describe its programs targeted to communities to generate and sustain selected patterns of action deemed to be beneficial in major development sectors: health, population, and nutrition. Some of the best discussions published to date about the challenges involved in social mobilization programs are contained in McKee (1992), *Social Mobilization and Social Marketing in Developing Communities.*

demise of donor funding; by the early 1980s, almost all of them had ceased to function. The question that naturally arises is, "If they were so successful, why didn't they continue?"

Although much of the data concerning these experiments is locked away in donors' archives (and, therefore, inaccessible), there is some documentation available on these projects. Frequently, those who advised on the replication of the *Farm Forum* model advocated the establishment of evaluation strategies; however, few of them were actually systematically evaluated (Bryam and Kidd, 1983). One possible reason for the demise of the Radio Farm Forum experiments is the lack of research and evaluation to demonstrate that they *actually made a positive difference* in the lives of the group members or their communities. Therefore, while available literature on the use of the *Farm Forum* model (or radio learning groups) explains how to set them up (see, for example, Crowley, Etherington and Kidd, 1978), there are few analyses of the long-term benefits of this model in community development.

Certainly, in Africa, the adoption of radio as the most appropriate medium for the dissemination of development information to communities was predictable in the context of the old development and communication paradigms. It is the most pervasive of the mass media in Africa, the most easily accessible (especially for communities without electrification), the most affordable and, in most cases, has the most well-developed infrastructure. However, the old paradigm of "top down" development has been discarded in face of its inutility. Therefore, today the challenge is to determine whether the radio medium, with its ready availability and popularity, can be transformed into an appropriate tool for community-initiated development activity: can it be democratized and used by African communities to assist them in their self-development?

Over the past three years, the International Development Research Centre (IDRC) has been supporting investigations of this question in Kenya and Zimbabwe in two separate but interrelated research activities[2].

The Development through Radio (DTR) Project in Zimbabwe

Since 1985, the Federation of African Media Women of Zimbabwe (FAMWZ), with funding from UNESCO and the Friedrich Ebert Foundation and the partnership of the Zimbabwe Broadcasting Corporation's Educational station, ZBC Radio 4, has established a total of 45 radio listening clubs in four provinces of the country. The project, called "Development through Radio," is targeted to women in the rural areas of Zimbabwe, who, in many cases, have been left to manage the household and farm because the men of the family have migrated to urban areas to find work.

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[2] IDRC funds action research in a variety of development fields--health, environment and natural resources, information and communication, and the social sciences. The Centre funds research on development problems which Third World researchers themselves consider to be pressing national needs. Therefore, the concept of participatory problem-solving (i.e., the self-development paradigm) is a familiar one.

The DTR model has evolved from the Radio Farm Forum concept. The Radio Listening Clubs, originally formed from local branches of the Zimbabwean Association of Women's Clubs, have memberships ranging from 10 to 20 women who gather together once a week to use the radio cassette recorder provided through the project to listen to a DTR radio broadcast in their local vernacular language and to discuss and comment on the broadcast. Additionally-- and, perhaps, most importantly--the DTR members raise issues from their discussions to be addressed in future DTR programs. Thus, although the programs are compiled and produced in an urban setting--the Harare studios of ZBC Radio 4--they avoid the inherent danger of becoming mass programming with a top-down and urban-oriented focus by making the women's groups essentially the program's producers.

The DTR Project Leader has described the operation of the Radio Listening Clubs as follows:

> The Radio Listening Clubs meet weekly to discuss their most pressing problems and other issues of interest in the community; their deliberations are recorded and the tapes taken to collection points where the Coordinator/Producer... collects them. Back at the station, the Coordinator/Producer listens to the recordings and arranges with appropriate experts, Ministries and non-governmental organizations (NGOs) to record their responses to the problems and issues discussed by the clubs. Such responses may consist of information the communities need to solve their problems themselves, or of actions to be taken by ...experts, Ministries or NGOs in response to the problems or issues. The Coordinator/Producer then packages the RLC inputs and his own recordings to produce a half hour program which is aired every week in ...[Ndebele and Shona]. After listening to the program, the RLC members respond to it and record their discussion for use in follow-up programs. (Moyo, 1991: 19)

For many of the RLCs, the result of the participation in the DTR project has been more than passive acceptance of mediated messages. A typical example of the potential role of the Radio Listening Clubs in village and/or community development has been documented in the Mhondoro District of Zimbabwe (Moyo, 1991: pp. 19-20). As part of one of their post-program audiocassette recordings, the Changachirere RLC in Chivero documented the fact that they were suffering a shortage of clean water because of a lack of wells in the district. The community had complained to its Member of Parliament and District Administrator, but had received no response to its complaints.

The Changachirere RLC organized and audiotaped a discussion of the water problem. With the assistance of the DTR Coordinator/Producer and other members of the community, they collected water samples from the riverbed -the sole source of water for the community-- and sent them to Harare for analysis at the Government laboratory, where the water was discovered to be contaminated and in urgent need of treatment. The laboratory report was communicated to the community through the weekly RLC broadcast, in a program which presented the situation (as recorded by the RLC group members) and taped responses obtained

by the Coordinator/Producer from the District Council Chairman, the Zimbabwe Red Cross Society (who offered to help the community if they formed local Red Cross chapters), the Ministry of Energy and Water Resources, the local health inspector and the District Administrator.

Since the initial programs discussing the problem, the Zimbabwe Red Cross, World Vision International, and the Catholic Development Commission have assisted the communities to develop wells in the district.

Although not originally involved in the DTR project, in 1991, the Communications Division of IDRC agreed to support the evaluation of the DTR pilot experiment. FAMWZ has received many enquiries from other Women's Clubs in Zimbabwe requesting that they be allowed to join the project. However, FAMWZ felt that any expansion should be preceded by an evaluation of the project as it has operated thus far. In keeping with the participatory nature of the RLCs, FAMWZ wanted to conduct a participatory evaluation, encouraging the existing RLCs to design and administer the evaluation themselves to determine whether the RLC concept should be expanded, and if so, what improvements need to be made in the project's structure and administration. Preliminary results have identified several operational difficulties with the project; nevertheless, they show an enthusiastic affirmation of the concept of the Radio Listening Clubs as contributing positively to mobilization of the community around its particular development needs. FAMWZ is currently compiling the findings of this evaluation for incorporation into a larger community-based development scheme in Zimbabwe, and possible replication of the DTR model in other countries in Southern Africa[3].

The Establishment of Radio Listening Groups (RLGs) in Kenya

Whereas the Communications Division of IDRC did not become involved with the DTR experiment until the evaluation stage, it has funded and encouraged the evolution and development of the Kenyan experiment from the outset.

In 1989, Ms. Mary Ngechu, the radio lecturer from the University of Nairobi's College of Education and External Studies (CEES), approached IDRC with the idea of developing radio programs which would disseminate the results of agricultural research to smallholder farmers in Kenya, who, for the most part, she believed, were excluded from service within the traditional extension system.

Her initial proposal was built on a number of assumptions: (1) that the old "dominant paradigm" of top down information dissemination would effect the transfer of information in the rural Kenyan context; (2) that radio sets were widely available, in serviceable condition and

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[3] Women's NGOs in the neighboring countries of Malawi, Zambia and Lesotho have been asking FAMWZ to assist them in replicating the DTR model in their countries.

accessible to her espoused target audience, the smallholder farmer; and (3) that development information delivered by radio would be accepted and acted upon by that audience.

In face of the need to explore the validity of all these assumptions, and, in addition, to obtain a clear definition of the composition and demographics of her proposed target audience, the Centre and Ngechu agreed that prior to the funding of a major research experiment in the usefulness of radio in delivering development information, she should undertake a feasibility study to ensure the accuracy of some of her assumptions and to discover answers to some of the questions inherent in the project design.

The results of this feasibility study were illuminating (Ngechu, 1991). The study indicated that radio was the most widely-used information resource in the areas of rural Kenya she studied, and therefore, held promise as a channel for the delivery of development information. Moreover, because the radio was their primary information resource, households put a priority on the purchase of batteries to keep their radios operational.

When asked how they currently obtained advice on agricultural questions, all respondents, male and female, stated that their most frequently-used information resource was advice from their neighbors. Indeed, of the 216 interviewees in the sample, none had ever had an extensionist visit his/her farm!

Interviewees, both men and women, indicated that they would listen to programs which would give them advice and information on agricultural practices, if such information were broadcast, which they did not perceive it to be at present. However, they also stated that their preferred way of listening to such programming, if given the opportunity, would be *as participants in radio listening groups which included an extension advisor*. They believed it important to have a means of "talking back" to their radios, either by being able to ask a local resource to answer any questions they might have, or to communicate directly with the program producers.

One important learning from this study, beyond the interviewees' enthusiasm for two-way communication with the radio medium, was the fact that females in the households studied had far less access to, and little, if any, control of the radio medium (Ngechu, 1992). Because women constitute by far the greatest percentage of the practicing smallholder farmers in Kenya (more than 70 percent, according to Ngechu's research), and since they are effectively excluded from obtaining information from the male-dominated extension system by the cultural practices of the tribal system[4], women's current problem of access to information resources is acute.

On the strength of the information gathered in this feasibility study, the IDRC has now funded a major pilot study of the use of radio listening groups to improve farmer adoption of

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[4] Among the Kikuyu and Embu peoples, who were the subjects of this study, male strangers cannot approach women in a household directly. They must address the women through the males of the household.

development information. The initial intention was to provide exclusively *agricultural* information; however, by moving the decision making on content to be addressed in the programs out of the producer's hands to the farmers themselves, the subject matter to be addressed in the programs must not be so constrained. If, for example, a radio listening group determines that its most pressing problem concerns the community's access to health care, then the programming must adapt itself to the listeners' expressed needs.

The intent in this experiment is to determine whether the radio medium can be democratized in Kenya in the same way and to the same extent that it has been in Zimbabwe through the DTR project. The method for attempting this democratization is to turn the old dominant communication paradigm (Source - Medium - Receiver) of the 1950s and 1960s "on its head" to create a *dialogue* between the radio audience and the program producers through feedback from the listeners in the RLGs, to see whether such a dialogue can increase smallholder farmers' adoption of development information.

Another important component in the design of this project is its evaluation strategy. Prior to the production of the programs to be broadcast, the initial radio listening groups formed as part of the project will decide what kind of format they prefer for the programs. Three sample programs with different presentation modes (for example, "magazine" segments, drama and songs, formal instruction) will be produced for the groups' evaluation. The remainder of the programs will be produced according to the groups' selection of preferred presentation style. When the programs begin to be produced for broadcast, the RLGs will evaluate the content of each program aired in the series, and suggest future programming subjects.

Since the DTR project in Zimbabwe has been operational for more than five years, it will be able to offer important advice to the newly developed RLGs project in Kenya. IDRC is ensuring that the two projects develop a close information exchange, so that each can build on the other's lessons by having the two project leaders each visit the other's project.

These two experiments represent a careful attempt to transform a mass medium into an "alternative" medium: a community-driven information resource. The development, implementation, and participants' evaluation of the Kenyan experiment will be carefully documented, so that there will be a chronicle of the Radio Farm Forum model for the future. In this case, there will be important records of the usefulness, or lack thereof, of radio listening groups as a development tool.

SUMMARY

What is the relevance of these two experiments for reaching women in grassroots communities with information about infant and young child nutrition?

The Radio Listening Group model--both as it has been structured in Zimbabwe and as it is being structured in Kenya--holds promise of being able to increase women's interest in and use of nutrition-related information in the selection and preparation of food for their families.

In most cultures in the African continent, women are solely responsible for providing food for their children. They are the farmers and the cooks, and they determine how to manage the household inputs to meet their children's nutrition requirements. If one can motivate the women of Africa to discover the role of nutrition-related information in the health of their children, and if the women can then participate in a dialogue with nutrition experts through the radio medium, one can anticipate that infant and child health will be sustainably improved. Mothers must be the target of such an information campaign.

The DTR project in Zimbabwe is targeted exclusively to rural women. The evaluation of the DTR project has provided evidence that women are willing and able--sometimes in face of extreme difficulties[5]--to invest time and effort in a radio-focused development activity, and that they believe the effort is worth the return on their investment.[6] Since reaching and creating a dialogue with women would be a primary aim of any communication strategy attempting to improve infant and young child feeding, it is important to know that it *can* be done effectively and over a considerable period of time.

Approximately one-half of the groups in the Radio Listening Groups (Kenya) model will be composed exclusively of women, although the project will encourage the constitution of mixed and all-male listening groups for comparative purposes. It is anticipated that the women's groups will request information on nutrition-related subjects, since the women are ultimately responsible for their children's health and feeding. However, it must be realized that, since the groups are effectively the executive producers of the programming foci, the program content can only be an educated guess at this juncture.

The potential applicability of these experiments, however, relate to their *participatory* focus:

> ... Too much emphasis has been placed on informational value to individuals and very little importance given to the organizational value of communication for communities. There is much more benefit in treating a community as the unit of manipulation rather than individuals since many innovations are beyond the resources of individuals (Hornik, 1988 quoted in Melkote, 1991: 233).

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[5] The current evaluation of the DTR has revealed that some of the RLC members travel as many as fifteen kilometers to attend the weekly meeting and listen to the broadcast.

[6] When asked why they travel so far to attend the meetings, one group of women replied, "Before we had the Radio Listening Club, we had to walk long distances to get clean water. Now we have a borehole." - as reported by the FAMWZ Coordinating Committee

The "community" being created through the Farm Forum model is the listening group which has been formed to plan, contribute to, listen to, respond to, and to participate in the production of problem solving programming targeted to the groups: the RLC and RLG communities have their unique sets of priorities and values, drawn from cooperative discussions within the individual groups and, sometimes, the larger communities in which they exist, and they have evolved a method of dialogue which makes those groups the ultimate evaluators of the programs broadcast.

As Ascroft and Masilela (1989) explain, these types of projects hold the promise of genuine beneficiary participation in the development process: they fit their definition of *development support communication*, whose effect is "...[to] create a climate of mutual understanding between benefactors and beneficiaries" (1989: p. 17). The promise of democratized programming on national broadcasting systems is that the listeners cease to be passive recipients of exogenous messages: they begin to participate in and take responsibility for improvements which *they* perceive to be important in the quality of their lives.

For those concerned with improving the quality of infant and young child feeding in a Third World context, the importance of attempting to develop community-based messages based on the perception, espoused needs, and interests of the communities themselves cannot be overemphasized. The value of understanding the "cultural landscape" (George, 1991: p. 48) when undertaking development support communication is captured in the following anecdote:

> I remember in my second year of teaching in a small Eskimo fishing town... the frustrations of a newly-arrived... teacher who had the classroom next to mine. He claimed that he "couldn't get through to the Eskimos" because of "deficiencies in hearing"--and this...was the reason for his yelling, screaming and pounding the blackboard day after day. After several weeks...I told him about Eskimo eyebrows. Eskimos give sharp definition to "yes," "no" and "maybe" answers with their face and eyebrows. He had come there expecting verbal feedback. When he didn't get it, he assumed it was because of bad hearing among the Eskimos, so he raised his voice. There is a saying in that part of Alaska that white people are craziest when they first get to the village (Schwartz, 1974: p. 112).

By facilitating the audience's participation in the message selection, program design, and delivery, the RLC/RLG model encourages cultural relevance for the listeners and keen interest in the messages to be broadcast. Whether the promise of the model will hold up under the scrutiny of participatory evaluation still needs to be demonstrated, but the potential warrants support.

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PLENARY SESSION III:

STRATEGIES FOR REACHING THE COMMUNITY -- MAKING THE INTERPERSONAL CONNECTION

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MOTHER-TO-MOTHER SUPPORT GROUPS: THE PERIURBAN MODEL

Maryanne Stone-Jiménez and Irma (Mimi) de Maza

INTRODUCTION

The purpose of this presentation is to share some general ideas about the small group and interpersonal communication techniques of the La Leche League, International (LLL,I) model of mother-to-mother breastfeeding support. Also included are programmatic experiences, observations, results and lessons learned related to the adaptation and implementation of the La Leche League (LLL) model to low-income, low-literacy, periurban communities in Guatemala.

DISCUSSION

Defining the La Leche League Model

Mother-to-mother support may be defined as the giving of emotional support and technical assistance to one woman by another. Mother-to-mother support groups may be defined as informal guided discussion groups through which this emotional support and technical assistance is offered. The La Leche League, International model for mother-to-mother breastfeeding support is a formalized support system created over thirty-five years ago in the United States to fulfill a need that was once met by informal or traditional family networks. The La Leche League model is based on grass roots organizing and consciousness raising, with a focus on interpersonal and small group communication. As such, it offers an excellent model for community based breastfeeding promotion in a variety of settings.

The goal of mother-to-mother support and support groups is threefold:

- to help mothers who want to breastfeed,
- to foster good mothering through breastfeeding, and
- to give adequate information and support for breastfeeding.

Mother-to-mother support, whether in a group setting or on an individual basis, always takes place in an atmosphere of acceptance where the following characteristics are present: warmth, empathy, eye contact, verbal language, body language, active listening, praise, thanks, respect, and response. Interaction of a human, supportive, friendly, and loving nature is encouraged.

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Informal Guided Group Discussion

The informal guided group discussion format of La Leche League provides an opportunity for experienced breastfeeding mothers to share technically correct information, personal experiences, doubts, and thoughts with pregnant women and other breastfeeding mothers. It is a dialogue rather than a formal class where "experts" teach. The intended outcome is a better understanding of breastfeeding and an opportunity for a woman to reflect on her own personal situation and make her own decision about how she breastfeeds her baby. This kind of dialogue hinges on a true appreciation for and sensitivity to the level of knowledge, individual situations, personal concerns, and attitudes of women about breastfeeding issues. Accordingly, appropriate listening and counseling techniques are an essential ingredient for a successful group meeting, where agreement, curiosity, disagreement, disapproval, skepticism, impatience, and hostility are all acceptable responses.

Based on the La Leche League model, a series of specific topics are presented during small, informal support group meetings, usually scheduled on a monthly basis. The general plan for each meeting includes an introduction, during which the tone and mood of the meeting is established; an exposition of the topic or theme of the meeting (including advantages of breastfeeding for baby. mother and family, arrival of baby, possible breastfeeding problems and how to overcome them, and nutrition and weaning); a guided discussion of the topic by the La Leche League leader; and a summary.

Individual Counseling or Informal Contacts

Direct, informal mother-to-mother support is often provided on an individual basis as well. La Leche League leaders sometimes counsel or provide advice to pregnant women and new mothers by telephone, in doctor's office, at the bus stop, in the market, in their own homes, and/or in the home of the woman being counseled.

This individual contact can be very rewarding and very valuable in that it affords an opportunity for La Leche League leaders to better understand the individual situation of the woman she is helping to support.

Breastfeeding and The Periurban Mother Support Model of Guatemala

Guatemala is widely known as a "breastfeeding country." Why then are there such high rates of infant morbidity and mortality? The reasons are varied and complex, but one clear answer is that bottle feeding and the use of breastmilk substitutes has already become firmly established in many parts of the country, even in the very poor periurban communities where there is often no indoor plumbing and drinking water is brought into the community by truck. Studies have shown that although rates of prevalence of breastfeeding remain relatively high in Guatemala, actual breastfeeding practices are poor. Mothers often discard colostrum, the first milk produced, and very few women exclusively breastfeed during the first four to six months of life.

Launching the La Leche League Child Survival Project

In 1988, La Leche League of Guatemala received a three-year Child Survival Project grant with a one-year extension, supported by the United States Agency for International development (A.I.D.) and La Leche League, International. The stated goal of this project was to decrease infant morbidity (especially diarrhea) and infant mortality by fostering adequate breastfeeding practices through the formation of mother support groups for pregnant women and breastfeeding mothers in several periurban communities surrounding Guatemala City.

La Leche League had been introduced in Guatemala more than fifteen years earlier among upper middle class and middle class women, both Guatemalans and expatriates living in Guatemala. Now the question was: how do we adapt and implement this model for a periurban setting, ensuring its relevance to communities characterized by high morbidity and mortality rates, malnutrition, very limited economic resources, lack of traditional network systems, lack of knowledge of existing organizations within their communities, lack of coordination between organizations, lack of dissemination of activities, and underuse of resources? The intended target audience or beneficiaries of the Child Survival Project could be characterized as low-income, low-literate women, who very often have a low level of self esteem.

The following is a general summary of the process taken to launch the Child Survival/La Leche League Project in Guatemala. Steps included conducting a community needs assessment, adapting the La Leche League mother-to-mother breastfeeding support and support group model based on the needs assessment, and designing and implementing this new model in 17 communities surrounding Guatemala City.

Conducting a Community Needs Assessment

The steps for conducting a community assessment included the following:

- identification of the communities in which the Child Survival Project would focus;

- identification of all government and nongovernment organizations that were involved in infant feeding and/or interested and able to promote breastfeeding, especially in those communities (i.e., the professional support system);

- identification of community leaders such as traditional birth attendants, religious and political leaders, and experienced mothers who exhibited leadership skills;

- exploration of possible collaborative relationships and establishment of some level of coordination with professional organizations and community leadership;

- identification of the communities' "felt needs" or priorities through formal and informal interviews with mothers and leaders in the community (it was unlikely, however, that a community would say that health care is a felt need and much less likely that poor breastfeeding practices would be identified--the people of most periurban communities view "health" as simply not being sick, and breastfeeding as a common and natural phenomenon);

- identification of existing breastfeeding practices, knowledge, and attitudes of mothers;

- identification of hospital practices, knowledge, and attitudes of health workers who serve the targeted community;

- discussion of findings with mothers and community leaders and the establishment of agreement concerning the advantages of establishing a mother-to-mother support group program in the community.

Adapting, Designing, and Implementing the La Leche League Model

Based on the results of the needs assessment, the LLL mother-to-mother breastfeeding support and support group model was adapted. A periurban model was designed and implemented, having very distinct characteristics, but still based heavily on the LLL model. The following steps were taken as part of this process:

- *Establish the qualifications/profile for the volunteer breastfeeding advocates (breastfeeding advocates) and define their functions and role:* At the beginning of the Child Survival project, much time was dedicated to developing a profile of the breastfeeding advocate. Qualifications were established, anticipated functions were outlined, and other criteria for selection were specified. (Figure 1 summarizes the qualifications and functions of the LLL,G breastfeeding advocate as compared to LLL leaders).

- *Identify and select potential breastfeeding advocates in their respective communities:* Based on the qualifications, functions, and other established criteria, potential breastfeeding advocates were identified by LLL,G in close consultation with community leaders. Midwives, mothers that are working as volunteer health promoters, and women with natural leadership skills were primary choices. The goals of the project and breastfeeding advocate responsibilities were discussed with the candidates, and a final selection was made.

- *Train breastfeeding advocates:* Through the Child Survival Project, La Leche League, Guatemala has trained 212 breastfeeding advocates in seventeen communities surrounding Guatemala City. A twenty-hour training course for

breastfeeding advocates was established with a focus on the following areas: breastfeeding promotion, the management of breastfeeding problems, counseling techniques, and data collection. Participatory techniques are used in order to motivate participation and provide breastfeeding advocates with the interactive tools and skills needed in order to counsel effectively and play a more active, knowledgeable, and supportive role in their respective communities.

After the breastfeeding advocates complete the twenty-hour training course, they have a celebration to recognize their accomplishment. LLL,G gives them a diploma and a card that acknowledges them as LLL breastfeeding advocates. The card is often used in the communities, health centers, and clinics. to show that they have been trained in breastfeeding.

- *Form mother support groups (mother support groups) in the targeted communities:* Following the training, each breastfeeding advocate is assisted in forming their own mother-to-mother support group. These groups are often established in churches, health centers, clinics, or even in an advocate's home. Some breastfeeding advocates have formed teams in order to support each other in their volunteer work in the community. Over the last four years, forty mother support groups have been formed. (Figure 2 illustrates the growth in the number of groups held and the number of women who received support between July 1989 and December 1992).

- *Establish a health information system:* In order to keep track of the work that breastfeeding advocates do in their groups and communities for purposes of project monitoring and reporting to the funding agencies, as well as to be able to provide feedback to the breastfeeding advocates about their impact, LLL,G designed a very simple health information system containing three elements:

  (1) "Group sheets" are used in the mother support groups to keep a record of the mothers who have attended the meetings.

  (2) Attendance forms are used to note the names, ages, and addresses of the women who participate in the groups. It is further noted if a women is pregnant or breastfeeding and the current infant feeding status. What the infants have eaten in the last 24 hours is also recorded. This form allows the breastfeeding advocates to identify special counseling needs.

  (3) Informal contacts and breastfeeding counseling calendars were designed to keep track of the individual counseling breastfeeding advocates provide in the community. It was decide that a record of this nature was important so that the informal contact could be "captured" and appropriately acknowledged. Since individual, informal counseling is a

large part of what the breastfeeding advocates do, it was important to document this effort.

The number of referrals made by the breastfeeding advocates to other child survival services in the community was also documented. These services included prenatal care, immunization, growth monitoring, nutritional rehabilitation, diarrheal and respiratory disease control, and child spacing. (Figure 3 illustrates the growth in the number of informal contacts and referrals to appropriate services over a four-year period of time and Figure 4 specifies the kind of referrals made during the third and fourth year of the project.)

- *Support leaders and groups with educational materials and other necessary resources:* LLL,G has had sixteen years of experience counseling mothers in the urban area. Since initiating the Child Survival Project in 1989, the challenge has been to adapt the breastfeeding training and educational materials, that have been obtained from LLL,I and other sources, into simple, low-literacy material that can be easily understand and handled by the breastfeeding advocates. The development of culturally appropriate materials was supported in part by the Child Survival Project and also through a Breastfeeding and Child Spacing Project, supported by the Institute for Reproductive Health, Georgetown University, with funding by the A.I.D. Office of Population. Two distinct materials have formed the basis for training breastfeeding advocates and counseling in the periurban communities:

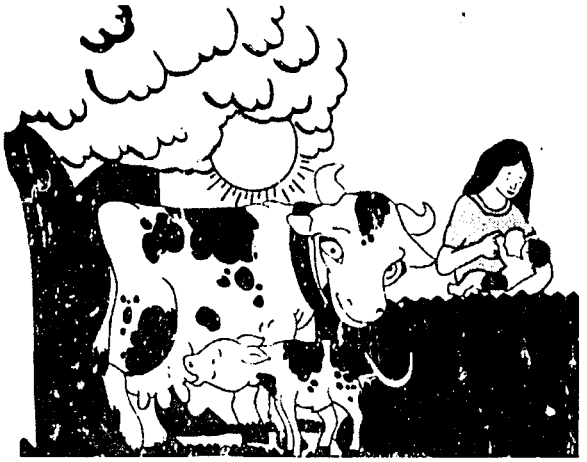
Illustration 1

(1) A training reference manual for breastfeeding advocates was developed with many illustrations and very few words (see Illustration 1). It summarizes the content of the twenty-hour breastfeeding training course, including information on leading informal guided group discussions. This book is given to the breastfeeding advocates during their training for future reference.

(2) A set of 12 cloth posters (mantas) were also designed specifically for training low-literacy breastfeeding advocates and community health workers (see Illustrations 2, 3, and 4). These posters are also used, however, by the breastfeeding

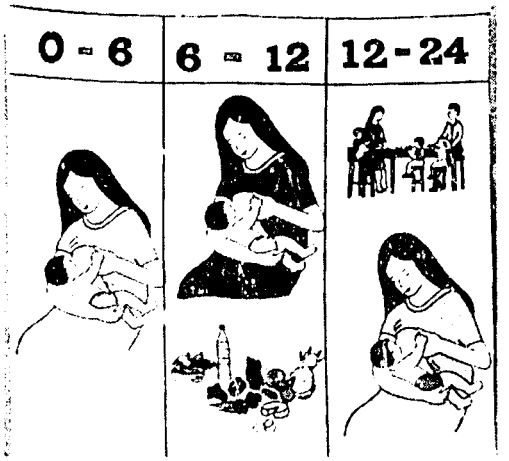
advocates in their mother support groups to stimulate discussion and reinforce the breastfeeding information and messages.

Illustration 2



Cloth poster on the specificity of human milk

Illustration 3



Recommendations for infant feeding, 0-24 months

Illustration 4

BA counseling mothers on the use of the Lactational Amenorrhea Method (LAM)

- *Monitor and evaluate the breastfeeding advocates, the group dynamics, and other program activities:* Monitoring and evaluation is conducted on a regular basis on the breastfeeding practices and health status of the infants in the community in order to provide feedback to the leaders themselves and the funding agency, and to be better able to adjust the program based on the findings.

- *Conduct appropriate follow-up activities:* LLL,G tries not to leave the breastfeeding advocates alone in their communities. Support and updated breastfeeding information is provided to breastfeeding advocates frequently in order to keep them active, enthusiastic, motivated and involved. "Refresher" workshops, follow-up training activities, and coordination meetings take place on a regular basis so that none of the breastfeeding advocates feel isolated.

  LLL,G has also provided training to health care personnel in the various health clinics that serve the periurban communities. It was determined that this training was important so that the medical personnel would be both more knowledgeable about breastfeeding in general and would be supportive of the work of the breastfeeding advocates. If physicians and nurses were giving the same messages about breastfeeding as the breastfeeding advocates, for example, it would strengthen the breastfeeding advocates position in the community.

SUMMARY

Preliminary Results of the Child Survival Project

Training breastfeeding advocates and forming mother support groups is a very labor and time intensive process. LLL,G is convinced, however, that the mother support group strategy works. It empowers women to make decisions that affect duration of breastfeeding in general and exclusive breastfeeding in particular. In the initial target community of Santa Fe/La Libertad, exclusive breastfeeding under four months increased from 15.7 percent to 22.2 percent from 1990 to 1992. In the same timeframe exclusive breastfeeding under six months increased from 10.1 percent to 17.7 percent. The percentage of children between 20 to 24 months who were still breastfeeding (and being given semisolid or solid foods) rose slightly from 25.0 percent to 28.4 percent.

LLL,G would like to conduct an impact evaluation specifically designed to determine the impact of participation in mother support groups on breastfeeding practices.

Lessons Learned

A number of lessons can be drawn from our experience to date in implementing the periurban La Leche League model. These lessons can abe divided into the following eight categories: (1) community needs, (2) establishing an urban program, (3) networking and

collaboration, (4) setting objectives, (5) training, (6) setting up an urban health information system, (7) sustainability, and (8) the replication of mother support groups.

1. Community Needs: In the community, the concept of "health" means "not being sick." There is little understanding of cause and effect. The prominent need in the community is perceived as being survival--not health. These perceptions must be addressed in our programs.

2. Establishing an Urban Program: Community involvement in any successful project is of prime importance. Training midwives as breastfeeding advocates has proven to be a successful strategy. It has been our experience that women trained as breastfeeding advocates must be recognized and respected community members.

Dialogue, training, refresher courses, and focus groups with health personnel at community health centers (MOH), NGOs, and among community women needs to be continuous and ongoing during the entire process of project development. We have also found it useful to present health centers and NGOs in the community a letter that introduces and explains the project and its goals and activities.

Several other lessons were learned in establishing the program. A national workshop on breastfeeding that reached community members was a strong catalyst in locating potential project communities and future breastfeeding advocates. Active membership and coordination with the National Commission for the Promotion of Breastfeeding has provided integration of programs and unification of criteria. Finally, LLLG realized that mother support group formation based on the LLL model is a long-term goal.

3. Networking and Collaboration: Networking and collaborating with MOH and NGOs in communities where we have an established training program of breastfeeding advocates and mother support groups is of utmost importance in formation and strengthening of the mother support groups and the establishment of a two-way referral system. This collaboration also took the form of shared training and technical assistance opportunities.

The establishment of community health teams has proven instrumental not only in the functioning of the mother support groups but also in the coordination of all related community health issues. In addition, we offer technical assistance in breastfeeding to all public and private organizations working in established project communities to provide information, establish interinstitutional collaboration, unify breastfeeding criteria and practices, introduce the breastfeeding advocates to other health personnel, and give support to the breastfeeding advocate. The effort, energy, and time expended in the often grueling, slow activity of coordination with other NGOs, government agencies, community health teams, technical teams, and community health workers inevitably bears positive results.

4. Setting Objectives: In Guatemala, as in other projects discussed at this conference, we have learned that objectives must be clear, concise, few, and obtainable. The

project must stay centered on these few objectives, and all evaluation of the project must proceed from a consideration of the objectives.

5. Training: The initial meeting session with breastfeeding advocate candidates has been developed into one of reflection in which the women themselves, through reflection, discussion, and guidance, come to an understanding of the characteristics that a breastfeeding advocate should possess and the role and responsibilities of a breastfeeding advocate. A summary of this reflection and discussion is then the basis for a written statement of commitment as a Community breastfeeding advocate.

In our project, we found that it was most effective to allow the breastfeeding advocates decide on the scheduling and location of training and to request and incorporate their constant feedback on all training materials. We also found it important to train personnel from various counterpart institutions on the formation and support of mother support groups in order to garner additional support for the project.

We have learned that breastfeeding advocates and mother support groups need continuous and ongoing nurturing. We have provided this nurturing through positive feedback, interest, support, guidance, and incentives such as written invitations to workshops, Mother's Day celebrations, Christmas greeting cards, and "gifts". Refresher workshops that provide the breastfeeding advocate with timely information on various health related topics (i.e., cholera) and show them the important role they play in the improvement of health in their family, their community, and their country are well worth the effort of careful planning and execution. The breastfeeding advocates need and are provided support through a structure that gives them inservice, ongoing education in breastfeeding and counseling, answers their questions, and provides them with moral support. We learned not to expect too much of the volunteer breastfeeding advocate, but to maintain perspective and a good sense of humor.

6. Urban Health Information System: Our project has shown us that we must keep our information system as simple as possible. If the information is not going to be "used," it should not be collected. We have involved the breastfeeding advocates in the decision of which information is useful to them--not just to the institution. If the breastfeeding advocates do not perceive the necessity of data collection, it is a futile exercise. We had to be open to modify the format of our data collection as the understanding of the community personnel grew and as community needs changed.

7. Sustainability: By collaborating with the MOH, NGOs, and the Integrated Program of Health (PIS) in communities where the project is established, we impart a sense of ownership to the community. To succeed in our goal of sustainability, we have become members of 12 other institutions that comprise the National Commission for the Promotion of Breastfeeding in Guatemala (CONAPLAM). This interinstitutional Commission coordinates and collaborates breastfeeding activities and thus backstops the La Leche League project.

In order to help the breastfeeding advocates become more self reliant in their own communities and grow more independent as LLL,G, three strategies were employed: (1) each community elected from among their breastfeeding advocates a coordinator and subcoordinator; (2) once a month the coordinators and subcoordinators gather at the La Leche League office to share experiences, successes, failures, and an update of information and knowledge. This provides a viable contact with LLL,G, imparts more responsibility to the coordinator with regard to the other breastfeeding advocates, since she is responsible for collecting the health information forms and relaying important information to the breastfeeding advocates on her return to the community, and transforms LLL's role into one of facilitator. And point (3), the coordinators and subcoordinators elected from among themselves a general coordinator and subcoordinator for all of the periurban communities where breastfeeding advocates and mother support groups have been established. Decentralizing and placing responsibility at the community level allows the community again to feel ownership of the project.

8. Replication of mother support groups : In order to replicate the focus groups that have been formed, the organizing institution should have sufficient human resources to provide adequate training, supervision, and support to breastfeeding advocates over a minimum period of two to three years. The population in the targeted communities should live in a relatively concentrated area so that transportation and distance will not be major obstacles to participation. The organization should identify contacts (health personnel, doctors, midwives, religious and community leaders) in the community who can promote support groups. Finally, the organization should encourage self-selection in the training process for breastfeeding advocates so that the women who are highly motivated will continue while those who are not able to participate as breastfeeding advocates can withdraw from the training without embarrassment.

