

Community-based Breastfeeding Support: *A Planning Manual*

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Foreword

What is community-based breastfeeding support?

Community-based support is a manner of promoting breastfeeding which focuses on identifying and strengthening the skills and abilities of community members themselves as primary resources to resolve their community's maternal and infant health and nutrition problems. To have maximum effect, community-based support for breastfeeding should build a network of mothers who are able to exchange and transfer breastfeeding knowledge and develop the skills necessary to reach out to others in their communities. This support may include individual peer counseling, mother-to-mother support groups, and a wide variety of community education activities.

Why was the "Community-based Breastfeeding Support Trilogy" developed?

In 1992 a workshop was held in Guatemala on strengthening community support for breastfeeding, with participation from Latin American Ministries of Health and non-governmental organizations. During this workshop, participants expressed the need for guidelines on development of community-based breastfeeding support activities. Three specific topics were identified: planning and implementation; training on lactation management at the community and primary health care levels; and counseling and facilitation.

In response to the growing need for materials to strengthen the promotion and support of breastfeeding at the community level, a series of documents was developed. The materials were designed as three separate documents, intended to guide the various stages of program development at the primary health care and community level. These documents form a trilogy entitled "*Community-based Breastfeeding Support*," which includes the following:

- ▶ *A Planning Manual*
- ▶ *A Training Curriculum*
- ▶ *A Guide for Trainers and Supervisors*

What is the "Community-based Breastfeeding Support Trilogy"?

The documents in this trilogy were designed to complement each other as support for breastfeeding in the community unfolds. While each volume can stand on its own, the series is intended to support a comprehensive plan for initiating, implementing, and improving community-based breastfeeding support. *A Planning Manual* is designed to help managers in NGOs and planners in Ministries of Health to create new community-based activities in support of breastfeeding, as well as to monitor, expand, or improve the breastfeeding components of existing programs. *A Training Curriculum* contains the information needed, utilizing a participatory, hands-on approach, to train volunteers and other community-level workers in the fundamentals of breastfeeding management and support, with an integrated approach to maternal and child health and nutrition. It can be easily adapted for use in different settings. *A Guide for Trainers and Supervisors* provides a detailed discussion of interpersonal counseling and facilitation skills. It also contains sections on implementation of educational and promotional activities in community-based breastfeeding programs.

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Abbreviations

BFHI	Baby Friendly Hospital Initiative
BIB	Breast is Best League, Belize
CEPREN	Centro de Promoción y Estudios en Nutrición, Peru
CONASUMI	Consejo Nacional de Salud Materno Infantil, Dominican Republic
DHS	Demographic and Health Surveys
EBR	Exclusive Breastfeeding Rate
LLL	La Leche League
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
PBR	Predominant Breastfeeding Rate
PHC	Primary Health Care
TBAs	Traditional Birth Attendants
TCR	Timely Complementary Feeding Rate
WHO	World Health Organization

Introduction

What information does this manual contain?

The main focus of this manual is on breastfeeding support and program planning at the primary health care and community level. The manual is divided into three sections:

- Section I: Overview of Breastfeeding
- Section II: Planning for Breastfeeding Support
- Section III: Implementing the Workplan

Section I provides background information on breastfeeding and discusses why breastfeeding support at the community level is critical to achievement of child survival, infant health and nutrition, and women's reproductive health care goals. It also gives a summary description of comprehensive breastfeeding programs and community-based breastfeeding support activities.

Sections II and III are the "how to" parts of the manual. Section II describes the initial steps in planning a community-based program. These planning steps include assessing breastfeeding practices and support activities in the community, engaging the community in the planning process, setting goals and objectives, developing a workplan, and preparing a budget. Section III addresses managerial issues related to program implementation such as human resource development, training, supervision, project monitoring and evaluation, and sustainability. Throughout the manual, examples are drawn from Latin America where there has been substantial experience with breastfeeding promotion in the community.

Each chapter includes worksheets to help in planning and implementing community-based breastfeeding activities. The annexes include a list of references cited in the manual and additional resources on breastfeeding, training, and planning.

Who can use *A Planning Manual*?

This manual is designed for any person interested in developing, implementing, or expanding community-based activities to improve breastfeeding practices. It is a particularly helpful resource for policy makers, program planners, program managers, project officers, administrators, health care workers, and community leaders interested in developing or expanding community activities to improve breastfeeding.

These individuals may be found in a variety of organizations and institutions, such as:

- Maternal and Child Health or Nutrition Divisions within the Ministry of Health;
- Non-governmental organizations (NGOs) or private voluntary organizations (PVOs) responsible for developing programs to improve breastfeeding and complementary feeding or promote growth monitoring, community outreach, or primary health care;
- Breastfeeding promotion organizations;
- Health facilities with community outreach programs; and
- Women's, religious, and community development organizations.

Individuals new to the topic as well as those with experience in breastfeeding promotion will find this manual useful. Organizations that are familiar with breastfeeding promotion may use the manual as a guide for assessing current projects, expanding existing programs, or introducing new activities. NGOs already engaged in community-based projects will find this manual of use as they place greater emphasis on breastfeeding in child survival or related programs.

How can this manual be used?

The manual was designed to be used in several ways:

- As a "how to" guide in planning program activities;
- As a community-level resource for training in breastfeeding promotion and other health related topics;
- As a reference for field operations; and
- As an example of practical worksheets to assist in program design, monitoring, and evaluation.

The manual has been put in a three-ring notebook so that pages relevant to country or community programs can be added. The authors encourage users to adapt the manual for their purposes.

What is beyond the manual's scope?

A Planning Manual emphasizes support for optimal breastfeeding practices, including exclusive breastfeeding for about the first six months and sustained breastfeeding from 6-24

months and beyond. It concentrates on breastfeeding and not broader infant feeding issues such as improving the diet and feeding practices of the weaning-age child. References on young child feeding can be found in the manual's Resources Annex.

Other elements of a comprehensive breastfeeding promotion program, such as supportive legislation, hospital practices, policies in the work place, social marketing, and mass media communications, are outside the scope of this manual. The authors have addressed the basic elements of community development but have not attempted to provide in-depth information on these concepts. The reader is referred to materials addressing these topics either in the text or Resource Annex.

This manual was developed as part of a trilogy entitled **Community-based Breastfeeding Support**. The three documents that form the trilogy are meant to be used at different stages in the development and implementation of community-based breastfeeding counseling and support activities. They were designed to complement each other. *A Planning Manual* will be of assistance from the first stages of program development through the evaluation stage. *A Training Curriculum* gives the guidance needed to train volunteers and other community-level workers in the fundamentals of breastfeeding management. This curriculum can be easily adapted for use in different settings. *A Guide for Trainers and Supervisors* provides a detailed discussion of counseling skills and the implementation of educational and promotional activities in community-based breastfeeding programs.

Section I

Overview of Breastfeeding

Chapter 1 Background Information on Breastfeeding

Chapter 2 Overview of Breastfeeding Support

Chapter One

Background Information on Breastfeeding

This chapter provides the rationale for committing resources for the improvement of breastfeeding practices. After discussing the benefits of breastfeeding for community-level programs, the chapter examines breastfeeding trends worldwide and in selected Latin American countries and compares these trends with recommended breastfeeding practices.

A clear understanding of the benefits of breastfeeding and the impact of improved breastfeeding practices on other health interventions will provide the program manager with the information and motivation necessary to mobilize resources for community-based breastfeeding counseling and support.

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I. Benefits of breastfeeding

Breastfeeding is the most significant contributor to overall health and nutrition during the first year of life, particularly if there is exclusive breastfeeding for about the first six months of life. Exclusive breastfeeding means that the child receives no other food or fluids, not even water. Breastfeeding promotion, protection, and support should be an integral part of child survival, primary health care, family planning, and reproductive health programs. Breastfeeding will help these programs achieve their goals because:

- *Breastfeeding is a child survival intervention.*

Each year breastfeeding prevents an estimated 6 million deaths from infectious diseases. A case control study in Brazil illustrated that the risk of mortality from diarrhea was 25 times higher in non-breastfed infants aged 0-2 months compared to exclusively breastfed infants.¹ The World Bank Health Sector review on acute respiratory infections identified breastfeeding promotion as one of the five most cost-effective interventions to reduce mortality from acute respiratory infections.²

- *Breastfeeding protects against infectious diseases.*

Colostrum (the first milk) is a child's first immunization. It contains anti-bacterial and anti-viral agents that protect the infant against infectious diseases. Breastmilk continues to strengthen the development of an infant's own immune system and reduces the risk of many common childhood ailments. Moreover, breastmilk is clean and free of bacteria and cannot make an infant ill. It eliminates risks associated with exposure to contaminated breastmilk substitutes, bottles, and artificial nipples.

- *Breastfeeding provides perfect nutrition for growth and development.*

Breastmilk contains all of the nutrients that a baby needs for the first six months. It is a source of vitamin A and iron and prevents deficiencies in these micronutrients. Breastmilk is also more easily digested than any substitute and actually changes in composition to meet the nutritional needs of the growing infant.

- *Breastfeeding aids in the recovery of the sick child.*

Breastfeeding provides a nutritious, easily digestible food when a sick child loses appetite for other foods. When a child is ill or has diarrhea, breastfeeding helps prevent dehydration. Frequent breastfeeding also diminishes the risk of malnutrition and fosters catch-up growth following illness.

- *Breastfeeding promotes child spacing and reduces fertility rates.*

By delaying the return of menses, breastfeeding protects millions of women from pregnancy each year. Birth intervals are lengthened by more intensive and frequent breastfeeding and longer duration of breastfeeding.

- *Breastfeeding contributes to women's reproductive health.*

The fertility-reducing effect of breastfeeding allows women more time to recuperate between pregnancies. Breastfeeding reduces a mother's risk of fatal postpartum hemorrhage, anemia, osteoporosis, and ovarian, breast, and uterine cancer.

- *Breastfeeding saves health and family planning resources.*

Optimal breastfeeding practices result in savings for hospitals and health services by reducing contraceptive requirements and the need for bottles, formulas, drugs, treatment, and services.

- *Breastfeeding enhances the quality of care in health and family planning services.*

Counseling and support skills developed for breastfeeding promotion extend to other areas of care. These skills open the way for preventive care counseling in growth monitoring, immunization, and family planning programs.

II. Current status of breastfeeding practices

A. Breastfeeding practices worldwide

Incidence/prevalence

The vast majority of infants born in developing countries are breastfed. Data from the nationally representative Demographic and Health Surveys (DHS) conducted since the mid-1980s show that the percentage of women initiating breastfeeding in 25 developing countries ranged from a low of 84% in Mexico to over 95% in most countries in Asia and Africa. In certain cases, breastfeeding campaigns have contributed to higher incidence rates such as in Trinidad and Tobago where the incidence rose from 80% to 89% after an eleven year campaign.

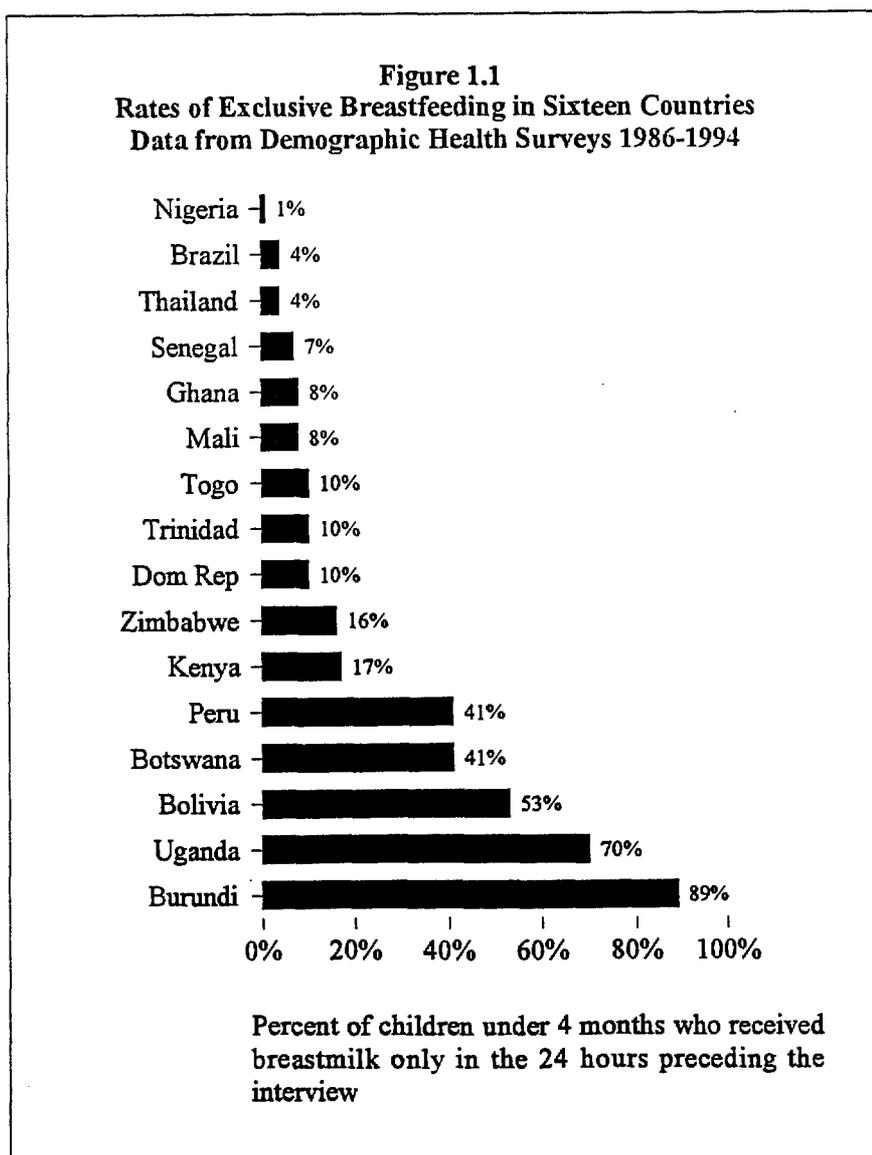
Total duration

The duration of breastfeeding varies by region, urban/rural residence, and education. In developing countries, shorter durations are evident among urban women and women with higher education. African and Asian women, on average, breastfeed 19

months and 17 months respectively, compared to 11 months for Latin American women.

Exclusive breastfeeding

The prevalence of exclusive breastfeeding during the early months of life is extremely low throughout most of the world as illustrated in Figure 1.1. While most mothers breastfeed, they also give young infants other foods and fluids, increasing the risk of infection and malnutrition. Low rates of exclusive breastfeeding exist in both urban and rural areas.



B. Breastfeeding practices in Latin America

The Demographic and Health Surveys demonstrate a lower prevalence and duration of breastfeeding in Latin America when compared with Asia and Africa. The measures of comparison include (1) the percentage of children for whom breastfeeding was ever initiated (ever breastfed), (2) the percentage of children under four months of age who receive only breastmilk (exclusive breastfeeding), and (3) the median duration of breastfeeding. Table 1.1 reports on these three breastfeeding practices in eight Latin American and Caribbean countries. It shows that although initiation is high in Latin America, suboptimal practices are widespread.

Table 1.1
Breastfeeding Practices in Eight Latin American and Caribbean Countries

Country	Year	Ever Breastfed (%)	Exclusive Breastfeeding of infants <4 months* (%)	Median** Duration of Breastfeeding (months)
Bolivia	1989	98	59	16
Brazil	1986	91	4	6
Colombia	1986	94	19	9
Dominican Republic	1986	93	14	7
Ecuador	1986	96	31	13
Mexico	1987	84	38	8
Peru	1991	95	32	16
Trinidad & Tobago	1987	90	10	7

* The percentage of children who receive only breastmilk, based on feeding practices in the last 24 hours preceding the interview, among all infants under 4 months of age

** The median duration of breastfeeding, which uses so-called current status information, is based on information on the child's current age and breastfeeding status at the time of the survey. The median duration represents the age when 50 percent of the children are breastfed.

Source: Demographic Health Surveys

C. Recommended breastfeeding practices

Currently recommended breastfeeding practices, shown in Box 1.1, are based on evidence from research on the properties of breastmilk and breastfeeding's benefits to mothers and their children. This research is referenced at the end of the chapter. Box 1.1 is followed by a brief discussion of the rationale for each recommendation. The rationale focuses on how the practice helps to ensure that infant and mother receive the full benefits of breastfeeding discussed in the beginning of the chapter.

Box 1.1

OPTIMAL BREASTFEEDING PRACTICES

- **Initiation of breastfeeding within about one hour of birth**
- **Frequent, on-demand feeding (including night feeds)**
- **Exclusive breastfeeding until the infant is about 6 months of age**
- **Breastfeeding complemented with appropriate local foods beginning around the sixth month**
- **Increased breastfeeding frequency during illness and recovery**
- **Sustained breastfeeding well into the second year of life or beyond**

- *Initiation of breastfeeding within about one hour of birth*³
 - Stimulates production of breastmilk
 - Takes advantage of a newborn's intense sucking reflex during the first hour
 - Promotes bonding between the mother and her infant
 - Decreases risk of infection because of the protective effect of colostrum
- *Frequent, on-demand feeding (including night feeds)*⁴⁻⁵
 - Increases breastmilk production and maintains supply
 - Prevents breastfeeding problems
- *Exclusive breastfeeding until the infant is about 6 months of age*⁶⁻⁹
 - Maintains milk supply
 - Maximizes the health benefits to the infant
 - Suppresses ovulation

- *Breastfeeding complemented with appropriate local foods beginning around the sixth month*
 - Meets the older infant's increased energy and nutrient needs
 - Reduces risks of illness during the weaning period
- *Increased breastfeeding frequency during illness and recovery*¹⁰⁻¹¹
 - Prevents interruption of milk production and premature weaning
 - Promotes energy and nutrient intake during a period when loss of appetite for other foods/liquids is common
- *Sustained breastfeeding well into the second year of life or beyond*¹²⁻¹³
 - Remains an important food source for meeting the nutrient needs of growing children
 - Continues to protect infants from many infectious illnesses

D. Suboptimal breastfeeding practices

Studies from all over the world document that few women practice optimal breastfeeding. The most common suboptimal practices include:

- *Delayed initiation of breastfeeding*

In certain cultures, mothers wait to initiate breastfeeding for as long as up to two or three days. During the first hours and even days, many newborns are fed teas, glucose, and milks other than breastmilk. For cultural reasons, colostrum may be expressed and discarded, thus depriving the baby of its protective and nutritive value.

- *Use of other milks and liquids*

The introduction of infant formula, fresh animal milk, water, and other liquids greatly increases the risk for infection, particularly diarrhea. The exclusive feeding of human milk during the first six months is increasingly rare.

- *Shortened duration of breastfeeding*

Increasing urbanization, with its attendant changes in family support systems, has been associated with shortened duration in breastfeeding.

- *Use of feeding bottles*

Feeding bottles are commonly used even with breastfed infants. For example, more than half of breastfed infants in Brazil are also fed at times with a feeding bottle. There is increased risk of infection from contaminated feeding bottles and nipples.

- *Inappropriate timing for the introduction of complementary foods*

Around six months, complementary foods should be introduced into the breastfeeding child's diet. However, early supplementation is a frequent occurrence, putting infants at risk of malnutrition and infection. Late introduction of soft foods is also a significant problem, depriving infants of necessary nutrients for growth and development.

III. Implications for primary health care and community-level activities

Suboptimal breastfeeding practices reduce breastfeeding's health benefits to infants and mothers. This is why it is so critical to integrate breastfeeding into child survival, primary health care, family planning, and reproductive health programs. When breastfeeding is not integrated in these programs, opportunities are lost for supporting this cost-effective health intervention. Below are some examples of ways of integrating breastfeeding support at the community level into child survival and primary health care activities, family planning services, supplementary feeding programs, and women's programs.

- *Child Survival and Primary Health Care Programs*

- Revise child survival and primary health care training curriculum to include the most current information on breastfeeding promotion and lactation management
- Train midwives and traditional birth attendants and healers in lactation management and counseling skills
- Train both paid and volunteer community health workers and health center staff to counsel mothers on breastfeeding during immunization and growth monitoring sessions
- Train community distributors of oral rehydration salts to counsel mothers on how to manage common breastfeeding problems
- Train pharmacists about the risks of bottle-feeding and about their role in referring women for breastfeeding support

- *Family Planning Programs*

- Train clinic and community-level health care workers on the lactational amenorrhea method
- Train family planning staff to counsel women on lactation management and appropriate family planning methods for breastfeeding women
- Use community-based distributors of family planning methods to counsel mothers on optimal breastfeeding practices and contraceptive use for breastfeeding women
- Develop and disseminate guidelines for contraceptive use for breastfeeding women

- *Supplementary Feeding Programs*

- Train staff and volunteers to counsel on exclusive breastfeeding and the appropriate use of food supplements for the mother's nutrition

- *Women's Groups*

- Educate women on maintaining optimal breastfeeding practices while on the job
- Educate women about health interventions that decrease their dependency on consumer goods, such as infant formula, and increase their confidence in their own ability to nourish their children
- Support women's rights to adequate health care, including breastfeeding counseling

The integration of breastfeeding into existing health care interventions need not be difficult. It may be as simple as updating a training curriculum and providing guidelines to more fully address breastfeeding promotion and lactation management. Sometimes it may be necessary to add a number of hours or days (depending upon the curriculum) to a training program to adequately cover breastfeeding.

Support to breastfeeding is more effective when integrated into existing programs because it maximizes resources and provides a comprehensive approach for improving health outcomes. Table 1.2 suggests ways of integrating breastfeeding into existing programs. Worksheet 1.1 can be used to identify opportunities for integrating breastfeeding into your own program.

Table 1.2
Programmatic Interventions to Promote Optimal Breastfeeding Practices

Type of Program	Intervention	Benefits to Program
Diarrheal Disease Programs	1) Promote exclusive breastfeeding for infants < 6 months 2) Give ORS (oral rehydration solution) only if child shows signs of dehydration 3) When necessary, give ORS by cup, not bottle 4) Increase frequency of breastfeeding during diarrheal episodes 5) Keep mothers with infants during inpatient and outpatient treatment	1) Lower diarrhea rates and fewer deaths due to diarrhea 2) Less unnecessary use of ORS; increased exclusive breastfeeding rates 3) Protection against introduction of pathogens and nipple confusion 4) Protection against weight loss 5) Less staff needed because mothers can treat infants; infants recover faster due to breastmilk consumption
Acute Respiratory Infection Programs	1) Encourage exclusive breastfeeding, especially in infants < 6 months	1) Reduced ARI morbidity and mortality
Growth Monitoring Programs	1) Promote interaction among mothers so they see that exclusively breastfed infants < 6 months grow well (average weight gain 500 g/month during first 6 months) 2) Teach mothers practical ways of assessing breastmilk adequacy for growth (such as 6-8 wet diapers in 24 hours)	1) Mothers easier to convince that adequate growth is possible through exclusive breastfeeding 2) Mothers recognize that their breastmilk is adequate for growth and understand the importance of frequent feedings
Immunization Programs	1) Inform mothers of the benefits of colostrum and exclusive breastfeeding at first BCG vaccination and other vaccination points 2) Encourage mothers to breastfeed immediately after vaccination	1) Protection against infections 2) Comfort to child after vaccination

Type of Program	Intervention	Benefits to Program
Micronutrient Programs	1) Provide vitamin A, in endemic deficient areas, in a single dose within 4-6 weeks postpartum to lactating women 2) Counsel lactating women on their additional caloric requirements; encourage consumption of foods rich in vitamin A	1) Improvement of vitamin A status of mother and level of vitamin A in her breastmilk 2) Adequate breastmilk production and protection against maternal nutritional stress
Safe Motherhood Programs	1) <u>Prenatal</u> : breast exam, breastfeeding history, monitoring of maternal weight and intention to breastfeed, breastfeeding counseling (early initiation, feeding of colostrum, frequent feeding, exclusive breastfeeding) 2) <u>Postpartum</u> : facilitate immediate suckling and rooming-in, prohibit use of glucose water, assess breastfeeding, counsel before discharge (signs of adequate milk intake, importance of breastfeeding during maternal and infant illness, information about breastfeeding resources in the community)	1) Identification of potential problems, such as inverted nipples; attention to needs of mother and child 2) Reduced risk of postpartum hemorrhage and breastfeeding problems; lower staff, equipment, and supply requirements
Family Planning Services	1) Promote breastfeeding 2) Include Lactational Amenorrhea Method* in family planning programming 3) Provide non-hormonal methods or progestin-only contraceptives to lactating women	1) Reduced number of acceptors needed to reach family planning goals; reduced contraceptive requirements 2) Method for developing consciousness of pregnancy risks and the need for timely introduction of other contraceptives 3) No interference with breastmilk production
Supplementary Feeding Programs	1) Supply food for mothers, not infants < 6 months; ensure that complementary foods for infants > 6 months are solids and not liquids	1) Maximum health and developmental benefits from breastmilk; added nourishment for lactating woman

* The Lactational Amenorrhea Method (LAM) is a non-hormonal method of family planning. It is based on the physiological infertility experienced by breastfeeding women. Three conditions should be met: (1) menses has not returned; (2) breastfeeding without regular supplementation or long periods between breastfeeds during the day or during the night; and (3) baby is under six months of age.

Worksheet for Chapter One: Background Information on Breastfeeding

Analyze your program and think how you could integrate activities in support of optimal breastfeeding practices. Use this worksheet to record your ideas. Table 1.2 on the previous page offers some examples.

Programmatic Interventions to Promote Optimal Breastfeeding Practices

Type of Program	Intervention	Benefits to Program
Diarrheal Disease Programs		
Acute Respiratory Infection Programs		
Growth Monitoring Programs		
Immunization Programs		
Micronutrient Programs		
Safe Motherhood Programs		
Family Planning Services		
Supplementary Feeding Programs		

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- ¹¹Brown KH, Stallings RY, Creed de Kanashiro H, Lopez de Romaña, Black RE. Effects of common illnesses on infants' energy intakes from breastmilk and other foods during longitudinal community-based studies in Huascar (Lima), Peru. *American Journal of Clinical Nutrition* 1990;52:1005-13.
- ¹²Taren D, Chen J. A positive association between extended breast-feeding and nutritional status in rural Hubei Province, People's Republic of China. *American Journal of Clinical Nutrition* 1993;58:862-7.
- ¹³Grummer-Strawn LM. Does prolonged breast-feeding impair child growth? A critical review. *Pediatrics* 1993;91(4)766-771.

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Chapter Two

Overview of Breastfeeding Support

Various obstacles can interfere with breastfeeding. This chapter begins by identifying these obstacles and then describes a comprehensive program for addressing them. The three main elements of a comprehensive breastfeeding program are policy, health care services, and community support. The chapter provides an overview of these elements, their role in the promotion and protection of breastfeeding, and a summary of the characteristics of successful community support programs.

I. Obstacles to breastfeeding	2-2
II. Comprehensive breastfeeding programs	2-3
A. Policy	2-3
B. Health services.	2-5
C. Community support.	2-7
III. Features of successful community support.	2-7
Worksheet	2-13

I. Obstacles to breastfeeding

As discussed in Chapter 1, breastfeeding provides many benefits to infants, mothers, families, and society. Very often these benefits are not experienced because breastfeeding is never initiated, cut short, or undermined by suboptimal practices. Various obstacles, identified below, can interfere with breastfeeding.

- *Lack of information*

Many women are unaware that breastfeeding benefits their health and also benefits their children's physical and intellectual development. They need to know:

- Differences between infant formula and breastmilk;
- Health implications of feeding choices;
- How to breastfeed successfully;
- Impact of breastfeeding on fertility;
- Economic cost of feeding choices; and
- Where to go for information and support.

- *Social barriers*

Attitudes that undervalue breastfeeding discourage women from initiating or sustaining breastfeeding. These attitudes are often communicated in the media and reflected in the advice of relatives and friends.

- *Non-supportive work environment*

Few mothers are provided with paid maternity leave or a time and a comfortable place to breastfeed or express their milk. Inadequate child care arrangements can also be an obstacle to breastfeeding.

- *Detrimental practices in health services*

Distribution of free samples of infant formula through the health care system encourages bottle-feeding and dependence on expensive artificial milks. Some health care providers recommend bottle-feeding because they have never been trained to help mothers find practical solutions to breastfeeding problems.

- *Commercial pressures*

Infant formula advertising often misleads mothers into thinking that there is little difference between breastmilk and infant formula and their health outcomes. Some advertisements suggest that mothers will be unable to produce enough breastmilk, undermining women's self-confidence.

II. Comprehensive breastfeeding programs

In order to overcome these obstacles to breastfeeding, women need accurate information and adequate support to nourish and nurture their children. Experience has shown that the obstacles to breastfeeding need to be addressed through a comprehensive breastfeeding program that focuses on three elements:

- A. Policy
- B. Health services
- C. Community support

These elements are intricately linked and reinforce each other, as illustrated in Figure 2.1. Below is a discussion of the key elements.

A. Policy

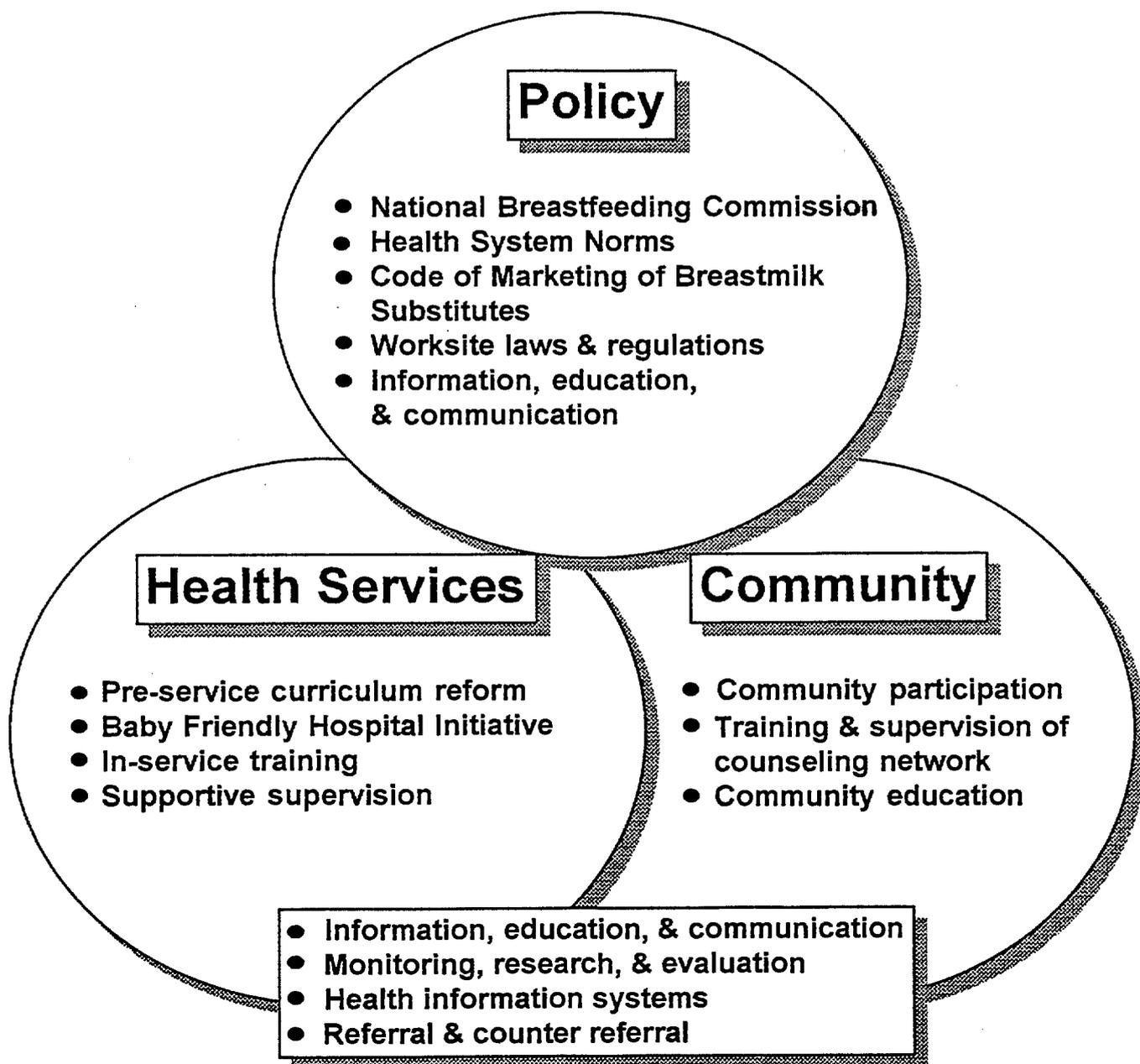
Political commitment brings visibility to the importance of breastfeeding and galvanizes support for breastfeeding activities. Without political will and policies that protect breastfeeding, breastfeeding promotion is often confined to isolated activities carried out by individuals or organizations with a commitment to breastfeeding promotion. These efforts are often limited by time, resources, and the ability to expand beyond the person or organization generating the activities.

