Learning from large-scale community-based programmes to improve breastfeeding practices

World Health Organization

unicef

AED Academy for Educational Development

USAID FROM THE AMERICAN PEOPLE

Africa's Health in 2010

LEARNING FROM LARGE-SCALE COMMUNITY-BASED PROGRAMMES TO IMPROVE BREASTFEEDING PRACTICES

World Health Organization
unicef
AED
Academy for Educational Development
USAID
FROM THE AMERICAN PEOPLE
Africa's Health in 2010

WHO Library Cataloguing-in-Publication Data

Learning from large-scale community-based programmes to improve breastfeeding practices.

1.Breast feeding - psychology. 2.Community health aides - education. 3.Community health aides - utilization. 4.Community health care - organization and administration. 5.Guidelines. 6.Program evaluation. 7.Developing countries. I.World Health Organization.

ISBN 978 92 4 159737 1 (NLM classification: WS 125)

© World Health Organization 2008
All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed in Geneva

TABLE OF CONTENTS

Acknowledgments 1

Executive Summary 3

Introduction 5

1. Evolution of Community-based Breastfeeding Promotion and Support 10
2. Providers of Community-based Breastfeeding Promotion and Support 11
3. Case Studies 15
   3.1 Programme Frameworks for Breastfeeding Promotion and Support 16
   3.2 Description of Community Activities 18
      3.2.1 Gaining political commitment and support 18
      3.2.2 Engaging the community 18
      3.2.3 Working with community health workers 19
      3.2.4 Involving other community members 21
      3.2.5 Training community health workers and other volunteers 22
      3.2.6 Using behaviour change communication (BCC) to change individual behaviours and community norms 24
      3.2.7 Monitoring and evaluating programme progress 27
   3.3 Key Finds and Critical Questions 27
   3.4 Conclusion 31

References 33

Annexes

Annex 1 Resources for Community-based Breastfeeding Programmes 37
Annex 2 Questionnaire for Community-based Breastfeeding Case Studies 39
Annex 3 Health and Nutrition Indicators of the Ten Countries Featured in the Case Studies 43
Annex 4 Case Studies in Community-based Breastfeeding Promotion and Support 45
Benin ……46
Bolivia……49
Cambodia……...52
Ethiopia……..…...55
Ghana ……..……..58
Honduras ……..……61
India …….…64
Madagascar ……...68
Mali ……...71
Nepal ……73

Figures

Figure 1 Trends in National Exclusive Breastfeeding Rates in Ten Countries 9

Tables

Table 1 Providers of Community-based Breastfeeding Activities 14
Table 2 Role of Community Health Workers and Their Training 23

Boxes

Box 1 Components of a National Plan of Action for Infant and Young Child Feeding 11
Box 2 Behaviour Change Communication for Improved Breastfeeding Practices 28

ACKNOWLEDGEMENTS

The primary author of this paper is Luann Martin in collaboration with SM Moazzem Hossain, Carmen Casanovas, and Agnes Guyon. Julia Krasevec collected information on country health and nutrition indicators with collaboration from the Division of Policy and Planning in UNICEF. We are grateful to those who completed the questionnaires or provided additional information on community-based breastfeeding programmes including Victor Aguayo (Benin and Mali), Mary Ann Anderson, Deepika Nayar Chaudhery, and Ashi Kohli Kathuria (India), Marcia Griffiths and Tom Schaetzel (Honduras), Agnes Guyon (Ethiopia and Madagascar), Kyoko Okamura (Ethiopia), Pragya Mathema (Nepal), Thazin Oo and Mary Chea (Cambodia), Maryanne Stone-Jimenez (Bolivia), and Gil Won Cusack and Joan Schubert (Ghana). Review comments from Victor Aguayo, Ann Brownlee, Judy Canahuati, Peggy Henderson, Kathleen Kurz, Miriam Labbok, Judiann McNulty, Ellen Piwoz, Randa Saadeh, and Mary Taylor were insightful and prompted discussions and revisions. We greatly appreciate the support of Ian Darton-Hill, Dorcas Lwanga, Doyin Oluwole, Nune Mangasaryan, and Werner Shultink and their recognition of the importance of this work.

Special thanks are extended to the following organizations for their support in development of this paper: the United States Agency for International Development, Africa's Health in 2010 Project; UNICEF, Nutrition Section; the World Health Organization, Nutrition for Health and Development; and the Academy for Educational Development (AED). These organizations have been in the forefront of breastfeeding promotion and support for decades. The opinions expressed in this paper are the responsibility of the authors and do not necessarily reflect the views of these organizations.

Executive Summary

A large body of evidence demonstrates the benefits of breastfeeding for child survival, growth, and development. An estimated 1.30-1.45 million child deaths could be prevented each year with improved breastfeeding practices. Community-based breastfeeding promotion and support is one of the key components of a comprehensive programme to improve breastfeeding practices, as outlined in the WHO/UNICEF Global Strategy for Infant and Young Child Feeding (IYCF). *Learning from Large-scale Community-based Programmes to Improve Breastfeeding* shares the experiences and lessons from community-based approaches so that others can use the information to strengthen existing programmes and design new ones. The paper will be of particular value to individuals who are interested in studying different models and the results and lessons emerging from them and assessing their applicability in a new setting. The paper is not a "how to" guide. Rather, it is the story of vision, innovations, partnerships, trials and errors, and results. An annex lists manuals, training materials, and other resources for those wanting guidance on programme design and implementation.

Information was gathered through document review, a questionnaire, and correspondence. Programmes in the following 10 countries were selected as case studies: Benin, Bolivia, Cambodia, Ethiopia, Ghana, Honduras, India, Madagascar, Mali, and Nepal. The programmes illustrate diversity in programmatic approaches, partnerships, geography, and results, with national exclusive breastfeeding rates ranging from 30 percent to 67 percent.

The first part of the paper describes the programme anchor in the case studies, including frameworks focused primarily on breastfeeding, a cluster of six or seven nutrition actions, a larger set of nutrition and health interventions, and a broad set of social development interventions. The case studies illustrate the multiple opportunities for breastfeeding promotion and support and highlight community resources, their activities, training, and links with the health system. Behaviour change communication features prominently in the case studies with numerous examples of creative ways to promote and support breastfeeding through interpersonal communication, folk and traditional media, and mass media. Mass media was used to reinforce messages, raise awareness, extend reach, and create a supportive social environment for behaviour change. The second part of the paper sums up the key findings of the case studies and poses questions for further investigation. Each case study is described in detail in an annex.

Finding 1: The community offers indispensable resources for breastfeeding promotion and support, and these resources need continual mentoring and encouragement. The programmes described tapped into existing community resources, but community health workers (CHWs) and other volunteers were often not adequately trained, supported, or supervised. One way to elevate the role and status of volunteers is to give them public praise and recognition, duties that earn them respect in the community, and adequate training, skills, and supervision. Mechanisms need to be put into place to motivate, compensate, and recognize community health workers and other volunteers that are acceptable to all parties (community health workers, the community, and the government).

Finding 2: Multiple programme frameworks offer opportunities for community-based breastfeeding promotion and support. The case studies illustrate that breastfeeding promotion can occur within programmes focused on infant and young child feeding, child survival, essential nutrition actions, reproductive health, newborn care, community IMCI, growth monitoring and promotion, and social development. The various frameworks and strategies represent different roads to the same destination—child survival, growth, and development. Improved breastfeeding practices add value to all of these programmes.

Finding 3: Breastfeeding practices can change over a relatively short period and need continued reinforcement to be sustained. Some programmes showed sizable change within a year of programme implementation. The largest gains in Madagascar came at a time of heightened community activities. When the programme had to shift its focus from community and district activities to provincial activities, a drop was seen in the exclusive breastfeeding rate in the following years. Just as

positive change can occur over a relatively short period, so can negative change. Gains can be lost without due diligence and ongoing breastfeeding promotion and support. Dramatic change, both positive and negative, should be interpreted carefully.

Finding 4: Effective communication and advocacy are vital to set policy priorities, influence community norms, and improve household practices. Key elements of a behaviour change communication strategy include a behavioural assessment, targeted, concise messages promoting doable actions, counselling and communication skills for health and community workers, consistent messages and materials, multiple exposure of specific audiences to messages through appropriate media, and social support. At the national level, many of the programmes engaged in national-level policy work along side community-based activities, recognizing that behaviour change requires effective communication strategies at many levels to create an enabling environment. In the words of an individual who completed the case study questionnaire, "Knowledge alone does not lead to behavioural change, particularly for exclusive breastfeeding. An enabling environment needs to be created that includes a reduction in workload, support from family members, and counselling support from peers to clarify misconceptions about breastfeeding, particularly concerning the 'milk is not enough' syndrome."

Finding 5: More attention needs to be given during training to interpersonal counselling skills. Focusing on the 3Rs— the Right messages, delivered to the Right person, at the Right time— represents a major advance in IYCF programming, but mothers need more than accurate and timely information from CHWs and health care providers. They also deserve encouragement, skilled and practical help, and empathetic listening.

Finding 6: Partnerships, leadership, proof of concept, and resources facilitate programme scale up. Scale was reached by communities, government ministries, NGOs, and complementary large-scale health programmes working together to achieve shared objectives. Political leadership and nutrition champions helped garner commitment and resources. Pilot activities that demonstrated "proof of concept," documented programme strategies, and disseminated innovations, results, and practical tools led to programme expansion as did adequate and sustained funding.

Finding 7: Monitoring and evaluation is critical to measure progress, identify successful and unsuccessful strategies, and make appropriate programme adjustments. Those programmes that carried out baseline and endline surveys as well as annual rapid assessments in programme areas were best positioned to spot problem areas and adjust programmes accordingly. Thanks to several well-designed surveys and cost studies, we now can say with greater confidence "what works" and at "what cost." This information is valuable for programme planning and implementation as well as evidence-based advocacy.

The case studies help answer some of the questions about community-based breastfeeding promotion and support, but they also elicit a number of questions that need further investigation regarding the time required to establish a true partnership with the community, the length and content of breastfeeding training for CHWs, strategies to ensure equitable access to breastfeeding support and foster an enabling environment, interventions that are best "bundled" together, and conditions for sustainability.

In summary, the review of 10 case studies demonstrates: 1) the importance of community-based activities for achieving scale, 2) the role of the community as partners, not recipients, and 3) the feasibility of improving practices through a comprehensive approach that involves partnerships at many levels, capacity building, behaviour change communication, and the creation of an enabling environment.

Introduction

Improved breastfeeding practices can contribute significantly to the achievement of the Millennium Development Goals. An estimated 1.3 million (Jones G et al., 2003) to 1.45 million (Lauer et al., 2006) childhood deaths in developing countries are attributed to suboptimal breastfeeding practices. Initiation of breastfeeding within the first hour of birth, exclusive breastfeeding for the first six months,[1] and continued breastfeeding to two years and beyond are optimal practices based on scientific evidence of their health impact. The inclusion of breastfeeding promotion and support in various programmatic frameworks is supported by evidence presented in the *Lancet* series on child survival, neonatal survival, and child development along with the Disease Control Priorities Project's[2] recognition of the importance of better child feeding practices in reducing the burden of disease.

The extensive body of evidence of the importance of breastfeeding continues to grow, with new understandings of the immunological components of breast milk (Labbok et al., 2004), the long-term benefits of breastfeeding (Horta et al., 2007), and the importance of exclusive breastfeeding for HIV-exposed infants (Iliff et al, 2005; Coovadia et al., 2007).[3] Recent research findings (Edmond et al., 2006) indicating that breastfeeding within the first hour of birth could prevent an estimated 22 percent of newborn deaths in Ghana confirms the importance of early initiation and its role in newborn programmes. The challenge is to:

- ensure that mothers and babies everywhere receive the full benefits of breastfeeding;
- build the evidence base for programmatic approaches to improve breastfeeding practices, including those focused on policy advocacy, health systems, and the community; and
- demonstrate that community-based approaches can contribute to change on a broad scale.

The purpose of this paper is to share the experiences and lessons from community-based approaches to improve breastfeeding practices so that others can use the information to strengthen existing programmes and design new ones. Recent increases in optimal breastfeeding practices in some countries and the goal of broader coverage have prompted field offices to request information on "what works." Descriptions of community activities are often brief, report on pilot or small-scale activities, and/or are found only in unpublished papers. This paper attempts to provide a fuller description of large-scale community-based breastfeeding promotion in various programmatic contexts and geographical settings and to present results and key findings. The examples can inform those planning to scale up current activities and can encourage poor performing countries as well.

The paper begins with an overview of the evolution of community-based breastfeeding promotion and a description of providers of breastfeeding support within a community. The second part draws upon 10 case studies to describe common features of community-based programmes, summarize key findings, and list some remaining questions. The annexes include a list of resources, the case study questionnaire, national health and nutrition indicators of the 10 countries selected as case studies, and two to three page descriptions of each case study.

---

[1] Following a comprehensive study in 2001 on the optimal duration of exclusive breastfeeding and recommendation of an expert panel (WHO, 2002), the World Health Organization recommended 6 months of exclusive breastfeeding. The exclusive breastfeeding rate is based on 24-hour recall of mothers with children less than six months of age; therefore, it overestimates the percentage of infants who are exclusively breastfed. The exclusive breastfeeding rate should not be interpreted as the percentage of mothers that exclusively breastfeed for a full six months.

[2] The Disease Control Priorities Project (DCPP) is a joint enterprise of The World Bank, the Fogarty International Center of the National Institutes of Health, the World Health Organization, and the Population Reference Bureau. DCPP is an ongoing effort to assess disease control priorities and produce evidence-based analysis and resource materials to inform health policymaking in developing countries.

[3] For the infant of an HIV-positive woman, the 2006 WHO consensus statement recommends exclusive breastfeeding for the first 6 months unless replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If these conditions are still not met at 6 months, continuation of breastfeeding with complementary foods is recommended until an adequate and safe diet without breast milk can be provided.

Methodology

For the purpose of this paper, community-based breastfeeding promotion and support refers to activities that take place within the community and outside of a health facility. A dictionary definition of "community" is "a social group of any size whose members reside in a specific locality and share government, and often have a common cultural and historical heritage." The paper is the result of a consultative process of UNICEF, WHO, and USAID through the USAID-funded Africa's Health in 2010 Project, managed by AED. The writing team reviewed breastfeeding trends across countries and identified projects and initiatives that could have contributed to improvements in breastfeeding practices. Criteria for selection of country case studies were set, and a questionnaire (annex 2) was developed and sent to selected UNICEF field offices and several organizations involved in breastfeeding promotion. Responses to the questionnaire were supplemented with e-mail communications with project staff and a review of programme documents.

We used the following criteria for selection of the case studies:

- Evidence of improvement in breastfeeding rates through Demographic Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and/or data from large-scale programmes, with special consideration to countries with exclusive breastfeeding rates of 50 percent or more or countries that had made rapid progress in improving exclusive breastfeeding rates
- A clearly defined programme area reaching at least 1 million people and a plan to continue expansion
- Significant level of community activities
- Availability of reports documenting results and community activities
- Representation of countries from several continents

Although research studies and small-scale projects provide valuable information on approaches and strategies, we excluded them as case studies because of our interest in programmes with broad coverage. We eliminated several countries that were initially considered as case studies because the completed questionnaires did not have an adequate description of community activities or the questionnaire was not returned. As shown in figure 1, of the 10 countries selected for case studies, five have exclusive breastfeeding rates above 50 percent: Bolivia, Cambodia, Ghana, Madagascar, and Nepal. Nepal's rate has been declining, but we kept Nepal as a case study because it illustrates an innovative community-based approach through the social sector. When Benin was included as a case study, the preliminary national exclusive breastfeeding rate from the latest Demographic and Health Survey was the highest of the 10 countries, but the final published figure was far lower than the preliminary figure (43 percent versus 70 percent) but still showed a trend of improved breastfeeding practices.

We decided to include Benin and four other countries as case studies to enrich our understanding of large-scale efforts to improve breastfeeding practices. Mali's exclusive breastfeeding rate is still low but serves as an example of a country that has made impressive gains in recent years. In Ethiopia, the national exclusive breastfeeding rate declined between 2000 and 2005, but the exclusive breastfeeding rate in three regions that had a recent breastfeeding programme was considerably higher than the national rate. In Honduras, the national exclusive breastfeeding rate is low and has not improved in the past five years. We included Honduras as a case study to offer regional representation and learn about an approach that evolved to a national programme and served as a model for several other countries.

To understand different contexts for breastfeeding promotion, we selected a large-scale, well-documented programme managed by a nongovernmental organization (CARE) in nine states of India. We recognize that the experience in other states, programmes, and cultural traditions could be notably different from what is reported here. We determined that much could be learned from programmes that achieved improvements as well as those that did not register sizable gains. We had hoped to feature a country with HIV prevalence with large-scale community breastfeeding programmes but were unsuccessful in collecting the information.

Limitations of the Information
Interpreting the information reported in the case studies is challenging for several reasons.

- *Missing data*. For some of the case studies, information was not yet available because data collection or analysis was still underway. The absence of baseline surveys and discarded answers because of survey errors limited analysis.
- *Programme vs. national data*. Unless a programme was national in scope, reliance on data from Demographic and Health Surveys may not give a true reflection of the effect of breastfeeding promotion in the programme area.
- *Survey inconsistencies*. Changes in the wording of questions from one survey to another and in the season in which the data were collected could account for some differences in results.
- *No control groups*. Other interventions may have been occurring at the same time, which affected the results. The absence of data from a control group limits the ability to assess impact of the programme interventions.
- *Timing issues*. In some cases the community-based activities were only in place for a short time when a national survey was conducted, calling into question the links between the community activities and the results.
- *Other factors*. This review focuses on community-based breastfeeding promotion. Policy initiatives, the Baby-friendly Hospital Initiative, and economic and social factors could also have influenced breastfeeding practices. Another factor to consider is the level of investment in breastfeeding promotion. The scope of this assignment did not extend to an examination of the effect of each of these factors on breastfeeding practices or their interaction.

Results
Despite these limitations, results reported in the case studies do tell a story and suggest the following:

- <u>Breastfeeding practices can be changed in a fairly short time</u>. One year after programme implementation, sizable changes were achieved in programme areas in Madagascar with the exclusive breastfeeding rate almost doubling, from 46 percent to 83 percent. When the same approach was used in other areas of the country, success was also achieved within one year, with the exclusive breastfeeding rate increasing from 29 percent to 52 percent. In programme areas in Ghana, the rate rose the first year from 68 percent to 78 percent and stayed at that level at the time of the final survey two years later.

- <u>Trends show steady progress in addressing major barriers, but sub-optimal practices are still the norm in many countries</u>. Mali started with a very low exclusive breastfeeding rate (8 percent in 1995/96), increased to 25 percent in 2001, and reached 38 percent in 2006 (preliminary DHS data). In Benin, the exclusive breastfeeding rate rose from 17 percent in 1996, to 38 percent in 2001, and to 43 percent in 2006. This trend indicates that progress is being made in addressing the belief that young infants need water, a major barrier to exclusive breastfeeding in West Africa.

- <u>Any dramatic change should be carefully interpreted</u>. Cambodia showed remarkable gains, with the exclusive breastfeeding rate increasing from 11 percent in 2000 to 60 percent in 2005. Some have suggested that the timing of the survey and the phrasing of some questions could partially account for differences. Even if these factors are taken into account, major improvements in feeding practices were achieved. In Bolivia the gain in exclusive breastfeeding was at first modest but within three years increased from 54 percent to 65 percent. An assessment of breastfeeding practices three years after programme support ended showed a sharp decline in exclusive breastfeeding in programme areas, which indicates that gains can be lost without due diligence. Resources did not permit an investigation to determine the cause of this decline.

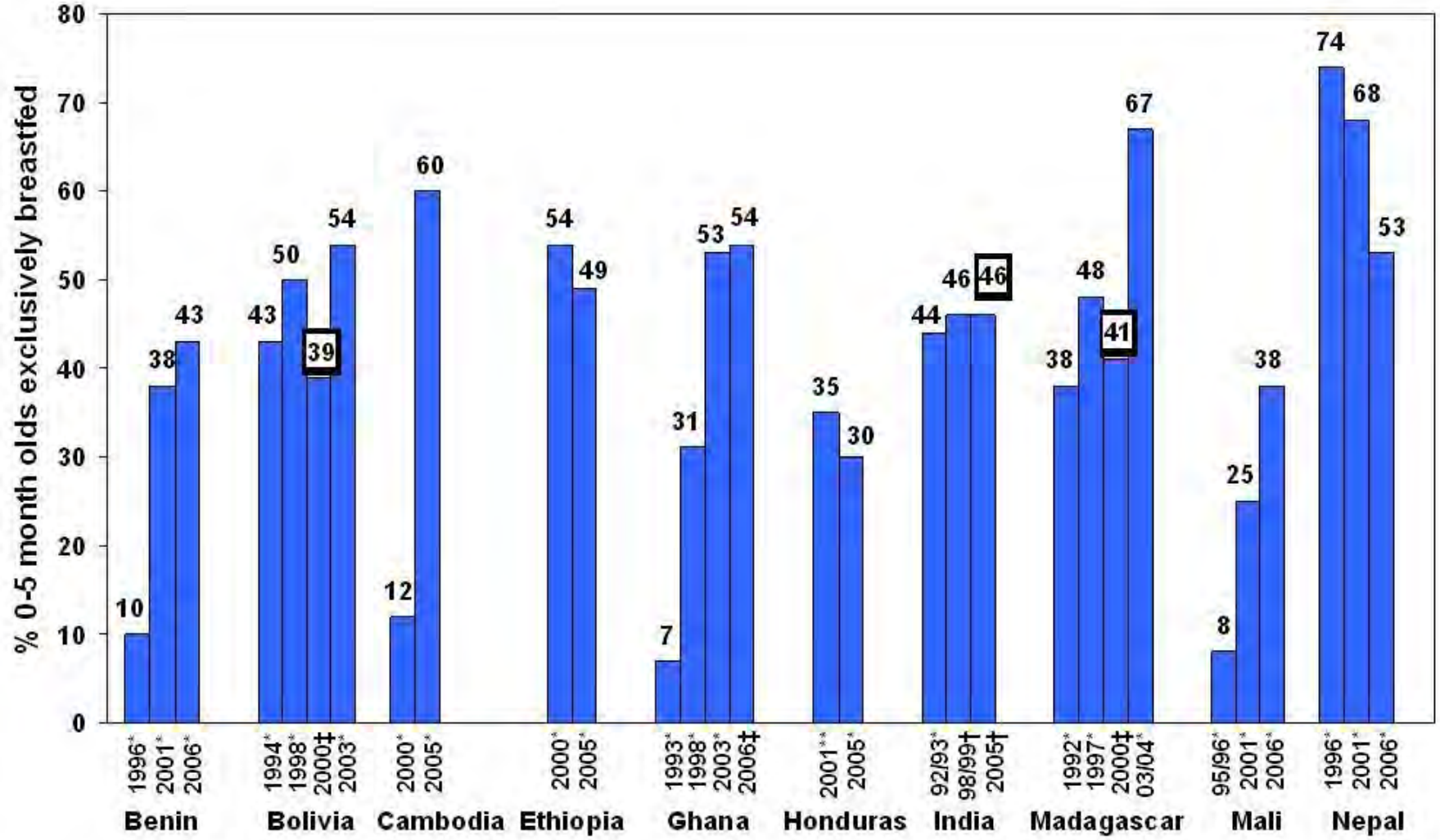
- <u>Regional differences within a country indicate the need for tailored strategies</u>. Programme areas in five of the eight states in India where CARE works showed improvements in exclusive breastfeeding, but three did not. Increases in timely initiation of breastfeeding were

observed in seven of the eight states (CARE, 2007). In Ethiopia an assessment in three regions showed marked improvements in timely initiation of breastfeeding in programme areas in two of the three regions. Only one of the regions showed large increases in exclusive breastfeeding, but the rate in all three states (ranging from 62 percent to 81 percent) was considerably higher than the national rate (49 percent) (Guyon et al, 2006).

