

Improving Exclusive Breastfeeding Practices



by using

Communication for Development
in Infant and Young Child Feeding Programmes

UNICEF Web-based Orientation Series for Programme and Communication Specialists

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Preface

Exclusive breastfeeding was chosen as the subject of this module because of its large impact on nutrition and child survival outcomes and because it is one of the key indicators that all countries monitor. The module on *Improving Exclusive Breastfeeding Practices* consists of this manual and a Web-based orientation program. Participants should read this manual before they take the Web-based workshop and have it with them during the workshop. Together, these two parts of the module provide an introduction to:

- The benefits and challenges of optimum breastfeeding practices,
- Why exclusive breastfeeding is a basic human and children's right,
- The shift to a Communication for Development (C4D) strategy for exclusive breastfeeding,
- Key aspects of incorporating a C4D approach into an Infant and Young Child Feeding programme to promote, support and protect exclusive breastfeeding and
- Why both community empowerment and social transformation are necessary to achieve and sustain improvements in exclusive breastfeeding practices.

"Social transformation" is an evolving term. Current understanding in UNICEF is that social transformation is the outcome we hope to achieve through identifying and addressing social norms, systems, policies, services, supplies, human resources and other key factors that promote exclusive breastfeeding and many other behaviours that are in the best interests of children.

The module contains information that decision-makers in Ministries of Health and other national-level offices, funding agencies and development organizations, as well as UNICEF staff, will find helpful in designing policies and programmes to improve breastfeeding practices and thus support the right of children to survive, grow and develop in good health.

In addition to background information about the subject, the module presents lessons learned from earlier programmes that had limited success and from more recent programmes that have made significant gains in rates of exclusive breastfeeding, as described in the report, *Learning from Large-scale Community-based Programmes to Improve Breastfeeding Practices*.

At the end of this workshop, participants will:

- Be able to list the benefits and challenges of making exclusive breastfeeding the norm for babies less than six months old,
- Understand the shift to the C4D approach,
- Know the major elements of interventions to improve rates of exclusive breastfeeding,
- Be able to discuss how to integrate C4D principles into major elements of a programme and
- Understand why both individual and community empowerment and social transformation are necessary to achieve and sustain improvements in exclusive breastfeeding practices.

Abbreviations and acronyms

ADB	African Development Bank
ARVs	antiretroviral drugs
BFHI	Baby-Friendly Hospital Initiative
C4D	Communication for Development
CIDA	Canadian International Development Agency
c-IMCI	community integrated management of childhood illness
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
EBF	exclusive breastfeeding
EC	European Commission
ECD	early childhood development
HIV	human immunodeficiency virus
HSAs	health surveillance assistants
IMCI	integrated management of childhood illness
IYCF	infant and young child feeding
M&E	monitoring and evaluation
MTCT	mother to child transmission (of HIV)
NGO	non-governmental organization
PMTCT	prevention of mother to child transmission (of HIV)
RH	reproductive health
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Improving Exclusive Breastfeeding Practices by Using Communication for Development

“Breastfeeding is a natural safety net against the worst effects of poverty. If a child survives the first month of life... exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence.”

—James P. Grant, former UNICEF Executive Director

Chapter 1. Background: Benefits and challenges of exclusive breastfeeding

Introduction

Strategies to improve infant and young child feeding (IYCF) are a key component of the child survival and development programs of many nations, supported by UNICEF and the World Health Organization (WHO), include infant and young child feeding (IYCF) as priorities. The *Convention on the Elimination of All Forms of Discrimination Against Women* (1979) is relevant to food rights and breastfeeding, in that obstacles to breastfeeding for women who wish to breastfeed infringe on their rights.

This Convention is in line with the *Universal Declaration of Human Rights* (1948), *International Covenant on Economic, Social, and Cultural Rights* (1976) and *Convention on the Rights of the Child* (1990). The World Alliance for Nutrition and Human Rights acknowledged the importance of breastfeeding at its first meeting in 1993: “Believing that obstacles to breastfeeding often serve as a human being’s first hindrance to adequate nutrition, food, and care, the alliance pledges itself to further the principles of *Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding*”¹. Moreover, all infants should where possible enjoy the right to be exclusively breastfed for the first six months of life, and thereafter to be breastfed for up to two years or beyond, together with age-appropriate, nutritionally adequate and safe complementary foods.

Beyond the child’s right to survive and develop, the scientific rationale for this decision is clear. The *Lancet Series on Child Survival 2003*² underscored that exclusive breastfeeding (EBF) and continued breastfeeding with complementary feeding are major factors in child survival, growth and development. Evidence also demonstrates that lack of breastfeeding is associated with various chronic diseases and obesity later in life, poor school performance, reduced productivity and impaired intellectual and social development³.

The benefits of optimum breastfeeding practices, which include exclusive breastfeeding for the first six months, are abundant. However, the challenges to making exclusive breastfeeding the norm are also numerous.

“We should not be lauding the advantage of breastfeeding any more than we praise the practice of breathing air. Rather we should be articulating clearly the harm and disadvantages of any alternative.”

—Michael C. Latham, Cornell University Program of International Nutrition

¹ ‘Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding’. Geneva: World Health Organization, 1990.

² Lancet Child Survival Series, 2003.

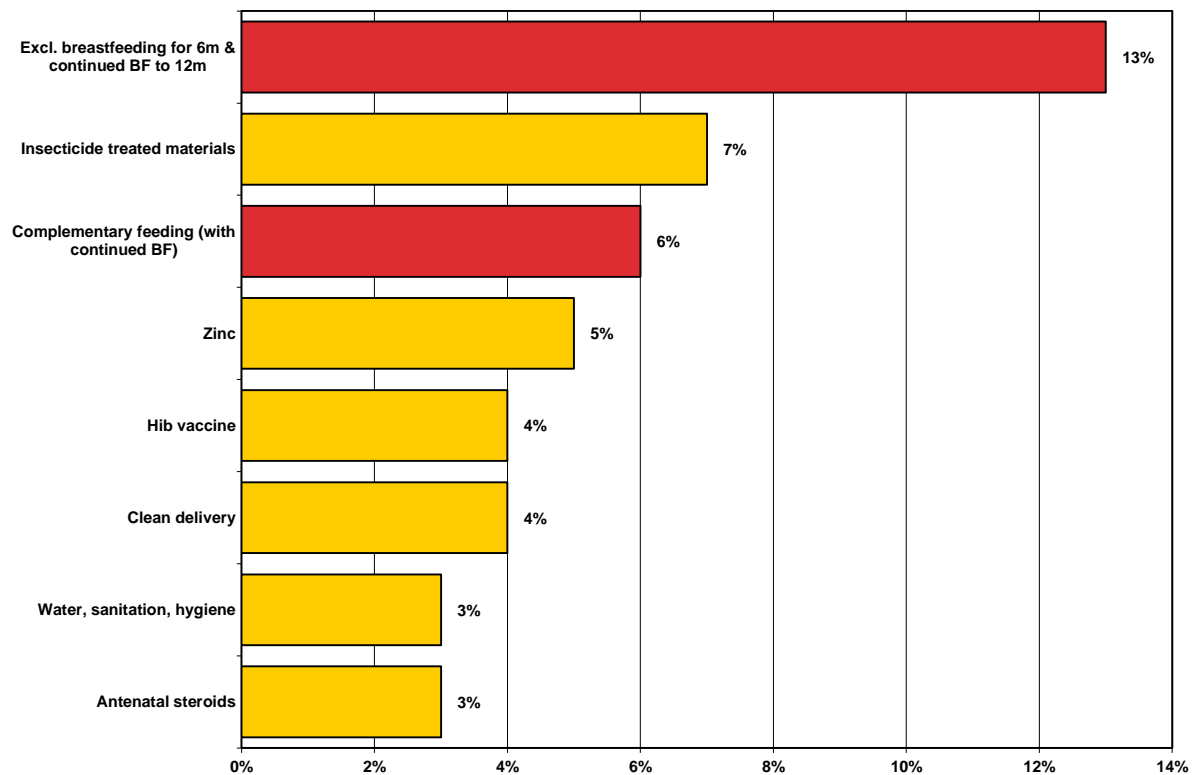
³ World Health Organization, ‘Global strategy: Breastfeeding critical for child survival,’ 2003. Available at: <http://www.who.int/mediacentre/news/releases/2004/pr19/en/index.html>.