Figure 1

Comparison Between the Qualifications and Functions of LLL Leaders and LLL Breastfeeding Advocates	
LLL Leader	**LLL Breastfeeding Advocate**
1. Leads urban support groups	1. Leads periurban support groups
2. Selected from existing MSGs	2. Selected from the community
3. Has breastfeeding experience	3. Has breastfeeding experience
4. Has completed at least one series of 4 support group meetings	4. Has lived in the community in which the support group meets
5. Has read "The Womanly Art of Breastfeeding"	5. Is a community "leader"
6. Has experience in BF (preferably minimum of one year) and motherhood	6. Has experience in BF and motherhood
7. Has good interpersonal skills	7. Shows interest in and willingness to share BF experience and lead groups
8. Has demonstrated ability and interest in LLL	8. Has received 20-hr. training course
9. Holds MSGs, usually in a home	9. Holds MSGs in a church, health center, clinic, or home
10. Pays a yearly fee to LLL	10. Receives a diploma and identification card identifying her as a BA
11. Provides counseling through informal contacts	11. Provides counseling through informal contacts
12. Refers women to health professionals	12. Refers women to health centers
13. Works as a volunteer	13. Continues work as a volunteer
14. Receives continuing education through LLL literature	14. Receives continuing education through refresher workshops
15. Maintains simple records of contacts	15. Maintains a) information on mothers who attend MSGs, BF practices of mothers, and return of menses; and b) information on informal contacts and referrals
16. Uses LLL books and handouts for counseling and reference	16. Uses reference manual and cloth posters for counseling and reference

Figure 2

Number of MSG Groups Formed Through LLL, G Child Survival Project between July 1989 and December 1992					
	Year 1	Year 2	Year 3	Year 4	Total
No. of groups	10	112	157	323	602
No. of Women Counseled	74	1,437	1,917	3,827	7,255
New Mothers	29	541	920	1,486	2,976
Pregnant Women	7	200	402	468	1,077
Breastfeeding Women	24	518	1,088	2,206	3,836

Figure 3

Individual Contacts Made by BAs between July 1989 and December 1992					
	Year 1	Year 2	Year 3	Year 4	Total
Informal Contacts	0	728	10,225	26, 532	37,485
No. of Referrals	0	0	2,640	7,997	10,637

Figure 4

Number and Kind of Referrals made by BAs during Years 3 and 4			
	Year 3	Year 4	Total
1. Respiratory Infection	324	935	1,259
2. Growth and Development	371	1,044	1,415
3. Inmunization	448	1,157	1,605
4. Diarrheal Disease	370	1,236	1,606
5. Malnutrition	285	947	1,232
6. Prenatal Care	505	1,446	1,951
7. Child Spacing	337	1,232	1,569
8. Total	2,640	7,997	10,63

MOTIVATING VOLUNTEERISM AMONG PEER COUNSELORS

Beverly M. Spencer

INTRODUCTION

This paper presents four factors--funding, training, recognition and reward, and flexibility--used to motivate volunteerism and commitment among peer counselors in a community-based program. It describes the main functions of the La Leche League of MD, DE, DC, Inc., Breastfeeding Peer Counselor Program and identifies several ways an awareness of the cultural context of the community can influence the success of a breastfeeding promotion program.

DISCUSSION

As the Program Coordinator of the La Leche League of MD, DE, DC, Inc., Breastfeeding Peer Counselor Program working in Rockville, Maryland, I began writing funding proposals in 1989 to train peer counselors. We received our first private foundation funding in February 1990 and began recruiting to conduct our first training class in May of 1990. Since that time, we have trained forty-two peer counselors in four training sessions. Our program and training curriculum are based on the model developed by La Leche League International in 1987 that has been used to promote breastfeeding among low-income populations in Great Britain, Guatemala, Hungary, South Africa, and in twenty states throughout the United States. In 1991, the peer counselors participating in these programs had contacted and counseled more than 25,000 women in their local communities, so the flexibility and outreach potential for this type of community-based program has been documented as La Leche League representatives have trained mothers around the world to provide mother-to-mother support for breastfeeding.

Our program currently has twenty-seven peer counselors who serve in the six Montgomery County Health Department Clinics and WIC Offices, and the Holy Cross Hospital Maternity Clinic. During 1991, the peer counselors provided more than 1,400 hours of service and contacted more than 2,000 women in our community. The slogan for Montgomery County is "Making a County a Community." Our program strives to meet that goal through providing mother-to-mother support for breastfeeding.

The sense of community is fostered through recognizing that the metropolitan Washington DC area has a large number of people who have recently moved to the area, including many immigrants from Central America. Montgomery County has the largest Hispanic population of any county in Maryland. Recently, mothers in the clinics have come from Africa, Eastern Europe, Korea, the Philippines, Russia, Vietnam, and other Asian countries. These women no longer have the extended family support for breastfeeding that they might have in their native countries, so we strive through our program to create a community of breastfeeding women who can offer mother-to-mother support and humanize the clinics where they serve.

Funding

The first factor we use to motivate the peer counselor commitment is **funding**. We are an example of a public/private partnership with grants from foundations that give the program a means of providing stipends to peer counselors for child care and travel expenses during training and service to the community. The Eugene and Agnes E. Meyer Foundation provided initial funding and follow-up funding for the program, along with a private donor and the Maryland State WIC Program. The Morris and Gwendolyn Cafritz Foundation began providing funding for the program in 1992. The emphasis of the program on maternal and child health, strengthening the communication and counseling skills of women, and reinforcing a sense of community, make this program an excellent candidate for funding by many private foundations that are seeking to fund programs that address these vital issues.

The funding is an important motivator because it shows the women that they are valued and can really make a difference in the lives of these women who are committed to their families and to breastfeeding. Most of these women are dealing with the stress of poverty and want to serve other women in the community who are in a similar situation.

Private funding provides a flexibility for the program free from the bureaucracy of local or state government. The key is finding a community person willing to coordinate and develop funding proposals through a non-profit organization and a local agency with a person who is willing to collaborate on efforts to recruit, train, and promote breastfeeding among low-income mothers who want to breastfeed. In a recession and an environment where all agencies are cutting budgets and stretched to serve those eligible for services, this program, with its private funding, can enable agencies to promote breastfeeding in an effective way.

Training

Training is a second major motivating factor for helping the women identify and use the talents and skills they have to serve the community. Our program uses the La Leche League curriculum and offers twenty-four hours of comprehensive training taught by trained La Leche League leaders, a Certified Lactation Consultant, WIC nutritionists, and other experts. Private funding enables the program to provide each peer counselor with a copy of ***The Womanly Art of Breastfeeding***, ***The Working Woman's Guide to Breastfeeding***, and a notebook with extensive information sheets on breastfeeding issues, community resources and other materials. Each Hispanic peer counselor receives a copy of ***The Womanly Art of Breastfeeding*** in Spanish. A copy of ***The Breastfeeding Answer Book*** is available in each of the clinics for reference along with copies of The Womanly Art of Breastfeeding in English and Spanish. A canvas bag with the La Leche League logo of a mother and a baby are given to each peer counselor along with a calendar for scheduling her monthly service to the community.

The peer counselors feel valued by receiving the resource materials during training and are able to be more confident as they begin to serve in the clinics. They have the materials to research most breastfeeding problems they encounter and may call on the WIC nutritionists,

program coordinator, or lactation consultant for guidance. Monthly peer counselor support meetings are held to schedule service, answer questions, and provide continuing education.

During training, current peer counselors discuss how they serve the community and what it is like to counsel mothers in the clinics. At graduation, peer counselors give a brief talk on what the training has meant to them and how they hope to serve the community. After graduation, each peer counselor serves an internship in a clinic where she is paired with an experienced peer counselor for at least two clinic visits to observe how the experienced peer counselor approaches and discusses breastfeeding with mothers and how the paperwork is completed to document the mothers contacted and the hours served. The peer counselors share ideas on how to organize their paperwork and clinic schedules to fit in with their busy lives as mothers.

Peer counselors discuss breastfeeding with women in a clinic setting.

Continuing education is ongoing in the monthly peer counselor support meetings to address issues as they arise. At least quarterly, a session is conducted to reinforce or to amplify the information covered in training or new issues that arise. Sessions have included how to use ***The Breastfeeding Answer Book*** as a reference guide for problems and suggestions on when to refer to someone else; a display of pumps and guidance on working with mothers who need to return to work; another session on breastfeeding reference material available in the WIC Clinic and how to use it; and a session on community resources that was repeated for WIC staff and the Holy Cross Hospital Maternity Clinic staff. The peer counselors also attend the La Leche League Area Conference each year with more than 500 other breastfeeding parents where they learn the latest information on breastfeeding research and share ideas with other women who counsel mothers who want to breastfeed. Peer counselors have spoken at the La Leche League Area Conferences, Leader Development Seminars, and the Georgetown University National Capital Lactation Center's Lactation Consultant Training Course.

Recognition and Reward

Recognition and reward are motivators for the peer counselors in every facet of the program. In recruiting, we seek to identify and recognize the women with leadership potential to participate in the program. During training we strive to help the women find ways to identify and use their talents and skills in the clinic--particularly language skills. Women who can speak Spanish and French are needed to communicate with some of the women who come to the clinics. One of the Hispanic peer counselors was hired as a translator for a clinic. The peer counselors feel valued by receiving stipends that adequately cover child care and transportation costs. Training materials, professionally printed business cards with a program logo and the peer counselor's home number or the clinic number, and name tags that are similar to those worn by other members of the health team in the clinic give the peer counselors a sense of pride in what they are doing. They are members of the health team and contribute to an effort to promote breastfeeding by helping mothers and babies in the community. Peer counselors gain a sense of accomplishment from counseling mothers one-on-one, conducting support meetings in the clinics, creating bulletin boards and meeting notices, and giving presentations that challenge their creativity.

Graduation is a highlight of the program and is used as a motivator for all participants. Many of the women may not have had the opportunity to graduate from high school or college, so completing the training for this program is a major accomplishment and a milestone. Families, friends, health professionals and La Leche League leaders are invited to graduation, as well as potential peer counselors. In the recent graduation ceremony in June 1992, the Director of the Montgomery County WIC Program spoke and welcomed the new peer counselors to the health team. The Area Coordinator of Leaders for La Leche League of MD, DE, DC, Inc., welcomed the new peer counselors and told them that they were carrying on a tradition begun by seven mothers who founded La Leche League in 1957 to help other mothers. Flowers, a cake, framed certificates, and balloons for the children made the occasion memorable and special. One of the peer counselors from the first graduating class of June 1990 who was hired as a translator in one of the clinics told what serving the community these last two years had meant to her.

As the program completed training the fourth group of graduates in June 1992, an effort was made to assess where the program was and what modifications needed to be made to accommodate for the fifteen new graduates as the program entered its third year of operations. An effort was made to develop expanded opportunities for service for peer counselors with more experience or with a special expertise. For example, since July 1991, one of the peer counselors with a bookkeeping background has served as the treasurer for the program and helped with documentation of peer counselor service for funding proposals and progress reports. During the summer of 1992, one of the peer counselors from the first graduating class took on the added responsibility of Clinic Schedule Coordinator because with twenty-seven peer counselors serving six sites, we wanted to maximize the potential for service and be sure none of the peer counselors was omitted. Each peer counselor may serve a maximum of five clinic visits in a month due to funding constraints, but we attempt to ensure that everyone gets

to serve in the clinics as often as they would like. The Clinic Schedule Coordinator is called if a peer counselor cannot serve so that other peer counselors are offered the opportunity.

Many similar programs have faced the problem of apathy and a lack of motivation to serve. The peer counselors participating in this program, however, would serve the community more if the program coordinator could find sufficient funding. Another supervisory position recently became available as the opportunity to serve at the Holy Cross Hospital Maternity Clinic became a reality. One of the peer counselors in the first graduating class had mentioned that she would love to help the mothers she saw when she went to the Maternity Clinic at Holy Cross. Negotiations began in the spring of 1991. The original request included a collaboration on funding for the peer counselors as well as access to the mothers in the clinic. A second proposal in the spring of 1992 withdrew the request for funding and was accepted by the Supervisor of the Maternity Clinic. The Holy Cross Project Coordinator is a peer counselor who had been a nurse and worked in the hospital setting for many years. This position provided a challenge and renewed her commitment to the program.

Flexibility

The final motivator for the peer counselors is **flexibility** in as many aspects of the program as possible. The peer counselors must attend at least twenty of the twenty-four hours of training offered in order to graduate. After graduation, each peer counselor selects a clinic in which to observe two clinic sessions as an intern. At the monthly support meetings the counselors sign up for their service for the coming month. They sign a letter of agreement to serve at least twice each month and may serve as many as five clinic visits or three clinic visits and two sessions at Holy Cross per month. The mothers may choose to serve more when their home schedules allow or they may only serve twice a month if they have other demands at home. Several of the peer counselors have had new babies and returned the next month to the support meeting to proudly introduce their new family member. The idea that they can control their schedule of service, based on the clinic schedule and the limitations of funding, is one of the reasons many peer counselors enjoy their involvement in the program. It gives them a sense of accomplishment and control that they may not have in some other areas of their lives.

Program Functions

There are several key functions at a program level that support the work of the counselors: development, coordination and integration, administration, and evaluation.

Development: One of the key function of the program is development. The program coordinator pursues funding and continually assesses community needs and contacts. For example, an effort has been made to attract graduate students to the program to help assess the impact and value of the program for the peer counselors and the community. One doctoral candidate from the Anthropology Department of Catholic University interviewed the Hispanic peer counselors to determine what motivated them to participate in the program and what factors they saw as important in a Hispanic mother's decision to breastfeed. She is currently

analyzing the data and will write the dissertation in the spring of 1993. Another doctoral candidate from the Education Department of Columbia University is working with the program on a dissertation that will describe the adult learning process of the peer counselors as a result of their involvement in the program. The findings of these two dissertations will be invaluable in documenting the progress and impact of the program as well as influencing the future development of the program.

Coordination and integration: The program coordinator has seen the process of coordination and integration evolve since 1990 between the WIC Program, the Montgomery County Health Department Clinics, the Holy Cross Maternity Clinic, and the community at large. This collaborative effort to promote breastfeeding among low-income women shows the potential for public/private partnerships, particularly in a recessionary climate of budget cuts and increased demand for services. An effort to identify common goals and objectives and to find ways to meet the needs of the organizations involved can be very rewarding. In the case of the Holy Cross Project, several meetings with administrators and special training for the peer counselors facilitated this new area of outreach for the program.

Administration: The administration of the program includes recruiting, interviewing, and screening potential peer counselors. This process is accomplished by recruiting posters posted in the clinics, and applications distributed by WIC staff, clinic staff, and current peer counselors. A meeting is held to explain the program, discuss the training schedule, and present the expectations of peer counselors. The training and graduation take place in a four- to six-week period so that the peer counselors may begin serving in the clinics as soon as possible after graduation. The follow-up services and continuing education include monthly support meetings to schedule peer counselors and discuss what is happening in the clinics. The peer counselors may identify an area they want to know more about and continuing education in that area will be scheduled for a future support meeting. Peer counselors are offered the opportunity to attend the La Leche League Area Conference on an annual basis, the March of Dimes Conference, the Georgetown University National Capital Lactation Center's Lactation Consultant Training Course, and other training as funds are available.

Evaluation: Evaluation of training and services is done on a regular basis with feedback from training classes, monthly reports, and discussion with WIC and clinic staff, in addition to the monthly support meetings when the peer counselors break into groups by clinic to discuss how things are going and what needs or problems should be discussed. From October 1992 through March of 1993, peer counselors may voluntarily participate in a dissertation project. The sessions will be held in conjunction with the monthly support meetings and will involve group discussions on communication skills, goal setting, and personal development. This dissertation will document how the program is impacting the peer counselors' communication and counseling skills, confidence, and self-esteem. The program is evaluated using breastfeeding data from the Maryland State WIC Program, special reports prepared by the State WIC Program documenting use of reduced and no formula infant packages, incidence and duration reports, and peer counselor reports of contacts made and hours served.

SUMMARY

One of the challenges for anyone striving to promote breastfeeding in the 1990s is to consider how the promotion effort can best create a community among breastfeeding women where they support and comfort one another. A peer counselor program can serve as an effective mechanism if the factors motivating the peer counselors include adequate funding, training, recognition and reward, and flexibility for the peer counselors. Each of the functions of the program should be undertaken with a goal of motivating the peer counselors. Commitment to the program will be increased as will the impact of the program if the recruiting, training, and services strive to reflect the cultural and age diversity of the mothers in the community.

Our programs need to reflect the demographics of the community. The local agency may have demographics by ethnic background of the population served by the agency. A sensitivity to the cultural aspect can make a difference in the impact of the program as language and cultural differences are considered. Breastfeeding practices are often influenced by cultural factors, so a peer counselor from a similar background can establish rapport and help a mother feel comfortable and confident in her decision to breastfeed.

SKILL BUILDING IN COUNSELING

Valerie Uccellani

INTRODUCTION

More and more, people who work to promote optimal infant feeding all over the world are recognizing the importance of effective interpersonal communication. While communication through groups, posters, brochures, radio, video, slide shows, promotional materials, television, and other channels may be effective in moving people toward healthier behaviors, many feel that communicating with people **face to face** is essential for long lasting behavior change.

A recent literature review[1] indicates that improved interpersonal communication between a health provider and a client improves the outcome of that encounter. What kinds of outcomes have been linked to improved interpersonal communication? Studies, primarily conducted in the United States, suggest that improved interpersonal communication can lead to: (1) more accurate health worker diagnosis; (2) greater satisfaction on the part of the client and the health worker; (3) greater use of services and follow-up; (4) better client recall and understanding; (5) improved health practices. Studies conducted on interpersonal communication between health workers and clients in developing country settings are, unfortunately, sparse. Nevertheless, the work that has been done suggests something very interesting: that the health system, the health worker, and the client him/herself all contribute to successful communication. In other words, an encounter between health worker and client will only be successful if the health worker uses good communication skills; the client responds to these skills; and the system supports the communication. The literature suggests several ways in which the health worker, client, and system could strengthen interpersonal communication. The following items seem to be the most essential:

- The client: question-asking; disclosure of information; checks on understanding; participation in decision making.

- The health worker: question-asking; effective listening; sufficient dialogue; offering the ideal amount of information.

- The system: supervision; effective use of wait periods; use of pretested materials as supports for client and health worker.

A great deal of time could be spent in a discussion of only these factors and how, if strengthened, health systems around the world could be much more effective, satisfying, and efficient. However, the basis of this paper is that we accept, for the time being, that improved

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[1] Unpublished literature review, Quality Assurance Project.

interpersonal communication does have great benefits and that good interpersonal communication by health workers is something to strive for.

Many people say that *you cannot turn someone into a good communicator--either you have it or you do not.* Many trainers have asked themselves the question: *can I help someone become a good communicator?* A recent counseling evaluation conducted by Johns Hopkins University's Population Communication Services indicates that training can greatly enhance the way health workers communicate. When observed during client sessions, trained staff surpassed untrained staff. They listened more attentively (97 percent vs. 66 percent) and gave clearer explanations (95 percent vs. 75 percent). Furthermore, clients of trained staff kept return appointments more often (84 percent vs. 44 percent).

We can assume further that health workers can be trained to communicate better. This leads us to two key questions: What skills and attitudes should be the focus of interpersonal communication training? What are effective ways to build these skills and attitudes among health workers?

Over the past three years, the Nutrition Communication Project (NCP) of the Academy for Educational Development (AED) has worked with other organizations in Africa, Asia, and Latin America to address these key questions and to design interpersonal communication training materials specifically for workers in the area of nutrition. This paper focuses on some of the examples of this work and the lessons we have learned.

DISCUSSION

Working with several governmental and nongovernmental organizations in Latin America, NCP and UNICEF produced a Spanish-language video and guide called ***Comuniquémonos, Ya.*** (***Let's communicate.***) The video and facilitators' guide have been used to train nutrition workers in many countries of Latin America by modeling good communication between nutrition workers and mothers in diverse programs of Latin America. Feedback to the video/guide has been extremely positive. Many workers seem to enjoy the role of communicator and appreciate training on skills that will help them to more effectively educate and support the clients with whom they meet. They seem to especially enjoy the use of video as "window" into the work of nutrition promoters in other countries and as an opportunity to discuss this sensitive, but often ignored, aspect of their work.

The remainder of this paper focuses on a training manual: ***Learning to Listen to Mothers: A Trainers Manual to Strengthen Interpersonal Communication for Growth Promotion***, which NCP is producing in partnership with five organizations around the world. The collaborative process of developing the manual has taught the project a great deal about the focus of interpersonal communication training and effective training methods.

It seems intuitive that, while interpersonal communication styles may vary from one country to the next, there are certain interpersonal communication strategies that will work in

most any culture. For example, a provider who empathizes with a mother, invites her to share her concerns, and focuses on her most immediate needs, is bound to be more effective in promoting optimal infant feeding, and the literature suggests that skill practice and feedback are the most effective ways for trainers to improve the interpersonal communication skills of health providers (be they nurses, doctors, community volunteers, or peer counselors). In order to find out whether certain communication strategies work in some countries and not others, we selected collaborative organizations in five sites around the world: Bolivia, Honduras, India, Indonesia, and Kenya. We looked for a variety of cultural settings and programmatic realities. For example, in Honduras, the manual was used with auxiliary nurses who, in turn, used it to train their physician colleagues. In Indonesia, the manual was used to train community health workers (*kader*) who enriched it with their own style of participatory games.

In each country, the workshops were observed, trainers were interviewed, and participants were asked for feedback. Two recommendations emerged concerning the development of training materials for wide use: (1) try to give trainers a rough draft of the material and work with it extensively before any sessions become final; and (2) try to observe the workshop and talk with trainers/participants directly to effectively incorporate their experience into the revision of the material before final production. In our rush to develop training materials and "make them look good" for production and distribution, we unfortunately often sacrifice the time it takes for trainers to experiment and to suggest substantive changes that would make the material more useful for others in the future.

We learned a great deal when we field tested ***Learning to Listen to Mothers***. The results of the field test in five countries confirmed that an experiential approach to interpersonal communication training works. What are the essential components of an experiential approach? Generally speaking, the group members:

- reflect on their own experiences;
- define for themselves which communication skills and attitudes would be effective with their clients/in their program;
- practice new communication skills in realistic situations;
- exchange thoughts and ideas about the communication training they received;
- set specific goals and guidelines for better communication on-the-job.

Through the field test of ***Learning to Listen to Mothers***, we discovered that trainers want--and often need--guidance on the experiential approach. We found that specific notes to the trainer for each training session helps them to break out of their routine of didactic training and take on the role of facilitator. Effective facilitators:

- model good communication;

- constantly give feedback;
- find the positive and share it;
- prepare a mix of activities (small group discussions, stories, dialogues) in order to constantly involve the group and inspire participation.

We applied the experiential approach to the topic of growth monitoring and nutrition promotion. One sample activity from the manual is called "Name what the mother needs." It is designed to (1) help workers understand what the client wants and needs; (2) learn key basic nutrition information; and (3) selectively share appropriate information with clients (i.e., so that the client is not confused or overwhelmed). We provide the following directions to workshop participants: *Imagine you are a young mother coming to the health center for the first growth monitoring promotion (GMP) session since your baby was born. The baby is now two and a half months old. You breastfeed him and you have started to give him some teas and juice. He is your first baby. Until now, he has been growing well.*

At this point, participants are given a copy of UNICEF's prime breastfeeding messages as reference. (Note: We did find through our field testing that many nutrition workers lack confidence in their own nutrition knowledge and that interpersonal communication training without specific technical substance can frustrate workers and could be ineffective.) The UNICEF messages include the following:

1. Breastmilk alone is the best possible food and drink for a baby in the first four to six months of life.
2. Babies should start to breastfeed as soon as possible after birth. Virtually every mother can breastfeed her baby.
3. Frequent sucking is needed to produce enough breastmilk for the baby's needs.
4. Bottle feeding can lead to serious illness and death.
5. Breastfeeding should continue well into the second year of a child's life and for longer if possible.

In small groups participants are asked: *What are three questions that you would ask this mother to find out what you need to know? Please write one question on each card.*

Through practice and discussion, the participants developed several open-ended questions which invite the mother to talk honestly. Examples of the questions created by participants are:

- *Why did you begin to give other liquids (besides milk)?*

- *What kind of problems have you had with breastfeeding?*

- *How are you giving him the teas/juice?*

We discovered that this focused activity engaged the participants because they were given a concrete situation in which to practice key skills: how to create an open-ended question and how to decide which information is **most** appropriate for a given mother at a given time.

A manual of this sort can contribute a great deal to improve the communication skills of trainers as well as those of field workers. Through observation of trainers in the five field test countries, we found that few trainers understand the concept of giving feedback and need guidance to do so effectively. We came up with a very simple form for trainers to give feedback. Our goal was to develop something that captured the essence of good feedback as simply as possible so that trainers could use it in other training sessions, and as supervisors on-the-job.

FEEDBACK FROM TRAINERS	
What the participant has done well...	What the participant could have said or done better...
•	•
•	•
•	•

You can use this form throughout this and other trainings.

Using these simple guidelines, trainers gave such feedback to health workers as:
Things they did well:

- *Helped the mother to weigh her baby (rather than taking the child from the mother's arms and weighing it);*

- *Helped the mother to make a plan (rather than telling the mother what she should do without knowing that it is feasible for her).*

Things they could have done better:

- *Try to understand difficulties/problems and condition of the mother;*

- *Ask about food habits of mother herself (especially during breastfeeding) rather than focus only on the health and well being of the baby.*

Interpersonal communication training, like any other type of training, must be **evaluated**. Many trainers shudder at the idea of evaluating interpersonal communication training because they know that the only real way to know if participants learned anything is to document that they communicate better on the job. Below is a sample observation form developed with our partners in Bolivia.

"Communications Actions"
Observation Form from Bolivia

	Promotor	**Madre**	**Promotor** N = H = ? = ?A= R = **Madre** H = ? = **Total acciones positivas** = **Promotor** Rñ= G = I = D = **Total acciones negativas**
ANTES DE PESAR AL NIÑO			
DURANTE EL PESADO			
DESPUES DE PESAR AL NIÑO			

This form was used to visually record whether nutrition promoters and mothers were communicating during GMP sessions. Trainers felt that, like the feedback form, an adaptation of this form could be used to observe how health/nutrition workers were communicating in any type of encounter. Ideally, of course, it would not be used primarily to evaluate a training, but rather to direct future training content and approaches.

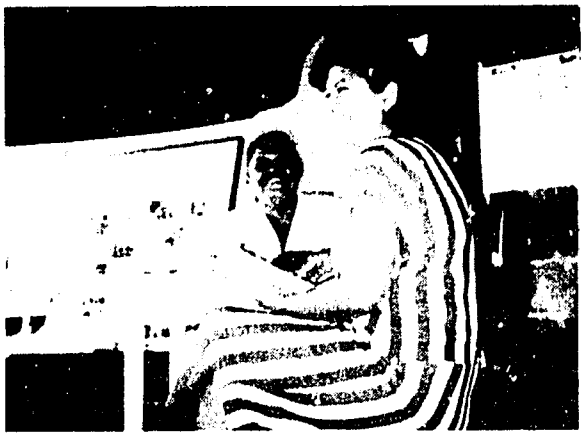
SUMMARY

We learned a great deal from the feedback that the participants in workshops in three of the five field test sites provided to us at the close of the sessions. Their comments included the following:

- *Individual and small group work gave me a chance to be heard.*
- *The most important things are listening, knowing how to ask questions, and giving people time to respond.*
- *Communication can help with the hardest parts of our work: mothers' use of services, our time, having mothers understand messages, having mothers collaborate with us.*

The experience of developing this interpersonal communication training manual with partners in five different countries was inspiring and helped us increase our understanding about communication skills and training methods. Several important conclusions can be drawn from this experience:

1. Allow the participants' own experiences to guide their choice of which interpersonal communication skills they should use with client.
2. Prepare concrete opportunities for participants to practice interpersonal communication skills both during the workshop and afterward.
3. Offer trainers guidelines for giving feedback to participants.
4. Ensure that trainers "model" effective communication skills such as asking questions and listening.
5. Give participants substantive health or nutrition information with which to practice new communication skills.
6. Allow time for trainers in different sites to use the material on their own and experiment with it: with time they will gain the confidence they need to be innovative with training activities appropriate for their own participants.



What makes a good communicator? The person or the training?

Two keys to counseling training: feedback and practice

Innovations in training -- trust games

Role playing -- Name what the mother needs

PLENARY SESSION IV:

COMMUNICATION STRATEGIES FOR SUPPORTING HEALTH CARE WORKERS

DEVELOPMENT OF COMPLEMENTARY TRAINING AND EDUCATIONAL MATERIALS ON EXCLUSIVE BREASTFEEDING IN PERU

Laura C. Altobelli[1]

INTRODUCTION

The Peru Breastfeeding Project was a two-year (1988-1990) controlled trial to extend the duration of exclusive breastfeeding among low income women in Lima, Peru. The long-term objective of the study was to reduce the incidence of diarrheal disease and improve infant growth through the promotion of exclusive breastfeeding and the provision to health professionals of education in lactation management. The purpose of the study was to develop and evaluate a set of public hospital-based interventions designed to increase the proportion of mothers who exclusively breastfed their infants up to four months of age. The study encompassed three stages: (1) an identification of (a) baseline institutional constraints to promotion of exclusive breastfeeding, and (2) knowledge, attitudes, practices, and constraints of mothers regarding infant feeding; (2) development and application of a set of hospital-based educational interventions that addressed the issues identified in the first stage of the study; and (3) evaluation of the extent to which the interventions served to modify maternal infant feeding practices and subsequent child health status.

The intervention hospitals in Lima, Peru, were the Cayetano Heredia Hospital (which is a major teaching and research hospital connected to the Universidad Peruana Cayetano Heredia Faculty of Medicine, School of Nursing and School of Public Health), and the public hospital Dos de Mayo. The training of a core multidisciplinary team in lactation management and development of appropriate training programs and educational materials for health personnel and mothers provided the basis for expansion to other hospitals upon completion of the study.

A hospital-based intervention was chosen due to (1) the high proportion of Lima infants who were born in hospitals (75 percent in 1984); (2) the powerful influence of medical advice on all levels of Peruvian society; and (3) a strong suspicion that health personnel frequently promoted early supplementation of breastmilk.

Major funding for the research component and the lactation management training of the multidisciplinary team at Wellstart, San Diego, in January 1989, was provided by the Office of Population, A.I.D., through the Population Council. The Office of Nutrition, A.I.D., through the Academy for Educational Development's (AED) Nutrition Communication Project (NCP), provided technical assistance and production funds for the adaptation of an existing pocket-sized health care provider breastfeeding guide and the development of two new educational materials to be used in counseling mothers--a flipchart containing ten messages, and a

[1] Due to travel complications, Laura Altobelli was unable to present this paper at the conference.

poster/calendar to be given to each mother. These three materials represented a significant aspect of the hospital based interventions. The Population Council covered the actual costs of duplicating the materials that were produced in collaboration with AED.

DISCUSSION

Methodology

In addition to the two large public hospitals in Lima that were selected for the intervention, a third hospital (Loayza) was selected as a control. In Stage 1 of the project, several baseline studies were undertaken: a rapid ethnographic assessment in four districts of Lima to examine mothers' beliefs and practices related to breastfeeding and supplementation, particularly in regard to the use of water; a KAP survey of health personnel (physicians, nurses, midwives, and auxiliary nurses) in the obstetrical and neonatology services in each of the three study hospitals; and an interview survey of postpartum mothers in each of the three hospitals to determine what type of support and advice they received in the hospital for initiation of breastfeeding. This interview was also used to establish the sociodemographic and socioeconomic comparability of mothers delivering at each of the three hospitals.

In Stage 2, the intervention was developed and implemented in Cayetano and Dos de Mayo hospitals. First, the five-member project intervention team, consisting of one pediatrician, one obstetrician, two nurses, and one other health professional, received training at the Wellstart/San Diego Lactation Program, where they developed an inservice training course based on the Wellstart model, adapted to sociocultural aspects of infant feeding in Peru. Additionally, the educational materials were developed for health personnel and for education of mothers, with technical assistance from AED/NCP.

In Stage 3, the effect of the intervention was evaluated by a repeat KAP survey of health personnel in the three hospitals, and a prospective study from birth to 12 weeks of age of a cohort of 120 mother-infant pairs delivering at each of the three hospitals. The Population Council provided funding support for this research.

Baseline Results

The baseline ethnographic assessment found that nearly all mothers had breastfed their youngest child, and that 80 percent of children had been given water before one month of age, validating the findings of a 1983-1985 study by Kenneth Brown and colleagues that showed a doubled risk of diarrhea in infants given water in addition to breastmilk as compared to exclusively breastfed infants (Brown et al, 1989).

In the ethnographic assessment, 80 mothers were asked to state why they had given water to their infant, and then, if there were any other reasons why they had given water. Combining responses to both questions, 62 percent of these mothers responded with "thirst" to either of these two questions, and 60 percent of mothers gave "colic or gas" as the primary

or secondary reason. The third most frequently given reason was "constipation," mentioned by 37.5 percent of the mothers. Other less frequently cited reasons for giving water to infant were, "for dehydration," "for digestion," "by recommendation," "for heat of summer," and others. Since thirst and colic were by far the most dominant responses, they were given particular attention in the educational materials that were developed. As suspected, health personnel were implicated by 40 percent of these mothers as the major source of advice for giving water.

The baseline KAP survey of hospital personnel in the three study hospitals revealed inadequate knowledge regarding the establishment and management of lactation and appropriate timing of supplementation. Nearly 80 percent of hospital personnel thought water should be given in addition to breastmilk: a majority indicated that this should be done in the first week of life. There was also poor knowledge of prevention and management of common lactation problems. Personnel interviewed identified a number of conditions in the mother (e.g., mastitis, tuberculosis, typhoid, anemia, pregnancy), or medicines taken by the mother, as factors which "contraindicate" breastfeeding--most of which were not contraindications according to available scientific data. The pretest showed that health personnel from the first intervention hospital, Cayetano, were generally better informed at the beginning of the study than either of the other two study hospitals: it was a teaching hospital, had practiced rooming-in program since 1978, and had several policies in place to support breastfeeding, such as a permanent ban on baby bottles on the postpartum ward. Personnel from Dos de Mayo and the control hospital, the two oldest hospitals in Lima, had similarly low scores on the pretest.

Development of Complementary Training and Education Materials

Training

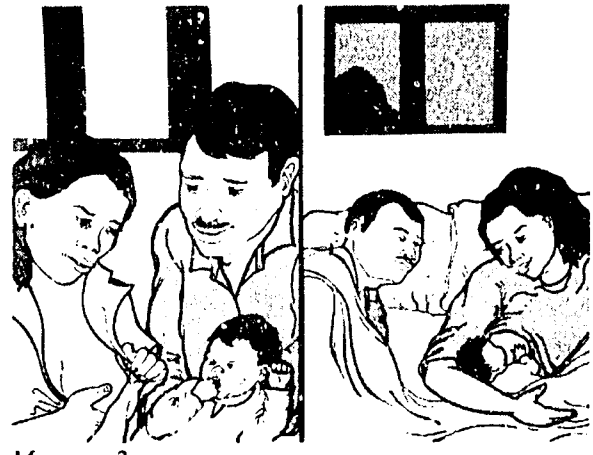
A 20-hour inservice training course was provided to all medical, nursing, midwifery, and auxiliary personnel in obstetrical and neonatology services in the two intervention hospitals. The curriculum was based on the Wellstart model, with a focus on exclusive breastfeeding. Teaching material was taken directly from the Wellstart course, with the addition of how to manage the sociocultural aspects of breastfeeding with Peruvian mothers integrated into the scientific orientation of each class session. At every opportunity, the course attempted to illustrate why mothers should be discouraged from supplementing with water or other milks, and how to do so with the help of the educational materials that had been developed for counseling mothers. Auxiliary nurses were required to attend an extra day of clinical practice to learn how to teach and advise mothers using the flipchart and how to demonstrate breastfeeding techniques to the mother with her own baby. Approximately 100 staff members from each intervention hospital attended the entire course, and another 50 or so in each hospital attended parts of the course. Those who had full attendance received a certificate and one hour of academic credit at the Cayetano Heredia University.

Educational Materials

Educational materials were developed and distributed as part of the intervention. These included: (1) a flipchart for counseling new mothers with ten major messages on breastfeeding; (2) a pocket-sized health care provider breastfeeding manual/booklet entitled, ***Breastfeeding: A Guide for Health Personnel***; and (3) a take-home poster/calendar on exclusive breastfeeding to be provided to each mother delivering at the two intervention hospitals during the study period. All of the illustrations and simple messages about breastfeeding and avoidance of water and teas were used in all three of the materials to create a coordinated "package."