A strong political commitment helps to overcome obstacles to breastfeeding in health care systems, the workplace, and the community. It also creates a favorable atmosphere for integrating breastfeeding into the maternal and child health programs of local and international organizations.

Additionally, policies protect breastfeeding by regulating the marketing of breastmilk substitutes, setting standards of care in health care institutions, and establishing laws to facilitate breastfeeding in the workplace. Supportive worksite laws include paid maternity leave and nursing breaks. Policies also create mechanisms for providing and safeguarding support to breastfeeding. For example, many countries have established a national breastfeeding commission to coordinate and sustain support for breastfeeding at a national level. A chronology of policies and international recommendations that support women and breastfeeding is found at the end of this chapter.

Figure 2.1

Elements of a Comprehensive Breastfeeding Program



B. Health services

Institutional support for breastfeeding should be evident in health care personnel, health care practices, and the physical environment. In order to counsel mothers on the benefits of breastfeeding and the management of breastfeeding problems, health care personnel need to be educated in lactation management and interpersonal communication skills. Curriculum reform and pre-service training for health care professionals are needed. In-service training is also needed for health facility staff, from teaching centers to primary health care service delivery points.

Another aspect of institutional support for breastfeeding is the elimination of practices that interfere with the establishment of breastfeeding, such as feeding newborns glucose water or giving pacifiers. A physical environment that supports breastfeeding is also important. For example, keeping mothers and newborns in the same hospital room helps them initiate and establish breastfeeding.

In an effort to encourage health care facilities to support breastfeeding, UNICEF and the World Health Organization developed the Baby Friendly Hospital Initiative (BFHI). As part of this initiative, they recommend "Ten Steps to Successful Breastfeeding." These ten steps address the issues of knowledgeable, supportive health care staff, a favorable environment, and practices that encourage breastfeeding. Box 2.1 lists the Ten Steps.

Box 2.1

Ten Steps to Successful Breastfeeding in Maternities

1. Have a written breastfeeding policy.
2. Train all health care staff in necessary skills.
3. Inform all pregnant women.
4. Initiate breastfeeding within a half-hour.
5. Show mothers how to breastfeed.
6. Give newborn infants no food or drink other than breastmilk.
7. Practice rooming-in.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers.
10. Refer mothers to breastfeeding support groups.

Source: WHO/UNICEF

Step 10 of the Baby Friendly Hospital Initiative makes the following recommendation: "Refer mothers to breastfeeding support groups." This step is being implemented in a variety of ways. For example, in the Dominican Republic, two auxiliary nurses in each of 25 hospitals were trained in lactation management and counseling by La Liga de la Leche/DR. The nurses were then charged with setting up community-based programs using volunteer peer counselors. In Honduras, La Liga de la Lactancia Materna worked closely with several hospitals to provide weekly breastfeeding education sessions for postpartum mothers and to establish a system for referral to group meetings and individual counseling sessions.

Some Ministries of Health have provided guidelines to hospitals and health centers to implement Step 10. For example, the Ministry of Health in Peru, in conjunction with UNICEF and the Centro de Promoción y Estudios en Nutrición (CEPREN), developed guidelines for the establishment of support groups through hospitals. These guidelines are summarized in Box 2.2.

Box 2.2

Proposed Model for Implementing Step 10 Within a Hospital Setting in Peru

- Appoint a sub-committee, as part of the hospital's Breastfeeding Committee, to coordinate Step 10.
- Elect or choose an honorary president who will actively promote support groups through the mass media and other channels.
- Select a health professional as coordinator who is trained and experienced in lactation management. His or her role is to recruit, train, and supervise breastfeeding counselors and to monitor their activities.
- Recruit breastfeeding counselors from the hospital staff, health promoters, community leaders, mothers, and other volunteers. The counselors' job is to form, lead, and monitor support groups within the hospital or health center as a part of their daily activities. These counselors can visit mothers at prenatal and well-baby clinics, encourage them to attend the hospital-based support groups, serve as a technical resource, and promote other needed changes within the hospital.
- Recruit mothers participating in hospital-based support groups to initiate support groups within their own communities. They can work in conjunction with community-based mothers clubs or other formal and informal community groups.
- Establish a system to monitor and supervise community-based counselors.
- Establish a referral system to link the community-based support groups to the hospital.

Adapted from: Maria Teresa Schul. Decimo Paso: Grupos de Apoyo a la Lactancia Materna. CEPREN. Lima, Peru. 1993.

C. Community support

In traditional societies, relatives and close friends provided women with the support and practical advice needed in order to successfully initiate and maintain breastfeeding. In rural areas of developing countries, much of this traditional community structure is still in place, and women may continue to breastfeed for long periods of time. Nonetheless, incorrect information may lead to breastfeeding practices that fail to provide optimal benefits to mother and child.

In urban and peri-urban areas, traditional support systems have broken down. Women have neither the support nor the practical information that will enable them to establish and maintain breastfeeding in social settings where optimal breastfeeding is not socially valued.

Community-based breastfeeding support activities have developed in response to this need for information and support. This information and support is provided through community-based workers who have been trained in lactation management and counseling skills. They may be experienced breastfeeding mothers, health promoters, or health workers.

One of the advantages of community-based breastfeeding support is the ability of this network of trained community workers to reach women who do not seek or do not have access to health services. Another advantage is the ability to provide on-going support. Those women who do attend prenatal clinics and deliver in hospitals and maternity clinics often receive limited prenatal or postpartum counseling on breastfeeding. Their time in the hospital or clinic after delivery is often very short. They leave before breastfeeding is well established.

The accessibility of service providers in the community is one of the primary features of community-based breastfeeding support activities. The success of these activities stems from their knowledge and understanding of cultural norms, commitment to breastfeeding, practical skills, and rapport with mothers.

III. Features of successful community-based breastfeeding support

Although a network of trained counselors, health promoters, and health workers is at the heart of community-based support activities, there is no one model. In a survey of 31 nongovernmental organizations in Latin America that provide breastfeeding support, 68 percent reported that they offer individual and group counseling, 13 percent provide only individual counseling, and 19 percent counsel only through group meetings.¹ In addition to counseling, most of these organizations coordinate other types of breastfeeding activities such

¹ Adler MR, Huffman SL, Martin L. Breastfeeding support to mothers: results of a 1992 survey of NGOs. Bethesda, MD: Nurture, 1994.

as mass media publicity, literature distribution, or advocacy for legislation and policies that facilitate optimal breastfeeding.

Community-based breastfeeding activities may be provided through hospital outreach services, primary health care services, breastfeeding promotion organizations, and informal community groups such as women's groups and credit associations. Some commercial enterprises offer opportunities for educational talks, peer support groups, and individual counseling. Box 2.3 gives examples of the breastfeeding support activities of various organizations.

Although there are many different ways of providing breastfeeding support at the community level, there are certain features commonly found in successful programs. These features are briefly discussed below.

A. Community participation

For individuals working through a health system, "community" may mean their colleagues and clients. For others, "community" may refer to several neighborhoods, a town, a city, or some other geographic region. Whatever the community may be, community participation refers to the involvement of community leaders, health service providers, and representatives of the target group in the identification of group needs and the selection and design of development activities. Community participation emphasizes self-reliance and results in more sustainable development.

B. Interpersonal counseling

Person-to-person counseling is an extremely effective way of influencing behavior change. Counselors acquire the skills necessary for assisting mothers in learning how to identify difficulties and make informed choices among alternate behaviors. This counseling can occur during home visits, informal contacts, and contacts with health workers.

- *Home visits*

Through home visits, counselors establish rapport with families and learn about the conditions that affect a family's breastfeeding decisions. Based on this rapport, counselors are better able to provide postpartum mothers with the necessary information and support needed to establish and maintain optimal breastfeeding. Home visits are an effective way of reaching mothers who may not attend clinic or group meetings or be involved in community activities.

Box 2.3: Examples of Mechanisms for Providing Breastfeeding Support

Government Primary Health Care Services

- **Honduras** -- In 1993, the Ministry of Health's Division of Maternal and Child Health (MCH) began a five-year program to integrate breastfeeding promotion into MCH activities. The program includes the formation of a national network of volunteer breastfeeding counselors.

Non-government Health Services

- **Brazil** -- Pastoral da Crianza, a national Catholic church-affiliated lay movement, supported by Caritas, has integrated breastfeeding support into its family visiting program. Every volunteer promoter of Pastoral visits about twenty families monthly. Volunteers receive training in simple breastfeeding messages.

Community Organizations

- **Argentina** -- NUNU, the Association for Maternal Assistance, trains mothers and health professionals as infant feeding counselors to work with teenage mothers. The program employs a nutritionist and a lactation consultant, offers an intensive training course for peer counselors, and provides training for health professionals interested in conducting group sessions.
- **Venezuela** -- Círculos Femeninos Populares includes breastfeeding messages in its group meetings and coordinates over 250 mothers' groups among low-income women throughout the country. These meetings are organized by 500 volunteer coordinators who mobilize women on a variety of women's health issues.

Breastfeeding Promotion Organizations

- **Belize** -- The Breast is Best League (BIB) trains mothers and health care professionals as counselors to support breastfeeding. These counselors work in hospitals, prenatal and postnatal clinics, and in the community. Most of the counseling is on a one-to-one basis. BIB has trained male promoters. They work with fathers and community groups to advocate support for breastfeeding mothers. BIB staff and counselors raise public awareness of optimal breastfeeding by talking with community groups and schools, participating in radio and television programs, and displaying breastfeeding information on billboards and murals on public walls.

Commercial Enterprises

- **Guatemala** -- CEMACO, a chain of department stores, offers classes on breastfeeding to interested employees. It encourages employees to bring their babies to work and has a "no bottles" commercial policy, neither furnishing artificial milks to their employees or selling bottles, milks, or pacifiers to the public.

- *Informal contacts*

Because counselors live in the community that they serve, there will be chance meetings with community members. At some of these encounters, mothers or their relatives may ask questions or voice nutritional or health concerns. During these informal contacts, counselors can provide information and support and make referrals, when appropriate, to a health facility. Informal contacts can also be used as opportunities for promotion and ways of recruiting mothers or reminding them of upcoming group meetings.

- *Contacts with health workers*

Contacts with health workers at growth monitoring, prenatal, well-baby, immunization, and family planning sessions provide excellent opportunities for individual counseling on breastfeeding.

C. Support groups

Support groups offer opportunities for women to share their experiences and learn from other women living in similar circumstances. They provide a safe, secure environment that is non-judgmental for the discussion of a topic of interest to the group.

A breastfeeding support group is a group of women who meet for one to two hours at a regular time to discuss breastfeeding and share information and practical hints. The size of the group ranges from about 4 to 20 people. Led by a group leader or facilitator, the group may meet in a home, church, community center, clinic, or work site. The group leader encourages the other group members to share their experiences and facilitates the introduction of correct information when appropriate.²

This type of interaction reinforces what an informed health worker tells the mother and helps to counter the negative feedback that she may receive from others, such as family members or uninformed health workers. If a mother in the group recommends and practices exclusive breastfeeding, other mothers in the group may be more likely to adopt this behavior.

D. Community education

In addition to pregnant and breastfeeding women, counselors and health promoters will need to contact other people within the community who may

² Armstrong HC. Training guide in lactation management. New York: UNICEF, 1992.

influence mothers, such as community leaders, family members, and neighbors. Health promoters can work with teachers to educate children and adolescents about the importance of breastfeeding. In addition, they can promote breastfeeding in community meetings and events. Box 2.4 describes the community education activities of Grupo Origen in Brazil.

Box 2.4

Community Education Activities in Brazil

Community education is a major component of Grupo Origen's breastfeeding promotion program. Outreach activities include:

- Presentations to community organizations
- Seminars for teens
- Radio talk shows that address common breastfeeding questions
- Distribution of pamphlets, educational and training materials, videos, and fact sheets
- Use of dance, music, and carnival dolls to communicate breastfeeding messages at community events
- Drama performances six times a year

In the drama, a new mother receives conflicting breastfeeding advice. The audience decides, by secret ballot, what the mother should do and then discusses the drama.

E. Network of trained, supervised breastfeeding counselors/health promoters

Most existing community-based breastfeeding programs reach their target groups through a network of individuals who focus primarily on breastfeeding counseling or include this service along with other activities. A network of individuals promoting breastfeeding offers support at multiple points of contact with women in the community. It also provides an opportunity for continuous exchange of information and support among its members. When a network does not exist, support for breastfeeding tends to be random and unsustainable. Counselors may lose momentum and feel isolated and discouraged.

Ideally, a community network should consist of health care providers from health care facilities, health care promoters, community counselors, community leaders, and volunteers. All of these people need to give consistent information and messages about breastfeeding promotion and management so that they do not contradict each other. Additionally, members within this network need to know when they can help a mother with a problem and when they need to refer her to another member of the network or to a health care facility.

F. Supportive supervision

Supportive supervision should provide an opportunity for constructive exchange of information and experience. Supervisors should be trained to interact with supervisees in a way that encourages open and honest communication that leads to improved skills and enhanced knowledge.

G. Program monitoring and evaluation

Monitoring provides essential information about the program for use in decision making. While monitoring tracks the progress of the program, evaluation provides information about program impact.

A summary of the features of successful community-based breastfeeding support programs is shown in Box 2.5. Additional discussion of some of these features is found in other chapters of this manual. Chapters 3 and 4 discuss community participation. Chapter 10 focuses on supportive supervision, and Chapter 11 examines monitoring and evaluation. The companion volume to this manual, *A Guide for Trainers and Supervisors*, includes separate chapters on support groups, interpersonal counseling, follow-up and supervision, and community education. Other sources for information are *A Training Curriculum*, the third document in this series on *Community-based Breastfeeding Support*, and materials cited in the Resource Annex of this manual.

Box 2.5

Features of Successful Community-based Breastfeeding Support Programs

- Community participation in planning and development of activities and materials
- Interpersonal counseling
- Support groups
- Community educational sessions
- Network of trained counselors, promoters, and health care workers
- Supportive supervision
- Program monitoring and evaluation

Worksheet for Chapter Two: Overview of Breastfeeding Support

The purpose of this worksheet is to identify policies, health care services, and community support that currently exist to promote, protect, and support breastfeeding in your country, region, or community. This review process will help you to recognize opportunities for intervention and collaboration.

1. Which supportive breastfeeding policies currently exist in your country, region, or community? Refer to the table on Policies and International Recommendations in Support of Breastfeeding. This table is found following the worksheets.

2. Are hospitals and maternity centers in your project area aware of the Baby Friendly Hospital Initiative? Are the Ten Steps to Successful Breastfeeding being implemented?

3. What features of community-based support exist in your community?

- Community participation

- Community educational sessions

- Interpersonal counseling

- Support groups

- Network of trained, supervised breastfeeding counselors/health promoters

- Supportive supervision including mentoring

- Program monitoring and evaluation

**Policies and International Recommendations
in Support of Women and Breastfeeding**

YEAR	ORGANIZATION	DOCUMENT/EVENT	SUMMARY
1919 1952	ILO	Convention Number 3 Convention Number 95 Convention Number 103	Establishment of 12 weeks of leave of absence with at least 2/3 pay
1979	WHO/UNICEF	Joint Meeting on Infant and Young Child Feeding	Promotion of BF; appropriate weaning practices; strengthen education, training, information on feeding practices; promote health, social status of women; establish need for marketing codes for breast milk substitutes
1981	World Health Assembly	International Code of Marketing of Breast-milk Substitutes	Control of marketing of breast milk substitutes and supplements, bottles and teats
1982	FAO/WHO	Codex Alimentarius	Establishment of minimum quality and hygiene requirements for breast milk substitutes
1986	World Health Assembly	Resolution 39.28	Limits placed on free and low-cost supplies; follow-up formulas unnecessary
1988	Expert working group in Bellagio, Italy	Bellagio Consensus	From a research review, establishes the probability that full breastfeeding provides 98% protection from pregnancy during the first six months of life when the mother is amenorrheic
1989	WHO/UNICEF	<i>Protecting, promoting and supporting Breast-feeding: the special role for maternity services</i> A Joint WHO/UNICEF statement	Establishment of 10 steps for successful breastfeeding
1990	32 Governments and 10 International Organizations	<i>Innocenti Declaration for the Promotion, Protection and Support of Breastfeeding</i>	Promotion of exclusive breastfeeding until 4-6 months old and continued bf with appropriate supplements until at least 2 years of age; formation of national committees/programs to assure that the national health services meet the 10 steps by 1995; agreement to stop distribution of substitutes
1990	UN	Convention on the Rights of the Child	Legal obligation of the Member States to protect mothers and families; support of breastfeeding practices

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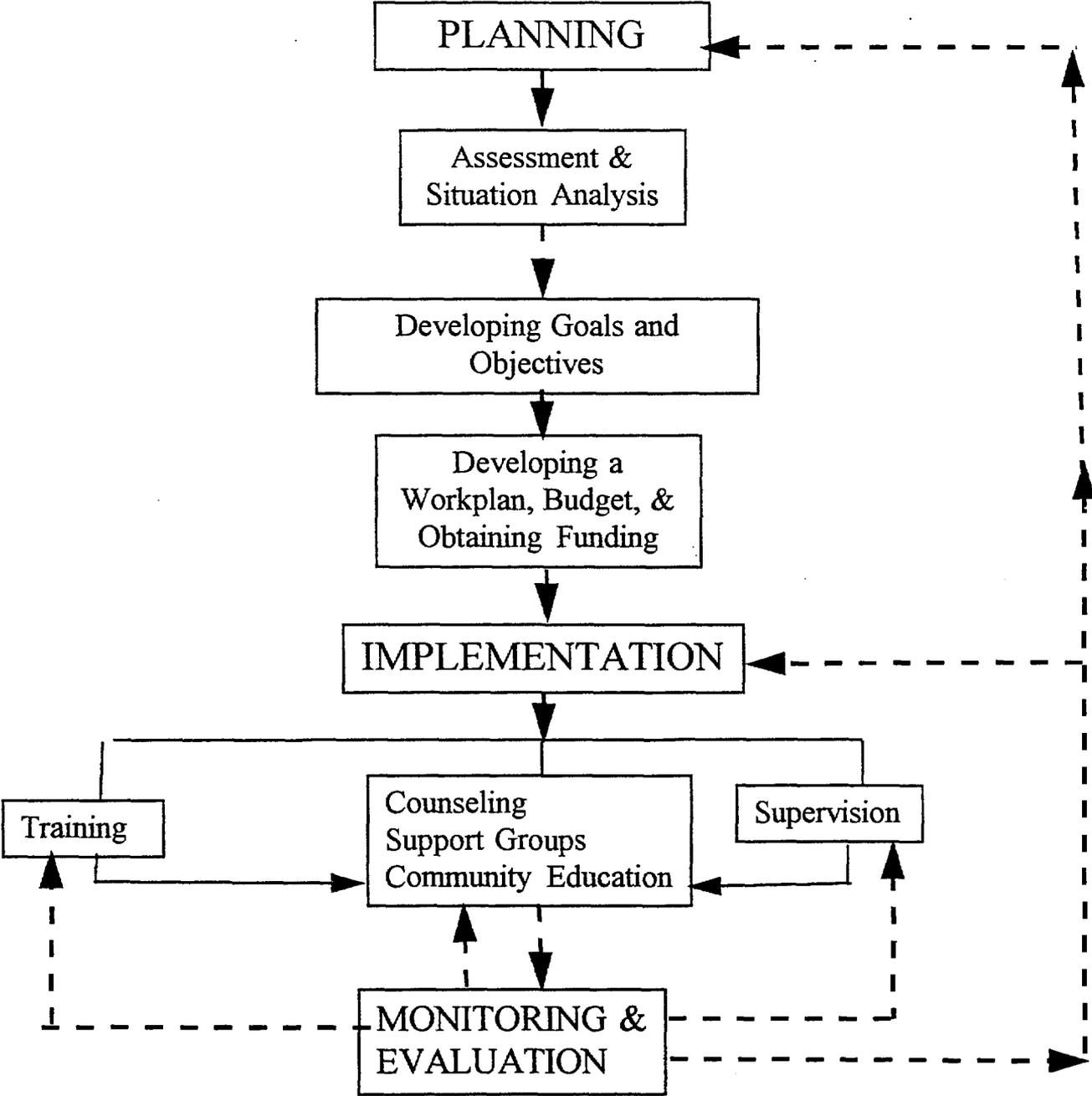
YEAR	ORGANIZATION	DOCUMENT/EVENT	SUMMARY
1990	UNICEF and 79 Heads of State	World Summit for Children	Goal that all women fully bf for 6 months and continue to bf with complementary foods thereafter into the second year
1991	UNICEF/WHO	Baby Friendly Hospital Initiative (BFHI)	Adoption of the 10 steps; creation of a favorable environment for children in maternity wards; removal of formulas
1991	PAHO/WHO	Fortaleza Declaration	Establishment of the importance of natural birth and negative consequences of unnecessary practices
1992	UN	International Conference on the Environment, Rio de Janeiro, Agenda 21	Protection of women so they may breastfeed for at least the first 4 months postpartum
1992	FAO/WHO/159 countries and European Community	International Conference on Nutrition Plan of Action	Declaration that breastfeeding is one of the 9 strategic actions for reaching adequate nutritional development; removal of obstacles to bf
1992	World Health Assembly	Convention on the Elimination of all forms of Discrimination against Women (CEDAW)	Elimination of all forms of discrimination against working women
1992	UN	World Summit for Children follow-up	Establishment of intermediate goals for BFHI and the elimination of free samples by 1995
1994	World Health Assembly	Resolution 47.5	Unanimously adopted prohibition against free and low-cost supplies of breastmilk substitutes in all parts of the health system
1994	UN	International Conference on Population and Development, Cairo	Promotion of breastfeeding as part of family planning and child survival strategies
1995	UN	World Summit for Social Development, Copenhagen	Promotion of full access to education on the benefits of breastfeeding and to supportive services
1995	UN	Fourth World Conference on Women, Beijing	Elimination of discriminatory employment practices; facilitation of bf for working mothers; right to relevant and accurate information; legal, economic, practical and emotional support for bf

Introduction to Sections II and III

The chapters which follow in Sections II and III of this manual lead you through the process of design, planning, and implementation of a community-based breastfeeding program. The information contained in Section II describes the assessment and planning phases while the chapters in Section III focus on the management and administration of programs.

The diagram on the following page presents a model of this development process. The model highlights the inter-relationships between various aspects of the process. For example, the information collected during Monitoring and Evaluation feeds back into Implementation and ultimately back to the beginning of the Planning cycle. It may be useful to refer back to this diagram as you review the chapters in these Sections.

BREASTFEEDING COMMUNITY SUPPORT PROGRAM DEVELOPMENT MODEL



Section II

Planning for Breastfeeding Support

Chapter 3 Assessing the Situation

Chapter 4 Engaging the Community in the Planning Process

Chapter 5 Setting Goals and Objectives

Chapter 6 Developing and Using a Workplan

Chapter 7 Preparing the Budget

Chapter Three

Assessing the Situation

This chapter provides guidance for selecting urban or rural communities for breastfeeding support activities and assessing breastfeeding practices and socio-cultural factors at the community level. It also identifies the type of information that should be collected and tools, such as quantitative and qualitative techniques, for gathering this information. Guidelines for mapping, which can be used to determine the number and location of pregnant and breastfeeding women in the community, are presented.

I. Community selection	3-2
II. Information gathering in the community	3-3
A. Current status of breastfeeding practices	3-4
B. Cultural, economic, and social influences	3-4
C. Health services, community organizations, and training resources	3-5
III. Assessment tools	3-5
A. Quantitative techniques	3-7
B. Qualitative techniques	3-7
C. Community maps	3-9
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I. Community selection

Community selection for breastfeeding counseling and support activities may already be determined by your organization's designated area of influence. Health centers and clinics usually have a designated area of influence as do most NGOs working at the community level. If this area is large, the initial focus may be a few communities or neighborhoods. If the area has not been established, two possibilities to consider are: 1) high risk areas where the need for an intervention is greatest or 2) areas with lower risk but more probability of success.

High risk areas are generally characterized by low rates of exclusive breastfeeding, high rates of diarrhea, and/or high rates of acute respiratory infections. These areas may have few economic resources and health services. If high risk areas are selected for program activities, the organization will need to have sufficient economic and human resources, as well as an established infrastructure, to provide the support needed to organize and implement community-based activities.

An organization without the resources and infrastructure may want to consider working in communities or neighborhoods where there is greater likelihood of success, such as those with supportive health services and individuals trained in breastfeeding support. Developing a coalition with other organizations such as churches, clinics, NGOs, or women's groups already working in these areas is another approach. Some breastfeeding promotion organizations work only in communities that have both requested their support and demonstrated the capacity to sustain community-based activities.

When selecting communities for support activities, refer to Worksheet 3.1 and consider the following issues:¹

- *Accessibility:* Is the community so dispersed it will be difficult for women to attend meetings and for breastfeeding counselors to conduct follow-up visits?
- *Demography:* Are there enough women in the community pregnant or with infants to justify an intervention?
- *Community organization:* Are there nongovernmental organizations and informal community groups with which to network?
- *Support:* Are there key community people who will support the program?
- *Sustainability:* Do sustainable organizations interested in breastfeeding promotion and support exist in the community?

¹Bezmalinovic B, Lundgren R. La Liga de La Leche Materna en Guatemala: Evaluación de sus actividades. Guatemala City: DataPRO S.A., 1991.

II. Information gathering in the community

Once the communities or neighborhoods have been identified for breastfeeding counseling and support activities, a community assessment, sometimes referred to as a "situational analysis," should be conducted. It is important to have a systematic understanding of the existing circumstances in the community before developing interventions to support breastfeeding. You will need to know prevailing breastfeeding practices in the community and the cultural, economic, and social factors that influence them. Baseline information about the community will make it possible to evaluate program outcomes and impact. If Ministries of Health or NGOs are initiating a child survival or integrated maternal child health intervention, information about breastfeeding should be part of the baseline data collection.

The *Guide for Country Assessment of Breastfeeding Practices and Promotion*² provides an excellent framework for asking questions about breastfeeding. In most places, the community assessment will be conducted by the group that plans to undertake or include a breastfeeding support and counseling intervention. Sometimes a multi-disciplinary, inter-sectoral working group will be formed to assist in the collection of information and data. Some organizations incorporate a systematic diagnostic of infant feeding practices, health system coverage, and social constraints into the community workers' activities, either as part of their training or as the first community activity.

Community participation in the assessment process helps to raise consciousness and mobilize community support from the outset. Depending on the local situation, the community can participate in a variety of ways: a health committee may provide information about existent data sources and community-level beliefs; a local women's group may help in information gathering in homes; a local NGO may provide a staff person to assist with data collection; or the community church may offer a site for community meetings.

The assessment should provide information about:

- Current status of breastfeeding, based on what is known or can be easily collected;
- Cultural, economic, social, and other factors that support or deter breastfeeding;
- Existing health services and community organizations for breastfeeding support activities;
- Educational/training resources and materials currently being used for breastfeeding support or promotion; and
- Gaps in information that require additional investigation.

A discussion of the types of information to gather in the assessment follows.

²Griffiths M, Anderson MA. *Guide for country assessment of breastfeeding practices and promotion*. Washington, DC: MotherCare, 1993.

A. Current status of breastfeeding practices

A primary reason for conducting a community assessment is to gather information about pregnant women and mothers of infants in the community. At a minimum, information should be collected on:

- Number of pregnant women in the community
- Prevalence of breastfeeding
- Timing of the initiation of breastfeeding
- Prevalence of exclusive breastfeeding
- Timing of the introduction of complementary foods
- Use of feeding bottles

Sources of information about breastfeeding and infant feeding practices may already exist in the community and should be investigated. If it is anticipated that the counseling and support intervention will take place within a health facility, some information should be available about the population that facility serves. Few health services, however, require monthly summaries of breastfeeding or infant feeding information.

NGOs working at the community level may be another source of information. They often have community maps and lists of women and children in the areas in which they work. Other possible sources of data are listed in Worksheet 3.2 at the end of this chapter.

B. Cultural, economic, and social influences

It is important to gather information about local knowledge and attitudes regarding breastfeeding. Traditional beliefs and attitudes may positively or negatively affect breastfeeding practices, so it is important to be aware of these beliefs. Other influences, such as radio, television, and cinema, may affect attitudes about breastfeeding. In many places, infant formulas are aggressively marketed through the mass media, commercial outlets, and the health system. The local assessment might include the following topics:

- Local attitudes and beliefs about colostrum, breastfeeding, and infant feeding
- Attitudes and practices of health workers in both the private and public sectors
- Breastfeeding messages on the radio, television, and other mass media
- Commercial activities promoting breastmilk substitutes
- Social, cultural, political, and economic factors that support or discourage optimal breastfeeding practices such as women's status, laws and practices in the formal and informal sectors, etc.

C. Existing health services, community organizations, and training resources

In addition to collecting information on breastfeeding practices in the community, you will want to find out what mechanisms exist in the community for breastfeeding support. This information should include MOH and NGO health and nutrition interventions in the project area; community outreach programs; activities of established women's groups; and training activities, materials, and resources.

A summary of any breastfeeding support activity that exists at the community level will provide useful information for the development of new initiatives. For example, information on community-level training activities and materials on breastfeeding promotion and lactation management will help you define training needs, identify potential human resources for your program, and develop a program that builds on existing systems and materials.

Table 3.1 presents a framework for an assessment of community structures for breastfeeding support.

III. Assessment tools

There are various ways to collect information at the community level. They do not need to be complex or time consuming. No single technique is appropriate for all types of information from all sources. Often the best option is to use a variety of techniques to gather information.

The most commonly used techniques are questionnaires, interviews, and observations. Quantitative techniques, such as surveys, collect information that can be counted, such as the number of pregnant women in the community or the number of women exclusively breastfeeding at four months. Qualitative information is collected in a less structured way, by asking people's opinions on different topics, watching behavior, or listening to comments in group discussions. These methods of collecting information are explained in the following sections.

Table 3.1
Assessment of Community Structures for Breastfeeding Support Activities

Community Structure	Types	Services Offered
1. Hospitals	<ul style="list-style-type: none"> • Government • Private • Maternity centers 	<ul style="list-style-type: none"> • Prenatal education about breastfeeding • Hospital practices in support of breastfeeding • Breastfeeding information and support provided at delivery • Lactation clinic or other support
2. Primary health care	<ul style="list-style-type: none"> • Institution-based clinics • Outreach programs 	<ul style="list-style-type: none"> • Home visits • Lactation clinic, family planning clinic, and other women's health support • Support groups for pregnant and lactating women • Community education and mobilization • Growth monitoring
3. PVOs and NGOs	<ul style="list-style-type: none"> • Community development projects (eg, Child Survival, family planning) 	<ul style="list-style-type: none"> • Breastfeeding education or counseling services
4. Breastfeeding organizations	<ul style="list-style-type: none"> • Mother to mother support • Support and promotion • Advocacy 	<ul style="list-style-type: none"> • Breastfeeding education or counseling • Support groups • Nonmedical lactation management • Advocate for supportive labor and health policies • Monitoring of promotion of breastmilk substitutes
5. Community organizations	<ul style="list-style-type: none"> • Women's groups • Credit associations • Religious groups 	<ul style="list-style-type: none"> • Community mobilization • Education and information • PHC education and home visiting • Support for mothers breastfeeding in public
6. Commercial enterprises	<ul style="list-style-type: none"> • Factories • Unions • Day care • Department stores • Restaurants • Transportation systems 	<ul style="list-style-type: none"> • Support for breastfeeding in the workplace • Provision of places for mothers to feed their babies comfortably
7. Educational structures	<ul style="list-style-type: none"> • Schools and other educational institutions 	<ul style="list-style-type: none"> • Breastfeeding appropriately included in the curriculum at all ages and levels • Support for adolescent mothers to continue education and breastfeed (day care on site)
8. Mass media	<ul style="list-style-type: none"> • Television, radio, newsprint, billboards 	<ul style="list-style-type: none"> • Media support for breastfeeding • Restriction of advertisements of breastmilk substitutes

A. Quantitative Techniques

Before any data collection is begun, it is important to identify exactly what information is needed and for what purpose. Use of existing information, where available and appropriate, can save time and resources. In many places, the Ministry of Health, nongovernmental organizations, and other groups routinely gather information about the health and nutrition of mothers and children. Often this is done through surveys at the national, regional, district, or even community level.

When community-level data are not available from an existing source, a survey will be necessary. It is important to focus on just a few pieces of information for use in developing a breastfeeding support program.

"Rapid surveys," which are alternatives to traditional large-scale sample surveys, have been developed to provide a shortcut in the assessment process. They are particularly useful for collecting information about the local community. Prototype questionnaires, such as those developed by the Primary Health Care Management Advancement Program,³ save time and can be modified to fit the particular needs of the location and situation.

The Baby Friendly Hospital Initiative assessment guide gives many examples of questions.⁴ This guide is the most valuable tool if your "community" is a hospital outpatient population. A sample questionnaire that could be used during a rapid community-based or clinic-based survey is found in Chapter 11, Table 11.2.