Benefits of exclusive breastfeeding

A case can be made for moving away from statements about the advantages of breastfeeding for babies and mothers toward messages about the negative outcomes for babies and mothers of not breastfeeding. Nevertheless, it is important for planners of an IYCF programme to know what the benefits of optimum breastfeeding practices are, not just for infants and mothers but for the larger community and society as well.

EBF is known to be most effective preventive intervention to reduce early-childhood mortality. Optimum breastfeeding practices—exclusive breastfeeding for the first six months and continued breastfeeding to 12 months—tops the list of preventive interventions that would most reduce the number of deaths of children less than five years old from all causes (Figure 1)ⁱ. Optimum breastfeeding practices have the potential to prevent 1.4 million deaths every year among children under five yearsⁱⁱ. In fact, Figure 1 shows that this one preventive intervention could have almost twice the impact of the next most effective preventive action in reducing mortality for this age group. Note that coverage of exclusive breastfeeding was set at 90 per cent.

Figure 1. Child deaths (%) that could be prevented with 99 per cent coverage of preventive interventions



Source: *Lancet* Child Survival Series, 2003.

Breastfeeding has profound benefits for infants that extend beyond childhood, numerous benefits for mothers and benefits for the family. Beyond these well-documented positive aspects for long-term health and well being, breastfeeding has a beneficial impact on the workplace, the health care system and the larger society, as described below by category.

Survival benefits for infants. There is growing evidence that early initiation of breastfeeding has a significant impact on **reducing overall neonatal mortality**. Recent studies from Ghana and Nepal show that early initiation—

within the first hour of life—could prevent around 20 per cent of neonatal deaths. **Breastfed children have at least a six times greater chance of survival** in the early months than non-breastfed children. In the first six months of life, breastfed infants are six times less likely to die from diarrhoea and 2.5 times less likely to die from acute respiratory infection. **Breastfeeding protects infants against diarrhoea through two mechanisms:** (1) reduced risk of bacteria from contaminated formula, other liquids and complementary foods and (2) the transfer of maternal antibodies through breastmilk.

In emergencies, breastfeeding saves lives among the most vulnerable infants under six months by avoiding illness-causing pathogens in artificial milk, boosting their immune systems and providing all required nutrients and sufficient fluid to prevent dehydration.

Benefits for infants' nutritional status. Breastfeeding protects against weight loss due to diarrhoea. Exclusive breastfeeding often means that babies will breastfeed more, which helps keep up the milk production so they get more nutrition. (The practice of giving water together with breast milk in the first six months means the water displaces breast milk, so babies nurse less and the mother produces less milk.) Because of its large impact on reduction of infectious diseases, breastfeeding plays a role in reduction of stunting, a condition in which infectious diseases are important determinants. However, breastfed children will become stunted if they do not receive an adequate quantity and quality of complementary foods from the age of six months onward.

Benefits for reducing risk of chronic conditions. Breastfeeding lowers infants' risk of chronic conditions later in life compared with formula-fed infants, including asthma, overweight and obesity, diabetes, heart disease and cardiac risk factors such as hypertension and high cholesterol levels, and cancers such as childhood leukemia and breast cancer later in life.

Benefits for infants' intellectual, motor and emotional development. Many studies confirm that children who are breastfed do better on tests of cognitive and motor development, as well as academic outcomes, than children who are not breastfed, and infants who are fed breastmilk tend to have higher IQ scores. A recent study adds to the body of literature concluding that children who are breastfed for more than six months have a lower risk of mental health problems as they enter their teenage years⁴. Other aspects of exclusive breastfeeding are harder to quantify but profoundly beneficial. These include the additional opportunities for bonding of mother and infant through more time together with skin-to-skin contact and the contribution this prolonged time of secure physical closeness makes to the infant's well being.

Benefits for maternal health. Initiation of breastfeeding immediately after delivery helps to contract the uterus, expel the placenta and reduce bleeding. Breastfeeding may lead to a more rapid return to pre-pregnancy weight. Exclusive breastfeeding in the first six months may delay the return of fertility, thus reducing exposure to the maternal health risks associated with short birth intervals. In the longer term, mothers who breastfeed tend to be at lower risk of pre-menopausal breast cancer and ovarian cancer.

Economic and social benefits. Breastfeeding is the least expensive method of infant feeding. For many poor households, the high cost of breast-milk substitutes, feeding and sterilizing equipment and fuel represents a substantial drain on scarce household resources. Added to this are the costs of health care for the sick infant exposed to contaminants from mixed feeding or water in addition to breast milk. When mothers miss work to care for sick infants, employers and the economy are also affected. Moreover, as previously stated, breastfeeding is a **basic human right**, so effective EBF practices should become available to all, including vulnerable and marginalized populations. Breastfeeding can help bridge economic and social gaps.

Table 1 provides an overview of the benefits of breastfeeding discussed so far in this section. Overall, the combination of physical and emotional benefits provided by exclusive breastfeeding gives children the best platform for a healthy start in life.

⁴Oddy W, et al., *Journal of Pediatrics*, May 2010.

Table 1. Overview of benefits of exclusive breastfeeding for infants, mothers and society

<p>Benefits for infants</p>	<ul style="list-style-type: none"> • Provides adequate water for hydration. • Provides superior nutrition for optimum growth. • Protects against infection and reduces overall child mortality. The biggest impact on reducing illness relates to diarrhoea, through two mechanisms: (1) reduced risk of bacteria from contaminated formula, other liquids and foods and (2) transfer of antibodies through breast milk. • Reduces overall neonatal mortality by around 20% (early initiation of breastfeeding). • Promotes bonding and development. • Results in better cognitive development and IQ than in formula-fed children. • Lowers the risk of chronic conditions such as diabetes, heart disease, obesity, certain cancers etc. compared with formula-fed infants.
<p>Benefits for mothers</p>	<ul style="list-style-type: none"> • (Early initiation) helps contract the uterus, expel the placenta and reduce bleeding. • Helps mothers return more rapidly to their pre-pregnancy weight and a lower body mass index after 5–6 years. • Lowers risk of pre-menopausal breast cancer and ovarian cancer. • May delay return of fertility.
<p>Benefits for society</p>	<ul style="list-style-type: none"> • Lowers family food and health expenditures. • Decreases workforce absence due to decreased infant and maternal illness. • Lowers health care provider costs due to decreased infant and maternal illness, staff time, kitchen requirements, space, nursery beds, etc. • Is a basic human right and may help bridge the divide between marginalized and vulnerable populations and more privileged groups.

Challenges to exclusive breastfeeding

“Breast milk is the best food but has the worst marketing. Why is it that breastfeeding, so obviously beneficial for children and for the child survival agenda, continues to be low priority, under-supported or neglected, controversial, misrepresented, under-taught and countered by many forces? Unlike infant formula (and indeed any other products, including beneficial products like ready to use therapeutic food, micronutrients, etc.), breastfeeding has no significant commercial advocate.”