- Gains achieved during intensive pilot activities are a challenge to achieve during programme scale up. In a 2002 assessment in Honduras in programme sites, the exclusive breastfeeding rate was 40 percent among non-participants and 56 percent among participants. Five years after the adoption of community-based growth monitoring and promotion as a national strategy, the national exclusive breastfeeding rate remained low (30 percent).

Early and exclusive breastfeeding rates are not the only relevant indicators of programme impact. Other indicators of programme effectiveness include the empowerment of individuals to provide optimal nutrition and care for their infants, the empowerment of communities to address malnutrition and take collective action, and the integration of infant and young child feeding and behaviour change strategies and tools into government services and partner organizations. Because these elements are difficult to measure, they are not studied even though sustainability of the results achieved in improved breastfeeding behaviours will, to a large extent, depend on them. As noted by Quigley and Ebrahim (1994), “Communities do not care much about ‘projects’. What they desire is a continuous programme, which develops in step with their capacity to participate and guide it. From this point of view, success of a project should be measured not only by the tangible outputs, but also by the increased confidence and capacity to organize.”

Figure 1. Trends in National Exclusive Breastfeeding Rates in Ten Countries



Source: UNICEF Database as of November 2007: * Demographic Health Survey (DHS); ‡ Multiple Indicator Cluster Survey (MICS), ** Encuesta Nacional de Epidemiología y Salud Familiar (Honduras); † National Family and Health Survey (India).

1. EVOLUTION OF COMMUNTIY-BASED BREASTFEEDING PROMOTION AND SUPPORT

Community-based breastfeeding promotion and support is rooted in a primary health care approach that fosters active involvement and participation of those in the community, expects reliable support from the formal health system, and emphasizes equitable development. In 1978, the Alma Ata Declaration on Primary Health Care recognized the value of resources within communities to address health problems and the right and duty of communities to participate in health care planning and implementation. The Millennium Development Goals (MDGs) represent a renewed call for equitable access to health care and a concerted effort to reduce child undernutrition and mortality.

For more than 25 years, various strategies have been put forth and implemented to support early, exclusive, and continued breastfeeding. In the 1980s, breastfeeding was promoted as part of the "child survival revolution" along with growth monitoring, oral rehydration, and immunization. Most of the breastfeeding promotion efforts focused on health provider skills, hospital practices, and policies (Jelliffe DB, Jelliffe EFP, 1988).

In 1990, representatives from 30 countries and multilateral and bilateral partners gathered to create a global action plan to reverse declining breastfeeding rates. From this meeting emerged the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding. The preamble to this landmark document called for social mobilization and the elimination of obstacles to breastfeeding at the community level. The operational targets focused on national breastfeeding committees, implementation by maternity services of the Ten Steps to Successful Breastfeeding, and national legislation to protect the breastfeeding rights of working women and to give effect to the International Code of Marketing of Breast-milk Substitutes. Maternity services were linked to the community through Step 10: "foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic," but this step proved to be a stumbling block for many programmes.

By 2002 the community was no longer a preamble to a declaration but a key component of the comprehensive Global Strategy for Infant and Young Child Feeding (WHO/UNICEF, 2003), endorsed by the World Health Assembly in 2002. The strategy reaffirms the operational targets of the Innocenti Declaration and adds five additional targets, including one that specifically refers to the community:

> Ensure that the health and other relevant sectors protect, promote, and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require in the family, community, and workplace.

The Global Strategy states that community-based support networks should be welcomed within the health care system and should "participate actively in the planning and provision of services". Many women have limited contact with health care providers, but they do have daily contact with family members, friends, neighbours, employers, and others in their community who can influence their infant feeding behaviour.

The WHO/UNICEF *Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding* (2007) recognizes the importance of creating an enabling environment for breastfeeding at all levels and places community-based breastfeeding support within this comprehensive framework (box 1). The framework addresses various factors that can influence a woman's breastfeeding decisions including commercial influences, workplace conditions, economic and time factors, hospital practices, access to accurate and complete information, access to skilled assistance to prevent and/or address breastfeeding problems, community and family support, and health provider attitude, skills, and knowledge.

In addition to the planning manual, WHO has drafted *"Implementing Community Activities on Infant and Young Child Feeding: A Manual Based on the Experience from Haryana, India"* (draft, 2007). Other resources to assist in planning and implementation of community-based programmes are listed in annex 1.

Box 1. Components of a National Plan of Action for Infant and Young Child Feeding

Community-based breastfeeding promotion and support should feature prominently as part of a national plan of action with the following components:

Comprehensive strategy: development and implementation of a strategy that includes:
- National Code of Marketing of Breast-milk Substitutes
- Legislation to protect the breastfeeding rights of working women
- Use of the Convention of the Rights of the Child as a legal instrument to protect, promote, and support IYCF
- Application of relevant standards of the Codex Alimentarius

Health services: strengthening the capacity of health services to support appropriate IYCF
- Revitalizing and expanding the Baby-friendly Hospital Initiative
- Improving the skills of health providers in first and referral level health facilities to give adequate feeding support

Community: strengthening community-based support for IYCF
- Identifying community-based decision-makers and groups
- Motivating groups for action
- Conducting assessments and formative research
- Building capacity of groups and peer counsellors
- Planning and implementing a communication strategy
- Providing on-going support to community action through health and community services, community-based groups, and other mechanisms

Integration: integrating activities into existing programmes and initiatives

Monitoring and evaluation

Source: WHO/UNICEF, 2007.

2. PROVIDERS OF COMMUNITY-BASED BREASTFEEDING PROMOTION AND SUPPORT

Community-based breastfeeding activities are often part of a Ministry of Health's nutrition or health programme, the programme of other government agencies, the outreach services of health facilities, or a component of NGO development projects. They are also found in programmes focusing on neonatal health, child survival, and the prevention of mother-to-child transmission (PMTCT) of HIV and sometimes in micro enterprise, education, food distribution, and reproductive health programmes.

Those who promote and support breastfeeding at the community level are part of a broader network of community workers described by Chen et al. (2004) as follows:

> "The base of the worker system consists of family members, relatives, and friends—an invisible workforce consisting mostly of women. They are backed by diverse informal and traditional healers and, in many settings, by formal community workers. Beyond these front-line providers are doctors, nurses, midwives, professional associates, and managers and non-medical workers who support effective practice."

Common characteristics of the primary providers of community-based breastfeeding support services and the advantages and disadvantages of each type of provider are summarized in table 1.

These providers include:

- Health care professionals who take part in community outreach activities
- Peer and lay counsellors who focus on breastfeeding and nutrition
- Multi-purpose community health workers (CHWs*)* who are involved in activities such as health and nutrition education, integrated management of childhood illness, immunization, family planning, malaria control, etc.
- Community development and extension workers
- Traditional health practitioners, particularly traditional birth attendants
- Breastfeeding advocates such as grandmothers and other family members, community and religious leaders, and local media

Health care professionals. Health professionals remain central to breastfeeding promotion and support both in the facility and the community. In many surveys, the majority of women name health professionals as their primary source of information on breastfeeding. Two-way referral between health professionals and community workers ensures that mothers and their babies receive full support and care for optimal breastfeeding.

Community health workers. The main provider of community-based activities, including breastfeeding support, is the multi-purpose community health worker. A resurgence of interest in this cadre of workers is partly the result of decentralization of health systems, continued lack of access to health services, and a focus on broad-scale coverage. As expressed by one reviewer of this paper, CHWs should not be viewed as "the only option where there is no PHC (primary health care) system . . . but as part of a dynamic PHC system that reaches to all communities and seeks universality of primary health care delivery" (UNICEF Senior Nutrition Advisor, West and Central Africa).

In general, the role of CHWs is to serve as a bridge between health care professionals and the community, help communities identify and address their own health needs, promote a wide range of health-related behaviours, mobilize community resources, and act as advocates for the community. Literacy requirements, proportion of male and female workers, time commitment, incentives, remuneration, and function (promotive only or curative as well) vary among communities and districts. Frankel et al. (1992) found that the most effective community health workers were members of the communities where they work, selected by the communities, answerable to the communities for their activities, and supported by the health system, although not necessarily a part of its organization.

Two recent reviews (Lehmann et al., 2004; Haines et al., 2007) of community health workers concluded that they have an essential role to play in increasing coverage. CHW programmes are not viewed as "a panacea for weak health systems" but as a complementary activity to reach vulnerable groups. Their success depends on the ability to motivate involvement of CHWs, offer opportunities for personal growth and accomplishment, retain CHWs after they have been trained, sustain their performance, and provide supervision, support, and recognition from the health system and community (Bhattacharyya et al., 2001).

Peer and lay counsellors. In addition to community health workers, peer and lay counsellors offer breastfeeding support. A breastfeeding peer counsellor is typically a woman who has given birth to at least one child and has breastfed successfully. The lay counsellor, on the other hand, may not have personal or recent breastfeeding experience and may be a man. Peer and lay counsellors may be part of the outreach activities of the health system or associated with a nongovernmental organization. They may volunteer their services or receive stipends. Activities often include individual counselling, facilitation of support groups, and educational talks in the community and health facility.

A Cochrane Review (McCormick et al., 2007) of the efficacy of breastfeeding support found that lay support was effective in extending the duration of exclusive breastfeeding. Women who received any form of support were less likely to stop exclusive breastfeeding before five months than those who received no support. Combinations of lay and professional support were more effective than

professional support alone in prolonging any form of breastfeeding, especially in the first two months. Of the 34 studies included in the systematic review, eight examined community-based breastfeeding support to mothers of infants in low- and middle-income countries (one study each in Bangladesh, India, Iran, Nigeria, and Mexico and three studies in Brazil). The interventions included home visits at varying frequencies and intervals, some beginning during pregnancy and others postpartum. The visits were conducted by outreach staff of the health facility in two studies, by peer counsellors for breastfeeding support in three studies, and by a combination of health care professionals and peer counsellors in one study.

None of the studies in the Cochrane Review assessed the efficacy of peer support through mother-to-mother support groups. A review by Green in 1998 of mother support groups found that little research had been conducted on their impact on breastfeeding practices. In 1999 a study in Guatemala (Dearden et al., 2002) of women who had contact with peer counsellors through support groups and home visits found that they had better breastfeeding practices than those in the control community without these contacts.

Table 1. Providers of Community-based Breastfeeding Activities

Provider	Common Characteristics	Advantages	Disadvantages
Health care professionals	• Paid staff • Organize, implement, supervise outreach staff	• Advice respected by mothers	• Limited time per contact • Relatively higher costs
Peer and lay counsellors	• Women with current or recent BF experience (peer counsellors) or strong commitment to BF (lay counsellors) • Similar socio-cultural characteristics as clients • May counsel in homes, health facilities, mother support groups, informal setting	• Model optimal BF practices in case of peer counsellors • Understand mothers' situation • Accessible • Focused attention on feeding issues	• Often high turnover rates among volunteers • Part-time work limits number of contacts
Multi-purpose community health workers	• May be affiliated with health facility, community group, or NGO • May not have personal experience breastfeeding • May receive salary or small stipend	• Integrated with other health services • Wider outreach	• More limited BF support • May be distracted by other duties
Community development and extension workers	• Outreach extends beyond mothers and children • Broader set of issues	• Linked with other sectors such as agriculture • Re-enforcement of messages; non-health contact points	• Limited time for BF support • Balancing many duties
Traditional health practitioners (TBAs, traditional healers, herbalists, etc.)	• Provide health care using traditional methods/ products • May have knowledge of traditional and modern medicine	• Serve women/ families least likely to attend health facilities • Respected and more likely to understand mother/family situation (similar background)	• May require special training curricula, materials, trainers • May be reluctant to abandon harmful traditional practices
Local breastfeeding advocates (Grandmothers, supportive men, local media, members of village health committees)	• Opinion leaders within a family, the community, or country	• Broaden support network, reach secondary audiences • May have special skills and stature in community	• Usually not ideal candidates for facilitating BF support groups

Adapted from Community-based Breastfeeding Support: A Planning Manual, Wellstart, 1996.

3. CASE STUDIES

Randomized controlled trials of community-based breastfeeding counselling by health providers and community-based workers (Bhandari et al., 2003) and peer counsellors (Morrow et al., 1999; Haider et al., 2000) show that community strategies to improve breastfeeding practices can be effective for a relatively small intervention group. But can such improvements be achieved at scale? The case studies for this paper reflect the experiences of programmes with a sizable community-based component to improve breastfeeding practices in 10 countries: two in Latin America (Bolivia and Honduras), five in Africa (Benin, Ethiopia, Ghana, Madagascar, and Mali), and three in Asia (Cambodia, India, and Nepal). Annex 3 sets out national-level health and nutrition indicators for the 10 countries, providing the national context for breastfeeding promotion. Annex 4 features each case study and includes a description of the approach, community interventions, results, and lessons learned reported in project documents or noted by programme managers and implementers in their response to the questionnaire. Other reports of efforts to improve breastfeeding practices have been prepared by UNICEF, WHO, and AED and are available in separate documents.[4]

Coverage. As mentioned earlier, countries selected as case studies had programmes reaching at least 1 million people. Coverage for breastfeeding programmes can be expressed as the total population, the number of women of reproductive age in a programme area, or the number of infants and young children younger than 24 months in the programme area. Since many breastfeeding programmes reach out to family and community members and to a larger audience through the media, the total population is often used to express programme coverage From the outset, the USAID-funded LINKAGES Project (1996–2006) made large-scale coverage of community-based breastfeeding programmes one of its objectives. The programmes reached 1 million people in Bolivia, 15 million in Ethiopia, 3.5 million in Ghana, and 6.3 million in Madagascar. In Benin and Honduras, the nutrition strategies presented in the case studies are in the process of being scaled up to the national level. The national population is 8.4 million in Benin and 7.2 million in Honduras. In Mali the total population reached by programme activities was almost 7.5 million in 2007. In India CARE worked in partnership with the Ministry of Health and the Ministry of Social Welfare to strengthen the capacity of government staff to deliver effective health and nutrition services to approximately 6.6 million pregnant and lactating women and children up to six years of age. The programme covered 78 districts in nine states with a total population of more than 102 million people.

Human and Financial Resources. While coverage is an important indicator, the intensity of effort as indicated by human and financial resources should be considered. The number of community health workers trained in breastfeeding gives some indication of the level of effort, but comparisons among the programmes described in the case studies are difficult to make because of differences in the quality, content, and length of training as well as the time workers actually spend in breastfeeding-related activities.

Financial resources dedicated to breastfeeding varied greatly among the case studies. In many countries, breastfeeding activities are part of a broader programme that includes interventions at the national and regional levels and other nutrition and health services, making it difficult to isolate the breastfeeding costs from other costs. A comparison of costs among the 10 case studies would require detailed costing information and an analysis of contextual factors, differences in the types of

[4] Case studies of the significant progress of five countries in east and southern Africa (Botswana, Malawi, Uganda, Zambia, and Zimbabwe) are presented in a document prepared by UNICEF-ESARO in 2005 titled *Implementation of the Global Strategy on Infant and Young Child Feeding: Towards Child Survival, Growth and Development.*" Community outreach and support is recognized in the document as the weakest area of implementation of the IYCF strategy in the region. A detailed account of the experience in rural areas in the state of Haryana, India, is reported in *"Implementing Community Activities on Infant and Young Child Feeding: A Manual Based on the Experience from Haryana, India"* (WHO, forthcoming). The LINKAGES Project summarized its country programs in a series titled World LINKAGES (www.linkagesproject.org.).

programmes and the way in which they were implemented, and variations in costing methodologies and results reporting. Costing information is available for four of the programmes reported in this paper: Ghana (Chee et al., 2002), Honduras (Fiedler, 2003), India (Fiedler, 2006), and Madagascar (Chee et al., 2004). The studies in Ghana and Madagascar provide the most information on costs associated with breastfeeding promotion.

The cost of promoting exclusive breastfeeding in two regions (population 1.3 million) of Madagascar by LINKAGES and its partners over a 21-month period was separated out from the cost of promoting five other optimal behaviours. The amount spent to promote exclusive breastfeeding was almost $300,000. Of this amount, 76 percent was spent on activities related to community-based breastfeeding promotion: 64 percent for training community nutrition promoters, 7 percent for communication materials, and 5 percent for community sensitization meetings, outreach, and festivals. The remaining amount was spent on training health professionals (13 percent), BFHI activities (5 percent), mass media (4 percent), and other activities (1 percent). The cost per new acceptor of exclusive breastfeeding was approximately $10 in Madagascar and $34 in Ghana. Potential explanations for the higher costs in Ghana include smaller coverage, higher baseline rate, and a more limited range of interventions than in the Madagascar programme. In both cases the cost per new acceptor of exclusive breastfeeding was less than the cost per new acceptor ($59) in a hospital-based study in Brazil (Chee and Makinen, 2006).

3.1 Programme Frameworks for Breastfeeding Promotion and Support

The 10 cases studies illustrate different contexts and frameworks for breastfeeding promotion and support at the community level. Community-level interventions generally were part of a broader framework that included national-level advocacy and health facility strategies. Some programmes focused almost exclusively on infant and young child feeding, others incorporated other nutrition and health issues, and one addressed all eight Millennium Development Goals.

Infant Feeding. The Ministry of Health of Cambodia launched the Baby-friendly Community Initiative (BFCI)[5] in 2004 with support from UNICEF, the Reproductive and Health Alliance, and CARE to create a supportive community environment for improved breastfeeding and complementary feeding practices. In 2007, the government approved national expansion of the BFCI as part of its Nutrition Strategic Plan. In Ghana, a three-year government programme remained focused almost exclusively on infant feeding practices, particularly breastfeeding, and the creation of supportive conditions at the community level. The Ghana programme partners included government ministries, USAID through the LINKAGES Project, UNICEF, journalists, and NGOs involved in child survival, micro enterprise, water and sanitation, growth monitoring, and community development. The LINKAGES Project was a 10-year global project (1996-2006) to improve breastfeeding, complementary feeding, and maternal nutrition.

Integrated Child Survival and Reproductive Health. Members of the PROCOSI network of NGOs in Bolivia provide child survival and reproductive health services, particularly in rural areas. The LINKAGES Project worked with 16 members of the network to strengthen their IYCF components and improve access to the lactational amenorrhoea method (LAM), a modern family planning method for breastfeeding women. Efforts were also made in Ethiopia and Madagascar to integrate LAM and support for early and exclusive breastfeeding in the work of community-based reproductive health agents.

[5] BCFI was first launched in Gambia in 1993 as an extension of the 10th Step of the Baby-friendly Hospital Initiative and proposed as a model for countries with more home than health facility deliveries. A description of The Gambia BCFI model is found in: Semega-Janneh IJ. The Baby Friendly Community Initiative—An Expanded Vision for Integrated Early Childhood Development in The Gambia. Banjul, The Gambia: National Nutrition Agency, 2001 (unpublished).

Essential Nutrition Actions (ENA). The Essential Nutrition Actions served as the framework for programmes in Benin, Ethiopia, India, and Madagascar. This framework emphasizes interventions at the period of heightened nutritional vulnerability (pregnancy and the first two years of life), prioritizes actions based on public health impact, offers guidance on age-specific messages and points of delivery,[6] and uses behaviour change communication (BCC) at all levels to promote and reinforce the recommended actions. All four countries offered an integrated package promoting optimal breastfeeding (especially early and exclusive breastfeeding), adequate complementary feeding, control of anaemia, and control of vitamin A deficiency. All but India included control of iodine deficiency disorders and feeding of the sick child. Ethiopia, India, and Madagascar also promoted improved dietary practices during pregnancy and lactation as part of the package. Offering an integrated package was viewed as an effective use of resources to address the problems of nutrition, most of which are interrelated. The set of interventions in the CARE/India programme also included strengthening community-based newborn care and primary immunization.

Community-IMCI. In 1992 WHO, UNICEF, and USAID introduced Integrated Management of Childhood Illness (IMCI) to provide integrated case management for the most common causes of child death along with disease prevention and health promotion, particularly for immunization, micronutrient supplementation, and improved infant and young child feeding practices. The strategy includes improvements in case management skills of health workers, health systems, and family and community practices. The IMCI programme identified 16 key family and community practices related to the promotion of child growth and development, disease prevention, appropriate care at home, and care-seeking outside the home. Three of the practices relate to IYCF: exclusive breastfeeding for 6 months, timely and appropriate complementary feeding, and feeding during illness. These practices are also promoted as part of Community-IMCI (WHO, 2004). Community-IMCI is the context for the activities of CARE and numerous NGO partners supporting breastfeeding activities in Cambodia and other countries. The Essential Nutrition Actions framework often emphasizes the nutrition component of C-IMCI.

Growth Monitoring and Promotion. Integrated Community Child Health (AIN-C) is a national community-based programme, funded and implemented by the government of Honduras. In some areas of the country, NGOs are supporting government expansion of the programme. AIN-C relies on volunteers to assess the growth of children younger than 2 years old during monthly growth monitoring sessions, provide individualized counselling on infant and young child feeding, promote care-seeking practices and healthy behaviours, and engage the family and community in problem solving. The approach combines facility-based IMCI, community-based IMCI, and growth monitoring and promotion.

Accelerated Child Survival and Development. Governments, UNICEF, and partners are implementing key family and community practices through the Accelerated Child Survival and Development (ACSD) project in selected districts in 11 countries in West and Central Africa. Antenatal care, immunization of children and pregnant women, infant and young child feeding, micronutrient supplementation, and provision of oral rehydration salts and bednets are incorporated in ACSD. Until recently, IYCF did not feature prominently in ACSD, but the Mali case study illustrates the role breastfeeding promotion and a behaviour-centred approach can play.

Social Development. Among the 10 case studies, the most all-encompassing framework is Nepal's Decentralized Action for Children and Women (DACAW). With the support of UNICEF, the Government of Nepal initiated DACAW in 1999 to address all eight major Millennium Development Goals through strengthening community action processes, service delivery, and local governance. The programme works through existing community organizations with credit and savings activities.

---

[6] The ENA contact points include antenatal, delivery and immediately postpartum, postnatal and family planning, immunization, growth monitoring/well child, and sick child visits. The approach can also be applied outside the health sector in such settings as communities, schools, agricultural outreach, and emergency programs.

Breastfeeding promotion as part of community-based growth monitoring is one among many components of this human rights based, social development programme.

3.2 Description of Community Activities

The programme anchor for breastfeeding promotion varied, but the strategies were often similar. Although significant gaps remain in our understanding of community-based breastfeeding activities, the case studies offer rich experiences at the community level that can inform programme planners and managers. For each category of community activities, a few examples are given from the case studies.

3.2.1 Gaining political commitment and support

In Cambodia, Ghana, and Madagascar, large-scale activities at the community level followed two or more years of policy and advocacy activities at the national level. These national-level activities involved raising awareness of the importance of nutrition for child survival and national development, identifying partners, achieving consensus on messages and approaches, and developing a community-based strategy. At the district level, individual and stakeholder discussions with health and other government officials and with representatives of donor agencies, NGOs, and training institutions led to invitations for collaboration and a plan of action for community involvement. Policy advocacy and community activities were often concurrent, and the community activities were not dependent on finalization of national policies. In Bolivia district-level advocacy followed the initiation of community activities.