B. Qualitative Techniques

Unlike quantitative techniques, collection of qualitative information is more informal. It focuses more on "why" people behave the way they do rather than on "what" they do. The most common qualitative techniques are discussed below. More detailed discussion of these techniques can be found in several excellent resources⁵⁻⁶.

³Aga Khan Health Services and University Research Corporation Center for Human Services. Primary health care management advancement programme series. Module 3: Assessing community health needs and coverage. Washington, DC: Aga Khan Foundation USA, 1993.

⁴WHO/UNICEF. Hospital self-appraisal tool for the WHO/UNICEF Baby Friendly Hospital Initiative. 1992.

⁵Favin M, Baume C. A guide to qualitative research for improving breastfeeding practices. Washington, DC: Wellstart Expanded Promotion of Breastfeeding Project. 1996.

⁶Debus M. A handbook for excellence in focus group research. Washington, DC: Academy for Educational Development, 1995.

- *Focus groups*

Focus groups are a type of group conversation that provides for an in-depth discussion of a pre-selected topic, guided by a trained facilitator. Focus groups, usually composed of people of similar sex, age, and economic status, can foster a group spirit. They offer insights into the emotional as well as the intellectual aspects of a topic. These groups work best if members trust one another and if the facilitator is experienced in organizing and leading focus groups.

- *Key informant interviews*

Key informant interviews are discussions with persons in the community who are knowledgeable about a subject and reflect the ideas in the community. These interviews may provide insights into beliefs, attitudes, and cultural and social norms that support or hinder breastfeeding. Key informants can usually provide information about training activities that may be taking place in the community and organizations that influence community members. In general, they will be the source of information about breastmilk substitute marketing and promotion practices.

Key informant interviews might include the following people:

- private and public health services personnel
- traditional birth attendants
- traditional healers
- leaders of community women's groups and advocacy groups

- *Observation*

Observing breastfeeding and infant feeding in the home and community is a good way of collecting information about actual practices. Through this technique, you can capture nonverbal behaviors, note physical conditions in the household, and explore interactions among mothers and their infants. A checklist is a helpful tool for reminding the individual of behaviors to be observed and for documenting the observation.

Locations for observation of feeding practices include health centers and clinics, women's group meetings, and community events. Home visits with family planning, MCH, or other community-based workers are opportunities to observe behaviors and practices. Observations in households, pharmacies, and shops can provide information on the use, availability, and promotion of breastmilk substitutes and feeding bottles. Additional information can be gathered by noting media messages and advertisements.

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There are certain limitations to findings based on observations. They are subjective and may reflect the point of view or biases of the observer. They usually are based on the observation of a limited number of people. Among those observed, the presence of the observer may alter their behavior.

Another limitation is that the observer may conclude that the presence of breastmilk substitutes in pharmacies, corner stores, etc., reflects sales patterns, which may not be the case. The promotion of breastfeeding or breastmilk substitutes in the media may not give a complete idea of its impact on consumers. Despite these limitations, observation can be a useful tool for collecting information that may be missed by other techniques.

- *Literature review*

A literature review of published ethnographic surveys of the community or a similar community may be helpful in understanding socio-cultural influences. Similarly, a review of training curricula, training plans, supervisory guides, and other materials of the MOH, universities, primary and secondary schools, and NGOS may indicate the types of messages that are communicated about breastfeeding.

C. Community maps

A key part of an assessment is the collection of "baseline" information on the number and location of women in the community with infants and toddlers. If the counseling and support program is part of the outreach activities of a hospital or health center, places should be identified in the community where the target population gathers for maternal and child health services. Program managers or supervisors should work with the community in making a list of the women and children in the area who should be included in breastfeeding support activities.

Maps are among the easiest tools used to identify the location of the target population. They can be an especially powerful tool for programs that depend heavily on community involvement. Sources for community maps include primary health care programs, research studies, government surveys, or rapid surveys.

These maps may be adapted for use in a community-based breastfeeding program. In the mapping systems used in many primary health care programs, each house is numbered on the map. A code is used to designate particular households. This map could be adapted so that houses with pregnant women are marked by a green line and houses with breastfeeding women with a blue line. Another technique is to use a single line for pregnant women and crossed lines for breastfeeding women.

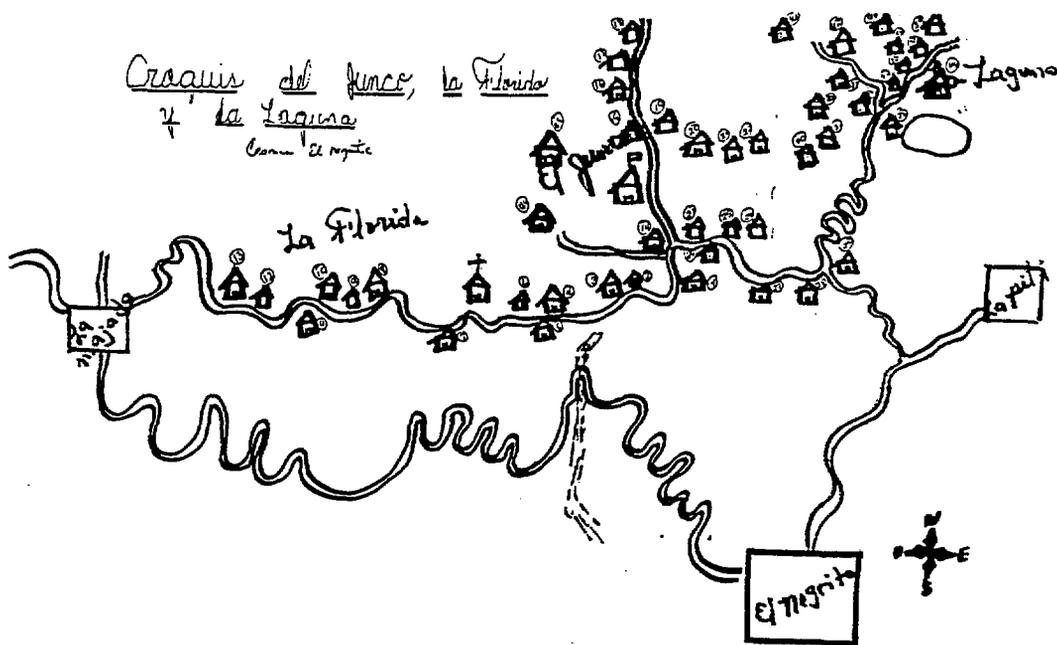
If there is no existing system for identifying mothers, community workers can draw a simple map that shows roads, houses, health facilities, schools, local landmarks, and households with women of childbearing age, using some of these same symbols. In some cases, a formal map may not be required. In Guatemala, illiterate traditional birth attendants who were trained as counselors could name all pregnant women and mothers with newborns in their communities. They did not use a formal map, but they knew whom to visit.

Any identification system will need to be updated periodically (yearly or semi-annually). The information can be used to:

- Define the size and location of the target population,
- Locate women who might otherwise be missed,
- Establish a benchmark against which program goals and coverage can be measured, and
- Mobilize the community around the issue of breastfeeding.

Instructions for developing a community or neighborhood map are provided in Worksheet 3.3. Figure 3.1 is an example of a community/village level map.

Figure 3.1
Example of a Community/Village Level Map
Developed by a Volunteer Working with the Breastfeeding League of Honduras



Worksheets for Chapter Three: Assessing the Situation

Worksheet 3.1

Potential Communities/Services for Breastfeeding Counseling and Support

This worksheet will help you to consider the advantages and disadvantages of initiating breastfeeding counseling and support in various communities in your catchment area, if these areas have not been previously determined.

List communities or health services in the area of influence where breastfeeding activities could be initiated. Write down any advantage or disadvantage of starting activities in these communities or services. Consider: levels of malnutrition, logistics of reaching the target population, and bases of support (health center staff, local government organizations/elected leaders, NGOs, clubs and associations, and informal networks). Also include the level of control or influence on mothers/families (social services, for example, or food distribution networks).

Potential Communities/Services for Breastfeeding Counseling and Support Programs

Communities/Services	Advantages	Disadvantages

Worksheet 3.2
**Collecting Information about Breastfeeding Practices,
Services, Resources, and Materials**

The purpose of this worksheet is to help you gain an overview of the breastfeeding situation in your community/region/country. In addition, it will help you reflect on opportunities for initiating or improving support to breastfeeding at the primary health care and community level.

Some resources for obtaining this information are:

- Nutrition surveys
- Demographic or family health surveys (usually national level; sometimes district level)
- Community health surveys
- Health sector assessments of PVOs, NGOs, and/or international agencies
- Research studies on pertinent topics

These resources may be available from:

- Ministry of Health (MCH, Family Health, or Nutrition Division)
- Local/regional health services
- Universities or research centers
- Donor agencies (UNICEF, USAID, World Bank)
- Municipal Census Offices
- Census Bureaus (household surveys)
- Community development organizations
- International NGOs and agencies (WHO/PAHO, Save the Children, PLAN, breastfeeding support organizations, Population Council)

1. List local sources of information on maternal and infant health in your community. Does any organization or institution routinely track activities in support of breastfeeding? Collect the instruments that they use.

2. List the places in your community where you could obtain information on maternal and infant health.

3. List the places where you can get information about existing training activities, curricula, and resources. Talk to trainers, managers, and staff of each institution, organization, or group that you have identified in the community. If possible, collect the organizations' training materials so they can be reviewed for their content on breastfeeding.

The matrix below shows the kind of information that should be gathered. Information can be put in a matrix as an easy way of consolidating data, showing training resources, and identifying training gaps. Refer to the Training Assessment Worksheet in Chapter 9 (Developing a Training Plan) for an example of a questionnaire that could be used in an assessment of community-level training activities.

**Example of the Information Collected
for an Assessment of Community-level Training Activities
in the Dominican Republic**

Agency responsible	CONASUMI	LLL/DR	Profamilia
Region	Regions 4 & 6	Regions 1-7	Region 3
Audience trained	Health Promoters	Breastfeeding Counselors	Health Promoters
Number trained	515 Promoters	250 Counselors	5 promoters
Length of course	18 hours	24 hours in 4 six-hour sessions, one month apart	2 hours
Refresher courses	none	monthly	none
Trainers	Supervisors	League leaders	Community Agent
Curricula	Manual for Supervisors and Promoters	Adapted Honduran curriculum	none
Supervision	none	monthly	none
Monitoring	none	monthly	none
Evaluation	none	none	none

Worksheet 3.3
Mapping the Community⁷

Read the information on community mapping and the guidelines provided below and then develop a map of the local community. You may want to use the sample legends for map landmarks shown on the next page.

Community maps are often available from the Census Bureau, local government, Ministry of Health, or political parties. These maps can be used to locate the target populations. If no maps are available, a map can be drawn of your local community as part of the community assessment process. A community-level map should be easy to make and understand. Community workers can usually be taught to draw maps of their own villages, although this may necessitate some compromise in the quality of the map. Distances, for example, may not be drawn accurately. However, when drawn by a community worker, the map is an invaluable tool to identify households and/or pregnant and breastfeeding women.

1. Effective map making requires that information on geographic features, locations of landmarks or buildings, and distances be depicted as accurately as possible.
2. At the community or neighborhood level, the map should show a single village or community with the following (see the example on page 10 of this chapter):
 - roads
 - houses
 - services such as a health post or a private clinic
 - water sources
 - schools
 - places of worship
 - pregnant women and women with infants less than 12 months
3. If the houses already have numbers, then these numbers can also be put on the map.
4. If possible, a scale should be used that indicates the relationship between distances shown on the map and real distances, e.g., 1 cm on the map = 1 km of real distance.
5. Maps should be modified periodically to include newly pregnant or delivered women and new facilities, houses, or other features identified after working in the area for an extended period.

⁷Adapted from The Primary Health Care Management Advancement Programme, developed by the Aga Khan Foundation and University Research Corporation. "Planning and Assessing Health Worker Activities" -- Module 3.

6. Map legends (symbols and colors representing structures, geographic features, or administrative boundaries) should be recognizable and consistent. Below are some examples of map legends.

≈	WATER
○	HOUSE
†	RELIGIOUS ORGANIZATION
□	COMMERCIAL ESTABLISHMENT
▣	FACTORY
‡	RAILROAD
==	STREET
⌠	SCHOOL
⊖	PREGNANT WOMAN
⊕	WOMAN WITH INFANT < 12 MONTHS
+	HEALTH ORGANIZATION/CLINIC
◇	FAMILY PLANNING DISTRIBUTOR/CLINIC

Chapter Four

Engaging the Community in the Planning Process

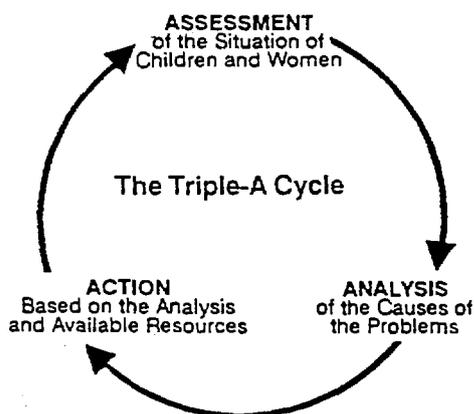
Several steps must be taken in order to progress from the community breastfeeding assessment discussed in Chapter 3 to the implementation of community-based breastfeeding activities. The first step is to engage the community in a dialogue and diagnosis of health problems identified during the community assessment. This process can then lead to an agreement of actions to address these problems. A community assessment workshop, described in this chapter, can facilitate this process.

In this chapter, "community" refers to the larger area where a group of community-based workers will carry out their activities. This larger area could be made up of a sector of an urban area or several small villages served by one health post or health center. Once an agreed upon strategy has been developed with this larger group, it will be important to repeat the process on a smaller, more informal scale within each local village or neighborhood where the community-based counselors will work.

I. Community assessment workshop	4-2
A. Identification of participants	4-2
B. Presentation of assessment findings	4-3
C. Analysis of the community assessment	4-3
D. Identification of potential target groups and interventions	4-4
E. Formation of a planning group	4-7
Worksheets	4-9

I. Community assessment workshop

The purpose of a community assessment workshop (or series of meetings) is to review the findings of the community breastfeeding assessment, identify possible causes of the problems, and determine target groups for possible interventions. The ideas emerging from the workshop will feed into the development of a Plan of Action with goals, objectives, and strategies, discussed in the following chapter. UNICEF refers to this approach as the Triple A Cycle: Assessment, Analysis, and Action, illustrated below.



A. Identification of workshop participants

In the workshop's initial planning stages, the inclusion of a broad base of support will contribute to successful community interventions. Possible participants to include in this process and the rationale for their involvement are listed in Table 4.1.

**Table 4.1
Potential Workshop Participants**

Types of Participants	Rationale for Participation
• Health center staff	• Health service delivery contact point
• Local government representatives	• Input on policy and community mobilization
• Staff of non-governmental organizations (NGOs)	• Service delivery integration and coordination
• Members of clubs and associations	• Community opinion leaders
• Informal community leaders	• Local influential individuals

Worksheet 4.1 at the end of this chapter will help you identify the participants for your workshop. Worksheet 4.2 suggests guidelines for planning the workshop.

B. Presentation of assessment findings

The workshop should begin with introductions. If participants do not know one another, a short period for introductions is critical. If the meeting is large, it will be necessary to take time during the working groups for participants to introduce themselves. These introductions are important even if the meeting is short. If the workshop is longer than a couple of hours, it will be valuable to include some team building exercises.

Presentation of the findings from the community breastfeeding assessment (see Chapter 3) should follow the introductions. When making the presentation, some key points to remember are:

- Make the presentation short. Focus on the problems identified in the assessment and the relationship between breastfeeding and infant health and nutrition.
- Provide written statistical summaries. Do not overwhelm the participants with statistics during the presentation.
- Use pictures or slides, possibly with a graphic presentation of some aspects of the situation that will help to generate discussion.

C. Analysis of the community assessment

At the close of the presentation, the workshop or discussion facilitator should raise discussion questions based on the information that has been presented. He or she should not present solutions. Plenty of time should be allowed for discussion. Examples of questions that could be raised are shown below.

- Why do some mothers feed young infants liquids other than breastmilk?
- Why are some infants fed foods inappropriate for their age?
- What are some of the difficulties that health workers encounter in counseling mothers about breastfeeding?
- Who makes decisions about feeding practices?
- Who influences feeding decisions? What social, cultural, and economic factors influence these decisions?

At the conclusion of the analysis of the assessment findings, the group should be able to agree on one or more problems related to breastfeeding in their community and identify some possible causes.

D. Identification of potential target groups and interventions

Once there is consensus on problems and possible causes, the discussion should focus on groups or individuals who make decisions that affect breastfeeding practices. Table 4.2 illustrates how problem identification helps in determining the target groups for interventions that promote, protect, and support breastfeeding.

**Table 4.2
Problem Identification and Potential Target Groups**

Problem	Potential Target Group
Delayed initiation of breastfeeding because colostrum is believed to be dangerous	<ul style="list-style-type: none"> • Pregnant women • Mothers and mothers-in-law of pregnant women • TBAs and health workers
Lower initiation of breastfeeding by women delivering in hospitals	<ul style="list-style-type: none"> • Pregnant women receiving private or public health prenatal care • Health workers
Average duration of exclusive breastfeeding of less than two months	<ul style="list-style-type: none"> • Pregnant women • Postpartum women • Health workers
Higher rate of low birth weight infants among adolescent girls	<ul style="list-style-type: none"> • Adolescents • Parent of adolescents • Teachers
Inappropriate timing of the introduction of complementary foods and liquids	<ul style="list-style-type: none"> • Pregnant women and new mothers • Grandmothers, fathers, and other close relatives

As shown above, target groups of community-based counseling and support programs are usually pregnant women, mothers of infants, health workers, and family and community members who influence breastfeeding decisions. Interventions will vary for each of these groups. It is basically through changes in the attitudes and practices of clinic staff, primary health care workers, community health volunteers, teachers,

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and the trainers of all of these service providers that significant changes can be expected in the primary target groups: pregnant women and mothers of infants. The rationale for targeting these various groups and possible interventions are discussed below.

- *Pregnant women*

During pregnancy, most women think about how they will feed their infants after birth. Patterns of feeding and care established with the first child greatly influence patterns later used with other children. This is why it is so important to counsel pregnant women, particularly first-time expectant mothers, about breastfeeding.

Strategies for reaching pregnant women include counseling in prenatal clinics, homes, childbirth preparation classes, parenting education classes, or breastfeeding support groups. Counseling activities can be supported by pamphlets, media messages, posters, etc.

- *Mothers of infants*

Lack of exclusive breastfeeding is a significant cause of infection in early infancy and can result in malnutrition as well as a series of other health problems. Therefore, mothers of infants under 6 months of age (and their immediate families) are a critical target group. They require encouragement, support, and information about lactation management. First-time mothers may be a particularly important target group because they have not yet established an infant feeding pattern. The decision to emphasize first-time mothers or to include all mothers of children under 12 months will depend on available resources.

- *Adolescent girls*

Teen mothers,¹ who are usually first-time mothers as well, are at higher risk of giving birth to premature and low birth weight babies. They often lack role models and/or support for infant care, especially for infants with special needs. Therefore, teen mothers need practical and psychological support to initiate and maintain breastfeeding and to manage special feeding situations.

¹ Teenage pregnancy is not uncommon. In Latin America, 8 percent of 15 to 18 year old women give birth each year, ranging from a low of 6 percent in Chile to a high of 15 percent in El Salvador. By age eighteen, 15 percent of Latin American girls are already mothers. Most teenage mothers are single or partners of common-law marriages. Teen births are more common among rural girls and girls with little or no formal schooling. The majority of teen mothers surveyed in six Latin American countries said that they did not want their most recent child. (Center for Population Options, 1994)

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Important interventions for teen mothers are support for optimal breastfeeding, counseling on birth spacing to delay the next pregnancy, nutritional support for the mother who has not concluded her own growth, and the development of programs that allow teen mothers to continue their education.

- *Family and community members*

Other persons in the community often influence how a woman chooses to feed her baby. Comments of family members build or undermine a woman's confidence and her determination to breastfeed. Grandmothers may challenge feeding practices, such as exclusive breastfeeding, that differ from their own experiences. Fathers may regard bottle feeding as a sign of modernity and as a status symbol. Neighbors and friends may pass on negative breastfeeding experiences and misconceptions about feeding practices. Family and community members need to be educated on the benefits of breastfeeding to the infant, family, and community.

- *Health workers*

Mothers hold doctors and nurses in high regard and may ignore the advice of breastfeeding counselors if it is contradicted by health professionals. It is critical that health workers assure women that they will be able to breastfeed, help them to establish lactation, provide accurate information, and refer them to support networks in their community.

Interventions for health workers include education about breastfeeding and lactation management as part of medical and nursing school curriculum, training of auxiliary nurses and health promoters, and on-going and in-service training for all health professionals. Health workers also need opportunities to learn and practice effective communication techniques and to understand the importance of peer support for breastfeeding.

In considering potential target groups and interventions, workshop participants may want to discuss these questions:

- What activities would support women to exclusively breastfeed for the first six months?
- What is feasible in your community?
- How should these activities be organized?

- What resources exist to support these activities and what new resources might need to be developed?

Worksheets 4.3 and 4.4 are tools that can be used in a workshop to aid in the process of identification of problems, target groups, and possible interventions.

E. Formation of a planning group

At the end of the discussion, a planning group should be formed to develop a Plan of Action with goals, objectives, and strategies. The formation and composition of this group can be part of an agreement of understanding or "*convenio*" with the community. This agreement lists what is expected of each group and helps to clarify roles and responsibilities.

Worksheets for Chapter Four: Initiating the Planning Process

Worksheet 4.1 Identifying Workshop Participants

List formal and informal leaders and organizational representatives for possible participation in a workshop to analyze the community assessment and discuss the development of a community or primary health care-based breastfeeding program. Refer to the organizations you identified using the worksheets and assessment tools in Chapter 3. Criteria you may wish to consider when inviting participants may include the following: Who is in a position to assist in developing the intervention? Who has the most influence in the community? Who is most supportive of breastfeeding?

Depending on the scope of your community assessment and the program you will be discussing, participants in the assessment workshop may include:

- Staff of different Ministry of Health divisions (Maternal and Child Health, Nutrition, Control of Diarrhea, Planning, Community Health, etc.);
- Health center staff
- Hospital administrators and department heads
- Workers in the hospital outpatient department (particularly if you will be beginning activities within a hospital)
- Local government organizations/elected leaders
- Teachers
- NGOs working in breastfeeding promotion or related activities
- Prominent community and religious leaders
- Local non-governmental organizations (NGOs)
- Representatives of clubs and associations
- Informal community leaders (whatever your community may be: hospital, health clinic, or catchment area for your institution or organization)
- Representatives of other health and community organizations identified during your assessment process (see Chapter 3)

Worksheet 4.2: Workshop Planning - Guidelines

Read the following guidelines for planning a community assessment workshop, and then complete the checklist on the following page.

A. Purpose of the workshop: It is usually better to have limited goals for an assessment workshop. Developing a plan for community work will take time, so it is better to plan a ½-or one-day workshop and reconvene with a smaller planning group. A shorter workshop with a focused discussion, followed by a series of smaller meetings, will give participants the opportunity to think about the ideas presented and mobilize the community.

B. Sites: Public meeting place: such as municipal, religious, hospital or health center conference rooms? Community associations meeting place? Hotel, conference center? Try to choose a place that is politically neutral in your community so that all community members feel comfortable attending. A site should offer the opportunity to break into working groups. If the group is small enough, you may need only one or two working groups. With larger groups, more space will be needed for working groups.

C. Times: Part of several days? An entire day? A weekend?

D. Child care: Participating community members may be breastfeeding mothers. Breastfeeding babies can stay with mothers, but some participants may have older children who will need to be accommodated. You may need to assign someone child care duties and provide some simple entertainment, toys, and books for the children, especially if the meeting will be longer than a few hours.

E. Invitations: If you have written invitations, they should be distributed at least three weeks before the workshop, so that people have the opportunity to adjust their work schedule. Verbal invitations can be given from one to two weeks prior to the workshop, depending on the regularity of encounters with the invited group. In any case, you may want to reconfirm the attendance of key participants a few days before the workshop.

F. Food: Will you serve food? If so, what kind? Who will pay? Will you receive donated food? If food is provided, non-breastfeeding children and their caretakers will need to be included.

G. Equipment and Materials: Flip charts, paper, markers, overhead projector and transparencies, programs, summaries of assessment, worksheets, and audio-visual equipment if needed and appropriate

H. Setting up the meeting room: The day of the meeting, you will need to check the room to make sure that all necessary equipment is in place. If the group is small enough, you may wish to place the chairs in a circle or try to sit around a table. Such an arrangement is far more conducive to discussion than is the typical arrangement of a room for a lecture.

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Worksheet 4.2: Workshop Planning - Checklist

To help in your planning, consider the issues identified in the left column and put down your ideas in the other column. Jot down possible sites for the workshop. Determine the length of the workshop and the individuals who will be responsible for making the necessary arrangements.

Issues to Consider	Your Plan
What is the purpose of the workshop? (Mobilize the community? Identify problem areas? Develop a strategic plan?)	
Who will be invited?	
What staff support will be needed?	<p>Moderator/Facilitator:</p> <p>Person(s) responsible for logistics (invitations, materials for distribution, room arrangements, food, child care, etc.):</p> <p>Person responsible for note taking during the session and report writing:</p>
Where will the workshop be held?	
When will it be held?	
How and when will people be invited?	
Will food be provided?	
Will child care be needed?	
What equipment and materials will be needed?	
How much will the workshop cost?	

Worksheet 4.3
Analysis Worksheet

An example of a possible *Community Analysis Worksheet* is shown below with a blank form for you to complete on the following page. This type of worksheet can help workshop participants to state a problem, name contributing causes, identify individuals who are involved in decision making, document values and beliefs related to the problem, and consider possible program interventions. Participants can use this worksheet to begin planning breastfeeding interventions at the community level.

Example of a Community Analysis Worksheet

Selected Breastfeeding Program Interventions from the Profamily Nutrition Project, Sealandia				
Problem	Possible Causes	Control of Decisions	Values and Beliefs	Program Interventions
Short duration of exclusive breastfeeding	Lack of awareness of immunological advantages of breastfeeding	Teachers, media	Women do not produce important things	Radio jingles, curriculum reform
	Lack of knowledge of breastfeeding as a food	Teachers, media, health workers	Same	Advertising campaign, community mobilization, community day care, curriculum reform
	Too much work for mother	Family, community	Lack of importance of mother work or respect for women	Development of co-ops, participation of fathers in child care, counseling on milk extraction
	Belief that babies need water	Mother, grandmother?	Water is life-giving	Educational poster, counseling, radio campaign
	Belief that baby's frequent waking means insufficient milk	Mother, father?	Milk is not sustaining; children need to sleep all night	Postpartum home visits in first week, counseling, radio soap opera on sleeping with baby

Record in the table below the workshop participants' assessment of the reasons for poor infant health and nutrition in their community and their proposed interventions for addressing the problems. How can community-based breastfeeding counseling and support help in addressing these problems? Review the example on the previous page.

Community Analysis Worksheet

Problem	Possible Causes	Control of Decisions	Values and Beliefs	Program Interventions

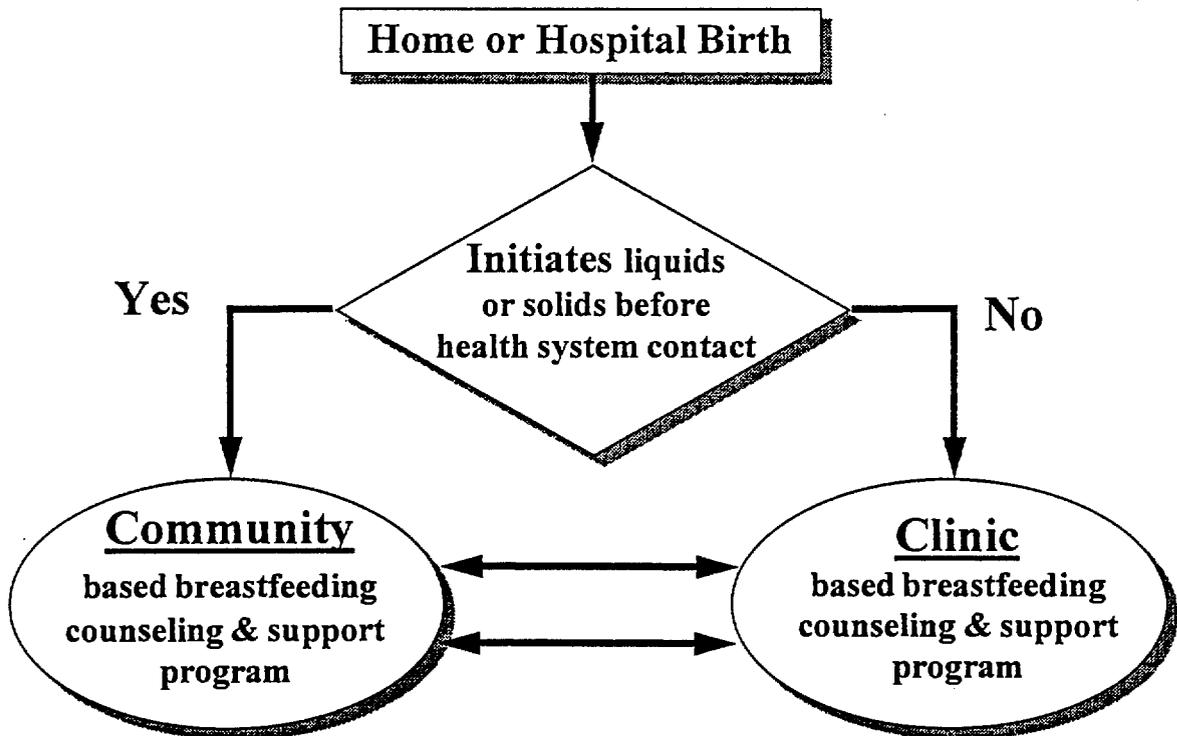
**Worksheet 4.4
Decision Models**

Visual presentations can be an aid in workshop discussions. Below is an example of a decision model. The model addresses the questions:

- When do mothers initiate other liquids or solids?
- When do mothers have postpartum contact with the health system?

Looking at the interplay of these two factors -- duration of exclusive breastfeeding and postpartum contact with the health system -- will help you decide whether your breastfeeding support system should be initiated by the hospital or clinic or by a community-based organization. As the following decision model illustrates, emphasizing community or hospital/clinic-based activities really depends on whether mothers initiate other liquids or solids before they have contact with formal health system personnel.

Create your own decision model. Pose a question and illustrate the options.



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Chapter Five

Setting Goals and Objectives

In any health intervention, there are recommended steps to ensure that the program focuses on a clearly defined problem with specific goals and measurable objectives. In developing goals and objectives for a community-based breastfeeding program, it is important to continue working closely with the community and with others who will be collaborating with the program. This chapter leads you through this process.

I. Program design	5-2
A. Statement of the problem	5-2
B. Agreement on the goals	5-3
C. Development of the objectives	5-3
D. Agreement on the strategy	5-4
E. Selection of the activities	5-7
 Worksheet	 5-11

I. Program Design

The planning process described up to this point included a community assessment (Chapter 3) followed by a workshop to discuss the assessment findings (Chapter 4). During the workshop, participants identified problems, possible causes, and potential target groups and interventions. The task of the planning group, formed at the conclusion of the workshop, is to take the ideas that emerged during the workshop and develop a Plan of Action. This plan states the goals, objectives, strategies, and activities of the program. Steps in the development of this plan are described below.

A. Statement of the problem

The first step is to state the problem. A problem statement provides focus and direction for an intervention. It should articulate concerns about the health and nutritional status of infants and children in the community that are related to breastfeeding practices. Generally, an intervention or project will only have one problem statement. An effective problem statement does the following:

- Concisely states a situation that needs to be changed.
- States who or what is affected.
- Quantifies the problem (how many or how much).
- Addresses organizational needs or purposes.

An example of a problem statement that would apply to many communities throughout the world is shown below. For purposes of illustration, the country is called "Sealandia."

EXAMPLE:

Problem statement -- Low levels of exclusive breastfeeding are common in urban and rural areas of Sealandia. Both women who deliver in hospitals and at home abandon exclusive breastfeeding before postpartum contact with health personnel. As a result of suboptimal breastfeeding practices, diarrhea is common in young infants who average two episodes within the first six months. Furthermore, mothers do not experience the full fertility-reducing benefits from optimal breastfeeding. This is of particular concern because only 30% of the women who deliver in any given year use an effective method of family planning.

B. Agreement on the goals

Once the problem is clearly stated, your goal should describe the desired long-term outcome of the intervention or program. The goal should address the issues raised in the problem statement and answer the question: "What result do we want?." There may be several goals for an intervention. Below is an example of a goal based on the problem statement shown above.