—Miriam Labbok, University of North Carolina

Despite the many benefits of EBF, sound breastfeeding practices are not the norm in many countries, and large differences exist in the EBF rates between regions and among countries. The promotion, support and protection of optimum breastfeeding take a different type of engagement from the health system, because **breastfeeding is a social behaviour and not a medical practice**. It is not a typical intervention, because there is no pharmaceutical product to be purchased or distributed and the practice is not dependent on a facility or health provider. These factors pose particular challenges, which have been addressed with varying degrees of success by breastfeeding programmes.

In developing countries, the rate of exclusive breastfeeding for infants less than six months is only 37 per cent, and there has been very little progress since the early 1990s. It is estimated that that global burden of children who are not exclusively breastfed is around 32 million childrenⁱⁱⁱ. Challenges to improving breastfeeding practices include:

- Complacency, which may be one of the biggest threats to optimal infant feeding
- Widespread promotion of breast-milk substitutes
- Belief that infants need water in addition to breast milk
- The issue of breastfeeding and HIV transmission
- Lack of support for breastfeeding at home, in the community, in health care facilities and in workplaces (e.g., policies for maternity leave and worksite facilities for breastfeeding), linked to the perception that behavior change is difficult or even impossible
- Lack of commitment and resources for behaviour change programmes needed to support optimum breastfeeding
- Poor understanding of the role of breastfeeding in advancing human and health rights

Poor understanding of local practices and existing myths

Sometimes the challenge is simply giving women accurate information about how to position the baby and how to breastfeed effectively. For example, Ghana identified a problem in “breastfeeding on the run”—a common situation in which mothers gave a little bit of milk from both breasts, so children were not suckling enough to get the rich hind milk. Because of this practice, mothers thought their babies were hungry (they were) and were tempted to give other foods. The standard message to give the breast at least 10 times a day was thus inappropriate for Ghana, because mothers were already giving the breast as often as 20 times a day. What they needed were messages about **how** to breastfeed, not how often. This example shows the importance of understanding local practices and local contexts.

It is also customary in many countries for adults to give babies water, teas, porridge or other foods in addition to breast milk, even during the first few weeks of life^{iv,v}. Even when mothers want to breastfeed exclusively, they often face pressure in the community and from husbands and other family members to follow these social norms for mixed feeding^{vi,vii,viii}. When this happens, social norms conflict with human rights by inhibiting the mother’s right to breastfeed her infant exclusively and interfering with the baby’s right to survive and develop with all health benefits breast milk provides in the early months. Several myths about breastfeeding still persist (e.g., those listed in Box 1) and should be researched and addressed by communication efforts.

Box 1. Myths about breastfeeding

- Colostrum should be discarded.
- Colostrum is dirty.
- Colostrum is yellow because it has been in the breast for too long and has gone bad.
- A baby should not be suckled until the “white milk” comes in.
- A sick infant should be given only rice water.
- Breast milk is not enough and therefore babies need other foods and milk.
- Breastmilk is too thin.
- Breast milk gives some babies allergies.
- Breast milk that accumulates when the mother is separated from her baby should not be given to the baby.
- Babies need water.
- Babies need to receive traditional teas and medicines.
- Bottle feeding is harmless and hygienic.
- Babies in industrialized or middle-income countries can safely be fed water or formula together with breastmilk because the risks of contamination and diarrhoea are minimal.
- Mothers cannot eat or drink certain foods or liquids during breastfeeding.
- A mother who is angry or frightened should not breastfeed.
- A mother who is ill should not breastfeed.
- A mother who is pregnant should not breastfeed.
- A mother who breastfeeds cannot take medications.

- A mother who takes medications cannot breastfeed.
- A mother who is breastfeeding cannot have sex because the milk will go bad; therefore, she should stop breastfeeding soon so that sexual relations can resume.

Myths versus facts: A few examples

Myth: Stress makes milk dry up.

Fact: Although extreme stress or fear may cause milk stop flowing briefly, this response to anxiety is usually temporary. Evidence is growing that breastfeeding produces hormones that reduce tension, calm the mother and the baby and create a loving bond.

Myth: Babies that have diarrhoea need water or tea.

Fact: Because breast milk is 90 percent water, exclusively breastfed babies that have diarrhoea do not usually need additional liquids such as glucose water or tea. Water is often contaminated in emergency situations. If diarrhoea is severe, oral rehydration therapy (administered by cup) may be required.

Myth: Once breastfeeding has stopped, it cannot be started again.

Fact: With an adequate re-lactation technique and support, mothers and their babies can be helped to restart breastfeeding after a switch to infant formula. This is sometimes vital in an emergency.

Myth: Mothers who don't have enough to eat can't breastfeed.

Fact: Only the most severely malnourished mothers will have reduced production and quality of breast milk. Mothers should be encouraged to breastfeed frequently so they will see that production of breast milk improves. Supplementary feeding for pregnant and lactating mothers also is essential.

Overall underestimation of IYCF impact

Another challenge to exclusive breastfeeding is the fact that IYCF interventions often do not receive the attention and resources that are appropriate to their potential impact. (Figure 1 shows that two of the top three preventive interventions involve EBF and complementary feeding.) This underestimation has many reasons, but one is simply the larger context in which child-focused interventions exist. That context includes competing priorities, disease-specific funding, interest in technologies and prioritization of nutrition campaigns and products. For example, IYCF programmes face challenges such as:

- Limited commitment to a comprehensive approach at scale
- Poor sustainability of interventions
- Small, fragmented community-based efforts
- Training and structures in the health system that do not support effective counselling and communication with specific groups and communities
- Scattered and unplanned communication efforts that (1) do not take into account socio-cultural behaviours and barriers and (2) are implemented without efforts or inspiration to support and protect breastfeeding as a human right of mothers and infants, particularly in the face of aggressive marketing of breast-milk substitutes
- Exclusive focus on short-term improvements in breastfeeding practices rather than the long-term social transformation that is necessary to encourage and sustain individual and community empowerment

Limited enforcement of the *International Code of Marketing Breast-milk Substitutes*

The *International Code of Marketing of Breast-milk Substitutes* was developed “to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through

appropriate marketing and distribution”⁵. The *Code* includes a requirement for informing parents about the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes. However, the *Code* is not binding on signatory states, many countries still do not have national legislation and even if they do, it is violated routinely and not monitored or enforced effectively. The *Code* is a minimum requirement. Countries need to translate the *Code* into national legislation.

A few countries have passed legislation that is stronger than the *Code*. Papua New Guinea, for example, made bottles for infant feeding available only by prescription^{ix}. The industry’s own analysis shows that sales of breast-milk substitutes are curbed in countries with strong *Code* implementation (such as India) and are increasing in countries with no *Code* legislation (such as China). Some marketing messages about breast-milk substitutes, especially claims that artificial milk is as good as mother’s milk or even better, may need to be countered with positive ones that reinforce the benefits of breastfeeding and resonate with different participants groups (e.g. mothers, grandmothers, spouses, health workers, etc.). Messages should also address and counteract existing myths about breastfeeding and provide relevant information and statistics on the benefits of EBF.

Special challenges of HIV-positive mothers

In addition to the many other challenges to exclusive breastfeeding, there are special challenges in counselling mothers who are HIV positive. Social pressures for mixed feeding are strong in many parts of the world. Evidence on HIV transmission through breastfeeding, highlights that exclusive breastfeeding for up to six months is associated with a three- to four-fold decreased risk of transmission of HIV when compared with non-exclusive breastfeeding (mixed feeding)^x. However, despite a slight risk that HIV-positive mothers will transmit the AIDS virus to their infants via their breast milk, the risks of not breastfeeding are far greater, especially in settings with poor water and sanitation, poor health services and widespread poverty^{xi}.