- *In Cambodia* the development of a national policy on IYCF and a high-level consultation among child survival partners led to a commitment to promote breastfeeding.
- *In Ghana* a nutrition advocacy workshop used PROFILES, a participatory advocacy process with interactive computer-based models to estimate the health and economic impact of poor nutrition practices, including sub-optimal breastfeeding. The process engages political leaders and policy makers in the dialogue. The two-week PROFILES workshop and a community assessment of nutrition practices prompted the Ghana Health Service to include breastfeeding promotion and protection among its top five child survival strategies and to dedicate resources for breastfeeding.
- *In Madagascar* creating an overall positive policy environment for nutrition through effective policy analysis and advocacy was essential for coalition building, partner “buy-in” to the programmatic approach, and resource mobilization. The formation of an Intersectoral Nutrition Action Group with more than 75 representatives from 50 organizations created a critical mass of nutrition champions to move the country’s nutrition agenda forward at multiple levels.
- *In Ethiopia* an advocacy presentation titled “Why Nutrition Matters” was developed based on PROFILES analysis of national data. The presentation was shown more than 40 times over a period of 3 years at meetings of donors, government agencies, NGOs, and university instructors. The presentation helped create a supportive environment for development and adoption of a national IYCF strategy and related initiatives.
- *In Bolivia* advocacy presentations were made in 55 districts to local municipal government authorities, health district technical staff, and educators. From 2000 to 2003, all 55 districts committed resources to nutrition.

3.2.2 Engaging the community

Reports on community-based breastfeeding activities often do not discuss the process used for entering and engaging the community. Mention is made of orientation sessions in the community to raise awareness of IYCF and gain support of community leaders and decision-makers such as chiefs, elders, teachers, public health nurses, religious leaders, members of local committees and district

assemblies, and community-based volunteers. In Honduras, the auxiliary nurse of a health centre met with community leaders and families to assess their interest and willingness to have a community-based growth monitoring and promotion programme in their community. In Cambodia, health centre staff organized village-level meetings to introduce the Baby-friendly Community Initiative. Active members of the community such as the village chief and traditional birth attendants were recruited during the community meeting. The community elected two women to be part of a team that promoted breastfeeding in the community.

The Decentralized Action for Children and Women programme in Nepal places high priority on local governance and community-driven and owned processes. To facilitate community dialogue and discernment, the programme uses tools such as participatory rural appraisal and the Triple A Cycle of assessment of the situation, analysis of the problems, and action based on the analysis and the availability of resources. In Nepal and Honduras data on growth were used at the community level to stimulate community analysis and discussion of solutions.

3.2.3 Working with community health workers

In the programmes reviewed, implementation of community-based breastfeeding activities was often through multi-purpose community health workers and other volunteers responsible for promoting nutrition and health interventions. Various names are used to describe these workers, but in this paper they will all be referred to as community health workers. Opportunities for breastfeeding promotion and support include home visits, growth monitoring and promotion sessions, meetings of local groups, immunization days, community events such as local festivals, and informal encounters. Homes, clinics, markets, schools, houses of worship, workplaces, and outdoor gathering places can serve as venues for CHW activities.

Recognizing that community health workers must address many health topics and reach a sizable area, some programmes have trained members of the community to focus on a more limited number of topics and fewer households. In Madagascar, women were chosen from existing women's associations and groups to become community nutrition promoters. In three regions of Ethiopia, community members were trained to support the work of the government's health extension workers. They relate to 30–50 households while the health extension worker is responsible for around 500 households. In India, community members known as change agents received training to support outreach activities of auxiliary nurse midwives and staff of government childcare centres.

Links with health system. Many of the programmes conducted in-service training for health professionals to strengthen service delivery at health facilities and to ensure consistent messages by health professionals and community health workers. For example, the LINKAGES programme updated breastfeeding knowledge and skills of approximately 1,900 health professionals in Madagascar and provided Baby-friendly Hospital training for 300 staff in health facilities in programme areas in Ghana. In Cambodia 1,560 health centre staff received 10-day training on nutrition and growth monitoring, which included sessions on infant and young child feeding.

Theoretically, CHWs are linked to the health system through training and supervision by health centre staff, periodic meetings at the centre to review activities and performance, two-way referrals, and joint outreach and mobilization activities. Midwives and auxiliary nurses often serve as the link between the community and the health centre. Women's groups and CHWs also bring the concerns of the community to the attention of health centre staff. As part of their duties, CHWs in Madagascar and Bolivia gave educational talks in community health centres. Despite these examples, links with the formal health system were often reported to be weak.

CHW Profile. CHWs are usually volunteers who are members of existing community groups. In Madagascar, women who belonged to a group or association were more likely to be dynamic nutrition promoters than those without group affiliation. Married women represent a large percentage of lay counsellors involved in breastfeeding promotion. However, in rural Bolivia the majority of CHWs are

men. They often schedule visits for Sundays when husbands are at home. In Ethiopia, health extension workers are women, but community health workers are both women and men, some of them priests. Educational levels of community service providers vary widely. Although literacy is generally preferred, many of the volunteers in Ethiopia and Mali have low or no literacy skills.

As part of the Baby-friendly Community Initiative in Cambodia, teams are created to promote and support breastfeeding. The team is made up of two village health support group volunteers (one man and one woman per village), a traditional birth attendant (TBA), the village chief, and two mothers. The criteria for selection of the "model mothers" are positive breastfeeding experience, literacy, respect in the community, communication skills, and motivation to participate. The TBA plays an important role because the majority (79 percent) of deliveries in Cambodia take place at home, and TBAs assist in 55 percent of them. The TBAs continue to provide care to mothers and babies for several months after delivery.

Time commitment. The amount of time spent in breastfeeding promotion varies greatly among the CHWs depending on opportunities, responsibilities, and expectations. In the Honduras Integrated Community Child Health Programme, the CHWs included breastfeeding promotion in their activities. They spent approximately 15 hours per month in the following activities: one growth monitoring session (4½ hours), home visits averaging 1-1½ hours per visit (5 hours), curative care (1½ hours), and a monthly meeting at the health centre with other community volunteers (3½ hours). A team of three saw between 22–27 children during the monitoring session. Many CHWs limited their involvement to the monthly growth monitoring session. In Ethiopia and Madagascar, the most likely times for the CHWs to promote health messages are during everyday activities such as the coffee ceremony, visits to neighbours, religious ceremonies, meetings of traditional money lending groups, and informal encounters such as while fetching water and purchasing food at the market. The traditional coffee ceremony is another opportunity in Ethiopia for discussing infant and young child feeding.

Incentives. Programmes have used various incentives to keep the volunteer CHWs engaged including tee-shirts or other items to distinguish them as health agents, training opportunities, and certificates presented at public ceremonies. Incentives used in Honduras have included an identification card with a photo, a diploma and letter of appreciation upon completion of their training, a bag to keep counselling cards and other supplies, free care in some cases at MOH inpatient health facilities, and a yearly party or dinner for all community health personnel. The community health workers involved in the Accelerated Child Survival and Development programme in Mali receive bicycles for home visits and outreach activities. Expanding the duties of the Female Community Health Volunteers in Nepal to include distribution of vitamin A capsules and treatment for pneumonia helped them gain respect in their community because they were providing services the communities wanted and giving more than advice. This proved to be a major motivating factor for the volunteers.

Supervision. Someone associated with the government health programme is frequently designated as the supervisor of CHWs and project staff. For example, the health extension workers in Ethiopia supervise the CHWs and are expected to organize monthly meetings with them to discuss the volunteers' progress and challenges and to work with them to find solutions. In Mali, the intent is for community health workers to meet monthly with health centre staff and the community management team to discuss their home counselling activities and receive technical updates; however, the monthly meeting is not always adequately practiced. In Madagascar, the CHWs reported that the heads of the community health centres provided little or no follow-up of their work. Logistic and time constraints often limit contact between the auxiliary nurses in Honduras and the community volunteers that they supervise.

Lack of supervision, mentoring, and encouragement is a common theme and a reason CHWs become discouraged. Although they are often regarded as neighbourhood resources for health and nutrition information, some feel that they do not receive enough respect from their community. A number of CHWs interviewed in Madagascar encountered opposition during home visits from those who

questioned what made them "experts" and why someone from their own social class and community should tell them how to care for their children.

3.2.4 Involving other community members

Besides those officially designated as community health workers, others in the community can serve as resources for breastfeeding promotion and support.

Mothers. Women who model good breastfeeding practices and share their experience with others are valuable community resources for breastfeeding promotion and support. The primary channel for community-based breastfeeding promotion in the Ghana Health Service/LINKAGES programme was various women's groups, including mothers clubs of the Red Cross and Catholic Relief Services, NGO micro enterprise and income-generating groups, and MOH-initiated breastfeeding mother-to-mother support groups affiliated with health facilities. Some of the support groups associated with a hospital included men as well as women. Although these various groups differed in their organizational structure and activities, they shared a common purpose of providing a safe environment where women could learn from each another, exchange experiences and concerns, and provide support and encouragement for good infant feeding practices.

Other programmes reviewed for the case studies also worked with women's groups. In Bolivia, seven NGOs received training in mother-to-mother support methodology through the PROCOSI/LINKAGES programme. In Cambodia CARE formed clubs for mothers of children younger than five years old as part of C-IMCI activities. Through the Baby-friendly Hospital Initiative, the government of Benin and UNICEF/WHO sponsored mother-to-mother support groups.

Family members and community leaders. In Cambodia, the Reproductive and Health Alliance engaged nuns and grandmothers associated with various pagodas (*wats*) in the promotion of good breastfeeding practices. Over a two-year period, more than 2,500 religious workers were trained in three provinces. They made more than 60,000 house visits in 450 villages (Kannitha et al, 2002). The nuns were selected by colleagues at the pagoda to provide health education in the village and at the pagoda during ceremonies. The "wat grannies"[7] were selected by community members to provide monthly small group health education sessions and make home visits. Approximately one "wat granny" was elected for every 50 households. Other programmes described by Aubel (2004) have tapped into the potential of grandmothers in breastfeeding and nutrition promotion strategies.

Employers. Other potential change agents in the community are employers. Breastfeeding support is one of the key practices monitored by the Better Factories Cambodia programme, which is managed by the International Labour Organization and supported by the Royal Government of Cambodia, the Garment Manufacturers' Association, and unions. The labour law stipulates that enterprises employing at least 100 women must set up a functional and accessible lactation room at or near the workplace. A monitoring visit by the Better Factories Cambodia programme found that only 30 percent of the 60 factories visited in 2006 were in compliance with this aspect of the law (Makin, 2003). In Madagascar, the LINKAGES Project supported the Ministry of Health in its advocacy for the establishment of lactation rooms at the workplace and the development of modules for employer and employee to increase understanding of the benefits of optimal infant and young child feeding practices. By 2006 eleven workplaces were designated as baby-friendly workplaces.

[7] "Wat grannies" are usually elderly, widowed/single women who dedicate their time to serving pagodas. They live in the pagodas, help clean, and cook for the monks. Due to their religious status, they are well respected in the community.

3.2.5 Training community health workers and other volunteers

The purpose of training CHWs and other volunteers in breastfeeding is to equip them to effectively share accurate and relevant information and to encourage and support mothers so that they will try, adopt, and maintain new behaviours.

Cascade training. To support community-based breastfeeding activities, the case studies reported IYCF technical updates and skills training for master trainers. These trainers were often associated with the Ministry of Health and training institutes. As part of cascade training, they trained health personnel or NGO staff responsible for training activities in their health area or organization. CHWs and their supervisors were the next groups trained. Some programmes offered refresher training to reinforce knowledge and skills and energize and encourage those working in the community. In Ghana, Ethiopia, and Madagascar, journalists were invited to participate in trainings to increase their awareness and understanding as well as their interest in reporting on infant and young child feeding.

Course content and duration. As one would expect, the level of training in breastfeeding usually corresponds with the priority placed on this intervention, the responsibilities of the community health worker, and local realities. How much does the CHW need to know about IYCF practices? Does the CHW also need to know about a cluster of behaviours related to six or seven essential nutrition actions, or the 16 C-IMCI family health practices? The number and difficulty of the skills that must be learned and the knowledge and experience participants bring to the training also affect course content and duration. Common topics covered in IYCF training for CHWs and other volunteers include the advantages of early and exclusive breastfeeding, positioning and attachment of baby to the breast, breast milk production, solutions to common difficulties, myths and beliefs about breastfeeding, mother-to-child transmission of HIV, introduction of complementary foods, interpersonal communication, and group facilitation. Role plays, case studies, group work, problem-solving discussions, demonstrations of positioning and attachment with babies or on dolls, and peer observation and feedback of participants counselling mothers in the community help enliven training sessions for CHWs and provide “hands-on” training and opportunities for immediate application of skills.

As shown in table 2, training of CHWs and other community resources ranged from several hours to 8 days in the programmes reviewed. In Madagascar, three short trainings (one or two days each) were scheduled over several months. This approach allowed shorter periods away from home, the opportunity to review and reinforce information from the previous training, and discussion of successes and constraints in applying new skills.

Performance monitoring. The effectiveness of training activities can be evaluated through knowledge tests administered at the beginning, at the end, and several months after the training. Performance monitoring can also involve observation of CHWs counselling mothers and interviews with mothers following individual counselling or a group educational session. In Honduras, the CHWs involved in growth monitoring and promotion attended a 5-day training in growth monitoring, optimal feeding practices, and prevention of malnutrition and illness. Following 3–4 months of practice in the community, they took a test. If a CHW received a proficiency of 95 percent, she advanced to a 3-day training in the recognition and treatment of illness.

A performance evaluation conducted as part of the PROCOSI/LINKAGES programme in Bolivia indicated that the community health workers knew the educational messages, but their ability to use negotiation skills with mothers during home visits was inadequate. Consequently, refresher training on negotiation skills was conducted for more than 1,600 CHWs. A second evaluation 4–6 months after the refresher training showed that 55 percent of the CHWs were able to effectively demonstrate negotiation skills based on four essential steps (verify current practice, identify difficulties, make recommendations, and encourage mother to try out the new behaviour). Programmes in Ghana and Madagascar reported that negotiation of feeding practices with mothers was effective but challenging

for the CHWs. Observation of CHWs by an evaluation team in India indicated that they did not demonstrate adequate IYCF counselling skills during home visits.

An issue facing many programmes is high turnover of staff and community health workers, which affects training costs, quality, and sustainability. To overcome the turnover of CHWs, short trainings in breastfeeding were conducted for large numbers of CHWs—4,500 in Madagascar and more than 25,000 in Ethiopia. High turnover is also found among programme staff. A performance evaluation in Ethiopia of 12 NGOs whose staff had participated in an ENA training course found that none of the trained staff was any longer employed by four of the NGOs. In one organization, only two of the six trained staff were still with the organization 2 to 3 years after the training. No follow-up was made to determine if those who left the organization were applying the training in their current job.

Table 2 summarizes the responsibilities and training of the CHWs as reported in the case studies.

Table 2. Role of Community Health Workers and Their Training

Country	Community Health Workers	Responsibilities	Training
Benin	*Relais communautaires* (community volunteers)	Promote the Essential Nutrition Actions, link the community with the health system	Training in ENA, especially the use of printed materials
Bolivia	Community health workers of NGOs (many are men)	Conduct home visits and educational talks in clinics, community settings, and mothers' clubs	3-5 day training in behaviour change, IYCF, counselling/negotiation, and use of IEC materials
Cambodia	Team made up of 2 village health support group volunteers, a TBA, the village chief, and 2 "model mothers"	Provide group education in conjunction with monthly outreach session by health staff and individual counselling during home visits	3-day training on breastfeeding counselling and support (from IMCI training module)
Ethiopia	Community health workers (women); employees of Ministry of Health	Responsible for around 500 households: immunize children, conduct home visits, mobilize the community to improve sanitation and protect against major illnesses, supervise CHPs	10-month training in 16 health topics
	Community health promoters (CHPs - men and women); volunteers	Provide health and nutrition messages to around 50 households during everyday activities; serve as an example to others	½-day training on breastfeeding
Ghana	Facilitators of mother-to-mother support groups	Organize mother-to-mother support groups on IYCF using a participatory methodology	5-day training in IYCF and facilitation skills; 3-day training for mother-to-mother support group leaders to prepare for World BF Week
Honduras	*Monitoras* (monitors/ women volunteers)	Weigh children less than 2 years of age monthly and counsel caregiver, make home visits, refer sick children and those with growth faltering to health centre, organize community meetings, compile monitoring data	5-day training in prevention of malnutrition and illness and growth monitoring, 3-4 months practice in the community, 3-day training in recognition and treatment of illness

India[8]	*Anganwadi* workers	Provide care at government child care centres, monitor child growth, distribute monthly take-home rations, make home visits	5-hour training on Essential Nutrition Actions designed but implementation dependent on staff motivation
Madagascar	Nutrition promoters (women volunteers chosen from women's groups)	Provide nutrition messages during home visits, health festivals, community meetings, informal contacts, educational activities at health centres, national vaccination and vitamin A campaigns, and activities within their respective associations	2-day training in breastfeeding, LAM, and use of IEC materials followed months later by 2 separate trainings on the other essential nutrition actions
Mali	Community health worker	Responsible for 35 households: visit households monthly to discuss key family practices and deliver vitamin A during semi-annual national nutrition weeks	5-day training in promotion of 13 key family practices and communication and counselling skills
Nepal	Community mobilizer (usually a married woman)	Weigh children less than 3 years of age monthly, facilitate group discussion, may conduct home visits, report growth monitoring data	Training in IYCF, HIV, water and sanitation, and facilitation skills
	Female community health volunteer	Administer vitamin A supplements, distribute other health products, educate family on good nutrition practices, participate in national health campaigns	18 days of initial training, logistical support, and on-going learning to deliver vitamin A supplements and other health and nutrition interventions

3.2.6 Using behaviour change communication (BCC) to change individual behaviours and community norms

Behaviour change communication features prominently in community-based breastfeeding promotion.

Behavioural assessment. A systematic BCC process begins with a behavioural assessment, also referred to as formative research. Bolivia and Nepal drew upon the findings of a literature review of infant feeding practices in their programme areas. In Cambodia three formative research studies on infant feeding practices and two surveys on knowledge, attitudes, and practices supported programme development and communication planning. Benin, Ghana, Ethiopia, Honduras, and Madagascar conducted formative research before launching community activities, in some cases using trials of improved practices (TIPs).[9] CARE staff in India received a 5-day training in formative research on IYCF, including TIPs, in-depth interviews, and focus group discussions.

[8] CARE India developed a cadre of community volunteers known as Change Agents to serve as a bridge between families in their neighborhoods and government health and nutrition programs supported by auxiliary nurse-midwives and *anganwadi* workers. Due to insufficient evidence of the value added by the Change Agents in terms of home visits and the disproportionate time required to recruit and train them, this component of the program greatly diminished in the final years of the project.

[9] TIPS is a consultative research process in which interviewers are encouraged to listen to a mother's concerns about infant feeding and find ways to help her overcome constraints. The process involves three visits to households: 1) an assessment of current feeding practices through an interview with the mother, 2) counseling on problems through dialogue, negotiation, and identification of a new practice such as exclusive breastfeeding that the mother agrees to try, and 3) discussion of the mother's experience trying the new practice.

Targeted messages with do-able actions. In several of the case studies, the literature reviews and field research indicated the importance of directing messages to secondary audiences as well as the primary audience (pregnant women and mothers of children less than two years of age). In Ethiopia, the assessment findings resulted in an emphasis on IYCF messages directed to men. In Ghana, a review of the literature indicated that grandmothers command respect and like to be recognized as guardians of family health but lack new information on optimal feeding practices (Schubert and Martin, 2003). In a two-week workshop, partners in northern Ghana drafted messages and materials for three different audiences: mothers of children 0–12 months old, grandmothers, and men. Focus group discussions with mothers, fathers, older women, traditional healers, and health workers provided additional information on local beliefs and customs leading to refinement of the messages and materials with specific, do-able actions. Workshop participants later returned for training in the use of the draft counselling cards. The training included field visits to negotiate behaviour change and promote better breastfeeding practices in the community. Nearly one year passed between the first workshop to draft messages and materials and the actual production and dissemination of the counselling cards. While the materials were under development, work was initiated with regional radio stations and mother-to-mother support groups.

Multiple communication channels. All of the case studies reported the use of several channels of communication to convey messages.

Interpersonal communication. Home visits, group discussions, growth monitoring sessions, and informal encounters provided an opportunity for community health workers and other community resources to personalize the message, ask and respond to questions, teach and demonstrate skills, and provide ongoing encouragement and support. In Nepal and Benin, CHWs were encouraged to discuss breastfeeding during twice-yearly vitamin A campaigns. CARE India stressed the 3 Rs: the Right message to the Right person at the Right time.

To assist CHWs and others, many of the programmes developed job aids such as counselling cards, flip charts, posters, and illustrated health booklets with key messages and immunization schedules. In Honduras, one of the findings of the pilot test of community-based growth promotion was the need for job aids to enhance the performance of volunteers and their supervisors. Before scaling up the programme, the MOH and USAID developed a guide for MOH personnel, a manual for volunteers, 20 counselling cards indexed by child age and growth status, a minimum expected weight gain card, a growth card, a bar chart to show community progress from month to month, and a supervisory checklist. Eighteen of the 20 cards included breastfeeding messages. In Ethiopia and Madagascar, the cost of printing tens of thousands of counselling cards was prohibitive as programme coverage increased. In their place, a family health booklet was developed that included hygiene, sanitation, child survival, and reproductive health messages from pregnancy to 24 months. All families with pregnant women and children under one received the booklet as a reference for improving family health practices.

If used ineffectively, the most attractive counselling cards, family health booklets, and other job aids will be of little value. For that reason, programmes such as those in Bolivia, Ethiopia, Ghana, and Madagascar trained community health workers and other volunteers in their use and in communication skills, encouraging them to go beyond “giving the message” to asking the individual or audience to imagine barriers they may have in adopting the recommended behaviour and to think of ways of overcoming them.

Folk and traditional media. Community-based programmes used music, dance, skits, parades, storytelling, festivals, health fairs, baby shows, and puppet shows to share information, celebrate accomplishments, launch new activities, and mobilize and recognize community health volunteers. World Breastfeeding Week was often a heightened time for community activities. In Cambodia 35 development partners were involved in planning World Breastfeeding Week. In Ghana partners and dynamic leaders of mother-to-mother support groups planned annual World Breastfeeding Week activities to ensure coverage from national to community levels. Activities included parades and

festivals attended by chiefs, elders, opinion leaders, members of the district assembly, and community members. In 2002 women wore tee-shirts with that year's theme and sang songs they had composed about infant feeding as they marched through the streets. One community awarded soap and plastic buckets to women who had exclusively breastfed their babies. In Ethiopia and Madagascar, festivals provided an opportunity to distribute "diplomas" in recognition of volunteers involved in breastfeeding promotion and support.

Mass media. Mass media was used to reinforce messages given through interpersonal communications, raise awareness, extend reach, and create a supportive social environment for behaviour change. The following examples illustrate various channels for reaching communities through mass media.

- *In Benin* youth, traditional singers, and representatives of theatre, women's, and other community groups participated in workshops to develop messages and materials. Community radio stations broadcast spots, games, and dramas developed during the workshops. The dramas and songs were recorded on audio tapes and provided to local transporters, hairdressing salons, and tailors. A popular interactive "quiz show" invited radio listeners to call in with their answers, and television stations broadcast breastfeeding messages during World Breastfeeding Week.
- *In Ghana* a radio journalist developed a popular eight-part radio drama that was translated into four languages and broadcast by radio stations especially during World Breastfeeding Week.
- *In Ethiopia* cassettes and CDs with breastfeeding stories and audio spots were distributed to regional and local radio stations, NGOs, and community programmes.
- *In Cambodia* popular songs recorded by children that encouraged breastfeeding were sold in local markets for download to mobile phones. Five radio and TV spots on breastfeeding and complementary feeding were broadcasted as part of a broader health campaign titled "Good Health, Bright Future." Television is proving to be a popular channel for message dissemination. In remote areas, televisions are commonly shared among a large number of people and run off car batteries (BBC World Service Trust, 2006).
- *In Bolivia* a story/drama video was produced to stimulate discussions at community gatherings. A radio campaign in rural Bolivia included 30-second spots, testimonials, folk songs, and mini-dramas. An evaluation of the campaign showed that respondents who remembered the radio programmes and spots had more correct knowledge about infant feeding practices and were more likely to practice early initiation of breastfeeding than those who did not recall the radio spots. This suggests that a radio campaign can be effective in improving knowledge and behaviour in some settings where other programme interventions are not available.
- *In Mali* messages on early initiation and exclusive breastfeeding were broadcasted three times a day in four languages during a two-month radio campaign in 2006.
- *In Madagascar* a popular singer was enlisted as the country's breastfeeding and nutrition ambassador. She talked and sang about breastfeeding and nutrition at her concerts. Her song on breastfeeding titled "Proof of Love" was a national hit. The celebrity served as a spokesperson for breastfeeding on television and at numerous press conferences, community nutrition festivals, and World Breastfeeding Week activities. In a survey, 9 percent of those questioned said that the famous singer and breastfeeding ambassador was their main source of information on the essential nutrition actions.