EXAMPLE:

Goal -- To increase birth intervals, improve infant nutritional status, and reduce infant morbidity and mortality through improvements in breastfeeding practices.

C. Development of the objectives

Objectives are a series of specific, measurable achievements that are needed to reach the program goal. They are stated in much greater detail than the goal and are time-bound. In other words, they are to be achieved in a certain number of weeks, months, or years.

The clearer the objectives, the easier it is to plan and implement activities that will lead to achievement of these objectives. Writing clear objectives also makes it easier to monitor progress and evaluate the success of the program. Objectives should answer the following questions:

- When will the objective be accomplished? (time reference)
- What will be accomplished? (measurable results)
- Where will the objective be accomplished? (target population/area)

An example of one objective to meet the goal stated above is the following:

EXAMPLE:

Objective --

When? By December 1992

What? the rates of exclusive breastfeeding will increase from 20 percent to 40 percent

Where? among mothers of infants ages 0-6 months from three communities near Santiago, Sealandia.

As a final check on writing objectives, make sure that they are:

- time-bound,
- measurable,
- area and population specific, and
- realistically achievable.

Remember that there can be more than one objective for achieving a goal.

D. Agreement on the strategy

The next step is to agree on the strategy or strategies needed to achieve the objective. A strategy is the approach that will be used to address the problem. Choices about the best way of working in a given community and the appropriate mix of interventions will depend on the local situation, local problems, etc.

To assist in this task, an international committee identified seven basic strategies for implementing breastfeeding programs¹. This framework can be helpful when considering various strategies. The seven strategies are briefly described below.

1. **Promotion** uses mass media, social mobilization, and information, education, and communication materials to reinforce acceptable cultural behaviors regarding breastfeeding and to move toward desirable behaviors that are not being practiced.

¹*Lactancia Materna, Lineamientos Estrategicos: Plan Regional de Acciones Integradas en la Promoción, Protección y Apoyo de la Lactancia Materna en América Latina y el Caribe: (PRAIL-LAC), 1995, Wellstart International, Washington, DC.*

2. **Protection** refers to policies and legislation that protect a women's right to optimally breastfeed. Examples of supportive policies are paid maternity leave, child care and breastfeeding breaks at the workplace, and regulation of the marketing of breastmilk substitutes.
3. **Support** is assistance, encouragement, and problem solving, individually or in a group.
4. **Coordination** is collaboration between sectors and agencies to foster the effective use of resources and a clear understanding of duties and responsibilities.
5. **Information** is the collection, analysis, and dissemination of epidemiological, anthropological, cultural, social, and health services data to assist informed decision making. Utilizing the information strategy is central to monitoring and evaluation.
6. **Education** is the process of knowledge transfer in formal and informal settings. Curriculum reform is part of this strategy.
7. **Research** assists in documenting experience, testing interventions, or evaluating programs and practices.

One or more strategies may be needed to reach an objective. A large organization, such as a Ministry of Health, may decide to use all of the strategies. A smaller organization may concentrate on only one or two strategies or may apply various strategies sequentially.

The suggestions for interventions made by participants at a community assessment workshop serve as a starting point for a planning group's discussion of possible strategies. Table 5.1 is an example of ideas for increasing the rates of exclusive breastfeeding that might be suggested during a brainstorming session at an assessment workshop. The proposed interventions shown in Table 5.1 focus primarily on four strategies:

- Promotion: mass media and community education
- Protection: child care
- Support: counseling and home visits
- Education: curriculum reform

The task of the planning group is to determine which strategies to concentrate on. This decision will be influenced by the organization's priorities, target population, and resources. The planning group will also want to consider whether the strategy complements and reinforces other activities in the community to support breastfeeding.

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Table 5.1
Example of Interventions Suggested for Increasing the Rates of Exclusive Breastfeeding Suggested during a Community Assessment Workshop

Possible Causes	Potential Target Groups	Possible Program Interventions
Lack of awareness of immunological advantages of breastfeeding	Teachers, media	Radio jingles, curriculum reform
Lack of knowledge of breastfeeding as a food	Teachers, media, health worker	Advertising campaign, community mobilization, community day care, curriculum reform
Too much workload for mother	Family, community	Development of co-ops, participation of father in child care, counseling on milk extraction
Belief that babies need water	Mother, grandmother?	Educational poster, counseling, radio campaign
Belief that baby's frequent waking means insufficient milk	Mother, father ??	Post-partum home visits in the first week, counseling, radio soap opera on sleeping with baby

In the example of "Sealandia" presented in this chapter, the decision was to select mothers as the target group and to provide them with the support that they need to practice exclusive breastfeeding. This strategy is shown below.

Example:

Strategy -- Provide breastfeeding counseling to pregnant women and mothers of infants through the use of trained, volunteer breastfeeding counselors

E. Selection of activities

The activities will be the key interventions for applying the strategy. They should be chosen with careful thought to ensure that the interventions are appropriate for the communities chosen and are an effective means for bringing about change.

In selecting program activities, it will be helpful to ask the following questions:

- Who are the target groups?
- How many people do these target groups include?
- Who will contact them?
- When will they be contacted?
- Where will they be contacted?
- What takes place during a contact?
- How will follow-up contacts be made?
- How will you know that the contact was successful?

Programs to improve breastfeeding practices often use several strategies and include a variety of activities such as individual counseling, support groups, and community education. These activities may be carried out as part of other community health efforts or as discrete activities focused primarily on breastfeeding. Table 5.2 lists the most common activities of breastfeeding community workers and their supervisors. These activities are discussed in greater detail in Chapters 8 and 10 and in the companion manual, *Community-based Breastfeeding Support: A Guide for Trainers and Supervisors*.

Table 5.2
Activities of Community-based Breastfeeding Community Workers and their Supervisors

Activity	Community Workers	Supervisor/Mentor
Individual Counseling Home visits Clinic visits	Observe home conditions for constraints to optimal infant feeding choices; build rapport with families	Observe a home visit monthly; provide feedback to counselor; work together to find ways to improve her counseling
	Treat breastfeeding problems; help with child feeding concerns	Provide backup support for difficult cases
	Refer for health care	Check on referral
	Invite to group meetings	See if invitation is accepted; if not, investigate why
Support Group Meetings	Provide correct information on optimal infant feeding; facilitate peer support; discuss feeding problems; build leadership skills	Observe a support group monthly and help counselor
	Refer for immunization, family planning, prenatal care (preventive); refer for illness (diarrhea, ARI, malaria) (curative)	Meet with health center to assure referral system is working well
Community Education	Educate and motivate secondary targets	Observe session periodically and help community worker
Community Mapping	Locate homes of pregnant women and those with young children	Help counselor interact with the community
Monitoring	Complete monitoring form	Review monitoring form with counselor; distribute new materials and forms

Source: Revised from URC. Module 3. Planning and Assessing Health Worker Activities. p. 35.

In our example of "Sealandia," the activities selected were home visits, groups meetings, and informal contacts. As a summary of the chapter, Box 5.1 combines the various elements of the Plan of Action. After studying the example and reviewing the guidelines presented in this chapter, use Worksheet 5.1 to write down the problem statement, goals, objectives, and activities. After this activity, you will be ready to develop the workplan, the subject of Chapter 6.

Box 5.1

Breastfeeding Promotion Program in Sealandia

The Problem:	Low levels of exclusive breastfeeding are common in urban and rural areas of Sealandia. Both women who deliver in hospitals and at home abandon exclusive breastfeeding before postpartum contact with health personnel. As a result of suboptimal breastfeeding practices, diarrhea is common in young infants who average two episodes within the first six months. Furthermore, mothers do not experience the full fertility-reducing benefits from optimal breastfeeding. This is of particular concern because only 30% of the women who deliver in any given year use an effective method of family planning.
The Goal:	To increase birth intervals, improve infant nutritional status, and reduce infant morbidity and mortality through improvements in breastfeeding practices.
The Objectives:	
When?	By December 1996
What?	the rates of exclusive breastfeeding will increase from 20 percent to 40 percent
Where?	among mothers of infants ages 0-6 months from three communities near Santiago, Sealandia
The Strategy:	Provide breastfeeding counseling to pregnant women and mothers of infants through the use of trained, volunteer breastfeeding counselors.
The Activities:	Home visits Mother support groups Informal contacts

Worksheet for Chapter Five: Setting Goals and Objectives

1) Write a problem statement. Base it on the results of any assessments on breastfeeding practices that have been conducted in your country/region/community.

Problem Statement:

2) List one goal to address the problem.

Goal:

3) Develop at least two objectives for achieving the goal. Do your objectives answer the questions: When? What? Where?

Objective 1:

When?

What?

Where?

Objective 2:

When?

What?

Where?

4) Consider the seven strategies: promotion, protection, support, coordination, information, education, and research. Which ones will you use to reach your stated goal? Write down your strategy or strategies.

The Strategy:

5) Look at each of your objectives. List three activities. Remember, they are the key interventions for applying the strategy.

The Activities:

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Chapter Six

Developing and Using a Workplan

Careful and thoughtful development of a detailed workplan is an important step in the planning process. A workplan, also referred to as an operational plan, is developed on an annual basis. It provides a framework for activities at several levels, moving from the more general to the specific, and links program goals and objectives to the implementation of activities in the community.

This chapter discusses the features of a good workplan and ways of using it as a management tool. In addition, it provides detailed guidelines for calculating the number of community workers needed to implement community-based breastfeeding activities.

I. Development of a workplan	6-2
A. Listing of activities	6-2
B. Timing of activities	6-3
C. Identification of resource requirements	6-3
II. Use of a workplan	6-4
Worksheets	6-7

I. Development of a workplan

A good workplan is an indispensable guide for the implementation of a program. It is the final outcome of earlier stages in the planning process: the community assessment, the assessment workshop, and the identification of goals, objectives, strategies and key activities (see Chapters 3 - 5). Worksheet 6.1 provides an example of a workplan.

In most community-based programs, the workplan is developed by a planning group made up of program staff and volunteers. In preparing a workplan, the planning group should consider the following questions¹:

- What are the most important activities to include in the workplan?
- In what sequence should these activities be carried out?
- In what detail do the activities need to be described in the workplan?
- Do the people to whom the activities are assigned have the skills and the time to carry them out effectively?
- How much will it cost to carry out the activities? Are the resources available?

The planning group will need to determine the detail, sequence, and timing of activities and identify personnel and resources needed to implement them. These responsibilities are discussed below.

A. Listing of activities

The selection of key activities is part of the process of defining goals, objectives, and strategies, described in Chapter 5. A workplan is a detailed accounting of the actions that are necessary to implement the key activities and achieve the program goals and objectives.

In the example given in the last chapter, the strategy was to use trained, volunteer counselors to provide breastfeeding counseling through three main activities: home visits, mother support groups, and informal contacts. If this is to happen, many actions are required. Foremost among them is training of the counselors. The workplan lists the actions required, such as development of a training plan, selection of a curriculum, training of trainers, identification of workshop participants, etc. This detailing of actions applies in other areas, such as supervision.

¹Adapted from: The Family Planning Manager's Handbook, Chapter Two--Developing and Using Workplans. Management Sciences for Health, 1991.

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The range of potential activities should be analyzed and discussed by those who will implement the program. This discussion will help community workers to understand why certain actions are necessary and to assess realistically their own time commitment.

B. Timing of activities

- *Sequence of activities*

Once it is decided which activities are to be implemented during a particular year, it is important to determine the right order in which to implement them and to break them down into manageable tasks. Some activities must be carried out before others; some can occur at the same time. In the initial stages of developing the workplan, it is worth the time and effort to ensure that the right sequence of activities is adopted.

- *Development of a time schedule*

For some interventions, the time frame for implementation will be pre-determined, often at three or five year intervals. This is particularly true when breastfeeding support activities are conducted in combination with other maternal or child health activities or are tied to the funding cycles of donors.

The length of time allocated for the intervention will determine how "tight" the scheduling will be. The earliest starting date for each activity and its completion date should be included in the workplan. Since start up and implementation often take longer than expected, it is wise to allow additional time for activities.

A chronogram or Gantt chart is a concise representation of the program's activities and the time schedule for implementation. It is a comparatively simple technique, often used in small programs. Worksheet 6.2 gives an example of a chronogram.

C. Identification of resource requirements

Another function of the workplan is to identify individuals responsible for implementing the activities and to project resource requirements. Resources include personnel, facilities, equipment, and materials.

In order to project resource requirements, tasks must first be assigned to the program manager, administrative staff, supervisors, trainers, and service providers (community workers). The number of supervisors and trainers that will be needed depends on the number of community workers.

The number of community workers depends on the:

- Size of the target groups
- Types of interventions (group meetings, individual counseling, etc.)
- Desired number and frequency of contacts
- Type of service provider (paid or volunteer, full-time or part-time, or multi-purpose worker or breastfeeding counselor)

A critical decision to make is whether to use paid community workers or volunteers. This decision affects many aspects of the program. For instance, there is often a high turnover rate with volunteers, increasing training requirements and costs. Since most volunteers work part time, more counselors are needed to reach the target population. A large network of volunteer counselors also requires more supervisors.

To calculate the number of community workers needed in a breastfeeding counseling program, refer to the guidelines in Worksheets 6.3 at the end of this chapter. Instructions for determining other personnel requirements are provided in Chapter 9, "Developing a Training Workplan," and Chapter 10, "Designing a Supervisory System."

Other chapters in this manual may also be of assistance in developing the workplan. Chapter 8, "Utilizing Human Resources," discusses the advantages and disadvantages of using different types of service providers. Chapter 7, "Preparing the Budget," lists materials and equipment frequently needed to support and implement community-based breastfeeding activities. Chapter 11, "Monitoring and Evaluating the Program," identifies indicators for measuring the outcome of the activities.

II. Use of the Workplan

Once the workplan is developed, it becomes a management tool that can be used by the program director, staff, and volunteers. The workplan can serve the following purposes:

- *Sequencing and scheduling activities*

The workplan assists a staff member in developing an individual workplan and setting priorities for the month.

- *Monitoring progress in the implementation of planned activities*

The manager can refer to the workplan to see if activities are proceeding as planned.

If the activities are not on schedule, adjustments may need to be made to the activity plan or the timetable.

- *Monitoring the budget and expenses*

Regular review of the workplan offers a status report on resources used and remaining budget allocations.

- *Measuring program objectives and performance objectives of staff and volunteers*

The workplan establishes benchmarks. It lists the activities that need to be completed by a certain date and the persons responsible for their completion. Thus, the workplan serves as a checkpoint for determining individual accomplishments.

- *Identifying problems and weaknesses in the program*

The workplan can identify activities that never occurred, lagged behind schedule, or consumed more resources than anticipated. Review of the workplan alerts the program manager to problem areas that may need to be reassessed or revised.

The workplan will only serve the functions outlined above if it is carefully developed and viewed as a working document. As a summary of the chapter, Box 6.1 lists the main features of a good workplan.

Box 6.1

Features of a Good Workplan

- Clearly states the objectives of the selected interventions
- Lists all the activities to be undertaken to achieve the objectives
- Identifies the individuals responsible for implementing the activities
- Projects the resource requirements
- Provides a time schedule for implementation
- Identifies clear indicators for measurement of the outcome of the intervention (see Chapter 11)

Worksheets for Chapter Six: Developing and Using a Workplan
Worksheet 6.1 - Example
Development of a Workplan

Study the sample workplan below. Then use the form on the next page to schedule activities, assign tasks, and identify resources needed to complete your activities.

Example of a Workplan for a Community-based Breastfeeding Support Program

Project Activities	Month/week	Persons responsible	Cost/resources needed
1. Recruit and train 2 persons with knowledge and experience in breastfeeding	January	Program Director	Mobilization & coordination costs
2. Develop and pre-test training materials and curriculum	January, February	Program Director & Trainers	Recruitment and training costs
3. Identify people to work as community workers	February, March	Trainers	Recruitment costs
4. Train 50 community workers in counseling techniques and community-level breastfeeding management	March to July	Trainers	Workshop costs
5. Update mapping in community to identify pregnant women and mothers of infants	July	Community workers	Paper, pens, etc.
6. Begin individual counseling	July-August onwards	Community workers	Honoraria?, travel costs
7. Supervise community workers and monitor activities	July onwards	Supervisors	Supervision costs, travel costs, etc.
8. Train community workers in support group organization and facilitation	September onwards	Trainers	Training costs
9. Initiate mothers' support groups	October onwards	Community workers	Refreshments?
10. Conduct and monitor community education sessions	September onwards	Community workers	Audiovisuals
11. Conduct in-service training for community workers	November	Trainers	Workshop costs

Worksheet 6.1 - Form
Workplan for a Community-based Breastfeeding Support Program

Project Activities	Month/week	Persons responsible	Cost/resources needed

**Worksheet 6.2- Example
Development of a Timeline of Activities**

Below is an example of a timeline or chronogram based on the activities identified in the sample workplan shown in Worksheet 6.1. Transfer the information from your workplan to the worksheet on the following page.

Example of a Timeline of Program Activities

Activities	J	F	Mr	A	My	Jn	Jy	A	S	O	N	D
1. Recruit and train 2 persons with knowledge and experience in breastfeeding	X											
2. Develop and pre-test training materials and curriculum	X	X										
3. Identify people to work as community workers		X	X									
4. Train 50 community workers in counseling techniques and community-level breastfeeding management			X	X	X	X	X					
5. Update mapping in community to identify pregnant women and mothers of infants							X					
6. Begin individual counseling							X	X				
7. Supervise community workers and monitor activities							X	X	X	X	X	X
8. Train community workers in support group organization and facilitation									X	X	X	X
9. Initiate mothers' support groups										X	X	X
10. Conduct and monitor community education sessions									X	X	X	X
11. Conduct in-service training for community workers											X	

Worksheet 6.3
Determining the Number of Community Workers Needed

Worksheet 6.3 provides guidelines for calculating the number of community workers, supervisors needed in a community-based breastfeeding support program. The worksheet is divided into four sections:

- Part I** **Guidelines** for calculating the number of workers needed, drawing upon the experience of various projects

- Part II** **Assumptions** used in making the calculations

- Part III** **Example** based on the assumptions

- Part IV** **Form** for you to complete

The guidelines identify issues you will want to consider. They should be adapted to reflect the local situation and the experience of community workers in your area. For example, 30 minute home visits may underestimate the time needed to counsel mothers. Replace "30 minutes" in the guidelines with the time period that you feel is more realistic, and then adjust the other figures accordingly.

Worksheet 6.3 - Guidelines
Determining the Number of Community Workers Needed
for a Counseling Program

Ratio of Community Workers to Target Population

- If home visits are to be undertaken, and the distances between houses are not too great, a suggested ratio is one full-time community worker for every 60 women who are either pregnant or the mother of a child less than 12 months of age.

Minimum Number of Volunteers per Community

- A volunteer peer counselor should not be required to work alone, nor should she be expected to carry out all of the health promotion functions that would be carried out by paid staff. At a minimum, any community should have at least two to three volunteers. They can be a peer counselor and two breastfeeding advocates or one peer counselor and two growth monitoring promoters with breastfeeding support training.

Volunteer Time

- If a volunteer peer counselor works out of a community-based clinic, she should not be expected to volunteer for more than one day a week. In this case, a program would need five to six volunteers.

Support Groups

- If support groups are a part of the intervention, at least two counselors should attend each support group meeting or community education session.
- Support groups should not have more than 10-12 attendees on a regular basis.
- Support groups may be held monthly or more often.
- An average support group meeting will take about two hours.

Home Visits

- An average home visit will last about 30 minutes.
- Peer counselors may make individual home visits to mothers monthly except during the first month postpartum when they may occur weekly or even more frequently. With pregnant women and older nursing mothers, attendance at a support group may substitute for a home visit.

Follow-up Training and Supervision Sessions

- Peer counselors/breastfeeding advocates should attend at least one follow-up training/supervision session each month.

Worksheet 6.3 - Assumptions
Determining the Number of Community Workers Needed
for Breastfeeding Counseling

In an average community of about 1,000 people, there will be about 60 women who are either pregnant or mothers of children under 12 months of age. These women make up the primary target population of a community counseling program.

- For the purposes of calculating the number of full-time community workers needed in a community program that will include individual counseling, you can assume that a full-time community worker works approximately 8 hours per day.
- Depending on whether the location is rural, urban, or clinic-based, the community worker may spend up to six hours in actual home visiting, clinic or telephone counseling and/or community education.
- If you assume that each counseling contact takes on average 30 minutes, the community worker may have up to two contacts per hour. In six hours, she can counsel up to 12 individuals (6 hours x 2 contacts per hour). So, a full-time community worker can theoretically contact up to 12 mothers per day. This may vary by location, depending on the social expectations in that community, cultural practices, season of the year, and other factors.
- In an average month, the full-time community worker may spend 20 days working. Out of these 20 days, she can spend at most 16 days in counseling activities and the other 4 days in training sessions, group meetings, and completion of paperwork.
- If the community worker carries out community education sessions systematically, time will need to be allocated for this activity. This will result in a reduction in the number of counseling sessions.
- If the full-time worker counsels 16 days per month and contacts an average of 12 women per day, she can make up to 192 counseling contacts in one month. These 192 counseling contacts do not necessarily represent 192 different women. On average, the community worker may see up to half of these women more than once. Therefore, a full-time counselor could work in one community (of about 60 target women in each community) in one month.

If part-time community-based workers or volunteers are used, the numbers needed for the target group will go up correspondingly.

Worksheet 6.3 - Example

Determination of the Number of Community Workers Needed	
Population of the project area:	10,000
Number of target women to be reached (60/1,000)*:	600
Number of counseling contacts ² : (12 contacts per day x 16 days per month = 192 contacts per month rounded to about 200 per month)	200
Number of full-time community workers needed:	$600 \div 200 = 3$

Determination of the Number of Part-time Community Workers Needed	
Population of the project area:	10,000
Number of target women to be reached (60/1,000):	600
Number of counseling contacts: (2 contacts per day x 12 days per month = 24 contacts per month)	24
Number of part-time community workers needed:	$600 \div 24 = 25$

* These assumptions are based on a 3% per annum birth rate. You will need to adjust the calculations to reflect your region's birth rate.

² You may want to change these assumptions, based on conditions in your area. For example, a full-time community worker may not be able to make 12 home visits per day if she has far to travel. If she works in a clinic or does telephone counseling, she may be able to make more contacts.

Worksheet 6.3 - Form
Determination of the Number of Community Workers Needed
in a Community-based Breastfeeding Program

Population of the project area: _____

Number of target women to be reached (60/1,000): _____

Number of monthly counseling contacts:
(? contacts per day x ? days per month = ? contacts per month) _____

Number of full-time community workers needed: _____

Chapter Seven

Preparing the Budget

In order to initiate and sustain your program, you will need to clearly understand how much it costs. Through the development of a budget, you will identify all the costs that are expected to result from implementation of the program's activities. A budget is linked to the workplan of activities, enabling the program manager to estimate annual costs. This chapter provides guidance for the preparation of the budget for the program.

I. Preparation of the budget	7-2
A. Personnel expenses	7-2
B. Travel and per diem expenses	7-3
C. Equipment and supplies expenses	7-4
D. Total expenses budget	7-6
E. Revenue budget	7-6
F. Financial assessment	7-7
Worksheets	7-9

I. Preparation of the budget

A budget is used to list, in monetary terms, the activities that will be undertaken in a program. It also serves as a tool for monitoring the financial status of the project throughout its lifetime. There is no single "correct" way to prepare a budget. Budgets are prepared in various ways, depending on standard procedures within an organization, the requirements of a donor, or other considerations. Some groups prepare budgets that relate to the objectives of a program while others base their calculations on the activities that will be undertaken. This manual uses the latter approach.

Previous steps in the planning process feed into the development of a budget. These steps, discussed in Chapter 6, include identification of key program activities, determination of resource requirements, and preparation of a workplan. A budget lists sources of revenue and assigns a cost to program activities, personnel expenses, and equipment and supplies. The various components of the budget are discussed below.

A. Personnel expenses

Personnel expenses include salaries of staff (people employed by the organization), fees of consultants (people who are hired independently), honoraria for trainers, bonuses, and fringe benefits. It may be helpful to consult an accountant familiar with program budgeting for advice about the best way to calculate personnel costs.

• Salaries

If your organization employs fewer than 20 people, list each staff person and his or her salary. If the organization is larger, you may want to list staff positions (such as supervisors, trainers, administrative staff, etc.) and then multiply the average salary level by the number of people in each position. Include in the annual salary any additional months that are paid. In many countries, there is a 13th and 14th month of salary paid in addition to the normal 12 months.

In calculating the salaries, it is important to factor in the percent of time (either full-time or part-time) that each staff person will work. You should not expect staff to work more than the time budgeted for them. At the same time, you should not pay staff for more than they actually work. Inaccurate budgeting of staff time can lead to loss of funds, dissatisfied staff, and high personnel turn-over.

• Fringe benefits

Fringe benefits are expenses that conform to local labor laws and are the usual policy and practice of the organization. Small organizations often overlook these costs which can represent a significant portion of the personnel budget (30% or more). Fringe benefits for staff are additional costs that include:

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- Payroll taxes paid by the employer,
- Vacation and sick leave,
- Unemployment insurance or a fund for severance pay and other required taxes/insurance, and
- Other benefits paid by the employer, such as health insurance, accident insurance, required social benefits, child care costs, pensions, etc.

The basis for the calculation of fringe benefits should be explained in the text that accompanies the budget. Some organizations calculate benefits as a fixed percentage of salaries and wages. An accountant can help determine what percentage of salary costs should be used to determine the costs of fringe benefits.

- *Consultant fees*

Often it is possible to hire consultants for short-term activities. For example, you may need to pay master trainers a consultant fee or provide honoraria for conducting short-term training activities. Because consultants do not need to be paid fringe benefits, it may be cheaper to use short-term consultants than to employ full-time staff. Program planners may want to consider seeking consultant fees as in-kind contributions from donors, who often find it easier to provide consultants than money.

B. Travel and per diem expenses

Travel expenses include the cost of transportation for staff, consultants, and volunteers related to program activities. There are several ways to budget for travel costs. You may need to include the purchase or lease of a vehicle or the purchase of bicycles or motorcycles for supervisors to use. If this is the case, you will want to consider how long, on average, each vehicle will last and the cost of replacement. You will also need to include the estimated costs of fuel, replacement parts for the vehicles, insurance, and taxes. Some guidelines for estimating vehicle costs are:

- Vehicles can be amortized over five years.
- Annual fuel costs can be estimated by calculating projected annual mileage/miles per gallon multiplied by the cost per gallon of fuel.
- Maintenance costs can be estimated using a share of the vehicle's replacement cost per year (10%).

If appropriate, the budget should include the costs of reimbursing staff for public transportation. You can do this by estimating the average number of trips for each type of staff and the cost of each trip.

Per diem expenses are the costs of room and board (lodging and meals when staff work outside of the area where they live). The per diem costs may be paid in two ways. You may want to reimburse staff for their actual expenses or give them a set amount for food and lodging. If you provide food during training sessions, the per diem costs paid to participants may be less. In this case, you will need to include food as an "equipment and supplies" expense.

C. Equipment and supplies expenses

Lists of equipment and supplies for the program are also needed to prepare the expense budget. If you are starting up a program, you will need to buy or rent/purchase some basic equipment such as telephones, computer, fax, modem, and photocopier. The budget for the supplies expenses can be based on a per item cost, such as US\$ 2 per training manual. For items such as clip-boards, paper, and pens, you can estimate their cost in a line item called "stationery."

Annual costs for computer diskettes, e-mail services, paper, ink cartridges, and annual preventive and corrective maintenance costs for computers and telephones should be included. You may want to include the cost of repair maintenance/replacement of computers, photocopiers, etc. in your budget. If a project will use existing computers and telephones, the budget either should consider these under "overhead costs" or assign a share of replacement costs to the project. If equipment is donated to the project, this can be reflected in the revenue budget as a "gift," enabling the expense budget to reflect more accurately total project costs.

Box 7.1 lists the equipment and material frequently used in breastfeeding counseling and support programs.

Box 7.1

**Illustrative List of Materials and Equipment
to Include in Budget Calculations**

• ***Administration***

- Office rental, office equipment (for example, a typewriter, chairs, desks) and office supplies (pens, paper, stationery)

• ***Training Materials***

- Reference manuals
- Teaching materials (flip charts, slides, dolls, models of breasts, posters of fetal development, etc.)
- Child care (staff to care for children and child care materials, such as toys, sleeping mats, and a separate location for child care)
- Snacks, refreshments for training breaks
- Reimbursement for travel and lodging
- Reimbursement for food for trainees
- Diplomas and identification markers such (signs for the house, a pin worn by the counselor, or both)
- Stipend

• ***Counseling***

- Counseling cards
- Breast pumps
- Food for cooking demonstrations
- Breastfeeding dolls, models of breasts, baby carriers
- Incentives (such as clothing, food rations, free medical services)

• ***Supervision***

- Transportation to field sites
- Reimbursement for food and lodging

• ***Monitoring and Evaluation***

- Monitoring forms
- Computer
- Transportation

D. Total expenses budget

Once the individual budget components have been prepared, you can calculate the total budget by combining the figures from the personnel; travel and per diem; and equipment and supplies budgets and adding the administrative costs. Most organizations have costs that are not necessarily related to only the community-based outreach program. For example, breastfeeding counseling and support may be one of a number of activities sponsored by an organization. Hence, costs such as office rent, utilities, and telephone hook-up service charges need to be prorated among the program activities.

One way of distributing these costs is to estimate the percentage of the services and facilities that will be used in each project. Use this percentage in calculating the amount of administrative costs that should be attributed to a project.

Another way of distributing costs is to determine the "overhead." Overhead is made up of the administrative costs of running a program and includes rent, utilities, telephone charges, and any other general costs necessary for the operation of the organization. The organization's total annual budget divided by the administrative costs will give the percent that can be attributed to overhead.¹ Because it is often difficult to figure out how much of the rent and other general expenses should be billed to one program, an accountant can help determine the overhead. In a Ministry of Health project, you may not need to include overhead costs in your budget.

E. Revenue budget

In addition to the preparation of the expense budget, you will need to develop a revenue (income) budget. The revenue budget lists the source of funds for the program. If the project is a part of the MOH, the Ministry may pay the salary costs of staff, but the program may need to identify funds for the training of volunteer counselors.

It is often helpful for fundraising to set up the expense and revenue budgets so that they are directly linked. In this way, a donor can identify its contribution with a particular input, activity, and even with the achievement of a specific objective. For example, it might be appealing for program planners to be able to tell a donor that it is financing motorcycles that will provide 50 breastfeeding community workers with the transportation to reach 5,000 mothers. This linkage of expenses with revenues and with activities is helpful for defending budgetary allocations as well. It enables

¹For example, if an overall budget is \$100,000 and administrative costs total \$20,000, then the overhead rate is calculated by dividing 100,000 by 20,000 ($20,000/100,000 = 1/5$ or 20%).

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a MOH project manager, for example, to say to the Minister that a cut of 10% will lead to 2,000 fewer mothers receiving monthly counseling over the next year.

F. Financial assessment

Once budget calculations are complete, you can compare the available or projected resources (income) with the budgeted costs. If adequate income is lacking to cover all the costs of the program, it will be necessary to consider alternatives. When available funds are insufficient, it may be possible to find other ways to meet some of the needed resources rather than paying for them. For instance, training materials may be available free from UNICEF or the World Health Organization. It may be possible to share travel costs for supervision with other nongovernmental organizations (NGOs) working in the area. Sites for training sessions may be available at no charge from local churches or other local organizations.

Lack of resources is a major issue in any community program. Funding sources may vary by location and can change from year to year. No one solution will be the answer for every program. However, because adequate, reliable funding is often hard to find and maintain, it is necessary to make decisions about which activities are the most important ones. Based on these priorities, you can then make decisions about what the program can afford to do. Box 7.2 lists four issues to consider in setting priorities for the project and determining the best use of limited funds.

Box 7.2

Issues to Consider in Setting Project Priorities

Coverage:	How many people do we want to reach? How frequently should contacts be made? Are there groups that are particularly "at risk"?
Activities:	Which activities are likely to have the greatest impact?
Staff Qualifications:	How much training should staff receive? What previous training should be required of staff?
Quality of Services:	How important is quality of service compared to coverage? How frequent should supervision be?

The potential consequences of these decisions, discussed on the following page, should be considered when determining program priorities.

- ***Less highly trained workers*** will need more on-going training and supervision than more highly trained staff. Volunteer workers usually cannot work as many hours as paid workers; therefore, more workers will be needed to reach the population. Because of time constraints, volunteer community workers may limit their activities to group meetings or reserve home visits for women with particular problems. The drop-out rate may be higher for volunteers than for paid staff.
- ***Infrequent supervision*** can result in morale problems among counselors, high staff turnover, and a reduced quality of services. High turnover can increase training costs since more community workers will need to be trained to replace those that drop out.
- ***Reduction in the size of the project area*** means lower coverage and a higher cost per woman reached by project.
- ***Fewer activities*** can limit breastfeeding promotion and support at all levels: individual, group, family, and community.