In fact, non-breastfed children of HIV-positive mothers have much higher mortality rates because of malnutrition, diarrhoea and other diseases than do breastfed babies. Thus, the focus should be expanded to **ensuring HIV-free survival**, not just on preventing mother-to-child transmission.

“The family will offer to buy her formula when she has chosen to breastfeed, they will tell her that breast milk is not enough for the baby, she must also mix it with formula feeding, and she can’t deny that because she hasn’t told them why she chose to exclusively breastfeed her baby so she will just mix feed.”

—South African health worker^{xii}

New World Health Organization guidelines for HIV and infant feeding

In 2009, in response to more recent evidence, WHO issued new recommendations for feeding of infants in the context of AIDS (N.B This is an update to the 2006 guidelines)^{xiii}. The evidence shows that administering anti-retroviral drugs (ARVs) to all HIV-positive mothers with CD-4 counts less than 350 throughout the breastfeeding period or *providing extended anti-retroviral prophylaxis to infants born to HIV-positive women with CD-4 counts greater than 350, along with prophylaxis for the mother*, can significantly reduce post-natal transmission^{xiv}.

For HIV-positive mothers who receive ARVs, breastfeeding is made dramatically safer and the “balance of risks” between breastfeeding and replacement feeding is fundamentally changed. The mother’s own health is also

⁵ WHO, *International Code of Marketing of Breast-milk Substitutes*, 1981. Available at: http://www.who.int/nutrition/publications/code_english.pdf.

protected. This new evidence fundamentally transforms the landscape in which decisions on infant feeding practices are made by individual mothers, national health authorities and international development partners⁶.

The 2009 WHO guidelines advocate that national or sub-national health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to (1) breastfeed and receive ARV interventions *or* (2) avoid all breastfeeding, as the strategy that will most likely give infants the greatest chance of HIV-free survival. The national authorities will thus make a single recommendation; there will no longer be counselling on choosing from among different options.

The new guidance makes the following recommendations on feeding infants:

- ***HIV-exposed infants who do not have HIV or have unknown HIV status:*** Exclusive breastfeeding for the first six months of life, introducing appropriate complementary foods thereafter, and continued breastfeeding for the first 12 months of life
- ***HIV-positive infants and young children:*** Strongly encourage exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years of age or beyond

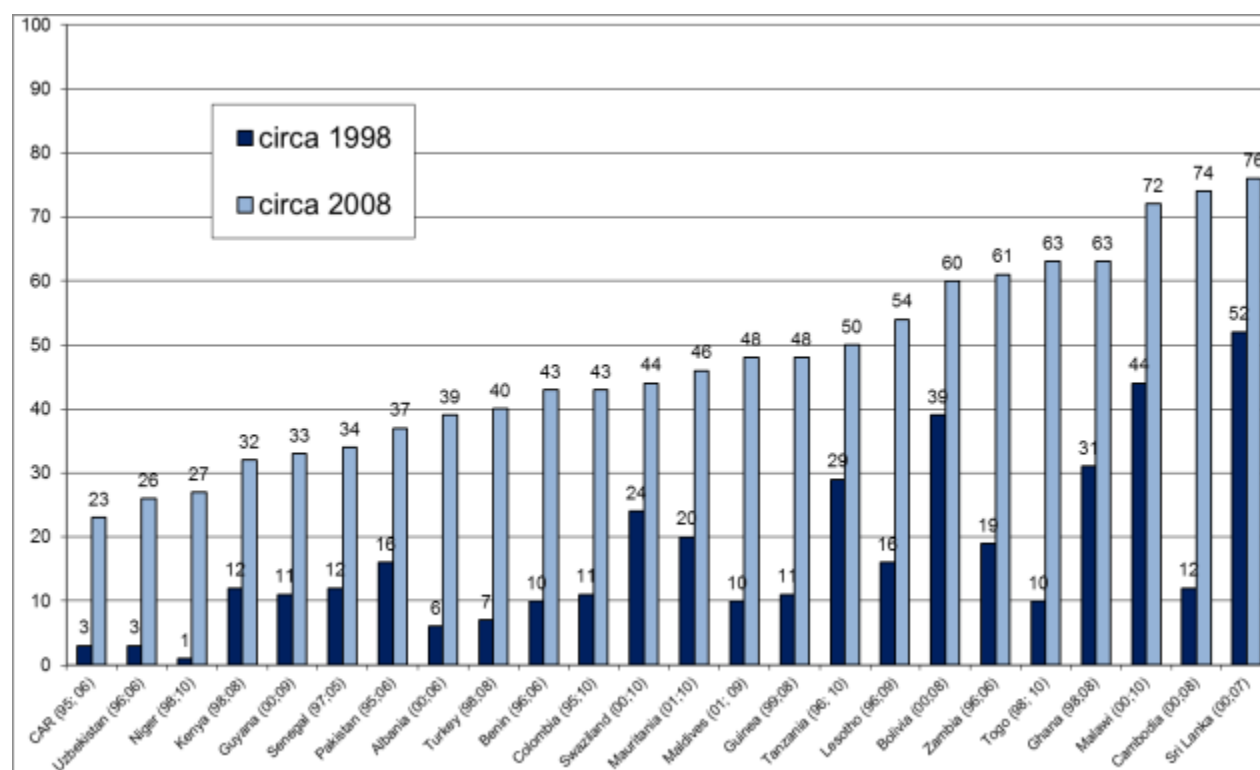
In Kenya, improved IYCF support for exclusive breastfeeding reached 73 per cent of women who received antenatal care and Prevention of Mother to Child Transmission (PMTCT) services in 2008—an estimated 1.1 million of the 1.5 million pregnant and lactating women in Kenya. The approach used in Kenya strengthens the crucial infant feeding aspect of PMTCT and extends IYCF counselling and communication to the general population.

Integrated, multi-level programmes can make progress

Rapid and significant increases in breastfeeding are possible, as shown by data in Figure 2 representing 16 countries. The results come from integrated, multi-level programmes of advocacy and social mobilization that made progress in behaviour and social change at individual, cultural, institutional and governmental levels.

⁶ See UNICEF's *Programme Guidance for Infant and Young Child Feeding*, 'HIV and Infant Feeding' chapter

Figure 2. Countries that increased EBF rates more than 20 per cent since the 1990s*



Sources: UNICEF, *State of the World's Children 2012*, and *Progress for Children 2007*

Common to most of these successful country initiatives is the large-scale implementation of comprehensive programmes to promote, support and protect breastfeeding, with strong government leadership and broad partnerships^{xv}. The programmes involve action across levels:

- The **national level**— including the adoption of legislation on the *International Code of Marketing of Breast-milk Substitutes* and maternity protection for working women as well as the development of workplace policies and breastfeeding facilities
- The **health system level**— including counselling and support to help ensure that optimal breastfeeding practices are implemented at key contact points, such as antenatal care, maternity facilities and child health clinics.
- The **community level** — including counselling, support and communication by family members, community leaders, community health workers, other community cadres and mother-to-mother support groups

The country with the highest rate of exclusive breastfeeding in the developing world is Rwanda, with 88 per cent of children less than six months exclusively breastfed. Rwanda has maintained these high rates—more than 80 per cent—since the early 1990s.

Even though only six of the countries listed in Figure 2 have increased exclusive breastfeeding for more than 50 per cent of the population, the gains in all 24 countries are significant. However, the behaviour is not changing fast enough.