Madagascar is an example of a country that made extensive use of all of the communication channels, with the exception of mother-to-mother support groups. Nearly 4,500 members of women's groups were trained in breastfeeding and communication skills for interpersonal counselling during home visits and group sessions in the community and health facility. The programme recognized that scale could only be achieved with the use of mass media and that radio penetrated most rural areas. Over a 5-year period, the programme launched 11 mass media campaigns with 33,000 radio broadcasts over 20 stations and 2,500 television broadcasts. Village theatre, festivals, and events were additional avenues for reinforcing key breastfeeding messages.

3.2.7 Monitoring and evaluating programme progress

The two benchmark indicators for breastfeeding promotion programmes are early (timely) initiation of breastfeeding and exclusive breastfeeding for 6 months. These standard indicators, defined by the international community in 1991, are evidence based and fairly easy to measure although the exclusive breastfeeding rate is often misunderstood. The programmes in Bolivia, Ghana, Ethiopia, and Madagascar collected data on early initiation and exclusive breastfeeding through a baseline household survey, annual rapid assessments, and an endline survey. They also gathered information on other aspects of the programme to determine their effectiveness such as a media survey following a radio campaign. Demographic and Health Surveys (DHS) in the programme areas served as additional points of comparison. In Bolivia, a survey was conducted three years after the close of programme activities to assess maintenance of the improved practices. The programmes in Benin and Honduras conducted their own data collection during pilot activities. The CARE programme in India conducted state-level household baseline and final surveys. Three rapid assessment surveys between the baseline and final surveys provided monitoring information from a selected district in eight states. Additional information was available through a quasi-experimental evaluation in one district in two states. Mali and Nepal have relied on DHS data but will have impact and coverage data available in 2008 for specific zones involved in Accelerated Child Survival and Development, and the Decentralized Action for Children and Women, respectively. Data from an assessment of the Baby-friendly Community Initiative in Cambodia will also be available in 2008.

3.3 Key Findings and Critical Questions

The rich experiences in community-based breastfeeding promotion offer many lessons for future programming. The key findings are summarized below.

Finding 1: The community offers indispensable resources for breastfeeding promotion and support, and these resources need continual mentoring and encouragement.

The programmes described in this paper tapped into existing resources in the community to promote and support breastfeeding, including outreach workers from health facilities, community health workers and other volunteers, community and religious leaders, mothers, and family members. As stated in the WHO/UNICEF *Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding*, "Families and communities are not only recipients but also indispensable resources in the support of appropriate infant and young child feeding."

The full potential of community resources is not always realized because members are often not adequately trained, supported, or supervised. One way to elevate the role and status of volunteers is to give them public praise and recognition, duties that earn them respect in the community, and adequate training, skills, and supervision. As pointed out in a study of the nutrition volunteers in Madagascar, "changing community attitudes concerning nutrition volunteers can probably only occur if leaders themselves are convinced of women's contribution to their community. If leaders do not view nutrition as a health priority for their community, it is unlikely that they will want to invest their energy in recognizing and supporting nutrition promoters" (Hoang, 2002). Mechanisms need to be put in place to motivate, compensate, and recognize community health workers and other volunteers that are acceptable to all parties (CHWs, the community, and the government).

Finding 2: Multiple programme frameworks offer opportunities for community-based breastfeeding promotion and support.

The case studies illustrate that breastfeeding promotion can occur within programmes focused on infant and young child feeding, child survival, essential nutrition actions, reproductive health, newborn care, community IMCI, growth monitoring and promotion, and social development. The various frameworks and strategies for community-based breastfeeding promotion and support represent

different roads to the same destination—child survival, growth, and development. Improved breastfeeding practices add value to all of these programmes and can best be achieved through a continuum of care that is available at the health facility, community, and household. Several of the programmes tested innovations within these frameworks such as giving recognition to baby-friendly communities and workplaces, introducing mother-to-mother support groups and exchange visits, and offering the lactational amenorrhoea method as a family planning option.

Finding 3: Breastfeeding practices can change over a relatively short period and need continued reinforcement to be sustained.

Some people have expressed doubt that breastfeeding promotion can overcome longstanding resistance to early and exclusive breastfeeding, but the case studies show that change can happen, even in places such as Mali with a strong tradition of giving water to babies. The largest gains in Madagascar came at a time of heightened community activities. When the programme had to shift its focus from community and district activities to provincial activities, a drop was seen in the exclusive breastfeeding rate in the following years although the rate was still high at 70 percent in comparison to the baseline at 46 percent (Guyon et al, 2006).

Just as positive change can occur over a relatively short period, so can negative change. This appears to be the case in Bolivia that experienced a sizable drop in the exclusive breastfeeding rate in programme areas within three years of the programme's conclusion. The Demographic and Health Surveys in Nepal show that the exclusive breastfeeding rate dropped from 74 percent in 1996 to 68 percent in 2001 and then to 53 percent in 2006. Changes in questions in the surveys make the exclusive breastfeeding rates incomparable. In any case, countries such as Nepal with high rates of exclusive breastfeeding need ongoing community-based promotion and support to maintain good practices and to reach those who have not yet adopted early and exclusive breastfeeding.

Finding 4: Effective communication and advocacy are vital to set policy priorities, influence community norms, and improve household practices.

To provide insights into family and community knowledge, feeding practices, and social, cultural, and economic challenges to behaviour change, the majority of the programmes conducted behavioural assessments. This information was used to guide development of training interventions, community mobilization strategies, relevant messages, and materials for primary and secondary audiences.

The tool or channel for communication depended on the audience to be reached. To change breastfeeding practices, evidence shows that successful efforts use multiple channels to reach priority audiences with age- and context-specific messages on particular behaviours. These messages are consistently delivered and mutually reinforced by health providers and communities, and they reach the primary audience frequently enough to stimulate lasting behavioural change. The large-scale programmes reviewed used a mix of activities such as interpersonal counselling, community mobilization, and mass media. Box 2 summarizes the key elements of the behaviour change strategy of the LINKAGES Project.

Box 2. Behavior Change Communication for Improved Breastfeeding Practices

Policy dialogue to build support for IYCF

Behavioral assessment with an analysis of benefits and barriers to change within the population and identification of specific, feasible actions that achieve the desired outcomes

Targeted, concise messages to promote "do-able" actions along with practical help

Counseling and communication skills for health and community workers

Consistent messages and materials across all program communication channels to address critical behaviors

Multiple exposure of specific audiences to messages through appropriate media (electronic, print, interpersonal, event, traditional)

Social support such as mother-to-mother support groups, women's clubs, and other existing groups at the community level

Source: Adapted from Quinn et al., 2005.

At the national level, seven of the 10 countries (Benin, Bolivia, Ghana, Ethiopia, India, Madagascar, and Mali) used the PROFILIES advocacy process of policy dialogue to build support for IYCF among policy makers. These programmes were engaged in national-level policy work along side community-based activities, recognizing that behaviour change requires effective communication strategies to influence behaviour at many levels including the broader social, cultural, and policy/ regulatory environment that can determine whether an individual will be successful at adopting and sustaining a practice. The importance of creating change at many levels was expressed by a UNICEF officer in Nepal who completed the case study questionnaire. He wrote, "Knowledge alone does not lead to behavioural change, particularly for exclusive breastfeeding. An enabling environment needs to be created that includes a reduction in workload, support from family members, and counselling support from peers to clarify misconceptions about breastfeeding, particularly concerning the 'milk is not enough' syndrome."

Finding 5: More attention during training needs to be given to interpersonal counselling skills of community health workers.

Focusing on what the CARE India programme referred to as the 3Rs— the Right messages, delivered to the Right person, at the Right time—represents a major advance in IYCF programming. A qualitative assessment of the programme found that government officials frequently mentioned the 3Rs, and statements similar to the following one by a community-based worker were heard across sites: "Earlier I used to say everything at once [to a woman]. Now I think about who needs what advice at what time. Earlier we didn't know what to say to mothers. Now we know." (Bongiovanni et al, 2007).

The final evaluation of the programme in India reported that in general community health workers knew the key messages but did not demonstrate adequate IYCF counselling skills during home visits or make a serious effort to identify barriers to change. A similar finding was reported in a performance evaluation in Bolivia, leading to refresher training for more than 1,600 CHWs. As noted in the announcement for World Breastfeeding Week 2008, mothers need more than accurate and timely information from CHWs and health care providers. They also deserve encouragement, skilled and practical help, and empathetic listening.

Finding 6: Partnerships, leadership, proof of concept, and resources facilitate programme scale up.

As the programmes discussed in this paper attempted to expand, they faced several challenges including ongoing costs of training, quality control, inadequate supervision, competing priorities, and the integration of new components into the programme. The case studies indicate that the following factors helped facilitate programme expansion.

Partnerships. Scale can be reached by communities, government ministries, NGOs, and complementary large-scale health programmes working together to achieve shared objectives. A wide array of partners enriches programmes with their perspective and experience, ensures harmonization and reinforcement of messages, expands coverage, and maximizes resources. The programme benefits from the insights partners can bring to joint planning, formative research, monitoring and evaluation, and the development of behaviour change strategies, BCC materials, and training curriculum. Partner involvement can also build organizational capacity, create IYCF champions within an organization, and foster sustainability through an organization's adoption of innovations, methodologies, and tools.

In Madagascar, the IYCF programme merged with a large-scale USAID-funded bilateral project and trained multiple partners including NGOs and the World Bank-funded Seecaline project. In Ethiopia, the programme also collaborated with a large USAID bilateral. Partners funded activities beyond the bilateral target area and paid for two-thirds of training expenses. In Bolivia an existing network of organizations was the vehicle for broad coverage. In Ghana a new coalition was formed with a

diversified set of partners including the Ministry of Health, universities, NGOs, community leaders, radio journalists, and multi-lateral agencies. In Cambodia members of a child survival coalition and the government championed breastfeeding. In India the long established partnership of CARE with communities and the government placed it in a position to roll out innovations on a large scale and support the government's expansion of services.

Political leadership. In Benin, Ethiopia, and Madagascar, the government adopted the ENA programme framework as the strategy for the country, giving momentum to expansion. In Ghana nutrition champions in the Ministry of Health and the Directorate of Human Resources successfully advocated for resources devoted to breastfeeding. In Cambodia political support for breastfeeding promotion was evident in the adoption of a national IYCF policy, a national nutrition plan outlining breastfeeding activities, development of an implementation plan by an IYCF Technical Working Group, and a Sub-decree on Marketing of Products for Infant and Young Child Feeding.

Proof of concept and replication of approach. Pilot activities with detailed documentation of programme strategies and dissemination of innovations, results, and practical tools contributed to programme expansion in several countries. Honduras served as a testing ground for the community-based growth monitoring and promotion framework. After pilot activities demonstrated "proof of concept," the government decided to adopt this approach. Before going to scale, approximately 18 months were spent developing tools and a training curriculum to enhance performance of the community volunteers. The approach is currently being rolled out throughout the country. Each year health centre staff introduce community-based growth promotion in 400 more communities. Complete coverage in a health centre's catchment area can take 6 years (Griffiths and McGuire, 2005). In some parts of Honduras, a dozen or more NGOs have incorporated community-based growth promotion in their programmes. These programmes are integrated with MOH programmes, and are contributing to expansion. The World Bank's classification of the approach as a "good buy" based on a cost-effectiveness study (Fiedler, 2003) has heightened interest in the model, with several countries in Latin America and in other regions of the world adopting the approach.

Results in a few districts in Madagascar and Benin that piloted the Essential Nutrition Actions approach led to government and donor support for expansion. Ethiopia was able to "fast track" its programme, building on Madagascar's ENA experience, advocacy, training, and BCC. Elements that led to the expansion in Benin included demonstrated technical leadership in the Ministry of Health, immediate results showing progress, high quality and attractive products, and involvement of key stakeholders in the early stages of implementation (BASICS II, 2004). In West and Central Africa, the exchange of experience and tools and the common framework provided by the Accelerated Child Survival and Development programme facilitated quicker adoption of the strategy. The experience of the Baby-friendly Community Initiative in The Gambia stimulated programmes elsewhere, including Cambodia.

Dedicated resources and accountability. Adequate and sustained funding, a mandate to measure changes in breastfeeding practices, and a commitment to achieve scale at the beginning of the planning process created a sense of urgency for rapid programme expansion and provided the political and financial support to move forward in several countries.

Finding 7: Monitoring and evaluation is critical to measure progress, identify successful and unsuccessful strategies, and make appropriate programme adjustments.

Those programmes that carried out baseline and endline surveys as well as annual rapid assessments in programme areas were best positioned to spot problem areas and adjust programmes accordingly. A small set of clearly articulated indicators helped keep breastfeeding promotion focused on the essentials and provided trend data for assessing progress and informing programme strategies. Interpretation of results is problematic when questions are not asked the same way in different surveys and baseline data are not collected. Four programmes conducted studies to determine the costs

associated with different approaches. Thanks to several well-designed surveys and costs studies, we now can say with greater confidence "what works" and at "what cost." This information is valuable for programme planning and implementation as well as evidence-based advocacy.

QUESTIONS

The case studies help answer some of the questions about community-based breastfeeding promotion and support. At the same time, they elicit a number of questions, including the following:

Can the desire for quick results and scale be reconciled with the time required to develop relationships and cultivate a true dialogue and partnership with the community for sustainable change? There is a temptation to enter a community with a predetermined set of interventions. At the outset, IYCF is generally not mentioned as a community's top priority. In a workshop of partners involved in the Ghana Health Services/LINKAGES programme, participants noted that entry into the community requires time, patience, listening, and diplomacy. They emphasized the importance of understanding and building on community and family knowledge and working in harmony with traditional and political structures (LINKAGES Ghana, 2003).

Can the process of behavioural assessments be streamlined? Some programmes are reluctant to carry out behavioural assessments because of the investment in time, training, and resources. The process may appear particularly daunting if a programme aims to reach thousands of communities in large areas of a country.

How much training does a multi-purpose community-based health worker need in breastfeeding? The amount of training CHWs receive in breastfeeding varies greatly. As mentioned above, greater attention needs to be given during training to interpersonal communication skills. What are the "essentials" that a CHW needs to know to provide adequate breastfeeding information and support?

Who are the non-adopters of optimal breastfeeding practices in high performing countries and how can they be reached? What strategies are needed to ensure that there is equitable access to breastfeeding information and support and to create an enabling environment for breastfeeding for all women?

What interventions are best "bundled" together? In the programmes reviewed, breastfeeding was bundled with other nutrition, health, and social development interventions. Is there a point of diminishing returns with the addition of more interventions? What number of interventions is it realistic to expect CHWs to effectively promote, deliver, and counsel on? How much attention can CHWs give to breastfeeding if other interventions require delivery of supplies and/or treatment?

What elements need to be in place to sustain change? Answers have been offered such as community ownership, community models that require fewer financial resources, pre-service education and curriculum development, baby-friendly health services, supportive policies, protective legislation, and the government's capacity to provide sufficient funds to train CHWs and supervise programme implementation. The challenge is to learn more about the conditions for sustainability and the cost and programmatic implications for community-based breastfeeding promotion and support.

3.4 Conclusion

This review of 10 case studies demonstrates: 1) the importance of community-based activities for achieving scale, 2) the role of the community as partners, not recipients, and 3) the feasibility of improving practices through a comprehensive approach that involves partnerships at many levels, capacity building, behaviour change communication, and the creation of an enabling environment. Authors of *The Lancet* Child Survival series (Jones et al., 2003) estimate that exclusive breastfeeding in the first 6 months could prevent 13 percent of child deaths if 90 percent coverage were achieved.

Although some countries are moving closer to this level, most are far from achieving it. Community and facility approaches must work together if this goal is to be achieved. A continuum of care should be available in the facility, community, and household. Energizing the community is essential for delivering child survival services and support at the community level.

The experience in community-based breastfeeding promotion shows that significant changes can occur in a relatively short period, and partners and communities can be mobilized to work together to improve breastfeeding practices and provide a supportive environment. The challenge now is to transfer this accumulated experience and knowledge, take proven interventions to scale, seek innovations to overcome barriers to good practices, and sustain change and commitment.

REFERENCES

Aubel J, Touré I, Diagne M. Senegalese grandmothers promote improved maternal and child nutrition practices: "The guardians of tradition are not averse to change." *Social Science & Medicine* 2004; 59:945–959.

Bhandari N, Bahl R, Mazumdar S, Martines J, Black RE, Bhan MK. Effect of community-based promotion of exclusive breastfeeding on diarrhoeal illness and growth: a cluster randomized controlled trial. *Lancet* 2003; 361:1418–1423.

Bongiovanni A, Acharya K, Kumar S, Tripathy P. Assessment of CARE India's Integrated Nutrition and Health Program Tools and Change Agents. Washington, DC: Food and Nutrition Technical Assistance Project, AED, 2007.

BBC World Trust. Cambodia health campaign: research results. Press release issued 30 October 2006.

Baker J, Huffman S, Martin L, Steel A, Bruce L, Canahuati J. Community-Based Breastfeeding Support: A Planning Manual. Washington, DC: Wellstart International, 1996.

Basics II. BASICS II Country Report: Benin. Published by the Basic Support for Institutionalizing Child Survival Project for the United States Agency for International Development. Arlington, Virginia, 2004.

Bhattacharyya K, Winch P, LeBan K, Tien M. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability. Published by the BASICS Project for USAID. Arlington, Virginia, October 2001.

CARE India. Infant and Young Child Feeding Practices: Results and Lessons from CARE's Reproductive and Child Health and Nutrition and HIV/AIDS (RACHNA) Program. 2007 (unpublished).

Chee G, Makinen M. Comparative Analysis of the Cost and Effectiveness of LINKAGES' Infant and Young Child Feeding Programs in Ghana, Madagascar, and Zambia. Bethesda, Maryland: Abt Associates, Inc., 2006.

Chee G, Makinen M, Sakagawa B. Cost and Effectiveness Analysis of LINKAGES' Breastfeeding Interventions in Ghana. Bethesda, Maryland: Abt Associates, Inc., 2004.

Chee G, Smith K, Makinen M, Rambeloson Z. Cost and Effectiveness Analysis of LINKAGES' Infant and Young Child Feeding Program in Madagascar. Bethesda, Maryland: Abt Associates, Inc., 2002.

Chen L, Evans T, Anand S, Boufford JI, Brown H, et al. Human resources for health: overcoming the crisis. *Lancet* 2004; 364:1984–1990.

Coovadia H, Rollins N, Bland R, Little K, Coutsoudis A, Bennish ML, et al. Mother-to-child transmission of HIV-1 infection during exclusive breastfeeding: the first six months of life. *Lancet* 2007; Mar 31; 369(9567):1107–1116.

Edmond KM, Zandoh C, Quigley MA, Menga-Etego S, Owusu-Agyei S, Kirkwood BR. Delayed breastfeeding initiation increases risk of neonatal mortality. Pediatrics 2006; 117(3):e380-e386.

Fiedler JL, Jain M. A Cost Analysis of the CARE/India RACHNA Program. Arlington, Virginia: BASICS III and A2Z Micronutrient and Child Blindness Program, 2006 (unpublished).

Fiedler JL. Cost Analysis of the Honduras Community-Based Integrated Child Care Program. Washington, DC: The World Bank, 2003.

Frankel S, Doggett MA. The Community Health Worker: Effective Programmes for Developing Countries. New York: Oxford University Press, 1992.

Griffiths M, McGuire JS. A New Dimension for Health Reform—The Integrated Community Child Health Program in Honduras. In: Health System Innovations in Central America: Lessons and Impact of New Approaches. La Forgia GM, ed. Washington, DC: The World Bank, 2005.

Guyon A, Quinn V, Rambeloson Z, Hainsworth M. Final Report: Using the Essential Nutrition Actions Approach to Improve the Nutritional Practices of Women and Children at Scale in Antananarivo and Fianarantsoa Provinces of Madagascar: Results and Trends 2000 to 2005. Washington, DC: LINKAGES Project, AED, 2006.

Guyon AB, Beyero M, Hainsworth M, Mulligan B, Solomon E. Community Assessment in Selected ESHE Focus Woredas in Amhara, Oromia, and SNNPR, Ethiopia: The LINKAGES Project Endline Survey. AED: LINKAGES Ethiopia, October 2006.

Haider R, Ashworth A, Kabir I, Huttly SRA. Effects of community-based peer counselors on exclusive breastfeeding practices in Dhaka, Bangladesh: a randomized controlled trial. *Lancet* 2000; 356:1643–1647.

Haines A, Sanders D, Lehmann U, Rowe AK, Lawn JE, Jan S, Walker DG, Bhutta Z. Achieving child survival goals: potential contribution of community health workers. *Lancet* 2007; 369:2121-2131.

Hoang AT. The Experience of Involving Members of Women's Groups to Promote Nutrition in Madagascar. Antananarivo, Madagascar: AED/LINKAGES Madagascar, 2002.

Horta BL, Bahl R, Martines JC, Victora CG. Evidence on the long-term effects of breastfeeding: Systematic reviews and meta-analyses. Geneva, WHO, 2007.

Iliff PJ, Piwoz EG, Tavengwa NV, Zunguza CD, Marinda ET, Nathoo KJ, et al. Early exclusive breastfeeding reduces the risk of postnatal HIV-1 transmission and increases HIV-free survival. *AIDS* 2005; 19:699-708.

Jelliffe DB, Jelliffe EFP. Programmes to Promote Breastfeeding. New York: Oxford Medical Publications, 1988**.**

Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, Bellagio Child Survival Study Group. How many child deaths can we prevent this year? *Lancet* 2003; 362: 65–71.

Kannitha K, Savery T, Titus M. EngenderHealth makes creative strategies in low-resource settings. *Global HealthLink*, March-April 2002.

Labbok M, Clark D, Goldman AS. Breastfeeding: maintaining an irreplaceable immunological resource. *Nature Reviews* 2004; 4(7):565–572.

Lauer JA, Betrán AP, Barros AJD, de Onís M. Deaths and years of life lost due to suboptimal breast-feeding among children in the developing world: a global ecological risk assessment. *Public Health Nutrition* 2006; 9:673–685.

Lehmann U, Friedman I, Sanders D. Review of the Utilisation and Effectiveness of Community-Based Health Workers in Africa. Joint Learning Initiative Working Paper 4-1, February 2004.

LINKAGES and Partners. Lessons Learned in Promoting Better Infant and Young Child Feeding: Experiences from Northern Ghana. Report on a meeting of Lessons Learned/The Way Forward Conference in Ghana in February 2003.
www.linkagesproject.org/publications/Ghana_Lessons_Learned_03.pdf

Makin J. Cambodia: Women and Work in the Garment Industry. ILO Better Factories Cambodia, the World Bank, CARE International, UNIFEM, 2006.

Martin L, Schubert J. Development of Messages and Materials to Promote Improved Infant and Young Child Feeding: A Case Study in Northern Ghana. Washington, DC: AED, 2003. www.linkagesproject.org/media/static_pdfs/ccards/ghana_bcc_casestudy.pdf.

Morrow AL, Guerrero ML, Shults J, Calva JJ, Lutter C, Bravo J, Ruiz-Palacios G, Morrow RC, Butterfoss FD. Efficacy of home-based peer counselling to promote exclusive breastfeeding: a randomized controlled trial. *Lancet* 1999; 353:1226–1231.