Flipchart: In considering what type of educational material would be most useful, a series of large illustrated teaching cards was chosen as a flexible instrument that could be used at the bedside of an individual postpartum mother or with small groups of pregnant or lactating mothers. Selection of messages began with analysis of the rapid ethnographic assessment, review of other previous studies on breastfeeding in Peru, and the identification of eighteen to twenty initial messages. A local social communicator and artist were contracted to assist with focus groups with mothers to test these messages. Based on the focus group findings, twelve major messages were selected, which were later reduced to ten. Once the artist had illustrated each of the ten messages, focus groups were repeated to test the messages and art work together. After modifications were made in wording of messages and illustrations, focus groups were held to retest the material. The text to be written on the reverse side of each teaching card was simplified to questions to ask mothers and a listing of the correct responses to the questions. Focus groups were held again to test the revised version. Finally, a local company was contracted to produce the teaching cards and fasten them into flipcharts. The ten messages and corresponding illustrations used in the flipchart were the following:

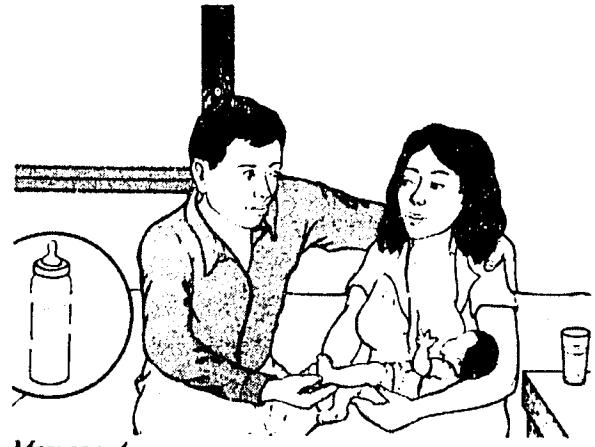
Message 1



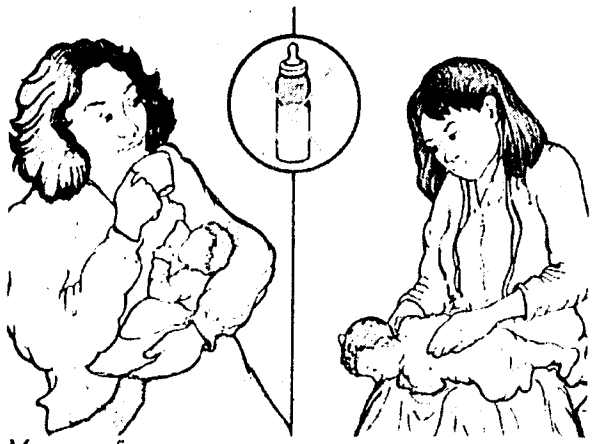
Message 2

1. In the first days, even though you have little milk, this is sufficient for the nutritional needs of your baby. It is called colostrum.
2. If your baby breastfeeds frequently, day and night, you will have all the milk that he needs.

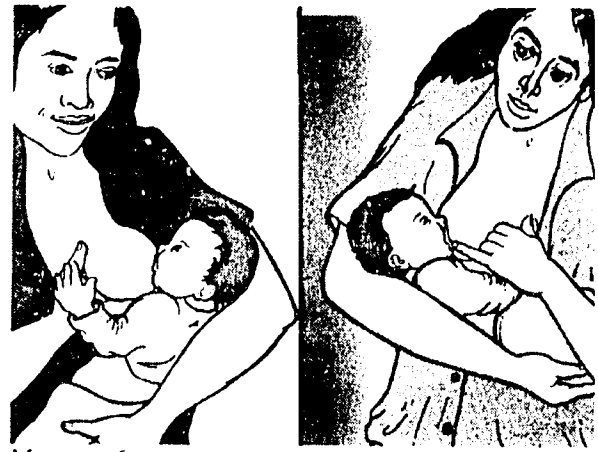
Message 3



Message 4



Message 5



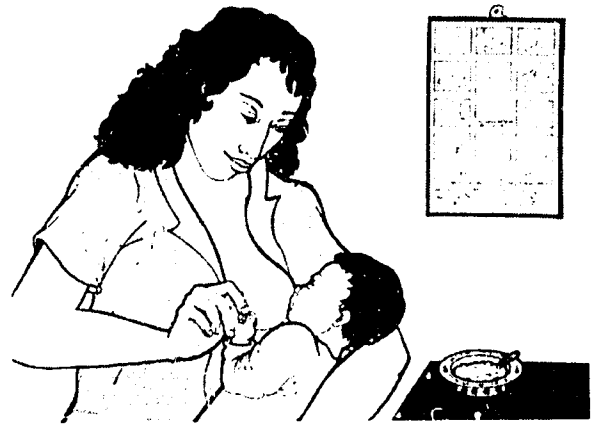
Message 6

3. If you fill the stomach of your baby with water or other milks, the baby will not have room for mother's milk that he needs. (Many people will tell you to give *aguitas* [referring to water, sugar water, juice, and/or teas]: you have the right to say no!)
4. If you think your baby is thirsty, give him breastmilk more frequently. This contains the quantity of water that the baby needs.
5. The *aguitas* do not solve the problem of colic. On the contrary, they can make it worse. Breastfed babies have colic less frequently than babies who take a bottle.
6. Correct positioning of the baby ensures that he breastfeeds well and that your nipples do not get hurt.

Message 7

Message 8

Message 9



Message 10

7. To avoid your breasts from getting hard, breastfeed your baby more frequently.
8. Breastfeed your baby even if you are sick.
9. The mother who breastfeeds needs to eat more of the same foods that she normally consumes.
10. Until 6 months, your baby needs only breastmilk. From then on, in addition to breastmilk, you should give him other foods.

Manual/booklet: Since learning from a training course can diminish rapidly, we felt that a permanent reference guide would be of great use to health personnel following the course. Development of this guide was simplified by the existence of a previously published manual for nurses which was written for a Population Council breastfeeding promotion study in municipal hospitals in New York City. Based on the Peru Breastfeeding Project objectives and the results of the baseline surveys, a breastfeeding communication expert, Peggy Koniz-Booher from AED/NCP, adapted the English text of the Population Council Manual, ***A Nurse's Guide to Breastfeeding***. The adaptation was then translated into Spanish, and further text modifications were completed by the Wellstart-trained team. Next, a contract was made for

typesetting, layout, cover design, and printing. Careful arrangements were made for distribution of the guide to target health personnel in the two intervention hospitals. The manual, which incorporated the same illustrations and simple messages of the flipchart, contained elements of the training course, with emphasis on how to discourage the early use of water and teas.

Poster/calendar: A take-home poster/calendar was also developed and distributed to mothers upon discharge from the hospital. This educational material also incorporated the ten key messages and their corresponding illustrations. A two-year calendar was printed and health care workers were asked to indicate on the calendar the month during which the mother should begin to introduce complementary foods in her baby's diet, in addition to breastmilk. It was hoped that this notation would help to reinforce the concept of "exclusive" breastfeeding during the first four to six months of life (for the mother and the health workers as well).

Evaluation Results

Results of the post-intervention KAP survey of health personnel, which took place 9 to 11 months following the training courses, showed extraordinary improvements in key areas of knowledge in lactation management in both intervention hospitals, with little or no change among control hospital personnel.

Before the intervention, Cayetano Heredia Hospital had more informed responses than the other two hospitals: physicians, nurses, and auxiliary nurses responded, on average, that mothers should introduce water to infants at ten weeks of age. (Cayetano nurse-midwives were not as well informed.) The other two hospitals had average responses of one to two weeks. After the training intervention in Cayetano and Dos de Mayo, responses improved dramatically to an average of 20 weeks for nearly all professional groups (See Figure 1). No real change was seen in the responses of Loayza, the control hospital. Again, the post-survey of health personnel was done 9 to 11 months following the training intervention. Similar improvements were seen in the intervention hospitals on responses about need for water in the first hours of life, the need to give water to infants in the heat of summer, and so forth.

The results of the prospective study of a random sample of mothers who delivered in the three study hospitals are illustrated in Figure 2. Mothers were recruited and interviewed while in the hospital, and were visited at home at 2, 4, 8, and 12 weeks postpartum. Figure 3 demonstrates that the three populations of mothers were very similar in terms of their distribution of socioeconomic status. All study subjects were between the ages of 18 and 35, and had delivered a normal weight infant with a normal, uncomplicated delivery.

At their first home visit at two weeks postpartum, we asked study mothers specific questions about their recent hospital experience in order to determine if they had been exposed to the project intervention. In that way, we could determine how well the breastfeeding intervention was being implemented by hospital personnel in their interactions with mothers.

Figure 4 shows that 90 percent of mothers in Cayetano, 75 percent in Dos de Mayo, and 40 percent in the control hospital had received any explanation about breastfeeding while in the hospital to deliver. Mothers reporting having received a talk in the hospital using a colored flipchart on breastfeeding included 86 percent of Cayetano and 61 percent of Dos de Mayo mothers, while 8 percent of control hospital mothers reported hearing such a talk. Those receiving a poster/calendar on breastfeeding while in the hospital included 95 percent of Cayetano mothers, but only 46 percent of Dos de Mayo mothers.

These data suggest that nearly all Cayetano (Column A) mothers were exposed to the ten educational messages we designed to prolong the duration of exclusive breastfeeding. On the other hand, while hospital personnel from Dos de Mayo (Column B) demonstrated a highly significant increase in levels of breastfeeding knowledge, **this did not necessarily carry through to their behavior in educating mothers with key messages**. There was a strong association between a mother's exclusive breastfeeding and her having heard a talk with the flipchart and having received a copy of the poster/calendar while in the hospital.

Study mothers were asked to name the three recommendations about breastfeeding that they most remembered having received during their hospital stay (see Figure 5). Detailed coding and analysis of responses revealed that 60 percent of control hospital mothers (Column C) received no information, or could not remember any information received, and that information received was likely to be simply about the superiority of breastfeeding. Some mothers received information on correct use of other milks, and others on correct and/or incorrect breastfeeding techniques. Intervention hospital mothers were most likely to remember having received correct information on use of supplementary milks or water and teas (i.e., that they should not be used), as well as benefits of breastfeeding and correct breastfeeding techniques.

The final results of the study on proportion of mothers by hospital of delivery who were exclusively breastfeeding at 2, 4, 8, and 12 weeks postpartum are shown in Figure 6. Among mothers delivering at Cayetano Hospital, as many as 52 percent were still exclusively breastfeeding their infants at 12 weeks of age. Dos de Mayo mothers had a statistically significant greater proportion of exclusive breastfeeders in comparison with control hospital mothers, at least through the fourth week, after which the difference failed to reach significance. We can attribute some of the less successful results of Dos de Mayo as compared to Cayetano mothers to their lower level of exposure to the educational messages of the project via the flipchart or poster/calendar, as shown earlier.

Figure 7 shows the reasons why mothers gave water/teas to their infant, or if no liquids had been given. At age 2 weeks, 63 and 41 percent of the two intervention hospital mothers (Columns A and B) had given no liquid, and only 21 percent of control mothers had given no liquid. Similar to baseline findings, thirst was the main reason why control mothers had given liquid, at 36 percent. At age 12 weeks, 52 percent, 17 percent, and 8 percent, respectively, of mothers at the two intervention hospitals and the control hospital still had not given liquids. Among those that had given liquids, the most frequent reason was still thirst: this was true of

26 and 28 percent of intervention hospitals (A and B) but as much as 70 percent among the control hospital mothers.

To ask the question another way, we asked each mother at each home visit whether she thought the child had experienced thirst in the previous two-week period, and if so, what the mother did to relieve the thirst (see Figure 8). The result was that the proportions of mothers from the three hospitals who reported that their child had experienced thirst in the previous two-week period were extraordinarily similar to the proportion of non-exclusive breastfeeders. This suggested the determining influence that the perception of thirst has on abandoning exclusive breastfeeding.

Apparently following the message transmitted with the educational materials used in the hospital, about 20 percent of mothers from both intervention hospitals gave breastmilk to relieve thirst, versus only 9 percent in the control hospital. By 12 weeks of age, only 35 percent of all Hospital A (Cayetano) study mothers had begun to give water for perceived thirst, as compared to 62 percent of Hospital B (Dos de Mayo) mothers and 81 percent of control hospital mothers. Cayetano intervention mothers were apparently able to change their belief that infants need water because they are thirsty.

As opposed to thirst, which is more likely to be a perception in the mind of the mother, colic is more of a true phenomenon of which etiology we know little, but can be identified by a baby's incessant crying. Figure 9 shows the distribution of treatments given to infants who had colic reported in the two week period prior to the home visit interview. Similar numbers of infants in each hospital group were reported to have had colic.

At 2 weeks of age, intervention mothers were less than half as likely as control mothers to rely on medicines to relieve colic (28 and 31 percent in Hospitals A and B versus 71 percent in control Hospital C). This could follow from the fact that intervention mothers had been exposed to alternate methods of treating colic as part of the flipchart messages. In addition, as many as 28 percent of Hospital A mothers actually gave breastmilk to treat colic--another part of our messages.

At 12 weeks of age, similar proportions (55 to 61 percent) of colicky infants in all hospitals were given medicine. However, Hospital A intervention mothers still persisted in giving either breastmilk or a neutral treatment in higher proportions than either B or C Hospital mothers, suggesting a long-term effect of the educational intervention in the hospital on these mothers; however, this behavior could also be associated with continued visits to the same hospital for well-baby care with reinforcement of these same messages by outpatient staff who also received the training intervention and copies of the educational materials.

We wanted to see if there could be a statistical relationship between exposure to the educational messages designed for this project and actual feeding practices of the mother. As seen in Figure 10, in Hospital A (Cayetano), the difference in proportions of exclusive breastfeeders between those mothers who were and were not exposed to the flipchart and

poster/calendar is not significant at 2, 4, and 8 weeks postpartum. This is mainly due to the fact that so few mothers were not exposed to the materials (about 10 percent), and this 10 percent of mothers at least had received verbal information on breastfeeding.

Hospital B (Dos de Mayo) did show significant differences between those mothers who were and were not exposed to the educational materials. There is a descending strength of association from $p<.01$ at Age 2 Weeks, to $p<.05$ at Age 4 Weeks, to not significant at Age 8 Weeks. This declining tendency over time suggests that the hospital intervention was responsible for the early strong difference at 2 weeks postpartum, but that other factors caused interference in the effect as time went on. (Note: Week 12 is not included on the table because it is similar to week 8.)

SUMMARY

The following conclusions and recommendations can be drawn from this study:

- The development of specific messages for mothers and the training of health personnel together form a more effective strategy than either one or the other alone for promoting and maintaining exclusive breastfeeding.

- It is essential to focus both personnel training and educational messages for mothers on the same specific behaviors that need to be changed (i.e., early use of water).

- Messages for mothers, as well as health professional training, should be designed on the basis of previous analysis of mothers' beliefs and practices.

- Educational materials should be available in all areas of a hospital where mothers are attended in order to improve the quality, completeness, and consistency of information provided to mothers.

- Frequent retraining should be provided to health personnel due to frequent turnover of personnel.

- Strategies need to be developed to ensure that changes in KAP of health personnel are accompanied by changes in the quality and quantity of education given to mothers, because this does not occur automatically: these could include, for example, written hospital policies and personnel supervision.

- Additional strategies in mass media social communication are essential to reach members of mothers' social support and advice systems for the period beyond the first month or two when health personnel may not have enough continued contact with mothers to help them maintain the exclusivity of breastfeeding.

Figure 1

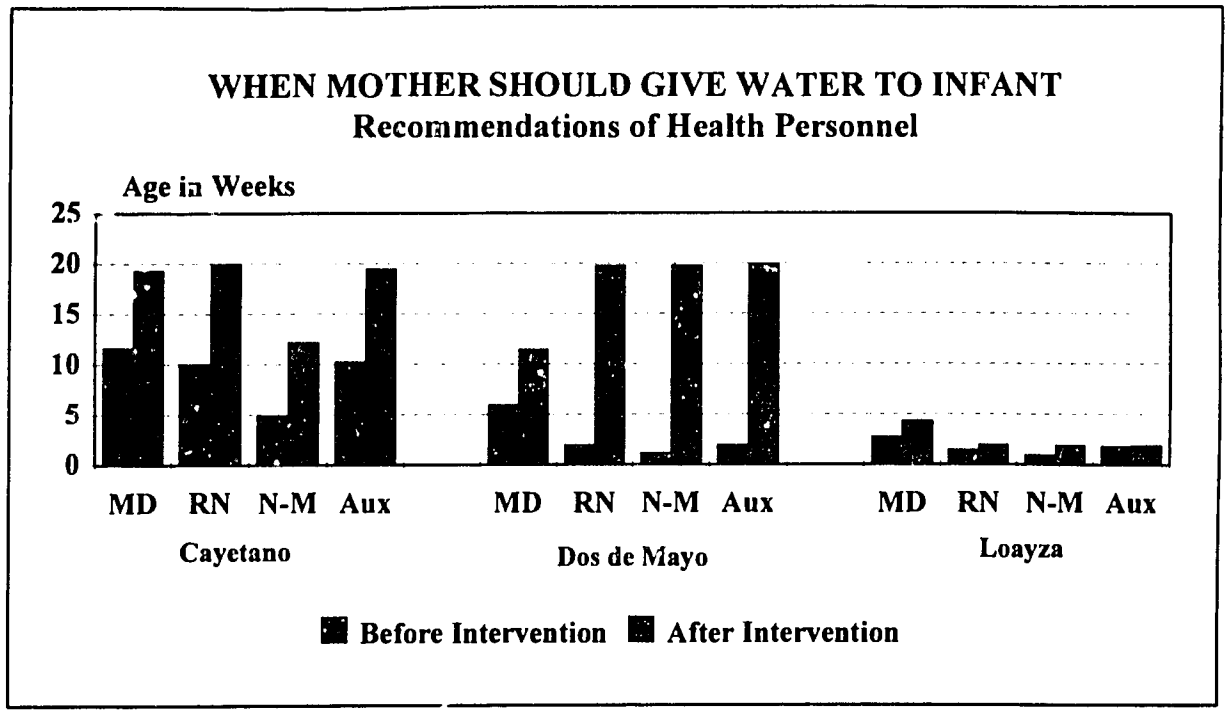


Figure 2

PROPORTION OF MOTHERS STATING EACH REASON FOR INTRODUCING WATER OR TEAS TO INFANT

Factor	No. of Mothers	%
Thirst	50	62.5
Colic or Gas	48	60
Constipation	30	37.5
Dehydration	25	31.3
"For digestion"	22	27.5
Recommendation	12	15
Heat of summer	12	15
Other *	<10	11.3
TOTAL	**80**	

* Includes to accompany medicines, baby crying, mother had little milk, so baby would sleep peacefully, to prevent allergies, saw other mothers doing so, "always need liquid," to rest from milk, mother had a cold or insomnia, "so kidneys would work," "when baby is fussy," "when baby has been frightened."

Figure 3

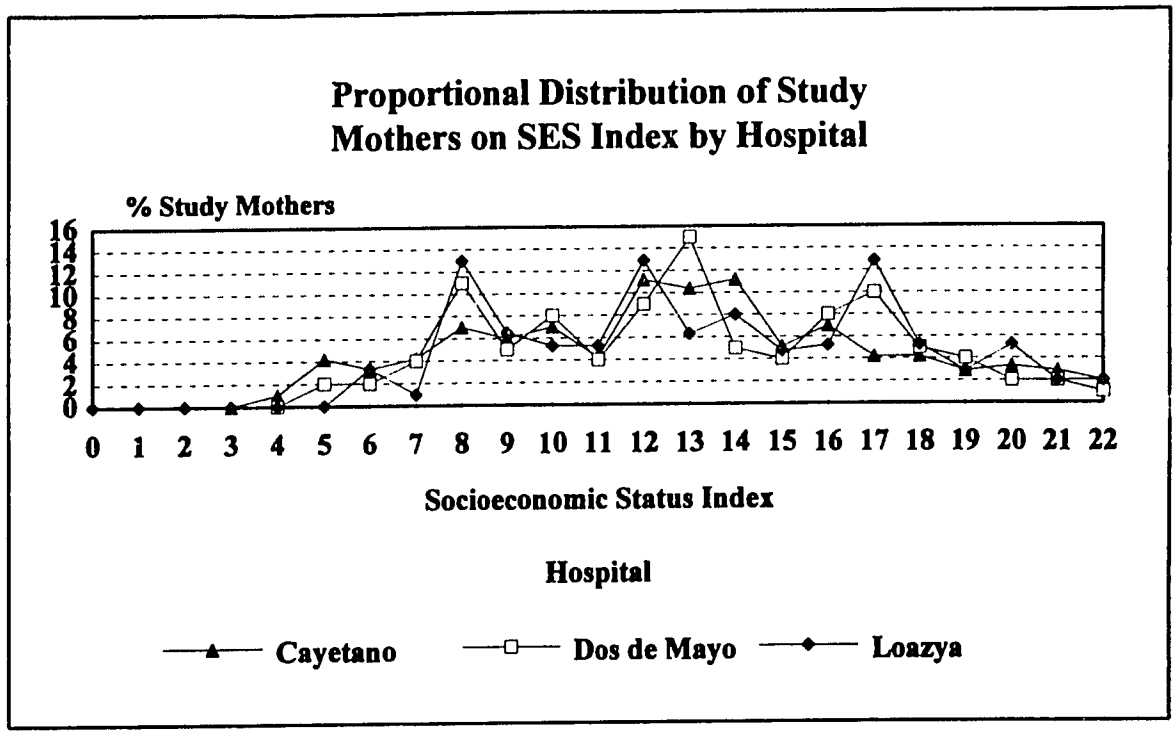


Figure 4

EXPOSURE OF STUDY MOTHERS TO PROJECT INTERVENTION AS REPORTED 2 WKS. POSTPARTUM

	HOSPITAL		
	A	B	C
RECEIVED ANY EXPLANATION ABOUT BREASTFEEDING	90	75	40
RECEIVED A TALK WITH THE FLIPCHART	86	61	8
RECEIVED THE POSTER/ CALENDAR	95	46	0
N =	115	99	107

Figure 5

RECOMMENDATIONS RECEIVED BY MOTHERS IN HOSPITAL AS REPORTED AT TWO WEEKS POSTPARTUM

	HOSPITAL		
	A	B	C
No recommendation	14	25	60
Benefits of BF	27	27	19
Correct Use of Other Milks	59	40	16
Correct Use of Water/Teas	38	10	0
Correct BF Techniques	14	32	14
Incorrect BF Techniques	2	16	16
BF When Child is Ill	10	1	1
BF When Mother is Ill	9	2	0
Maternal nutrition	2	2	2
Incorrect information	2	1	5
N =	**117**	**101**	**111**

Figure 6

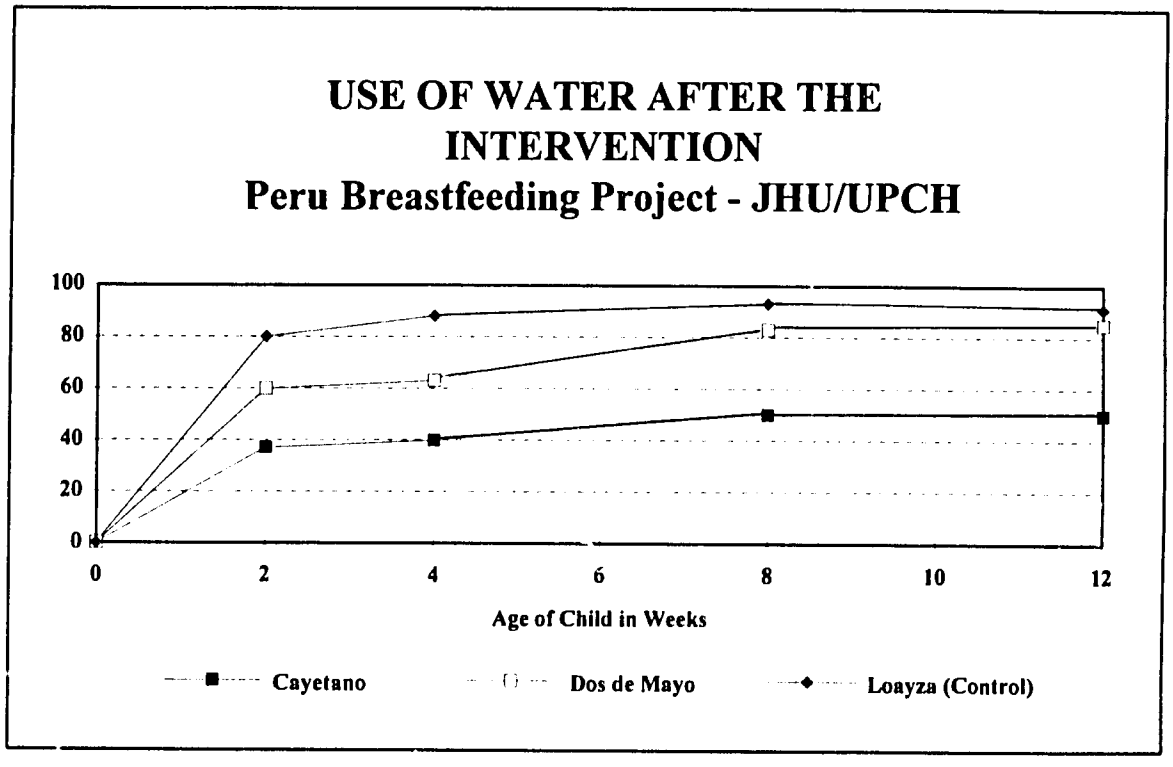


Figure 7

REASONS WHY MOTHER GAVE WATER OR TEA TO BABY

	HOSPITAL		
	A	B	C
AGE 2 WEEKS			
Insufficient milk	10	14	13
Thirst	10	8	36
Colic	7	17	10
Other	12	19	20
No liquid given	63	41	21
N=	**115**	**99**	**107**
AGE 12 WEEKS			
Insufficient milk	6	8	2
Thirst	26	28	70
Colic	5	22	1
Other	13	23	20
No liquid given	52	17	8
N=	**111**	**91**	**104**

Figure 8

WHAT MOTHERS GAVE TO RELIEVE BABY'S THIRST

	HOSPITAL		
	A	B	C
AGE 2 WEEKS			
Breast milk	19	20	9
Water or other milk	21	34	65
No thirst reported	60	46	25
AGE 12 WEEKS			
Breast milk	24	16	5
Water or other milk	35	62	81
No thirst reported	42	22	14
N=	**110**	**90**	**104**

Figure 9

WHAT MOTHERS GAVE TO RELIEVE BABY'S COLIC

	HOSPITAL		
	A	B	C
AGE 2 WEEKS			
Breast milk	28	10	0
Neutral treatment	14	24	10
Water	31	35	19
Medicine	28	31	71
N=	**29**	**29**	**21**
AGE 12 WEEKS			
Breast milk	17	4	0
Neutral treatment	10	8	10
Water	22	29	28
Medicine	52	58	61
N=	**29**	**24**	**18**

Figure 10

ASSOCIATION BETWEEN EXPOSURE TO FLIPCHART AND POSTER/CALENDAR AND EXCLUSIVE BREASTFEEDING

	HOSPITAL		
	A	B	C
AGE 2 WEEKS			
Breast milk	59%	48%	0%
Water or other milk	83%	24%	19%
p value	**ns**	**<.01**	--
AGE 4 WEEKS			
Exposed	57%	33%	0%
Not exposed	67%	16%	12%
p value	**ns**	**<.05**	--
AGE 8 WEEKS			
Exposed	41%	17%	0%
Not exposed	50%	9%	6%
p value	**ns**	**ns**	--

COMMUNICATION STRATEGIES FOR SUPPORTING HEALTH CARE WORKERS: THE ROLE OF INFORMATION

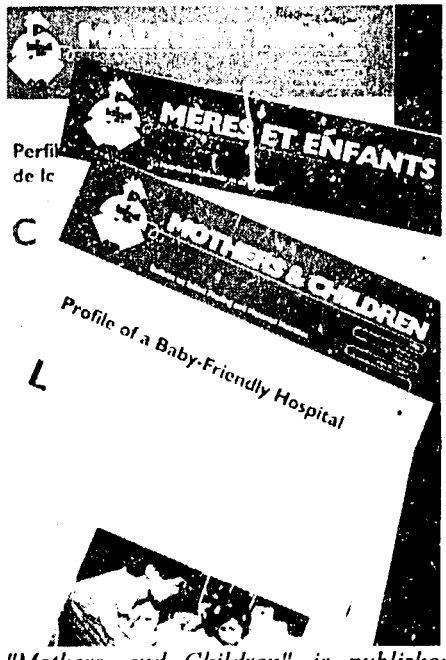
Gayle Gibbons

INTRODUCTION

Information is an essential element in all communication strategies to support infant and young child nutrition. Communication activities may use a variety of strategies and approaches but they all require information. Too often in workshops about communication, information, or information and young child feeding, is not mentioned. If it is, it is perfunctory--as in, "we need information."

In this paper, I present information as it relates to capacity building and sustainable programs; the role of new technologies and communication in enabling organizations to become information producers and providers; and the challenges of organizing, collecting, and disseminating information. Some of the examples will be based on our experiences the last 12 years collecting, producing, and disseminating information at the Clearinghouse on Infant Feeding and Maternal Nutrition and publishing the newsletter ***Mothers and Children***.

Clearinghouse logo



"Mothers and Children" is published in three languages.

The definition of information used throughout this presentation is broad. It includes print and non-print materials from a wide range of sources: journals, newsletters, books, libraries, meetings, organizations, databases, and people. It is not limited to technical information or technical experts. Since so much information relevant to programs and health

workers is unpublished and not widely distributed, a major task is to identify and support sources of this kind of information and to ensure that this information is disseminated to the people who need it in a form that they can use. This can be referred to as "appropriate information," and it contrasts with a preformulated and top-down view of information.

DISCUSSION

We assume too often that an article from the American Journal of Clinical Nutrition is all that is needed to disseminate nutrition information. Technical articles are important, but that information also needs to be adapted so it is relevant and useful to others in the community. The kinds of information needed are as varied as the kinds of activities that are necessary to build sustainable programs. There is a lack of technical information available to health practitioners in the field, but in our work at the Clearinghouse, we also see some other information gaps.

1. Program information: Information about projects and programs is not available. Organizations are unaware of programs that are underway in neighboring countries and frequently in neighboring states. New projects are started without the benefit of the experiences and lessons of others. Disseminating program information is often overlooked or forgotten and it is seldom a budget item. Disseminating the outcomes of programs is a complex, seldom straightforward, and far from automatic process--nevertheless, it is an important process. Unless a program can disseminate its ideas and start having an impact on a larger scale, it remains a costly experiment. Documentation is an important tool in dissemination. However, the simple distribution of materials on their own is not enough. What is required is strategic planning at an early stage of program development to ensure that the possibilities for dissemination are built in and budgeted for from the start.

2. Basic information: The Clearinghouse staff responds to several thousand information requests every year. The majority of these requests are from Africa, Asia and Latin America. The information they need is very different from the information requested by researchers, consulting firms, and donor agencies.

3. Information about information: How and where to obtain information is a critical need. There are many publications and libraries that people in the field do not know about or have access to. The Clearinghouse currently receives more than 550 newsletters and periodicals. Of these, 170 are produced in Asia, Africa, and Latin America. Locally produced publications like these play an important role in synthesizing new information from other sources, translating this information into the local language, covering current programs, focusing on the practical applications of research and technical information, and tailoring their contents to the specific needs of the local community, particularly health workers.

A key issue in any discussion of information is **access**. Who controls information? Where does it come from? Who has access to it? In other sectors there has been a great deal of debate about the "information order," and we see that in the nutrition field as well.

1. Technical articles on infant and young child nutrition are largely from journals published in North America and Europe, and usually only are available in English.

2. Articles about the nutrition situation of children in a particular country are written by outside researchers, not by the people in country--and seldom by individuals actually involved in the program.

3. There is little formal exchange of information between organizations and programs within a country and between countries. If there is, it is ad hoc.

During the next five years, the Clearinghouse project is going to focus on some of these issues and undertake activities to strengthen information capacities and capabilities of some of the organizations we are collaborating with in the field. Currently, we are finishing a workshop for information and communication practitioners from Latin America. The objectives of the workshop were to: (1) develop and strengthen skills in information management; and (2) establish a network of organizations in the field that are producing information and using information to improve the nutrition, health, and overall socioeconomic development of families and communities with special emphasis on women and children.

In addition to providing the participants with hands-on experience, an important purpose of the workshop has been to provide the participants an opportunity to exchange information among themselves, with us, and with other organizations. The six individuals attending the workshop all work in information and communication at their organizations. They have been an important resource for the workshop and we see them and their organizations as future information focal points in their countries. It has been exciting to work with this group and to learn firsthand how they integrate information and communication--the way that they look broadly at nutrition and information as being completely integrated. Increasingly we see the role that new technologies can play in improving access to information and enabling organizations in other countries to be both providers and producers of information.

Information and communication practitioners from Latin America, participating in the 1992 Clearinghouse workshop

For example, in the past, few organizations had easy access to the various medical databases. Now these databases are available on CDRom and updated quarterly. A CDRom can hold 200,000 pages of text. A basic maternal child health library (with full text) could be put on several discs. This process enables organizations to have a library almost instantly with a computer and a CDRom reader. The information that is currently available on CDRom is still somewhat limited to scientific and technical databases, and remains relatively expensive. In the future, there will be many more available on specialized subjects. It is already possible to store images, so, for example, it will be possible to produce CDRoms of actual images and text of education materials produced in a particular region.

The Health Learning Materials project (HLM) supported by UNDP and WHO is an example of an organized approach to improving access to information. This program is working in 30 countries (primarily in Africa) to facilitate the sharing of ideas, information, and training materials as well as human and other resources. Communication mechanisms are a key factor both in networking between countries and transferring information and skills within a country. For example, a training manual for nurses developed in one country is sent via diskette to another country. The manual can then be easily adapted, revised, and modified to meet the training needs in another setting. Too often organizations must start from scratch when they develop materials. Exchanging diskettes allows organizations to build on and benefit from what has been done and tailor it to their specific needs. All the HLM country programs are linked together electronically. These networking systems allow computer users to communicate efficiently, rapidly, and economically to exchange information, access information and resources on distant computers, transfer computer files, and participate in conference discussions. Not only does this process promote information exchange but it also fosters collaboration between members.

In preparation for the UN Conference on Environment and Development in Rio in June 1992, thousands of organizations exchanged information through computer conferencing. These electronic conversations enabled participants to share technical information, fundraising ideas, ongoing developments and urgent alerts about the conference. This process also begins to shift the balance of where information is originated and allows organizations that have traditionally been excluded to participate. The network of Smoking Control Activists uses electronic networking to communicate with members in more than 30 countries. The technology allows for a kind of collective strategic thinking. It also provides an ongoing capacity to be creative and encourages people who normally would not speak at a meeting to actively and continually participate.

Often when these technologies are discussed, there are comments about cost and appropriateness. We see, however, that many of these technologies are already being used creatively and effectively in the field, particularly desktop publishing, CDRom, and video. For example, four of the participants attending our information workshop regularly use CDRom and are networked electronically--and these people do not represent huge organizations in the field. All of these are stand alone technologies that do not require a major infrastructure and contribute to the field having access to information. Just as important, they make information

available on demand. The other comment that comes up frequently is that it is too soon, that we should wait till the technologies are further along. If organizations in the field are to have any influence on how the products and technologies evolve, it is important to be involved in these early stages of development so that we can shape how these technologies are used. For example, the World Bank health care training project in the Philippines recently undertook a "technology" tour to look at the potential for using interactive digital video for training midwives in the Philippines. There are 14,000 midwives in the Philippines who provide primary health care at the village level. Representatives from the Ministry of Health were interested in ways to disseminate information to the midwives other than the traditional approach of training trainers at the national level who train trainers at the regional level who in turn train trainers at the provincial level and so on. By the time it gets down to the midwife who is working at the village level, it may be years and the information may be outdated. Was there a way to package the information so it could reach the village midwife level sooner and without any distortion of content or substance? The tour of various multimedia facilities gave them a view of training possibilities that left conventional health care training far behind. The point is not that they will begin using interactive video for training next week but they begin to look at interactive video as a possible approach to training and disseminating information and not as a single technology. Their long-term strategy, documented in a short video they produced, does include interactive components. In the short term, however, they are expanding their production of training materials using desktop publishing, strengthening their distance teaching, and producing a series of short training tapes using desktop video.

SUMMARY

New communication technologies can help organizations "leapfrog" some of the barriers to access and dissemination of information. We see examples of this already: from typewriter to microcomputer; from telephone to fax; from mimeograph to desktop publishing; from training trainers to interactive digital video. However, it is important to remember that information is not an end in itself but a catalyst to effect change. Information has an important role to play in empowering communities to determine the kinds of programs they need, and can help organizations to adopt the most appropriate communication activities and media for their community.

BUILDING MOTIVATION FOR THE BABY FRIENDLY HOSPITAL INITIATIVE AT THE HOSPITAL LEVEL IN INDONESIA

Hadi Pratomo

INTRODUCTION

Hospital health care providers--OB/GYNs, pediatricians, nurses, midwives, and hospital administrators--are an important audience to influence when we are attempting to implement broad-based changes in hospital practices. However, for changes to be implemented and sustained, we know that change must take place within the actual system in which these providers operate.

The communication objectives of our program in Indonesia are not limited to a change of knowledge, attitude, and skills of the health care providers, including administrators, towards breastfeeding. We also include a strategy to change the hospital management, which can be so key in changing the current promotion and support of breastfeeding. We have found that respected, well-trained OB/GYNs, pediatricians, nurses, midwives, and other health care professionals, are our most credible source of information and skills related to breastfeeding.