Further, successful programmes implement a **comprehensive communication strategy** that uses multiple channels to address barriers to breastfeeding in specific regions or among specific participant groups. In Sri Lanka, factors contributing to success in improving breastfeeding practices included a well-developed health system, strong

breastfeeding advocates and dedicated professionals, supportive policies, frequency of contacts between public health midwives and pregnant and postpartum women, use of a variety of communication channels and extensive lactation management training for nearly all health workers in the field and in major hospitals. (See also Annexes I and II for case studies on programmes in Malawi and Cambodia.) Box 2 discusses some key lessons learned and results from the integration of communication as part of a comprehensive programmatic approach in Cambodia.

Box 2. Integrating communication as part of a comprehensive approach in Cambodia

Key results and lessons learned

The EBF rate increased from 11 per cent in 2000 to 60 per cent in 2005 for children less than six months old. The programme's strategy featured:

- Design of programme and communications to recognize Cambodia's high percentage of home births (89 per cent), rural population (85 per cent), home access to mass media (50 per cent) and network of community health workers for all villages in the country
- High-level advocacy of government and development partners
- Realignment of partners' policy frameworks
- A sub-decree on marketing of infant and young child products
- "Breastfeeding-friendly" accreditation of hospitals
- A communication strategy focused on mass media (more than 35 health development partners supported nationwide activities for World Breastfeeding Week)
- Training of health workers and NGO staff

(See Annex II for more information about Cambodia's programme.)

Lessons learned: Findings from 10 community-based breastfeeding programmes

A report evaluating programmes in 10 countries—Benin, Bolivia, Cambodia, Ethiopia, Ghana, Honduras, India, Madagascar, Mali and Nepal—drew the following conclusions⁷:

1. The community offers indispensable resources for breastfeeding promotion and support that need continual mentoring and encouragement.
2. Multiple programme frameworks offer opportunities for community-based breastfeeding promotion and support.
3. Breastfeeding practices can change over a relatively short period and need continued reinforcement to be sustained.
4. Effective communication and advocacy are vital to set policy priorities, influence community norms and improve household practices.
5. Interpersonal skills of community health workers need more attention during training.
6. Partnerships, leadership, proof of concept (pilot testing) and resources facilitate programme scale-up.
7. Monitoring and evaluation are critical to measure progress, identify successful and unsuccessful strategies and make appropriate adjustments.

Additional lessons learned from these 10 programmes are:

⁷ WHO, 2008, op. cit.

- Instead of generic messages (e.g., “breast is best”) with no discussion of why and no context, use evidence from studies of knowledge, attitudes and practices and barrier analysis to design strategies (including messages).
- Instead of relying heavily only on information, education and communication (e.g., posters, slogans, mass media), use multiple channels with emphasis on interpersonal communication and community-based approaches.
- Instead of expecting a campaign approach to be adequate (e.g., World Breastfeeding Week), ensure continuous communication at multiple levels.

Successful approaches to improve breastfeeding practices emphasize interventions to change behaviour and social norms—to clear up false beliefs, lower barriers and increase social support for the practice. These results can be reached only through a combination of strategic communication activities that will result (among others) in: (1) supportive national policies and legislation, (2) increased number of healthcare providers who have skills in counselling and communication and work within a responsive health system, (3) community participation and support of EBF behavior; and (4) continuous communication efforts at all levels. To that end, a shift in approach is needed to a process that:

- Is systematic, strategic, evidence-based and participatory,
- Has measurable objectives and integrated communication strategies,
- Reflects values, local and larger contexts and potential for children to be agents of change,
- Focuses on social transformation for sustainable results and
- Is based on human rights principles

Ultimately, sustainable gains in overall child survival, growth and development require interventions that are evidence-based, effective, comprehensive and at scale to improve infant and young child feeding. C4D incorporates many of these factors and, in integration with existing strategic communication models and other public health strategies, can help achieve these goals faster.

Chapter 2. Exclusive breastfeeding: A shift in approach

Many IYCF programmes have used communication interventions to help promote optimal breastfeeding practices. These programmes typically relied only on communication materials, media campaigns and health education sessions to inform women about the benefits of exclusive breastfeeding. Although they have generated some improvements, they have not produced desired changes in women’s practices on a wide scale. As with many other sectors and communication models, C4D has evolved over time and today is focused on the participation and empowerment of individuals and communities and less on the one-way, top-down sharing of knowledge.

“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.”

—UNICEF officer in Nepal⁸

Communication for Development approach

An examination of some earlier efforts identified specific areas that limited the success of communication strategies. Table 2 shows key areas of previous communication approaches and the changes made in response to lessons learned from large-scale programmes. Of course, this is a generalization and does not apply to specific interventions and/or communication planning models and frameworks that may already reflect many of the key tenets of the C4D approach.

Table 2. Comparison of previous approaches and C4D approach

Aspect of strategy	Some previous (and still-used) approaches	C4D approach*
Objective	<ul style="list-style-type: none"> To increase knowledge as health intervention 	<ul style="list-style-type: none"> To change behaviour and social norms as part of a social transformation process that involves women and other key participant groups (e.g., grandmothers, spouses, older children, health workers, etc.)*
Interpersonal communication	<ul style="list-style-type: none"> Generally top-down and one-way (didactic) 	<ul style="list-style-type: none"> Two-way dialogue with active participation across levels
View of breastfeeding	<ul style="list-style-type: none"> Easy, natural behaviour with focus on individual mother 	<ul style="list-style-type: none"> Behaviour that requires support of family, community, health system, employers and ultimately is agreed upon by each community
Messages	<ul style="list-style-type: none"> Treated women as a single, 	<ul style="list-style-type: none"> Tailored to circumstances of

⁸ WHO, 2008, op. cit.

	uniform group	different groups of women and other participant groups (e.g. grandmothers, spouses, older children, health workers, etc)
Materials	<ul style="list-style-type: none"> • Emphasized long-term benefits • Too general or too technical 	<ul style="list-style-type: none"> • Address immediate and long-term benefits • Are specific to participant groups • Use clear, non-technical language • Position EBF as a children's right

*See UNICEF working definition of social transformation earlier in this manual. More information on social transformation and system shifts processes is available in the C4D Webinar module, as well as in the full course on C4D.

This manual, along with a Web-based interactive session, provides a preliminary overview of how to design, monitor and sustain a comprehensive Communication for Development strategy in IYCF programmes. It should be used in conjunction with another manual and Web-based session, *Using Communication for Development in Child Survival and Development Programmes: Integrating Children's Rights and Social Transformation Perspectives in Communication Planning*, which provides a more detailed description of basic C4D principles. The C4Dorientation package also complements the UNICEF Nutrition Section's manual, *Strengthening IYCF Programmes: Programme Guidance*; both manuals can be used together.

The C4D approach: Changing individual behaviours and social practices

The Communication for Development approach is designed to change behaviours and social norms across levels and to create a sustainable process of social transformation. It is a participatory process built on value-based strategies, messages and activities to promote social transformation by changing health systems, public systems and social norms through ongoing efforts. The C4D approach complements IYCF programme activities and structures.

Key elements in a C4D strategy

To improve breastfeeding practices and change the social norms that influence them, Communication for Development should be comprehensive and include the following elements.

Communication strategies

- **Connect with people and create local partnerships** to encourage participation, generate EBF demand and create a long-lasting process of social transformation. Include vulnerable populations and consider children as key agents of change whenever possible.
- **Use a two-way dialogue and a problem-solving approach** when communicating with mothers and others about exclusive breastfeeding (e.g., ask about their experiences and opinions).
- **Use contact points with the health system and community groups and networks** to inform, counsel, support and encourage breastfeeding women (e.g., doctors, nurses, community health workers, mother support groups).
- **Engage family decision-makers creatively**—expand traditional roles to support mothers who are breastfeeding (e.g., fathers, grandmothers, mothers-in-law, perhaps older children as well).
- **Create opportunities for dialogue** among community members, networks and organizations about how they can support women who are breastfeeding (e.g., identify influential elders and formal or informal social structures).
- **Address social norms** to improve the social acceptability of breastfeeding practices (e.g., if breastfeeding with addition of water or teas is traditional).