Quigley P, Ebrahim GJ. Women and community health workers promoting community health and development. *Journal of Tropical Pediatrics* 1994; 40:66–71.

Quinn VJ, Guyon AB, Schubert JW, Stone-Jiménez M, Hainsworth MD, and Martin LH. Improving breastfeeding practices on a broad scale at the community level: Success stories from Africa and Latin America. *Journal of Human Lactation* 2005; 21(3):345–354.

Quinn V, Guyon A, Hainsworth M, Ravelojoana V. Improving Exclusive Breastfeeding at a Broad Scale in Two Coastal Provinces of Madagascar. Bangladesh: Child Health and Nutrition Research Initiative, 2006.

World Health Organization Division of Child Health and Development. Indicators for Assessing Breastfeeding Practices: Report of an Informal Meeting 11–12 June 1991. Geneva: WHO, 1991.

World Health Organization. The Optimal Duration of Exclusive Breastfeeding: Report of an Expert Consultation. Geneva, Switzerland 28–30 March, 2001. Geneva: WHO, 2002.

World Health Organization, UNICEF. Global Strategy for Infant and Young Child Feeding. Geneva: WHO, 2003.

World Health Organization, UNICEF, CORE. Child Health in the Community: “Community IMCI” Reference Document. Geneva: WHO, 2004.

World Health Organization, UNICEF. Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding. Geneva: WHO, 2007.

WHO HIV and Infant Feeding Technical Consultation Consensus Statement. Geneva, Switzerland, 25–27 October, 2006. Geneva, World Health Organization, 2007.

Annex 1. Resources for Community-based Breastfeeding Programmes

BACKGROUND DOCUMENTS

WHO/UNICEF (2003). Global Strategy for Infant and Young Child Feeding. WHO, Geneva. Available at: www.who.int/child-adolescent-health/New_Publications/NUTRITION/gs_iycf.pdf

WHO (2003). Community-based strategies for breastfeeding promotion and support in developing countries. WHO, Geneva. Available at: www.who.int/child-adolescent-health/publications/NUTRITION/ISBN_92_4_159121_8.htm

WHO (2004). Family and community practices that promote child survival, growth and development: A review of the evidence. WHO, Geneva. Available at: www.who.int/child-adolescent-health/publications/CHILD_HEALTH/ ISBN_92_4_159150_1.htm

Mukuria AG, Kothari MT, Abderrahim N (2006). Infant and Young Child Feeding Update. ORC Macro, Calverton, Maryland. Available at: www.fantaproject.org/downloads/pdfs/IYCF_Update_2006.pdf

ASSESSMENT, PLANNING, AND IMPLEMENTATION GUIDES

Wellstart International (1996). Community-based Breastfeeding Support: A Planning Manual. See: www.wellstart.org/publications.html

WHO/LINKAGES (2003). Infant and young child feeding: A tool for assessing national practices, policies and programmes. Geneva, 2003. Available at: www.who.int/child-adolescent-health/New_Publications/NUTRITION/icyf.pdf

WHO/UNICEF (2007). Planning Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding. WHO, Geneva. Available at: www.who.int/child-adolescent-health/New_Publications/NUTRITION/ISBN_978_92_4_159519_3.pdf

WHO (draft, 2007). Implementing Community Activities on Infant and Young Child Feeding: A Manual Based on the Experience from Haryana, India.

Favin M, Griffiths M. World Bank (1999) Communication for Behavior Change in Nutrition Projects.World Bank, Washington. Available at: http://siteresources.worldbank.org/NUTRITION/Resources/Tool9-frontmat.pdf

Dickin K, Griffiths M and Piwoz E (1997). Designing by Dialogue. A Program Planners' Guide to Consultative Research for Improving Young Child Feeding. AED/SARA, Washington. Available at: www.pronutrition.org/files/Designing%20by%20Dialogue%20Young%20Child%20Feeding.pdf

Howard-Grabman L, Snetro G (2003). How to Mobilize Communities for Health and Social Change. Health Communication Partnership, Baltimore, Maryland. Available at: www.hcpartnership.org/Publications/Field_Guides/Mobilize/htmlDocs/cac.htm

TRAINING GUIDES

AED/LINKAGES (2004). Behavior Change Communication for Improved Infant Feeding: Training of Trainers for Negotiating Sustainable Behavior Change. AED, Washington. Available at: www.linkagesproject.org/media/publications/Training%20Modules/BCC_and_IF.pdf

AED/LINKAGES (2004). Formative Research: Skills and Practice for Infant and Young Child Feeding and Maternal Nutrition. AED, Washington. Available at: www.linkagesproject.org/media/publications/Training%20Modules//Formative_Research_Module_2-23-04.pdf

AED/LINKAGES (2003). Training of Trainers for Mother-to-Mother Support Groups. Available at: www.linkagesproject.org/media/publications/Training%20Modules/MTMSG.pdf

Wellstart International (1996). Community-based Breastfeeding Support: A Training Curriculum and A Guide for Trainers and Supervisors.
See: www.wellstart.org/publications.html

WHO/UNICEF (2006). Infant and Young Child Feeding: An Integrated Course (Director's Guide, Trainer's Guide, Participant's Manual, Guidelines for Follow up) WHO, Geneva.
Available at: www.who.int/nutrition/iycf_intergrated_course/en/index.html

WHO/UNICEF/CORE (2004). Child Health in the Community, "Community IMCI", Briefing Package for Facilitators, Reference Document, Training Guide. WHO, Geneva. Available at: www.who.int/child-adolescent-health/publications/CHILD_HEALTH/Community_IMCI.htm

Vella J, Uccellani V (1993). Learning to Listen to Mothers: A Trainer's Manual to Strengthen Communication Skills for Nutrition and Growth Promotion. AED, Washington.
Available at: www.globalhealthcommunication.org/tools/49

MONITORING AND EVALUATION TOOLS

Descriptions of key infant and young child feeding indicators, an IYCF monitoring manual, and questionnaires are available at: www.linkagesproject.org/tools/m&e.php

COUNSELLING CARDS

For example of counselling cards on breastfeeding used in community-based programmes, see: www.linkagesproject.org/tools/ccards.php

Annex 2. Questionnaire for Community-based Breastfeeding Case Studies

UNICEF, WHO, and USAID are collaborating in the development of a paper that will present the experience and lessons from community-based approaches to improve breastfeeding practices at scale. This information can be used by others to strengthen existing programmes and design new ones as part of their infant and young child feeding strategy. Information gathered may also be used in UNICEF's 2008 State-of-the-World's Children Report. The paper will include case studies from different regions. The information requested below will help give some consistency to the case studies and provide the information needed to answer such questions as:

- Did the project operate at scale?
- What place did community-based activities have in the overall BF promotion programme?
- What actually happened in the community?
- How was progress monitored?
- What were the results?
- What lessons were learned in planning and implementing community-based activities?

Please complete the questionnaire below and email it with relevant reports (project reports, evaluation reports officially published or circulated, etc.) to Moazzem Hossain (smhossain@unicef.org). Please provide as many details about the community component of the programme as possible.

1. **Name of project/programme:**

2. **Duration of project/programme (start and end dates)**

3. **Location of programme activities (name and # of regions, # districts, rural/urban, etc.):**

4. **Total population reached by programme activities:**

5. **Funding sources:**

6. **Partners/organizations involved in programme implementation:**

7. **Total programme cost and % for community-based activities:**

8. **Method of data collection (type of survey):**

Results (Please complete the table on the following page. If definitions used are different from those provided below, please provide your definition.)

Timely Initiation of Breastfeeding (TIBF) Rate: the percentage of infants less than 12 months of age who are put to the breast within one hour of birth.

Exclusive Breastfeeding Rate (EBF): the percentage of infants less than 6 months old who receive only breast milk, and no other solids or liquids including water (based on 24-hour dietary recall), with the exception of drops or syrups consisting of vitamin or mineral supplements, and medicines.

Continued Breastfeeding Rate: the percentage of children 20–23 months of age who were breastfed in the last 24 hours.

Programme Results

Indicator	Date of baseline	Number surveyed at baseline	Baseline* % achieving indicator	Date of endline (or last survey)	Number surveyed at endline	Endline % achieving indicator
Timely initiation of BF						
Exclusive BF						
Continued BF (20-23 months)						
Other BF indicators collected e.g. frequency if feeds, bottle feeding? If so, please list.						

* If no baseline was conducted at the start of the programme, please provide data from a survey conducted prior to the programme.

Strategies used by the programme: Listed below and on the following page are various activities found breastfeeding promotion programmes. The list is not confined to community activities since we want to know the relationship of community-based activities to the broader programme. Please indicate which of the activities are/were part of your programme. Use column 3 to elaborate on your response.

INTERVENTION	YES/NO	EXPLAIN/COMMENTS
National-level/advocacy		
• Code of Marketing of Breast-milk Substitutes		
• Development of IYCF strategy		
• HIV & infant feeding guidelines		
• Maternity legislation		
• PROFILES or other nutrition advocacy process		
• Other		
Training		
• Community workers/volunteers		
• Health providers		
• Programme managers/administrators		
• Pre-service instructors		
• Other (please specify)		
Types of Training		
• Breastfeeding		
• Lactation management		
• Complementary feeding		
• Infant and young child feeding counselling course		
• Counselling and communication skills		
• Baby-friendly hospital		
• HIV and infant feeding		
Pre-service Curriculum Development/Revision		

Behaviour Change Communication		
• Formative research (behavioural assessments)		
• Workshop to develop messages and materials		
• Radio campaign		
• Television campaign		
• Print materials (please describe in column 3)		
Community-based Activities		
• Sensitization/orientation meetings with local leaders, community dialogue (please describe)		
• *Individual counselling* - Who is the counsellor? - Where does the counselling take place – in the home, at a health facility, in the community? - On average, what is the frequency of the counselling sessions? Please answer in column 3.		
• *Group education sessions* Where are these sessions held (health post, school, community, microfinance meeting, women's group meeting, etc.) – please specify in column 3.		
• *Community mobilization* List the types of community events in column 3 such as fairs, puppet shows, dramas, local music shows, baby shows, Child Health Days, World BF Week activities, etc.		
• Local media (please describe)		
• Mother-to-mother support groups for breastfeeding Did the project/programme form these groups or did they already exist? What organization sponsors them? How many are there?		
• Involvement of other types of women's groups (credit, mothers clubs, social groups, religious groups, etc.): specify		
• Community links with health facilities (please describe)		
• Workplace initiatives		
• Other (please describe)		

Description of community workers/volunteers and their activities

Please provide a profile of the community workers (e.g., gender, age, martial status, education, occupation)

- How were the community workers recruited?
- How many community workers were involved in the programme?
- What training did they receive?
- Who trained them?
- Who supervised them?
- What were the primary activities of the community workers?
- What fees or incentives, if any, were provided?
- What were the main benefits of using community workers?
- What were the main challenges of using community workers?

Context for breastfeeding promotion activities

Was breastfeeding promotion a vertical programme? If no, was it integrated in other programmes such as child survival programmes, early childhood care & development, growth monitoring and promotion, PMTCT, community development, IMCI, etc.? Please describe.

Sustainability

What happened to breastfeeding promotion activities in the programme area when the programme ended?

Lessons Learned from community-based breastfeeding promotion

Plans for future breastfeeding programmes

We welcome additional comments that will enrich understanding of the community component of your project/programme.

Annex 3. Health and Nutrition Indicators of the Ten Countries Featured in the Case Studies[10]

Indicator	Year	Benin	Bolivia	Cambodia	Ethiopia	Ghana	Honduras	India	Madagascar	Mali	Nepal
Total population	2006	8,760,000	9,354,000	14,197,000	81,021,000	23,008,000	6,969,000	1,151,751,000	19,159,000	11,968,000	27,641,000
Annual number of births	2006	358,000	264,000	377,000	3,159,000	700,000	199,000	27,195,000	714,000	579,000	791,000
Annual number of under-five deaths	2006	53,000	16,000	31,000	389,000	84,000	5,000	2,067,000	82,000	126,000	47,000
Under-five mortality rate[11]	2006	148	61	82	123	120	27	76	115	217	59
Infant mortality rate[11]	2006	88	50	65	77	76	23	57	72	119	46
Neonatal mortality rate[11]	2000	38	27	40	51	27	18	43	33	55	40
% of children < 6 months of age exclusively breastfed	2000-2006[12]	43[13]	54	60	49	54	30	46	67	38[14]	53
% of 6-9 months olds fed breast milk and complementary foods	2000-2006[12]	72[13]	74	82	54	58	69	56	78	30[14]	75
% of 20-23 months olds still breastfeeding	2000-2006[12]	57[13]	46	54	-	56	48	-	64	69	95
% of under-fives suffering from underweight[13]	2000-2006[12]	18[13]	8	36	38	18	11	43	42	32[14]	39
% of under-fives suffering from stunting	2000-2006[12]	43[13]	27	37	47	22	25	48	48	34[14]	49
% of under-fives suffering from wasting	2000-2006[12]	8[13]	1	7	11	5	1	20	13	13[14]	13
% of 6-59 month olds who received full coverage with 2 VAS doses	2005	92	39	65	59	95	40	64[15]	95	66	96
% of households consuming adequately iodized salt	2000-2006[12]	72	90	73	20	32	80	51	75	74	63

10. Data are from: UNICEF (2008) State of the World's Children, unless otherwise specified.
11. Mortality rates are presented per 1000 live births.
12. Data refer to the most recent year available during the period specified.
13. Demographic and Health Survey (2006) Final Report. Accessed online, 24 March 2008; url: http://www.measuredhs.com/pubs/pdf/FR197/12Chapitre12.pdf
14. Source: Demographic and Health Survey (2006) Preliminary Report provided through Country Office.
15. Identifies countries with VAS programs that do not target children up to 59 months of age.

Annex 4. Case Studies in Community-based Breastfeeding Promotion and Support

Benin ……46

Bolivia……...49

Cambodia……...52

Ethiopia……..55

Ghana ……58

Honduras ……...61

India ……..64

Madagascar ……...68

Mali ……...71

Nepal ……73

BENIN Case Study in Community-based Breastfeeding Promotion and Support

Up until the introduction of the Essential Nutrition Actions (ENA) framework in 1997, nutrition activities in Benin were scattered across various ministries and seldom integrated in routine services. The Baby-Friendly Hospital Initiative (BFHI) was the main vehicle for the promotion of exclusive breastfeeding, but relatively few births took place in hospitals, and exclusive breastfeeding rates remained low (14 percent in the 1998 DHS survey for infants 0–3 months).

Essential Nutrition Actions Framework

In 1997 the USAID-funded BASICS child survival project introduced the ENA framework in Benin, where it is referred to as the Nutrition Minimum Package. This framework focuses nutrition investments and activities on six priority interventions: exclusive breastfeeding, appropriate complementary feeding with continued breastfeeding, vitamin A supplementation, iron and folic acid supplementation, iodized salt promotion, and nutritional care and counselling for malnourished and sick children. The Borgou Region was chosen as an early implementation site. The objective of the programme was to deliver the six priority interventions in health facilities and communities and to reinforce key nutrition behaviours through an integrated communications programme. Start-up activities included a participatory situational analysis, formative research, baseline studies, testing and development of tools, a traditional media survey, and a health facility assessment. The strategy included three components: health system strengthening, community mobilization, and communications. As part of health system strengthening, health workers received training based on the ENA framework including the technical basis and skills and tools for counselling and negotiation. UNICEF facilitated expansion of the ENA framework to the rest of the country and funded consensus building, human resource capacity building, and tools development.

Community Interventions

The primary community interventions were:

- *Community mobilization*. Community leaders participated in a workshop to help identify community volunteers (*relais communautaires*) for training in the promotion of do-able/feasible actions. Youth, traditional singers, and representatives of theatre, women's, and other community groups participated in workshops to develop messages and materials. Community theatre groups performed dramas in villages and neighbourhoods, and community radio stations broadcast spots, games, and dramas developed in the workshops. Dramas and songs were recorded on audio tapes and provided to local transporters, hairdressing salons, and tailors.
- *Communications*. Formative research studies and trials of improved feeding practices helped tailor messages to the specific conditions of targeted audiences. These messages were disseminated through a variety of channels. Flipcharts, brochures, and health cards were designed to meet the needs of a largely illiterate audience. Other channels included radio spots aired on local and national stations, audio cassettes, and newspaper articles.

The ENA framework draws upon those within a community who can promote and support breastfeeding such as midwives, community volunteers, women's groups, the staff of the Ministry of Family, Women and Children's centres of social promotion, and NGOs. The community volunteers and the women's groups are the interface between the community and the health system. In some districts *mediatrices* (trained community workers) constitute the formal link between the community and health facilities. They work with women's groups and village leaders and bring their concerns to the attention of health providers in the facilities. Through the BFHI programme, UNICEF/WHO and the Government supported and continue to support mother-to-mother support groups. This has been an important element of the national programme (often the missing step in implementation of BFHI's 10 Steps to Successful Breastfeeding) as the proportion of women with access to prenatal care and skilled-attendance delivery has increased up to 80 percent and 66 percent respectively.

Evolution of the Programme
The programme started in four sub-regions of Borgou region (population 600,000) in 1998 and expanded to the 10 other sub-regions in 1999–2000. In 2002 senior health officials representing the other five regions of Benin adopted ENA as a national strategy during a consensus workshop. At a subsequent workshop, IEC materials were adapted for different parts of the country. Elements that fostered scale up included demonstrated technical leadership, immediate results, the quality of the materials and tools, and involvement of national stakeholders in the early stages of implementation in Borgou.

From 1997 to 2003 the BASICS Project provided financial and technical assistance for implementation of the ENA approach, first in Borgou and then nationwide. Staff members of the health region and health facilities were involved in project design, pre-testing, implementation, and follow-up. The Ministry of Health coordinated community-level activities among donors. The USAID bilateral project (PROSAF) developed and applied an ENA module to train community volunteers. The Swiss Agency for Development and Cooperation, Catholic Relief Services (CRS), GTZ, and other NGOs operating in Borgou were also involved in implementation. The World Bank supported ENA training sessions, tools development, and the consensus workshop.

During the two years after support from the BASICS Project ended, breastfeeding promotion received less attention and supervision became slack. The focus turned to vertical programmes such as insecticide-treated nets and vitamin A supplementation campaigns. In 2004–2006 a new framework of interventions that were evidence based, low cost, and high impact placed breastfeeding as a central intervention of integrated policy and programme action for maternal, newborn, and child survival, health, and nutrition.

Results
The 1996 Demographic Health Survey reported that in Borgou only 16 percent of newborns were breastfed in the first hour, and 14 percent of infants 0–3 months were exclusively breastfed. A 1999 CRS survey in selected communities in Borgou reported 40 percent exclusive breastfeeding in this age group. Two other surveys in selected areas in Borgou in 2000 and 2002 confirmed this trend (53 percent and 61 percent, respectively). The 1996, 2001, and 2006 DHS surveys provide trend data on exclusive breastfeeding of infants 0–5 months. Nationwide, the exclusive breastfeeding rate increased from 17 percent in 1996 to 38 percent in 2001 and reached 43 percent in 2006.

Lessons Learned Reported by Programme Managers and Implementers
- Prioritized nutrition interventions that were evidence based, low cost, and high impact for child survival and development could be delivered at national scale through a combination of facility, outreach, and community strategies.
- Political will and commitment to support the programme was critical to its success.
- Capacity building of health workers and community members was an important building block for the programme because it equipped them with specific, practical actions and gave community health workers the skills and recognition needed to perform their tasks.
- Effective communication strategies and the link between health facilities and communities through influential individuals in those communities were vital to ensure that messages reached the communities. When ENA was limited to one region, all of the programme components were implemented and supervised, with the involvement of community opinion leaders. This did not always happen with programme expansion, particularly with regards to the communication component and supervision.
- Integration of breastfeeding promotion into other programmes sometimes results in diminished attention to breastfeeding including sub-optimal supervision and monitoring.
- Mother-to-mother support groups demand timely mentoring and support. They can play an important role in scaling up improved breastfeeding practices at the community level.

- Inadequate attention to breastfeeding promotion and support during contacts with the health system resulted in missed or underused opportunities to deliver interventions, particularly during prenatal care.

Ongoing Breastfeeding Promotion
Building on ENA's prioritization of evidence-based, do-able interventions, UNICEF is supporting current national efforts to ensure that breastfeeding protection, promotion, and support—with a focus on early and exclusive breastfeeding—is a core intervention in the context of child survival policy and programme action in Benin.

Sources

BASICS II. Country Report: *Benin*. Published by the Basic Support for Institutionalizing Child Survival Project for the United States Agency for International Development. Arlington, Virginia, 2004.

Response to questionnaire from UNICEF Benin.

BOLIVIA Case Study of Community-based Breastfeeding Promotion and Support

In 1998 the USAID-funded LINKAGES Project teamed up with the NGO network PROCOSI (Programme for Integrated Health Coordination) and 16 of their members[16] to improve and strengthen infant and young child feeding practices and increase awareness of the lactational amenorrhoea method (LAM) as a modern family planning method for breastfeeding women. Findings from the 1998 Demographic and Health Survey indicated the challenge ahead: one-third of children between 3 to 36 months in rural areas were stunted, and only one-half of children less than 6 months old were exclusively breastfed.

PROCOSI Programme Framework

The IYCF activities fit within PROCOSI's overall goal of improving the health of low-income people, particularly in rural areas, by strengthening the institutional capacity of its member organizations to provide child survival and reproductive health services and control infectious diseases. A participatory planning process followed a needs and resource assessment of PROCOSI members. Ministry of Health staff at all levels and NGO community and technical staff attended regional behaviour change workshops to identify priority behaviours, analyse factors that influence these behaviours, and develop behaviour change strategies. These strategies involved activities at community, district, regional, and national levels to support breastfeeding. The activities aimed at improving breastfeeding through negotiation with mothers, equipping health and community workers with knowledge and skills to support breastfeeding, and framing the issues so policymakers recognized the importance of breastfeeding for human and economic development.

Community Interventions

The four years of community-level activities extended to the country's three eco-regions, reaching approximately 1 million people in 2,389 communities in 149 districts.

Capacity building. The 1998 needs assessment of PROCOSI members revealed that NGO staff were highly motivated and experienced in community work but needed technical updates and training in interpersonal communications. In 1999 NGO supervisors responsible for training community health workers in their respective organizations participated in regional training workshops. The training included discussions of key messages, role plays, demonstrations, and practice in the use of educational materials in individual counselling and group sessions. The training also focused on practice in negotiating behaviours with mothers in a community setting and implementation of the mother-to-mother support group strategy.

As part of the PROCOSI/LINKAGES programme, 1,710 NGO community health workers (CHWs), 350 MOH auxiliary nurses, and 205 additional health personnel participated in 3–5 day trainings in behaviour change communication, breastfeeding, complementary feeding, LAM, maternal nutrition, counselling and negotiation skills, and the use of counselling cards and flip charts. In 2000 the skills of 21 trained CHWs were observed during a performance monitoring evaluation. Although the CHWs knew the educational messages, their negotiation skills during home visits were inadequate. More than 1,600 community health workers participated in refresher training on negotiation skills.

A second performance monitoring evaluation was conducted in 2002, 4–6 months after the refresher training. The evaluation found that 55 percent of the CHWs were able to effectively demonstrate negotiating skills based on four essential steps (verify current practice, identify difficulties, make recommendations, and encourage mother to try out the new behaviour), and 90 percent demonstrated

[16] APROSAR (Asociación de Promotores de Salud del Area Rural) * APSAR (Asociación de Programas de Salud en el Area Rural) * CARE * CARITAS * CEPAC (Centro de Promoción Agropecuaria Campesina) * CRECER/Freedom from Hunger * CSRA (Consejo de Salud Rural Andino) * Esperanza * Plan International * Project Concern International * PROSALUD (Protección a la Salud) * SACOA (Servicios de Asesoria a Comunidades Agrarias) * Save the Children/Canada * Save the Children/US * SERVIR (Servicios Educativos) * Universidad NUR.

effective facilitation of mother-to-mother support groups. During client exit interviews, over 90 percent of women were able to recall messages following home visit counselling sessions and mother-to-mother support group sessions.