Project priorities may change over time and will certainly be affected by the level of funding available to the project. In many small projects, funding levels and sources may change from year to year, so it is important to be creative about ways of supporting the program's activities.

Worksheets for Chapter Seven: Preparing the Budget

There are five worksheets to guide you through the budgeting process. The budget categories and level of detail will depend on the size of the program and the organization's resources. Select the budget line items that are appropriate for your organization.

Use Worksheets 7.1 - 7.3 to calculate the costs of your program. Transfer the figures from these three worksheets to Worksheet 7.4 to find the total expense budget for your project. Worksheet 7.5 provides a format for a revenue budget. Examples of project budgets are provided for each worksheet. The Worksheets in this chapter are:

- Worksheet 7.1: Personnel Costs
- Worksheet 7.2: Travel and Per Diem Expenses
- Worksheet 7.3: Equipment and Supply Costs
- Worksheet 7.4: Total Expense Budget
- Worksheet 7.5: Revenue Budget

**Example 7.1: Personnel Costs
Budgeting for Staff and Consultants**

Budget Item: Staff	Salary/year¹	No. of Staff²	Cost per year
Community workers	volunteer (\$0)	20	\$ 0
Supervisors	\$2000	2	\$4000
Trainers	\$2000	2	\$4000
Evaluation/monitoring staff: Evaluation specialist	\$4000	1	\$4000
Data entry person	\$ 500	1	\$ 500
Administrative staff	\$ 500	.2 ³	\$ 100
Manager	\$5000	.2 ⁴	\$1000
Sub-total			\$13,600
Fringe Benefits ₄	20% of salary		\$ 2720
Total Staff costs			\$16,320
Budget Item: Consultant costs:			
Master Trainers	\$ 500	1	\$ 500
Accountant/auditor	\$ 500	1	\$ 500
Budget Item: Total personnel costs			\$17,320

¹ Include in the annual salary, any additional months that are paid (in many countries in Latin American, there is a 13th and 14th month of salary paid in addition to the normal 12 months).

² Full time staff. If part-time staff are used, calculate the number of full-time staff that would be used instead to do the budget. For example, if two part-time staff work 50% time, the number of full-time staff is 1.

³ The amount of time spent by administrative/management staff on this project should be estimated.

⁴ Fringe benefits include payroll taxes paid by the employer, vacation and sick leave, unemployment insurance and other required taxes/insurance, and other benefits paid by the employer, including health insurance, child care costs, pensions, etc.

Worksheet 7.1
Calculating Staff Costs

Staff	Salary/year¹	No. of Staff²	Amount
Community workers			
Supervisors			
Trainers			
Evaluation/monitoring staff: Evaluation specialist Data entry person			
Administrative staff ³			
Manager			
Sub-total			
Fringe Benefits ⁴			
Total Staff costs			
Consultant costs: Master Trainers Accountant/auditor Others			
Total personnel costs			

¹ Include in the annual salary, any additional months that are paid (in many countries in Latin American, there is a 13th and 14th month of salary paid in addition to the normal 12 months).

² Full time staff. If part-time staff are used, calculate the number of full-time staff that would be used instead to do the budget. For example, if two part-time staff work 50% time, the number of full-time staff is 1.

³ The amount of time spent by administrative/management staff should be estimated.

⁴ Fringe benefits include payroll taxes paid by the employer, vacation and sick leave, unemployment insurance and other required taxes/insurance, and other benefits paid by the employer, including health insurance, child care costs, pensions, etc.

Example 7.2
Calculating Travel and Per Diem Expenses

Budget Item: Travel and Per Diem	No. of trips = a	Cost per Trip = b	Cost per year = c; c = a x b
Travel			
<i>Supervision</i>			
Visits to community workers	20 community workers x 1 trip/supervisor/month x 12 months = 240 trips (for supervisors)	\$2	\$ 480
Monthly meetings of community workers	20 community workers x 1 trip per community worker x 12 months = 240 trips (for community workers)	\$2	\$ 480
Annual meeting of community workers	20 community workers x 1 trip/year = 20 trips	\$2	\$ 40
<i>Training</i>			
Community trainees	40 trainees x 1 trip = 40 trips	\$2	\$ 80
Supervisor trainees	2 supervisors x 1 trip = 2 trips	\$2	\$ 4
Support staff trainees	10 staff x 1 trip = 10 trips	\$2	\$ 20
<i>Monitoring</i>			
Program manager	12 trips	\$ 10 Fuel/trip \$ 100 lease of jeep/trip	\$ 122 \$1200
Sub-total Travel			\$2426
Per Diem			
<i>Supervision</i>			
Visits to community workers	240 trips (for supervisors)	\$5 per diem/trip	\$1200
Monthly meetings of community workers	240 trips (for community workers)	\$5 per diem/trip	\$1200
Annual meeting of community workers	20 trips	\$5 per diem/trip	\$ 100
<i>Training</i>			
Community trainees	40 trainees x 1 trip = 40 trips	\$5 per diem/trip	\$ 200
Supervisor trainees	2 supervisors x 1 trip = 2 trips	\$5 per diem/trip	\$ 10
Support staff trainees	10 staff x 1 trip = 10 trips	\$5 per diem/trip	\$ 50
<i>Monitoring</i>			
Program manager	12 trips	\$5 per diem/trip	\$ 60
Sub-total Per Diem			\$2820
Total Travel and Per Diem			\$5246

Worksheet 7.2
Calculating Travel and Per Diem Expenses

Budget Item: Travel and Per Diem	No. of trips = a	Cost per Trip = b	Cost per year = c c = a x b
Travel			
<i>Supervision</i>			
<i>Training</i>			
<i>Monitoring</i>			
Sub-total Travel			
Per Diem			
<i>Supervision</i>			
<i>Training</i>			
<i>Monitoring</i>			
Sub-total Per Diem			
Total Travel and Per Diem			

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Example 7.3
Calculating Equipment and Supply Costs

Budget Item: Equipment and Supplies	No. of Items	Cost per Item	First year cost
Equipment			
<i>Supervision</i>			
File cabinet	1	\$100	\$100
<i>Training</i>			
Slide Projector	1	\$200	\$200
<i>Monitoring</i>			
Computer and printer	1	\$1500	\$1500
Sub-total Equipment			\$1800
Supplies			
<i>Supervision</i>			
Supervisors manual	2	\$ 10	\$ 20
Clip-board, paper, pens		\$ 50	\$ 50
<i>Training</i>			
Reference manuals	20	\$ 10	\$ 200
Curriculum	2	\$ 25	\$ 50
Flip-charts, markers, paper		\$ 100	\$ 100
Food for training sessions		\$ 500	\$ 500
Toys and games for childcare		\$ 100	\$ 100
<i>Monitoring</i>			
Forms		\$ 500	\$ 500
Computer discs	2 boxes	\$ 15	\$ 30
Carbon paper, pens, clipboards		\$100	\$ 100
Sub-total Supplies			\$1650
Total Supplies and Equipment			\$3450

Worksheet 7.3
Calculating Equipment and Supply Costs

Budget Item: Equipment and Supplies	No. of Items	Cost per item	First year cost
Equipment			
<i>Supervision</i>			
<i>Training</i>			
<i>Monitoring</i>			
Sub-total Equipment			
Supplies			
<i>Supervision</i>			
<i>Training</i>			
<i>Monitoring</i>			
Sub-total Supplies			
Total Equipment and Supplies			

Example 7.4
Total First Year Expense Budget

Budget item	Amount
Personnel	
Staff	13,600
Fringe	2,720
Consultants	1,000
Sub-total Personnel	17,320
Travel and Per diem	
Travel	2,426
Per Diem	2,820
Sub-total Travel and per Diem	5,246
Equipment and Supplies	
Equipment	1,800
Supplies	1,650
Sub-total Equipment and Supplies	3,450
SUBTOTAL ALL	26,016
Overhead Costs⁵ (20%)	5,203
TOTAL	31,219

⁵Overhead costs include office rent, telephone/fax, utilities, and other expenses needed to maintain the organization that cannot be charged to one particular project.

Worksheet 7.4
Total Expense Budget

Budget item	Amount
Personnel	
Staff	
Fringe	
Consultants	
Sub-total Personnel	
Travel and Per diem	
Travel	
Per Diem	
Sub-total Travel and per Diem	
Equipment and Supplies	
Equipment	
Supplies	
Sub-total Equipment and Supplies	
SUBTOTAL ALL	
Overhead Costs⁶	
TOTAL	

⁶You will need to calculate the overhead rate for your program as described on page 7-6 of this chapter.

**Example 7.5
Revenue Budget**

Source of Funds	Purpose	Amount
Ministry of Health	Personnel	\$17,320
UNICEF	Training travel and supply costs	\$ 5,000
WHO	Training curriculum	\$ 200
UNICEF	Reference manuals	\$ 1,000
Fund raising events	Expenses not covered by project or donor	\$ 1,000
Fees for service/training health personnel	Expenses not covered by project or donor and cost recovery	\$ 500
Total		\$25,020

Worksheet 7.5
Revenue Budget

Source of Funds	Purpose	Amount
Total		

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Section III

Implementing the Workplan

- Chapter 8 Utilizing Human Resources**
- Chapter 9 Developing a Training Plan**
- Chapter 10 Designing a Supervisory System**
- Chapter 11 Monitoring and Evaluating the Program**
- Chapter 12 Sustaining the Program**

Chapter Eight

Utilizing Human Resources

Interested, committed people are at the heart of any successful program. In order to utilize human resources effectively, there must be a clear understanding of staff roles and responsibilities and an awareness of the desired qualities for personnel. This chapter identifies the human resources usually involved in community-based breastfeeding counseling and support. It also provides guidance on the preparation of job descriptions, the recruitment and selection of project staff, and personnel policies.

I. Categories of personnel	8-2
II. Preparation of a job description	8-5
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A. Program staff	8-6
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I. Categories of Personnel

As discussed in Chapter 2, breastfeeding support may be provided through breastfeeding promotion organizations, hospital outreach programs, primary health care services, informal community groups, and commercial enterprises. In general, these structures utilize some combination of the following five categories of personnel.

Manager	oversees administrative and management tasks, training, monitoring, and evaluation
Administrative staff	assure that supplies and equipment are in place and that logistics function smoothly
Supervisor	promotes continuing improvement of the community workers' performance
Trainer	teaches skills that will make community workers more competent in performing their job
Community-based Workers	guide, inform, and support families in their efforts to feed and care for their infants

Some managers of breastfeeding support activities have a staff in place that will assume responsibility for counseling, training, supervision, and administrative tasks. Other managers will need to recruit staff or volunteers. In both situations training, the subject of the next chapter, will likely be required to equip personnel for their new duties.

The personnel used to provide breastfeeding support services are often peer counselors, health care professionals, hospital-based health promoters, multi-purpose health care promoters, traditional health care providers, and breastfeeding advocates. Table 8.1 summarizes the characteristics of various types of service providers and the advantages and disadvantages of using each type of worker.

The type of worker that is selected depends on the program's objectives and target population. For instance, if the objective is to generate support for breastfeeding in the community, an individual with communications skills but no breastfeeding experience may be a good candidate for promoting breastfeeding at special community events. This person will not, however, be the best candidate for facilitating discussions at mother support group meetings. If the objective is to increase breastfeeding rates among adolescent mothers, the manager will need to determine whether adolescents respond best to someone who is a peer or to an older, more experienced mother.

Table 8.1
Providers of Breastfeeding Support Services

Provider	Common Characteristics	Advantages	Disadvantages
Peer counselors	<ul style="list-style-type: none"> • Women with current or recent breastfeeding experience • Similar socio-cultural characteristics as clients • May counsel in homes, hospitals, PHC facilities, mother support groups 	<ul style="list-style-type: none"> • Model optimal breastfeeding practices • Understand mothers' situation • Accessible 	<ul style="list-style-type: none"> • Often high turnover rates among volunteers • Part-time work limits number of contacts
Health care professionals	<ul style="list-style-type: none"> • Paid staff, may be lactation management specialist • Organize, implement, supervise outreach staff 	<ul style="list-style-type: none"> • Advice respected by mothers 	<ul style="list-style-type: none"> • Limited time per contact • Relatively higher costs
Hospital-based health promoters	<ul style="list-style-type: none"> • Auxiliary nurses • Bedside counseling • Referral to community support groups 	<ul style="list-style-type: none"> • Help mother initiate exclusive breastfeeding 	<ul style="list-style-type: none"> • Difficulty providing 24 hour service
Multi-purpose health care promoters	<ul style="list-style-type: none"> • May be affiliated with PHC facility or community, religious, family planning, or NGO 	<ul style="list-style-type: none"> • Integrated with other health services • Wider outreach 	<ul style="list-style-type: none"> • More limited breastfeeding support • May be distracted by other duties
Traditional health care providers	<ul style="list-style-type: none"> • TBAs, traditional healers, herbalists, etc. 	<ul style="list-style-type: none"> • Serve women least likely to attend PHC facility 	<ul style="list-style-type: none"> • May require special training curricula, materials, and trainers
Breastfeeding advocates	<ul style="list-style-type: none"> • Grandmothers, other women with no personal or recent breastfeeding experience • Supportive men 	<ul style="list-style-type: none"> • Broaden support network, reach secondary targets • May have special skills in community promotion and education 	<ul style="list-style-type: none"> • Usually not ideal candidates for facilitating breastfeeding support groups • May be reluctant to abandon harmful traditional practices

In choosing among the various types of providers of breastfeeding support services shown in Table 8.1, the following issues should be considered:

- *Single-purpose or multi-purpose providers*

Single-purpose workers may be able to provide more extensive counseling and support than multi-purpose workers. Multi-purpose workers, however, may contact more women and be better linked to other health services.

- *Paid or volunteer providers*

Community-based programs often depend on a network of volunteers. Some program managers object to asking women, who already are overworked, to volunteer for activities in the community that would be paid if undertaken by men. Others believe that dependence on volunteers may, in the long run, threaten a program's sustainability. Experience worldwide shows that workers who are paid for their services are more likely to remain in the program.

On the other hand, some programs find that volunteers demonstrate great commitment to the objectives of the program and continue to work long after active supervision ceases. Some managers are concerned that payment of community workers could upset the balance in the community if other organizations use volunteers for similar activities.

- *Literate or illiterate providers*

Record keeping is easier if a counselor can read and write. However, many illiterate women are excellent counselors; their other skills more than compensate for their lack of formal education. Program managers may decide to use illiterate women in roles that require minimal record keeping. Findings from the community assessment may indicate the appropriateness of using literate or non-literate providers. If young mothers agree that traditional birth attendants and grandmothers are the people they turn to most frequently for advice, it may be important to utilize their services even if their literacy level is lower than the level of younger women.

- *Full-time or part-time providers*

Full-time employment may give more continuity to a program, but part-time employment draws upon the rich experiences and skills of women who must also attend to home and other responsibilities. A large network of part-time workers increases the demands for training and supervision.

II. Preparation of a job description

Once you know the type of staff suitable to your program goals and target audience, you are ready to prepare job descriptions and recruit candidates. A job description defines the job holder's role and responsibilities. It states the position title, terms of service, qualifications, duties, and supervisory responsibilities. A clear job description helps to avoid confusion about who is expected to perform specific tasks.

In preparing a job description, you will need to list tasks to be performed by the staff member, identify desired qualifications, and indicate terms of service.

- *List tasks to be performed*

The first step in preparing a job description is to determine the roles of the various categories of workers. Based on these roles, a list should then be prepared with the tasks for each category of worker. Tasks should be distributed fairly; they should utilize the skills of each staff person.

- *Identify desired qualifications*

After listing the tasks to be performed for each category of worker, you will need to identify the level of experience, training, and skills required to complete these tasks. Certain skills are desired for the program manager, trainers, supervisors, and community-based workers. These key skills are:

- Trusted, respected member of the community
- Parental role model (good parenting skills and well-nourished children)
- Good communicator
- Advocate of optimal breastfeeding practices

Trainers and supervisors should be experienced working at the community level and be able to encourage and support community workers in a positive manner. They should be knowledgeable about optimal breastfeeding practices and appropriate counseling skills. Supervisors must be willing and able to travel frequently in order to provide on-going supervision.

Qualifications for community-based workers are discussed in detail in *Community-based Breastfeeding Support: A Guide for Trainers and Supervisors*, a companion document to this manual. Box 8.1 is a composite profile of successful breastfeeding counselors in peri-urban communities in Guatemala and Honduras.

Box 8.1

**Composite Profile of Successful Breastfeeding Counselors
in Peri-urban Communities in Guatemala and Honduras**

- Breastfeeding experience (six months or longer)
- Ideally, currently breastfeeding
- Believes in breastfeeding based on personal experience and desires to share conviction with others
- Recruited from existing support groups
- Respected community member
- Midwife or health promoter
- Articulate and self-confident
- Able to visit mothers to invite them to meetings
- Experience working with groups

Source: The Population Council, Data Pro. 1992.

• *Indicate terms of service*

A job description should state the terms of service (full-time or part-time position, paid or volunteer). Even for volunteers, it should give an estimate of the number of hours per week that they are expected to work.

Box 8.2 gives an example of a job description for a person who functioned as a supervisor and trainer in a breastfeeding counseling program through La Liga de la Leche Guatemala. Sample job descriptions for counselors and program managers are included with the worksheets at the end of the chapter.

III. Recruitment

A. Program staff

The program director, trainers, and supervisors should be selected before community-based workers are recruited. As noted in Chapter 6, the number of trainers and supervisors will depend on the number of community-based workers needed to carry out the activities. If individual counseling is not one of the activities, fewer community-workers, trainers, and supervisors will be needed.

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Box 8.2
Example of a Job Description for a Supervisor/Trainer
La Liga de la Leche Guatemala

1. POSITION TITLE <i>Trainer/supervisor</i>	2. POSITION STATUS Full-time; Permanent	3. DATE OF PREPARATION
4. POSITION SUMMARY: <i>To train and supervise volunteer breastfeeding counselors and their support groups among low income women in urban and peri-urban Guatemala City</i>		
5. REPORTS TO: Program Director	6. POSITIONS DIRECTLY SUPERVISED BY INCUMBENT Breastfeeding advocates	
<p>7. SPECIFY REQUIREMENTS:</p> <p>7.1 Education/professional qualifications <i>College degree; previous supervisory experience.</i></p> <p>7.2 Experience and training <i>Breastfed for at least one year; experience in conducting breastfeeding support groups; previous training experience.</i></p> <p>7.3 Knowledge, skills, ability <i>Good communication and parenting skills, interest in breastfeeding and infant health.</i></p>		
<p>8. DESCRIPTION OF DUTIES/RESPONSIBILITIES List duties under two separate headings: REGULAR and PERIODIC DUTIES:</p> <p>A. REGULAR DUTIES/RESPONSIBILITIES: <i>Train and supervise the breastfeeding advocates; Maintain an ongoing program of continuing education</i></p> <p>B. PERIODIC DUTIES/RESPONSIBILITIES <i>Observe on-going support group meetings; revise and review monitoring forms; participate in recruitment of new advocates; plan the annual meeting of advocates</i></p>		
9. PREPARED BY: 10. REVIEWED BY:	11. % TIME SPENT Supervision 80%; Training 20%	

Source: Aga Khan Foundation and University Research Corporation. Primary Health Care; Management Advancement Program. Module 3. Facilitator's Guide. p. 21. Example adapted from the La Liga de La Leche, Guatemala City.

With a new program, it will be necessary to find trainers and supervisors who have worked in other health programs. Staff can be recruited through informal networking, radio announcements, and job notices in local newspapers. Once the program has been operating, it may be possible to recruit trainers and supervisors among the experienced counselors.

For the position of program manager, the implementing agency may be able to recruit someone within the organization who has management experience and technical background in breastfeeding and community-based work. If the program manager is recruited outside of the implementing organization, candidates may be capable administrators with at least one year of experience promoting breastfeeding for a breastfeeding organization, health agency, or NGO. In the Ministry of Health, the program director may be the person responsible for breastfeeding in the Maternal and Child Health or Nutrition Division or the person responsible for the Baby Friendly Hospital Initiative. In a health center, the program director may be the head physician or nurse.

B. Community workers

Potential candidates for community workers can be recruited by:

- Seeking recommendations from informal and formal leaders in the community, health care providers, clinic attendants, nongovernmental organizations, and community groups;
- Notifying women already involved in health promotion (community health workers and traditional birth attendants);
- Contacting breastfeeding mothers and older, respected women; and
- Advising people about the program during presentations at mothers' clubs, neighborhood health committees, churches, schools, and other community groups.

In communities with organizational infrastructure, such as an NGO, a functioning health committee, a church or women's group, etc., you may want to hold an open meeting and elect volunteers. Many programs have found that volunteers who accept assignments from the community become very committed to the program.

Once community-based workers are selected and begin holding meetings, making home visits, and carrying out other breastfeeding support activities, they can recruit new community workers from existing mother support groups or through referral from other sources. Not all of those recruited as community workers will complete the recruitment

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and training process; therefore, it is necessary to recruit at least twice the number of individuals from each community than will likely be needed.

IV. Final selection

The final selection process will differ depending on whether the program will utilize full-time paid staff or a combination of paid staff and volunteers.

A. Paid staff

For paid staff, the selection process should include the establishment of selection criteria and a meeting to discuss the job and employee benefits. Selection criteria might include: years of experience, technical competency, skills in interpersonal relationships, initiative, level of enthusiasm and commitment to breastfeeding, work habits, and recommendations of previous employers.

In most programs, the final step in the selection process is a meeting between the manager and the applicant or an interview committee and the applicant. At this meeting, the job description should be discussed openly and frankly. This is the time to clarify job expectations and discuss employee benefits and working conditions.

As a program manager, you need to make sure that your organization's work environment and personnel policies are supportive of breastfeeding. When the staff are restricted from practicing optimal breastfeeding at the worksite, it is very difficult for them to encourage optimal practices within the community. Examples of supportive policies in the workplace are:

- Part-time employment
- Flexible hours
- Paid maternity leave for three or more months
- Job protection during maternity leave
- Provision of a comfortable and private place to express breastmilk
- Nursing breaks
- Permission for mothers to bring their infants with them to work
- Creches in organizations with 20 or more female employees

Many countries have national policies and legislation concerning maternity leave, creches in the workplace, and nursing breaks. The manager should learn about these policies and legislation and implement them within the organization. If none exists, the manager should at least be familiar with the policy issues and, if possible, initiate a dialogue with decision-makers. Policies are often developed in conjunction with the Baby Friendly Hospital Initiative.

B. Volunteers

Organizations have developed various selection criteria by which to evaluate candidates for volunteer positions. The criteria vary by organization as well as by the type of position. Volunteers are self-selected. In other words, they express interest and want to come to a training program. Two illustrations of selection criteria for community-based breastfeeding peer counselors are shown below in Box 8.3.

Box 8.3

Examples of Selection Criteria for Volunteer Breastfeeding Counselors

- NUNU, a nongovernmental organization in Argentina, requires that potential peer counselors attend 80 percent of the training sessions before being considered for final selection. In addition, they must make presentations on certain topics covered during the course. In this way, comprehension and communication skills can be evaluated.
- La Liga de la Leche Guatemala invites community women to attend a meeting where they discuss the proposed program. At this meeting, the women themselves decide on the criteria for the final selection of counselors, including the proportion of classes a counselor should attend. At the beginning of the next day's training, the trainees sign a contract agreeing to the terms that were outlined on the preceding day.

V. Follow-up

It is recommended that workers at all levels, including those based in the community, develop their own individual workplans. These workplans are derived from their job description and the annual workplan for the program (see Chapter 6). Individual workplans should list all planned activities, the sequence of those activities, and resources needed. At the community level, a worker should develop an individual workplan, in collaboration with the supervisor, based on planned activities, coverage area, the number of households to be visited or contacts to be made, travel time, and so on.

Worksheets for Chapter Eight: Utilizing Human Resources

**Worksheet 8.1
Service Providers Assessment**

A. For Health Service Providers, NGOs, Community Groups, and Commercial Enterprises

1. Consider the various types of health service providers:

- single and multi-purpose workers
- paid and volunteer workers
- literate and illiterate workers
- health professionals or health promoters

Which one of these service providers is involved with your organization? Do they provide breastfeeding support to your organizational clients?

2. If you had peer counselors or breastfeeding advocates, what new activities could you develop that would enhance your service delivery?

3. In your own organization, who can give support to the development of breastfeeding service delivery or the enhancement of existing service provider skills?

4. If you will need to develop new skills among your service providers or develop new types of providers, such as peer counselors, what organizations exist in your community to assist you?

B. For Breastfeeding Promotion and Support Organizations

1. What service providers do you have in your organization that could assist other organizations in enhancing their capacity to deliver breastfeeding support services?

2. What support do you need in order to be a more effective provider of breastfeeding support services to other organizations or to the public?

Worksheet 8.2
List of Tasks

Consider the role of each staff position. Next make a list of tasks needed to fulfill this role. Refer to the list of activities for counselors and supervisors in Chapter 5, Table 5.2. Chapter 9 discusses the tasks of trainers. Examples of administrative and counseling tasks are shown below.

List of Administrative and Management Tasks

- Plan program activities
- Manage the program operations

- Recruit, train and supervise staff
- Pay salaries; reimburse expenses
- Review personnel policies

- Establish linkages with the health care system, MOH, NGOs and policy making bodies

- Work with the board of directors (if supported by an NGO)
- Secure funds and report to funders
- Prepare the budget and manage finances

- Arrange logistics
- Order/reorder supplies
- Check inventories

List of Counselor's Tasks

- Identify pregnant women and mothers of children under six months or under twelve months of age (depending on the project strategy)
- Promote healthy behaviors and improved infant feeding practices
- Provide accurate information and practical ideas

- Organize group meetings and community education sessions to discuss the advantages of optimal breastfeeding and complementary feeding practices, management of normal feeding experiences, and specific concerns
- Encourage and support breastfeeding women through home visits and informal contacts
- Assist with growth monitoring and nutrition counseling
- Follow up on infants and children at risk of growth retardation
- Recognize problems and make timely referrals

- Maintain records
- Report to the supervisor
- Recruit and mentor new counselors

Worksheet 8.3
Preparation of a Job Description

Using the form below, fill in a job description for a staff position in your program. Refer to the example on page 8-6 and the worksheet examples that follow. Review what you have written and ask these questions:

- Is the job consistent with program goals and objectives?
- Is the workload reasonable?
- Will candidates be found with the desired qualifications?
- Will the terms of service be attractive to candidates?

1. POSITION TITLE	2. POSITION STATUS: Full-time; Part-time; Paid; volunteer	3. DATE OF PREPARATION
4. POSITION SUMMARY		
5. REPORTS TO:	6. POSITIONS DIRECTLY SUPERVISED BY INCUMBENT	
<p>7. SPECIFY REQUIREMENTS:</p> <p>7.1 Education/professional qualifications:</p> <p>7.2 Experience and training</p> <p>7.3 Knowledge, skills, ability</p>		
<p>8. DESCRIPTION OF DUTIES/RESPONSIBILITIES: List duties under two separate headings: REGULAR and PERIODIC DUTIES:</p> <p>A. REGULAR DUTIES/RESPONSIBILITIES:</p> <p>B. PERIODIC DUTIES/RESPONSIBILITIES</p>		
9. PREPARED BY:	11. % TIME SPENT	
10. REVIEWED BY:		

Reference: Aga Khan Foundation and University Research Corporation. Primary Health Care; Management Advancement Program. Module 3. Facilitator's Guide. p. 21.

Example of a Job Description for a Counselor

1. POSITION TITLE <i>Counselor</i>	2. POSITION STATUS Part-time; volunteer	3. DATE OF PREPARATION
4. POSITION SUMMARY <i>To provide infant feeding counseling to mothers of children under two years in X communities.</i>		
5. REPORTS TO <i>Supervisor</i>	6. POSITIONS DIRECTLY SUPERVISED BY INCUMBENT <i>None</i>	
<p>7. SPECIFY REQUIREMENTS:</p> <p>7.1 Education/professional qualifications <i>Literacy and experience in community groups is desirable but not required</i></p> <p>7.2 Experience and training <i>Breastfed for at least one year</i></p> <p>7.3 Knowledge, skills, ability <i>Respected resident of the community, good communication and parenting skills, interest in breastfeeding and infant health, eager learner</i></p>		
<p>8. DESCRIPTION OF DUTIES/RESPONSIBILITIES</p> <p>List duties under two separate headings: REGULAR and PERIODIC DUTIES: <i>Promote healthy behaviors and improved infant feeding practices through:</i></p> <p>A. REGULAR DUTIES/RESPONSIBILITIES <i>Home visits, group meetings, informal contacts, community education sessions, referrals to health services, daily activity register</i></p> <p>B. PERIODIC DUTIES/RESPONSIBILITIES <i>Attend on-going training programs and supervisory and peer counselor meetings</i></p>		
9. PREPARED BY: 10. REVIEWED BY:	<p>11. % TIME SPENT</p> <p><i>Counseling and Education 90%</i></p> <p><i>Record keeping 5%</i></p> <p><i>On-going training 5%</i></p>	

Reference: Aga Khan Foundation and University Research Corporation. Primary Health Care Management Advancement Program. Module 3. Facilitator's Guide. p. 21.

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**Example of a Job Description for a Program Director
La Liga de la Leche Guatemala**

1. POSITION TITLE <i>Program Director</i>	2. POSITION STATUS:	3. DATE OF PREPARATION
4. POSITION SUMMARY <i>To coordinate and supervise the functioning of support groups among low-income women in urban and peri-urban Guatemala City</i>		
5. REPORTS TO: Board of Directors	6. POSITIONS DIRECTLY SUPERVISED BY INCUMBENT Trainers, supervisors, secretary, accountant	
7. SPECIFY REQUIREMENTS: 7.1 Education/professional qualifications: <i>College degree; previous supervisory experience.</i> 7.2 Experience and training <i>Breastfed for at least one year; experience in conducting breastfeeding support groups.</i> 7.3 Knowledge, skills, ability <i>Good communication and parenting skills, interest in breastfeeding and infant health.</i>		
8. DESCRIPTION OF DUTIES/RESPONSIBILITIES: List duties under two separate headings: REGULAR and PERIODIC DUTIES: A. REGULAR DUTIES/RESPONSIBILITIES: <i>Supervise the planning and implementation of the community-based counseling and support program; plan and manage the annual program budget; manage the daily finances of the program; supervise the work of the accountant; negotiate with other NGOs and the MOH; seek funds for the program; negotiate contracts with technical staff</i> B. PERIODIC DUTIES/RESPONSIBILITIES <i>Observe on-going training programs, supervisory and peer counselor meetings; review and update the management information system; write reports on the program's activities</i>		
9. PREPARED BY:	11. % TIME SPENT <i>Supervision 40%</i> <i>Record keeping 20%</i> <i>Training 20%</i> <i>Fund-raising 20%</i>	
10. REVIEWED BY:		

Reference: Aga Khan Foundation and University Research Corporation. Primary Health Care; Management Advancement Program. Module 3. Facilitator's Guide. p. 21. Example adapted from the La Liga de La Leche, Guatemala City.

Chapter Nine

Developing a Training Plan

Training is often a means to achieve program goals and objectives. This chapter summarizes how a training plan is linked to program objectives, outlines the essential elements for developing a training program, and briefly discusses the annual training workplan. Linking a training plan to program objectives will enable the program manager to supervise and monitor training activities more effectively.

I. Development of a training plan	9-2
A. Statement of the training objectives	9-2
B. Review of the training assessment	9-3
C. Components of the plan	9-3
II. Preparation of the annual training workplan and budget	9-8
Worksheets	9-11

I. Development of a training plan

Many activities in community-based breastfeeding programs cannot proceed until training occurs. Consequently, one of the top priorities at the beginning of a program is the development of a training plan. Taking the time to prepare a plan that carefully identifies resource requirements and realistically relates available resources to expected outcomes helps to ensure that training and program objectives are achieved.

A. Statement of the training objectives

Chapter 5 describes how to develop program goals, objectives, strategies, and activities. You will need to follow the same process in developing training goals and objectives. Training objectives, like program objectives, should be time-bound, measurable, area and population specific, and realistically achievable. By selecting measurable objectives, for example, you will be able to evaluate more effectively the training activities. The training goals, objectives, strategies, and activities provide the framework for a training plan. Box 9.1 illustrates how program objectives and strategies are linked to training objectives and strategies, using the "Sealandia" example from Chapter 5.

Box 9.1

Linking Training Objectives to Program Objectives	
Program Objectives:	By December 1996 the rates of exclusive breastfeeding will increase from 20 percent to 40 percent among mothers of infants ages 0-6 months from three communities near Santiago, Sealandia.
Program Strategy:	Provide breastfeeding counseling to pregnant women and mothers of infants through the use of trained, volunteer breastfeeding counselors.
Training Objectives:	By December 1996 one hundred fifty (150) mothers from three communities near Santiago, Sealandia, will have the skills to provide breastfeeding counseling to pregnant women and mothers of infants in their communities.
Training Strategy:	Provide training in lactation management and counseling skills
Activities:	Training of Trainers Ten 40-hour workshops for trainees

B. Review of the training assessment

Development of a training plan first requires a review of existing training activities, curriculum, and resources. If you conducted the type of community assessment outlined in Chapter 3, you will have gathered information on training activities, materials, and resources as part of that assessment. An assessment of the status of training on breastfeeding promotion and lactation management makes it possible to develop a training plan that builds on existing systems and materials and focuses on areas that need to be strengthened. Review of the information and materials that were gathered may be done by a working group composed of project managers and trainers from local NGOs and the Ministry of Health.