- **Sustain the activities of field workers** (NGO, government, volunteers) with training in communication skills and supportive supervision.
- **Use advocacy at the national level** to motivate leaders and decision-makers (including national authorities, national associations representing the private sector, etc.) to support IYCF and EBF programmes actively through change and enforcement of policies, allocation of resources and public statements (e.g., national policies about breast-milk substitutes; standard workplace and labor policies).
- **Focus also on sub-national levels** to improve communication and coordination among the health system, local government, employers/private sector and community members (e.g., workplace policies about maternity leave and breastfeeding facilities).

Objectives and results

- **Develop communication and monitoring plans that work from common objectives** and clearly state actions and behaviours the participants will undertake as a result of the communication strategies and the social transformation process.
- **Use research** to feed the planning process and to provide evidence of results to modify the C4D strategy on a continuing basis.
- **Monitor results of C4D activities at several levels**—track indicators for family and community support for breastfeeding women, actions taken by leaders and decision-makers, performance of frontline workers and results of partnerships, as well as the end result: increases in optimal breastfeeding practices (see also Table 4. Shifts in measurement of outcomes and impact, in Chapter 4).

Figure 3 shows how a C4D strategy works at each programme level to improve outcomes. To simplify the link between C4D and programme activities, think about your programme in the three levels shown in that figure, which are highlighted with separate colors. Each level has its own objectives, as shown below. Different C4D approaches are necessary to achieve objectives for behaviour and social change at each level.

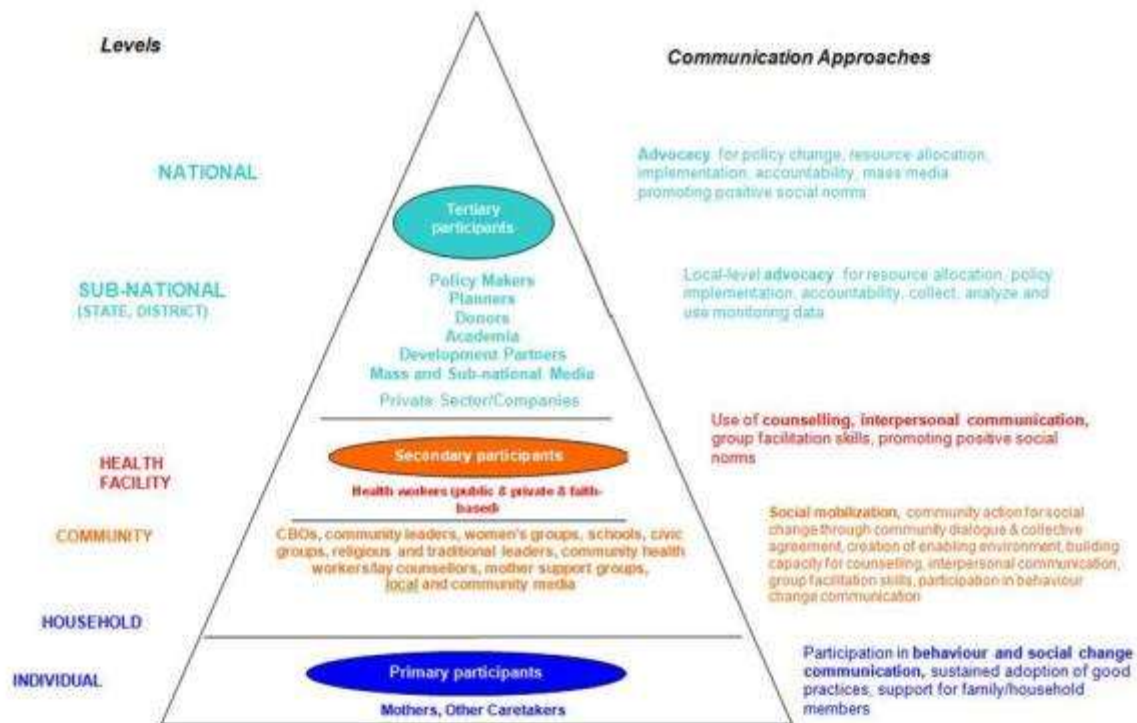
- **National and sub-national – tertiary participants (green)**
Objective: Advocacy, which includes development of policies and mobilization of resources and extends to the private sector (e.g., negotiation of maternity leave and breastfeeding facilities in workplaces)
- **Community and facility level – secondary participants (orange)**
Objective: Social mobilization and community action, which includes building partnerships and capacity for a sustainable social transformation process
- **Household and individual – primary participants (blue)**
Objective: Behaviour change communication

In Senegal, programmes use five categories of participants:

1. Primary participants – those whose behaviour they want to change
2. Secondary participants– those in the family who influence primary groups (e.g., grandmothers, fathers)
3. Tertiary participants – those in the community who influence primary and secondary groups (e.g., leaders, civil society organizations)
4. Meso level –those who implement C4D activities or deliver services (e.g., non-governmental organizations, health system, schools)
5. Macro level –the political level

Figure 3, which establishes a relationship between participant levels and specific communication approaches, divides participants in three groups (primary, secondary and tertiary). However, different approaches for dividing participants groups should be considered on the basis of specific needs at country and community levels.

Figure 3. Coordinating across levels to effect change



Source: Adapted from *Strengthening IYCF Programmes: Programme Guidance*. UNICEF, New York, forthcoming.

Once the key participants groups have been identified, it's important to further coordinate efforts at the different levels listed below. For example:

Coordination at the national level. A multi-disciplinary team at the national level is essential to ensure the coordination and support necessary to plan, implement and sustain an effective communication strategy for exclusive breastfeeding within a broader IYCF communication strategy. A national coordination team for IYCF or Child Survival and Development might already exist. To focus on exclusive breastfeeding issues, you might need to add members to the existing team, form a task force or start a new coordinating body. Whatever the structure, team membership should include breastfeeding, IYCF and other health officers, C4D and monitoring experts and relevant stakeholders, government counterparts and implementing partners. If some aspect of the programme is contracted out to a social research or communication agency, those contractors should participate as well. Most important, community members and representatives of vulnerable populations should be given a voice early in the planning and coordination process, ideally including a permanent seat in the national coordinating body.

Coordination on communication strategy. Some countries may have a communication strategy to accompany their Child Survival and IYCF plan, or communication activities might be ongoing without a national strategy. If there is a call to develop a national C4D strategy, this gives the opportunity to reconsider the role of behaviour and social change in improving Child Survival and Development and IYCF practices and to integrate a comprehensive C4D strategy into the national programme.

Coordination with IYCF. The Honduras IYCF programme found that positioning breastfeeding training within a broader context of infant and young child nutrition and growth helped sustain support for breastfeeding. When C4D is a major component in an IYCF programme, you will achieve better results by sharing research, monitoring and evaluation tools and findings; jointly planning and coordinating activities; and agreeing upon common objectives that reflect both traditional and C4D indicators for outcomes and impact. Additional information about incorporating C4D into the breastfeeding component of IYCF programmes is available in *Programme Guidance on Infant and Young Child Feeding* (see Box 3 and the Resources section at the end of this manual). While only one of the bullet points in box 3 explicitly refers to communication planning and strategies, ideally communication specialists should be involved in all steps of IYCF programmes since for all of them there are or may be communication aspects.