Behaviour change communications. The majority of community health workers in Bolivia are men. Many of them schedule home visits for Sundays when husbands are at home. CHWs made more than 800,000 homes visits and gave 163,200 educational talks in clinics, community settings, and mothers' clubs. They also participated in local health fairs and referred community members to MOH personnel. Some of the NGOs initiated mother-to-mother support groups for breastfeeding as one of their BCC strategies. Staff from seven of the partner NGOs received training in mother-to-mother support group facilitation by La Leche League of Bolivia.

To support the CHWs in their various activities, PROCOSI/LINKAGES developed six laminated counselling cards and a 12-panel cloth flip chart with images and messages appropriate for each of the three eco-regions. Several images showed a man providing support to his wife to breastfeed, such as encouraging her to initiate breastfeeding immediately after delivery and caring for an older child while she breastfeeds the new baby. Calendars reinforced the images and the messages, and CHWs received a manual with information on the messages along with instructions on how to use the educational materials. Partner NGOs used a story/drama video—*A New Life for Tomorrow*—to stimulate discussions at community gatherings.

Results

The percentage of infants less than 6 months old that were exclusively breastfed in the programme areas (as measured by 24-hour recall) was 54 percent at baseline in 2000 and 65 percent at the close of the programme in 2003. Three years after the end of direct technical assistance to the NGOs, LINKAGES conducted a follow-up survey to assess the status of key infant feeding behaviours in the same areas as the original programme. In the follow-up survey, the rate of exclusive breastfeeding dropped sharply to 39 percent, below both the baseline rate and the 2003 DHS rate (54 percent). Timely initiation of breastfeeding began at 56 percent in 2000 and reached 74 percent by the final survey in 2003. At the time of the follow-on survey, the rate decreased to 66 percent but remained above the baseline and 2003 DHS results (61 percent). The survey was conducted near the end of the LINKAGES Project. Time and budget constraints prevented an assessment to explore the reasons for these results.

Lessons Learned Reported by Programme Managers and Implementers

- Community-based breastfeeding promotion needs to be ongoing; otherwise, gains that are achieved can be temporary.
- Responsibility for infant feeding programming should be part of the scope of work of NGO personnel and include mentoring and monitoring community health workers in infant and young child feeding activities.
- Supervision, monitoring, and follow-up plans need to be in place before training begins and the joint responsibility of the MOH and NGOs. Post-training activities for ongoing performance monitoring and skills refresher updates should be included in training plans.
- Training MOH and NGO personnel responsible for CHW activities, supervision, and follow up along side community health workers helps harmonize messages and skills, validate CHW activities, and provide a common reference point for measuring CHW performance.
- Negotiation skills are best developed over time, with supervision and mentoring. Smaller, more frequent trainings on negotiation skills, with time in between trainings for supervision, may be a practical strategy for developing these skills.
- A radio broadcasting campaign can be effective in improving knowledge and behaviour in some settings where other programme interventions are not available. PROCOSI/LINKAGES conducted a radio broadcasting campaign in 2001 which included 30 second spots, testimonials,

folk songs, and mini-dramas. In an outcome evaluation, 64 percent of respondents reported hearing advice on the radio about feeding young children and 82 percent reported hearing the PROCOSI/LINKAGES radio campaign. The evaluation showed that respondents who remembered the radio programmes and spots had more correct knowledge about infant feeding practices and were more likely to practice early initiation of breastfeeding than those who did not recall the radio spots. Evaluation results also indicated higher rates of exclusive breastfeeding practices among respondents who remembered elements of the media campaign; however, this cannot be stated conclusively due to the small sample size of mothers of infants less than 6 months old.

Sources

Maxwell K, Borwankar R, Torrez A. *Evaluation of a Bolivian radio broadcasting campaign: "For Stronger and Healthier Children."* Washington, DC: AED, 2002 (unpublished).

LINKAGES Project. *World LINKAGES Bolivia*. Washington, DC: AED, 2004.

LINKAGES Project. *Bolivia Follow-up Survey Results*. Washington, DC: AED, 2007 (unpublished).

NGO Networks for Health. *PROCOSI: Profile of a Health Network*. La Paz, Bolivia, PROCOSI, 2001.

CAMBODIA Case Study in Community-based Breastfeeding Promotion and Support

In 2002 the Government of Cambodia adopted a national infant and young child feeding (IYCF) policy and launched the five-year Cambodia Nutrition Investment Plan (CNIP). The Plan included breastfeeding activities related to policy, communication, training of health workers, preservice curriculum development, and support for the Baby-friendly Hospital Initiative. An IYCF sub-technical working group, formed in 2001 under the Ministry of Health (MOH), was tasked to coordinate implementation of all nutrition-related interventions under CNIP. During a high-level consultative meeting in June 2004 of the Royal Government of Cambodia and the Global Child Survival Partnership, breastfeeding was identified as one of 12 high-impact child survival interventions to be pursued in Cambodia to reduce under-five mortality. This decision was endorsed in two subsequent national child survival workshops that year. Government approval of a Sub-decree on Marketing of Products for Infant and Young Child Feeding in November 2005 followed by dissemination workshops and training on monitoring and enforcement of the sub-decree kept attention focused on the importance of protecting breastfeeding.

Breastfeeding Promotion within Multiple Programme Frameworks
Breastfeeding promotion was incorporated in multiple programme frameworks including nutrition, child survival, Integrated Management of Childhood Illness (IMCI) and Community-IMCI (C-IMCI), reproductive health (antenatal counselling), and prevention of mother-to-child transmission of HIV (PMTCT). Over a three-year period, more than 1,500 health workers received training in breastfeeding counselling during nutrition trainings. Staff from the 13 hospitals joining the Baby-friendly Hospital Initiative and trainers of midwives attended a five-day breastfeeding counselling course.

Community Interventions
The descriptions below illustrate the multiple frameworks for breastfeeding promotion and the various community interventions including training of community volunteers, health education in the community, mothers clubs, and home visits.

- Community-Integrated Management of Childhood Illness (C-IMCI). In 2004 C-IMCI was adopted by the Ministry of Health and presently, with the support of WHO and UNICEF, reaches about 20 percent of the country. By the end of 2006, 1,680 health centre staff from 41 percent of the country's health centres had participated in IMCI and C-IMCI training, which includes a session on IYCF. These health centre staff in turn trained 3,780 community health volunteers through C-IMCI programmes.

  CARE is one of the non-governmental organizations implementing C-IMCI. In 2001 CARE, with funding from USAID, piloted C-IMCI in one district and then expanded to 28 villages over 18 months. CARE trained community volunteers on oral rehydration therapy, diarrhoea management, and breastfeeding. Village health support groups and village health volunteers provided health education on maternal and child health and nutrition, especially during immunization and antenatal care. Mothers clubs were formed with trained facilitators who talked with mothers of children less than five years of age about healthy family practices, including early and exclusive breastfeeding. The programme trained health centre staff on optimal breastfeeding practices and ways to communicate messages in the community and trained midwives in infant feeding and PMTCT counselling. CARE's MCH activities reached about 285,000 people over six years.

- Reproductive and Child Health. In 1996 the Royal Government and USAID founded the Reproductive and Health Alliance (RACHA). In 2000 the Ministry of Health and RACHA developed a poster on exclusive breastfeeding. The poster was used as part of RACHA's Nuns and *Wat* (pagoda) Grannies programme to promote good breastfeeding practices. From March 2000 to March 2002 more than 2,500 religious workers were trained in three provinces. They made more than 60,000 house calls in 454 villages. Colleagues at the pagoda selected the nuns to provide health education in the village and at the pagoda, and community members selected *wat* grannies to provide monthly small group health education sessions and make home visits.

- Baby-friendly Community Initiative (BFCI). In 2004 the MOH, with support from UNICEF, WHO, RACHA, and CARE, launched the Baby-friendly Community Initiative. UNICEF helped start the programme in 35 villages in three provinces. By 2007 BFCI had been introduced in 11 of Cambodia's 24 provinces and reached approximately 517,000 women of reproductive age in 2,675 villages (19 percent of the country's villages). The initiative is built on what is referred to as Mother Support Groups (MSG). A group consists of village health support group volunteers (one man and one woman per village), a TBA, the village chief, and two mothers elected based on their positive breastfeeding experience, literacy, communication skills, and respect.

  Health centre staff facilitate establishment of a Mother Support Group. They organize a village-level meeting, help prepare elections of "model mothers," and provide training, follow-up, and supervision to MSG members. The primary role of MSG members, with the exception of the village chief, is to provide group education and individual counselling on IYCF. The village chief coordinates the group and calls the community together. Many of the MSG members receive a three-day training on breastfeeding and complementary feeding counselling and communication based on the breastfeeding and IYCF module of C-IMCI. The key practices promoted to mothers are early and exclusive breastfeeding, continued breastfeeding to 2 years or beyond, and appropriate complementary feeding starting at six months of age. Individual counselling usually takes place in homes. The members are encouraged to organize monthly group education sessions in conjunction with the outreach activities of health centre staff. Quarterly meetings of the Mother Support Group at the health centres are used to discuss progress/constraints and provide refresher training, but these meetings do not always take place. The main challenges are supervision and follow-up, keeping MSG members motivated, and monitoring and evaluating the BFCI.

  At a December 2007 workshop, participants agreed on "Guidelines for Establishing and Maintaining BFCI." The proposed criteria for maintaining Baby-Friendly communities are: 1) participation of commune council, 2) follow-up and supervision after training, 3) regular meetings for BFCI volunteers at the health centre, 4) refresher trainings, 5) annual BFCI review meeting, and 6) targeted home visits and monthly "baby-friendly gatherings" (group education and discussion sessions) at the village level.

Print Materials and Mass Media

Breastfeeding has been promoted through print materials (leaflets, booklets, flipcharts, and posters) and extensive media campaigns focused on early initiation of breastfeeding and exclusive breastfeeding, with an emphasis on "do not give water." A national communication strategy for the promotion of IYCF was developed for the period March 2005 – December 2007. The BBC World Service Trust organized a series of workshops and consultations with Cambodian practitioners and stakeholders to determine key maternal and child health messages and ensure harmonization across programmes and provinces. From 2003–2006 the BBC World Service Trust's Maternal and Child Health Project produced TV, radio, and supporting print materials to convey more than 50 essential health messages, several of them on breastfeeding. Annual radio campaigns on breastfeeding were implemented beginning in 2004, primarily around the time of World Breastfeeding Week. More than 35 health development partners supported nationwide World Breastfeeding Week activities. Five radio spots on breastfeeding complemented TV spots on early initiation of breastfeeding, exclusive breastfeeding, and complementary feeding, and TV soap operas, call-in shows, and roundtable discussions featured breastfeeding. Songs recorded by children encouraging breastfeeding were particularly popular and were sold in local markets for download to mobile phones. Large billboards depicting a breastfeeding woman and baby were placed in town and rural areas.

Results

The 2000 Demographic and Health Survey conducted in Cambodia found that only 11 percent of infants initiated breastfeeding within one hour of birth, and 11 percent of infants 0–5 months old were

exclusively breastfed in the previous 24 hours. Five years later the DHS[17] reported a timely initiation rate of 35 percent and an exclusive breastfeeding rate of 60 percent. The percentage of infants under 6 months receiving breast milk and water declined sharply (from 64 percent to 22 percent) which explains to a large extent the dramatic change in the exclusive breastfeeding rate. Some of the increase in the exclusive breastfeeding rate may be due to the timing of the survey and changes in the phrasing of the questions. The 2005 survey was conducted in cooler months than the 2000 survey, so respondents may have been less inclined to give their infants water. Even taking this into account, major improvements in feeding practices were achieved. The degree to which the various programme elements described above contributed to changes in breastfeeding practices reported in the DHS is difficult to ascertain. Although community-based breastfeeding activities prior to the 2005 DHS were limited in scale, they demonstrated approaches that are currently being adopted in various parts of the country.

Lessons Learned Reported by Programme Managers and Implementers

- Community-based activities, nationwide media campaigns, and coordinated messages with an emphasis on "not giving water to the child" set a strong foundation for positive behaviour change.
- Integration of breastfeeding promotion into reproductive health, IMCI, PMTCT, and comprehensive nutrition training created multiple programme opportunities to reach women and their children. These activities along with the Baby-friendly Community Initiative, the Baby-friendly Hospital Initiative, and media campaigns extended participation and involvement of many different partners and increased reach.
- Bringing together and supporting existing human resources at the community level created effective partnerships.

Ongoing Breastfeeding Promotion

The draft Nutrition Strategic Plan for 2008-2015 calls for an expansion of BFHI and BFCI, continued efforts in behaviour change communication, and effective implementation of the marketing code. New elements to be included in the expansion of the Baby-friendly Community Initiative are early childhood stimulation and feeding of the sick child. Other components, such as child growth monitoring and promotion and action-taking upon identifying a malnourished child, are being discussed as other components to incorporate systematically into C-IMCI.

Sources

Foote D. Review of Baby-Friendly Community Initiative and Baby-Friendly Hospital Initiative in Cambodia. Report prepared for UNICEF, October 2007.

Goossens-Allen T. *CARE Cambodia Health Program Achievements and Lessons Learned*. CARE, April 2006.

Kannitha K, Savery T, Titus M. EngenderHealth makes creative strategies in low-resource settings. *Global HealthLink*, March-April 2002.

National Institute of Public Health, National Institute of Statistics [Cambodia] and ORC Macro. 2006. *Cambodia Demographic and Health Survey 2005*. Phnom Penh, Cambodia and Calverton, Maryland, USA: National Institute of Public Health, National Institute of Statistics and ORC Macro.

Ministry of Health, Kingdom of Cambodia. [Draft] Implementation Guidelines for Baby-Friendly Community Initiative. 2008.

Response from UNICEF Cambodia to questionnaire.

[17] Data for the 2005 DHS were collected between September 2005 and March 2006.

ETHIOPIA Case Study in Community-based Breastfeeding Promotion and Support

In 2004 the Federal Ministry of Health of Ethiopia adopted the Essential Nutrition Actions (ENA) framework.[18] The alliance between two USAID-supported projects[19] reached 64 focus woredas (districts) in three regions covering 15 million people. Other parts of the country were reached through training of partner staff from UNICEF, the World Bank, 16 nongovernmental organizations, government health bureaus in all (11) regions, 23 PMTCT sites in six regions, and seven universities. Partners were involved primarily in child survival, HIV/AIDS, food security, and reproductive health programmes.

Essential Nutrition Actions Framework

The ENA framework aimed to ensure that nutrition actions were harmonized in relevant health and non-health programmes and to extend nutrition and child survival support beyond the facility level to the community and family. The comprehensive approach for preventing malnutrition and improving nutritional status involved the following four key components:

1. Policy and advocacy at the national level through the formation of partnerships, harmonization of messages, technical updates, and support for the development of a national Infant and Young Child Feeding Strategy and a Code of Marketing of Breast-milk Substitutes.
2. Capacity building of health care providers through pre-service and in-service training to promote ENA at key contact points within and outside the health sector. More than 150 trainings were held between July 2003 and October 2006.
3. Community involvement to create a supportive environment and build the capacity for improved nutrition practices by engaging family members, community members, health care providers, the media, and local, district, and national leaders.
4. Behaviour change communication (BCC) to reach various audiences with interpersonal communication, group discussions, and mass media. Three formative research studies identified existing practices and obstacles to better infant and young child feeding and provided critical information for the development of messages and materials.

Community Interventions

The USAID-supported projects collaborated with Regional Health Bureaus to involve communities and households as partners in promoting healthy behaviours. Community nutrition-related activities included the promotion of improved breastfeeding and complementary feeding practices, bi-annual vitamin A supplementation of children beginning at 6 months, and postpartum vitamin A supplementation of women. Thirty thousand community health workers (CHWs) and more than one thousand facility-based health workers were trained in ENA from 2003 to 2006 in three regions: Amhara, Oromia, and Southern Nations, Nationalities, and Peoples Region (SNNPR). The CHWs are volunteers, selected by the community, who attended short trainings on key health themes, including breastfeeding and complementary feeding.

In 2005 the Government of Ethiopia initiated the Health Extension Programme to increase access of communities to preventive services. The government plans to deploy 30,000 trained health extension workers (HEWs) by 2009. The HEWs immunize children, conduct home visits, and mobilize the community to improve sanitation and protect against major illnesses. They also provide oral rehydration salt packets for children with diarrhoea and treat malaria with antimalarial drugs. Each worker is responsible for around 500 households. Community health workers (one for every 30–50

[18] The ENA approach focuses on the nutrition of women and children under two years of age, promotes an integrated package of seven proven clusters of nutrition behaviors, delivers appropriate messages and provides adequate nutritional support at multiple program opportunities, and uses behavior change communication at all levels to promote and reinforce the recommended actions. The clusters of behaviors are optimal breastfeeding (especially exclusive breastfeeding in the first six months), adequate complementary feeding with continued breastfeeding, nutritional care of the sick child, women's nutrition, and the control of anemia, vitamin A deficiency, and iodine deficiency disorders.

[19] The LINKAGES Project was managed by AED and the Essential Services for Health in Ethiopia Project by John Snow Inc.

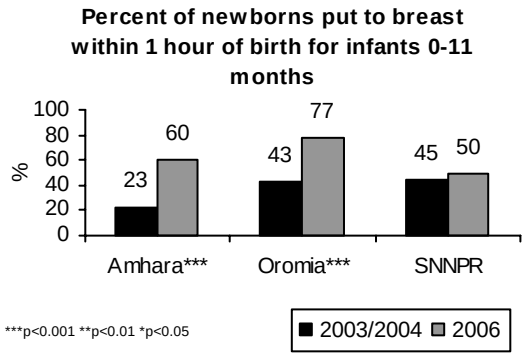
households) expand the promotion and organizational work of health extension workers in three regions. HEWs are all women, but the community health workers (CHWs) are both men and women. In one area, many priests function as CHWs.

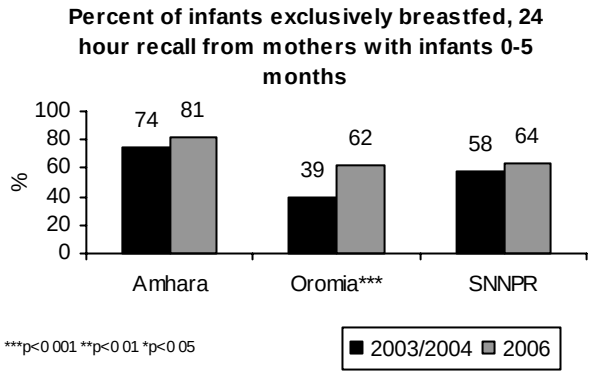
The community health workers are encouraged to take action in their own home and become a model to their friends and neighbours. They promote health messages during everyday activities such as the coffee ceremony, visits to neighbours, religious ceremonies, meetings of traditional money lending groups, and while fetching water and purchasing food at the market. They also help organize the community for outreach services.

An ENA course was adapted for training community health workers, many of whom are illiterate. More than 25,000 of the volunteer CHWs received training in breastfeeding in 2005–2006. Training was also provided for newly deployed HEWs and their instructors. To assist them in their tasks, the CHWs and extension workers received a complementary feeding counselling tool and an illustrated family health booklet to help parents follow the actions they need for the health and nutrition of their children. Drawings in the health booklet were enlarged and laminated for use in community programmes. To reinforce the messages of the HEWs and CHWs, community programmes and local radios stations received cassettes with audio spots on breastfeeding, complementary feeding, and maternal nutrition.

Results

Baseline information was gathered in 2003/2004 in three regions, and a community assessment of infant feeding practices was conducted in May/June 2006. The assessment targeted 2,200 households in each of these regions among communities where community health workers had been active for at least six months. The assessment showed that initiation of breastfeeding within one hour of birth increased significantly in project sites in Amhara and Oromia Regions but showed no statistically significant change in the Southern Nations, Nationalities, and Peoples Region (SNNPR). Exclusive breastfeeding for the first six months showed large increases in Oromia (23 percentage points) but no statistically significant change in Amhara and SNNPR. The baseline rate for exclusive breastfeeding in Oromia (39 percent) was considerably lower than the rate in the other two regions which explains in part the much larger gains in exclusive breastfeeding in that region. For all three regions, the exclusive breastfeeding rate in 2006, which ranged from 62 percent to 81 percent, was considerably higher than the national rate (49 percent) reported in the 2005 Demographic Health Survey.





Lessons Learned Reported by Programme Managers and Implementers

- Messages on breastfeeding serve as an entry point for promoting other messages. Breastfeeding messages empower families to take immediate action to improve their children's lives and do not depend on logistics, delivery systems, or supplies for their adoption.
- Starting out by promoting behaviours that are one time and fairly easy to change helps gain the confidence of the community and its receptiveness to other recommended practices. For example, when people saw the impact of immediate initiation of breastfeeding on the expulsion of the

placenta, they valued the community health worker's advice, and the CHW became more credible in their eyes.

- The illustrated family health card and complementary feeding tool make it easy for health workers and promoters to draw the interest of mothers—particularly those who are non-literate—and discuss optimal infant and young child feeding practices.
- Health extension workers and District Health Offices need to provide regular monitoring and quality support for community health workers to maximize their interactions with families and communities.

Ongoing Breastfeeding Promotion

Ethiopia is continuing and accelerating the promotion of breastfeeding and strengthening community outreach mechanisms through the ESHE Project, which is funded through 2008, and as part of the national Health Extension Programme. The Country Programme of Cooperation between the Government of Ethiopia and UNICEF for 2007–2011 includes child survival and development as one of five focus areas. The community-based nutrition component, which is expected to reach about 22 million people in 150 districts, will feature monthly growth monitoring and a community discussion forum. The forum will help create an enabling environment for optimal breastfeeding and provide an opportunity for community members to assess and address feeding practices.

Sources

LINKAGES Project. *World LINKAGES Ethiopia*. Washington, DC: AED, 2006.

LINKAGES Project. *LINKAGES Ethiopia Final Report: 2003-2006*. Washington, DC: AED, 2006.

Response to questionnaire by UNICEF Ethiopia.

GHANA Case Study of Community-based Breastfeeding Promotion and Support

Efforts in Ghana at the national level to protect, promote, and support breastfeeding began in 1988 with discussion and drafting of a Code of Marketing of Breast-milk Substitutes and continued to 2007 with finalization of an Infant and Young Child Feeding Strategy. In 1997 UNICEF organized a nutrition advocacy workshop using PROFILES, a process for engaging political leaders and policy makers in an assessment of the health and economic impact of sub-optimal nutrition practices, including breastfeeding. The two-week PROFILES workshop and a community assessment in 1998 prompted the Ghana Health Service (GHS) to include breastfeeding promotion and protection among its top five child survival strategies and to dedicate resources for breastfeeding.

From 2000–2004 the GHS and LINKAGES, a USAID-funded project managed by AED, implemented a community-level nutrition behaviour change communication (BCC) strategy to improve infant and young child feeding in nine districts in the three regions of northern Ghana (Upper East, Upper West, and Northern). In addition to community interventions, the programme included advocacy activities at the national and regional levels, training for staff of health facilities, baby-friendly hospital assessments, and revision of the curricula of all (51) medical and paramedical training institutes to ensure that they adequately addressed breastfeeding and other nutrition issues. The GHS/LINKAGES programme helped set in motion efforts that continue today.