In our attempt to motivate these groups, we emphasized building interpersonal communication among those providers themselves. How this was accomplished is presented later in this paper; however, the main focus of this paper is a presentation of a process in which these health care providers were involved: the development of a lactation management training module.

DISCUSSION

Background

Facts About Indonesia: Geography and Health Care System

Indonesia is made of up approximately 13,000 islands which stretch 3,200 miles between Australia and the Asian mainland. The country is the fifth most populous in the world (179.3 million inhabitants), and has more than 300 discrete ethnic groups, 250 dialects, and numerous religions, spread among its 27 provinces, 287 districts, and 62,000 villages. As of 1990's Central Bureau of Statistics Survey, the Infant Mortality Rate in this country was 58 per 1,000 live births.

In 1985, there were 683 government and private hospitals, although the number of health personnel was still considered insufficient for the population: there were, as of 1988/89, approximately 13,614 general physicians; 3,424 specialist doctors; 1,773 dentists; 16,000 midwives; and 76,238 nurses. The smallest organizational health unit which provides

integrated health services to the community is the *puskesmas*, or public health center, which serves the basic health needs of mother and child health and also provides family planning services.

There are some fourteen medical teaching hospitals in Java, a few in Sumatra and Sulawesi, and ten private medical institutions affiliated to teaching hospitals. All of the teaching hospitals are used as paramedical training locations as well.

Breastfeeding Promotion and Support Efforts in Indonesia

The first efforts to promote breastfeeding officially began in 1974, at a National Workshop on Nutrition, where President Soeharto issued a decree on community nutrition improvement. Promotion of breastfeeding was one of the aspects of the health education messages of the resulting program. The Indonesian Pediatric Association (IDAI) has played a key role in breastfeeding promotion since 1974. Other professional, women's, and social organizations began to take part in breastfeeding promotion as well. The National Working Group on the Protection and Promotion of Breastfeeding (BK.PP-ASI) was established in 1977 as an NGO to assist the government in its efforts to protect, promote, and support breastfeeding. Members of the organization are medical and paramedical workers, members of professional organizations (such as the Indonesian Pediatric Association, the Indonesian Society of Obstetrics and Gynecology, the Indonesian Medical Association, and the Indonesian Midwives Association), government officials, members of women's organizations, journalists, and others, located throughout the country.

The First National Symposium on the Promotion of Breastfeeding was held in Semarang in 1977, and the second was held in Manado in 1980. Indonesian pediatricians have been active in promoting breastfeeding as well, especially after the Second Asian Congress on Nutrition, which was held in Jakarta in 1980. Discussion between Indonesian pediatricians, nutritionists, and Dr. Derrick Jelliffe at that Congress resulted in the idea of the "Traveling Seminars."

One of the immediate objectives of the Indonesian Society for Perinatology (Perinasia), which was established in 1981, was to promote breastfeeding as it contributed to the safe birth and health of newborns.

Other efforts have included the government establishing rooming-in hospitals and "Traveling Seminars" on breastfeeding that have been conducted since 1982 with the support of the Ministry of Health and USAID. In 1984, BK.PP-ASI and Perinasia conducted a workshop and seminar on breastfeeding and perinatal care in Jakarta. In 1985, Perinasia, with support from Family Health International (FHI), conducted an infant survey in 16 private hospitals in Indonesia. The results of this survey indicated that much still needed to be done in order to promote breastfeeding successfully in the hospitals.

A National Workshop on Breastfeeding was held in Jakarta in 1989, sponsored by the Minister of State for the Role of Women and BK.PP-ASI. This workshop took place one day after the International (ASEAN) Symposium on Breastfeeding, which was held in Jakarta.

In June 1990, during a one-day seminar on breastfeeding held in Jakarta and organized by the Delivery Hospitals Association and BK.PP-ASI, a declaration on protecting, promoting, and supporting breastfeeding was developed and proclaimed by the Minister of State for the Role of Women. Indonesia also sent representatives to the Innocenti Meeting in Florence, Italy, and President Soeharto attended the UNICEF Child Summit Meeting in New York, which contributed to a renewal of his commitment to motivate and enable all mothers to breastfeed. Other efforts to promote breastfeeding are ongoing and continue to involve both governmental and nongovernmental organizations. Several Indonesian teams have received Wellstart training in San Diego, California.

In celebration of Mother's Day on December 22, 1990, the President of Indonesia declared breastfeeding promotion as a national movement. President Soeharto released a statement noting that "With breastmilk, mothers make the first move in improving the quality of the Indonesian nation." BK.PP-ASI received direct support from the President to hold the First National Congress on Breastfeeding in 1991 and to strengthen BK.PP-ASI commissariates at the provincial and regency levels.

Following the President's Mother's Day Declaration, the First Lady announced the first Baby Friendly Hospital Competition on August 3, 1991. In addition, the MOH issued a policy on breastfeeding and guidelines on the Indonesian Code of Marketing Infant Formula, and developed standards of perinatal health services in the district hospitals and public health centers to support the Baby Friendly Competition. Winners in the competition were announced on Mother's Day in 1991. In 1992, the country was preparing a Second Baby Friendly Hospital Competition, to be funded primarily by the MOH.

In 1992, the Government of Indonesia pressured infant formula producers and importers to sign an agreement that they would not distribute free samples to hospitals and health workers.

The Indonesian team of OB/GYNs, pediatricians, nurses, and midwives who have been trained by Wellstart continue to initiate lactation management training programs in their own hospitals and continue to be actively involved in the in-country lactation management training for district hospital teams. They were also involved in the revision of breastfeeding teaching materials for use in the local medical and nursing schools' curricula in the late 1980s. Perinasia has, as already noted, developed a standardized lactation management training module intended for teams of district hospitals. This module was developed with the support of the MOH and technical assistance from the Program for Appropriate Technology in Health (PATH) and has been used in regional lactation management training sessions of the MOH.

The Lactation Module Development Process

As a result of the breastfeeding promotion and support carried out by various organizations in Indonesia between 1974 and 1990, we have been able to accomplish a great deal in the country in terms of dissemination of information and skills. But what we found in 1990 was that not all key health providers had attained the level of skills necessary, and the training conducted throughout the country by Wellstart graduates was found to be inconsistent. Although these training sessions had been conducted as a result of needs identified in assessments of training needs in hospitals in the late 1980s, we identified several key areas of knowledge and skills that required further uniformity or standardization.

With the support of the MOH and PATH, Perinasia began to develop a standardized Lactation Management Training Module for future professional training and education in the country. The module has three main features: (1) it includes a trainers' guide for the lactation management trainers; (2) it provides 32 hours of instruction with standardized slides, videotape, anatomical models, and other visual materials; and (3) its target audience is a team consisting of an OB/GYN, a pediatrician, and a midwife from a district hospital. To enable sufficient interaction between the facilitator and the trainee, the suggested number of participants for each training session is limited to 15-20 persons (3-5 teams of the district hospitals).

The module consists of 11 units: (1) Introduction, (2) Biochemistry, Immunology, Benefits of Breastfeeding and Hazards of Feeding Infant Formula, (3) Anatomy of Breasts and Physiology of Lactation, (4) Lactation Management, (5) Breastfeeding Problems, (6) Nutrition for Pregnant and Lactating Women, (7) Hospital, Family, Community, and Government Support for Breastfeeding, (8) Rooming-in and Lactation Clinic (Hospital Support), (9) Field Practice, (10) Program Planning of Promoting Breastfeeding in the Hospitals, and (11) Conclusions.

Knowing that the target audience will be mainly adults, this module was developed to emphasize an adult participatory education approach which requires active participation of the learners. Different educational methods appropriate for adults are used, such as group discussion, brainstorming, role-playing, group project, demonstrations, and field practice.

The process of the module development was started by conducting a Workshop for the Lactation Development Module Team in which key Wellstart Associates from Perinasia, BK.PP-ASI, and the MOH (Ciptomangunkusumo Hospital in Jakarta and Karjadi Hospital in Semarang) and a PATH consultant (Ms. Linda Bruce) developed the first draft of the module. The first draft was shared with all Wellstart Associates in the country to incorporate their comments and suggestions between July and August 1990.

After incorporating the input of the other Wellstart Associates in the first draft, the module team, with the support of the MOH, conducted a pretest of the module. Four district hospital teams participated in the pretest and provided feedback in October 1990. In November 1990, supported by the MOH and PATH, the module was used for a training of trainers in

Jakarta. Selected Wellstart Associates from Jakarta, Semarang, Bandung, and Bali, as well as representatives from the MOH, were recruited and participated in the session.

Fifteen teachers from nursing academies were selected as a simulated audience. After the training, the module was again refined in terms of clarity of materials, time allocation for each unit, and guidance for trainers. During the Training of Trainers, Wellstart Associates who would be involved in further training developed a plan of action.

In 1991 the MOH conducted three sequential training sessions for regional district hospital teams which took place in Jakarta, Bandung, and Denpasar. Each training session was attended by 20 participants (four district hospital teams). During the training Wellstart Associates who had been trained as trainers led the training process and combined into different training teams: for example, for training in Denpasar, Wellstart Associates from Bandung and Bali worked together to conduct the training. After this set of training sessions was completed, members of the module development team, who also participated in the training process, were able to solicit some feedback to improve the pretested training module. From one training to the next, the module was continuously improved by feedback from participants.

During the first Baby Friendly Hospital Competition, part of the training materials developed were used to provide orientation to the hospital administrators and the provincial judging team who were overseeing and judging the competition.

In 1992, the MOH, with support from UNICEF (Dr. Felicity Savage King), reviewed the module after conducting several on-the-spot visits to winners of the Baby Friendly Hospital Competition. Currently the module is being revised and the MOH has pledged support for several training courses to use this module in 1992 to prepare for the Second Baby Friendly Hospital Competition in the country.

SUMMARY

Several conclusions or lessons learned can be drawn from the Indonesian experience:

1. Political support is critical to making changes which are appropriate to local culture.

2. A National Breastfeeding Movement can be used as a driving force for planning and implementing breastfeeding programs and activities.

3. The development of standardized, user-friendly curricula helps make training more effective. Key elements in the development of a successful training module include:

   - providing standardized information in training content: it should not be assumed that all trainers present the same information, have the same knowledge base,

or possess training skills. Therefore, a standardized curricula ensures that all trainers are disseminating the same accurate information.

- pretesting the curricula to help ensure that it can be used correctly by a variety of trainers;

- training the trainers in use of the modules to help ensure that they use them appropriately; and

- continuous evaluation and revision of the modules.

4. The use of local professionals as technical resource persons fosters program sustainability. Such professionals include Wellstart Associates and representatives from local NGOs, governmental agencies, and local breastfeeding committees.

5. Government support and involving governmental representatives in the planning and implementation process is crucial to the successful integration of training activities into the health care system.

6. A means of integration includes continuous cooperation and a conducive environment. The opportunity to interact, share, and work together keeps health professionals' motivation high.

7. Maintaining and promoting multisectoral coordination helps to ensure a wider dissemination of training activities.

8. Encouraging interagency collaboration helps to prevent the "reinvention of the wheel."

The spirit of promoting infant feeding in the hospitals in Indonesia has reached an important and challenging stage. Our goal is for the momentum to be maintained and further strengthened. The current high level of political support must be capitalized upon in order to achieve exclusive breastfeeding by the year 2000.

APPLICATIONS FOR NEW VIDEO TECHNOLOGIES: THE PHILIPPINES EXPERIENCE

Bruce Ross-Larson

INTRODUCTION

I believe that I was invited here today to provide a few examples of technological pyrotechnics--CD-ROM, hypermedia, interactive laser disks, virtual reality--all of those wonderful things that are going to be at the disposal of health and nutrition educators and trainers sometime in the near future.

I am also here to share a process of exposure to new technologies and subsequent realization of a comprehensive communication/training strategy based on that exposure. About eighteen months ago, the Undersecretary of Health in the Philippines, Mario Taguiwalo, came to the World Bank with a fairly universal communication/training problem. He returned a few months later with a team of colleagues to tour a number of innovative communication technology labs and discuss possible solutions, and he left with a resolve to revolutionize the Department of Health's entire training program.

DISCUSSION

During Mario Taguiwalo's first visit to the World Bank during the spring of 1991, Stan Scheyer, the Philippines Project Officer, brought him to visit one of my company's offices located at the Bank. Our group has a reputation for doing fairly interesting things and always trying to come up with innovative ways of communicating. Those innovations sometimes are not necessarily profound. Generally speaking, we look for new ways of addressing an audience rather than producing a product. For example, we brought desktop publishing into the Bank fairly soon after its appearance in the marketplace, and use it to distill highly technical information into an appropriate and digestible format for fairly targeted audiences.

Identifying the Problem

Taguiwalo asked us to consider the following problem: how do we train 14,000 midwives in remote settings, under difficult conditions, with limited resources? This training goal was part of a fairly typical, very large World Bank health project with a budget of approximately $104 million, $20 million of which was earmarked for information, education, and communication, and $7 million for training. The original plan was to use 1970s technology--16 millimeter film driven by generators--in the outer islands--and thick volumes of training manuals produced by a Canadian consultant. Typically, in the Philippines, midwives are brought into the provincial capitals for training, where they are expected to sit close together on desks or small benches. They are then, generally speaking, inundated with information for two or three weeks at a time--experiencing a very steep learning curve and an even steeper forgetting curve.

The current system for training midwives and other health workers in the Philippines--a total of 67,000 people--deployed in 31 bureaus and offices in Metro Manila and 14 regions nationwide--obviously is hampered by many deficiencies in consistency and delivery:

- The design and content of training are not standardized.
- Training materials, mostly printed, are difficult to update and revise.
- The print materials are for trainees not instructors, who have little material to support their instructional tasks.
- Training sessions are centered on instructors and do not lend themselves to interaction with trainees.
- Training takes a long time to deliver, because there are few good trainers, many program areas, and frequent scheduling mismatches.
- Demand outpaces capacity because health and clinical issues are rapidly changing.
- The demands on regional and provincial training staff are also soaring.
- The system relies on an echo training approach, where trainers train new trainers, but because of the foregoing problems, the approach is not effective.

Training has been improving recently, but the Department of Health still has too few trainers and technical staff to provide sound technical assistance to program managers at the center and in the regions. It thus devotes most of its efforts to disseminating information about training programs and providing the limited assistance it can deliver.

Part of the problem is the way all health training is currently designed. All too often training programs at the regional and provincial levels have been undertaken with no reference to a master, or strategic plan. Thus, training content has not been standardized and training methodologies vary in their utility and effectiveness. At the core of the design is conventional classroom learning, with lectures and some discussion. Each program area in public health services adopts its own methods for developing curricula and instructional materials. There are no standards for designing or producing these materials, and desktop publishing methods are seldom used. The Department has little capacity for developing audiovisual materials, and is generally limited to slides and overhead transparencies, with occasional use of off-the-shelf training films and videos. The physical distribution of training materials remains a nagging problem. Evaluations are seldom collected systematically from regional and provincial offices, so feedback is shaky.

Added to these problems, the demands on the limited cadre of trainers are considerable and growing. Eighty-four staff work full time as trainers in the regions, and 350 part time in training hospitals and the provincial offices. Training, however, is an additional assignment for senior technical staff in the central office and managers in field offices. Nor is the selection of (part-time) trainers systematic: qualifications are spotty, and turnover is high. Few trainers have received professional training as trainers, and most are training administrators rather than learning facilitator. As a result, they lack facilitating skills, particularly in the use of audiovisual materials and in media planning.

What I eventually proposed to Taguiwalo for consideration was a slightly different approach which avoided the continued use of a great deal of paper. Taguiwalo was very open to new ideas, and so I showed him a video "walkperson," a color television, and fully portable video cassette recorder. I suggested that we produce some highly tailored videos for the midwives, so that they would be able to plug into a fairly sophisticated geographic information system that Taguiwalo would have in his office. Using this information system, the Undersecretary would be able to hit a key on his computer, call up a map of the Philippines, hit another key, and he would have Cebu Province, hit another and have Cebu City, hit another key, and he would be able to focus on the *barangay* level. He could get color coded distributions of immunization rates--above 80 percent, 60 to 80 percent, 40 to 60, under 40. Under 40 percent, they have a problem. That is where they would focus their resources to train the midwives in immunization.

How would this training be accomplished? What I encouraged him to consider doing was to send the training <u>to</u> the midwives using one of these video walkpersons rather than pulling the midwives into the capitol to the trainers. We would help set up a desktop video editing station for him where his trainers could put together, for example, a 7- to 12-minute module on immunization for those midwives. Given that there are 87 dialects in the Philippines, rather than create a video in *Tagalog*, which few midwives speak, we would pick the sound track for the appropriate dialogue for that set of *barangays* east of Cebu City and lay down that particular audio track onto the video. The video would go then into the portable walkperson, and we would send it out to the health care worker who is going to be working with the midwives in training, and have them watch it, again and again and again. It is a very hands-on approach in that the midwife can stop it, repeat parts of it, control it. She can go through the material, a particular component of the immunization training, for example, time and time again. Using this approach, we can put together some fairly sophisticated material cheaply and easily. All it takes is a bit of thought.[1]

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[1] A cautionary note: It is very easy to do video badly. It is comparable to desktop publishing when it was first introduced. A designer friend's reaction when I first discussed the idea with him was: "Terrific. Now anybody can be a lousy designer." Unfortunately, that is what has happened with desktop publishing. There are 17 fonts, and lots of potentially wild abuses of the technology. The same is true of desktop video. Now, anybody can be a lousy director or a lousy producer because they can get in there and tinker with the technology. However, that is also the beauty of it--a sort of democratization of the media, discussed later in this paper.

Taguiwalo went back to the Philippines thinking that it might be interesting to try a new approach. Soon afterward, he put together a team of Filipinos for a technology, or multimedia, assessment mission. The team returned to the United States to look at what we were doing, explore in greater depth the various alternatives, and design a comprehensive strategic plan. He had decided to formulate a new approach for training not just the 14,000 midwives under the World Bank project, but rather all 67,000 health workers within the Department.

Currently, approximately one month per year is devoted to training each health worker in the Philippines, a relatively enormous investment in time and money. Taguiwalo felt that a great deal of the training was ineffective. Not only was the training ineffective, but also many of their educational materials and corporate communication--communication within the Department of Health--were ineffective. They were trying to produce and disseminate a new message on family planning, for example, and although their message was fine at the central level, by the time the message was delivered in the provinces, there were seven different views. The message was going through too many filters. By the time it got to the *barangay*, there were a hundred views. Taguiwalo wanted to try to inject some consistency into their whole health communication system. Video and multimedia were viable alternatives.

The Tour and Identification of Approaches

In November 1991, we put together a two-week study tour or mission that started, appropriately, in Hollywood. There were five people on the mission: Mario Taguiwalo, the Undersecretary; Virgie Orais, Director of Training for the Philippines Department of Health; Carne Abella, the President of the Development Academy of the Philippines, which conducts a great deal of training; and two professional film directors, Maurice Gallaga and Lorenzo Reyes. There was a little difference right there--two film directors. One had a long braid--not your typical health worker--not someone who had produced their conventional health materials. The tour actually was designed and organized jointly with Caby Verzosa of the Academy for Educational Development, who also participated in the tour.

We began the tour at the American Film Institute's Apple Multimedia Lab in Hollywood, California, where we saw an array of Apple multimedia products--laser disk, compact disk-read only memory (CD-ROM), and disk-resident program. The display of new products was so impressive that most members of the group literally did not recover for about two hours after leaving Apple's facility.

Fortunately for us, a workshop was being held the next day in nearby Pasadena with some of the country's top producers of multimedia products, which quickly gave the group an immersion in multimedia, including interactive video disk, interactive compact CD-ROM programs, and disk-resident programs. Although inappropriate at this moment in time for the Philippines, some of these technologies may not be two, three, or four years from now. The exposure got them thinking, however, it starting to trigger all manner of synapses in their brains. How might this technology be applied in the Philippines? Virgie Orais, who is in her fifties, had told Taguiwalo before coming on this tour that she was tired and wanted to retire.

She had seen enough of conventional training and claimed to have beaten her head against the wall for years without getting anywhere. After leaving Pasadena, however, she asked the Undersecretary of Health if she could stay on for another three years or so. She wanted a chance to apply some of these new ideas.

Our next stop on the tour was "Silicon Valley" near San Francisco where the team was given a three-hour presentation by Steve Meyer, founding chairman of Digital F/X, which produces a piece of hardware loaded with software that compresses the equivalent of a $1.5 million dollar video editing suite into a $13,000 box driven by a MacIntosh Computer. This box is truly responsible for "democratizing" video, just the way the desktop publishing began in 1985 and 1986 to "democratize" the whole printing and publishing process. (Witness the number of newsletters and books in the world today: far more than there were just seven or eight years ago.) The same will begin to happen with video because we can now easily produce video, of almost broadcast quality, using fairly simple, inexpensive machinery. This box is bringing the cost of producing video down from $35,000 to $50,000 a few years ago to $3,000 to $5,000 today.

Before flying back to Washington, DC, the group visited Hyperpro, one of the leading producers of on-screen presentations using interactive video disks, followed by a visit to the Hypermedia Group in Berkeley, California, which has also done a lot of interactive multimedia presentations. Here they spent a day looking at Communications Development's desktop video stations and discussing possible applications for the Philippines. The California experience was followed by a couple of days at my company in Washington looking at desktop video stations and beginning to think about applications for passive video, rather than interactive video. We then went to Philips-Capital Disk Interactive, the leading producer of interactive compact disk programs (CDI), and saw what would soon be available in yet another format.

The Computer Medicine Department at the George Washington University (GWU) School of Medicine was the mission's next stop, where the group learned that some medical courses no longer use instructors. The student sits at a video computer screen, goes through the lesson, takes the tests, and the test scores are recorded in a mini-computer. It was at GWU that we found over 300 videos on health education--plain videos, not interactive, but very interesting. Rather than producing their own videos, maybe some existing videos could be adapted for use in the Philippines by laying down an appropriate sound track. Here they also saw an example of virtual reality where they can now train eye surgeons using a virtual reality glove. Using a small stylus, which emulates a laser knife, held between the fingers of the glove, and a computer screen--3-D imagery based on magnetic resonance imaging (MRI)--the student can practice performing eye surgery--reattaching a retina, separating tissues, for example--on the computer screen, performing the entire operation in virtual reality rather than reality.

The Strategic Plan

By this point in the tour, members of the mission felt that they had seen some tremendously useful training devices. But, were these technologies appropriate to the Philippine situation? What would the problems be in transporting this technology? To help answer these and other questions, we visited the final stop on the tour, the National Library of Medicine, where we saw 30 to 50 interactive video stations ranging from CD-ROM, laser disk, and simple disk-resident programs.

It was at this time that the group sat down together to discuss and reflect on the various technological alternatives to which they has been exposed. As a result of the multimedia study tour, a three-pronged strategy was developed to address the specific training-related problems and constraints outlined above.

The team's vision was to give trainers more power in the training process by giving them new tools and techniques, and to give trainees more power by allowing them to proceed through interactive tutorials at their own pace and in the directions they desired. This strategy recognizes that almost all the Department's training and communication efforts will be traditional for many years. It also recognizes that trainees will learn mostly in groups rather than in isolation--and that multimedia systems will support rather than supplant trainers.

Members of the team felt that the application of these three strategic initiatives would improve the Department's training and corporate communication system by professionalizing the system, eliminating bottlenecks in production and distribution, making the most of the print and video resources already available to the Department, and beginning to take advantage of low-cost technologies in print and video. The overall strategy opened the possibility for greatly strengthening the impact of training and communication by making modest, sensible investments in new equipment and skills.

The following summarizes each of the three components or initiatives of the strategic plan, although, over the next few years, resources will be focused only on the first two. The use of interactive multimedia technology will be explored later.

1. Strategic Initiative 1: Improving Traditional Training and Communication: Traditional methods will for several years dominate training and corporate communication within the Department of Health. With this in mind, the greatest effort will go into improving and augmenting those methods, along the following lines.

Produce better print materials and presentation graphics. Desktop publishing (DTP) software makes it possible to give training and corporate communication materials a professional look—and to update them easily. DTP means using a conventional personal computer to set type and produce presentation graphics (for handouts, overhead transparencies, and slides). Getting started in DTP generally requires buying a few software packages, additional memory for the computer, a laser printer, and a large screen display. It also requires

having the operators learn by doing for about six months, with periodic guidance from computer and design specialists.

Make better use of video equipment. To get a bigger payoff from the Department's inventory of video equipment, a recommendation was made that senior staff be trained in how video cameras and players can be used to improve people's presentation skills and to record meetings, seminars, and site visits for viewing by others. It was further recommended that handycams and video walkpersons be acquired--in stages for the central and regional offices--and that two senior staff at each office be trained in their use.

Make better use of the video and film library. To make it easier to tap the Department's library of 300 films and tapes, it was recommended that they be transferred to a single format and that the content of each segment in each film and tape be logged. It was also recommended that a small videotape duplicating center be established to handle and produce tapes in various formats, such as VHS, Beta, HI8, and BetaSP.

Acquire off-the-shelf training materials. Some of the Department's needs for training materials are already being met, but the staff is only beginning to learn about who is producing what. The study team's visits to the Computer Medicine Department of George Washington University's School of Medicine and to the United States National Library of Medicine, revealed vast stores of slides, videotapes, computer programs, compact discs, and videodiscs on health and medicine. To find out which of these materials might suit the needs of the Department, however, a recommendation was made to establish ongoing relationships with the institutions just mentioned as well as with many others, such as TV Ontario and the Children's TV Workshop. A mechanism should be established to routinely review materials that might be appropriate for the Department's use and for purchasing materials that clearly are appropriate. Once the format of these materials is determined, they should be acquired in stages--compact disc players (CD-ROM drives), videodisc players--and memory added for the personal computers that they will operate with.

2. Strategic Initiative 2: Moving Quickly Into Desktop Video Production: The use of video in training and corporate communications is not new, but until now it has been expensive and fairly inflexible. With the advent of desktop video (DTV), production is now fast, easy, and inexpensive. DTV brings the cost of the editing suite down from $1,000,000 to $30-50,000. Although lacking some of the capabilities of a conventional suite, DTV stations can produce video of high quality. Perhaps most important, DTV puts editorial control in the hands of the client.

This video, which I put together last night at 6:00 o'clock, illustrates the simplicity of the system.

> *"To help train 14,000 midwives in the Philippines, we have developed a three-stage process of desktop video production. In the first stage, we use a handicam camera, Pi-8, and a video walkperson. We put it into the hands of people who*

will actually be doing the training to familiarize them with the medium of video, to have them do some actual shooting of what they are trying to train the midwives in, and to do some simple editing using this as the source deck and using this as the edit deck. With these simple devices, they can produce a rough-cut video that then moves on to the next stage.

Now, for stage two, we take the tape that the trainer produced and use it as the basis for re-shooting the entire production. Instead of using the little handicam, we use a professional grade, still fairly light-weight camera. It costs about $3,000 as opposed to $1,000, but it is far below the $35,000 that the typical Betacam camera costs. We also increase the quality of the sound by using a wireless microphone to get professional grade sound rather than using the microphone that is built into the handicam. We then edit on a serviceable quality editing deck to produce a second rough-cut that goes on to the third stage.

Now, for stage three of the process, we take the rough-cut that was produced reasonably professionally, at least by someone with a fair amount of experience, and use this as the edit decision list for cutting the final tape. The machinery? At the core of it is a digital effects box that crams about a million-and-a-half dollars' worth of video equipment into a $13,000, controlled by a MacIntosh Quadra-900. You could, however, use something that is quite a bit smaller. This screen allows us to control the edit. We are also able to control the sound. You can piece the show together as you like. If you want to experiment, move something before or move something after, you are able to do it easily. Once you have locked into the program you want, then, and only then, do you lay it down on tape.

Think of it this way. You have the midwives and the trainers out there with this $1,000 station, this work station in a handicam. Add another $1,000 for the video walk person, and they are able to do much of the development work out in the provinces, out in some barangay east of Cebu City. They send the tape which they have produced to a provincial capital, say, Cebu City, where somebody with greater experience pieces together the rough-cut and captures good quality footage. That then comes to the central facility in metro Manilla at the Department of Health where they piece together the final show. What is important to mention here is that the development work is being pushed back where it belongs; it is being pushed back to the client. It also allows the client, the trainers, to test the tapes they are producing. They give their tape to somebody with a bit more experience to be re-shot. The effectiveness of the tape is then tested, and final decisions are made about what to include. Then, and only then, does it come to the central facility where the final show is pieced together--highly portable video, very inexpensive--a new generation of training materials.

There you have it. Serviceable quality video in about 15 minutes."

Elements of the second strategic initiative were examined carefully by the team. They wanted to begin to produce their own video in the field, and to use desktop video technology for editing that video. They decided, as the first step, to acquire one of our desktop video stations.

Acquire the equipment. To give the Department the capability to produce broadcast-quality videos quickly and cheaply, a DTV workstation was recommended, as proposed by Communications Development Inc.--centered on the Video F/X box produced by Digital F/X of Mountain View, California. It was also recommended that professional grade cameras and low-end editing systems be acquired for the center and later for each of the regional offices.

Stan Scheyer, the World Bank Philippines Project Officer, at a desktop video workstation

Handicam camera, Pi-8, and a video walkperson

Train the users and operators. To institutionalize this DTV capability, it was recommended that short training sessions be held for senior staff in DTV's capabilities and possible uses. Two prospective operators should be identifying and sent for extended internships with the equipment supplier and users of this technology, such as Communications Development Inc.

Use outside talent. To support the DTV unit and complement the Department's skills, it was recommended that indefinite quantity contracts be opened to make it easy to enlist local directors, producers, editors, and cameramen.

Deliver video. To deliver videos on training and corporation communication, it was recommended that three routes be considered. The first is to mail Beta duplicates to the desired offices. The second is to send HI8 duplicates out on video walkpersons so that they could be played alone under battery power or plugged into a television. The third is to

broadcast over public television at low-demand times and to have health staff tape the videos on their videocassette recorders.

Produce the first two videos. To demonstrate power and capabilities of DTV, it was recommended that one video be produced for training (on counseling techniques) and one for corporate communication (on the structure and lines of communication in the Department).

3. Strategic Initiative 3: Experimenting With Interactive Multimedia: Multimedia, naturally, means many media--text, video, sound, music, graphics, animations. Interactive multimedia means that the intended audience interacts with it--rather than view it passively, as with a book, a lecture, a radio broadcast, or a television show. The reason for considering interactive multimedia is compelling: experts say that people retain 20 percent of what they see or hear, 40 percent of what they see and hear, and 60 to 75 percent of what they interact with.

Interactive media (IMM) thus means many things. At one end it means using telephones and telewriters for an instructor to interact with groups of trainees at numerous remote locations. At the other it means creating virtual reality to train airplane pilots in instrument use and inflight techniques without getting off the ground--and medical students in eye surgery without seeing a patient. In between it can involve video kiosks with touchscreens that allow users to navigate through a large body of information on, say, health services available to them--or training programs that on personal computers to train medical students in immunology.

Getting started in IMM generally requires deciding which form of IMM makes sense and then buying the services of one of the world's top producers of IMM programs for the first one or two projects, ensuring that the technology transfer is considerable and that the flow of technical assistance is ongoing. The key consideration in using IMM is delivery, and for the Department that means relying on the installed base of IBM personal computers and clones. Future alternatives include: interactive telephone and telewriters; interactive multimedia, disk-resident programs; interactive computers with compact disc capabilities (CD-ROM); interactive computers with videodisc capabilities; compact disk interactive, which differs from straight CD-ROM; and other emerging technologies such as Kaleida, Quicktime, full digital video, virtual reality, which are all exciting developments that could push up the timetable for moving into interactive multimedia.

SUMMARY

Time allows only a small sampling of what we can accomplish, but the applications of new technologies to education and training are almost limitless. There are many creative and imaginative solutions to be explored.

In summary, three strategic initiatives have been proposed for improving the effectiveness of training and corporate communications within the Department of Health in the

Philippines. The first is to improve what is already being done. The second is to increase the impact of training and corporate communication by moving quickly into desktop video production of training tapes and corporate messages. The third is to begin to empower trainees and to augment the tools of trainers by experimenting with interactive multimedia. We will monitor the progress of these initiatives in the Philippines and certainly will have interesting results to report in the near future.

PLENARY SESSION V:

DEVELOPING COMMUNITY BASED STRATEGIES -- USING COMMUNICATION FOR SOCIAL MOBILIZATION

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TARGETING TIP: THE BRAZIL BREASTFEEDING PROGRAM

Gerson da Cunha

INTRODUCTION

The purpose of this presentation is to consider some of the aberrations that all too often afflict a great deal of our communication programs in nutrition: among these considerations, I would like to emphasize the particular difficulties associated with targeting. To demonstrate some of these issues, I will present a program process of which I was a part that successfully tackled a formidable challenge in targeting and share some of the lessons we learned about this experience.

DISCUSSION

The Brazil Breastfeeding Program

The strategy behind the Brazil Breastfeeding Program, launched during the 1980s, was based heavily on the identification of numerous targets or target audiences, which were then prioritized and addressed with individual messages through specific media.

An audiovisual that launched a program

Members of the Brazilian Ministry of Health and UNICEF involved in designing the program were convinced that to bring about appropriate policy change, correct decision making, and the necessary political will to launch a breastfeeding program nationwide, they would have to create an audio slide set for breastfeeding advocacy. The content of the slide set, far from containing new information, was largely based on papers, reports, and previously published work, including the Jelliffe's Human Milk in the Modern World. The group took these largely print-based media and translated them into a professionally conceived and executed audiovisual piece. A slide of baby bottles filled with United States currency, for example, was used to illustrate visually the point that millions of dollars in foreign exchange were being wasted each year on the purchased breastmilk substitutes.

This audiovisual presentation was unusual in that it targeted only two people: The Ministers of Health and Social Welfare. Although it took some time to arrange the schedules

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of these two Ministers to permit a joint viewing, when the projection took place, the expected results were accomplished. The Ministers decided on the spot to launch a national breastfeeding program. Resources were allocated and a commitment was made to dedicate public service announcement time in one of the primary public television stations. The broad lines of program planning were to be guided by research, into which a major financial investment was made by the Government in both qualitative and quantitative research.

The research basis

The research resulted in not only an approach for the communication component in the planned program, but in a strategy for the implementation of the entire program. In many ways, this process was an example of communication actually being the program. The research also resulted in a number of other interesting findings: for example, factors that were negative to breastfeeding promotion and support were shown to originate in many different sectors, of which the mother represented only one.

These results helped the program planners build a hypothetical model of how obstacles to breastfeeding are created. The model was built up by sector of influences on breastfeeding. The first level was the ***mother***. What did she know? What was her attitude about breastfeeding? How was she actually practicing, or not practicing, breastfeeding? We found that although the mothers' knowledge of the benefits and techniques of breastfeeding was lacking, their attitudes were strongly positive, for the most part. Since a number of factors were influencing or impairing lactation or the physiology of lactation, the program and its planned communication component had, as a primary priority, to educate the mother and to heighten her confidence in herself and in her own breastmilk.

Another important sector of influence on breastfeeding was, not surprisingly, ***health care providers***. Doctors and nursing staff often were poorly informed about optimal breastfeeding practices; hospitals and maternity wards lacked rooming-in facilities; and common obstetrical practices frequently were unfavorable to breastfeeding. As a result of this finding, we knew that the program and its communication component would have to prioritize a transformation of the health system into a better source of information, motivation, and support for the woman who wished to breastfeed. Hospitals needed to change their approach, systems, and infrastructures: the health system needed especially to consider actions such as implementing rooming-in and discouraging or decreasing the number of caesareans and routine episiotomies. In other words, the hospitals needed to begin to become what we call today a "Baby Friendly Hospital."

The third sector that was found to have an influence on breastfeeding was the woman's ***environment***. The environment, including the ***community*** in which a mother found herself--family, friends, religious as well as community groups--was no longer as supportive of breastfeeding as it once had been. The fourth sector that was found to have an influence was the whole realm of ***"officialdom,"*** or ***government***, which includes policy formulators, legislators, and decision makers in government. The program and its communication

component therefore had a large and crucial task of advocacy and provision of information for this extremely important target audience. Enforcement of existing breastfeeding supportive legislation was a key issue. In addition, community and family based voluntary organizations, including women's groups, did exist and needed to be mobilized in the effort to support and promote breastfeeding.