If you have not carried out a training assessment, finalization of your workplan should be postponed until you do so. Otherwise, in the early stages of program implementation, you will probably need to readjust timelines, activities, and training objectives. Refer to Worksheet 9.1 at the end of this chapter and Worksheet 3.2 in Chapter 3 for assistance in assessing training activities.

C. Components of the plan

After reviewing existing resources, you are ready to define the components of the training plan. The training plan should answer the following questions:

- Who will be trained?
- How long will the training be?
- Who will conduct the training activities?
- How many trainers will be needed?
- What material(s) will be used to train the audience?
- When will the training take place?
- Where will the training take place?
- What follow up will take place after the training?
- How will the effectiveness of training activities be determined?

These questions are discussed in the following sections. Worksheet 9.2 will help you answer them for your own program.

- *Who will be trained?*

The program's goals and objectives should provide the answer to the question, "*Who will be trained?*." In many community-based breastfeeding programs, the primary group of trainees is community workers. Refer to Chapter 4 for a list of potential target groups for training.

Depending on time and resources, you may decide to expand training activities to a secondary audience, which may include MCH health officials, health care workers, health promoters, community leaders, and other decision makers in the community. Training programs are often more effective if a variety of members in the community are giving mothers the same messages on breastfeeding. Although there may be insufficient funds to train directly members of the secondary audience, you may coordinate with other groups or organizations to integrate breastfeeding into the training program of members of the secondary audience.

- *How long will the training be?*

Traditionally, most training on breastfeeding is done in 18 to 40 hour courses over three to five consecutive days. The duration of the training course will depend upon the topics to be covered, the time and funds available to conduct courses, and the willingness of participants to dedicate three to five days of their time to attend a training course.

When deciding on the length of the training course, it is important to consider the needs of the participants. Health workers, for example, may have limited hours when they can leave their clinic duties. Mothers may not be able or willing to be away from their homes eight hours a day for several consecutive days. An alternative is to offer shorter sessions extended over a longer period of time. This approach makes training more convenient for the trainee and provides an effective learning environment that will help to sustain skills.

Field experience suggests that one-shot training courses do not sustain knowledge and skills. Therefore, a variety of training approaches should be tried to provide participants with the information and support they need. An example of an alternate approach is described in Box 9.2.

Box 9.2

Alternate Training Approaches

La Liga de Leche in the Dominican Republic (LLL/DR) found that community counselors were having difficulty remembering all that they had learned after their three-day training course. Counselors felt frustrated at not being able to answer mothers' questions. Many dropped out of the program. LLL/DR decided to develop a different approach to training. They found that a six-hour session, conducted once a month for four months, was more effective than a one-time training course. Counselors retained more information and had an opportunity to practice their new skills between training sessions.

• *Who will conduct the training activities?*

The answer to "*Who will conduct the training activities?*" is critical. The ideal trainer for training at the community level should have the following characteristics:

- Expertise in breastfeeding promotion, lactation management, and counselling skills,
- Experience in training community members,
- Knowledge of participatory techniques of training, and an
- Ability and willingness to conduct training activities outlined in the training plan.

If your organization already has its own trainers, you will need to evaluate the appropriateness of their skills for training in breastfeeding counseling and support at the community level. It is likely that the trainers will need additional training on breastfeeding, counseling skills, and/or participatory training techniques. This training may be provided by local trainers with these skills or training consultants from regional or international organizations or agencies.

If your organization does not have a training staff, you may also want to consider using outside training consultants or qualified trainers from other local groups or organizations to train the target audience. These trainers, however, will certainly be more costly. You will need to evaluate the costs and benefits of hiring and training your own trainers compared to contracting from outside.

Some training projects assume that participants in a course on breastfeeding are automatically trainers. These "trainers" are generally sent back to their organizations

or institutions with the responsibility of "replicating" what they have learned, often with no back up materials or support. This "cascade" approach is not very effective because so many "trainers" fail to replicate what they learned in a training course. Additionally, one-shot training courses are generally not successful in imparting enough knowledge and skills for the participant to train others. Therefore, be sure that the trainers that you select to conduct your training activities are not only experts in breastfeeding but have extensive training experience, preferably at the community level.

• *How many trainers are needed?*

The answer to the question, "*How many trainers are needed?*," depends on the number of people to be trained. Worksheet 9.3 offers guidelines and assumptions for calculating the numbers of trainers needed to train a specific group within a designated time period. Using the worksheet will help keep a perspective on training possibilities given the resources available.

Rather than train a large number of people at the beginning of the program, it may be best to test first the training plan at a pilot site. As you are implementing the plan, you can build resources, benefit from lessons learned, and then expand the community support to other sites and regions.

• *What materials will be used to train the audience?*

In order to ensure that trainers are providing the same standard messages on breastfeeding in their training sessions, trainers will need to have a curriculum or training materials for use in preparing their training workshops. Some options include (1) using a curriculum which is already available in the country, (2) revising the existing curriculum to include more accurate, up-to-date information on breastfeeding, (3) adapting a curriculum from another region or country, or (4) developing new materials.

Community-based Breastfeeding Support: A Training Curriculum, a prototype curriculum for training at the community level, is a companion document to this manual. It can be adapted for use in most countries. The other document in the trilogy, *A Guide for Trainers and Supervisors*, is another valuable training resource. Other training resources are listed in Annex B at the end of the manual.

• *When will the training take place?*

The timetable is an essential component of the training plan. Sequencing of training activities and a time frame for their implementation should be included in the training plan.

- *Where will the training take place?*

The main issue to consider is whether to hold training workshops at a central site or in places closer to the trainees' home. Local training prevents major disruption of the trainees' lives, especially if it is difficult to travel to a central location. On the other hand, training away from home can enable participants to focus more fully on the workshop activities.

- *What follow up will take place after the training?*

From the very beginning, a training plan should make provisions for follow-up training. Too often, it only focuses on the initial training. Retention of knowledge and skills, as well as improvement in the quality of services, depends on a combination of training, mentorship, and retraining. In many programs, supervisors of community workers provide follow-up training. Follow up and supervision are the subject of Chapter 10.

- *How will the effectiveness of training activities be determined?*

Answering the question, "*How effective are the training activities?*," is often difficult. Community-based programs rarely have the funding, staff, or skills to conduct an impact study of the effect of training programs on the behavior and practices of breastfeeding mothers. If an impact evaluation of the training activities is beyond the scope or means of your program, you might consider taking the time to assess the appropriateness of your training plan.

A simple assessment of the training plan can provide valuable lessons for future training efforts. Therefore, it is important to include this assessment as one of the components of the training plan. Issues to consider when assessing the training plan are identified in Box 9.3.

Box 9.3

Assessing the Training Plan

- Did trainers use the training material? Why or why not?
- Were the training materials adequate/appropriate for training at the community level? Why or why not?
- How many people were actually trained?
- Were the training objectives met?
- What factors helped the program to achieve or surpass its objectives?
- What obstacles prevented the program from achieving the objectives?
- Were resources sufficient for achieving objectives?
- What are the recommendations for developing and implementing future training plans?

II. Preparation of the Annual Training Workplan and Budget

The training plan provides the program manager with an overall framework for linking training activities with program objectives. The annual workplan spells out, in detail, training activities, their sequence and timing, and the resources required for implementation. Chapter 6 offers guidelines for the preparation of workplans.

The activities that need to be included in the training workplan are:

- Review and adaptation or development of training resources,
- Training of the trainers,
- Training workshops (preparation, training, and administrative time), and
- Training evaluations.

Budget calculations are based on the planned activities. Budgeting should include cost of trainers, travel and insurance, per diem, production and reproduction of materials, equipment, food for the workshops, stipends, transport costs for participants, and other costs associated with training. When preparing the budget, it may be helpful to review Worksheet 9.4 which lists various resource requirements for training workshops.

The time and thought spent in articulating well-defined training objectives, developing the training plan, and preparing the training workplan and budget will contribute to the overall achievement of program goals and the sustainability of the program.

Worksheets for Chapter Nine -- Developing a Training Plan

Worksheet 9.1

Questionnaire for Use in a Training Assessment

How much of the information requested in this questionnaire do you have? What additional information about existing training activities, curriculum, and resources do you need? Where can you get the information? Refer to Chapter Three, Worksheet 3.2 for ways of organizing the information.

Questions to ask staff of various institutions, organizations, and community groups with training activities:

1. What target audiences are you currently training in breastfeeding promotion or support?
2. Where do the training activities take place?
3. Where are training activities focused?
 - List urban sites
 - List rural sites
4. How many persons are trained per course?
 - number of health workers
 - number of community workers
 - number of mothers
 - number of midwives
 - number of traditional birth attendants
 - number of health center staff
 - number of staff from local NGOs
 - number of local government representatives
5. How long are the training courses for each audience?
6. How many courses are conducted per year for each audience?
7. Are there refresher courses or updates?
 - For which target audience?
 - When are they given?
 - How often are they given?
8. Who trains the health workers?

9. Who provides breastfeeding education/training for:
 - community workers?
 - mothers in the community?
 - midwives?
 - traditional birth attendants?
 - health center staff?
 - staff from local NGOs?
 - local government representatives?
10. Who trains the trainers?
11. Which curriculum/training material is used for training PHC workers?
 - A. Who developed this curriculum/training material
 - B. When?
12. Which curriculum/training material is used for training community workers?
 - A. Who developed this curriculum/training material?
 - B. When?
13. Which curriculum/training material is used for training/educating mothers?
 - A. Who developed the curriculum/training material?
 - B. When?
14. Which curriculum/training material is used for training midwives and traditional birth attendants?
 - A. Who developed this curriculum/training material?
 - B. When?
15. What training materials are used to train other health center staff?
 - A. Who developed them?
 - B. When?
16. How have training activities been funded?
17. How are training activities supervised?
18. How are training activities monitored?
19. Have training activities been evaluated?
 - A. By whom?
 - B. When?
 - C. What were the results?

Worksheet 9.2
Components of a Training Plan

List the audiences to be trained.

Enumerate how many members of the target audience will be trained under the training plan.

Describe how the audience will be trained. (*Options: in a block course of 18 hours, 21 hours, 40 hours, or divided up in sessions over an extended period of time.*)

Enumerate how many workshops will be conducted in order to train the specific number of target members you wish to train.

List training curriculum or material to be used. Indicate if it needs to be adapted or revised.

List the trainers and the number of workshops each trainer will conduct.

List who will supervise the trainers.

Describe how the trainers will be supervised.

Describe how the training activities will be monitored.

Describe how the training plan will be evaluated or assessed.

**Worksheet 9.3 - Guidelines
Determining the Number of Trainers Needed
for a Community-based Program**

Role of the trainer

The role of a trainer may vary by the type of program and the location. Trainers may also be supervisors and may or may not focus only on breastfeeding activities. In many cases, however, the trainer may have other program responsibilities and may be able to devote only part time to breastfeeding training.

Trainers will carry out varied training activities

Trainers are expected to provide refresher courses, enrichment courses, follow-up courses, outside educational activities, and courses on support group facilitation. Time is needed for them to study to remain up-to-date on both training skills and training content.

Training is a team approach

A workshop to train new community workers should be conducted by at least two trainers. Although one may take the lead in a given session, the other should always be there to assist.

Time available for training is usually not full-time

Be sure to discount the time it may take to develop materials, train additional trainers, develop workplans, organize courses, take vacation, observe holidays, etc. (Example: If funding is available from September 1, 1996 to September 1, 1997, allow two months for administrative work, adaptation of curricula, vacation, etc., leaving only ten months to conduct training). Experience worldwide indicates that a team of trainers can realistically conduct one 40 hour workshop per month (5 training days/team). (Example: Two teams of trainers can each conduct one workshop per month for twelve months for a total of 24 workshops in one year.)

Effective training is small group training

More than 20 participants per workshop minimizes its effectiveness (15 participants per workshop is better). If there are more than 15 participants, interaction is compromised and any discussion is more prolonged. In addition, there is less opportunity to practice skills.

Drop-outs should be anticipated

To allow for people dropping out of the program, twice as many people should be trained as may be needed. Thus, if 50 community workers are needed, 100 should be trained.

Cost-effective training in breastfeeding is a specialist function

As in any technical area, the investment needed to produce a training expert in breastfeeding is considerable. It may be more cost effective for your organization to subcontract to a specialized organization or hire a specialized trainer than to develop your own trainers' expertise in this area if it does not already exist. If you decide to use your own trainers, they will need to have a TOT (Training of Trainers) and access to the most recent information on breastfeeding and counseling skills. Supervisors of community workers will also need to be involved in this training.

**Example 9.3 - Assumptions
Determination of the Number of Trainers Needed
for a Community-based Program**

Many breastfeeding programs do not employ full-time trainers. Therefore, you will need to determine how many weeks you will require their services. To do so, you should calculate the number of training courses needed based on the number of people to be trained. You should then determine the amount of time necessary to plan the workshop, train participants, and prepare training reports. This figure, multiplied by the number of workshops, will indicate the number of hours required for training services.

You will need to inform potential trainers of the time requirements and ask whether they are available for this length of time. If trainers have numerous other commitments and cannot find time in their schedule for all of the workshops, more trainers will be needed to meet the training objectives.

The calculations in the example box are based on the following assumptions:

- The program uses part-time community workers.
- To prepare for drop out, twice the number of workers are trained than currently needed.
- Fifteen people are trained at each workshop.
- Two trainers participate in each workshop.
- The duration of training workshops for new community workers is 40 hours (either in a block of time/or spread out over several months).
- Approximately one week is spent preparing for a one week workshop, and one week is spent completing reporting and financial forms after the workshop. (Estimate one day in preparation and one day in follow-up for each workshop day.)
- In-service training for community workers is carried out by their supervisors, but trainers run at least one course a year for supervisors and for community workers.

**Worksheet 9.3 - Example
Determination of the Number of Trainers Needed
for a Community-based Program**

Number of part-time community workers needed: (for a target population of 600)	25 community workers
Number of community workers to be trained: (25 community workers X 2 = 50)	50 community workers
Number of workshops needed: (50 workers ÷ 15 workers/workshop = 3)	3 workshops
Number of weeks per workshop for training services: (planning: 1 week, plus training: 1 week, plus follow-up: 1 week = 3 weeks)	3 weeks
Total number of weeks for training services (3 workshops X 3 weeks = 9 weeks)	9 weeks
Number of trainers per workshop:	2 trainers/workshop
Total number of trainers needed:	2 trainers

(Assuming that there are 40 weeks¹ available in the year for training activities, a trainer could, theoretically, take part in all three workshops. To do so, the number of weeks required for training services would have to be less than 40. Since the amount of time necessary for 3 workshops is 9 weeks, one team of 2 trainers is sufficient. In a work year, the maximum number of workshops a team of trainers could take on, using these assumptions, would be 13.)

¹Time is subtracted for vacations, holidays, and work not directly related to the training workshops.

Worksheet 9.3 - Form

**Calculations for Determination of the Number of Trainers
Needed in a Community-based Program**

Number of part-time community workers needed: _____ community workers
(for a target population of _____)

Number of community workers to be trained: _____ community workers
(_____ community workers X 2 = _____)

Number of workshops needed: _____ workshops
(_____ workers ÷ 15 workers/workshop = _____)

Number of weeks per workshop for training services: _____ weeks
(planning: _____ week, plus training: _____ week,
plus follow-up: _____ week = _____ weeks)

Total number of weeks for training services _____ weeks
(_____ workshops X _____ weeks = _____ weeks)

Number of trainers per workshop: 2 trainers/workshop

Total number of trainers needed: _____ trainers

(Assuming that there are 40 weeks² available in the year for training activities, a trainer could, theoretically, take part in 13 workshops.)

²Time is subtracted for vacations, holidays, and work not directly related to the training workshops.

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Worksheet 9.4

Workshop Preparation Requirements, Equipment, and Supplies Checklist

I. Preparation

- Curriculum reproduced
- Date set
- Site selected
 - accessible
 - training room (moveable, not fixed seating, tables for working groups)
 - restrooms
 - accessible place to eat
 - place for children to play
- list of participants (15-20)

II. Equipment

- overhead projector
- slide projector
- slide projector screen
- VCR and TV (if needed)
- flipchart stands
- extension cords
- electricity converters
- different size plugs
- small electrical generator (if needed)
- fuel for generator (if necessary)
- breast models
- dolls
- baby carrier
- visual aids (slides, overheads)
- materials for games
- toys for children
- diapers for babies
- first aid kit

III. Supplies

- extra bulb for overhead projector
- extra bulb for slide projector
- flipchart paper
- colored magic markers
- name tags
- masking tape
- scissors
- stapler
- pens/pencils
- scotch tape
- paper
- paper clips
- materials packet for participants
- handouts

Chapter Ten

Designing a Supervisory System

Supervision enables all members of a program team to perform their jobs more effectively. The term "supervision" is sometimes regarded negatively because it is associated with inspection, control, and criticism. In contrast, this chapter presents a model of supervision that is built on guidance, support, education, and encouragement. In this model, supervision is considered a continuation of the initial training that community workers receive. It focuses on people and ways to improve performance. Some organizations prefer to call supervisors "coordinators," "district advisors," or some other term to avoid negative connotations associated with the word "supervisor."

Designing a supervisory system requires the development of a supervisory plan. This chapter discusses the elements of such a plan.

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I. Rationale for supervision

Although many organizations complain that supervision is difficult because of lack of staff, resources, or transport, there is no justifiable basis for neglecting supervision. In a community-based program that depends on people's input for its success, on-going communication and exchange of information are necessary. Continual feedback provides valuable information on the status of activities to both program managers and those in the field. This sharing of information serves as the foundation for a monitoring system and indicates to field participants and the headquarters staff what adjustments may be needed in the program. As a program manager, if you know what is going on and you follow up, you will be more likely to make informed decisions. A supervisory system enables the manager to systematically guide and support office and field personnel to carry out their assigned tasks.

II. Development of a supervisory plan

A supervisory system grows out of a detailed supervisory plan based on well-defined objectives. The supervisory plan identifies the resources necessary to develop an effective supervisory system.

A. Statement of the supervisory objectives

The supervisory objectives will shape the type of supervisory system that an organization develops. If there are no objectives developed by the management team for supervision, then supervision usually becomes crisis management. Supervision affects program sustainability and the quality of services that are provided in the community. The purpose of a supervisory plan is to ensure that supervision is linked to program goals and that the human, material, and financial resources are available to provide quality services. Box 10.1 summarizes the objectives of supervision.

Box 10.1

Objectives of Supervision

- Guide, support, and motivate staff to perform their assigned tasks
- Provide a two-way exchange of information
- Improve worker performance by enhancing the skills and knowledge of both the supervisor and the supervisee
- Monitor program activities, making changes when necessary
- Facilitate linkages with health and other services

B. Components of the plan

The supervisory plan should support the achievement of the program's supervisory objectives. The plan should answer the following questions:

- Who will the supervisors be?
- How many supervisors will be needed?
- What skills will they need?
- What training will they require?
- What will they do?
- What resources will they need?

These questions are discussed in the following sections.

- *Who will the supervisors be?*

There are various levels of supervision in any program, depending on the complexity and size of the organization. For example, a Board of Directors usually supervises the program manager who in turn supervises the next level of staff. In some situations, an individual may function in two or more capacities, such as trainer/supervisor or manager/supervisor.

Supervisors of community workers may be:

- Trainers of community workers,
- Representatives of the formal health care system,
- Representatives of a local nongovernmental organization, or
- Experienced community health workers who will live in or nearby the community in which they work.

Representatives of the formal health services who are responsible for supervision of health facility staff may have little time for direct follow-up and supervision of community-based workers. As the program grows and more counselors are trained, their capacity to provide supportive supervision in a timely manner may soon be exhausted. Limited resources may also make it difficult to supervise in remote or rural areas. In such cases, experienced community workers living in the same area

can serve as mentors to new counselors. These "mentors" serve as a bridge between community-level workers and formal health services. Their responsibilities may include compiling individual activity reports and summarizing them for a district health facility. A detailed discussion of the use of "mentors" as supervisors is found in *Community-based Breastfeeding Support: A Guide for Trainers and Supervisors*.

- *How many supervisors will be needed?*

The number of supervisors needed for community-based breastfeeding activities will depend on the number of individuals that they supervise, the activities in which they participate, the frequency of supervision, funds available for travel, and other responsibilities of the supervisor. Worksheet 10.1 provides guidance on calculating the required number of supervisors.

- *What skills will they need?*

Desirable characteristics of supervisors are experience in community work, technical knowledge, and interpersonal skills.

Experience in community work: A supervisor with experience in community work can more easily empathize with community-level workers and understand the difficulties they may face than individuals who have not worked in the field.

Technical knowledge: To be effective, a supervisor should have technical knowledge on appropriate infant feeding practices. A sound technical background in breastfeeding programming and lactation management is essential for giving accurate and constructive feedback to community-level workers.

Interpersonal skills: Good interpersonal skills are necessary to ensure that communication between the supervisor and the supervisee is helpful, supportive, and motivating. The supervisor should be a good listener who can establish rapport with workers.

- *What training will they need?*

Supervisors will need to be trained in the supervisory process, outlined in Table 10.1. This process includes four stages: preparation and planning; community contacts and observation of activities; mentoring sessions; and follow-up. These four stages are designed to enable both supervisees and supervisors to perform their duties more effectively.

Table 10.1
Stages of Supervision

Stage of supervision	Main focus
<p>Stage 1: Preparation/Planning</p>	<p>The program manager/coordinator:</p> <ul style="list-style-type: none"> • Ensures that supervisors are trained, informed, and equipped with supplies, forms, and guidelines. <p>The supervisory team:</p> <ul style="list-style-type: none"> • Reviews expected program activities of each supervisee and the time schedules. • Schedules supervisory visits, allowing enough time to deal with unexpected problems.
<p>Stage 2: Community contacts and observation of activities</p>	<p>The supervisory team:</p> <ul style="list-style-type: none"> • Arranges to take part in the supervisee's activities, such as accompanying a worker on home visits or observing training, education, or support group sessions. • Makes community contacts to improve linkages to other resources and networks. • Uses an observation guide or checklist during the supervisory visit.
<p>Stage 3: Mentoring/feedback sessions</p>	<ul style="list-style-type: none"> • Mentoring sessions take place at all levels of the program, ie, between manager and supervisory team, manager and trainer, and supervisory team and community workers. • A session allows for review of activities and information forms, supportive feedback, retraining, problem discussion and resolution, and planning of future activities.
<p>Stage 4: Follow-up</p>	<ul style="list-style-type: none"> • After a supervisory session, the supervisor completes a supervisory report. It serves as a program update, monitoring tool, and planning guide. • Analysis of the supervisory report aids in identifying problems and training and resource needs.

As part of their training, supervisors should be taught how to make the supervisory process a learning experience for both themselves and the individuals that they supervise. Through this process, supervisors can gain an understanding of the needs of the individuals that they supervise, and supervisees can learn from their successes and mistakes. In addition to being a learning experience, supervision provides an opportunity to acknowledge the value of an individual's work, promote a sense of achievement, and encourage initiative.

Another objective of the training is to help supervisors gain good counseling skills and to develop these same skills in the individuals whom they supervise. *Community-based Breastfeeding Support: A Guide for Trainers and Supervisors* is an excellent training resource on counseling skills, group facilitation, and the supervisory process.

- *What will the supervisors do?*

Supervisory activities should be identified in the annual workplan. The development of a supervisory workplan follows the same steps outlined for the preparation of the program workplan, discussed in Chapter 6. These steps include the listing, sequencing, and timing of activities. The supervisor must be sure that the supervisory workplan is linked to program goals.

The supervisory activities included in the workplan will reflect the program's current stage of implementation. Box 10.2 illustrates the types of supervisory activities found in many community-based breastfeeding support programs. Table 5.2 (see Chapter 5) shows how the activities of supervisors can support those of the counselors.

If the program is in its initial stages, supervisors may be involved in community assessment and community mapping (described in Chapters 3 and 4) and in the recruitment of counselors. In the second year of the program, the activity list will focus more on direct supervision of the community-based counseling network. Some supervisors may be involved in start-up activities; others may enter the program after these activities have already been completed.

It is important that the workplan be developed in coordination with the training team to ensure that there are no conflicts in scheduling. Worksheet 10.1 discusses some of the issues that should be considered in calculating the amount of time that can be scheduled for different kinds of supervisory activities. Supervisees should also be engaged in the development of the workplan. Through a participatory process, the supervisor and community worker will need to develop an individual workplan that includes specific objectives for the numbers of families to contact, the numbers of support group meetings to be held each month, the number of community presentations to organize each month, etc. They will also need to set objectives for skill development.

Box 10.2

Supervisory Activities

Start-up activities:

- Community assessment
- Coordination with formal health services to ensure that an effective referral and counter-referral system between community workers and formal health services is in place
- Community mobilization and recruitment of counselors
- Coordination of the training of community level workers in breastfeeding and infant feeding support, counseling, group facilitation, and community education

Community-level supervision:

- Preparation of the supervisee's workplan along with a calendar of supervisory visits
- Development and use of appropriate community-based supervisory instruments
- Observation of activities, mentoring, and feedback

In-service training:

- Coordination of in-service training activities for community workers with the program trainer (If the supervisor also serves as the trainer, the supervisor will also be responsible for planning and implementing in-service training activities.)

Monitoring:

- Collection, tabulation, and analysis of information
- Feedback to community workers, program staff, and the formal health services in the program area

• ***What resources will support supervisors in their work?***

To perform their activities, supervisors need adequate time, financial support, and supervisory tools. In preparing the budget, supervisors will need to determine the level of supervision that can be provided with the existing financial and human resources. In order to economize resources, it may be necessary to combine supervision with other field visits and activities; schedule supervision with less frequency; supervise by telephone, letter, e-mail, or fax; or delegate responsibility for supervision to local groups and experienced counselors trained as mentors.

Checklists and supervisory reports are tools that can assist supervisors in performing their duties.

Checklist: A checklist reminds supervisors of certain behaviors to observe, information to gather, materials to review, and topics to discuss. Supervisors will want to document coverage of target groups in the community. They will also want to assess progress in project implementation, knowledge and skills

of community workers, and the quality of care being provided. Sample checklists are found in Worksheet 10.2.

Follow-up report: A supervisory report serves as a project update, a monitoring tool, and a planning guide. Supervisory reports are often consulted when decisions are made on project resources, training plans, counselor recruitment, and supply requirements.

An example of a supervisory report form is provided at the end of this chapter. It includes the following elements: analysis of the situation in the project community, observations by the supervisor and supervisee, recommendations for follow-up activities, identification of individuals responsible for follow-up, and the date of completion for proposed actions. The analysis should indicate whether there are any problems, such as lack of skills, supplies, motivation, or clear job assignments. Based on this problem identification, the supervisory team should recommend follow-up actions.

This chapter concludes with a story that appears in Box 10.3, taken from *Community-based Breastfeeding Support: A Guide for Trainers and Counselors*. It summarizes the main themes of this chapter:

- Supervision should be a supportive, participatory process.
- Supervision requires clearly stated objectives and a plan for achieving them.
- The workplan is a working document. It should be adjusted to reflect changing conditions and the needs of the individuals who must implement program activities.

Box 10.3

Example of Supportive Supervision in Action

A breastfeeding NGO estimates that each community-based counselor will work with 30 families in her neighborhood. Martita, a new breastfeeding counselor who is well liked and respected by her neighbors, understands that her responsibilities include identifying pregnant women and mothers with children under one year of age in her neighborhood. She is also expected to maintain a data sheet for each eligible family, make home visits at specified intervals, and conduct a monthly mothers' support group for her neighborhood.

Martita has had little formal education. She is overwhelmed by the data sheet and feels that she cannot possibly work with 30 families. Martita's supervisor is sensitive to her feelings. She suggests that Martita begin with only 10 families and add two more families each month. She also offers to help Martita keep up the data sheets for the first three months.

Source: Adapted from Community-based Breastfeeding Support: A Guide for Trainers and Supervisors

Worksheets for Chapter 10: Designing a Supervisory System

Worksheet 10.1 (Determining the Number of Supervisors) provides guidelines for calculating the number of supervisors that will be needed in a community-based breastfeeding support program. The calculations are based on the number of community workers needed (see the worksheets in Chapter 6). Each worksheet is divided into four sections:

- Part I** **Guidelines** for calculating the number of supervisors needed, drawing upon the experience of various projects
- Part II** **Assumptions** used in making the calculations
- Part III** **Example** based on the assumptions
- Part IV** **Form** for you to complete

Worksheet 10.2 (Preparing a Supervisory Checklist) includes a sample supervisory checklist. A **Sample Follow-up Report Form** is also provided.

Worksheet 10.1 - Guidelines
Determining the Number of Supervisors Needed

Participation in Individual Counseling Sessions

- Depending on the number of community level workers, a supervisor may participate in an individual counseling session with each community worker once a month. The frequency will depend on the number of other activities the community worker carries out, her longevity and experience in the program, and the extent of other, mid-level mentoring or supervision.

Participation in Group Meetings and Community Education Sessions

- The supervisor should agree with the community worker on the frequency of attendance at group meetings or community education sessions. They should also agree on when such support can taper off. If the community worker is involved in other health activities held in the community, such as monthly growth monitoring promotion, the supervisor may oversee those activities as well.

In-Service Training

- The supervisor should plan and run periodic "in-service" training sessions for the community workers that she supervises.

Monitoring

- On a monthly basis, the supervisor should collect, tabulate, and analyze the monitoring forms that are completed by the community workers.

Community Mapping

- As needed, the supervisor should assist the community workers to carry-out, make, or update community maps and surveys.

Worksheet 10.1 - Assumptions
Determination of the Number of Supervisors Needed
for a Community-based Program

The role of a supervisor may vary by the type of program and the location. If she focuses only on breastfeeding activities, she can devote full time to supervision of those activities. In some cases, however, she may have other program responsibilities and may be able to devote only part time to supervision of breastfeeding activities.

- If a supervisor works on average 20 days per month, she may spend up to 14 days of that time in the field supervising with the remaining six days spent in staff meetings, training, and administration.
- If a full-time supervisor works 8 hours per day and spends two hours of that time travelling, she can spend six hours in direct supervision of community workers. If, during that time, she spends 1 1/2 hours with a worker, she can supervise three people in one day (6 hours per day divided by 1 1/2 hours per person + lunch and internal travel within the community = 3 community workers contacted per day).
- A full-time supervisor, working in the field up to 14 days per month, can supervise a total of approximately 42 community workers per month. If she is carrying out other activities during a field visit, she will be able to give direct supervision to fewer people.

These assumptions are provided as examples for use in calculation. Most supervisors will probably spend, on average, fewer than 14 days per month in direct supervision of breastfeeding activities.

Worksheet 10.1 - Example
Determination of the Number of Supervisors Needed
for a Community-based Program

Number of days per month spent supervising: ¹ (20 days minus 6 days for other activities)	14 days
Number of community workers visited per day: (4-6 hours ÷ 1 1/2 hours per community worker)	3 community workers
Number of supervision days x number of community workers = number of community workers visited per month:	14 x 3 = 42 community workers
Number of community workers in target areas:	100
Number of supervisors needed: (100 community workers ÷ 42 workers visited per month = about 2-3 supervisors needed)	2-3

¹ These assumptions may change depending on your program area.

Worksheet 10.1 - Form

**Calculations for Determination of the Number of Supervisors
Needed in a Community-based Program**

Number of days per month spent supervising: _____
(? days minus ? days for other activities)

Number of community workers visited per day: _____
(? hours ÷ ? hours per community workers)

Number of supervision days x number of community workers:
= number of workers visited per month _____

Number of community workers in target areas: _____

Number of supervisors needed: _____
(? community workers ÷ ? workers visited per month = about
 ? supervisors needed)

Worksheet 10.2
Preparing a Supervisory Checklist

Refer to the checklists on the following pages. Prepare a supervisor's checklist that is appropriate for your situation. Remember to include questions related to interpersonal skills, knowledge, coverage, and management.

✓

□

□

□

□

□

□

□

□

**Checklist for Supervisors
of Community Workers**

✓

Interpersonal Skills

- In a home visit, does the community worker greet the mother in an appropriate fashion?
- Does the community worker ask open-ended questions?
- Does the community worker give the mother an opportunity to talk about her concerns?
- Does the community worker treat the mother with respect, avoid criticism, and give positive reinforcement?
- Does the community worker offer appropriate information in a non-authoritative manner?
- Before taking leave, does the community worker set up another visit at an appropriate time interval?