Breastfeeding Programme Framework

The community-based programme focused on the improvement of breastfeeding practices and built on established governmental and nongovernmental networks. The initial partners were MOH nutrition specialists and managers in the regional capitals, the government's public and community health nurses, other government agencies involved in community development and growth monitoring, UNICEF through its Child Survival and Development policy and programme action, and two NGOs (Ghana Red Cross and Catholic Relief Services) with child survival programmes. Quickly engaging eight other partners[20] facilitated rapid scale up. Partners participated in stakeholder workshops, action-oriented research using 36 focus groups, skills building workshops, and the pre-testing of messages, tools, and materials. Twenty-one capacity building workshops for partner representatives were organized on IYCF, with a particular focus on such topics as BCC and mother-to-mother support groups. Those trained were then responsible for training their staff and volunteers.

Community Interventions

Partners were involved in a variety of community activities including mothers clubs, child survival, small income generation and credit, water and sanitation, food distribution, and mobile clinic work. Individuals conducting or supporting community-level activities included the following:

- Public and community health nurses addressed breastfeeding issues during community outreach activities including baby weighing/growth promotion sessions, group health education, and home visits.
- MOH district staff provided support to leaders of mothers clubs and mother-to-mother support groups.
- NGO staff trained health care providers and community health volunteers in their district and community networks in infant and young child feeding, behaviour change communication, and mother-to-mother support group methodology.
- Community volunteers such as members of women's groups promoted improved care giving and care seeking practices in their communities. Members of community health teams assisted MOH nurses and made follow-up home visits.

[20] ActionAid, the Association for Church Development Projects, Freedom from Hunger, Ghana United Nations Students Association, NewEnergy, the University for Development Studies, World Food Program, and World Vision International.

Interventions at the community level included interpersonal counselling, mother-to-mother support groups, meetings with community opinion leaders, and community events such as festivals with parades, skits, and songs.

Mother-to-mother support groups. The primary channel for community-based breastfeeding promotion was through various women's groups, including Red Cross and CRS mothers clubs, NGO micro enterprise and income-generating groups, and MOH-initiated breastfeeding mother-to-mother support groups affiliated with health facilities. Mothers clubs have featured in the programme of the Ghana Red Cross for more than 20 years. In 1998 Catholic Relief Services established mothers clubs as part of its child survival programme with a particular emphasis on exclusive breastfeeding. LINKAGES trained MOH and NGO staff in infant and young child feeding and a methodology for mother-to-mother support groups that is participatory and fosters an environment where women can share their experiences and support each other. Three technical update and exchange meetings were held for leaders of women's groups, often women involved in subsistence farming and small commerce. These meetings helped motivate the leaders and enhance their self-image and pride in their work.

***Print, traditional media, and radio*.** Partners received counselling cards for use in their community programmes, nine with messages developed specifically for grandmothers and traditional birth attendants (TBAs) on breastfeeding and complementary feeding and eight cards for use with mothers. Formative research showed the importance of grandmothers and fathers—individuals who often have important direct or indirect influence on how a child is raised and fed. Counselling cards, posters, songs, and local radio programmes communicated the message that breastfeeding was a "wise family choice" for those wanting healthy, strong, and intelligent children.

Journalists and managers of three radio stations in northern Ghana were active partners, participating in training activities and incorporating key messages on a regular basis in their writings and broadcasts. Local radio helped reinforce messages promoted by health workers and other community members and greatly extended the reach of the programme's messages. Radio campaigns intensified during the annual World Breastfeeding Week. Over four years, the GHS and LINKAGES sponsored approximately 500 radio broadcasts on breastfeeding and improved child feeding. The broadcasts were in English and eight local languages, using a variety of formats such as radio call-in shows, quizzes, dramatic comedies, panel discussions with local nutrition experts, and advice from community leaders.

Results

At its conclusion in September 2004, the programme reached more than 3 million people in the 24 districts in the northern regions and seven districts in four other regions. In programme areas in northern Ghana, exclusive breastfeeding increased 16 percent (from 68 percent to 79 percent) between 2000 and 2003, and initiation of breastfeeding within the first hour increased 25 percent (from 32 percent to 40 percent). Freedom from Hunger, a partner NGO involved in credit with education, applied the BCC strategy in three districts in southern Ghana and achieved sizable gains in one year of programme implementation. From 2003 to 2004, exclusive breastfeeding in the Freedom from Hunger programme area increased 42 percent (from 55 percent to 78 percent), and timely initiation of breastfeeding increased 30 percent (from 47 percent to 61 percent). At the national level, exclusive breastfeeding of infants less than six months old increased from 6 percent in 1993, to 31 percent in 1998, and to 54 percent in 2003.

Lessons Learned Reported by Programme Managers and Implementers

- The experience of community mobilization in Ghana showed the importance of engaging a diversified set of development partners as well as women's groups, grandmothers and husbands, and local media in breastfeeding promotion.

- A variety of fora such as round table discussions, annual planning and refresher meetings, lessons learned conferences, and exchange meetings among leaders of women's groups helped keep partners involved and motivated.

- Training NGO staff and health promoters in programme areas resulted in visible, early gains that encouraged partners and donors.

Ongoing Breastfeeding Promotion
The initial focus of the GHS/LINKAGES programme was breastfeeding and timely initiation of complementary foods. As it evolved, the programme gave additional attention to complementary feeding and moved at the end towards a broader nutrition framework with the Essential Nutrition Actions incorporated in preservice curricula. In the current MOH/GHS Ghana Free from Malnutrition Strategy and the Health Sector Plan of Action, breastfeeding is a key component and part of the promotion of the Essential Nutrition Actions. UNICEF continues to provide support for the scale up of breastfeeding promotion through the Accelerated Child Survival and Development programme, and the USAID-supported Ghana Sustainable Change Project includes breastfeeding promotion as one of its interventions.

Sources

LINKAGES Project. *World LINKAGES Ghana*. Washington, DC: Academy for Educational Development, 2004.

LINKAGES and Partners. *Lessons Learned in Promoting Better Infant and Young Child Feeding: Experiences from Northern Ghana*. Report on a meeting of Lessons Learned/The Way Forward Conference in Ghana in February 2003.

Response to questionnaire from UNICEF Ghana.

HONDURAS Case Study of Community-based Breastfeeding Promotion and Support

Honduras has a rich history of promoting breastfeeding, beginning in the 1980s with lactation management training of health professionals, changes in hospital practices, and radio campaigns. During periods of national campaigns, the rates of initiation and duration of breastfeeding increased. From 1993–1995 UNICEF and USAID supported the creation of a community-based network of volunteers to counsel on infant feeding and the training of more than 680 volunteers. Core teams from all 29 public hospitals attended theoretical-practical courses in the Baby-friendly Hospital Initiative. Pilot activities of La Leche League Honduras in integrated community breastfeeding support in low-income and marginal urban and peri-urban communities provided lessons learned in community-based breastfeeding promotion.

Growth Monitoring and Promotion Framework

In 1991–1992 the government of Honduras with support from USAID introduced AIN (the Integrated Child Health Programme - *Atención Integral a la Niñez*). AIN provides another context for breastfeeding promotion, one in which all caring practices are addressed—breastfeeding, complementary feeding, hygiene, and child care more generally. AIN began in pilot health centres, using monthly growth monitoring as an early diagnostic tool for growth faltering. Low health centre coverage led to pilot tests in 1992–1993/94 of community-based growth monitoring in two health areas in about a dozen communities. In 1995 the government decided to base its entire child health programme on a community-based strategy. To prepare for this expanded strategy, large-scale formative research was conducted, and tools, materials, and a training curriculum were developed and tested to enhance the performance of volunteer workers and their supervisors.

The revised Integrated Community Child Health (AIN-C) programme was rolled out in late 1997 with a training of trainers. Nursing staff were then trained and expected to introduce the growth promotion programme in their area by meeting with local leaders and families in each community and recruiting a team of volunteers called *monitoras* (monitors). The first nine health areas implementing AIN-C were the poorest, with the highest population in the country. Almost 3 years were spent proving that AIN-C worked before the MOH issued a decree in 2000 establishing the facility and community components of the Integrated Child Health Programme as the national child health and nutrition programme. That same year the IMCI treatment component was added to AIN-C. By 2003 the programme reached every health centre in 24 of 42 national health areas and approximately 1,800 communities. Between 2001–2004 at least 10 NGOs implemented AIN at the community level in partnership with the MOH. Programme expansion continues.

Community Interventions

AIN-C relies primarily on community volunteers to assess adequate child growth of *all* children less than 2 years of age and to promote healthy behaviours. With additional training, the volunteers treat and refer sick children under 5 to IMCI trained providers in health services.

Activities of Community Volunteers (Monitoras) and Links with Health Facilities

The health centre nurse and staff from the health area introduce AIN to a community by meeting with community leaders and families to assess their interest and willingness to have AIN in their community. If the community accepts, the community selects a team often made up of three volunteers. Most of them are between the ages of 25–40 and work as a team responsible for about 25 children. A *monitora* spends approximately 15 hours per month in the following activities:

- One growth monitoring session (4.5 hours)
- Home visits averaging 1-1.5 hours per visit (5 hours)
- Curative care (1.5 hours)
- Monthly meeting at the health centre with other community volunteers (3.5 hours)

At the monthly AIN sessions, a *monitora* weighs each child under two years of age, records the weight, and plots the curve on the child's growth chart, which is kept by the caregiver. She selects the appropriate counselling card from a set of 20 to discuss the child's health and negotiates with the

mother to determine what feeding practice she might be willing to change in the next month to improve the situation. When a child is seriously ill, the *monitora* refers the child to a health centre. Home visits take place when families miss the growth monitoring session, the child shows inadequate growth, the mother has breastfeeding problems, or the mother has recently given birth. A *monitora* also identifies pregnant women and promotes prenatal care. The *monitora* team conducts home visits for between one-third and one-half of children under two years old each month. Every four months the *monitoras* organize a community meeting lasting about 1.5 hours. The purpose of the meeting is to review attendance at weighing sessions and community progress towards adequate weight gain and to organize collective community response to nutrition-related issues. *Monitoras* are periodically asked by the Ministry of Health to mobilize the community for immunization days and various campaigns.

The *monitoras* compile monthly monitoring data on the number of children registered, weighed, showing adequate/inadequate weight gain, and showing inadequate weight gain two months in a row. This information is presented in bar charts and presented to the health centres. The *monitoras*' supervisor—the health centre nurse—is expected to visit the community six times per year. However, there are reports that some auxiliary nurses rarely visit the communities due to logistic and time constraints. Lack of feedback information from health centres to communities has been cited as one of the weakest links of the programme.

Various incentives have been provided to encourage the *monitoras'* continued involvement including an identification card with a photo, a diploma and letter of appreciation upon completion of their training, a bag to keep AIN supplies, free care in some cases at MOH inpatient health facilities, and a yearly party or dinner for all community health personnel.

Training and Communication Tools

AIN-C involves several types of training: a) 5–8 day training of facilitators, b) 5–8 day training of health centre and sector level personnel, and c) training for the community *monitoras* and their supervisors (5-day training in home-based preventive actions followed by 3–4 months practice in the community and then 3-day training in the curative actions for those achieving 95 percent proficiency in the preventive module). NGOs implementing AIN-C estimated that the initial costs for training, equipment, and materials ranged from $400-$600 per *monitora*. Many *monitoras* have also received additional training in breastfeeding counselling through other programmes.

Various tools were developed to enhance performance including a guide for MOH personnel, a manual for the *monitoras*, 20 counselling cards indexed by child age and growth status, a minimum expected weight gain card, a growth card, a bar chart to show community progress from month to month, and a supervisory checklist. Of the 20 counselling cards, 18 include messages on breastfeeding. Trials of Improved Practices, a qualitative research method, were used to gain insight into families' feeding practices. Supportive communication materials were developed including small flipcharts for use by nurses in the health centres, radio spots, and posters.

Results

A baseline survey was conducted in 1998 for the AIN-C programme and a mid-term evaluation in 2000, which showed an increase in exclusive breastfeeding from 21 percent to 39 percent in AIN-C communities and a slight decrease in non-AIN-C communities (from 15 percent to 13 percent). A 2002 impact survey compared participants versus non-participants in AIN-C. The exclusive breastfeeding rate was 40 percent among non-participants and 56 percent among participants. The median duration of exclusive breastfeeding was 2.4 months among the non-participants and 4.0 months among participants. The percentage of women maintaining or increasing breastfeeding during diarrhoea was lower among non-participants than participants (89 percent versus 97 percent). The 2005/06 Demographic Health Survey for Honduras reported a national exclusive breastfeeding rate of 30 percent.

A World Bank analysis of the costs of the AIN programme concluded that it was a "good buy" and found that the facility-based AIN programme was nine times more expensive than community-based

AIN. Costs for the breastfeeding component were not separated from other costs. An evaluation in 2000 found that 92 percent of eligible children were enrolled in the programme. The AIN-C programme in Honduras has inspired similar programmes in several countries in Latin America and elsewhere.

Lessons Learned Reported by Programme Managers and Implementers

- Putting breastfeeding training within a broader context of infant and young child nutrition and growth helped sustain support for breastfeeding.
- Procedures and tools that make monitoring progress easy and achievement of the goal (adequate child growth) evident help supervisors and *monitoras* concentrate on the children requiring the most attention. Documentation and dissemination of the community process and concepts along with good training tools aid in national expansion.
- Focusing on care seeking practices and household practices and providing frequent contact with the family helps create an attitude that solutions should first be sought in the family and the community. The first step is to examine feeding practices.
- Adequate weight gain can serve as a dynamic and visible measure of progress but requires individualized counselling.
- Sustainability and expansion will depend on the government's capacity to provide sufficient funds to train the *monitoras* and to supervise programme implementation.

Ongoing Breastfeeding Promotion

The intent is for health centre staff to introduce AIN-C in two communities per year. On average, it takes about six years to reach complete coverage in all of the communities in a health centre's catchment area. The Inter-American Development Bank is providing support for the introduction of AIN-C in approximately 400 communities each year. When support from the World Bank becomes available, the intent is to reach 800 new communities each year.

Sources

Fiedler JL. *Cost Analysis of the Honduras Community-Based Integrated Child Care Program*. Washington, DC: The World Bank, 2003.

Griffiths M, McGuire JS. *A New Dimension for Health Reform—The Integrated Community Child Health Program in Honduras*. In: Health System Innovations in Central America: Lessons and Impact of New Approaches. La Forgia GM, ed. Washington, DC: The World Bank, 2005.

Serpa M, Joya de Suarez MJ. *PVO-NGO Experiences with AIN-C in Honduras Participatory Study*. Washington, DC: The CORE Group IMCI and Nutrition Working Groups, 2003.

Response to questionnaire from the BASICS Project and the Manoff Group.

INDIA Case Study of Community-based Breastfeeding Promotion and Support

In a country of 1.12 billion people and great diversity, one would need to write dozens of case studies to do justice to the topic of community-based breastfeeding activities. This case study features the Reproductive and Child Health Nutrition and HIV/AIDS (RACHNA) programme of CARE India funded by USAID and implemented in partnership with the Ministry of Women and Child Development, the Ministry of Health and Family Welfare, and local NGOs and community-based organizations. RACHNA was designed to support Integrated Child Development Services (ICDS), the Government of India's primary programme in the past 30 years to address child undernutrition through nutrition, health, and education interventions implemented through a network of *anganwadi* centres at the community level. Services provided through these child care centres include supplementary feeding, growth monitoring and promotion, immunization, health checkups and referrals, micronutrient supplementation, preschool education for 3 to 6 year olds, and health and nutrition education to adult women, including advice on infant feeding practices. Under RACHNA, food was distributed to approximately 6.6 million pregnant and lactating women and children up to six years of age.

In a report prepared in 2005 by the World Bank, the authors (Gragnolati et. al) concluded that one of the reasons ICDS failed to demonstrate effectiveness in reducing malnutrition was failure to reach the most vulnerable group—children under three—and to provide many parents with counselling on better feeding and child care practices. ICDS' limited impact in improving infant and young child feeding practices was attributed to overburdened community workers and an overemphasis on supplementary feeding and preschool education, leaving little time for growth promotion, health and nutrition education, and home visits. RACHNA tried to address these concerns by advocating for expansion of ICDS from treatment of children with malnutrition to prevention of malnutrition, targeting behaviour change interventions at children under two and pregnant women, and recruiting and training a new group of community workers to work with ICDS staff.

Essential Nutrition Actions Framework

RACHNA, with funding from USAID, operated from 2001–2006 in 78 districts in nine states[21] covering a population of over 102 million. Interventions focused on antenatal care, neonatal care, nutrition, and immunization with reproductive health integrated into the programme in late 2004. In 2002 the project adopted the Essential Nutrition Actions framework with an emphasis on six nutrition intervention areas[22] and age-specific recommendations. The programme strategy included home visits, strengthened supervisory processes, generation and local use of data, and behaviour change communication (interpersonal communication, print, and folk media), and community mobilization. The primary approach for improving infant and young child feeding practices was to encourage timely contacts and home visits by anganwadi workers or auxiliary nurse-midwives.

Community Interventions

Services in the community were supplied primarily through three types of service providers and volunteers:

- *Anganwadi Workers (AWWs)*. These honorary workers receive a stipend from the government to staff the *anganwadi* centres. Many have received at least a secondary education. Their nutrition responsibilities include monitoring and promoting children's growth, alerting parents when growth falters, making follow-up home visits, and encouraging families to attend nutrition and health days

[21] RACHNA built on the Integrated Nutrition and Health Project that began in 1996. The program was implemented in approximately 95,000 anganwadi centers (roughly 10 percent of all AWW centers in the country) in 747 blocks (sub-districts) in nine states: Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and West Bengal.

[22] The six areas are 1) early initiation and exclusive breastfeeding for six month, 2) appropriate complementary feeding, 3) vitamin A for children every six months from 9 to 36 months, 4) iron and folic acid (IFA) for pregnant women, 5) IFA for children from age 1 to 3 years, and 6) an extra meal and rest during pregnancy.

(NHDs) at the anganwadi centre. In reality, these responsibilities are often pushed aside by other duties. The AWWs also distribute take-home rations during NHDs. RACHNA planned a five-hour training on ENA for AWWs. The extent to which the training was carried out depended on the conviction and motivation of block and district ICDS staff.

- *Auxiliary Nurse-Midwives (ANMs).* The ANMs offer health services such as immunizations and antenatal care at the anganwadi centres during the NHD and make home visits as necessary.
- *Change Agents*. RACHNA developed a cadre of community volunteers to serve as a bridge between families in their neighbourhoods (about 15–20 households) and the government health and nutrition programme. The intent was for the Change Agents to work closely with the AWWs and ANMs. About 86 percent of the Change Agents were women or girls, most of them married and under 35 years of age. In a survey of Change Agents, 60 percent reported performing their duties fewer than 5 days a month. The Change Agents received about 6–9 days of classroom training divided in three rounds over six months, the first round covering pregnancy and newborn issues, the next immunization and infant feeding, and the last family planning. Around 250,000 change agents were trained through RACHNA.

The functions of the Change Agents were similar to those of the AWWs and ANMs—encouraging mothers to participate in NHDs, utilize health services, and adopt healthier feeding and caring practices. In the periodic assessments conducted by RACHNA, the proportion of women visited by an AWW or ANM far exceeded those visited by a Change Agent. Moreover, almost all mothers who reported being visited by a Change Agent had also been visited by an AWW or ANM during the same period. Due to insufficient evidence of the value added by the Change Agents and the disproportionate time required to recruit and train them, all states reduced emphasis on them in the final year of the project.

Behaviour Change Interventions

From 1997-2001 the LINKAGES Project collaborated with CARE India to integrate a systematic behaviour change methodology in their programme, which included training in formative research to understand local infant feeding practices and in behaviour change communication. However, the five-day recommended training in BCC and counselling was reduced to two days. As part of this collaboration, CARE developed counselling cards on breastfeeding and maternal nutrition. Other materials were developed under RACHNA, including a reference guide on the Essential Nutrition Actions for programme managers, a three-step counselling guide, five job aids on breastfeeding, a sample checklist for supervisors and ANMs, and a counselling guide for use during home visits. The 2006 evaluation team did not find widespread use of these materials. In the evaluation report, the team wrote: “The AWWs observed in the team’s field visits clearly did not demonstrate adequate IYCF counselling skills during home visits.”

Results

RACHNA conducted a state-level baseline household survey in 2001 and a final household survey in 2006 in intervention villages. Three rapid assessment programme surveys between the baseline and final surveys provided monitoring information from a selected district in each state. Additional information was available through a quasi experimental evaluation in one district in two states. Some of the key findings are presented below.

- *Early initiation of breastfeeding*. In eight states[23] with RACHNA activities, all but Rajasthan showed sizable improvements in early initiation of breastfeeding (in this case defined as within the first 2 hours of birth), with baseline figures ranging from 7 percent to 44 percent and endline figures ranging from 52 percent to 74 percent.
- *Prelacteal feeding* declined sharply from the state baseline surveys to the final surveys in all but Rajasthan. At the endline, from 71 percent to 85 percent of the mothers reported not giving prelacteal feeds in five of the eight states compared with 12 percent to 65 percent at the baseline.

[23] Data from Bihar were not collected.

- *Exclusive breastfeeding.* Differences in the way exclusive breastfeeding was measured in the baseline and endline surveys make it difficult to interpret changes in exclusive breastfeeding rates. Results from the rapid assessments, which reported increases of 10 percentage points in four states, no change in three states, and a decline in one state, show much higher rates than the endline survey. There was no significant improvement in exclusive breastfeeding in the quasi experimental evaluation. Giving water continues to be a major barrier to exclusive breastfeeding.
- *Contact with providers.* The proportion of mothers of children under 6 months who reported receiving advice from an AWW or ANM to breastfeed exclusively for 6 months increased in five of eight states. The percentage of mothers practicing early initiation of breastfeeding was higher among those contacted in the last trimester of pregnancy by an anganwadi worker or auxiliary nurse-midwife than those who were not contacted.

Lessons Learned by Programme Managers and Implementers and 2006 Evaluation Team

- Existing national programmes can carry simple infant feeding messages into the homes of millions of families through AWWs and ANMs with oversight from supervisors, NGOs, and project field teams. The ENA framework is concrete and focused on evidence-based interventions most likely to lead to positive change in the critical periods of the life cycle. The evaluation team wrote that the necessary counselling steps (asking (listening), then assessing, and lastly agreeing on actions or negotiating behaviour change with mothers) "are included in CARE's Essential Nutrition Actions, but did not appear to be operational at community level. . . .More effort is needed to fine tune the BCC strategies for improving IYCF practices" and to build the evidence base for these strategies.
- Anganwadi workers and their supervisors needed simple tools to help them focus on interventions and approaches that were most likely to be effective.
- Short trainings were probably not sufficient to build adequate skills across all subject areas. More attention should be given during the training to communication skills and to problem solving at the family level, particularly on issues related to the perception of "not enough milk."
- Change Agents were more effective for mobilizing the community to use services than for making home visits and counselling families. The evaluation team noted that the approach should not have been scaled up before adequate evidence existed on its effectiveness. Although the team found limitations in the strategy, it felt that village volunteers are needed to reduce the heavy workload of the anganwadi workers and auxiliary nurse-midwives, particularly with home visits.
- Efforts concentrated in the newborn period resulted in improved newborn care and one-time practices such as early initiation of breastfeeding, but this level of improvement was not seen later. Getting "off to a good start" is critical, but other issues should not be neglected such as frequency of breastfeeding, exclusive breastfeeding, and the many issues related to complementary feeding that need special attention.

Ongoing Breastfeeding Promotion

The Integrated Nutrition and Health Project III supports replication of demonstrated good practices that have contributed to improved nutrition in new blocks in current programme districts and other non-CARE districts. The three-year project (2006-2009) will be a period of consolidation and capacity transfer to the government and communities of programme interventions with the objective of sustained reductions in infant mortality and child malnutrition in targeted areas. Early, exclusive, and continued breastfeeding remain primary interventions along with appropriate complementary feeding, hand washing and hygiene, feeding during illness, vitamin A and iron folate supplementation, community-based antenatal and newborn care, and primary immunization.