The final sector whose influence was studied was ***industry***, which included the manufacturers of breastmilk substitutes--whose marketing practices had long been detrimental to breastfeeding--and industry in general: conditions of job security, maternity leave, provision of creches at the place of work, and several other aspects, all were strongly negative to the support and promotion of breastfeeding. Therefore, the new program would have to work with the government to end the undesirable marketing of breastmilk substitutes as well as the promotional aspects of this business. An additional focus would have to be the development and incorporation of the appropriate facilities for women to breastfeed within their communities and places of work.

Together, these five sectors--mother, health care providers, environment/community, government, and industry--accounted for all major problems associated with breastfeeding support and promotion in Brazil. The model we developed emphasized that each factor, or sector, contributing to the problem, regularly interacted with virtually every other sector. Each sector could cause the problem on its own as well. As a result, each sector had to be addressed or the mother who wished to breastfeed could not be appropriately supported. The model we developed also assisted us in depicting an analytical model that yielded target groups and demonstrated what kind of intervention was required in each. This step was the first taken in using design and media.

The program group began to work early on with a leading Brazilian advertising agency. Through the agency, a small sample qualitative research study was commissioned. The research suggested that an overwhelming proportion of women began breastfeeding their babies and wished to do so for six months and longer. However, these women rarely succeeded in this wish as a result of all of the factors listed above. There was an additional factor that was interfering that was very personal to the mothers, which I will now address.

In our primary target group, the typical low-income mother had a very poor self-image. She often suffered from abandonment or abuse, and was insecure about her ability to breastfeed and the quality of her own breastmilk.

As a result of this poor self-image, we found that perhaps the most destructive and counterproductive campaigns for these women were those extolling the romance of breastfeeding. For example, some of these campaigns advertised that breastmilk is "Love, Nutrition, and Protection," and showed beautiful women tranquilly breastfeeding their babies. These types of campaigns resulted in our target mother feeling completely inadequate, and responding to the images of one of these beautiful women breastfeeding with, "Yes, <u>she</u> can breastfeed, but <u>I</u> can't." This reaction would exacerbate her anxiety and could thus

psychologically inhibit her ability to lactate successfully. Therefore, the conventional approach to breastfeeding promotion, far from being helpful, was indeed harmful.

We saw that to be effective, our communication component needed consistently to provide helpful information on how to breastfeed and reassurance that all women can breastfeed. We had to address misinformation and misbeliefs about weak milk and other common problems.

After initial pretesting, the group agreed to a campaign theme of *Amamentaçao: seis meses que valem una vida* (*Breastfeeding: six months that are worth a lifetime!*) During the campaign, this main idea was placed firmly in the context of the realities of breastfeeding.

The television approach

The communication component of the program took several approaches, which are best exemplified by the television commercial campaign. There were five, thirty-second television commercials during the campaign, all of which used prominent Brazilian's to promote the case of breastfeeding.

1. **Socrates**: Socrates was the captain of Brazil's World Cup football team, therefore, in Brazil, enjoyed the status of a god. He had also graduated as a medical doctor. For the commercial, in an interview Socrates relates that all of his four sons were breastfed for many months. Both he and his wife made sure that their children were breastfed. He notes that only breastmilk provides certain immunities to infants.

2. **Marilia Gabriela**: The next commercial featured Marilia Gabriela, the presenter of Brazil's leading women's television program. In the commercial, she says that both her mother and she breastfed their children for more than a year. She adds that breastfeeding is not always easy. One of the tricks is to start breastfeeding the very day the baby is born. The commercial ends with the "payoff" for breastfeeding, which is always the theme, *Breastfeeding: six months that are worth a lifetime!.*

3. **Erasmo Carlos**: Carlos was a "macho" superstar in the music field. He tells the audience that he donated the theme music to the breastfeeding program as homage to women who bring up their children and look after the household--women like his wife. Although he himself often felt he was suffering because his wife was breastfeeding, he sees the real rewards: the health of his sons.

4. **Lucelia Santos**: Another superstar of television and film, Lucelia Santos, appears in a commercial in which she states that she too insists on breastfeeding her baby. She makes a plea to industrialists and employers to help nursing mothers to breastfeed their babies.

5. **Maria Zilda:** Zilda, a top actress in television serials, tells the television audience that she was at first uncertain about being able to breastfeed her son Rafael. She was surprised how easy things became when she persisted. She notes that proper breastfeeding takes several months.

Both the Marilia Gabriela and Socrates television spots focus on the advantage offered to the child by breastfeeding. Socrates represents male and medical authority. Marilia speaks from feminine experience that worked for her and her children. Each message was targeted to specific segments of the program universe. Erasmo Carlos stands for the support that a husband must provide to his breastfeeding wife, because despite difficulties and annoyances, breastfeeding has a wonderful payoff. Maria Zilda identifies herself with women who have "early problems," but urges women to confront their problems because they can persevere and succeed in breastfeeding their children. Finally, Lucelia Santos addresses some of the environmental/community problems a breastfeeding woman must face: employers, domestic, communal and individual.

As I have shown, the television spots addressed all of the main target audience segments--doctors, health workers, husbands, and business, legislative, and community leaders--while also addressing the issues important to the mother. The television spots accomplished a great deal by basing their messages on the research findings, resulting in identical message formats and a common theme.

It is important to note that the mass media are always expensive. The problem of cost was partially solved when CBBA, a major Brazilian advertising agency, agreed to work for the program if at least their out-of-pocket expenses were covered. Rede Globo, the country's main broadcast network, provided free air time. Each of these offers covered a two-year program.

What did we learn from our experiences with television? I will examine the results of the television campaign through a discussion of the results of the campaign in fifteen representative Brazilian cities in terms of weight and frequency of message delivery during the first ten months of the program. If we consider only our target group (lower income mothers), television reaches some sixty percent or more of them. In the first ten months, our spots reached all of this target audience through repeated viewings.

The campaign had a weight and frequency similar to that of the advertising for a cooking oil, a washing product, or cigarettes, in what we could describe as a medium to heavy effort. The breastfeeding campaign provided nearly a billion exposures to seven million target women. Each woman, therefore, had as many as 150 chances to receive, during a ten-month period, the messages of the campaign. In reality, the program lasted three years.

What was the value of the resources donated by private Brazilian organizations in the communication industry? In just the first ten months the market price of services, royalties, media time, and space contributed totalled 445 million Brazilian cruzeiros, or one million American dollars. What the breastfeeding program actually paid amounted to just ten million

cruzeiros, or 22,000 dollars! The balance of the cost consisted of donated time and services. I should emphasize that I have only discussed the television aspect of the communication component of the breastfeeding campaign. Other media materials were produced as well. For example, there was a press advertisement with the headline, *This advertisement may be worth a life*, which doubled as a sort of leaflet of instruction for the mother. The advertisement suggested that readers cut out the ad and give it to someone they knew who was expecting a child. We also produced a poster and a billboard advertisement.

A great deal of creative and production activity occurred during the campaign. Different types of activities were carried out in the various states of the country, including training of health workers, meetings with mother's groups, contacts with parish organizations and voluntary agencies, organization of and attendance at professional medical event meetings with hospital authorities, employers, Chambers of Commerce and Industry, State and City level administrations, and so forth.

SUMMARY

Since evaluation was built into the program design from the beginning, it was easy to study the net result of our efforts. A professional benchmark survey was conducted before the program was launched. The study looked at a sample of more than one thousand mothers in two cities, as well as a group of pediatricians, obstetricians, and health workers.

After the program had been underway for three years, a study was conducted in Sao Paulo in 1985, independently of the program. The study showed that the decline in breastfeeding practices "had been halted and was beginning to be reversed." Increases in the number of mothers breastfeeding and in breastfeeding duration was recorded across all socioeconomic groups.

The report from the Sao Paulo study notes that "The city of Sao Paulo, with over ten million inhabitants, appears to be the first large city in the Third World where a reversal of the trend toward early weaning has been documented." While the report does not trace all of the effects of the program presented in this paper, it does note that "...perhaps a new trend toward a return to breastfeeding (is) underway. It is worth noting that since 1981, a nationwide breastfeeding campaign has been underway in Brazil, focusing mainly on instructional messages conveyed through mass communication media across the country.[1]

The most effective component of the communication campaign appears to have been the television spots. The final report of the evaluation of the program notes that, "This evaluation of the media campaign's quality, of the interviewees' opinions and of the favorable results demonstrates the power and impact of television in changing values and habits." In

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[1] Carlos Augusto Monteiro, et al, *The recent revival of breastfeeding in the city of Sao Paulo, Brazil.* American Journal of Public Health, 1987; 77: 964-966.

fact, as many as four and five years after the spots I described were aired, they were remembered and quoted, some with greater accuracy than others.

The least effective component of the program appears to have been the health services and hospitals. Of the mothers in the sample evaluated, sixty percent either had heard nothing about breastfeeding at prenatal sessions or did not attend prenatal instruction at all. More than 60 percent of the mothers said that the staff in maternity wards and hospitals had no attitude at all towards breastfeeding, or had negative attitudes, or remembered nothing on the subject. And, finally, one out of four mothers reported support from nurses; slightly more than one out of ten reported that doctors were helpful.

I have attempted in this paper to present a program process which addressed a communication targeting challenge which was dealt with successfully. The Brazil Breastfeeding Program was able to take the five sectors--mother, health sector, environment/community, government, and industry--influencing breastfeeding support and promotion in the country; to develop a model that accounted for the interaction of each of these sectors on the other; to design media interventions to address each of these sectors and their complex interactions; and ultimately to positively influence the promotion and support of breastfeeding in the country.

Lessons Learned

1. Investment in research pays.

2. Creating a model that describes the solution pays. In Brazil, the model helped us to redefine the problem. The problem was no longer how to get more mothers to breastfeed longer, but instead, how to build the self confidence of a mother in herself and in the quality of her breastmilk--an important difference.

3. The use of mass media is critical: facilitated, activated, and stimulated by face-to-face communication and other community-level activities.

4. The element of persuasion is fundamental. The program in the end was neither informative nor educational but rather hinged on persuasion, meaning communications that offer benefits. Our communications focused on making the perceived value of breastfeeding higher than the perceived cost. The use of celebrities to "dress up" breastfeeding was an effort in that direction.

5. The development of an advertising/marketing framework helps to create separate "products" for separate "consumer markets". In those products, breastfeeding was only one ingredient and the other products were suited to the target audience.

6. Governmental change or change in priorities can cause havoc with national level programs. The breastfeeding program, for example, was suddenly inactivated after

several years of strategically planning and integrating activities. Breastfeeding rates dropped again. It is very obvious that something needs to be done about ensuring the continuation of programs.

DESIGNING A MEDIA STRATEGY TO END CHILDHOOD HUNGER

Ann Kittlaus

INTRODUCTION

The Food Research and Action Center (FRAC), located in Washington, DC, is the leading national nonprofit organization working toward improved public policies to end hunger in the United States. Founded in 1970, FRAC works on a variety of fronts, including research into the causes and extent of hunger; policy work, such as lobbying on Capitol Hill and working with federal agencies like the United States Department of Agriculture and the Department of Health and Human Services; and training and technical assistance to legal services attorneys. FRAC is involved in field organizing and support to state and local groups working to expand food assistance programs; and is also involved in broad public and media relations, which is primarily my job.

This presentation highlights a project which FRAC launched just over a year ago that has not only brought greater focus to our work, but also has galvanized and broadened anti-hunger efforts around the country as never before. Known as the Campaign to End Childhood Hunger, this project combines grassroots organizing, national and local advocacy, and public education and media relations to focus attention on the urgency of the domestic hunger problem and to build support for solutions. It has, thus far, been the most exciting and challenging project with which I and many of my colleagues have been involved.

DISCUSSION

The idea for a Campaign originated about two and a half years ago at a meeting of what FRAC calls its "hunger leaders"--the one or two lead anti-hunger advocates or food bank operators from each state and selected national group representatives. We were running through our agenda of "nuts-and-bolts" policy goals and legislative priorities, when it became clear that our network had other needs that were not being addressed. Members of the meeting started talking about how tired they were. They were discouraged from the defeats of the 1980s. They were stretched to the limit and feeling isolated. They said they came to FRAC meetings to renew energy and feel part of things, but that, this time, it was not enough.

They wanted to be part of something that was bigger than their individual agencies or states. They wanted to share common goals and common language and images. They wanted to share successes and failures. They wanted support and materials. They wanted tools to better reach the media and the government. They wanted to be part of a movement to end hunger in the United States and they wanted FRAC to pull it together.

We at FRAC were overwhelmed. Clearly, this mandate was not in our workplan and we knew we did not have the in-house expertise to make it happen; we are devoted to our

grassroots network, however, and they were devoted to this new movement. We saw the potential and wanted to make it work.

For the next 18 months, we met with groups and individuals. We had consultants and gurus talking about computer networks, video news releases, audio messaging, and teleconferencing. We brought in artists, sloganeers, and radio actualities, and had conference calling, media and spokesperson training.

Through all this "hot" technology and strategizing that we barely understood, we struggled to define "the what." Finally, the pieces started falling into place--and a year ago last March, in partnership with our network across the country, we launched the Campaign to End Childhood Hunger.

The Campaign got off to a magnificent start with press conferences and activities all across the country. In Washington, FRAC released the most comprehensive survey of hunger among low-income families with children ever conducted in this country--the Community Childhood Hunger Identification Project, or CCHIP. From that study, FRAC estimated that about five million children under age 12 are hungry and that millions more are at risk of hunger. We shared state-by-state estimates with our groups across the country and provided them with other tools to help them get the message out.

On the day of the release, I could feel a pulse moving across the nation. Between calls from the media, I took calls from members of the network who were practically jumping through the phone to share their excitement. For those on the outside, it seemed like the culmination of a lot of hard work. It certainly was that. But for those on the inside, it was a new beginning. The gates were opened and we were off!

Several things led to that tremendous beginning and have held us together through a very exciting first year:

First, we strengthened and expanded the anti-hunger network. We improved communications through computer networking, conference calling, and regular meetings, and provided the training and materials that people needed to get their work done. We boosted their confidence in working with the media and elected officials. We produced a videotape to educate and build coalitions. We provided opportunities for them to get to know each other and add new partners to their work.

Second, we defined "the what." We decided to focus our campaign on children and developed a clear set of policy goals. Long-term solutions must be found for hunger and its underlying causes, but hungry kids cannot wait for the long term. In the short term, we have an array of federal food assistance programs that if fully funded and utilized, can go a long way toward alleviating hunger. Our policy focus has been to improve school lunch and breakfast programs, the food stamp program, to bring summer meals to children out of school, and to bring more eligible people into the food program for women, infants, and children.

On the public education front, we have had a special challenge: hunger is this country is often invisible. America's hungry children do not have the distended bellies and emaciated bodies that children in famine-stricken areas of the world display. Instead, the impact of hunger among children here often manifests itself in the lower birth weights of newborns and in many specific health problems, such as unwanted weight loss, fatigue, headaches, irritability, an inability to concentrate, and frequent colds. Our hunger study, CCHIP, found that hungry children experience two to three times as many specific health problems as do children whose families do not experience hunger. The capacity of hungry children to learn is compromised, and their physical development, stamina, and resistance to disease is impaired.

In the United States, hunger is a condition of poverty and in 1990, 33.6 million Americans--including one in five children--were poor. We anticipate that the 1991 figures, that reflect the full impact of the current recession, will be much worse. This spring, more than one in ten Americans received food stamps.

Bringing attention to the childhood hunger problem and moving people and government to do something about it is the Campaign's challenge. Like the genesis of the Campaign, its activities are driven by the network and our policy goals.

A year later, the Campaign is being conducted by FRAC and a 50-state network of anti-hunger groups and emergency providers. We have the endorsement and involvement of more than 100 national organizations. We have an advisory committee comprised of hunger and poverty experts, congressional leaders, mayors, corporate executives, religious leaders, physicians, creative artists, and others.

The Campaign is being conducted in a series of coordinated media and public education activities. To its Campaign partners, FRAC provides information and materials, like the original CCHIP report, a school breakfast scorecard, a fact book on the Food Stamp Program, and a soon-to-be-released state-by-state analysis of summer food participation. This spring, we were partners in the release of the Medford Declaration to End Hunger in the United States. The Declaration is the broadest collective statement ever released on domestic hunger and it lays out a timeline with steps toward solutions.

With these substantive materials, we share sample news releases and opeds, talking points, radio actualities, video news releases, and state-specific information. We provide as many opportunities as possible for groups to use this information to gain the attention of their

local media and public officials. The Campaign's identifying logo and poster were designed and generously donated by award-winning children's book author and illustrator, Tomie dePaola. Our slogan, "Millions of Kids are Hungry in America," has been picked up in many forms. We now have two videos, posters, stickers, and t-shirts--and greeting cards are our next marketing experiment.

SUMMARY

The Campaign to End Childhood Hunger has contributed to a number of public education and policy achievements:

- As a result of the Campaign launch, millions of Americans were informed of the extent of childhood hunger in their states and nationwide.

- Public awareness of the hunger issue has increased significantly. According to a January 1992 national poll, more than 90 percent of registered voters consider hunger to be a serious and growing national problem and believe that the problem is solvable. Support for government action to improve food assistance programs is high, and two-thirds of voters polled said they are willing to pay more in taxes to end hunger.

- Food assistance programs were spared the budget ax in many states during the last year, despite the fact that just about every other state-level government program was being cut. The reason given for this protection was the attention the problem of hunger had received in the last year.

- Between 1990 and 1991, low-income student participation in the School Breakfast Program increased by almost 10 percent. The increase between 1991 and 1992 was 12.7 percent.

- Attention has been focused on the extraordinary benefits of the WIC program, adding fuel to successful efforts to expand funding at the national and state levels.

- Support has mounted in Congress for passage of the Mickey Leland Childhood Hunger Relief Act, the most important domestic anti-hunger bill in 15 years. The Leland bill has broad, bipartisan congressional support and has just been rolled into a larger "Children's Initiative."

- Groups and individuals concerned about children, hunger, and poverty are working together more effectively than ever before.

The second year of the Campaign to End Childhood Hunger promises to be as exciting and productive as the first.

- CCHIP surveys now being conducted in 12 states will provide important new data on the extent and effects of hunger.

- Additional focus will be placed on summer feeding, school breakfast and WIC.

- The Campaign and its allies will soon face the exciting challenge of educating newly-elected leaders at all levels of government on the hunger issue and intermediate and long-term solutions to the problem.

We feel that we are in a very strong position to accomplish these goals and move our efforts to end hunger in the United States one broad step further.

THE IRINGA PROJECT

Roy Miller

INTRODUCTION

I have been asked a number of times over the last few years to talk in various fora about the Iringa Nutrition Project, which is one of the few successful nutrition projects of the 1980s--or at least one of the few that people discuss and talk about repeatedly. This paper describes the project and discusses the reasons for its success. The program was more than a nutrition program, funded by a large multicountry nutrition program (the Joint WHO-UNICEF Nutrition Support Program, or JNSP). Tanzania was one of several participating countries, and was successful particularly in measuring changes in nutrition status to determine the progress that the intervention was making. Indeed, measuring its progress was one of the central elements of the project.

DISCUSSION

Background[1]

The Iringa Nutrition Program (INP) was an integrated, community-based program whose ultimate objective was to reduce infant and young child malnutrition, morbidity, and mortality. It began in 168 villages in the Iringa Region of Tanzania in 1983, covering an estimated population of 46,000 children under the age of five. Information generated from within the program itself suggests that during the period 1984 to 1988, the prevalence of total underweight children decreased from 55.9 percent to 37.9 percent (see Figure 1), and the prevalence of severely underweight children decreased from 6.3 percent to 1.7 percent (see Figure 2). Because of the unique approach that the INP employed along with the apparently dramatic impact it had on child nutritional status, the INP has created much interest among donors and developing countries in the possibility of adapting the approach to other countries.

The INP was distinguished from other nutrition-related programs by four special features: (1) the unusual size and scope of program activities which were supported by higher than usual levels of external resources; (2) a broad-based approach to sensitizing, educating, and training a wide range of program functionaries, support personnel, politicians, administrators, and the public, aimed at improving understanding of the social, environmental, and behavioral causes of protein-energy malnutrition and approaches for solving those problems; (3) emphasis on institutionalizing a process for problem *assessment*, *analysis*, and

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[1] For additional description of the Iringa Project, see David L. Pelletier, "The Uses and Limitations of Information in the Iringa Nutrition Program, Tanzania," Cornell Food and Nutrition Policy Program, Working Paper 5, February 1991.

action (the "triple-A cycle"), as opposed to emphasis on specialized services and service delivery systems; and (4) the unusual degree to which the program was built upon, dependent upon, and integrated with, the administrative infrastructure of the political party. Related to the latter point is that the program capitalized on Tanzania's socialist philosophy to gain political and popular support.

The "triple-A cycle"

The "triple-A cycle" is a general concept that the program applied in many ways. It embodies such earlier notions as problem identification and problem solving, learning by doing, error-embracing approaches to development, bottom-up planning, and flexible management. Fundamental to its operation is the political concept of self-reliance, meaning that each level of society (from households to villages and upwards) should strive to solve its problems using the resources available at that level, with higher levels playing supportive roles only as required. Although the INP has obviously made available a wide range of supports and services from above, this achievement does not detract from the program's emphasis on strengthening the capacities of villages to apply the triple-A cycle and enhance their own self-reliance.

The starting point for the triple-A cycle is the village health day, held at a central village location one day each month (or at least quarterly). Village health days include growth monitoring nominally for all children under five in the village and health and nutrition education lectures and demonstrations. Weight-for-age information collected on these days is used for individual follow-up of severely underweight children (less than 60 percent of weight-for age), to generate discussion at meetings of the village health committee, and to provide higher levels of management (wards, divisions, and districts) with a basis for monitoring and evaluation of progress in each village. In addition to information on nutritional status, village health committees transmit minutes of their monthly or quarterly meetings to the higher administrative levels to inform them of what actions were discussed, decided upon, and/or implemented to reduce malnutrition. The latter information is a vital component of the information system, which (with regular supervision) ensures that villages are completing the triple-A cycle and not simply weighing children for its own sake. In this respect, the INP information system played a special role in problem identification, planning and implementing interventions, program management, and impact evaluation.

Project administration and information system

The importance of the political administration system to the INP is seen in follow-up visits to severely malnourished children and in higher-level management. Soon after the village health day, the village health worker visits the household of each severely underweight child, often accompanied by one or more members of the village health committee. The purpose of the visit is a combination of nutrition education, microlevel problem analysis (triple-A), and social or political persuasion to produce behavioral changes. When circumstances require--as when no progress or back-sliding is seen in the child--a representative in addition

to or instead of the health worker may visit as appropriate. Thus, a team may visit, and often does, that includes party officials from village, ward, and/or divisional levels, or extension workers from health, agriculture, or social welfare. Apart from nutrition education, then, it is clear that the visits are designed to impress upon the household the importance of improving the child's weight-for-age by implementing the actions agreed upon at those visits.

In the case of higher-level management, the ward, divisional, and district party officials use the quarterly reports on nutrition status and the minutes of village health committee meetings to monitor progress at the village level. Accountability for malnutrition is built into each level of the system through standard bureaucratic procedures. Thus, the village health committee must explain to and convince the ward secretary concerning its actions in each quarter; and the latter must answer to the district implementation committee at quarterly progress meetings. Regular visits are made to villages by officials from ward, division, and district levels to help resolve administrative and technical problems.

Although the INP information system was designed primarily to catalyze the triple-A cycle at household, village, and higher levels, there is also great interest in its potential to assist in the evaluation of the program's impact in nutritional status. An important conclusion of the review is that, as a byproduct of its motivational and management roles, the INP information system does provide some information of potential value for impact evaluations. The potential, however, is constrained by the fact that plausible impact evaluation required greater quality control, data collection, staff effort, and technical skills than do motivation and management applications of the information. Attempts to meet the requirements for impact evaluation through substantial changes in program activities may compromise the motivational and management uses of the information; therefore, users of the information should be made aware of the technical limitations of the system.

Factors contributing to project success

There were many factors involved in the success of the Iringa Project. There was a time when the joint WHO-UNICEF Nutrition Support Program (JNSP), which was funding the effort, wanted to replicate Iringa all over the world. The person who convinced us that we should slow down and reconsider was the project manager of the Iringa Project, Mama Matala. We realized that it was important to understand that there was a context--both external and specific to the program--in Iringa that may not be replicable immediately everywhere. The external factors included the following:

- Peace: Many of the JNSP-supported countries were war torn: Angola, Burma, Ethiopia, Haiti, Mozambique, Nicaragua, Somalia, Sudan. Tanzania was peaceful.

- Decentralized health sector: Tanzania has a genuinely decentralized health sector, and most countries do not.

- Project planned in Iringa by the people of Iringa: The project was planned by the local people, not by consultants sent in by WHO and UNICEF.

- Flexible mechanisms of distributing funds: More flexible mechanisms than most donors agencies used were applied in the case of the Iringa project that allowed us to proceed more quickly on project start-up.

- Built on well developed, existing social structure: The social structure had built up in Iringa over 200 years of Tanzanian type village development. Without that structure, another program would have had to start by building that kind of village level social structure.

- Food surplus region (with some deficit subareas): Food availability in general was not a limiting factor and was not the cause of poor nutrition.

At the program level, there were about six characteristics or attributes that contributed to the project's success. The first four deal with issues essential to the purpose of this conference: the program was built on an idea of social mobilization at all levels, starting with the regional development director down to the woman in the furthest village. As someone who went to the furthest village and saw those women, I can attest that the program spread from the capital of the region--Iringa--to the furthest reaches.

- Deliberate implementation of a well orchestrated sequence of activities to inform people at all levels of the existence of the program and of its objectives: The introduction of the program to the people was very visible and graphic. Each village was approached by a team that showed them a highly motivational, professionally produced movie made specifically for the project. The team then presented an introduction to the program, its objectives, and its planned activities. There was a concerted effort to sensitize people to the project and to reinforce the initial contact repeatedly over the next five years. Upon later evaluation, people in Iringa--unlike people who are "recipients" of most other programs--had heard of the project and knew not only that it existed, but <u>why</u> it existed.

- Application of a common, unifying framework stressing problem solving at all levels--village, district, and region: The "triple-A" cycle, discussed earlier in this paper, was stressed at all levels. This type of assessment, action, and analysis was a form of empowerment since it encouraged the use of the project's resources to come up with creative solutions to problems. Because the cycle was ongoing, solutions that were not working were easily identified and dismissed, while those which were working were sometimes expanded. Solutions were relevant to the people who were the most affected.

- Joint consideration of the supply and demand side of the health equation: Not only did the Iringa project convince people to use services, but it also concentrated efforts on making sure that when people started demanding services, those services were available. With a "commodity" like breastfeeding, women do not need a supply side, but in other health interventions where the program goes into a country and markets a product, a responsive delivery system must be in place. If we do not respond to people the first time we get them into the system, we may not get them back to be responsive the second and third time.

- Use of nutritional status as an indicator of progress for entire villages: Using nutrition as an objective for a nutrition program makes sense. It helped give villages, districts, wards, and all the levels in Tanzania, a tangible and visible goal around which to rally and to monitor progress. Village leaders knew where their people were on the nutrition chart.

- Application of the full range of child survival, small-scale agricultural, and other interventions to the nutrition problem: The program was a nutrition program, but stressed immunization, diarrheal disease control, breastfeeding, agricultural interventions; in other words, it was a classic rural development/child survival/primary health care program with improvement in nutritional status as the objective.

- Use of research (largely conducted by Tanzanian researchers) to support the monitoring, evaluation, and problem solving needs of the project: An incredible amount of research was built into the Iringa project. The hotels in Iringa were crowded with researchers, mostly Tanzanian, but occasionally external researchers, who were helping with the "triple-A" cycle. Research was not conducted outside the program, but brought into the program. All research had applicability in the field, or was "field driven."

Training

Another distinguishing feature of the INP was that training, which included sensitization and education, was seen as an intervention in itself, and perhaps the most important intervention in the project. The INP basically set out to re-educate society vertically and horizontally, at all levels from regional management to villages, from civil servants to political administrators to the public. In order to accomplish this ambitious task, the INP used a variety of formats, strategies, and tools. They included production of a quarterly newsletters using materials from trained village correspondents; support for cultural and youth groups; showing in all villages three films, all made in Tanzania, on malnutrition; integrated training for various cadres; and implementation of the community-based monitoring system.

The project conducted a "crash training" in early 1984 for all 168 villages covered by the original JNSP funding. The training was designed to get the information system off the ground more quickly, while the more intensive and time consuming training of various cadres was taking place. The "crash training" was two days long and included instruction on how to maintain the village population and vital registers; how to weigh children, plot their weights on a chart, and advise mothers on treatment for diarrhea and malaria; and how to fill in the village summary form to be passed to the village health committee and ward implementation committee. The course was effective in establishing quickly the rudiments of the information system and giving the villages the means to identify the extremely malnourished children and ensured that the time-series of data on nutritional status for overall project evaluation would have all 168 villages represented from the outset, rather than being staggered over time.

After the crash training, village campaigns were organized to establish several stations where weighing, immunizations, education, feeding, and oral rehydration solution demonstrations were provided. The campaigns were tools for mass education and mobilization in preparation for later stages of the program. The program also provided child care for mothers engaged in subsistence agricultural activities. Village day care attendants received a two-day "crash training" to initiate the Village Day Care program.

Six-month training of village health workers was conducted in staggered intervals from 1984 to 1987. This training included two months of classroom instruction on village level primary health care, growth monitoring, reporting, referral, and follow-up systems, among other topics. This period was followed by three months of "field" experience in their own villages, and another one-month classroom period to resolve problems experienced in the field. Topical refresher courses are required as well. In addition, a wide variety of courses and seminars for training and orientation were organized to meet the needs of numerous other cadres involved in the project. This training approach resulted in an impressive level of understanding of the project on the part of many levels of project functionaries.

Grassroots approach

Ultimately the strongest evidence for the success of the INP approach comes from an understanding of how it operated at the grassroots level. Not only was the program heavily funded by a donor, there were other programs going on in Iringa which provided other input that was being supported by donors. Despite this external financial support, the community participated with their own resources. The following illustrates the potential for sustained community participation by demonstrating that communities were willing to come forward and pay their village health workers. A survey was conducted in 103 villages on the financing of the program:

- Of 103 villages surveyed, 101 employed village health workers and 96 employed day care attendants.

- Eighty-one villages paid the village health workers in cash; 18 paid in kind; and 23 paid with a work exemption.

- Similar payments are used for the day care attendants.

- The payments to the village health workers and the day care attendants account for almost 20 percent of all village budgets.

SUMMARY

In looking at the project's success and prospects for future activities, the most important information concerning the INP's transferability to others settings comes from an analysis of whether and how similar processes can be developed under prevailing local conditions. Thus, it may be that attempts to provide solid evidence for impact by placing greater demands on the information system would be self-defeating because they would compromise other program activities and detract from an emphasis on understanding the process issues that determine impact. To the extent that UNICEF is the primary institution whose policy and resource allocation decisions require plausible evidence for INP impact, the "process" evidence for impact and the institutional conviction of its plausibility are probably sufficient in any case. To the extent that similar decisions by other institutions are involved, there may be a need to address the limitations of the present impact evidence by more rigorous external evaluation in newly expanded areas.

Apart from its success in certain respects, the INP faced a number of important challenges as the program matured. One is the obvious need to adapt to lower levels of external resources without compromising the strong training and supervision that have characterized the program to date. Another, now that many villages appear to have brought the number of severe cases of malnutrition under control, is the need to refocus attention, concern, and commitment on ameliorating the causes of moderate malnutrition. Given the much larger number of children so affected and the possibility that different intervention approaches may be necessary, it cannot be assumed that this can be achieved though a straightforward extension of earlier methods.

Finally, decisions concerning the transferability and appropriateness of the Iringa approach to other settings must consider some of the special characteristics of Iringa (and Tanzania) that have probably conditioned the INP's success: first, strong ideological and political support for improving human welfare; second, a strong, pre-existing political administrative system on which to base the program; third, concurrent efforts greatly strengthen regional program management; fourth, close involvement of a local research institution (Tanzania Food and Nutrition Centre), which had completed much of the early conceptual work and which assisted greatly in operational research during implementation; and finally, the fact that Iringa is one of the few food surplus regions in the country and has a local reputation for being generally receptive and responsive to community development initiatives. These factors are as important, or more so, than the availability of fiscal resources as determinants of

transferability and deserve equal consideration in deciding which, if any, of Iringa's lessons are applicable elsewhere.

Figure 1

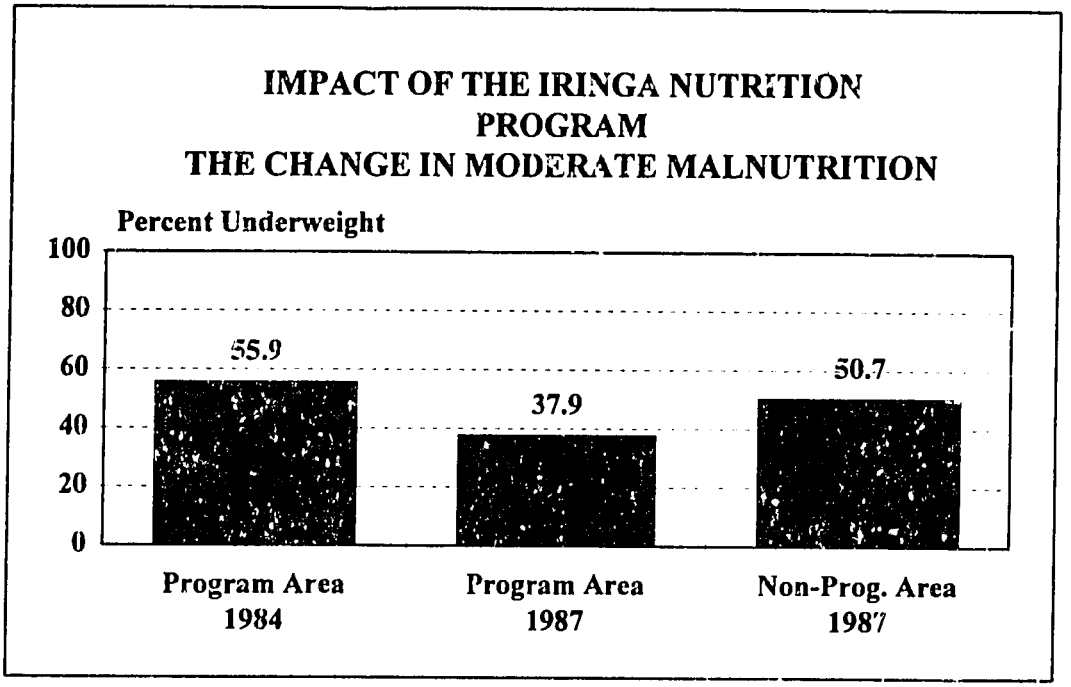
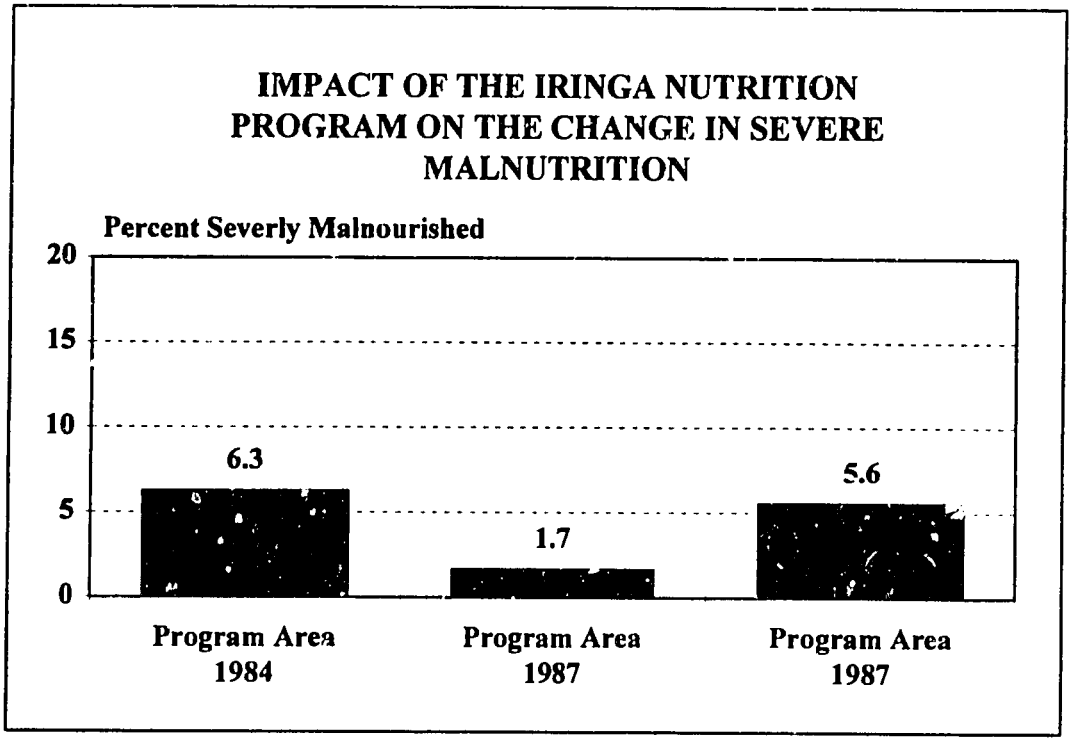


Figure 2



PLENARY SESSION VI:

DEVELOPING COMMUNICATION STRATEGIES IN SUPPORT OF INNOCENTI AND THE BABY FRIENDLY HOSPITAL INITIATIVE

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PLENARY SESSION VI: DEVELOPING COMMUNICATION STRATEGIES IN SUPPORT OF INNOCENTI AND THE BABY FRIENDLY HOSPITAL INITIATIVE

INTRODUCTION

To introduce Plenary Session VI: Developing Communication Strategies in Support of Innocenti and the Baby Friendly Hospital Initiative (BFHI), some basic background is provided on the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and the Baby Friendly Hospital Initiative, which was launched by WHO and UNICEF to promote breastfeeding through the creation of Baby Friendly hospitals throughout the world.