Box 3. Integrating the C4D approach in IYCF programmes

- Ensure adequate IYCF content/emphasis in the national pre-service and in-service curricula for various cadres of health providers.
- Improve breastfeeding practices in maternity facilities through institutionalization of the 10 Steps to Successful Breastfeeding or the Baby-Friendly Hospital Initiative.
- Build capacities and conduct supportive supervision for health workers and community health workers to implement integrated infant and young child feeding counselling and support (addressing both breastfeeding and complementary feeding) at key maternal and child health contacts in all settings, and possibly at mother-to-mother support groups in the community.
- Develop effective and participatory communication strategies to promote breastfeeding, using multiple channels and messages tailored to the local context and the specific barriers to breastfeeding in that area.
- Conduct focused monitoring and evaluation, followed by effective use of the data generated, including C4D results

Source: Adapted from UNICEF, Nutrition Section, *Programme Guidance on Infant and Young Child Feeding*, June 2010.

Chapter 3. Exclusive breastfeeding: Integrating C4D into programme planning

“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”⁹.

—ETHIOPIA Case Study in Community-based Breastfeeding Promotion and Support

A systematic planning process is necessary to design a strategy that is responsive to the specific needs and preferences of women who should breastfeed exclusively. The planning phase is the time to learn about the demands of exclusive breastfeeding, the characteristics of women who do or do not practice it as well as socio-cultural, economic and other factors that influence their behaviour. With this more informed understanding, planners can design activities, messages and materials and use channels that are tailored to the range of participants who can build a supportive environment for EBF practices. Planners should include not only UNICEF staff and government officials but also local advocates and community members who can become key actors in the social transformation process, as quickly defined earlier in this manual (For more information about C4D and its key principles and processes, see the C4D Webinar module and 5-day learning workshop).

“One step that is helping us here is continuous consultation/dialogue with key stakeholders—from community health workers and mothers to policy-makers at the stage of developing the strategy. We are building on our ongoing activities in the field while we are developing our communication strategy/framework. In addition, we did two big consultation meetings at national level.”

—Patricia Portela Souza, UNICEF, Bangladesh

The best way to learn about the context in which mothers make decisions about breastfeeding is to engage the right participants in discussions at this stage. As previously shown, Figure 3 provides examples of who is generally included in primary, secondary and tertiary participant groups, from the household level to the national level. It recognizes that women make decisions about feeding their infants in a larger context that includes, on a daily basis, husbands or partners and mothers and mothers-in-law, among others. Doctors, nurses, employers, even distributors of infant formulas—all should have a voice in the planning process for the communication strategy to be effective. Potential special needs should be acknowledged by including and giving a voice to marginalized and vulnerable groups, such as women living with disability, nomadic communities, ethnic minorities, and others.

The planning process contains three steps: (1) assessment, (2) analysis and (3) design of communication strategy. Although this manual presents these as sequential steps, they are often done simultaneously in whole or in part. There is no automatic starting point. They also are re-examined throughout the planning process as new information becomes available to change ideas. Two examples follow.

Buildings networks or demand first. Using HIV/AIDS as an example, evidence suggests that national and community leadership may be ready for advocacy on one issue—such as programmes on preventing mother-to-child transmission—but not on another issue, such as prevention among young people. In this case, it may be more productive to concentrate first on:

- Building a network for social mobilization with partners and allies who can put pressure on leadership, or
- Building demand in the population through community approaches, such as upstream dialogues—conversations with potential participants about the issue—to foster a gradual change in the perception of leaders¹⁰.

⁹ WHO, 2008, op. cit.

¹⁰ McKee, Niell, et al., A. *Strategic Communication in the HIV/AIDS Epidemic*, Sage Publications, 2004.

Re-examining participant groups. For example, planners identify primary participant groups as including (1) rural women who breastfeed but not exclusively and (2) women who use breast-milk substitutes and do not breastfeed at all. After analyzing results of formative research, they learn that significant numbers of women know the benefits of EBF and would like to practice it, but they stop breastfeeding when they return to work in the formal employment sector. Planners then adjust the participant groups to include women in the formal employment sector and design a strategy specifically to address their issues. (See also Annexes II and I for information about planning in the Cambodia and Malawi IYCF programmes.)

Assessment

Several important questions should be answered during the planning process from both existing information and results of formative research. They should be answered in a participatory way—usually through a series of workshops involving the coordination team, appropriate stakeholders and community members. For example, as part of the assessment process, the Mozambique programme conducted a study on barriers to EBF and based its strategy on the study’s findings. In Bangladesh, research showed that mothers are interested in what nurtures their child and helps in child development; diseases did not seem to be a main deterrent/an attractive message. Formative research also showed that mothers are not sure about the correct position for breastfeeding.

Assessment questions

1. What actions and behaviours to improve EBF practices do you want to achieve at each level as a result of planned activities and most importantly as part of the overall social transformation process?
2. Why haven’t these results been achieved up to now?
3. What resources for exclusive breastfeeding are already in place?
4. What information already exists about EBF practices of different groups of women as well as the behavior of key participant groups?
5. Which family and community members can support mothers during EBF months?

Analysis

The analysis step should also address important questions about participants and their behaviours. These questions help identify (1) gaps in information that was not acquired during assessment and (2) meaningful common characteristics of members of the primary participant groups that allow them to be further segmented for tailored messages and materials.

Participant analysis. Based on secondary and formative research, identify key participant groups and involve them in programme-planning and system-changing activities (changes at the community, social and political systems).

Behaviour analysis. Through a process of community consultation, discuss ideas for recommended practices and whether it’s feasible to implement such practices. Use focus group discussion *or* direct observation *and* research adapted to social and cultural context as well as different levels of comfort with participation levels, and solicit additional ideas and feedback.

Use qualitative methods to assess participants’ point of view on infant care, breastfeeding, EBF and family roles. Include the views of marginalized and hard-to-reach groups in the discussion.

Use quantitative methods to get information to measure change not only in the level of knowledge but also the proportion of people who hold certain attitudes and practice key health and social behaviours.

Analysis questions

1. What additional information do you need?
2. How can you segment women and key influentials into meaningful primary participant groups and make sure the practices you recommend fit their lifestyle?
3. How can you reach these participant groups and equip them to engage in the behaviour and social change process?

Box 4. Making sure recommended behaviour is feasible

Planners may recommend optimal behaviour without examining *whether it is feasible for women to do*. The more the recommended behaviour fits into women's lifestyle, the more readily they will adopt it. Take time to enable a social and political transformation process that would help promote feasible behaviours and social practices. Pre-test ideas through focus group discussions with homogeneous groups (e.g., separate discussions with women who practice EBF and with those who do not, with husbands, with senior women, etc.). **Make sure recommended practices fit women's lives and are not only needed but also actually wanted.**

Example: Women who will return to work or be separated from their infant during EBF months are often told: "Express breast milk and feed it to the baby from a cup". Make sure this advice is feasible for working women. What are breast-milk expression techniques? How long does it take to express enough milk for a feed? Does a working mother have a time and place to express milk? How should she store the milk? If room temperature is 36°C or 100°F, how long will the milk last without refrigeration? What are do-able feeding techniques? To make messages feasible for women who work outside the home, have focus group discussions with women who have expressed milk and observe how breast milk is expressed, stored and fed to infants.

Design of communication strategy

A communication strategy should have clear, feasible, measurable EBF objectives (see Table 3) that are based on dialogue with key participants and can be achieved through communication by:

- Enabling a sustainable process and environment for social transformation,
- Encouraging social and behaviour change through policies and practices that support women in EBF (e.g., in families and hospitals) and
- Providing information and services

A process of community consultation can identify suitable strategies about EBF for key participant groups, for example, an integrated approach that uses diverse media and channels to reach all intended participants at scale (e.g., not only the national mass media or development and distribution of posters, but also community media, interpersonal communication during door-to-door visits or at the health centre, puppet shows or street theatre and the efforts of community leaders).