Sources

Anderson MA, Arora N, Bartlett A, Kumar R, Khanna R, Nath LM, van Haeften R. Reproductive and Child Health, Nutrition and HIV/AIDS Program (RACHNA) Final Evaluation. CARE India, June 2006.

CARE India. RACHNA Program 2001-2006: Summary of Approaches and Results. January 2007.

CARE India. Engaging Communities and Community Volunteers for Improved Health and Nutrition Outcomes. Draft Working Paper, February 2, 2007.

CARE India. Working paper: Infant and Young Child Feeding: Results and Lessons from CARE's Reproductive and Child Health and Nutrition and HIV/AIDS (RACHNA) program. Draft Working Paper, December 2007.

Dreyfuss M, Li Y, Chaudhery D, Singh V. Evaluation Research of the Nutrition Interventions in the Integrated Nutrition and Health Program (INHP) II Areas of CARE India: Final Evaluation Report. CARE India, King Georges Medical University and the Johns Hopkins Bloomberg School of Public Health: September 2006.

Gragnolati M, Shekar M, Das Gupta M, Bredenkamp C, Lee Y. India's Undernourished Children: A Call for Reform and Action. Washington, DC: World Bank 2005.

LINKAGES Project. LINKAGES India Final Report 1997-2004. Washington, DC: AED, 2004.

MADAGASCAR Case Study of Community-based Breastfeeding Promotion and Support

Since 1999 the Ministry of Health and Family Planning/Vaccination Services, USAID, UNICEF, World Bank, WHO, and other partners have implemented an integrated maternal and child health package in two of Madagascar's largest provinces (Antananarivo and Fianarantsoa). In 1999 two projects[24] forged a strong alliance to integrate child survival, reproductive health, and nutrition at the community level, reaching 6.3 million people in 23 districts of two provinces at the peak of programme implementation.

Essential Nutrition Actions Framework

The projects promoted breastfeeding within a package of services that include other essential nutrition actions (ENA), immunization, reproductive health, and prevention and case management of sick children using IMCI. The integrated approach provided multiple platforms to promote breastfeeding and offered opportunities for collaborative training, community mobilization, and harmonization of messages and materials. The national Intersectoral Nutrition Action Group, formed in 1997 with representation from 50 organizations, provided a forum for developing the behaviour change strategy for nutrition, harmonizing messages and field approaches, and sharing experiences.

Community Interventions

Grassroots organizations implemented the vast majority of the community nutrition activities and received technical assistance, training modules, and materials to help in their efforts.

Community mobilization. The community component was built on previous community mobilization activities in pilot districts and a community mobilization strategy based on six principles shown at right. Government health and NGO staff, community leaders, volunteers, members of local groups, and others spearheaded community mobilization efforts. They reached mothers through small and large group activities, one-to-one counselling in homes and at local health posts, and community meetings and mobilization events. Village theatre, festivals, and other community events served as channels for celebrating accomplishments, sharing information, and launching new activities.

Six Principles of Community Mobilization

1. Agree on a small number of action-based messages.
2. Develop easy-to-use front-line teaching tools.
3. Launch short skills-based training activities.
4. Engage large numbers of volunteers.
5. Provide intensive mass media support.
6. Celebrate achievements.

Source: Gottert P. Six Guiding Principles of Streamlining Community-based Programs, AED, 2000.

Nutrition volunteers. Women were selected from a variety of existing women's groups to form a cadre of nutrition volunteers who functioned as peer educators and local animators for community mobilization. The women's groups varied from community to community in their composition (e.g., age or social status) and focus (e.g., income generation, religious activities, social work, or companionship). Women who were selected from these groups as nutrition volunteers conducted various educational activities such as home visits and group discussions at the community health centre, participated in national or commune-sponsored health and nutrition events, and promoted the essential nutrition actions when meeting mothers and pregnant women during their daily activities such as purchasing food in the market, washing clothing, and other informal encounters .

Capacity building. At the peak of implementation of community activities, the projects' technical field staff, with two assigned to each district, trained trainers from district health teams, various NGO partners, and SEECALINE, the large-scale nutrition project funded by the World Bank, in the essential nutrition actions and other child survival and reproductive health interventions. Those trained

[24] The Madagascar Smaller Healthy Families Project (Jereo Salama Isika) was a 5-year bilateral projected funded by USAID and managed by John Snow Inc. with AED responsible for BCC and community mobilization. LINKAGES was a 10-year global project to improve infant and young child feeding funded by USAID and managed by AED.

were then responsible for organizing and carrying out the training of health workers and community members. More than 250 community-level trainers and 12,000 volunteer community health promoters were trained in community mobilization skills. Nearly 4,500 members of women's groups participated in a specialized two-day training in breastfeeding and the lactational amenorrhea method of family planning, counselling and negotiation techniques, and the use of family health booklets and counselling cards. Many of them attended two short training sessions several months later on complementary feeding, feeding of the sick child, women's nutrition, and micronutrients. To ensure that messages delivered at the community level were reinforced in health facilities, approximately 1,900 health workers received training in breastfeeding and LAM, 2,000 in complementary feeding and feeding of the sick child, and 1,100 in women's nutrition and micronutrients.

Local media. Breastfeeding messages also reached households via the radio, which penetrates most rural areas. Key messages were conveyed through local radio broadcasts, traditional singers, and songs by Madagascar's musical celebrity and breastfeeding/nutrition ambassador. Local radio announcers received training to improve their ability to talk about nutrition, child survival, and reproductive health issues during their broadcasts. Radio spots were widely disseminated with approximately 33,000 broadcasts by 20 radio stations and 2,500 broadcasts by televisions stations.

Results

The largest gains were achieved during the period of the most intense community activities. Within one year of implementation of community activities, the exclusive breastfeeding rate in programme areas almost doubled from 46 percent to 83 percent. Timely initiation of breastfeeding rose from 34 percent to 69 percent. A shift in focus in 2002 from district and community level activities to provincial activities due to political disturbances may explain a drop in the exclusive breastfeeding rate the following years, but the rate in 2005 remained high at 70 percent with little change in the timely initiation rate (68 percent). Continued breastfeeding in children 18–23 months of age increased from 52 percent to 71 percent between 2000 and 2005.

Between the 1997 and 2003–2004 Demographic Health Surveys, the rates of timely initiation of breastfeeding, exclusive breastfeeding, and continued breastfeeding in children 18–23 months old improved from 34 percent to 73 percent, from 48 percent to 67 percent, and from 57 percent to 70 percent, respectively. As more government and NGO workers in other parts of the country used the ENA framework, messages, and materials promoted by the project through regional Intersectoral Nutrition Action Groups, greater coverage was achieved. It is plausible that this extended coverage and the use of mass media could have contributed to the increasing national levels of the three breastfeeding indicators.

Lessons Learned Reported by Programme Managers and Implementers

- **Scaling up**. Scale up was made possible by creating a shared vision among members of the Intersectoral Nutrition Action Groups, engaging many partners, especially those with large field programmes, building on the existing programmes of partners, harmonizing messages, and providing short, practical training that could easily be incorporated in various types of programmes.
- **Using a mix of interventions.** Multiple communication channels such as interpersonal counselling, community mobilization, and mass media contribute to behaviour change when the messages delivered are clear, consistent, and focused on feasible actions. Ensuring that health workers and other front-line agents know the right messages to give at the right time to the right audience guards against giving non-specific and non-effective advice to mothers and other caregivers.
- **Saturating the communities with messages.** Communities need to frequently see and hear the same messages in different formats to change their practices.

- **Using multiple programme opportunities.** Extending nutritional support beyond the traditional base of growth monitoring and promotion through an integrated approach is an effective use of resources to address the problems of nutrition, most of which are interrelated.
- **Finding common ground in breastfeeding.** Breastfeeding can serve as an entry point in the community and an integrating factor for child survival, family planning, and nutrition programmes.
- **Achieving simultaneous improvements in multiple indicators.** Promotion of an integrated package of nutrition interventions can result in improvements in breastfeeding and other indicators. In programme areas, iron folic acid supplementation during pregnancy increased from 32 percent to 76 percent, and postpartum vitamin A supplementation from 17 percent to 54 percent. Modest improvements were achieved in complementary feeding, feeding the sick child after illness, and maternal nutrition during lactation.
- **Engaging and sustaining nutrition volunteers.** Women who belonged to a group or association were more likely to be dynamic volunteers than those without a group affiliation. Continuation of the work of the nutrition volunteers will require support and recognition from local authorities, heads of health centres, and members of the community.
- **Replicating the ENA framework in other areas.** Success was not confined to the original project area. A second generation "spin-off" project that applied the ENA framework in two coastal provinces of Madagascar with a population of 1.4 million also yielded results. Timely initiation of breastfeeding increased from 29 percent to 58 percent and exclusive breastfeeding dramatically rose from 29 percent to 52 percent after only 9–10 months of implementation.

Sources

Guyon A, Quinn V, Rambeloson Z, Hainsworth M. *Using the Essential Nutrition Actions to Improve the Nutrition of Women and Children at Scale in Antananarivo and Fianarantsoa Provinces of Madagascar: Results and Trends 2000 to 2005*. Antananarivo, Madagascar: Ministry of Health and Family Planning and AED, 2004.

Guyon A, Quinn V, Rahantanirina P, Rakotonirina S, Ravelojaona V. *The Story of LINKAGES-AED in Madagascar: Using the Essential Nutrition Actions to Improve the Nutrition of Women and Children, 1997–2004*. Antananarivo, Madagascar: Ministry of Health Nutrition Service and AED, 2006.

Improving Family Health Using an Integrated, Community-based Approach. Published by the BASICS Project for USAID. Arlington, Virginia, 2004.

LINKAGES Project. *World LINKAGES Madagascar*. Washington, DC: AED, 2006.

Quinn V, Guyon A, Hainsworth M, Ravelojoana V. Improving Exclusive Breastfeeding at a Broad Scale in Two Coastal Provinces of Madagascar. Bangladesh: Child Health and Nutrition Research Initiative, 2006.

MALI Case Study in Community-based Breastfeeding Promotion and Support

West and Central Africa has some of the world's lowest exclusive breastfeeding rates (20 percent for the region) and one of the highest infant mortality rates (108 infant deaths per 1000 live births). Recent analyses estimate that 300,000 lives in the region could be saved annually with improved breastfeeding practices.[25] For many, increasing Mali's exclusive breastfeeding rate has been viewed as a daunting task. In fact, several NGOs involved in a nutrition programme in Mali in the late 1980s initially chose to concentrate on other infant feeding issues because they did not think they could achieve improvements in exclusive breastfeeding rates during the life of the project.[26] Although the challenges to improving infant and young child feeding practices persist in a country in which more than half of breastfed infants receive water in the first month of life, current efforts can build on the experience of previous ones in Mali and elsewhere. One programme attempting to do so is the UNICEF-supported Accelerated Child Survival and Development (ACSD) programme.

Accelerated Child Survival and Development Framework

UNICEF, in collaboration with national governments in West and Central Africa, is supporting implementation of ACSD to reduce infant, under-five, and maternal mortality. This integrated programme includes antenatal care, breastfeeding promotion, micronutrient supplementation, immunization of children and pregnant women, provision of oral rehydration salts to treat diarrhoea, and provision of bednets to protect against malaria.

The ACSD programme in Mali (2003-2007) supported activities in selected districts in four of Mali's nine regions and reached nearly 7.5 million people (about 62 percent of the total population). The programme integrated antenatal care/newborn packages, mother and child immunization, and facility- and community-based health and nutrition care for children. The latter focused on selected key family practices related to the promotion of improved care giving and care seeking practices for child survival, growth, and development. Promotion of exclusive breastfeeding and improved complementary feeding practices were two of these key family practices. In 2007 the Government of Mali decided to extend this strategy to all nine regions before 2010, naming and making it the National Strategy for Child Survival.

Community Interventions

The primary agent for the promotion of the key family practices is the community health worker (CHW). From 2002–2006 more than 10,000 CHWs were identified and trained in 16 of the 32 ACSD districts. By the end of 2007, the programme aims to train an additional 12,000 CHWs and have them in place in 26 districts through the following process and activities:

- *Training of health centre staff and community leaders.* A three-day training of trainers is provided at the health district level for health centre staff and presidents of community health care management teams. Following the training, the community leaders return to their communities and select community health workers for training in the same subject areas.
- *Training of community health workers.* During a five-day training at the health centre, the trained health care staff and community leaders train the CHWs in the promotion of the key family practices, monitoring and recording of these practices, and communication and counselling techniques during home visits.
- *Activities of community health workers.* Each CHW is responsible for 35 households. The CHW is expected to visit each household monthly and discuss key family practices with

[25] Lauer JA, Betran AP, Barros AJD, de Onis M. Deaths and years of life lost due to suboptimal breast-feeding among children in the developing world: a global ecological risk assessment. *Public Health Nutrition* 2006; 9(6): 673–685.

[26] Parlato M, Seidel R, eds. *Large-Scale Application of Nutrition Behavior Change Approaches: Lessons from West Africa.* Published for USAID by the BASICS Project. Arlington, VA, 1998.

caregivers on topics such as the risks of water feeding and the benefits of exclusive breastfeeding in the first six months of life. The CHW receives a bicycle to use for home visits and outreach activities. During semi-annual National Nutrition Weeks, the CHW delivers vitamin A to postpartum women and children 6–59 months old and intensifies promotion of exclusive breastfeeding and timely and improved complementary feeding. Two of the main messages are to initiate breastfeeding within one hour of delivery and to avoid giving water to infants younger than six months.

- *Supervision of CHWs*. During outreach services, health staff supervise CHWs. The intent is for CHWs to meet monthly with health centre staff and the community management team to discuss their home counselling work and receive feedback, updates, and support; however, the monthly meeting is not always adequately practiced. CHWs are to meet every six months with community leaders and health agents to review their monitoring records and determine if any changes are needed to improve performance.

Results

Results from an ACSD impact and coverage evaluation are expected in 2008. They can be compared with data from Demographic and Health Surveys, which show sizable improvements in breastfeeding practices. Timely initiation of breastfeeding increased from 10 percent in 1995/96, to 32 percent in 2001, and to 46 percent in 2006. During this same period, exclusive breastfeeding rose from 8 percent, to 25 percent, and then to 38 percent.

Lessons Learned Reported by Programme Managers and Implementers

- Breastfeeding promotion and support can be made a central feature of policy and programme action for child survival and development programmes at the national and sub-national (regional, provincial, and district) levels.
- Mobilizing for and supporting the adoption of key family practices requires investments in time and resources. Community leaders and resource persons are more likely to support these practices when they know that they are evidence based, low cost, and high impact.
- To ensure better performance and results, closer follow-up is needed of the large number of CHWs with limited education. Training, equipment, and regular supervision of CHWs affect their performance and motivation.
- The main challenges of using CHWs are low literacy skills and finding mechanisms to motivate, compensate, and recognize their work that is acceptable to all parties (CHW, community, and government). The CHWs are overloaded when numerous development partners solicit their involvement.

Ongoing Breastfeeding Promotion

Promotion of improved breastfeeding and complementary feeding practices is part of a three-year national campaign that started in 2007. The campaign will focus its programme action on three main practices: early initiation of breastfeeding (within one hour after birth), promotion of colostrum feeding in the first three to four days of life, and avoidance of water feeding in the first six months, which is the major barrier to exclusive breastfeeding. One additional goal is for all hospitals and the largest health centres in the country to achieve baby-friendly status by the end of the year. To date, mother-to-mother support groups have not been a strong component of BFHI with limited follow up. Advocacy is underway for ratification of the Code of Marketing of Breast-milk Substitutes.

Sources

Cellule de Planification et de Statistique du Ministère de la Santé (CPS/MS), Direction Nationale de lat Statistique et de l'Informatique du Ministère de l'Economie, de l'Industrie et du Commerce (DNSI/MEIC) et Macro International Inc. 2007. *Enquete Démographique et de Santé du Mali 2006*. Calverton, Maryland, USA : CPS/DNSI et Macro International Inc.

UNICEF WCAR response to questionnaire and Demographic and Health Surveys.

NEPAL Case Study of Community-based Breastfeeding Promotion and Support

Nepal made significant progress in the control of micronutrient deficiencies in recent years, but protein energy malnutrition persists. Half of children under five are stunted, a sign of chronic malnutrition. Over the past three decades several national nutrition strategies were developed to address the problem, the most recent one in 2004/2005. The Micronutrient Initiative, Save the Children Alliance, UNICEF, United Mission to Nepal, USAID, World Food Programme, and various NGOs have been helping the Ministry of Health implement nutrition programmes.

Some community-based programmes included breastfeeding promotion, but their activities were often limited to a few districts and/or supported for a relatively short period of time. Breastfeeding has never been the focus of a special programme although at times breastfeeding featured in media campaigns. A national consensus-building technical workshop held in 1998 resulted in a set of recommended health worker and household behaviours to improve breastfeeding, complementary feeding, and maternal dietary practices. In 1999 the Child Health Division of the Ministry of Health officially adopted the guidelines that came out of the workshop and distributed them to all district health offices and to 42 organizations. The guidelines were also disseminated through the national vitamin A programme, literacy activities, radio broadcasts, and NGO health worker training. In 2005 the Government developed an infant and young child feeding and care strategy.

Programme Frameworks for Breastfeeding Promotion and Support
This case study highlights different programmatic frameworks to promote and support breastfeeding in Nepal.

1) Decentralized Action for Children and Women (DACAW)
In 1999 the Government of Nepal initiated the DACAW programme with the support of UNICEF to address all eight major Millennium Development Goals relating to women and children. This is done through strengthening community action processes, service delivery, and local governance. DACAW works in 15 of Nepal's 75 districts through existing community organizations with credit and saving activities. Each organization consists of 20–30 households. DACAW assists them to assess and analyse the situation of children and women using the Triple A (assessment-analysis-action) process.

Approximately 7,000 community mobilizers and 300 village facilitators are involved in the programme, which reaches nearly 250,000 households. The community organization selects the volunteer community mobilizer, usually a married woman who in most cases can read and write. An external village facilitator, who is paid and recruited by the District Development Committee in consultation with UNICEF, meets monthly with the mobilizer and provides monitoring and technical support. The community mobilizer receives training in infant and young child feeding, health, HIV, water and sanitation, facilitation skills, and UNICEF's conceptual framework for understanding the causes and consequences of malnutrition. Once a month during a meeting of the community organization, the community mobilizer weighs all children under three years old, plots their status on growth cards, and facilitates group discussions on feeding and care practices using various participatory rural appraisal tools to identify the causes of malnutrition and actions to address them. The community tracks key indicators relating to nutrition, immunization, sanitation, antenatal care, and birth registration using a community information board. The mobilizer may conduct home visits, especially if a household has missed two growth monitoring sessions in row.

Every quarter the community plots the growth of all children on a large chart to see how the community as a whole is progressing. In DACAW areas over 85 percent of children under three are weighed on a regular basis. One encouraging sign of sustainability is the continuation of monthly monitoring and community discussion in DACAW areas after external technical and monitoring support has been phased out. The Government is also initiating the DACAW approach in other districts to address social issues.

2) Female Community Health Volunteer Programme

The roles and responsibilities of the FCHVs have evolved and expanded since the creation of the National Female Community Health Volunteer (FCHV) Programme by the Government of Nepal in 1988. One of the objectives of the 1992 Guidelines for Implementation of the National Vitamin A Deficiency Control Programme in Nepal was to increase dietary vitamin A intake through behaviour change, including through appropriate breastfeeding and child feeding practices. Female Community Health Volunteers were trained to administer vitamin A supplements, keep records of children receiving vitamin A, and educate families on good nutrition practices. Currently there are approximately 48,000 FCHVs in all districts of the country. They conduct vitamin A capsule supplementation, deworming, and nutrition education twice a year and distribute iron supplements, oral rehydration salts, zinc tablets, and Cotrim for the treatment of pneumonia. They also participate in national polio and measles campaigns, Nutrition Week, and World Breastfeeding Week activities. The government has allocated funds to Village Development Committees to carry out promotion activities during World Breastfeeding Week.

3) NGO Child Survival Programmes

Several NGOs have promoted breastfeeding as part of their child survival projects. In 1999–2000 approximately 300 trainers and field staff from CARE/Nepal, the Nepali Technical Assistance Group (NTAG), and Save the Children/US received training on the integration of IYCF and maternal nutrition messages within ongoing programming. Several international NGOs developed counselling cards on nutrition during the life cycle for use in their community programmes, and World Education developed and produced five booklets on nutrition as part of its post-literacy course. Good breastfeeding and complementary feeding practices have also been promoted through the IMCI programme, which is being implemented in 51 out of 75 districts.

Results

The 2006 Demographic and Health Survey in Nepal reported an exclusive breastfeeding rate of 53 percent. The contribution of the various programmes discussed above to improved breastfeeding practices is difficult to ascertain. Changes in questions make older Demographic and Health Survey figures on exclusive breastfeeding incomparable to the 2006 DHS. An evaluation of the DACAW programme in 2008 will provide information on trends in breastfeeding practices.

Lessons Learned

- Expanding the duties of the FCHVs gained their respect in the community and proved to be a major motivating factor. “The programme’s strong dependence on interpersonal communication, in particular through FCHVs, and the district and village departments activated to support them, made a national programme not far from the reach of each family” (UNICEF Regional Office for South Asia).
- Knowledge alone does not lead to behavioural change, particularly for exclusive breastfeeding. An enabling environment needs to be created that includes a reduction in workload, support from family members, and counselling support from peers to clarify misconceptions about breastfeeding, particularly concerning the “milk is not enough” syndrome.

Ongoing Breastfeeding Promotion

Future plans for breastfeeding promotion include cascade training on IYCF, intensified media activities focused on early initiation of breastfeeding and exclusive breastfeeding, piloting the mobilization of women cooperatives and community-based organizations as breastfeeding advocates and peer counsellors, and inclusion of breastfeeding issues in neonatal and safe motherhood packages. In mid-2007 the Ministry of Health, WHO, and UNICEF were in the process of designing an IYCF training for the Female Community Health Volunteers. An evaluation of the DACAW programme is expected in late 2007.

Sources

LINKAGES Project. *Breastfeeding & Policy: Context and Consensus*. Washington, DC: AED, 2000.

Ministry of Health and Population [Nepal] (MOHP), New ERA, and Macro International Inc. *Nepal Demographic and Health Survey 2006*. Katmandu, Nepal: MOHP, New ERA, and Macro International Inc., 2007.

UNICEF Regional Office for South Asia. *Getting to the Roots: Mobilizing community volunteers to combat vitamin A deficiency disorders in Nepal*. October 15, 2003 draft.

UNICEF Nepal response to questionnaire.

A large body of evidence demonstrates the benefits of breastfeeding for child survival, growth, and development. An estimated 1.30–1.45 million child deaths could be prevented each year with improved breastfeeding practices. Community-based breastfeeding promotion and support is one of the key components of a comprehensive programme to improve breastfeeding practices, as outlined in the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. *Learning from Large-scale Community-based Programmes to Improve Breastfeeding* shares the experiences and lessons from community-based approaches so that others can use the information to strengthen existing programmes and design new ones. The paper will be of particular value to individuals who are interested in studying and applying different models and the results and lessons emerging from them and assessing their applicability in a new setting.

For further information please contact:

World Health Organization
Department of Nutrition for Health and Development
20 Avenue Appia
1211 Geneva 27
Switzerland

Fax: +41 22 791 4156
E-mail: nutrition@who.int
Website: www.who.int/nutrition

UNICEF
Nutrition Section
3 United Nations Plaza
New York, NY 10017
USA

Tel: +1 212 326 7765
E-mail: nutrition@unicef.org
Website: www.unicef.org

Africa's Health in 2010
Academy for Educational Development (AED)
1825 Connecticut Avenue, NW
Washington DC 20009
USA

Tel: +1 202 884 8000
Fax: +1 202 884 8447
E-mail: ah2010@aed.org
Website: http://africahealth2010.aed.org/

ISBN 978 92 4 159737 1