During the late 1980s, members of an informal Interagency Group for Action on Breastfeeding (IGAB) representing WHO, UNICEF, the United States Agency for International Development (USAID) and the Swedish International Development Authority (SIDA) held a series of technical workshops on a variety of breastfeeding issues ranging from mother-to-mother support, to breastfeeding definitions, to working women. During this time, WHO and UNICEF issued their joint statement "Protecting, promoting and supporting breastfeeding: the special role of maternity services," which outlines the *Ten Steps to Successful Breastfeeding.* All of these efforts succeeded in stimulating action within the institutions involved in IGAB, culminating in a WHO-sponsored Technical Meeting on Breastfeeding during the spring of 1990. This meeting, "Breastfeeding in the 1990s: A Global Initiative," pulled together much of the state-of-the-art knowledge, scientific and cultural bases for breastfeeding, the end product of which was a synthesized, packaged document for Ministers of Health, government representatives, and other representatives who were invited to participate in the WHO/UNICEF-sponsored policy meeting on breastfeeding held July 31 and August 1, 1990, at the Innocenti Center in Florence, Italy. This meeting, strategically held just prior to the World Summit for Children, launched a set of operational targets outlined in the Innocenti Declaration, declaring that all governments by the year 1995 should have:

- *appointed a national breastfeeding coordinator of appropriate authority, and established a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations, and health professional associations;*

- *ensured that every facility providing maternity services fully practices all ten of the* ***Ten Steps to Successful Breastfeeding*** *set out in the joint WHO/UNICEF statement, "Protecting, promoting and supporting breastfeeding: the special role of maternity services";*

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- *taken action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety;*

- *enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.*[1]

Following the World Summit for Children, where breastfeeding received considerable attention, a new and powerful initiative was conceived by James Grant, the Executive Director of UNICEF. Known as the Baby Friendly Hospital Initiative, the plan was adopted at a meeting of pediatricians, obstetricians, community health workers, and members of nongovernmental organizations at a meeting in Ankara, Turkey, on June 28, 1991. The initiative aims at the adoption of the *Ten Steps to Successful Breastfeeding* by hospitals and maternity services, and the accelerated implementation of those ten steps. A global assessment tool was developed whereby those hospitals satisfactorily fulfilling the Ten Steps would receive a BFHI plaque to display, a type of "seal of approval."

While the term Baby Friendly clearly refers to babies, the concept extends to the other health needs of mothers and children in which the hospital could and should play a critical role. In fact, many countries have modified the goals and name of the initiative to reflect a clear focus on mothers as well.

The Ten Steps to Successful Breastfeeding state that *every facility providing maternity services and care for newborn infants should:*

1. *Have a written breastfeeding policy that is routinely communicated to all health care staff.*

2. *Train all health care staff in skills necessary to implement this policy.*

3. *Inform all pregnant women about the benefits and management of breastfeeding.*

4. *Help mothers initiate breastfeeding within a half-hour of birth.*

5. *Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.*

6. *Give newborn infants no food or drink other than breastmilk, unless medically indicated.*

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[1] Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. 1 August 1990, Florence, Italy.

7. *Practice rooming-in--allow mothers and infants to remain together--24 hours a day.*

8. *Encourage breastfeeding on demand.*

9. *Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.*

10. *Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospitals or clinic.*

The Baby Friendly Hospital Initiative represents the continuation of a long and productive collaboration between WHO and UNICEF in the field of infant and young child nutrition. The Initiative is also providing an opportunity for a broad mobilization of groups, institutions, and communities in support of the operational goals of the Innocenti Declaration as well as the breastfeeding related goals of the World Summit for Children. In particular, the Baby Friendly Hospital Initiative has brought together a large number of organizations of health professionals, consumer and women's groups, and other nongovernmental organizations, academic institutions, infant food industry, and, above all, a strong commitment to breastfeeding from a large number of governments as a follow-up to the Summit and the Innocenti Declaration.

The development of innovative communication strategies in support of Innocenti and the Baby Friendly Hospital Initiative clearly are needed at this time if the 1995 operational targets outlined in the Innocenti Declaration are to be met, and the BFHI is to continue to stimulate the interest, enthusiasm, and imagination of those committed to the protection, promotion, and support of breastfeeding and the overall improvement of infant and young child nutrition during this decade.

STAGING INTERNATIONAL EVENTS AS A POLICY PROPELLANT

Richard Reid

INTRODUCTION

It is a pleasure to be among you today--it feels like being back in the family, because I know so many of you. Many of us have worked together in the "vineyards" in one way or another, sometimes in the field of nutrition and breastfeeding, sometimes in other areas. The work at this conference focuses on the convergence of communication and nutrition, with a view to improving child feeding around the world. This particular convergence is a very necessary one. We need to communicate the messages that underpin nutrition much better than we do currently. We need to take steps to address the terrible setbacks and shortfalls in children's nutrition that we see around the world--not only in the countries of the world that have been characterized in the past as developing countries in the so-called South--but also those cases of malnutrition in the countries of the North, who had previously been thought of as well off but which, because of poor record keeping, have not been reflecting an accurate portrayal of the real conditions of their children.

Today I would like to address an issue that does not have to do with my "first love"--the Baby Friendly Hospital Initiative--but that certainly touches on it in a number of ways: using the personal involvement of top political leaders, and the impact of public events, to propel policies and bring about major gains against malnutrition and other conditions that afflict poor children around the world.

We might subtitle my presentation today "Have a High Profile Public Marriage with Your Political Leader, or be Ready to Settle for Mediocre Results." There is no way on a national, regional, or large-scale basis that we can make the things that we want to see happen for children--whether in the field of nutrition, girls' education, water and sanitation, or in any other area--without a very top-level, closely welded alliance with political leadership. UNICEF has found through the social mobilization programs for child survival that it has carried out in the past ten years with such partners as WHO, that political leadership and a political identification, or political assimilation, with high-level policy, is vital. Policies on children, like policies in any other sector, can be either inert--which is usually the case--or dynamic. The difference is in the nature of the leadership and of the events, if any, that attach themselves to these policies and propel them forward.

UNICEF often finds that for matters touching on children, policy and leadership merge best when they meet in the spotlight of a major international event--an event animated ideally by the passion of a cause that has measurable goals and targets that can be monitored over time. This convergence of event and leader publicly "marry" the leader and the cause and give the policies of the leader's government a forward propulsion they would never have had otherwise.

Today I will provide you with examples of international or large public events that have helped propel policy forward--as well as a few examples of such events that have had the capability of doing so but lacked the indispensable ingredient of a political linkage. When I speak today about politics, I am not referring to health, agriculture, defense, or finance ministers: I am speaking about the people who run the country--the people who can press the button and see the apparatus of the country move, who can galvanize a health ministry or a ministry of social affairs for the Baby Friendly Hospital Initiative, for a drive against a vaccine preventable disease, or for whatever the cause might be.

DISCUSSION

How does this process that I described work? What causes it to work--what are the catalytic elements that cause this to happen? Why is it possible to accomplish the kinds of things I described with political leadership? There are three ingredients which cause the "yeast to rise": (1) children's issues are good politics; (2) the "theory of elastic capacity"; and (3) solutions can be reached in low cost ways.

1. Children are good politics: Children touch the core of people's hearts worldwide. There is no question that a message focused on the plight of children--be it general or specific--will capture people's attention, and especially the attention of the political leadership. Political leaders often see urgent issues affecting children as a potential political harvest for their popularity. There are few political risks associated with programs taking actions for children. We can ensure that there are not only no political risks but also no financial risks, if we program the kind of low cost intervention that has characterized many of the child survival actions which reduced deaths so impressively through the 1980s. From approximately mid-1980 through the end of 1990, in the six WHO and UNICEF developing country regions, infant mortality was cut by nearly half. Mortality rates have reached a kind of plateau since late 1989 and have not fallen significantly since that time--in good part because malnutrition has not been reduced. The crucial uniqueness of the Baby Friendly Hospital Initiative has been its tackling of the issue of malnutrition.

2. "Theory of Elastic Capacity": When we begin to proceed with any program or initiative on a national scale, we need to consider a seldom recognized fact that I call the "Theory of Elastic Capacity." There is a great deal more dynamism at large in a country, whether in a health ministry or a group of ministries, or in a country's ability to deliver, than would appear from the normal functioning operations of a government. Basically, government social sector operations in any country, including this one, tend to move at an idling speed and are basically looking after self-perpetuation--the paying of salaries, the provision of basic supplies, maintenance of the bureaucracy, and so forth. These government ministries rarely have goals beyond status quo monitoring. Seldom do they set out to reform or change things radically. However, when a political leader takes an issue, such as child survival, as his or her own, which happened with many heads of state throughout the 1980s, we can see an impressive transformation of output. Output can be doubled or even tripled because the process no longer operates through a set of conservative, hard-and-fast, basically undisturbed

standing orders; instead, clear new instructions come from the top--an unmistakable policy propellant.

For example, in the mid-1980s, UNICEF Executive Director James Grant and I met with the incoming head of a large African state where a military coup had occurred. The new leader had come in to clean up corruption and still had no social program. We discussed with him the importance of national immunization and its current low level in the country. He asked us what it would cost to accomplish the goals we were discussing. We told him the amount, and he asked how much money was currently in the country's immunization budget. I responded with the same amount of money, and he asked me how it was possible to do much more immunization with the same budget. I said, "It is possible because of you. You will say that immunization is important, you will make it clear that this effort has real importance for you. This effort will not be done in a commonplace and routine way, with haphazard refrigerator and vehicle maintenance and staff that spend a great deal of their time playing cards and sipping tea. It is going to happen because of a galvanization of purpose." And that country was galvanized. People at all levels participated in a sustained way. This type of action is what I mean when talking about the "elasticity of capacity." We have seen it succeed in many countries.

3. Solutions that can be reached in low cost ways: There are low cost ways of achieving big and lasting things. The surest way to kill hope is to impute nothing but standard World Bank unit costs to getting things done in the social sector, and insisting on talking about the high costs that will prevail if we expand government operations conventionally. There are many ways of bringing in sectors that are presently not involved with health budgets or nutrition, but who easily can be enlisted and recruited: religious leaders, traditional leaders, leaders in the entertainment sector, labor syndicates and labor unions, and, crucially, school teachers--because in most countries in the developing world, there are five to eight times as many school teachers as there are health workers. There are many ways to accomplish objectives within a small budget by activating unused manpower toward a nationally shared goal that appeals to political leaders.

Examples of Events

The Baby Friendly Hospital Initiative

During the Baby Friendly Hospital Initiative we have had a series of large events, beginning with a meeting in Ankara in 1991 from which we had the Ankara Affirmation. The meeting that produced this affirmation gathered leadership from WHO, UNICEF, and the International Pediatrics Association, who merged to give birth to the idea of the Baby Friendly Hospital Initiative--the BFHI. There have been additional BFHI meetings in The Hague, Geneva, and New York. An important meeting which focused on the initiative was the Vancouver Health 2000 meeting in early 1991, which saw more than 1,500 physicians, mainly public health physicians, come together to talk about the outlook of the world's health. We were able to profile the Baby Friendly Hospital Initiative on that agenda.

Probably the largest BFHI events will be held in Latin America: the International Congress of Pediatrics will take place in Rio de Janeiro in September 1992. There, we expect approximately 7,000 to 8,000 pediatricians to meet in the same facilities that accommodated the Rio World Summit on the Environment. This meeting is held every three years by the International Association of Pediatricians. WHO and UNICEF will be there, and James Grant will be the keynote speaker. The meeting is expected to raise the Baby Friendly Hospital Initiative to a high level of visibility before a key audience. The First Lady of Colombia will be active at this meeting, and is then expected to take additional steps to gather First Ladies--President's and Prime Minister's wives from all over Latin America--to support not only the Baby Friendly Hospital Initiative but also measles eradication. She will then host the Latin America First Ladies meeting in December in Cartagena, Colombia. Both of these meetings will give a high platform and high profile to the Baby Friendly Hospital Initiative. We have found that involving First Ladies in many countries, such as Egypt and Indonesia, can be enormously helpful because they have an undoubted influence on public policy and can thus be important policy propellants.

International Conference for Assistance to African Children

Another large, politically oriented meeting for children that we are in the process of planning at UNICEF with the Organization of African United (OAU) is the International Conference for Assistance to African Children. This meeting will be held in Dakar, Senegal, from November 25-27, 1992. This again is a meeting about children, which will address, among other topics, malnutrition, diarrheal dehydration, upper respiratory infections, and the process for dealing with the large, stubborn remaining pockets of vaccine preventable diseases in Africa. We will discuss issues surrounding iodine and vitamin A deficiency and water and sanitation--all of the synergistic health issues--as well as girls' and women's education, which is one of those correlatives that has the highest impact on children's nutrition. All of these issues will be addressed at a high level, with government ministers as the main working group participants.

This type of meeting is being organized in order to do something before it becomes too late in Africa. With the end of the Cold War, Africa has become more and more marginalized. Africa is no longer strategically necessary: no great powers are any longer vying for the communication bases in Diego Garcia or wherever else they might have been around the continent. As a consequence the interest which the powerful countries of the world had paid to Africa has diminished sharply. It is clear that most of the assistance that went into the Angolas and the Mozambiques and the Ethiopias and the Egypts was given to them because of their strategic military importance.

We have long felt that the international organizations and African leaders must do something exceptional to reverse the alarming trends in Africa for children. Virtually all of the indicators that have to do with the quality of life of children--particularly malnutrition--are deteriorating every year. Many food and nutrition indicators, such as agricultural output per hectare, or the age of the individual farmer in Africa, are particularly distressing. Currently

the average farmer in Africa is about 43 or 44 years old, whereas the optimum age for a land farmer is about 26, when he or she is the strongest and most productive.

There is a need to arrest this deterioration in Africa, and we hope that this Dakar meeting, involving high-level political leaders, will tackle it. We hope to have three heads of state from outside Africa and four heads of state from Africa present, with co-chairing by a head of state from the industrialized countries and one from Africa. Representatives of the northern countries will come to the meeting to see how Africa, swept now by encouraging winds of democracy, and frankly confronting its problems of corruption and mismanagement, has changed its visible intent, and how it will move forward. We intend to surround this meeting with as much public visibility as we can, so that it will bond clearly the political leaders who will attend with the plan of action that will emerge from the meeting.

World Summit for Children

It is in much this same way that several other important meetings around the world have been held and have themselves been policy propellants. Perhaps the best example of this type of meeting was the September 1990 World Summit for Children, which convened 71 heads of state and 58 other observer delegations--the largest gathering of heads of state in history. These leaders met for two days to talk about nothing but children. The Declaration and Plan of Action that they developed comprised 27 time-bound goals, including a cluster of nutrition targets, toward which the clock of national progress is ticking. National plans of action now report on how the Summit goals are to be met all over the world. We now are gathering these reports from the countries of Africa to be shown to the donor countries at the November Dakar meeting. The Secretary-General has reported to the General Assembly on the progress of nations toward their Summit goals. Many of the best reports and many of the most clearly profiled plans for implementation have come from industrial countries: Canada, especially, has an outstanding plan called "A Brighter Future."

Examples of dynamic, momentum-generating meetings and events can be instructive for all of us even if we are working at the community level or at the district level, where we can cause things to happen by bringing together the political district commissioner, the head imam, the bishop, the tribal chief, and traditional and other leaders. Let me now mention a few other bigger meetings.

South Asian Conference for Regional Cooperation

In 1986 a meeting brought together the heads of state of the countries of the South Asian Conference for Regional Cooperation (SAARC)--among them Bangladesh, Bhutan, India, Maldives, Pakistan, and Sri Lanka--to develop a program of action for children which had, at its center, among other things, a drive against malnutrition. Since 1986 we have seen the attraction that this SAARC plan has had. Those SAARC countries could not in their first two meetings talk about much other than children, because their political alignments were so

different and there were so many politically sensitive areas that had to be approached in a gingerly way. But children are never politically sensitive.

Central American Conference

This type of process was repeated in 1987 when the heads of state of the seven countries of Central America--Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama--met and decided to use children as a bridge to peace. The meeting resulted in a poster, a wonderful enlarged cartoon, showing seven babies in diapers, each pushing toward the center a block that was the shape of the country she or he represented, to signify the movement toward political unity.

Meeting on the Convention on the Rights of the Child

Finally, we hope that soon there will be a similar meeting on the Convention on the Rights of the Child, which 122 countries have now ratified. The United States, India, and Japan are conspicuous absentees from the list of ratifiers. In Article 24 of the Convention there are strong paragraphs about child health and nutrition. We would hope too to be able to have a large world meeting address these topics. Again, we would be looking for political leaders to take the lead and move forward, as heads of state in Colombia and Turkey did at the start of the immunization campaign in the 1980s. These leaders linked their political fortunes to the success of these immunization campaigns, which generated reasons for national harmony as well as reasons for national external pride.

SUMMARY

This paper has attempted to reflect on the importance of getting political leaders behind what we do. We can never succeed in a village if we do not have the village head or the muktar on our side; and we can never succeed in a district, if we do not have the district chief behind us. That is the beginning of progress: other forces can line up behind it. In these policy propelling efforts, whether with a district chief or the head of state, we can accomplish a great deal for the world's children.

THE DISSEMINATION OF INNOCENTI AND THE BABY FRIENDLY HOSPITAL INITIATIVE--MEXICO

Manuel Manrique

INTRODUCTION

This presentation shares highlights of Mexico's experience since 1990 with the dissemination of the Declaration of Innocenti and the UNICEF/WHO Baby Friendly Hospital Initiative (BFHI)--to which Mexico has added its own special "twist." Given the current level of commitment, greatly stimulated by Innocenti and "Baby Friendly" ("Hospital Amigo"), to the re-establishment of a breastfeeding culture in Mexico, these highlights represent only the tip of the iceberg. In keeping with the goals of this conference, the focus of this presentation will be on key elements of a coordinated, multi-level, multi-institutional strategic approach.

DISCUSSION

Background

Approximately 2,400,000 infants were born in Mexico in 1991. Nearly 60 percent of Mexican women gave birth in maternity hospitals and clinics--almost one-and-a-half million--while the remaining 40 percent were assisted by traditional midwives in the community. As in many countries, the influence of "modern" medicine and the steady invasion of the infant food industry over the past four decades has had a strongly negative impact on hospital practices as they relate to breastfeeding. This 40-year period has been marked by intense marketing and distribution of breastmilk substitutes at perhaps a greater level than any other country in Latin America. Hospitals throughout Mexico have been constructed with large newborn nurseries which, by their very existence, discourage the rooming together of mother and baby. Combined with hospital protocols whereby infants are routinely taken away from their mothers immediately postpartum for an extended period of time, these factors laid the foundation long ago for the establishment of artificial infant feeding as the "norm." During the early separation of mother and child, infants have been routinely subjected for many years to a gastric cleansing, and administered glucose water and/or formula by bottle soon after birth, often while waiting for their mothers' milk to "come in."

As Mexico embarks on the development of a strategic plan and the initiation of actions needed to re-establish a breastfeeding culture, we are confronted by the enormous complexity of the task at hand. Given both the direct and indirect influence of medical professionals on breastfeeding practices, the necessity of changing hospital routines and policies is fundamental to any strategy. Removal of those obstacles which in any way discourage the initiation of breastfeeding immediately postpartum or cause any unnecessary separation of mother and child during their short maternity stay is the obvious, although difficult first goal. We must also focus on the reduction or elimination of the influence of the infant food industry on maternity hospitals, clinics, and pediatric practices throughout the country.

Another major contributing factor to the decline in incidence, duration and overall popularity of breastfeeding in Mexico beginning in the early 1940s was the establishment as a "right" the provision of free infant formula to workers throughout Mexico under the powerful Social Security system. The establishment of this "right," now well entrenched in Mexican society, was actually the result of a concerted union movement in response to a large economic expansion that was occurring in Mexico and the entry of a large percentage of women into the work force. One additional factor contributing to the establishment of bottlefeeding also occurred during the 1940s, when the Mexican Ministry of Health began advocating the virtues of infant formula over breastmilk. Formula, rather than mother's milk, became synonymous with good nutrition and infant care.

The Breastfeeding Movement

Advocacy organizations such as La Leche League, International, have continued to work tirelessly in Mexico in favor of breastfeeding, supporting many mothers in their decision to breastfeed and encouraging breastfeeding-friendly legislation and policy. However, the influence of these groups has been relatively limited, always pitted against much larger and more powerful forces which have greater financial resources at their disposal. Because of several international events and global initiatives, the efforts of these breastfeeding support organizations recently have been fueled and a new spirit of commitment to breastfeeding has been created. This process--and it has been a process--has helped to mobilize other institutions and professional associations as well, and a true breastfeeding revival has been launched nationwide.

The first mobilizing event was the 1990 WHO/UNICEF meeting in Florence, Italy, to which Yolanda Sentíes, Director of Maternal and Child Health, was invited as the Mexican representative. As already described, this meeting resulted in the Innocenti Declaration and the establishment of four specific operational targets for governments. This event was followed shortly thereafter by the World Summit for Children, where President Salinas de Gortari committed his support to the realization of the conventions of that Summit and charged the Mexican Ministry of Health, through the Division of Maternal and Child Health, with the responsibility of launching a national program to promote, protect, and support breastfeeding. It was also at this point in time that the Ministry formally announced its intention to dedicate resources to addressing and reversing the decline of breastfeeding.

Questions to be Answered by the Initiative

The first challenge for the dissemination of the concepts and targets of Innocenti and Baby Friendly was how to translate these ideas into reality, how to change the status quo of 40 years, especially in the health care system. The following questions are among the many which had to be addressed systematically:

- What could and should be done first to re-establish a breastfeeding culture in Mexico?

- Is it preferable to start small by working with individual hospitals and communities, or should a program be launched nationwide?

- Since the Ministry of Health is just one of nine health institutions forming the national health system, how should the other health institutions that exist in Mexico be actively involved in the promotion, protection, and support of breastfeeding?

- How should health workers throughout the National Health System be trained in breastfeeding?

- Can anything be done to influence the elimination of free or low-cost infant formula provided by industry though the health care system and also by the Social Security system to its workers?

Elements of the Mexican Strategic Initiative

Steps taken to date: To address these and other questions, a strategic plan was designed and initiated in the spring of 1991 to include the following major elements:

1. Establish a National Breastfeeding Commission: On May 28, 1991, in compliance with one of the operational targets set forth in the Innocenti Declaration, the Ministry of Health officially established the National Commission for the Promotion of Breastfeeding in Mexico, with representation from various health-related institutions, public sector associations and private voluntary organizations, including La Leche League.

2. Establish the "25 Actions": At the end of May 1991, the Mexican Ministry of Health, through the Division of MCH, announced the implementation of the "Baby Friendly Hospital Initiative (BFHI)," or "Hospital Amigo," throughout its nationwide network of hospitals, clinics, and health centers. With technical support provided by UNICEF, the MOH developed a globally unique conceptual framework for defining 25 characteristics of "Baby Friendly" which was translated into operational procedures--encompassing a much broader "package" of both maternal and child health goals than originally outlined by the "Ten Steps" of the WHO/UNICEF Joint Statement. The 15 additional items include other vital measures such as universal child immunization, surveillance of child growth and development, oral rehydration, early detection and control of respiratory diseases, and early detection of breast and uterine cancer.

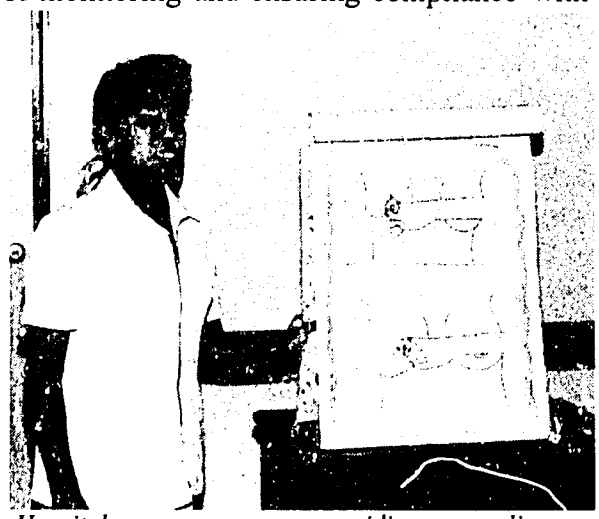
3. Develop Guidelines: The establishment of the 25 Actions was followed by the development of a set of operational guidelines for the establishment of Mother and Baby Friendly Hospitals, and a ***Manual for Rooming In and Breastfeeding***--viewed as the official set of norms for program implementation throughout Mexico--was developed and disseminated to all hospitals through members of the National Health System.

4. Establish an Inter-institutional Committee: Soon thereafter, an inter-institutional committee or working group was established to direct and support the Initiative and to monitor its implementation and expansion. The goals, responsibilities, and functions of this working group (with representation of all entities of the National Health Sector, including the Social Security System, the oil company, the Armed Forces, and others), are separate and distinct from those of the National Breastfeeding Commission.

5. Launch the Mother and Baby Friendly Hospital Initiative: The 25 Actions formed the basis for the expanded BFHI in Mexico, known as "Mother and Baby Friendly Hospitals." During June 1991, an aggressive program was planned and launched, supported jointly by the Division of Maternal and Child Health of the Ministry of Health, the Pan American Health Organization, and UNICEF. The goal of the Initiative was to establish at least one Mother and Baby Friendly Hospital in each of Mexico's 30 states and four in Mexico City by the end of 1991. In addition to health facilities operated directly by the Ministry of Health, the full collaboration of the other eight health institutions comprising Mexico's National Health System also was obtained, thus dramatically increasing the potential scope and impact of the Initiative. The ultimate goal is to make all hospitals and maternities throughout Mexico, both public and private, Mother and Baby Friendly.

6. Suspend the Supply of Free or Low-Cost Infant Formula: On November 19, 1991, the Mexican Council of Infant Food Manufacturers and the Mexican Chamber of Industrialized Milk Products signed an agreement with the Ministry of Health, whereby these companies agreed to permanently suspend, as of January 1, 1992, the practice of providing public and private hospitals, other health care facilities, and health care professionals with free or low-cost supplies of infant formula. A system of monitoring and ensuring compliance with

Mothers are now encouraged and supported to breastfeed immediately after birth.



Hospital nurses are now providing counseling as part of breastfeeding "Hospital Amigo."

this decision was developed and implemented simultaneously. This action has had a clear and positive influence on national perceptions and level of motivation/commitment to the "Hospital Amigo" in general, and the promotion of breastfeeding in particular.

7. Tour of the José Fabella Hospital: In January 1992, at the suggestion of James Grant, Executive Director of UNICEF, seven administrative level representatives from four key hospitals throughout Mexico traveled to the Philippines to visit the José Fabella Hospital and witness the extraordinary work of its Director, Dr. Ricardo Gonzales in breastfeeding promotion. Known as the world's first Baby Friendly Hospital, "La Fabella" has instituted a number of practices to ensure that mothers and babies room together and that breastfeeding is well established before mother and baby leave the hospital. Immediately following the return of the administrative staff, two of the Mexican hospitals participating in the tour eliminated the use of bottles with all infants born within the hospital, opting for cup feeding during those special circumstances when mother and child must be separated, or if the infant is ready for feeding by mouth but not strong enough to suck. The rapid positive response of the hospital staff to this change in routine practice is justification for the expense involved in organizing this "study tour." Having an opportunity to observe the "do-ability" of cup feeding, for example, and other changes in routines and protocols, was a highly motivational and cost-effective way to introduce these changes in Mexico.

Small cups, instead of bottles, are now used in many hospitals to feed infants if mother and child must be separated.

Hospital nurses give new mothers guidance and support in establishing breastfeeding prior to discharge.

8. Conduct an International Assessment of the Initiative: In February 1992, two international assessment teams visited four hospitals implementing the Mother and Baby Friendly Hospital Initiative to assess the degree of progress that had been made in each hospital. The teams, each comprising one international breastfeeding expert and representatives of UNICEF and PAHO, as well as the Ministry of Health, applied the global Baby Friendly criteria which has been established by UNICEF and WHO with technical assistance from Wellstart. Rather than an evaluation, these assessments were considered to be an integral part of the mobilization strategy--encouraging hospitals to work toward recognition as being Mother

and Baby Friendly. An important result of these visits was the opportunity they afforded hospital personnel to learn about and exchange experiences and ideas with professionals from other countries, cultures, and regions involved in the Initiative, thus creating a sense of shared commitment.

9. Develop a Training Package: During 1991, a bibliographic collection was made of all relevant breastfeeding documents and training related materials. In April 1992, a multi-institutional workshop was held to develop a breastfeeding/lactation management training package for use in training hospital personnel in health institutions throughout Mexico. The idea was not to "reinvent the wheel," but rather to build on existing material in order to prepare something that "belonged" to all health institutions. The entire process, therefore, was one of consensus building and inter-institutional teamwork so that the final product would meet the standards of and be acceptable to all groups involved. Following the workshop, the resulting package was further refined and reviewed by the various institutions in the National Health System. Following an initial training of trainers, the entire training package will be field tested in September throughout Mexico, and any necessary modifications will be made before printing and distribution.

10. Publish a Newsletter: The "Hospital Amigo" newsletter is being published on a regular basis to provide an opportunity to exchange information and ideas related to the creation of Mother and Baby Friendly Hospitals. This motivational newsletter provides a forum for giving Mexican institutions positive reinforcement for the changes they are making in their respective systems. It also provides a vehicle for sharing ideas and information about the Initiative from other countries.

11. Establish a National Breastfeeding Training Center: A National Breastfeeding Training Center in the Hospital General de Mexico in Mexico City was inaugurated in May 1992 by the Minister of Health, Dr. Jesús Kumati Rodríguez. Currently six intensive breastfeeding courses are planned per year for teams of master trainers from hospitals throughout the country. A modified Wellstart training approach will be followed and the training package described above will be utilized. Eventually, five satellite centers will be developed in other states throughout the country: Jalisco, Mexico, Nuevo Leon, Sinaloa, and Tabasco.

12. Launch an Integrated Communication Campaign: An integrated communication campaign is being planned and is scheduled to be launched during the fall of 1992. Two television spots have been created and will be aired during prime time television to help foster a more positive attitude toward breastfeeding. Other elements of the communication strategy to be developed later this year and during 1993 include: additional television spots; a series of radio spots; videotapes for hospital waiting rooms, recovery rooms and maternity wards; a videotape on the successful experience with the elimination of bottles in one of the Mexican hospitals; and a videotape highlighting the launch of the Mother and Baby Friendly Hospital Initiative in Mexico.

SUMMARY

The enthusiasm and success with which the "Hospital Amigo" Initiative is proceeding propels us to further--and greater--action for the future. Important lessons have been learned through our efforts to date which may help others as they proceed with their respective, unique adaptations of this exciting initiative.

Lessons Learned

1. *Political will is essential.* A number of critical factors have come together in Mexico which have led many of us to be extremely optimistic about the potential for re-establishing a breastfeeding culture throughout Mexico. First, and probably most importantly, Mexico has the political will to protect, promote, and support breastfeeding. A decision was made in the fall of 1990--at the highest level--to support the operational targets of the Innocenti Declaration and the Conventions of the World Summit for Children.

2. *Dedicated professionals and advocacy groups are fundamental to any movement to protect, promote, and support breastfeeding.* The ongoing commitment of such groups as La Leche League as well as the dedication of a virtual "army" of well-educated and committed mother-to-mother support group leaders and health care professionals is highly conducive to implementing a program such as "Hospital Amigo." These same health professionals can assist in monitoring the program's expansion into the community.

3. *Finally, an undeniable ingredient for success is a global commitment to breastfeeding*--a global mobilization of forces by UNICEF, WHO and other funding and policy groups. Being able to share in the international experiences--such as the José Fabella tour--has helped convince Mexican health decision makers and professionals of the importance of the "Hospital Amigo" Initiative and of its implications, not just nationwide, but worldwide as well. International assessment of the process lends needed credibility and legitimacy to the process and ensures its continued success.

(Photographs provided by Marilu Lopez Santoyo, UNICEF/Mexico)

PLENARY SESSION VI:

DEVELOPING COMMUNICATION STRATEGIES IN SUPPORT OF INNOCENTI AND THE BABY FRIENDLY HOSPITAL INITIATIVE

PART II - THE INNOCENTI/BABY FRIENDLY PANEL

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Presenters:

Pam Malebe, KENYA

Maureen Minchin, AUSTRALIA

Carmen Casanovas, BOLIVIA

Molly Anthony, UNITED STATES

Pauline Kisanga, TANZANIA

Elisabet Helsing, EUROPEAN COMMUNITY

Hadi Pratomo, INDONESIA
(Presented section of paper located under
Plenary Session IV: Communication Strategies
for Supporting Health Care Workers)

Ruth Elena de Arango, GUATEMALA

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PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Pam Malebe
KENYA

INTRODUCTION

This paper presents information about the breastfeeding situation in Kenya, as well as the progress we have made in the establishment of the Baby Friendly Hospital Initiative. Kenya has been able to accomplish a great deal in breastfeeding because activities are supported at the highest levels in the country. At the 1990 Innocenti Meeting in Italy, Kenya was represented by the Director of Medical Services--a high-level representative since he is in charge of all technical matters in the Ministry of Health.

One of the recommendations of Innocenti was that all governments by the year 1995 should have appointed a national breastfeeding coordinator and established a multi-sectorial national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional organizations. This initiative had been undertaken already by the Minister of Health in Kenya.

DISCUSSION

Breastfeeding Directives

As part of the breastfeeding campaign in Kenya, the WHO code of marketing of breastmilk substitutes was adopted in 1983, when the Kenya code was developed to adapt to our situation. To implement this code, the Director of Medical Services circulated a number of directives to all health institutions in the country. Since 1983, four of the directives were sent again to these institutions as reminders. The country has had a number of different director of medical services; since the directives were considered extremely important, we have felt it necessary to recirculate them each time a new person takes the post to ensure the continuity of the directives. These directives are to be implemented in all maternity facilities in both government hospitals that fall under the Ministry of Health, as well as private hospitals that either fall under individuals, missions, or other organizations. The directives highlight the following points: (1) rooming-in should be available to mothers; (2) no prelacteal feeds should be given; (3) breastfeeding should be on demand; (4) no advertisements of baby formulas or free gifts are permitted; (5) no formula company representatives are permitted in the hospitals; and (6) no use of bottles or teats would be permitted in any health institution.

These directives are enforced both in government and private hospitals. Since the inception of the Kenya Code and the Director of Medical Services Directives, no advertisements on baby formulas or posters from manufacturers are displayed in any hospital in the republic, and there are also no pictures of healthy babies on any of the infant formulas.

The use of feeding bottles and teats was prohibited in health institutions. To intensify this campaign, health workers needed to be educated on the benefits of breastfeeding and the health hazards related to bottle feeding. Therefore, in 1985, a national Breastfeeding Coordinator was identified to coordinate all breastfeeding activities in the country. Since then, more than a thousand health workers have been trained on breastfeeding management both at the national, provincial, district, and divisional levels. The teams at the district level have gone down to the grass roots to train the communities, such that at the national level they are in charge of training the provincial level, and these go down to the district, and the district level goes down to right to the communities.

Training, Information, and Education

Nineteen health professionals in Kenya have been trained by Wellstart International. These Wellstart Associates have been instrumental in facilitating ongoing training. A lactation management training center will be established at Kenyatta National Hospital, which is a referral hospital and a training institution for medical students. It is hoped that with the opening of this center more health workers will be trained at the hospital level, but also at the community health worker level. As a result of the training that has taken place to date, we have seen many changes in breastfeeding promotion and support. In addition to the Ministry of Health's initiative, the Breastfeeding Information Group, a local nongovernmental organization, has trained counselors who work with mothers in hospitals. It is due largely to these efforts that two hospitals already have been declared "Baby Friendly."