Knowledge

- Does the community worker know what exclusive breastfeeding is?
- Does the community worker know the benefits of exclusive breastfeeding?
- Does the community worker know how breastfeeding benefits the mother and newborn immediately after birth?

- If early introduction of water is a problem, is the community worker able to respond to the mother's concerns?
- Does the community worker know correct positioning of the baby when breastfeeding?
- Does the community worker know why correct positioning is important?
- Is the community worker able to address the mother's questions and concerns about the quality and quantity of milk?
- Is the community worker able to address the mother's concerns about her own nutrition?
- Is the community worker able to address the mother's questions and concerns about breastfeeding when she is ill?
- If the mother plans to work outside the home, can the community worker offer advice and suggestions on how to maintain optimal breastfeeding?
- Is the community worker able to discuss appropriate family planning methods?
- Is the community worker able to counsel appropriately about optimal feeding after weighing the child or examining the child's growth chart?
- Does the community worker know how to advise the mother about appropriate feeding during episodes of diarrhea, acute respiratory infections, or other illnesses?
- Does the community worker know how to advise the mother about appropriate catch-up feeding when the child is recuperating from episodes of diarrhea, acute respiratory infections, or other illnesses?

- Does the community worker encourage the mother to comply with the recommended immunization schedule?
- Does the community worker know when and where to refer the mother for problems that cannot be treated at the community level?

Coverage

- How many target mothers has the community worker seen in individual interviews, group settings, or other encounters?
- Does the community worker organize support groups in the community on a regular basis?
- Does the community worker organize other community educational activities?
- How many people participate in these other activities, and who are they?
- How many mothers of infants under six months of age are exclusively breastfeeding?

Management

- Has the community worker identified any problems?
- If so, were these resolved satisfactorily?
- Was the reporting form completed satisfactorily?
- If not, were appropriate revisions made?
- Were support materials delivered to the community worker?

- Was the current workplan reviewed?
- Was planning for the next period completed?
- Was a date agreed upon for the next supervisory visit?
- Were there any other comments or observations?

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**Checklist for Supervisors
of Trainers and Community Supervisors**

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- Was the implementation of the current workplan reviewed?
- Was planning for the next period completed?
- Has the supervisee identified any problems?
- If so, were these problems resolved satisfactorily?
- Are reporting forms completed satisfactorily?
- If not, were appropriate revisions made?
- Does the staff member have the support materials that are needed?
- Was a date agreed for the next supervisory session?
- Were there any other comments or observations?

Sample Follow-up Report Form

Community visited _____ Date _____
 Name of worker supervised _____
 Purpose of visit _____

List the persons and organizations contacted, the place and date of the meeting, and comments about the meeting.

Person Contacted	Place	Date	Comments
1.			
2.			
3.			

Note positive/negative feedback or concerns of both the supervisor and the supervisee.

	Supervisor	Supervisee
1.		
2.		
3.		

Identify needs, actions to be taken, person responsible, and date for action.

SUPERVISEE

Needs	Actions Required	By (date)	Persons in Charge
1.			
2.			

SUPERVISOR

Needs	Actions Required	By (date)	Persons in Charge
1.			
2.			

Scheduled date of next supervision visit:

Signature:
 Supervisor's Name:
 Report submitted (date):

Source: Adapted from *The Supervision of Health Personnel at District Level*. Flahault D, Piot M, and Franklin A. Geneva, World Health Organization, 1988.

Chapter Eleven

Monitoring and Evaluating the Program

Once program activities at the community level in support of breastfeeding have begun, it is important to know whether they are being implemented and how well they are being carried out. Monitoring is the regular collection of information on activities as well as an analysis of this information for decision making. Evaluation is a periodic assessment to determine whether these activities have had any effect or impact on program objectives. An evaluation is often conducted separately from the monitoring and is an additional cost to be considered (often about 10% of total program costs). This chapter discusses the development of monitoring and evaluation plans, the selection of appropriate indicators, and tools for data collection.

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I. Reasons for monitoring and evaluation

Monitoring reports on the implementation and progress of the program. Information from the monitoring system can be used to:

- Track activities of the program in relation to projected goals,
- Assess the quality of services, including the appropriateness of the activities,
- Track the process of change in breastfeeding behaviors,
- Identify training and supervisory needs,
- Determine problems and possible solutions, and
- Assess the adequacy of financial and/or material resources.

As part of monitoring, information is collected on inputs (personnel, finances, and materials), processes (the activities), and outputs. This information can help managers and supervisors monitor resources, support staff, and improve their own effectiveness. Besides providing information to central level authorities in the Ministry of Health, international agencies, and/or foundations, monitoring is useful for providing feedback to personnel at the operational level.

While monitoring tracks the progress of the activities, evaluation assesses the program's population-wide impact. For example, monitoring can show whether community workers are active in the program area. Evaluations can document whether changes in knowledge, attitudes, or breastfeeding practices have occurred as a result of the activities of community workers.

Table 11.1 illustrates how monitoring information feeds into the evaluation process.

Table 11.1
Flow Diagram for Monitoring and Evaluating
Community Counseling Programs

Inputs→→→→	Processes→→→→	Outputs→→→→	Outcomes→→→→	Long-term impacts
Resources	Activities	Services	Knowledge Attitudes Practices	Health and Nutritional Status
<ul style="list-style-type: none"> • Community workers • Institutional personnel • Counseling cards • Training manuals 	<ul style="list-style-type: none"> • Group meetings • Home visits • Community education • Training • Monitoring • Supervision 	<ul style="list-style-type: none"> • % of target group mothers visited • % of target groups women attending support groups 	<ul style="list-style-type: none"> • % of target women reporting that 6 months exclusive breastfeeding is optimal • % of mothers exclusively breastfeeding for 6 months 	<ul style="list-style-type: none"> • Morbidity • Mortality • Nutritional status

Source: Adapted from Aga Khan/URC. Module 5. Monitoring and evaluating programs.

II. Monitoring and evaluation process

Monitoring and evaluation are most effective and efficient if data are collected in a systematic way. Information that is gathered should be simple, timely, accurate, and useful for decision making.

Although the collection and analysis of information occurs at set intervals, the monitoring process should be a continuous activity. The frequency with which the program is monitored will depend on the monitoring objectives, in part, but also on staff size and available funds. Many organizations aim to gather information once a month or even once a quarter. Evaluation usually occurs mid-point or near the end of a project.

Steps in the monitoring and evaluation process, divided into planning, implementation, and assessment, are outlined in Box 11.1 and discussed in the following pages.

Box 11.1

Steps in the Monitoring and Evaluation Process

Planning

1. Decide on monitoring and evaluation objectives
2. Define the scope
3. Select the indicators
4. Develop data collection procedures and instruments

Implementation

5. Collect the data
6. Tabulate and organize the data

Assessment and Action

7. Analyze and report the findings and recommendations
8. Take appropriate action

Adapted from: Aga Khan/URC. Module 5. Monitoring and evaluating programs.

1. Decide on monitoring objectives

Community participants and those involved in program implementation and data collection should be involved in deciding on monitoring objectives. Staff, especially community workers who are the heart of monitoring, should see the need and uses for the information that they collect. Women in support groups or those receiving home visits should be told that the purpose of questions about breastfeeding practices or their attendance at group meetings is not to test them but to improve the quality of services being offered.

Monitoring objectives should focus on a few key issues, such as tasks that are new or very important to the program's success. These objectives can assess the quantity of activities, their quality, or the timeliness with which they are accomplished. For example, a monitoring objective that focuses on coverage of services could assess the percent of pregnant women and women with children under age six or twelve months who are identified by community workers.

2. *Decide on the scope of the monitoring system*

A monitoring system does not have to cover the entire program area. When the system is being developed, it is better to test it in a few selected communities. The scope of the monitoring may be defined by a geographic area, the activities to be monitored (e.g. group activities and/or home visits), the institutions involved (e.g. health clinics and/or NGOs), and personnel to be supervised (only volunteers, only institutional staff, or both).

3. *Select the indicators*

A few key indicators should be selected to monitor behaviors, activities, personnel, materials, and financial resources. These indicators are usually quantitative and may measure process, quality of services, and/or impact. A full discussion of indicators is found on pages 8-11.

4. *Develop data collection procedures and instruments*

Information to be gathered should be simple, relevant, and easy to collect.¹ There are several techniques for data collection such as review of program records, activity reports, supervisory checklists, and interviews. Annex C gives an example of a monitoring form for use in an integrated maternal child health care program. Evaluations often use other techniques such as household surveys, rapid assessment surveys, exit interviews, and qualitative surveys. These techniques are described on pages 11-14.

5. *Collect the data*

In general, community workers and their supervisors collect monitoring information on activities and coverage. If a formal evaluation is conducted, there are usually outside evaluators and staff.

The annual workplan should include monitoring as one of the regularly scheduled supervisory and managerial activities. The workplan's timetable should include reminders of when activities should be accomplished and when monitoring should occur. Time should be allowed for developing monitoring forms, pretesting and revising these forms, training community workers and supervisors in data collection, and gathering the information. If community workers will collect coverage data, both community workers and supervisors should fill in sample forms as part of their training.

¹Examples of monitoring and community diagnostic forms used in the MOH and La Liga de la Lactancia Materna program in Honduras are available in a case study of this program, entitled "National Breastfeeding Counselors Network: Joint Program of the Ministry of Health of Honduras and La Liga de Lactancia Materna: Case Study," published by Wellstart, 1996.

6. *Tabulate and organize the data*

It is advantageous to involve some community workers and supervisors in the data analysis. They can help to interpret the data in the context of the program activities and identify ways of relaying key findings to the community. Data can be tabulated manually. Some organizations have computer database systems for storage, tabulation, and analysis of data.

Once tabulated, data should be compared to the timetable presented in the workplan. If the program is lagging behind schedule, reasons can be discussed and solutions found. Adjustments may need to be made to the workplan. It is often helpful to compare the results from different areas and look for factors that explain differences in performance.

7. *Analyze and report the findings with recommendations for action*

Once the information is analyzed, findings should be communicated to the community, staff, funders, and decision makers. The evaluation team should discuss the findings, formulate a limited number of clear, concise recommendations, and prepare a written report. Pertinent recommendations for changes in the work plans, goals, objectives, etc. should be included. The findings can be communicated in short summaries, case studies, "lessons learned," memorandums, publications, and newsletters. Data can be displayed in simple lists, tables, or graphs.

8. *Take appropriate action*

Unless information is used to improve the program's effectiveness, time and money will be wasted. Some projects spend a large amount of time and money monitoring activities at the expense of project implementation. It is important to ensure that monitoring does not become an end in itself but continues to serve as a tool to improve the program.

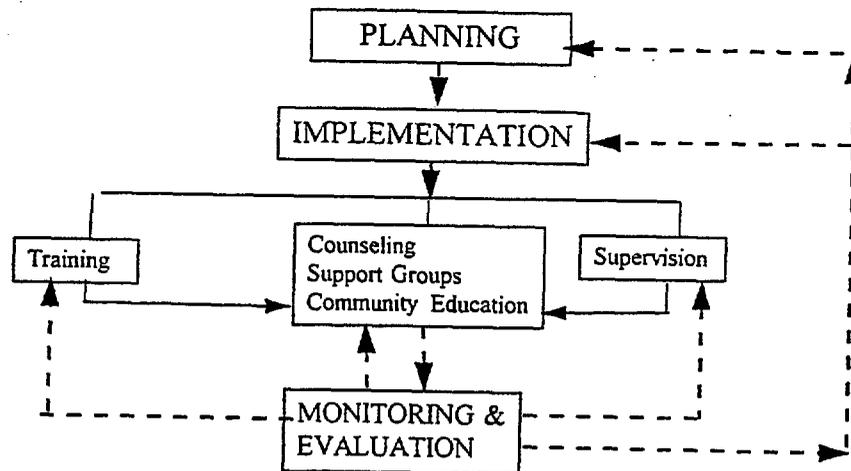
Data analysis should provide the basis for taking appropriate action in areas needing attention. For example, the analysis may indicate the need for training more workers, raising more funds, or experimenting with different approaches for reaching more mothers and their families. Based on this analysis of the data, the workplan may need to be revised. Filling in a table such as the one below can be useful in identifying appropriate actions.

Problem	Possible Causes	Possible Solutions

After a program evaluation, a follow-up meeting should be held to review the findings and consider their implications for program implementation. Groups to invite to the meeting include donor agencies, staff, leaders of community organizations, and program beneficiaries. For those recommendations that the group supports, individuals should be assigned responsibility for follow-up tasks or activities. A way of monitoring these tasks should be determined and a date estimated for their completion. This process helps to ensure that the results and recommendations of the evaluation are incorporated in program planning and implementation.

The objective of both monitoring and evaluation is to gather information that will enable the program manager and staff to make informed decisions. Figure 11.1 illustrates how information gathered during monitoring and evaluation provides feedback for future planning and implementation.

Figure 11.1
Relationship of Monitoring and Evaluation
to Planning and Implementation



III. Selection of indicators

In both monitoring and evaluation plans, it is important to focus on a few key indicators that the program is trying to influence. You will need to determine which indicators are most appropriate for your program. In addition to established international indicators, some programs may wish to evaluate program coverage, such as the number of women who received counseling or participated in support groups. Indicators may be constructed to monitor and evaluate process as well.

For some programs, the proportion of women exclusively and predominantly breastfeeding within the first four or six months may be the only indicators used in evaluations. If a program is also trying to increase the duration of breastfeeding among all women, then duration of breastfeeding may be an additional indicator. If a program wants to link these changes with programmatic activities, then some coverage indicators should be included.

Discussed below are five types of indicators that may be used in monitoring or evaluation: behavioral, activity, personnel, material, and financial.

- *Behavioral indicators*

Behavioral indicators for monitoring and evaluating breastfeeding practices include the never breastfed rate, exclusive breastfeeding rate, predominant breastfeeding rate, and timely complementary feeding rate. Methods for calculating these rates appear in an annex to this chapter. Definitions of terms are given below.

Exclusive breastfeeding: an infant receives only breastmilk (no other food or fluids with the exception of drops of vitamins, minerals supplements, or medicines).

Predominant breastfeeding: an infant receives breastmilk along with water, water-based drinks (sweetened or flavored water, teas, infusions), fruit juice, oral rehydration solutions but no other liquids or solids.

Timely complementary feeding: an infant receives solids (foods of mushy or solid consistency, not fluids)

Box 11.2 lists some quantitative breastfeeding behavior indicators that have been used in program monitoring and evaluation. You will need to determine which indicators are most appropriate for your program. Annex A of this chapter shows how to calculate key breastfeeding indicators.

Box 11.2

Possible Indicators for Monitoring and Evaluating Breastfeeding Practices

Key indicators:

- Never breastfed rate
- Exclusive breastfeeding rate: 0-<4 months (0-121 days) or 0-<6 months (0-182 days) The lower range is used by the World Health Organization while other organizations, such as USAID, recommend the higher range.
- Predominant Breastfeeding rate: same age groups as above
- Timely complementary feeding rate: 6-<10 months (or 183-304 days)

Additional indicators:

- Initiation of breastfeeding in the first hour of life
- Frequency of breastfeeding in 24 hours
- Mean duration of breastfeeding
- Mean duration of lactational amenorrhea
- Continued breastfeeding rate at one year: 12-<16 months (366-486 days)
- Continued breastfeeding rate at two years: 20-<24 months (608-730 days)
- Percent of infants using bottles at 0-<6 months (0-182 days)
- Percent of breastfeeding women using appropriate family planning methods
- Percent of women with breastfeeding education/counseling/home visit

• *Activity indicators*

In addition to established behavioral indicators, some programs may want to monitor and/or evaluate program coverage. If the program objective is for a specific level of coverage, then the indicator used should reflect coverage of service. For example, one of the program's objectives might be to reach all new mothers in 100 communities with information on optimal breastfeeding. Data from each community could be collected on the number of mothers reached with breastfeeding information compared with the estimated number of births in the community. This information will be summarized periodically in order to assist in evaluating the outcomes of the program. Box 11.3 illustrates other indicators that could be used to assess coverage.

Box 11.3

**Possible Indicators for Monitoring
Coverage of Activities**

- Percent of pregnant women identified by a community-based worker in the last month and counseled on infant feeding in their community
- Percent of mothers of children under 6 months of age identified by a community-based worker in the last month who were counseled on infant feeding
- Percent of pregnant women who participated in a support group in the last month
- Percent of mothers of children under 6 months of age who participated in a support group in the last month

• *Personnel indicators*

Personnel performance often improves when monitored on a regular basis. Monitoring personnel and providing staff with feedback is a way of motivating health workers. Personnel indicators could include:

- Number/percent of breastfeeding counselors active² in their communities
- Number/percent of supervisors making expected levels of supervisory visits each month (by geographical area and schedule)
- Types of follow-up activities developed from supervisory visits
- Number/percent of trainees completing training successfully according to the criteria developed by the institution, program, etc.

• *Materials indicators*

Resources, such as printed educational materials, counseling cards, breast pumps, or manuals for community workers may be appropriate for some programs. Monitoring indicators could include:

- Number and timeliness of educational materials distributed to mothers
- % of mothers of children 0-6 months of age who received materials and understood messages
- Number and timeliness of educational materials distributed to pregnant women
- % of pregnant women who received materials and understood messages

²You will need to define what "active" means. In some systems, "active" may mean facilitation of a support group meeting, submission of a report, and attendance at a supervisory meeting on a monthly basis. In other systems, these activities may be reported on every quarter rather than every month.

- *Financial resources indicators*

All programs, whether conducted by NGOs or the government, need to plan activities based on the level of available funds. Monitoring of the financial aspects of the project is essential to ensure that the funds are sufficient to cover expected costs. Examples of financial indicators are:

- Amounts budgeted for different activities
- Actual amounts spent
- Balance of funds remaining

IV. Data collection

A. Monitoring and evaluation tools

Cost, time, personnel, and logistical requirements need to be considered when deciding which tools to use in monitoring and evaluation. Surveys are often expensive and require extensive staff time. They are frequently conducted by evaluation specialists who can help with questionnaire design, sample selection, data collection, and analysis. The collection of monthly or quarterly information on behaviors at the community or clinic level may diminish the need for large surveys.

Community-based programs frequently use quantitative community-based surveys to collect information on changes in breastfeeding practices and qualitative surveys to provide information on why changes did or did not take place. Careful monitoring may reduce the need for large-scale evaluation surveys.

You will need to determine the approach to monitoring and evaluation that is best suited to your organization as well as the tools that you will use to collect data. These tools are described below.

- *Review of program records and reports*

Program records and reports usually provide a quantitative measure of the program's success in achieving its objectives.³ A review of financial records, such as payroll expenditures, helps to ensure that the financial system is functioning properly. Managers should monitor program records monthly. These records may be used for evaluation, particularly when attempting to establish the cost-effectiveness of activities.

³The Population Council and Management Sciences for Health have developed an excellent manual for improving the quality of family planning services that can serve as a guide for monitoring quality community counseling. (Manual de calidad en planificación Familiar. INOPAL II. The Population Council. Management Sciences for Health. Mexico, City. 1994.)

- *Community activity reports*

Community workers should keep records on the number of support group meetings held each month, the number of women attending group meetings, etc. If they have little formal education, record keeping should be kept to a minimum and should be suitable for illiterate or semi-literate women. For instance, forms can have pictorial representation of the indicators and be designed in such a way that information can be noted by simply placing a check in the appropriate column.

- *Supervisory checklists*

Observation by supervisors is another important monitoring tool. Supervisory checklists can provide information on the progress of project implementation and the quality of the services. Examples of supervisory checklists are found in Chapter 10.

- *Interviews*

Individual or group interviews with program participants, staff, and health workers in the area are another technique for monitoring program activities. During an evaluation, participatory discussions with the community workers and community members will provide managers and supervisors with valuable information on the effectiveness of program activities.

Exit interviews, such as interviews of a random number of mothers at health clinics, can help to assess the program's coverage. Exit interviews are easier to conduct and less expensive than surveys. They can be used for both monitoring and evaluation throughout the life of the program. Each time exit interviews are used, it is essential that there are similar numbers of children within each age group.⁴

Exit interviews are more open to biases than surveys. For example, mothers of infants attending immunization clinics or growth monitoring sessions can be interviewed about breastfeeding practices. These infants may differ from infants that do not attend clinics; therefore, they are not necessarily representative of the entire population.

⁴If more younger children are included in one exit interview and more older children in another 3 month exit interview, then even if the breastfeeding rates do not differ, the first period will show higher rates because the average age of the children in the first period is younger. These children would be more likely to be exclusively breastfed than older children. If the ages of the children differ, then it is necessary to standardize the results for the differences in ages, which requires a larger sample size. This also makes the analysis more difficult.

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- *Household surveys and census*

Baseline surveys and community census collect data on breastfeeding practices before activities are implemented. They serve as the basis for comparing breastfeeding practices in the same area after activities have been operating. Baseline data are compared to data collected after the program activities have been implemented for some time.

Although they are, perhaps, the best way of measuring impact, baseline surveys and community census are often difficult to conduct at the beginning of the program because so many other actions are needed to set up the program. If it is not possible for your organization to collect baseline data, you should look for opportunities to include breastfeeding questions in baseline surveys of health, nutrition, family planning, and other projects in your program area.

When baseline data are not available, an alternative is to compare feeding practices in the program area (the intervention) to practices in a similar area without program interventions (the control). An evaluation of this type, however, cannot clearly demonstrate that changes in breastfeeding rates are associated with the program and not due to other differences in the two areas. Thus, it is important to select areas for comparison that are similar in socio-economic conditions and other factors associated with breastfeeding rates.

- *Rapid assessment surveys*

Rapid assessment surveys are mostly used as part of an evaluation. They use a limited number of questions (about 30) to collect data within a short period of time. They also use a cluster sampling method to select the women included in the survey.⁵ Data may be collected from within the program area prior to and following implementation or from intervention and control areas. Most organizations will want to request technical assistance when conducting this type of evaluation.

- *Qualitative surveys*

Qualitative information can help in identifying problems and obstacles to success. Qualitative evaluations often provide insights into the quality of services or counseling provided and add a valuable dimension to quantitative evaluation.

⁵A cluster is a randomly selected population group such as a neighborhood or block. The number of blocks to be included in the sample is based on the number of women living in the block and the sample size needed to assess differences in breastfeeding practices.

Participant evaluations often use qualitative surveys. In a qualitative survey, mothers who participate in breastfeeding counseling activities and their counselors might be asked questions about how the program is functioning and what changes they would recommend to enhance its effectiveness.

B. Data collection guidelines

In order to ensure that the data collected are useful, attention must be paid to timing, the ages of children included in the survey, sample size, and the type and phrasing of the questions.

- ***Timing***

Before scheduling an evaluation, it is important to ensure that there has been sufficient time to observe an outcome or impact. For example, in order to observe outcomes such as increased rates of exclusive breastfeeding during the first months of life, enough time must elapse for community workers to reach a sizable number of women during their pregnancy. Monitoring records will assist the program manager in establishing when this point has been reached.

- ***Ages of children to be included***

Before selecting mothers to be interviewed, decisions will need to be made on the ages of the children to be included in the survey. If the program is focused on exclusive breastfeeding during the first three months of life, you may only want to survey mothers of infants 0-11 months. If the program's goal is to increase overall breastfeeding in the community, mothers of older children (0-35 months) should also be included.

- ***Sample size***

Sample size calculations need to be based on the proportion of infants that are currently breastfed (for example, exclusively breastfed) at a specified age and the change you would like to be able to observe from the program's activities. Refer to Annex B of this chapter for guidelines on determining sample size.

- ***Phrasing of the questions***

The World Health Organization and others have conducted a great deal of research to ensure that the questions on infant feeding produce valid and reliable results. Too often, the analysis of inappropriate questions has led to misunderstanding about the actual breastfeeding situation within a community. Table 11.2 illustrates the appropriate questions to ask about feeding.

Additional questions on types of local foods fed to children can be added, but it is essential that water, milk, and other liquids are kept as separate categories in order to help mothers understand that they are included as food. In many cultures, mothers would not include these liquids when asked about feeding practices.

Table 11.2
Sample Questions for Use in Surveys on Breastfeeding Indicators¹

Date of Interview: _____ Name of Child _____		
Question: For each child, ask the respondent:	Yes	No
1. Can you tell me how old this child (Name) is today? _____ (If possible, the exact date of birth is _____)		
2. Since this time yesterday, has (name) been breastfed?		
If yes, was breastmilk (name's) main source of food?		
3. Since this time yesterday, did (name) receive any of the following:		
Vitamins, mineral supplements, medicine		
Plain water		
Sweetened or flavored water		
Fruit juice		
Tea or infusion		
Infant formula		
Tinned, powdered or fresh milk		
Solid or semi-solid food		
Oral Rehydration Salts (ORS) or solution		
Other (Specify: _____)		
4. Since this time yesterday, did (name) drink from a bottle with a nipple/teat? If yes, please describe: _____		

Source: WHO, CDD. Indicators for assessing breastfeeding practices. Geneva, 1991.

Worksheets and Annexes for Chapter Eleven: Monitoring and Evaluating the Program

This chapter includes one worksheet and three annexes that can assist in the planning and implementation of monitoring and evaluation plans.

Worksheet 11.1: **Development of a Monitoring Form**

Annex A: **Calculating Rates for Key Breastfeeding Indicators**

Annex B: **Calculating Sample Size**

Annex C: **Example of a Monitoring Form**

Worksheet 11.1
Development of a Monitoring or Evaluation Plan

Use this worksheet to develop a monitoring or evaluation plan.

Action to Take (What)	Person(s) Responsible (Who)	Dates (When)	Other (Where, how, resources)
<ol style="list-style-type: none"> 1. Define objectives and decide if a consultant should be hired 2. Decide on scope (area, activities, personnel) 3. Select indicators 4. Identify sources of information 5. Establish a schedule for data collection and analysis 6. Find/develop and pretest data collection tools 7. Identify monitors/evaluators 8. Train community workers and supervisors in collection techniques 9. Gather data 10. Tabulate and analyze data 11. Communicate findings 12. Decide on follow-up activities 			

Chapter 11: Annex A
Guidelines for Calculating the Rates for Key Breastfeeding Indicators

These guidelines explain how to calculate the rates for three key breastfeeding indicators: exclusive breastfeeding, predominant breastfeeding, and timely complementary feeding.⁶ All of these indicators depend on collecting breastfeeding practices on the day preceding the survey. No retrospective data should be used because of the many biases involved in the analyses of such data.

The data needed for these indicators are completed ages (preferably calculated by subtracting the infant's date of birth from the date of the survey) and the breastfeeding practices on the day prior to the survey. When dates of birth are not known, the ages as given by the mother can be used.

• **Exclusive breastfeeding rate**

The exclusive breastfeeding rate (EBR) is calculated as the percent of all infants (of particular ages) who receive only breastmilk, with no other liquids or solids, with the exception of drops of vitamins, mineral supplements or medicines. The WHO indicator recommends using the ages of < 4 months (0-121 days). Since exclusive breastfeeding is recommended through six months, others suggest using < 6 months (0-182 days). However, the age range you decide to use will depend on the initial rates of exclusive breastfeeding and the impact you expect to achieve from the program.

The formula to use in calculating the EBR (using the WHO indicator) is:

$$\frac{\text{\# of infants ages 0-121 days exclusively breastfed}}{\text{Total \# of infants 0-121 days}} \times 100\%$$

• **Predominant breastfeeding rate**

The predominant breastfeeding rate (PBR) is calculated as the percent of infants (at particular ages) who receive breastmilk along with water, water-based drinks (sweetened or flavored water, teas, infusions), fruit juice, oral rehydration solution, but no other liquids or solids. The sum of the exclusively breastfed and predominantly breastfed rates is the rate of full breastfeeding in the community. Some programs have been able to increase the rate of predominant breastfeeding (by encouraging women to stop feeding milk to infants) but have been unable to change

⁶ Details on how to calculate other breastfeeding indicators listed in Box 11.3 are given in Indicators for Breastfeeding, Evaluation Project. Carolina Population Center, 1995.

the exclusive breastfeeding rate because of the insistence by the culture that infants need water. Thus, collecting both the EBR and PBR is necessary since the program may in fact have a major impact on predominant breastfeeding though not on exclusive breastfeeding.

The formula to use in calculating the PBR (using the WHO indicator) is:

$$\frac{\text{\# of infants ages 0-121 days predominantly breastfed}}{\text{Total \# of infants 0-121 days}} \times 100\%$$

• **Timely complementary feeding rate**

The timely complementary feeding rate (TCR) is calculated as the percent of infants 6- < 10 months of age receiving complementary foods according to breastfeeding status. The basic indicator uses 24-hour recall of whether the infant received breastmilk and/or solid foods. Solids are defined as foods of mushy or solid consistency, not fluids

Among children 6- < 10 months of age, the percentage who receive:

- breastmilk and solids (a);
- breastmilk but no solids (b);
- no breastmilk but solids (c);
- no breastmilk and no solids (d).

The sum of a + b + c + d = 100%.

The formulas to use in calculating the TCR (using the WHO indicator) is:

(a)
$$\frac{\text{\# of infants 6- < 10 months given breastmilk and solid foods in the last 24 hours}}{\text{Total \# of infants 6- < 10 months of age}} \times 100\%$$

(b)
$$\frac{\text{\# of infants 6- < 10 months given breastmilk but no solid foods in the last 24 hours}}{\text{Total \# of infants 6- < 10 months of age}} \times 100\%$$

(c) # of infants 6-< 10 months not given breastmilk but given
solid foods in the last 24 hours

$$\frac{\text{-----}}{\text{Total \# of infants 6-< 10 months of age}} \times 100\%$$

(d) # of infants 6-< 10 months not given breastmilk nor solid
foods in the last 24 hours

$$\frac{\text{-----}}{\text{Total \# of infants 6-< 10 months of age}} \times 100\%$$

Chapter 11: Annex B Guidelines for Calculating Sample Size

To calculate the sample size, you need to determine which indicator you are most interested in, then select the sample size based on the initial rate for that indicator. Alternatively, if you want to be able to observe differences in all the key indicators, you will need to repeat this process for each indicator. Base your overall sample size on the largest sample size needed for any of the indicators.

The table on the following page⁷ gives different sample sizes needed to observe an increase in breastfeeding rates of 10%, 15%, and 20% depending on the initial prevalence of breastfeeding in the population. As the change in breastfeeding increases (from the initial level to the post-intervention level), the sample size needed to observe this change decreases.⁸

For example, if the rate of exclusive breastfeeding for infants 0-3.9 months of age (0-121 days) in the community is currently 15%, and you would like to be able to measure an increase of 10%, then your sample needs to include 248 children ages 0-121 days. However if a larger impact is expected, and you want only to be able to measure a change of 20%, then you would only need to include 71 children in the sample at these ages.

In order to have a sample size of 71 children < 4 months of age, you will need to include 18 children at each month of age ($71/4=17.75$). If you decide to include children < 12 months of age, then the total sample size in your survey will need to be 216 children ($12 \times 18 = 216$).

⁷ Taken from Winikoff, B. and Sloan, N. Breastfeeding indicators for health facilities: A discussion paper. UNICEF/WHO. No date.

⁸ The level of confidence used in this table indicates there is a 95% likelihood that the difference seen was not due to chance, and that there is an 80% chance that you were able to observe that a change did take place.

Sample Sizes Needed to Compare Baseline Breastfeeding Rates to Post-intervention Rates⁹

Initial Rate of Breastfeeding	Post-intervention Rate of Breastfeeding	Sample Size Needed
5%	15%	132
	20%	69
	25%	44
10%	20%	195
	25%	96
	30%	59
15%	25%	248
	30%	119
	35%	71
20%	30%	292
	35%	137
	40%	80
30%	40%	355
	45%	162
	50%	93

⁹ Calculations of sample sizes based on the formula $n = z^2 (pq)/d^2$ where:
 $z = 1.96$ (given a 95% confidence level and type I error = .05)
 $p =$ estimated minimum prevalence of breastfeeding in the project area
 $q = 1 - p$
 $d =$ absolute accuracy (+, an absolute percent from the minimum prevalence) of the measurement at the given confidence level.

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Chapter 11: Annex C
Example of a Monitoring Form that Includes Breastfeeding Information
from an Integrated Maternal Child Health Care
Home Visiting Program for Children under One Year

The following forms include all of the basic indicators that are monitored in integrated maternal child health programs. If you are already monitoring some of the child survival or reproductive health indicators, you may want to add breastfeeding and complementary feeding indicators to your monitoring forms. Inclusion of these indicators should be discussed with the community workers who participate in the program. They will need additional training on how to collect the information.

The sample monitoring form in this annex has been adapted from the monitoring forms developed by La Liga de la Lactancia Materna de Honduras, La Leche League of Guatemala, and the Community Leader's Notebook from Pastoral da Criança in Brazil. It shows the first three months of data collection. The form can be placed on a large pad with mother's questions on one side and baby's questions on the other. Community workers can tear off sheets and have a note book in which to file them. Or, the organization might consider two bound soft cover books, one for mother's files and one for baby's files. Pastoral da Criança collects less information about feeding and family planning and combines everything on one sheet. La Liga de Lactancia Materna de Honduras uses a large sheet, with identifying pictures at the head of each column and uses one side for information about the mother and the other side for information about the baby.