The Baby Friendly Hospital Initiative

The Baby Friendly Hospital Initiative was launched in Kenya in October 1991. During the launching, Kenyatta National Hospital and Pumwani Maternity Hospital were declared Baby Friendly hospitals and awarded plaques with that designation to display. The hospitals also received monetary awards in local money to facilitate and encourage them to continue their efforts in being Baby Friendly. The money was to be used to purchase equipment or provide additional services to make their environments more conducive to breastfeeding, such as providing better couches for the mothers, chairs where necessary, proper beds, and so forth.

Since the national launch of Baby Friendly, three workshops have taken place in Nairobi, Mombasa, and Kisumo. Representatives from all 46 districts in Kenya were invited to attend to learn about Baby Friendly. Prior to the workshops, questionnaires and copies of the national policy on infant feeding practices were distributed to all these institutions, so that when that when they came for the workshops they were already prepared with the questionnaires and the national policy that will be used as a guide in all the hospitals in the implementation of Baby Friendly.

It is hoped that by the end of the year, all 24 health facilities in the country will have received information on the Baby Friendly Hospital Initiative. Teaching materials have already

been sent to most of the facilities, and a three-day curriculum has been developed to teach the health workers in the institutions.

National Policy on Infant Feeding Practices

The National Policy on Infant Feeding Practices is an adaptation of the Ten Steps to Successful Breastfeeding and the Director of Medical Services Five Directives. The policy encompasses the "Fourteen Steps." Why fourteen steps? In Kenya, we have found that our biggest problem is not initiation of breastfeeding, but continued exclusive breastfeeding. Nearly 80 percent of mothers initiate breastfeeding right after birth, but they often add complementary foods very early. Early weaning presents a problem to the duration of exclusive breastfeeding, so we have added steps to our policy that address this issue.

The National Policy on Infant Practices was formulated by the National Infant Feeding Committee, which is an advisory body on infant feeding practices. As noted earlier, the Minister of Health has a committee that addresses infant feeding practices, and this committee has drawn membership from different multisectoral organizations. These members include representatives of the pediatric department of the university, nongovernmental organizations, and other ministries. The Chairman of the Secretariat of the Division of Family Health has final oversight of all matters related to infant feeding.

SUMMARY

In Kenya, we see the Baby Friendly Hospital Initiative as being necessary at more than the hospital level: most of the hospitals, especially the government hospitals, do not keep a mother longer than one to two days after delivery. After that time, we lose much of our influence on her breastfeeding practices. In addition, since only 20 percent of Kenyan women deliver in hospitals, we need to extend our "baby friendliness" into the community. We plan, therefore, to train traditional birth attendants (TBAs) who provide much of the care to the 80 percent of mothers who deliver at home. We will attempt to inform the TBAs about Baby Friendly and how they can provide support to the mothers in their care. We will not stop our Baby Friendly Initiative at the Hospital: we will carry the message right to the community by using TBAs and other community health workers.

This extended initiative has already begun with the training in some of the districts. We hope that by the end of this year we will have provided training to all 24 health facilities in the country. We have support from our policy makers and hope that we will continue to make great strides in accomplishing our Baby Friendly goals.

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Maureen Minchin
AUSTRALIA

INTRODUCTION

It is critical to see the Baby Friendly Hospital Initiative with developed countries being at least as important to developing ones in the amount of assistance they need to become more supportive of breastfeeding mothers. The baby food issue has shown us very clearly what happens when an elite adopts inappropriate technologies and then models these to less affluent communities. This presentation will focus on what the issues and experiences are in Australia for implementing Baby Friendly.

DISCUSSION

In Australia, we see several obstacles to initiating Baby Friendly. The principal issues are obvious: health workers' knowledge, attitudes, and practices. There is a flow both ways between knowledge and attitudes that can, or may not, affect these things, but both knowledge and attitudes will affect practice, so there are a number of areas one can work on there. Hospital funding structures are another major problem. Because of the way Australian hospital funding works, Baby Friendly could mean hospitals lose money. This problem will make it a major point of resistance for hospital administrators, many of whom are very influential doctors. Industry and other vested interests also are likely to be obstacles unless they are appropriately addressed.

We need to remember that industry is a set of competing companies whose interests may not be identical. In general, they may seem to be, but in point of fact they are frequently not. In Australia, we have been able to exploit this fact by using the "least worst" company in Australia--Nestle--to bring into line the "most worst" company--at that time, Bristol Meyers. In fact, this use of one company against the other has been an important part of enabling negotiations with the Australian Code. Western health workers, however, are very uncomfortable about positions perceived as being anti-industry. Health workers' perceptions are another factor in this equation, and are very important to our efforts.

Health workers are people who have an understandable level of ignorance about infant feeding issues, particularly about the up-to-date clinical management of breastfeeding. Their ignorance is real, but we know that busy people may not always be able to keep up with all of the changes that have occurred during the past decade. It is a breakthrough that there is for the first time a scientific basis to understanding human lactation--an understanding we have had of much of the animal kingdom for much longer.

There are also people who genuinely care for ethical issues, which can be used to deal with industry questions. Most health workers care for babies and mothers. However, they tend to have very hierarchical attitudes: they are resistant to pressure from below, as they perceive it, and consumer activist groups and mothers tend to be seen as somewhat lower in the hierarchy. They tend also, however, to accept pressure from above, from appropriate institutions such as WHO, UNICEF, their professional colleges, and others. They may also tend toward territoriality. If an issue or program is being advanced by the Australian Lactation Consultants Association, the Australian College of Pediatrics may or may not think that it is a good idea. If the activity is in their territory, we need to proceed carefully when we present our case.

Health workers can be excited by good research, which is one of the main elements that can convince them about supporting breastfeeding programs. Generally speaking, health workers in Australia tend to be very conservative politically, which makes it very easy for them to collaborate with industry. They see industry as an essential part of the capitalist structure of the society in which they are doing very well. All of those factors are common in Australia.

If we want to change health workers, we need not only to provide motivation, we also need to provide management. To be able to make breastfeeding succeed better is in itself a motivation to want to do so. But equally, health workers will not learn those skills and that knowledge unless they are motivated to want to start in the first place. In 1984, when I first published Breastfeeding Matters, I argued strongly that the breastfeeding promotion campaigns of the early 1980s had been a bit of a waste of time--if not a disaster--because we had encouraged people to consider breastfeeding in an environment which was not supportive. When we see high initiation rates and then rapid fall-off rates, we can be certain that we have a group of dedicated women in the community who will support bottle feeding because of how badly they feel about their failed breastfeeding experience. Therefore, health workers need not only motivation, but also knowledge and skills.

In thinking about Baby Friendly in Australia, we recognized that it needed (1) to be an initiative that came from above to health workers, from within the health care system; (2) it needed to be based on accessible research; (3) it needed to be structured so that it would save hospitals money rather than cost them money; and (4) it needed to be not overtly anti-industry. Many people within the group working to establish Baby Friendly in Australia see it as a way of dealing with the problem of supply of free or no-cost formula to hospitals. We do, in fact, have some commitment to doing something about that from some of the companies and not from others. Baby Friendly will make it impossible for all of the companies not to take part.

Many groups have been involved in the process, including the President of the National UNICEF Committee, ACA, and the Australian Coalition for Optimal Infant Feeding (ACFOIF), which is a coalition of consumer and professional development agencies concerned about infant feeding issues in Australia and overseas. This group has been keeping track of Baby Friendly. We approached the President of the National UNICEF Committee, who is a committed and

very well-known international midwife, and presented the Baby Friendly concept. She was very receptive and called under her letterhead a meeting of professional, hospital, and consumer groups to discuss the idea. The meeting brought together obstetricians, midwives, pediatricians, directors of nursing, hospital associations--the private hospital association, Nursing Mothers (a breastfeeding mothers support group)--as well as the Australian Federation of Consumers Organization (a broad-ranging consumer group), the Baby Food Action Group (the Nestle Boycott group in Australia), World Vision, and others. These groups formed a task force on Baby Friendly implementation. The group created an executive committee which would work through the Baby Friendly Hospital Initiative documents to devise a strategy for Australia, to report back to the task force, and to create an information packet for our hospitals. Many hospitals have expressed interest, wanting to know how they can become Baby Friendly, or be certified as such. So we have already got that process happening.

In looking at the global priority documents and the hospital assessment procedures, we are looking mainly for any problems in them that will needlessly cause people to reject the whole concept. For instance, there are some things that may need to be modified on scientific grounds--which may already have happened because the documents we had were drafts--but there are also terminology issues.

We have proposed that after hospitals have had a chance to get this package of materials that we call a meeting on a state basis, and hospitals would be asked to send a team of a midwife, a doctor, and an administrator to discuss any problems foreseen by them in the implementation. We hope that hospitals involved in the meetings will share experiences and concerns. We will also offer explanation of some of the elements of the Initiative.

Although we are well aware of the current issues and of the many international issues and of the morbidity and mortality that infant formula causes in Australia, we are presenting Baby Friendly as a professional, quality assurance, mother oriented, mother friendly initiative. Any other way in a Western culture I think at the moment, given the prevailing propaganda, is in a sense almost doomed to failure.

The complicating factor that has already been raised, interestingly, not by the midwives so much as by the obstetricians, is the question of the mother's choice. For the majority of mothers, informed choice takes care of the issue: we inform women that they will be making the right choices about how to handle their babies in the postnatal period. That means we need appropriate antenatal education, skilled midwives postpartum, and positive hospital modeling of what are the right choices. We do not think most women, however much they may instinctively say, "I'm not going to be forced to do this, why can't I use a pacifier?" or whatever else, are unreachable when it comes to breastfeeding. However, some women may be more difficult to reach, particularly those who select to deliver in private hospitals, perhaps on the basis that the chef is a gourmet cook, or champagne is available in the refrigerator in the room. Many of these women are influenced by dominant Western concepts that separate women from their children, that emphasize the mother's rights as against the baby's needs in some way, as though those two things can be separated without damage to either. They stress

that the baby is a great deal of work, is demanding, needs to be tamed, needs to fit in. There are all Western concepts that are unheard of in other cultures. These women need skilled, supportive, and sympathetic help.

We feel that the hospital, while it cannot sacrifice good practice to patient pressure, must stand its ground, and there must be some evidence that it does that. If the evidence indicates that the hospital bends to pressure, then it would not be Baby Friendly. If evidence indicates that the hospital supports these women, because they still deserve support as childbearing women, but not their poor practices, then it could be Baby Friendly.

SUMMARY

The attitudes of care givers are our basic problem in Australia. We have health workers at all levels who make a number of erroneous assumptions--that breastfeeding matters only for poor people; that our nation's formula is suspect, while that of other nations is not; or if from a developing country, then your formula is suspect but American or imported formula is adequate and safe unless misused; and others. Some health workers are women who have themselves failed at breastfeeding in their personal lives because of a whole range of reasons--and they are now the key figures in the promotion and support of the Baby Friendly Initiative. We need to reach them, and we need to educate them. Once they know better, the change will accelerate and their commitment will increase.

In promoting Baby Friendly, we have to recognize, as industry has long recognized and has long targeted and long sought these people out, that health workers are the key to change. They certainly need change, and they can cope with challenge. They are among our society's most educated people, but they also need to be nurtured, not attacked. We might all do well to take a leaf out of industry's book and remember that, as my grandmother used to say, "You can catch more flies with a teaspoon of honey than a barrel of vinegar."

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Carmen Casanovas
BOLIVIA

INTRODUCTION

Most of the details about the Baby Friendly Hospital Initiative have been covered in other presentations; therefore, this presentation will focus on activities only in Bolivia. Bolivia is one of the twelve leading countries in this initiative. Last year an evaluation of the program looked at what was going on in most of our hospitals, and where we needed additional work. After the evaluation and some additional training, the Bolivia Baby Friendly Hospital assessors and trainers met in the United States to discuss the current situation. After the meeting a team of assessors went to Bolivia, conducted an assessment, and found that one hospital--the Hospital San Gabriel in La Paz City--met the criteria to be declared Baby Friendly. We have in Bolivia three main health institutions in the health sector: the public health sector, the social security sector, and the private sector. San Gabriel is a very special institution because its personnel are paid by the public health sector, yet the hospital receives private funding--so it is one institution that has been declared Baby Friendly that could be considered to be private sector.

DISCUSSION

All hospitals in Bolivia have declared their desire and intent to be declared Baby Friendly, and in June 1992, a training session took place for the hospitals in five cities. One person is in charge of the Initiative for the country, and he is working with the individuals in charge of each region and department in order to establish one Baby Friendly Hospital in each of the five cities by the end of the year. The other four departments will have one Baby Friendly Hospital each by the end of the next year. The training for these groups is being conducted by both people trained in the United States and people trained in Bolivia.

We provide training to the personnel in each institution. The supervision of the hospitals ensures that they are following all of the Ten Steps to Successful Breastfeeding, including the Tenth Step--building support groups. This step is the most difficult to implement because most institutions are not accustomed to working with support groups. La Leche League is working in one institution in La Paz, but the other cities do not have such a group. We will attempt to build on these experiences with La Leche League in other areas.

We believe that we are encountering many of the same difficulties as other countries as we implement the Ten Steps in Bolivia. Most hospitals, the Government, and the Ministry of Health have pledged to support the Baby Friendly Hospital Initiative, so we believe we will be successful--at least successful enough to establish one Baby Friendly Hospital in each city in Bolivia. The steps that have been less complicated for us include rooming in, because we

do not have enough money to have separate nurseries; giving babies no other food or drink other than breastmilk, because this saves money for the institutions; no use of artificial teats or pacifiers, because it also saves money; and breastfeeding on demand, because we have rooming in.

We have not experienced many difficulties with developing written policies. Training is ongoing. I have discussed already our problem with support groups. Several hospitals have reported difficulties in having all babies breastfeeding within the first half hour. We have therefore identified the areas to which we need to give more emphasis as we proceed with this Initiative.

SUMMARY

The Baby Friendly Hospital Initiative has been proceeding successfully to date, and we hope to be able to link its success to interventions later in the infant's life. For example, in Bolivia, we have problems with inadequate weaning practices. In addition, we must consider that 60 percent or more of our infants are not born in hospitals, so we have to somehow consider what happens outside institutions. Our belief is that the Baby Friendly Hospital Initiative is helping the mothers who are most in need of help--those who are under the care of health professionals.

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Molly Anthony
UNITED STATES

INTRODUCTION

The United States approach to the Baby Friendly Hospital Initiative is not unlike that of Australia, although our process is not as far along. This paper briefly shares some differences that are unique to the United States health care system, to explain why our approach to Baby Friendly is a bit different.

The United States is a pluralistic society, with limited national government responsibility assigned to the federal level. Much of the health services sector is not centralized, and is influenced by private medicine and state and local governments who have traditionally provided and been responsible for illness care to our citizens. The philosophic underpinnings of the United States health care system is a private provider/client relationship which allows the private medical community to establish its own medical standards, its quality of care, and its accreditation processes. As one of the payers of health care, federal and state governments negotiate plans to allow access to our health services for medically needy individuals, but generally we do not infringe on the scope of the care delivered. The credentialing process, as such, as institution accreditation or professional licensure, is overseen by professional organizations and state governments. Our 50 states have autonomy in most health issues. Voluntary participation is the cornerstone of our quality assurance efforts, and it has been demonstrated in standard setting, quality of care criteria, and national private accreditation and certification. States establish their own licensure requirements, but most providers often use a national accreditation or certification process in lieu of a state developed exam. This facilitates universal eligibility to practice and allows our population its mobility.

The nation has over 4 million births, and they go from states as small as Wyoming, with 6,900 births, to California, with 570,000 births in a year. Our experience in perinatal intensive care and other preventative health services activities supports the value of voluntary activities by our health sector. Public Health Service efforts over the last 10 years have included many demonstration and implantation grants on breastfeeding and family centered maternity care. We have training models, institutes, conferences, and fellowships for health professionals, and are sponsoring research in community and university settings in breastfeeding management and promotion. We have widely distributed the "Ten Steps to Successful Breastfeeding" and have been encouraging their use since they became available. The United States did sign the Innocenti Declaration, and Dr. Nor, the representative at that meeting, is the current acting Health Director for the Maternal and Child Health Bureau, and an Assistant Secretary. The United States Public Health Service has been promoting breastfeeding for a decade, and it has been a hard 10 years.

The interest and importance of the message behind the Baby Friendly Hospital Initiative has led the Public Health Service to make funds available to study the feasibility of how such an initiative could be addressed in a unified way throughout the nation's maternity services. Based on the nature of the United States system, we see the implementation of Baby Friendly Hospital Initiative as a voluntary activity. The efforts begin with testing the feasibility under various conditions over 1992 and 1993 by a coalition of health professional organizations. The feasibility of adapting the international Baby Friendly Hospital Initiative in the United States must address the compliance issue and adaptation of the "Ten Steps" to a self-supporting accreditation for up to 3,200 hospitals in the country who deliver babies. Pregnancy, the perinatal period, and infancy represent distinct philosophical and health policy changes for women and their offspring. During these critical developmental periods of life, human needs are critical to the promotion of optimal child health. Breastfeeding should be an integral component in our comprehensive, family centered care that we are striving to achieve. Breastfeeding is not an end in itself, but a natural progression of optimal child rearing and childbirth.

SUMMARY

As part of our health objectives for the nation by the year 2000, the United States has adapted a goal to increase to at least 75 percent the proportion of women who breastfeed their babies in the early postpartum period and to at least 50 percent of those who are still breastfeeding at five to six months. To give an idea of where we are, in 1991, 44 percent of hospital births were exclusively breastfed, and 53 percent were somewhat breastfed--so that is part of what can happen to close that gap to zero between fully breastfed and breastfeeding in hospital. And then we have very interesting drop-offs in rates as you go through the sector of the first six months of life. The Baby Friendly Hospital Initiative will help the United States establish successful early lactation and thereby move us toward our goals.

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Pauline Kisanga
TANZANIA

INTRODUCTION

This presentation reports the experiences from and impact of a series of lactation management workshops conducted for health personnel in hospitals in Tanzania from 1988 to 1992. The workshops, which began as training of trainers workshops, developed into one-week, hospital-based lactation management workshops for hospital teams. Simple evaluations and observations that were built into these training sessions revealed that the sessions were successful in influencing both the behavior of maternity ward personnel as well as hospital practices as a whole. The evaluations documented changes in the use of prelacteal feeds and contact of mother and baby after delivery in hospitals whose staff received training and in hospitals where no training was conducted. We concluded that when health worker attitudes are sound and the communities support breastfeeding, well-designed workshops emphasizing a team approach succeed in disseminating breastfeeding information and producing changes in breastfeeding practices.

DISCUSSION

Breastfeeding in Tanzania

Studies available on breastfeeding in Tanzania are few, not comprehensive, often area specific, and not standardized. The studies can be used only to give a general idea of trends in the country and would indicate declines in breastfeeding. A Dar es Salaam Breastfeeding Study investigating practices among high and low income women with children under two years old revealed that high income mothers weaned early and used infant formulas more than the low income group; and that, in the low income group, the children who were bottlefed has poorer nutritional status than their breastfed counterparts (Yambi et al, 1980).

In general, the major problems with breastfeeding in the country can be summarized as follows. At the community level, colostrum is frequently discarded, and the duration of exclusive breastfeeding is short. The duration of any breastfeeding, as well as the frequency of breastfeeding, also is declining. There are problems with either adding supplementary foods too early or too late, and supplementation usually is inappropriate, with the provision of foods of low nutrient density. At the hospital or health care level, several problems contribute to the decline in breastfeeding: delayed initiation of breastfeeding; the provision of prelacteal feeds by hospital/maternity staff; and the inability of hospital/maternity staff to address any breastfeeding problems a woman might encounter. However, health worker attitudes have been recorded as being positive even if their practices do not result in positive behavior.

The causes of these problems are lack of adequate health care worker and skills to deal with breastfeeding difficulties; an inadequate curricula for health care and extension staff; the decline of family or community support of breastfeeding; the availability and accessibility of infant formulas; the heavy work requirements for most women; the lack of supportive policies at the government level; and certain cultural practices.

The intervention described below was developed in order to address these problems.

Health Worker Workshops

The goal for conducting the lactation management sensitization workshops was to provide the health workers with the incentive for adopting breastfeeding-friendly behavior; the skills to facilitate the changes; the skills to resist a return to the former, detrimental behaviors; and the clinical skills necessary to carry out the changes. The incentives in this cases included the benefits of early initiation of breastfeeding versus the consequences of providing prelacteal feeds or infant formula, stressing the long-term as well as the short-term effects.

The development of self-regulatory skills for managing behavior was an integral part of the training design: for example, each health worker was asked to set goals, self monitor those goals, and overcome external forces. Competence was to be maintained through ongoing evaluation and feedback on achievements.

The Process

In 1987, IBFAN/Africa held the first national workshop, "Breastfeeding and its Contraceptive Value," in Tanzania by request of the government. At that time, breastfeeding was not perceived as a problem of public health significance. The first workshop led to the creation of a national group, "The National Consultative Group on Infant and Young Child Nutrition," which began a five-year program. Holding health worker workshops on breastfeeding was only one aspect of this group's five-year plan of action. The multisectoral National Consultative Group has members trained in lactation management and other issues such as the implementation of the International Code; therefore, it serves both as a core training group as well as a source to integrate breastfeeding information into other national programs and curricula.

The first of a series of health worker workshops was a training of trainers for maternal and child health regional coordinators and staff of antenatal, maternity, and pediatric wards of major hospitals. The group was comprised of 30 trainers from a senior level, but included no doctors. All of the participants had a secondary school education plus three to four years of specialized training in their relevant fields.

The objective of the training was to teach breastfeeding knowledge and clinical and training skills to the core group so that these trainees could (1) train others in their area of work on important issues relating to breastfeeding and successful lactation management; (2)

influence other staff behavior through example; and (3) influence hospital practices--particularly to help eliminate the use of prelacteal feeds and to encourage the early initiation of breastfeeding.

The course lasted two weeks, using a curricula that was modified from the IBFAN/Africa Lactation Management Course. Teaching methods included lectures, demonstrations, videotapes, group discussion, role plays, visits to hospital wards for observation of breastfeeding and identification of major breastfeeding problems in hospital situations, and visits to local shops to identify products contravening the International Code and marketing techniques.

The second series of workshops, which were a result of the first training of trainers and initiated by that group, consisted of a one-week training. Three of these sessions were hospital based and one was community based. Five other requests for training could not be met due to lack of funding. National Consultative Group members served as trainers, using a course content similar to the first training but concentrating more heavily on counseling skills. The major objective of the second series of workshops was to teach correct knowledge and lactation management skills; and secondly, to encourage a teamwork approach in bringing about hospital changes. Self-evaluation of each participant's hospital's breastfeeding situation and of the state of implementation of the International Code was an integral part of the training.

Evaluation

Informal evaluation was built into the training. Pre and post-tests were carried out during the workshops, and evaluation of the hospital practices and awareness was integrated into the second and subsequent training sessions. Therefore, the hospital received feedback each time a new step was taken. Major evaluation points included: time of initiation of breastfeeding after the infant's birth; the extent of the use of prelacteal feeds; health worker knowledge in comparison to those workers not receiving training; the amount of breastfeeding education provided in MCH clinics; and the use of bottles for feeding in the hospital.

Change in hospital practices

As evaluated through pre and post-tests, all of the health staff trained increased their breastfeeding knowledge by, on average, 15 to 40 percent. One year after the training the trained staff had a better understanding of breastfeeding issues than those not trained. Hospital focused workshops had a tremendous influence on workplace practices because the training involved all levels of employees in the workplace. The understanding that all workers were striving toward a common goal strengthened the workers' confidence and facilitated action. Where only one or two persons were trained in the hospital, the change was more gradual and depended greatly on the individuals trained.

Simple evaluations carried out in three intervention hospitals and two non-intervention hospitals revealed that in all intervention hospitals prelacteal feeds were eliminated and

breastfeeding was initiated within one hour of birth; while in the non-intervention hospitals, no change was observed.

SUMMARY

The Tanzania experience demonstrates practical implications for the Baby Friendly Hospital Initiative. At the national level, a multisectoral training approach produced a stronger multiplier effect, but as training filtered down to more specified action levels, such as the hospital, a team approach was the most effective. For example, after the hospital based training, ward based training should follow to address problems specific to each ward and later to the individual staff level. Informal evaluation and feedback are essential for maintaining positive action and sustaining competence.

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Elisabet Helsing
EUROPEAN COMMUNITY

INTRODUCTION

Since most aspects of the Baby Friendly Hospital Initiative have been covered extensively in this panel discussion, this presentation will describe very briefly the situation in the European Region. In the European Community, there are 32 member states from whom we are trying to obtain an understanding of the development and situation of breastfeeding. The picture we get is one of large diversity with regard to breastfeeding both among and within countries. This diversity suggests large variability in the way mothers are helped and supported in their first week of breastfeeding, and in maternity ward routines.

DISCUSSION

The WHO Regional Office for the European Region has been receiving regular reports from its member states on breastfeeding statistics. The trend in the late 1980s has ranged from initiation rates of approximately 30 percent in Ireland, to almost 100 percent in countries like Norway and Sweden. We have been unable to get reliable statistics or make real progress in breastfeeding support and promotion in Eastern Europe and the former Soviet Union countries.

The International Code of Marketing of Breastmilk Substitutes constitutes the clearest mandate for an action program in the field of breastfeeding that the World Health Organization has ever been given by its member states. While a great deal of attention has been focused on the commercial aspects of the Code, relatively little has been made of those aspects of the Code that address the responsibilities of health workers and health authorities. In 1986, we called a meeting of health workers' organizations focused on the Code and its implications for health workers. One of the recommendations of this meeting was that a "European Strategy for Breastfeeding Promotion" should be formulated. In 1987, an international workshop held in The Netherlands created the basic framework of such a breastfeeding promotion strategy, and proposed priority areas for action. The priority areas outlined were: the basic attitudes of health workers; maternity ward routines; how to form breastfeeding mother support groups; how to support employed mothers who want to breastfeed; research in breastfeeding; commercial pressure on health workers; and the need for advocacy of breastfeeding.

We have felt for a long time that the promotion of breastfeeding is not accomplished through one activity or campaign, but rather that it is the cumulative effect of activities from several different disciplines that finally results in a statistical increase in breastfeeding. We have learned a great deal from the Scandinavian experience in the 1970s and 1980s, when breastfeeding increased from about 30 percent at three months to almost three times that figure. At the same time, there was an increase in problem-based informational material about

breastfeeding; mother-to-mother support became more available; maternity leave was prolonged and paternity leave was instituted; maternity ward practices changed; the infant formula companies were keeping a low profile; the new feminist movement, essentially positive toward breastfeeding, may have made women more assertive and vocal about their desire to breastfeeding; and the relaxed Scandinavian attitude to the human body may have made these women less apprehensive about breastfeeding, even in public.

SUMMARY

It is clear from this experience that long-term, sustained action needs to be taken in a number of areas and at a number of levels. Ideally, activities would be coordinated by a national committee or an organizational body that has an advisory, and to some degree an executive, decision making function. Our challenges for this process are to identify such committees--because they often exist already; to find skilled assessors to assist us in assessing our current situations; to identify funding for large-scale, sustained breastfeeding support and promotion efforts, as well as research; and to find the time to carry out these activities.

We may encounter some resistance in the European Community to the implementation of the Baby Friendly Hospital Initiative--perhaps with the exception of the Scandinavian countries--due to a number of factors, similar to those in the United States, which include the following: entrenched infant formula industry; health worker attitudes; cultural attitudes; and so forth. While not insurmountable, these are issues that require great patience and persistence to accomplish our goals.

PLENARY SESSION VI: PART II - THE INNOCENTI/BABY FRIENDLY PANEL

Ruth Elena de Arango
GUATEMALA

INTRODUCTION

The focus of this presentation is the impact of the Innocenti Declaration and the Baby Friendly Hospital Initiative in Guatemala. I would like to begin by reflecting on actions taken by Guatemala toward fulfillment of the four operational targets established for governments as outlined in the 1990 Declaration of Innocenti, and then share some of our experiences associated with launching the Baby Friendly Hospital Initiative.

DISCUSSION

Fulfillment of the Declaration of Innocenti

The date officially established for the realization of operational targets by governments worldwide is the year 1995. Guatemala, having made a strong commitment to the protection, promotion, and support of breastfeeding during the late 1970s and early 1980s, had actually reached several of the proposed targets prior to the UNICEF/WHO meeting at Innocenti, Florence, Italy. Guatemala was invited to Innocenti, perhaps in part, to share some of its experiences in breastfeeding during the previous decade and to demonstrate that the proposed targets were indeed realistic goals toward which countries could strive.

The following is a brief summary of actions taken to date related to the four Operational Targets.

> *Operational Target 1: To appoint a national breastfeeding coordinator of appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health professional associations.*

Between 1976 and 1978, Guatemala participated in a WHO collaborative infant feeding study which revealed that Guatemala had a particularly high proportion of mothers who never initiated breastfeeding in comparison with the findings in seven of the other eight countries surveyed. The duration of breastfeeding among the women surveyed was often short, suggesting a decline in both the popularity of breastfeeding and the awareness among Guatemalan mothers of the appropriate length of breastfeeding.

Early in 1979, as an outcome of the WHO study, a two-day National Workshop for the Promotion of Breastfeeding was held in Guatemala. Forty-two high level representatives of both the private and public sectors as well as a myriad of professional associations participated in the identification of various cultural, educational, health, economic, and social issues

responsible for the decline of breastfeeding in Guatemala. A recommendation was made to establish an intersectoral national breastfeeding promotion program and to ensure the participation of every level of the national community. Actions required to promote breastfeeding in Guatemala were identified, as well as a set of general recommendations to support and facilitate the execution of the necessary actions. Subsequent to the National Workshop, the National Commission for the Promotion of Breastfeeding (CONAPLAM) was established and given legal status in 1981 by a governmental decree, SPG-28-81.

CONAPLAM has thirteen institutional members representing the government, nongovernmental sectors and professional associations. UNICEF, La Leche League, the Pan American Health Organization (PAHO), and the Nutrition Institute of Central America and Panama (INCAP) serve as permanent technical advisors to the Commission. CONAPLAM, whose operational budget has been supported primary by UNICEF, is charged with the following responsibilities:

- to monitor the country's breastfeeding practices;
- to define national guidelines for short, mid and long-term breastfeeding goals;
- to design projects and define activities that will promote breastfeeding; and
- to assign responsibilities to various sectors involved in the promotion of breastfeeding and coordinate these activities.

Operational Target 2: To take action to give effect to the principles and aim of all Articles of the International Code of Marketing of Breastmilk substitutes and subsequent relevant World Health Assembly resolutions in their entirety.

Guatemala was one of the first and remains one of the few counties to adopt the International Code of Marketing of Breastmilk Substitutes. In June 1983, after several years of preparation, Guatemala issued Decree Law Number 66-83, the Law of Marketing of Breastmilk Substitutes, reflecting the International Code in its entirety, with the exception of the second part of Article 8, which was not included. A National Regulation concerning the application of this law was issued in September 1987, through Governmental Agreement Number 841-87, in which certain aspects of the International Code and the Guatemalan Law were amplified and clarified. For example, the regulation established that:

- Both individual persons and legal entities (national and multinational) are subject to the disposition of the law.
- All restrictions/regulations related to propaganda, promotion, informative (educational) materials, labeling, and so forth, concerning products that could be used as breastmilk substitutes extend through the second year of the life of the child.

- Only health personnel are permitted to demonstrate the use of substitutes, and only to mothers or family members who have a medical indication to use them.

- Labels of breastmilk substitutes must display the notice concerning the superiority of breastmilk in letters no smaller than five millimeters.

The Division of Food and Drug Registration and Control, a unit within the Ministry of Health, is charged with the responsibility of monitoring compliance with the Law. Currently, one person is in charge of ensuring that all affected industry (manufacturers, producers and distributors of infant formula, weaning foods, baby bottles and nipples, among others) are aware of the Law. This person is also in charge of monitoring the distribution of free samples, product labeling, points of purchase advertisement and displays, "educational" materials produced and distributed by industry for medical personnel, and advertisement of products through all channels of mass media (television, radio, newspapers, and magazines). By law, all advertisements, labels, and literature produced by these industries related to breastmilk substitutes, bottles, and artificial nipples must be reviewed and approved by this unit. Given the enormous scale of this responsibility, it is fortunate that advocacy groups in Guatemala, such as La Leche League, and other members of CONAPLAM assist with this monitoring activity. To date, twelve legal suits have been filed by the Ministry of Health against manufacturers, producers, and distributors of products affected by the Law.

Operational Target 3: To enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

The protection of maternity rights and breastfeeding practices is addressed by the Political Constitution of the Republic of Guatemala, the Labor Code, the Social Security Laws, and by other specific laws and regulations.

CONAPLAM, through a multisectoral approach, has been successful in fostering several joint efforts between the Ministry of Labor, the Social Security Institute, the National Women's Bureau and the Commission to improve the dissemination of information concerning this legislation to both working women and their employers. As in many other countries, although laws exist to protect maternity leave and ensure job security, these laws are not always understood or enforced, especially if adherence to the laws is not monitored on a regular basis.

Currently, the creation of support services for working women within the work place is being promoted by CONAPLAM and its member organizations. Thirteen breastfeeding support centers, for example, are now operating--one of which was established within the Ministry of Labor. Five day care facilities--model projects developed under a cooperative agreement between the government, employers, and employees--have also been established, with CONAPLAM providing technical assistance. The long-term goal is to expand the number of work place support centers and day care facilities, as well as to reinforce the existing legislation.

Operational Target 4: To ensure that every facility providing maternity services fully practices all ten of the 'Ten Steps to Successful Breastfeeding' set out in the joint WHO/UNICEF statement "Protecting, promoting, and supporting breastfeeding: the special role of maternity services."

In 1988, the normative procedures related to the promotion and protection of breastfeeding in Guatemala were established within a component of a national Ministry of Health maternal and child policy. These procedures were subsequently unified with those established by the Guatemalan Social Security Institute, which is basically a separate health system operating within the country.

When the WHO/UNICEF Joint Statement was issued in 1989, a comparison revealed that the first nine of the ten steps to successful breastfeeding were addressed by the already existing national policy. In November 1991, a review and update of procedures resulted in the incorporation of Step Ten into the national policy. Furthermore, the recommendation concerning exclusive breastfeeding was officially increased to six months of age.

National Focus on the Baby Friendly Hospital Initiative

When the Baby Friendly Hospital Initiative was launched, it provided Guatemala with an additional incentive to train maternity staff in breastfeeding, implement the established norms, and identify other ways to improve the promotion, protection, and support of breastfeeding in order to achieve a level of excellence.

A national effort, both multisectoral and interagency, was organized within both the Ministry of Health and the Social Security maternity hospitals that has served to reinforce the actions that had already taken place in Guatemala. The major elements of this effort include the following activities:

- An assessment was made in 1991 of 73 maternity wards to determine their level of compliance with the national breastfeeding policy, including the Ten Steps outlined in the Joint Declaration.

- An interagency meeting was held with PAHO/WHO, UNICEF, the U.S. Agency for International Development, La Leche League, International, and the INCAP to present a situational analysis, unify criteria, establish collaboration, and to obtain the support and participation of all agencies involved in the Baby Friendly Hospital Initiative.

- Educational materials were designed to address specific issues that were identified by the situational analysis.

- Meetings were held between agencies and with authorities of the Ministry of Health and Social Security Institute in order to establish officially their support

and participation in the Initiative. Results of assessments of the Ministry and Social Security maternity hospitals were submitted to each.

- Ministry of Health and Social Security authorities then met with the directors of their respective hospitals to discuss their involvement in the Initiative. The individuals hospital assessments were shared with each maternity hospital. Training and national and international evaluation dates were established.

- Official commitments to the Baby Friendly Hospital Initiative were ratified by the directors of the maternities and the chiefs of health areas.

- Seven twenty-one-day training of trainer courses on breastfeeding were held for hospital staff, a total of 154 persons. The curriculum included both practical and theoretical information. Training materials were duplicated for use by each of the hospitals.

- Follow-up and support visits by CONAPLAM to each maternity hospital are being carried out to help solve specific problems; deliver small cups for providing expressed breastmilk to infants if separation of mother and child is unavoidable; provide educational support materials; provide follow-up training; and determine the feasibility of conducting a Baby Friendly assessment.

SUMMARY

After several years of fine tuning the Innocenti operational targets and working toward the realization of Baby Friendly Hospital status among all of our Ministry and Social Security maternities, we believe that Guatemala represents a positive example of the impact of multisectoral and interagency collaboration and coordination at the national level. Clearly, there is still a lot of work to do, new challenges to meet, and frustrations to overcome, but Guatemala as a nation is committed to the promotion, protection, and support of breastfeeding. There is certainly a strong foundation upon which we can continue to build.

In terms of the Baby Friendly Initiative, the following observations related to four of the Ten Baby Friendly Steps may be useful to other countries like Guatemala where only twenty percent of the births take place in hospitals:

1. Step Three: The number of mothers that receives prenatal care is very low; the majority of pregnant women are attended by traditional midwives. This fact necessitates the incorporation of primary health care programs into the Initiative and/or the extension of the Initiative into the community.

2. Step Six: In private or specialized hospitals which favor the use of glucose and formulas, it is difficult for physicians to accept that breastmilk supplements or substitutes must be medically indicated. Based on "scientific" information

received from industry, many doctors believe that both small and large for date infants should be given glucose water because they are considered to be at risk of hypoglycemia. This is a difficult belief to overcome and will require a concerted re-education effort.

3. Step Nine: Both the elimination of bottles within hospitals and the provision of expressed human milk to high risk infants has been difficult, especially in hospitals where there is a large number of these cases. Little cups and other alternate techniques have been successfully tried which are more conducive to establishing direct sucking.

4. Step Ten: To date, only La Leche League has worked with mother support groups in Guatemala. Currently, Guatemala is attempting to duplicate this mother support group model at the national level through a training of trainers program. The goal is to develop a cadre of breastfeeding advocates and to establish a network of mother support groups throughout the country.

Photo courtesy of UNICEF

AFTERWORD

AFTERWORD

These proceedings represent the culmination of a dream come true. Almost two years ago, a small group of international nutrition educators met at the 1991 Annual Meeting of the Society for Nutrition Education in Miami, Florida, to discuss the possibility of organizing a conference and to identify potential themes and funding sources. The resulting ideas were shared, shortly thereafter, with Margaret Parlato, Director of the Nutrition Communication Project managed by the Academy for Educational Development. Margaret, better known as Peggy, embraced our ideas, gently guiding their form and dimension. Thanks to her vision and that of Eunyong Chung, Susan Anthony, Frances Davidson, and others at the Office of Nutrition, United States Agency for International Development, the "seed" was nurtured and resources were committed to make it grow.

A multidisciplinary, interagency planning committee was formed and after several formal meetings and informal consultations, a two-day conference and related activities were planned. The goal, reached through a process of consensus building, was to provide a venue for the exchange of ideas on communication strategies aimed at improving the way that infants and young children are fed throughout the world. Program examples were identified, ranging from local to global initiatives, in both industrialized and non-industrialized countries. A true mix of technical experts, field-level project personnel, and representatives of various private voluntary organizations, universities, the United Nations, and other international development agencies were invited to share their collective knowledge and experiences from Africa, Asia, Europe, Latin America, and North America.

The focus of the conference itself was on the importance of strategic planning of communication interventions and methodologies for the promotion of optimal infant and young child nutrition. The planning committee wanted to blend traditional conference formats with smaller, more interactive sessions. Skill building workshops, audiovisual presentations, organizational exhibits, and round table discussions were designed to allow participants a unique opportunity to meet and engage other professionals from around the globe who were concerned with similar issues. Participants were exposed to a broad spectrum of strategic approaches and communication methodologies that have been successfully utilized for building coalitions, mobilizing resources, and effecting both policy and behavior change related to nutrition. Emphasis was placed on teamwork; conducting formative research; targeting multiple audiences; sharpening audience segmentation; developing culturally appropriate, simplified messages; involving policy makers; and matching available resources with materials, media and other technologies.

The successes of the conference and the content of this proceedings can be directly attributed to an inspiring program chair; a diverse planning committee dedicated to excellence; funding agencies committed to the realization of a shared dream; presenters, chairs, and discussants who understood the goal of the conference and came prepared to meet the challenge; and participants, who brought their own ideas and experiences to share in open discussion and debate. The list of conference participants is virtually a who's who in

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international nutrition, breastfeeding, and health communications. It is unfortunate that both the floor and round table discussions could not be included in this document since they added significantly to the richness of the conference, but a number of factors precluded their inclusion. It was clear by the end of the second day of the conference, however, that future international conferences should be organized in such a way as to capitalize on the valuable knowledge and experiences of all participants as well as those formally designated to present papers.

Finally, I would like to draw attention to the fact that this conference was dedicated to the memory of Derrick Jelliffe, a man who many of us admired, appreciated, and loved for years; a man who continually encouraged us--and whose legacy continues to inspire us--to strive a little harder to make a difference, be it large or small, in the lives of infants and young children everywhere. In small recognition of his tremendous contribution to our global society, a Jelliffe Foundation and Award was formally announced during this international conference. According to Elisabet Helsing, who spearheaded the establishment of the Award, its purpose is *to continue the Jelliffes' lifelong action by supporting young persons who are doing valuable work for the health and nutrition of infants and children and for enabling mothers to breastfeed.* Additional information about the Award is appended.

Peggy Koniz-Booher
June 1993

APPENDICES

APPENDIX A

1992 INTERNATIONAL NUTRITION COMMUNICATION CONFERENCE LIST OF PARTICIPANTS

Philip Abraham
Program Assistant
Manoff Group
2001 S St. NW
Washington DC 20009
T (202) 265-7469
F (202) 745-1961

Alida Acosta de Galletti
UPR, Medical Sciences Campus
2A-C-35 Hillside
Rio Pedras, PR 00926
T (809) 759-6546
F (809) 759-6719

Joan Allen-Peters
Acadia University
School of Nutrition
Wolfville, NS BOP 1XO
Canada
T (902) 542-2201
F (902) 542-1454

Stina Almroth
Cornell University,
Division of Nutritional Sciences
Savage Hall
Ithaca, NY 14853

Laura Altobelli
USAID/Lima
Washington, DC 20523-0001
T (011)-511-433-3200

Margarita Alvarez
Universidad Iberoamericana
Tuxpan #1
San Jeronimo, Mexico 10200

Rosalie Amos
Iowa State University
220 C Mackay Hall
Ames, IA 50011
T (515) 294-644
F (515) 294-4493

Jennifer Anderson
Colorado State University
Department Food Science
200 Gifford
Fort Collins, CO 80523
T (303) 491-7334
F (303) 491-7252

Molly Anthony
Public Health Nutrition Consultant
Maternal Infant Health Branch
Maternal and Child Health Bureau
Health Resources and Services Administration
Parklawn Building Room A18-39
Rockville MD 20857
T (301) 443-5720
F (301) 443-4842

Susan Anthony
R&D/N
413C SA-18
Agency for International Development
Washington, DC 20523-1808
T (703) 875-4035

Laurie Lindsay Aomari
The Nutrition Foundation
1126 16th St, NW
Washington, DC 20036
T (202) 659-9024
F (202) 659-3617

Ruth Elena de Arango
Technical Director
National Commission for the Promotion
of Breastfeeding (CONAPLAM)
25 Av 2-70 Zona 7
Colonia Altamera
Guatemala City Guatemala CA
T (502) 2-74-0188

Joanna Arpee
University of Maryland, College Park
4223 34th Street
Mt. Rainier, MD 20712
T (301) 405-4506

Beth Aurecchia
Office of Disease, Prevention and Health Promotion
330 C Street, SW, Room 2132
Washington, DC 20201
T (202) 472-5307

Karen Bachman-Carter
US Public Health Service
P.O. Box 548
Sell, AZ 85634
T (602) 383-7306
F (602) 383-7216

Linda Bardfield-VanOver
Academy for Educational Development
1255 23rd Street, N.W.
Washington, DC 20037
T (202) 862-1988
F (202) 833-6617

Susana Barrera
PROCOSI
CASILLA 14874
La Paz Bolivia
T (591) 2-32-67-94
F (591) 2-39-24-81

Carol Baume
Social Marketing Advisor
Wellstart E B P
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Naomi Baumslag
President
Women's International Public Health Network
7100 Oak Forest Lane
Bethesda MD 20817
T (301) 469-9210
F (301) 469-8423

Regine Beakes
Connecticut State WIC Program
150 Washington St.
Hartford, CT 06105
T (203) 566-1159
F (203) 566-8401

Jenni Beary
Department of Pediatrics
University of New Mexico
Ambulatory Care Building
Albuquerque, NM 87131
T (505) 272-5551
F (505) 272-6845

Micheline Beaudry
Universite Laval
Department of Nutrition
FAO SC Agriculture
Sainte-Foy, Quebec, G1W 3H7, Canada
T (416) 562-865
F (416) 656-5518

Alan Berg
Nutrition Advisor
World Bank
1818 H Street NW
Washington DC 20433
T (202) 473-3433

John Bowman
Senior Technical Advisor
US/AID R&D/Nutrition
Washington DC 20523-1808
T (703) 875-4074
F (703) 875-4394

Peggy Brandt
207 Virginia St, Apt. F
St. Paul, MN 55102
T (621) 222-3727

Francesca Bravo
USDA Food and Nutrition Service
WIC Program
3101 Park Center Drive, Rm 540
Alexandria, VA 22041-1107
T (703) 305-2730
F (703) 305-2420

Linda Bruce
Training Advisor
Wellstart EPB
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Robin Buck
University of Minnesota
928 Grand Avenue #204
St. Paul, MN 55105
T (621) 292-0778

Dianne Butler
Sanitarium Health Food Co.
146 Fox Valley Road, NSW
Sydney 2076 Australia
T (2)-487-1711
F (2)-489-0152

Mary Elaine Camacho
University of Guam
College of Agriculture and Home Economics
UDG Station
Mangilao, Guam 96923
T (671) 734-2562
F (671) 734-6842

Judy Canahuati
Outreach Advisor
Wellstart E B P
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Sibyll Carnochan
Center on Budget and Policy Priorities
777 N Capitol St, NE, Suite 705
Washington, DC 20002
T (202) 408-1080
F (202) 408-1056

Carmen Casanovas
Wellstart
Attn: Janine Schooley
4062 1st Ave
San Diego, CA 92103
T (619) 574-8763

Sarah Castle
27, Hall Ave, #2,
Sommerville, MA 02144
T (617) 666-8655

Daniella Chase
Trillium Health Products
JM Marketing
655 South Orcas Suite 200
Seattle WASH 98108
T (206) 762-8403

Eunyong Chung
Nutrition Advisor
US/AID R&D/Nutrition
Rm 411 SA-18
Washington DC 20523-1808
T (703) 875-4074
F (703) 875-4394

Richard Cook
University of Maine
121 4th Street
Bangor, ME 04401
T (207) 581-3118

Kristin Cooney
Deputy Director
Breastfeeding Division
Institute for Reproductive Health
Dept. Ob/Gyn
Georgetown University
3800 Reservoir Road NW
Washington DC 20007
T (202) 687-1392
F (202) 687-6846

Paula Correa
Institute for Reproductive Health
Georgetown University
3800 Reservoir Road, NW
Washington, DC 20007
T (202) 687-1392
F (202) 687-6846

Sheila Cosminsky
257 Windsor Ave
Haddonfield, NJ 08033

Gerson da Cunha
Communication Consultant
Bombay India
T 91-22-287-351-3
F same

Laurie Curry
Grocery Products Manufacturers
Ste 301, 885 Don Mills Road
Don Mills, Ontario, M3C 1V9, Canada
416-510-8024 X227
416-510-8043 (fax)

Frances R. Davidson
Nutrition Advisor
US/AID R&D/Nutrition
Room 411 SA-18
Washington, DC 20523-1808
T (703) 875-4074
F (703) 875-4394

Mary Debus
VP International Division
Porter/Novelli
1120 Connecticut Avenue, NW
11th Floor
Washington, DC 20036
T (202) 973-5863

Antonia Demas
Cornell University
60 Cayuga St.
Trumansburg, NY 14886
T (607) 387-6884

Katherine Dettwyler
4105 Nagle St
Bryan, TX 77801
T (409) 845-5242

Kim Dittus
Washington State University
RR 1 Box 121
Pullman, WA 99163
T (509) 335-8448

Jia-Yau Doong
Michigan State University
Department of Food Science and Human Nutrition
c/o Sharon Hoerr
East Lansing, MI 48828-1224
T (517) 355-9879
F (517) 335-8448

Ruth Dow
Eastern Illnois University
Home Economics
1701 Ninth Street
Charleston, IL 61920
T (217) 345-2743
F (217) 581-6607

Joan Elledge
Virginia Coop Extension Service
Virginia Tech
401 McIntire Rd
Charlottesville, VA 22901
T (804) 296-5803
F (804) 979-1281

Mary Engelland
Mead Johnson Research Center
2400 West Lloyd Expressway
Evansville, IN 47721-0001
T (812) 429-7105

Bibi Essama
Director, WINS Project
Education Development Center
Suite 300 1250 24th St. NW
Washington DC 20037
T (202) 466-0540
F (202) 223-4059

Martha Ewing
Health Education Coordinator
Int'l Medical Services for Health
45449 Severn Way Suite 161
Sterling VA 22170
T (703) 444-4477
1-800-521-1175
F (703) 444-4471

Martha Figueroa
Pragma Corporation
116 East Broad St.
Falls Church, VA 22046
T (703) 237-9303
F (703) 237-9326

Claudia Fishman
Deputy Director NCP
Academy for Educational Development
1255 23rd St. NW
Washington DC 20037
T (202) 862-8824
F (202) 862-1947

Rose Forbes
University of Idaho
School of Home Economics
Moscow, ID 83843
T (208) 885-7747
F (208) 885-5751

Ester Freese
212 13th St., #2, c/o K. Craven
Knoxville, TN 37916
T (615) 637-9550

Heather Fregin
Health Education Assistant
Int'l Medical Services for Health
45449 Severn Way Suite 161
Sterling VA 22170
T (703) 444-4477
1-800-521-1175
F (703) 444-4471

Holly Freishtat
University of Vermont
2904 Old Court Road
Baltimore, MD 21208
T (410) 484-8524

Joanne Gallagher
Ontario Milk Marketing Board
6780 Campobello Rd.
Mississauga, Ontario, L5N 2L8 Canada
T (416) 821-8970

Nancy A. George
Senior Program Officer
I. D. R. C.
P. O. Box 62084
Nairobi, Kenya
T (254) 2-330850/1/2/3
F (254) 2-214583

Gayle Gibbons
Director
APHA Clearinghouse on Infant Feeding
and Maternal Nutrition
1015 15th St. NW
Washington DC 20005
T (202) 789-5600
F (202) 789-5661

Inez Goncalves
Public Health Nutritionist
Conjunto Nuneslandia
TR W. E. 7 #904
Belem-Para Brazil 66.000
T 091-248-0513

Rob Gould
Research Director
Porter/Novelli
1120 Connecticut Avenue, NW
11th Floor
Washington, DC 20036
T (202) 973-5863

Shannon Green
U of Maryland Eastern Shore
3668 Forest Garden Avenue
Baltimore, MD 21207
T (301) 436-3575
F (301) 436-3487

Ann Greig
Maryknoll
Misioneros de Maryknoll
Apartado 444
Tacna, Peru
515-471-3790

Ted Greiner
International Child Health Unit
Uppsala University
Uppsala, Sweden 75185

Marcia Griffiths
The Manoff Group
2001 S St, NW
Washington, DC 20009
T (202) 265-7469
F (202) 745-1961

Miguel Gueri
Nutrition Advisor
PAHO
525 23rd Street NW
Washington DC 20037
T (202) 861-4349

Marlene Guroff
USDA Food and Nutrition Service
3101 Park Center Dr, Rm 510
Alexandria, VA 22302
T (703) 305-2057
F (703) 305-2420

Dora Gutierrez
Spanish Consultant
Tufts University
School of Nutrition
126 Curtis St.
Medford MASS 02155
T (617) 627-3223
F (617) 627-3887

Robert Harkins
McNeil Specialty Products, Co.
501 George Street
New Brunswick, NJ 08903-2400
T (908) 524-6770

Monica Harnish
2027A Hazelwood Ct
Urbana, IL 61801
T (217) 384-0318

Ruth Harvey
Nutrition Consultant
Center for International Health Information/ISTI
1601 N. Kent St. Suite 1001
Arlington VA. 22209
T (703) 524-5225
F (703) 243-4669

Barbara Heiser
La Leche League, Intl
9684 Oak Hall Drive
Ellicott City, MD 21042
T (410) 995-3726
F (410) 992-1977

Elisabet Helsing
WHO Europe Office
8, Scherfigsvej
Copenhagen, Denmark 2100

Lori Holladay
Syracuse University
PO Box 636
Leavenworth, WA 98826
T (509) 548-4290

Martha Holley
Wellstart EPB
3333 K Street, NW, Suite 101
Washington, DC 20007
T (202) 298-7979

Sandra Huffman
Wellstart EPB
3333 K St., NW Suite 101
Washington, DC 20007
T (202) 298-7979
F (202) 298-7988

Barbara Hughes
BA Hughes and Associates
4208 Galax Drive
Raleigh, NC 27612-3714
T (919) 787-2949
F (919) 781-4977

Vergie Hughes
Nursing Co-ordinator
National Capital Lactation Centre
3800 Reservoir Rd. NW
Washington DC 20007
T (202) 784-6455
F (202) 784-2575

Patrice Jelliffe
UCLA
10833 Le Conte Ave
Los Angeles, CA 90024
T (213) 206-7816

Catherine Tim Jensen
Consultant
International Conference on Nutrition
Food & Agriculture Organization
1001 22nd St. NW
Suite 300
Washington DC 20437
T (202) 653-2452
F (202) 653-5760

Kathy Johns
Penn State Coop Extension
RR 4 Greystone Building
Nazareth, PA 19054
T (215) 746-1970
F (215) 746-1973

Diane Veale Jones
College of St. Benedict
Nutrition Department
37 South College Avenue
St. Joseph, MN 56314
(612) 363-5976

Urban Jonsson
Unicef
3 United Nations Plaza
New York, NY 10017
(212) 326-7000

Hugh Joseph
Mass. Dept. of Food and Agriculture
100 Cambridge St.
Boston, MA 02202
T (617) 727-3000

Jean Bosco Kaberuka
Ministry of Health - Rwanda
B.P. 84
Kigali, Rwanda
T (230) 748-66
F (250) 420-40

Esther Kazilimani
Pragma Corporation
116 East Broad St.
Falls Church VA 22046
T (703) 237-9303
F (703) 237-9326

Rose Kehoe
Egg Nutrition Center
2301 M Street, NW #401
Washington, DC 20037
T (202) 833-8850
F (202) 463-0102

Anne Kepple
Cornell University
Ithaca NY 14850

Akbar Khan
Dept of Nutrition Education and Health
17-2, 1231/3 Yakutpura Station
Hyderabad, India 500023
T 918-425-25740
F 918-425-2722-3

Bernice Khan
Cornell University
55-J Hasbrouck Apts.
Ithaca, NY 14850

Shubada Khanani
Dept of Nutrition
Faculty of Home Sciences
MS University of Baroda
Baroda India 390002
T 22-537

Pauline Kisanga
Tanzania Food and Nutrition Center
PO Box 977
Dar-Es-Salaam, Tanzania
T 255-512-96215

Ann Kittlaus
Food Research and Action Center
1875 Connecticut Ave, NW Suite 540
Washington, DC 20009
T (202) 986-2200
F (202) 986-2525

Steva Komeh
1416 McCulloch Street
Baltimore, MD 21217
T (410) 333-2616

Peggy Koniz-Booher
Nutrition Communication Consultant
PO Box 765
111 Maple Ave
Washington Grove, MD 20880
T/F (301) 963-3827

Kathleen Kurz
Nutritionist
Int'l Centre for Research on Women
Suite 302
1717 Massachusetts Ave. NW
Washington DC 20034
T (202) 797-0007
F (202) 797-0020

Margaret Kyenkya
Unicef
3 UN Plaza
New York, NY 10017
T (212) 326-7379

Miriam K. Labbok
Director, Breastfeeding Division
Institute for Reproductive Health, Dept. Ob/Gyn
Georgetown University 3PHC
3800 Reservoir Road NW
Washington DC 20007
T (202) 687-1392
F (202) 687-6846

Virginia H. Laukaran
Sr. Associate for Research
Institute for Reproductive Health, Dept Ob/Gyn
Georgetown University 3PHC
3800 Reservoir Road NW
Washington DC 20007
T (202) 687-1392
F (202) 687-6846

Selina Lai
National Food Management
3868 Carson Street
Torrance, CA 90501
T (301) 540-2611

Miranda Lam
138 Lawrence Ave
Alameda, CA 94501

Beatriz Lares
UCLA Dept of Family Medicine
101 W Carson St, Suite F
Torrence, CA 90252
(310) 783-5205

Lora Beth Larson-Brown
Brigham Young University
471 WIDB
Provo, Utah
T (801) 378-6672

Michael Latham
Division of Nutritional Sciences
Savage Hall
Cornell University
Ithaca, NY 14853-6301
T (607) 255-3041
F (607) 255-1033

Celine Le Page
Laval University
1067-A Louis Hebert
Cap-Rouge
Quebec, G1Y1Z3, Canada
T (418) 656-3456
F (418) 656-2281

Mark Lediard
Vice President
Academy for International Development
1255 23rd St. NW
Washington DC 20037
T (202) 862-1900
F (202) 862-1947

Paloma Lerma
CEPPLAM
Apartado Postal #30
Chiapa de Corzo
Chiapas, México
968-606-41 (tel/fax)

Rebecka Lundgren
The Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
T 504 326-021

Chessa Lutter
Nutrition Consultant
5024 New Port Avenue
Bethesda MD 20816
T (301) 229-9526

Frances Ma
Teacher's College
Columbia University
Box 137
525 W. 120th Street
New York, NY 10013
T (212) 678-3950
F (212) 226-1378

Rebecca Magalhaes
917 E. College #7
Iowa City, IA 52240
T (319) 354-0956
F (319) 354-3687

Pam Malebe
Wellstart
Attn: Janine Schooley
4062 1st Ave
San Diego, CA 92103
T (619) 574-8763

Manuel Manrique
Director of Communication and Social Mobilization
Reforma 645
Lomas 11000 D.F. Mexico
T (011) 525-202-3233
F (011) 525-520-0527

Segametsi Maruapula
Family Health Division
PO Box 992
Gaborone, Botswana
353561
F 302092

Irma de Maza (Mimi)
President La Leche League Guatemala
11Av. 14-19 Zona 1
Guatemala City
Guatemala CA
T (502) 2-25916
F (502) 33-47-55

Faith McClelland
University of Maryland, College Park
13150 Music Master Drive
Silver Spring, MD 20904
T (301) 405-4514

Judiann McNulty
Director, Cooperative Extension Service
University of Wyoming
PO Box 463
New Castle, WY 59701
T (307) 746-3531

Roy Miller
Director
Center for International Health Information/ISTI
1601 N. Kent St.
Rm. 1001
Arlington, VA 22209
T (703) 524-5225
F (703) 243-4669

Maureen Minchin
Vice-President
Australian Lactation Consultants Association
P.O. Box 1129
Carlton, Victoria
3053 Australia
T (613) 576-0829
F (613) 576-0829

Adriana Moctezuma
DIF
Emiliano Capata 340
Mexico City, 03300 Mexico

Mary Murini
Eastern Illinois University
Home Economics
104 Division
Charleston, IL 61920
(217) 345-4708

Marion Nestle
New York University
14 Washington Pl, 12A
New York, NY 10003
T (212) 998-5595
F (212) 995-4194

Maggie Niall
4075 20th Street
San Francisco, CA 94114

Leon Nsengimaha
Ministry of Health - Rwanda
B.P. 84
Kigali, Rwanda
T (250) 748-66
F (250) 720-40

Chloe O'Gara
Director
Wellstart EPB
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Janet Ohene'Frempong
7907 Ronaele Drive
Elkins Park, PA 19117
(215) 978-6100

Christine Olson
Cornell University
Division of Nutritional Sciences
Room 376
MVR Hall
Ithaca, NY 14853
(607) 255-7574

Susan Parks
2026 South 127 Circle
Omaha, NE 68144
(402) 334-2024

Margaret Parlato
Director
Nutrition Communication Project
Academy for Educational Development
1255 23rd Street, N.W.
Washington, DC 20037
T (202) 862-1279
F (202) 862-1947

Susan Pohl
Iowa Department of Public Health
321 East 12th Street
Des Moines, Iowa 50319-0075
(515) 281-4545

Judith Pojda
Cornell University
Division of Nutritional Sciences
Savage Hall, Room 222
Ithaca, NY 14853
(607) 255-7574

Hadi Pratomo
Wellstart
c/o Janine Schooley
4062 1st Ave
San Diego, CA 92103
T (619) 574-8763

Marilyn S. Prehm
319 Wallace Hall
Blacksburg, VA 24061-0430

Claudia Probart
University of Florida
5-FLG
Gainesville, FL 32611
T (904) 392-0583
F (904) 392-3186

Linda Pursley
Cornell University
I-207 University Park Apartments
Ithaca, NY 14850
T (607) 257-9371

Elizabeth Rasmuson
Program Associate
Wellstart EPB
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Richard Reid
Director of Public Affairs
UNICEF
Three United Nations Plaza
New York NY 10017
T (212) 326-7464
F (212) 303-7911

Bruce Ross-Larson
American Writing Corporation,
1075 International Square
1825 I St. NW Ste. 400
Washington, DC 20006
T (202) 473-1057 (World Bank)
T (202) 775-2132
F (202) 429-6826

Randa Saadeh
Technical Officer
Nutrition Unit
World Health Organization
1211 Geneva 27
Switzerland
T 41-22-791-3315

Linda Sanei
Pragma Corporation
1601 N Kent St. Suite 902
Rosslyn VA 22209
T (703) 528-1388
F (703) 875-4686
(c/o AID R&D/H/HSD)

Aurora Sanchez
DIF
Emiliano Capata 340
Mexico City, 03300 Mexico

Cliff Sanders
Georgetown University
Institute for Reproductive Health
Senior Field Associate, Breastfeeding Divison
3800 Reservoir Rd, NW
Washington, DC 20007
T (202) 687-1392
F (202) 687-6846

Felicity Savage
Institute of Child Health, London
5 Ashwood Villas
Headingley
Leeds LS6 2EJ
Yorkshire, U.K.
T (011) 44-532-751-861
F (011) 44-532-788-558

Janine Schooley
Wellstart
4062 1st Ave
San Diego, CA 92103
T (619) 574-8763

Mohammad Shareff
Moulana Azad Institute of Nutrition
Education and Health
22-2-509 92/C Khcth Balsetty N B
Hyderabad, 500024 India
T 918-425-23831
F 918-425-27223

Wanda Shockey
Arkansas Dept of Education
Child Nutrition Sector
2020 W 3rd, Suite 404
Little Rock, AR 72205
T (501) 324-9502

Catherine Smith
Ontario Milk Marketing Board
6780 Campobello Road
Mississauga, Ontario,
L5N 2LB, Canada
T (416) 821-8970

Yosook Song
Michigan State University
1103 K University Village
East Lansing, MI 48823

Beverly Spencer
Program Coordinator
La Leche League of MD, Del and DC Inc.
Peer Counseling Program
7824 Rydal Terrace
Rockville, MD 20855
301-977-1303

Adwoa Steel
Community Health Advisor
Wellstart EPB
Suite 101
3333 K St. NW
Washington DC 20007
T (202) 298-7974
F (202) 298-7988

Laurie Stevens
Intern
US/AID R&D/Nutrition
Room 411 SA-18
Washington, DC 20523-1808
T (703) 875-4003
F (703) 875-5344

Cynthia Stewart
USA Meddac
Preventive Med Services
Community Health Nursing
Fort Drum, NY 13602
(315) 772-6404

Maryanne Stone-Jimenez
Director
Child Survival Project
La Leche League Guatemala
11 Av. 14-19 Zona 1
Guatemala City Guatemala CA
T (502) 2-25916
F (502) 2-33-47-55

Eleonore Suemo
CARE International
Boite Postale 422
Yaoundé, Cameroon
T 237-21-17-14
F 237-23-51-87

Carol Suter
Texas Agricultural Extension Service
Tamu, Room 223, Kleberg Center
College Station, Texas, 77843
T (409) 875-2798

Sally Swartz
Tri-County Health Department
15400 East 14th Place, Ste 309
Aurora, CO 80011
T (303) 341-9370
F (303) 367-8813

Charles Teller
Pragma Corporation
116 E Broad St
Falls Church, VA 22046
T (703) 237-9303
F (703) 237-9326

Thomas D. Tilson
VP & Director
International Basic Education
Academy for Educational Development
1255 23rd St. NW
Washington DC 20037
T (202) 862-1951
F (202) 862-1947

Toshie Tsuda
Kyoritsu Women's University
Omori-Nishi, 5-5-4, Ota-Ku
Tokyo, 143, Japan
T 332-372-494
F 332-372-692

Valerie Uccellani
Program Officer
Academy for Educational Development
1255 23rd St. NW
Washington DC 20037
T (202) 862-8824
F (202) 862-1947

Helen Ullrich
Nutrition Communications Associates
1116 Miller Avenue
Berkeley, CA 94708
T (510) 843-7572
F (510) 528-6958

Marjorie Van Veen
122 West Upland Road
Ithaca, NY 14850
T (607) 257-7054

Cecilia Cabanero Verzosa
Deputy Director HEALTHCOM
Academy for Educational Development
1255 23rd St. NW
Washington DC 20037
T (202) 862-1283
F (202) 862-1947

Jo Ann Vertetis
D'Youville College
222 West Park Street
Albion, NY 14411-1328
T (716) 589-1632

Sidiga Washi
PO Box 167
Anfad University for Women
Omdurman, Sudan

Ellen Wickberg
Jericho Hill for the Deaf
1829 MacDonald Street
Vancouver, BC, V6K 3X7, Canada
T (604) 224-1331

Eleanor Williams
5500 Friendship Blvd, #1528N
Chevy Chase, MD 20815
(301) 656-4950

Gretchen Williams
Intern
US/AID R&D/Nutrition
Room 411 SA-18
Washington DC 20523-1808
T (703) 875-4074
F (703) 875-4394

Christine Wilson
Ecology of Food and Nutrition
PO Box 3178
Annapolis, MD 21403
T (410) 280-0654

Bethan Witcher
Texas A&M University
218D Kleberg Center
College Station, TX 77843-2253
T (409) 845-1735
F (409) 862-2378

Agneta Yngve
Centre for Nutrition and Toxicology
Novum
Huddings, S-14157
Sweden
T 460-860-89209
F 460-860-81501

APPENDIX B

LIST OF EXHIBITORS

1. Academy for Educational Development

2. Institute for Reproductive Health, Georgetown University

3. Manoff Group

4. APHA Clearinghouse on Infant Feeding and Maternal Nutrition

5. Wellstart International
   International Lactation Management Education Program
   Expanded Promotion of Breastfeeding Program

6. The Nutrition Foundation

7. National Center for Education in Maternal Child Health

8. La Leche League, International

9. La Leche League, Guatemala

10. Center for the Promotion of Breastfeeding for Southeast Mexico and Central America (CEPPLAM)

11. Guatemalan National Commission for the Promotion of Breastfeeding (CONAPLAM)

12. World Alliance for Breastfeeding Action (WABA)

13. International Medical Services for Health

14. National Capital Lactation Center

15. Women's International Public Health Network (WIPHN)

APPENDIX C

ROUND TABLE LUNCHEON
Monday, July 13

1. Ted Greiner -- Avoiding New Dogmas in Infant Feeding
2. Chloe O'Gara -- The Expanded Breastfeeding Promotion Project
3. Mary Debus and Rob Gould -- Planning and Executing Media Campaigns: Working with Creative Teams
4. Caby Verzosa -- Dietary Management of Diarrhea and More
5. Marcia Griffiths -- The Management of Social Marketing
6. Michael Latham -- World Alliance for Breastfeeding Action
7. Claudia Fishman -- Nutrition Communication, A Focus on Africa
8. Maureen Minchin -- Development of a Training Video
9. Elisabet Helsing -- Nutritional Realities of Russia
10. Margaret Kyenkya -- The Baby Friendly Initiative: An Update
11. Kristin Cooney -- Applying International Breastfeeding Policy to the U.S.
12. Ruth Elena de Arango -- Communication to Support the International Code of Marketing of Breastmilk Substitutes (Spanish and English)
13. Catherine Tim Jensen -- The International Nutrition Conference

ROUND TABLE LUNCHEON
Tuesday, July 14

1. Miriam Labbok -- Promotion of Breastfeeding for its Fertility Impact: Why the Resistance?
2. Nancy George -- Using Radio for Community Mobilization
3. Mimi de Maza -- Responding to the 10th Step (Spanish and English)
4. Bruce Ross-Larson -- Experimenting with Interactive Media
5. Tom Tilson -- Bolivia School Radio Project
6. Janine Schooley -- Wellstart's Lactation Management Program
7. Stina Almroth -- The Impact of ORS Messages on Breastfeeding
8. Valerie Uccellani -- Tips Concerning Counseling
9. Gayle Gibbons -- Newsletters and Other Low Cost and Effective Ways to Disseminate Information
10. Felicity Savage -- Training Materials: Where To Go From Here?
11. Hadi Pratomo -- Supporting Infant Nutrition in Indonesia
12. Pam Malebe -- The National Breastfeeding Program of Kenya
13. Randa Saadeh, WHO update on the International Code of Marketing of Breastmilk Substitutes

APPENDIX D

CALL FOR CONTRIBUTIONS TO THE JELLIFFES FOUNDATION AND AWARD

The Jelliffes Foundation and Award have been established in admiration of the great pioneering work of the late Professor Derrick B. Jelliffe and his widow E.F. Patrice Jelliffe in promoting the health and wellbeing of the world's infants and children, and in gratitude for the unfailing support and encouragement which the Jelliffes always extended to others who were trying to work for the same cause.

The purpose of the Award is to continue the Jelliffes' lifelong action by supporting young persons who are doing valuable work for the health and nutrition of infants and children, and for enabling mothers to breastfeed.

To provide a firm financial basis for the Award, a Foundation capital of about US $200,000 will be necessary. The interest from the Foundation capital will constitute the Award which will be made annually, if possible each August during Breastfeeding Week.

The candidate receiving the Award will be selected on the basis of recommendations to the Foundation Board, of which Mrs. Patrice Jelliffe will be a member, and according to criteria set by her.

To establish the Foundation, a Deposit Account has been opened in the Société de Banque Suisse (the bank used by WHO), called The Jelliffes Foundation. Provisionally the account is opened in the name of Mrs. Patrice Jelliffe and Dr. Elisabet Helsing who works for the WHO Regional Office for Europe in Copenhagen and who provisionally will assume personal responsibility for it. Appropriate legal arrangements are being made to ensure proper procedures and accountability.

In the first phase, from 1 December 1992, appeals for contributions to the Foundation will be sent through various networks and channels to friends and admirers of the Jelliffes. All individuals, organizations and institutions who have benefitted from their work and support or who share their concerns and ideas are encouraged to make a donation. They will be appropriately listed as contributors to the Foundation.

The Foundation's account is as follows:

A/C D3-103, 996.0
Société de Banque Suisse
Bureau O.M.S.
Avenua Appia
1211 Geneve 27
Switzerland

Donations have to be marked:
E.F. Patrice Jelliffe and Elisabet Helsing for the Jelliffes Foundation.

16 Schistosomiasis and Malnutrition, Edited by Lani S. Stephenson (1986)

17 Hunger and Society - Volume 1. An Understanding of the Causes, Edited by M. C. Latham, L. Bondestam, R. Chorlton and U. Jonsson (1988)

18 Hunger and Society - Volume 2. An Examination of Country Cases, Edited by L. Bondestam, R. Chorlton, U. Jonsson and M. C. Latham (1988)

19 Hunger and Society - Volume 3. Causes and Strategies in Tanzania, Edited by U. Jonsson, M. C. Latham, L. Bondestam and R. Chorlton (1988)

20 Amino Acid Fortification of Cereals: Results and Interpretation of Trials in Three Countries, A Report of the Task Force on Amino Acid Fortification of Cereals (1988)

21 Dietary Guidelines: Proceedings of an International Conference, Edited by Michael C. Latham and Marjorie Scott van Veen (1989)

22 Timely Warning and Intervention Systems (TWIS) for Periodic Food Consumption Shortages: Experience from Indonesia, by R. Mark Brooks, Jean-Pierre Habicht and David F. Williamson (1990)

23 Women, Work and Breastfeeding, by Penny Van Esterik (1992)

Copies of the Monographs may be obtained from:

Dr. Michael C. Latham
Division of Nutritional Sciences
Savage Hall, Cornell University
Ithaca, New York 14853, U.S.A.

Price per monograph: U.S. $5.00 including postage surface mail.
Make check payable to: Cornell University

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