Community workers should schedule one "official" meeting with the mother to discuss and fill out all of the appropriate items. Additional visits may be indicated at the end of the mother's sheet with tally marks ††.

Programs will need to culturally define some of the terms, such as milks, and adjust terms as needed. "Appropriate weight gain" assumes policy guidelines for growth monitoring. If such guidelines have not been developed, the Ministry of Health or NGO may wish to form a working group to develop such guidelines. The definition of malnutrition will also vary according to the policy guidelines. For this community monitoring form, any child that has not gained the agreed upon minimum weight gain may be considered at risk for malnutrition. Mothers of these children will need extra support, counseling and, as necessary, supplemental food.

Once a community diagnostic or census has been developed, the careful completion of these forms, combined with annual or semi-annual updates of the census, will give program managers, staff, and the community a rich data base for evaluating the quality and outcomes of the activities.

Home Visiting Monitoring Form			
Baby's name _____	Birthdate ____/____/____	Birth Wt. _____	
Address _____	Year _____	Health Center _____	
Counselor _____	Code # _____		
A. Baby	Mo. 1	Mo. 2	Mo. 3
1. Date of this visit.			
2. Was ____ born this month? (Y for yes, N for no)			
3. Did ____ die this month? (Y for yes, N for no). If yes, ask mother about circumstances).			
4. Baby's age in months.			
5. Since this time yesterday, did the baby breastfeed? (Y for yes; N for no) If yes, continue. If no skip to #8).			
6. Between sun up and sun down yesterday, about how many times did ____ breastfeed?			
7. Between sun down yesterday and sun up today, how many times did ____ breastfeed?			
8. Did ____ drink milks? (F for formula, T for tinned, A for fresh animal milk, N for no).			
9. Did ____ drink either plain or sugared water ? (Y for yes; N for no).			
10. Did ____ drink juices, teas, or other liquids? (Y for yes; N for no).			
11. Did ____ eat any solid or mushy foods? (Y for yes; N for no).			
12. Did ____ eat any fruits or bright colored vegetables? (Y for yes; N for no).			
13. What was ____'s weight this month? (Mark weight. If not weighed, either weigh or refer).			
14. Did ____ gain minimum weight this month? (Y for yes; N for no. If no counsel or refer).			
15. Is ____ malnourished? (Y for yes; N for no) If no, skip to #17. If yes, continue.			
16. Is ____ in a program to help him/her gain weight? (Y for yes; N for no. If no, refer).			
17. Did ____ have diarrhea since the last visit? (Y for yes; N for no) If no, skip to 19. If yes, continue.			
18. Was ____'s diarrhea treated with ORS or a home remedy? (O for ORS; H for home remedy).			

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19. Is ___'s vaccine schedule up-to-date? (Y for yes, N for no). If no, refer.			
20. Is ___'s Vitamin A supplementation schedule up-to-date? (Y for yes, N for no). If no, refer.			
21. Did ___ have a cold or cough since the last visit? (Y for yes, N for no).			

CONTINUE WITH MOTHER'S QUESTIONS

Mother's name _____ Father's name _____ Address _____ Year _____	Participates in: Mother's Club <input type="checkbox"/> Support Group <input type="checkbox"/> Childbirth Class <input type="checkbox"/> Food Supplement Program <input type="checkbox"/> Mother's Occupation _____ Father's Occupation _____ Baby's name _____ Code # _____
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B. Mother	Mo.1	Mo.2	Mo.3
1. (Postpartum) Did you menstruate since last visit? (Y for yes, N for no).			
2. Are you pregnant? (Y for yes, N for no, DN for don't know), If yes, skip to #7. If no, continue.			
3. Do you want to become pregnant in the near future (Y for yes, N for no), If yes, skip to #6. If no, continue.			
4. Are you using a method to avoid being pregnant? (Y for yes, N for no), If yes, continue, if no, skip to #6.			
5. What method are you using? (M for Modern family planning method; L for LAM; T for traditional). If traditional or LAM, counsel and refer as necessary and skip to #10.			
6. Would you like to learn more about how to space your next pregnancy? (Y for yes, N for no). Counsel, refer and skip to #10.			
7. In what month of pregnancy are you? (Place month in box).			
8. Are you receiving prenatal care? (Y for yes; N for no). If no, refer.			
9. Is your tetanus vaccine schedule up to date? (Y for yes; N for no). If no, refer.			
10. Did you visit a health center since the last visit for your own health or for a check-up? (Y for yes, N for no). If yes, continue. If no, skip to #12.			
11. Were you satisfied with the care and attention you received? (Y for yes, N for no).			
12. Since the last visit, did you take (baby) to the health clinic for a cold, cough, diarrhea, immunization or other visit (Y for yes, N for no). If yes, continue. If no, refer if necessary and skip to 15.			
13. What was the reason for visiting the health clinic with your baby? (A for ARI, D for diarrhea, G for growth monitoring, I for immunization, O for other).			
14. Were you satisfied with the care and attention your child received? (Y for yes, N for no).			
15. TOTAL Number of visits to the mother this month (put totals in box for appropriate month).			
16. Did mother participate in support group, weighing sessions, or other group meetings this month? (S for support, G for weighing, E for other education, N for nothing).			

Summary Form

Counselor's name _____ Community _____
 Address _____ Health Center _____
 Code # _____ Year _____

A. Babies	Mo.1	Mo.2	Mo.3
1. # babies born this month.			
2. # babies died this month.			
3. Total babies under one year followed up.			
4. Total babies under six months followed up.			
5. # babies breastfeeding more than 8 times in last 24 hours.			
6. # babies under six months receiving only breastmilk.			
7. # babies under six months receiving breastmilk and other milks.			
8. # babies under six months receiving only other milks.			
9. # babies under six months receiving breastmilk and water.			
10. # babies under six months receiving breastmilk and other liquids.			
11. # babies under six months receiving solids.			
12. # babies over six months receiving solids.			
13. # babies over six months receiving breastmilk, other milks and solids.			
14. # babies over six months receiving other milks and solids, but no breastmilk..			
15. # babies this month with appropriate weight gain for age.			
16. # babies malnourished.			
17. # malnourished babies in nutritional recuperation program.			
18. # babies with diarrhea.			
19. # babies who received ORS.			
20. # babies with up-to-date vaccines for age.			
21. # babies with appropriate Vitamin A supplementation.			
22. # babies with ARI.			
23. # babies needing medical treatment for ARI.			

Summary Form			
Counselor's name _____	Community _____		
Address _____	Health Center _____		
Code # _____	Year _____		
B. Mothers	M 1	M 2	M 3
1. # of amenorrheic women with babies under six months.			
2. # pregnant women.			
3. # of women who want to space pregnancies (postpartum women who do not wish pregnancy).			
4. # of postpartum women menstruating.			
5. # postpartum women using modern family planning methods.			
6. # postpartum women using traditional methods.			
7. # of family planning referrals.			
8. # of women in prenatal care.			
9. # of pregnant women with up-to-date tetanus vaccine schedule.			
10. Total number of women visiting health center for any reason.			
11. Total number of women expressing satisfaction with attention received at health center.			
12. # of children taken to health center.			
13. # of children whose mothers express satisfaction with care received at health center.			
14. Total home visits this month.			
15. # of support groups or other group sessions held.			
16. # of participants in support groups or other group sessions.			

Chapter Twelve

Sustaining the Program

Many governmental and nongovernmental programs face funding cuts or withdrawal of donor support at some time. In recent years, concern about the sustainability of many primary health care activities has become widespread. This concern has been prompted by various considerations, foremost among them financial considerations, such as decreases in funds available for development activities and the need to "do more with less." In addition, the emergence of new diseases like AIDS has forced a realignment of health priorities in many locations.

Given the current environment, how can breastfeeding programs be sustained? Many breastfeeding promotion and support activities are still in their infancy. Often, there are few institutional or financial resources committed to the effort. This concluding chapter of the manual examines factors that can threaten programs and identifies ways of seeking program, institutional, and financial sustainability.

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I. Definition of sustainability

Sustainability means different things to different people. For some, it may imply program sustainability, which is characterized by a long-term continuation of activities. Others think of institutional sustainability with a focus on the ongoing existence of an organization and its particular objectives. Perhaps the most common definition of sustainability is financial sustainability, which means constant funding or financial support.

This manual adopts the broadest interpretation, viewing sustainability as the continuation of programmatic activities that will support breastfeeding, with whatever institutional or financial arrangements are necessary to preserve these activities. In the most basic sense, sustainability refers to a program's ability to continue supporting mothers in improved breastfeeding practices.

II. Factors affecting sustainability

Many factors can affect a program's sustainability. The remainder of the chapter examines the impact of various factors on program, institutional, and financial sustainability.

A. Program sustainability

Factors that may affect program sustainability are the target population, quality of services, personnel resources, and the program's ability to change.

Target population

Community-based programs extend breastfeeding support to women who are less apt to have routine contact with or easy access to the organized health care system. These women and their infants often represent a higher risk group and may be harder to reach. However, at the beginning of a new program, it is often advisable to start with those groups that are easiest to reach, accessible through an existing organization or facility, and dependent on a minimum input of human and other resources.

Another issue to consider in identifying target populations is their potential role in generating support for the program. If program planners define their activities and target groups too narrowly, they may pay inadequate attention to a constituency that could help gain broader public and political support for the program. This perspective should be considered in the early stages of planning when target groups and activities are being determined.

Quality of services and human resources

Programs must be responsive to the interests of the target population in order to sustain demand for their services. The provision of quality services is a major contributor to sustainability. Program quality depends upon trained, competent, and motivated staff and volunteers. Retention of these workers helps to ensure continuity, builds a network of experienced community-based workers, and reduces new training costs.

At the community level, staff or volunteers often quit because they lose interest, feel unappreciated, lack family support, seek paid employment, or become discouraged when mothers fail to attend meetings or change their behaviors immediately. Below are suggested ways of keeping staff morale and enthusiasm high.

- Provide supportive supervision at all levels in the program. See Chapter 10 for a discussion of supportive supervision.
- Ensure that all staff understand the goals of the program and are kept informed about progress in the achievement of these goals.
- Give personal and public recognition to staff.
- Offer opportunities for personal growth. Additional training and new responsibilities can also help to maintain workers' interest in their job and increase their status in the community. For example, experienced community workers can be hired to serve as assistants in breastfeeding training courses or employed as supervisors.

Program managers may want to make special efforts to ensure that community workers, especially volunteers, feel that they are an integral part of the program. Box 12.1 gives examples of efforts to maintain enthusiasm and motivation among community workers.

Box 12.1

Examples of Incentives for Community-level Workers

- Stipends, food rations, free medical services, and allowances during training are ways that the sponsoring organization can demonstrate to workers that they value their time and service.
- A formal certificate, graduation ceremony, and training diploma are public acknowledgments of a breastfeeding counselor's accomplishments.
- Special clothing and other articles distinguish community workers. In Brazil, breastfeeding workers wear a badge. The Breast Is Best League in Belize provides community-based counselors with a T-shirt, bag, textbook, and other materials.
- Income-generating or micro-enterprise activities sponsored by the program provide a source of income for community-level workers.

Ability to change

Programs that do not respond to changing conditions or demands are likely to fail. A program's monitoring and evaluation system should provide information that helps to track the current situation and identify threats and opportunities. Analysis of this information can help you understand the reasons for a change in any of the factors that affect sustainability and find appropriate strategies for addressing each problem or opportunity. Box 12.2 illustrates the change of program focus over time in Honduras.

Box 12.2

Changing to Improve Program Sustainability

In 1982, when the Breastfeeding Support Project (PROALMA) began in Honduras, hospital practices were not supportive of breastfeeding. For example, infant formula provided by health workers was introduced just after birth. Ten years later, over 98% of post-partum women initiated breastfeeding. During this period, hospital norms changed. Now all normal newborns and most high-risk babies receive only breastmilk. In response to these changes, the focus for breastfeeding promotion has shifted from hospital-based to community-based activities.

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B. Institutional sustainability

Whether an organization is governmental or nongovernmental, institutional sustainability depends on a clear organizational mission and strategy, political commitment, program visibility, and integration in health services. Linking with other health services, raising awareness of breastfeeding issues among policy makers, and educating the general public are important ways of fostering support for breastfeeding.

Political commitment

A factor affecting institutional sustainability is the level of political commitment for community-based breastfeeding activities. Although breastfeeding represents a priority public health intervention with enormous benefits to family, community, and nation, other pressing concerns are also on the agenda of decision makers. As a result, generally few resources are committed to breastfeeding programs. This limited programmatic base for breastfeeding support suggests the need to begin small, build up the program over time, and broaden the base of support for breastfeeding programs. Capturing and maintaining the interest of prominent local or national personalities is often an important task of program managers.

Program visibility

One way of creating interest in the program is to publicize it. As a means of "validating" their existence, organizations need to demonstrate impact and inform donors, program participants, other organizations, and the general public of their accomplishments. The ability to show results and document "lessons learned" is also a strategy for attracting additional funding.

A program that does nothing to disseminate information, promote its image, and build support beyond its immediate service population may have a difficult time sustaining itself. Ways of bringing visibility to the project include publishing articles based on monitoring and evaluation data, arranging for the press to interview satisfied participants, developing a sense of ownership of the program among influential policy makers, and keeping all concerned parties informed of program developments.

Linkages with health services

Lack of collaboration with other health services and community organizations results in isolation and threatens sustainability. Integration of breastfeeding into the larger context of health programming is important for institutional sustainability. This integration can occur in many ways, as illustrated in Box 12.3.

Box 12.3

Ways of Integrating Breastfeeding Counseling and Support into Health Services

- High priority given to breastfeeding promotion and support in the Ministry of Health
- Line item in the MOH budget for breastfeeding support
- Integration of breastfeeding into primary health care, child survival, and other basic community-level health programs
- Inclusion of breastfeeding topics in the curriculum of medical and nursing schools
- Routine collection of data on breastfeeding as part of the country's health information monitoring system
- Questions on breastfeeding practices in national level demographic, health, and similar surveys.

C. Financial sustainability

While the long-term goal of breastfeeding support may be programmatic sustainability, this objective is often overshadowed by the need to find financial support. Sound management and financial planning and effective control systems can help to ensure sustainability. Within an organization, a system must be in place that monitors expenditures and provides information on program costs. A poor time to consider sustainability is when the money runs out.

It is important for any organization, but particularly a private sector breastfeeding promotion and support organization, to develop an infrastructure that will allow it to achieve its organizational goals. Such a structure will help assure that breastfeeding (or other activities) are not "project" or "donor" driven. The decision to focus on community-based activities should be carefully considered, since once a commitment is made to the community, it does not help long-term sustainability to drop activities when funding ceases.

One of the program manager's most important roles is to secure financial support for the program. To do this, the manager should:

- Keep in touch with funders on a regular basis in order to learn about new opportunities,
- Find creative ways to utilize resources available to him or her,
- Look for alternate financing possibilities,
- Approach both large and small donors, and
- Involve the Board of Directors of NGOs in raising funds and soliciting financial support. The Board should contain members who have access to people or corporations that can donate money to the NGO. The Board can help raise money by sponsoring fund-raising activities, such as selling products, sponsoring parties or other entertainment activities, and encouraging their friends to make donations directly to the organization.

A helpful approach to achieving financial/institutional sustainability for some organizations is through the development of a strategic plan for achieving the organizational goals. One important aspect of such a plan is the focus on the need for financial sustainability. Organizations may want the assistance of an expert in strategic planning. This assistance may be available through large international donors or from the Business Administration Faculty of a local university.

Organizations that provide community breastfeeding support have been financed in various ways. Potential donors and alternate funding sources are discussed below.

Potential donors

Government agencies, local and international foundations, industries, corporations, commercial enterprises, or NGOs are all potential sources of funding. They may support the program with a contribution, grant, or a contract for training, research, or program activities. Their requirements for funding proposals may vary greatly. If program managers follow the planning process outlined in this manual and develop a comprehensive, well-conceived plan, they can readily turn this plan into a proposal for use in seeking donor or other financial support.

In addition, international donors are often good sources for assistance in improving organizational capacity and infrastructure. Donor support can be requested not only for program activities, but also for planning exercises, technical assistance in management, or aid in developing fund-raising proposals.

Alternate funding sources

Program managers should not limit themselves to traditional funding sources. Many NGOs have raised funds through various approaches, listed below.

- In-kind contribution of goods (such as office space and equipment) and services (trainers and consultants)
- Income-generating activities that provide services (day care) or produce items that are sold such as T-shirts, posters, and educational materials
- Fees charged for the provision of technical assistance, clinical services, or breastfeeding conferences
- Membership fees (individual and institutional)
- Personal contributions
- Breast pump rentals

Fund raising is a continual process. It is always necessary to think of the funds that will be needed in the future because it generally takes a minimum of six months (or more) to obtain new project funds.

The Sustainability Checklist on the following page and the worksheet will help you conduct a sustainability analysis of your organization or program.

Sustainability Checklist

Does your organization . . . ?

✓

- Understand the community and target groups?
- Engage the community in assessment, analysis, and action?
- Set specific project goals and measurable objectives?
- Decide on an appropriate strategy for the local situation?
- Have a management system that looks at overall program development and sustainability?
- Develop a financial management system that provides information to monitor the cost of services?
- Recruit qualified and motivated trainers and supervisors?
- Recruit reliable and respected counselors from the community?
- Provide in-service training for staff?
- Support counselors to provide a quality service?
- Reward staff for excellent job performance?

- Develop joint public and private ventures and community participation to reach the poorest and high-risk populations?
- Look for new strategies for generating income?

Adapted from The Family Planning Manager's Handbook. Management Sciences for Health. 1991.

Worksheets for Chapter 13: Sustaining the Program

Look at the factors that can affect sustainability in the example below. Describe the threat or opportunity posed to your program's sustainability on the blank form on the following page. Identify possible strategies in response to the problem or opportunity.

Sustainability Factors List - Example

Factor: Threat/Opportunity	Strategy
1. Target population Threat: increased density in catchment area	Concentrate services on pregnant women and mothers during the first six months postpartum
2. Target group knowledge, attitudes, and practices Threat: resistance to exclusive breastfeeding by mothers-in-law	Try to increase attendance of other family members, not just mothers, at support group meetings
3. Service quality Threat: poor attendance at group meetings	Schedule meetings at convenient times, broaden the topics of discussion
4. Management support Threat: inadequate supervision	Provide continuing education and training to management staff or reduce the number of counselors each supervisor must mentor
5. Organizational capacity Threat: little contact of local group with sponsoring organization	Strengthen links with the health community
6. Political commitment Threat: low, narrow-based support; conflicting advice from health professionals	Invite health professionals to attend breastfeeding training sessions
7. Personnel resources Threat: high turnover of counselors	Implement a staff incentive plan
8. Revenues Threat: inadequate revenue for program activities	Encourage local organizations to initiate income generating activities
9. Expenditures Threat: high costs	Reduce the frequency of household visits to low-risk cases
10. Environment Threat: deteriorating roads reducing number of supervisory visits	Use experienced, community-based counselors as mentors to new counselors

**Worksheet 12.1
Sustainability Factors**

After completing the table below, consider the financial implications of each strategy and the impact on revenues and expenditures.

Classify each factor, describe the threat or opportunity posed to program sustainability	Identify possible strategy in response to the problem or opportunity
Factor: Threat/Opportunity; Description	Strategy
1. Target population	
2. Target group knowledge, attitudes, and practices	
3. Service quality	
4. Management support	
5. Organizational capacity	
6. Political commitment	
7. Personnel resources	
8. Revenues	
9. Expenditures	
10. Environment	

Adapted from Primary Health Care Management Advancement Program. Aga Khan Foundation and University Research Corporation. Module 9, Sustainability Analysis, User's Guide.

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- Center for Population Options. Teenage pregnancy and sexually transmitted diseases in Latin America. Washington, DC: Center for Population Options, 1990.
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- Macro International Inc. Demographic and Health Surveys.

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World Bank. World development report: Investing in health. Washington, DC: The World Bank, 1993.

INFANT FEEDING RESOURCES

- Adamson P. *Facts for life*. Oxford: UNICEF, WHO, UNESCO, UNFPA, 1993.

This book presents essential child health information that all families have a right to know. "It is the most authoritative expression, in plain language, of what medical science now knows about practical, low-cost ways of protecting children's lives and health." Over 100 countries have produced their own adaptations. *Facts for Life* has been translated into more than 170 languages. Contact the UNICEF office in your country for copies.

- Dicken K, Griffiths M, Piwoz E. *Designing by dialogue: consultative research for improving young child feeding*. Washington, DC: The Manoff Group and Academy for Educational Development, forthcoming. Order from AED, 1255 23rd St. NW, Washington, DC 20037 USA.

- Favin M, Baume C. *A guide to qualitative research for improving breastfeeding practices*. Washington, DC: Wellstart International's Expanded Promotion of Breastfeeding Project, 1996.

Available in English from Wellstart International, 4062 First Avenue, San Diego, CA 92103.

- Griffiths M, Anderson MA. *Guide for country assessment of breastfeeding practices and promotion*. Washington, DC: MotherCare, 1993.

Designed to assist a team in preparing for a breastfeeding assessment that examines the current breastfeeding situation, factors supportive of breastfeeding, obstacles to breastfeeding, and gaps requiring further investigation or immediate action. In English. Copies available from MotherCare, 1616 N. Fort Meyer Drive, 11th floor, Arlington, VA 22209 USA.

- Jelliffe DB, Jelliffe EF. *Programmes to promote breastfeeding*. Oxford: Oxford University Press, 1988.

Discusses the experiences and different components of breastfeeding programs throughout the world.

- King FS. *Helping mothers to breast feed*. Nairobi: African Medical and Research Foundation, 1987.

Written for health workers, this manual summarizes current information on lactation management. Available in Spanish and Russian from Wellstart International, 4062 First Avenue, San Diego, CA 92103. Available in English from AMREF, 49 Sheridan Avenue, Albany, NY 12210.

- King FS, Burgess A. *Nutrition for developing countries*. 2nd Edition. Oxford: Oxford University Press, 1993.

Excellent resource. Presents a core of practical nutritional knowledge. In English with illustrations from Africa. Order from Oxford University Press, Saxon Way West, Corby, Northants NN18 9ES, England.

- La Leche League International. *The womanly art of breastfeeding*.

Provides practical information, reports the latest findings from the most recent breastfeeding research, and explains the benefits of human milk for babies. Available in Spanish, French, Italian, Dutch, Japanese, German, Indonesian, Hebrew. Contact the local La Leche League office or order from La Leche League International, P.O. Box 1209, Franklin Park, IL 60131-8209 USA.

- Labbok M, Koniz-Booher P, eds. *Breastfeeding: protecting a natural resource*. Washington, DC: IMPACT, Institute for Reproductive Health, Georgetown University, 1990.

An attractive, informative booklet to give to policy makers that summarizes the benefits of breastfeeding and programs to promote and support breastfeeding. Available in English, Spanish, French. Order from: Resource Center, Institute for Reproductive Health, Georgetown University Medical Center, Georgetown Center, Suite 602, 2115 Wisconsin Ave. NW, Washington, DC 20007.

- Saadeh RJ, Labbok M, Cooney K, Koniz-Booher P, eds. *Breast-feeding: The technical basis and recommendations for action*. Geneva: World Health Organization, 1993.

Designed to provide policy makers and program planners with up-to-date technical information and recommendations for strategic planning to protect, promote, and support breastfeeding. Available from Resource Center, Institute for Reproductive Health, Georgetown University Medical Center, Georgetown Center, Suite 602, 2115 Wisconsin Ave. NW, Washington, DC 20007.

- Valdés V, Pérez A, Labbok M. *Lactancia para la Madre y el Niño*. 1994.

This clinical handbook presents the tools necessary to support breastfeeding and to optimize its fertility impact. In Spanish. Order from Resource Center, Institute for Reproductive Health, Georgetown University Medical Center, Georgetown Center, Suite 602, 2115 Wisconsin Ave. NW, Washington, DC 20007.

BREASTFEEDING TRAINING RESOURCES

Wellstart International

Community-based breastfeeding support: A training curriculum. Wellstart, 1996.

This prototype curriculum was developed for use in training community-based counselors, health promoters, and auxiliary nurses in lactation management, counseling, and support group formation. The curriculum uses a participatory methodology which involves the trainees in the training process by encouraging them to reflect upon their own experiences and develop solutions to community problems as a group. This methodology has been very effective with low-literate health workers and community members. The curriculum is available in Spanish, English, and French from Wellstart International, 4062 First Avenue, San Diego, California 92103.

Community-based breastfeeding support: A guide for trainers and supervisors. Wellstart, 1996.

The manual, divided into training sessions with guides for trainers, discusses such issues as recruitment and selection of community personnel to support breastfeeding, effective communication, and counseling skills. Available in Spanish, English, and French.

La Leche League

La Leche League International. *Breastfeeding peer counselor program.* 1994.

The notebook discusses goals, methods, objectives, planning, budgeting, and training curriculum. It also includes articles on lactation management and sample materials such as a counselor certificate for participation in a training course.

Pan American Health Organization

Rodriguez-Garcia R, Schaefer LA, Yunes J, editors. *Educacion en lactancia para los profesionales de la salud.* Panamericana de la Salud, 1990.

"The design of the module allows it to be used with undergraduate and graduate level nursing students, as a post-graduate program for nursing or medical faculty and health and nutrition professionals, as well as for the continuing education of nurses, physicians, and other health personnel that work in maternity wards, prenatal clinics, the community, and other health service areas. . . . When it is used for community health workers, topics such as the anatomy and physiology of reproduction might be addressed more superficially while the topics of breastfeeding promotion and education techniques would be emphasized."

Varela CB. *Módulo para capacitacion sobre la lactancia materna.* No. 20. Serie PALTEX para técnicos medios auxiliares. Panamericana de la Salud, 1990.

Ministry of Health, Colombia

Osorno J. *Hacia una feliz lactancia materna: texto práctico para profesionales de la Salud*. Bogotá: Miniserio de Salud, ICBF, UNICEF, 1992.

Ministry of Health, Dominican Republic

Secretary of State of Public Health and Social Assistance, Department of Maternal-Child Health. *Manual de Lactancia Materna*. Dominican Republic, 1993.

The set of three manuals is used to train health promoters, supervisors, and coordinators. The promoter manual contains breastfeeding information and communication techniques. The supervisor and coordinator manuals contain a ready-made curriculum for training the health promoters.

UNICEF/IBFAN

Armstrong HC. *Training guide in lactation management*. New York: UNICEF/IBFAN, 1992.

The guide is usually used to prepare and teach an 80-hour course "to develop a cadre of personnel with enough knowledge of lactation management to become trainers. Considerable experience is necessary to prepare and conduct such a course."

UNICEF/WHO

UNICEF and WHO. *Breastfeeding management and promotion in a baby-friendly hospital*. New York: UNICEF, 1993.

The 18-hour course informs maternity workers about practices that support breastfeeding and introduces them to the Baby Friendly Hospital Initiative. It does not give detailed training in clinical and counselling skills.

UNICEF and WHO. *Breastfeeding counselling: a training course*. Geneva: WHO, 1993.

This course is designed for health workers in maternity facilities, hospitals and health centers. "A course is normally for 15-20 participants and 5-6 trainers. The duration is 5 days or 40 hours in which 33 sessions are covered. The training is structured in a sequence of presentation, discussion, demonstration and exercise followed by clinical practice with real mothers and babies in a health facility. There are four clinical practice sessions of about two hours each. When a course is introduced, an additional 40 hours, or 5 days are necessary for the preparation of trainers."

COMMUNITY DEVELOPMENT, PLANNING, AND MANAGEMENT RESOURCES

World Health Organization

WHO has developed a set of *Program Management* booklets called "modules" for managers of national programs on acute respiratory infections and diarrheal disease. The skills taught in these modules, such as setting national program policy, writing objectives, planning and monitoring program activities, and evaluating progress, also apply to the manager of community-based infant feeding counseling programs. The modules are available from WHO in Spanish and English.

Other management resources developed by WHO are the books, *On Being in Charge: a Guide to Management in Primary Health Care*, 1992, and *The Supervision of Health Personnel at District Level*, 1988.

Aga Khan Foundation and University Research Corporation

The *Primary Health Care Management Advancement Programme* is a series of 9 modules "to help local PHC (primary health care) management teams collect, process and analyze useful management information." At present, the modules are available in English. The titles of the modules are:

- Module 1: Assessing information needs
- Module 2: Assessing community health needs and coverage
- Module 3: Planning and assessing health worker activities
- Module 4: Surveillance of morbidity and mortality
- Module 5: Monitoring and evaluating programmes
- Module 6: Assessing the quality of service
- Module 7: Assessing the quality of management
- Module 8: Cost analysis
- Module 9: Sustainability analysis

The modules are available for \$30 from

University Research Corporation
Center for Human Services
7200 Wisconsin Avenue
Bethesda, MD 20814

Pan American Health Organization

Serie: Material de apoyo para la capacitacion en gerencia de programas de salud maternoinfantil y planificacion familiar. The three modules (I - *Gerencia y negociacion*, II - *Liderazgo*, and III - *Evaluacion de programas de salud y toma de decisiones*) are used to train program planners about the business, leadership, and evaluation of health care programs. Each manual is designed as a curriculum that includes theoretical background information, teaching activities, and case studies.

Pan American Health Organization
525 23rd Street NW
Washington, DC 20037-2895

Management Sciences for Health

The family planning manager's handbook: basic skills and tools for managing family planning programs is an excellent reference. Although designed for the manager of family planning programs, the management topics and skills apply to managers of other health programs.

Management Sciences for Health
400 Centre Street
Newton, Massachusetts 02158, U.S.A.

Office of International Training and Consultation, Northern Illinois University

Gajanayake S, Gajanayake J. *Community empowerment: A participatory training manual on community project development*. New York: PACT, 1993.

A manual to enable community development workers to identify, plan, implement, and evaluate community development projects. Includes 25 workshop sessions. In English.

PACT Publications
777 United Nations Plaza
New York, NY 10017

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Heifer Project International

Aaker J, Shumaker J. *Looking back and looking forward: A participatory approach to evaluation*. Little Rock, Arkansas: Heifer Project International, 1994.

The emphasis is on a process in which managers, field staff, and community leaders can plan and implement self-evaluations of their own development projects. (English and Spanish)

Heifer Project International
P.O. Box 808
Little Rock, AR 72203
(Phone: 1-800-422-0474)

Hesperian Foundation

Werner D, Bower B. *Helping health workers learn*. California: The Hesperian Foundation, 1982.

Good description of the community development model. The same organization has produced publications such as *Where There Is No Doctor*.

The Hesperian Foundation
P.O. Box 1692
Palo Alto, CA 94301

WELLSTART INTERNATIONAL

Wellstart International is a private, nonprofit organization dedicated to the promotion of healthy families through the global promotion of breastfeeding. With a tradition of building on existing resources, Wellstart works cooperatively with individuals, institutions, and governments to expand and support the expertise necessary for establishing and sustaining optimal infant feeding practices worldwide.

Wellstart has been involved in numerous global breastfeeding initiatives including the Innocenti Declaration, the World Summit for Children, and the Baby Friendly Hospital Initiative. Programs are carried out both internationally and within the United States.

International Programs

Wellstart's *Lactation Management Education (LME) Program*, funded through USAID/Office of Nutrition, provides comprehensive education, with ongoing material and field support services, to multidisciplinary teams of leading health professionals. With Wellstart's assistance, an extensive network of Associates from more than 40 countries is in turn providing training and support within their own institutions and regions, as well as developing appropriate in-country model teaching, service, and resource centers.

Wellstart's *Expanded Promotion of Breastfeeding (EPB) Program*, funded through USAID/Office of Health, broadens the scope of global breastfeeding promotion by working to overcome barriers to breastfeeding at all levels (policy, institutional, community, and individual). Efforts include assistance with national assessments, policy development, social marketing including the development and testing of communication strategies and materials, and community outreach including primary care training and support group development. Additionally, program-supported research expands biomedical, social, and programmatic knowledge about breastfeeding.

National Programs

Nineteen multidisciplinary teams from across the U.S. have participated in Wellstart's lactation management education programs designed specifically for the needs of domestic participants. In collaboration with universities across the country, Wellstart has developed and field-tested a comprehensive guide for the integration of lactation management education into schools of medicine, nursing and nutrition. With funding through the MCH Bureau of the U.S. Department of Health and Human Services, the NIH, and other agencies, Wellstart also provides workshops, conferences and consultation on programmatic, policy and clinical issues for healthcare professionals from a variety of settings, e.g. Public Health, WIC, Native American. At the San Diego facility, activities also include clinical and educational services for local families.

Wellstart International is a designated World Health Organization Collaborating Center on Breastfeeding Promotion and Protection, with Particular Emphasis on Lactation Management Education.

For information on corporate matters, the LME or National Programs, contact:

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