The design of an evidence-based communication strategy is key to the success of all interventions. For example, the Bangladesh programme attributes low EBF rates also to a lack of consistency in messages and lack of a comprehensive strategy with a clear focus and well-established objectives, among other factors.

Table 3 provides examples of programme and behaviour objectives. This is a fictitious example. In fact, the numerical target for expected results must be evaluated on a case-by-case basis early in programme and communication planning. In this example, the IYCF's plan to improve national EBF rates focuses mainly on women who start breastfeeding after birth but regularly add water, because the proportion of women who never initiate

breastfeeding is fairly small. Every objective has a numerical goal, which makes it measurable. These measurable objectives will make it possible to track the progress of the change strategy during the five years of the programme

Table 3. Sample of programme and behaviour objectives for exclusive breastfeeding, based on C4D values

<p>Programme objective: To increase the national exclusive breastfeeding rate for infants less than six months old by at least 20 per cent in five years(to be achieved as part of a sustainable process of community empowerment and social and political transformation)</p>
<p>Behavioural objectives:</p> <ol style="list-style-type: none"> 1. From baseline, at least 20 percentage points more women who breastfeed do not introduce water or other liquids during the first six months of the infant's life. 2. At least 60 per cent of selected field workers use at least four communication skills learned in training when they conduct group education sessions with women who are breastfeeding their infant. 3. At least 60 per cent of women with infants less than six months report at least one contact with a mother support group. 4. At least 80 per cent of district directors of health have allocated adequate human, material and financial resources to implement district-level IYCF communication activities.

In this table, programme and behaviour objectives are somewhat different:

Programme objectives focus on the child and the health of the child and mother. Listen. Do not force practices. Keep in mind that behavioral and social objectives need to be achieved as part of a sustainable process of social and political transformation.

Behaviour objectives focus on the many people whose behaviours affect child health

Communication and programme strategies may sometimes have different objectives, although they may share some of the same elements. In particular:

- Outcome objectives for the communication strategy focus on what can be achieved entirely through communication
- Outcome objectives for an EBF component of an IYCF programme rely on a broader range of strategies that includes communication.

Meeting communication objectives contributes to achieving the overall programme goals. However, it is important to remember that the main outcome of communication programs is usually a health or social behavior (or a variety of health and social behaviors that are specific to different participant groups) that support the overall program goal. For example, the behavioural objectives listed in Table 3 potentially could be achieved by implementing the C4D approach:

- Local-level advocacy to ensure resource allocation and coordination by district directors, to create and sustain social transformation
- Supportive supervision and training in communication skills for community health workers and health workers, to make sure they use appropriate messaging in training sessions that should be designed to empower the community to support EBF behaviour
- Strengthening of mother support groups, to empower individuals to participate in such groups

Reinforce messages with repetition throughout the community. People need to see and hear the same few messages many times, in different formats and through different channels, to participate in the social transformation process and ultimately adopt new behaviors.

Pre-testing messages, materials and communication channels

Before you launch your communication strategy, **pre-test messages, materials and communication channels** to make sure to get expected results for improving exclusive breastfeeding— such as changes in individual and community-level EBF behaviours that are supported by transformative social shifts (e.g., fathers caring for older children to allow mothers time to breastfeed, hospitals discouraging formula and teaching that water along with breast milk isn't needed and can be harmful).

Pre-testing is sometimes seen as an unnecessary step—a luxury that programmes with limited resources cannot afford. It is just the opposite. Pre-testing helps planners make sure that the messages and materials are appropriate and easily understood and that the communication channels chosen are the right ones to reach intended groups. (See page 26 of *Learning from Large-scale Community-based Programmes to Improve Breastfeeding Practices* for examples of the diverse channels used by breastfeeding programmes.)

As a result of pre-testing, Ghana learned that:

- Some of the pictures they intended to use in breastfeeding materials should be changed to reflect what people could identify with locally and culturally

Messages should incorporate an analogy for the rate at which the breast may fill up (“the rate at which the baby sucks is proportional to the rate at which the breast fills up”) by comparing it with the pumping of water from a well because water pumps are a common sight in almost all communities.

Pre-testing also helped identify problems with EBF materials in Mozambique. Mothers took away the message that they should stop breastfeeding after six months, so wording was changed to clarify the message and correct that misunderstanding.

Different communication channels will be appropriate to some groups but not others. Research can identify categories of people who are trusted by participant groups, and pre-testing of those channels of information delivery can confirm that they are effective. In Sri Lanka, public health midwives provide the link between the community and health services. In Ghana, health workers are the most credible source of information. The majority of community health workers in Bolivia's breastfeeding programme happen to be men; many of them are able to schedule home visits for Sundays, when other husbands are at home, to have access to this important participant group to deliver messages supportive of breastfeeding and how men can support their wives in this practice.

Communication tips for promotion of exclusive breastfeeding

Use non-technical language:

- ✓ Instead of “exclusive breastfeeding” say: “It's better for babies to have **only** breast milk for the first six months” or “Breast milk has all the water a baby needs in the first six months; if you think your baby is thirsty, give her breast milk, not water.”
- ✓ Instead of “Breast milk is complete” say: “Giving babies **only** breast milk for their first six months helps keep them healthy” (fewer episodes of ear infections, diarrhoea, respiratory illness).
- ✓ Use local dialects, which are naturally informal and non-technical, to explain and promote EBF.

Make sure messages are clear, concise and consistent. For example, many IYCF programmes conduct in-service training for health professionals to:

- ✓ Strengthen delivery of EBF-supportive services at health facilities.
- ✓ Ensure that all health professionals and community health workers use consistent messages.

Focus messages and materials for particular participant groups, even though a wider audience will be exposed to those communications. For example:

- ✓ Illustrated family health cards and a complementary feeding tool helped health workers attract mothers, particularly those with low or no literacy skills, for discussion of optimal IYCF practices.
- ✓ Messages were directed to grandmothers in Ghana after literature review showed that grandmothers command respect and appreciate being seen as guardians of family health.

Identify good times and places to convey EBF-supportive messages. In Ethiopia and Madagascar, community health workers found the most likely times were during everyday activities such as:

- ✓ Scheduled activities (e.g., the coffee ceremony, religious ceremonies, visits to neighbors, meetings of traditional money-lending groups)
- ✓ Informal encounters (e.g., fetching water, buying food at the market)

Use separate materials for supportive behaviours and social practices of family and community. For example, you might:

- ✓ Show fathers caring for older children while the mother breastfeeds.
- ✓ Show the mother refusing water from the grandmother for the baby.
- ✓ Show grandmother bathing the infant while the mother is napping.
- ✓ Show older children holding their mother's hand while she breastfeeds.

Emphasize positive immediate results but recognize (1) the constraints to the mother and (2) the positive long-term impact on child health, for example, with:

- ✓ Testimonials from working mothers about how they managed to continue exclusive breastfeeding after returning to work.
- ✓ Testimonials from older children talking about how knowing their mother breastfed them helps create a special bond...how grateful they are their mom wanted the best for them.

Portray positive social norms and gender roles for breastfeeding practices, for example:

- ✓ Show members of mothers' support groups visiting pregnant women in villages (see Annex II about Cambodia's breastfeeding programme).

Develop specific messages and images to appeal to a more middle-class population, if a country is becoming more urbanized, for example:

- ✓ Show images of professional women breastfeeding.
- ✓ Explain how working women can express milk for infants to drink from a cup while mothers are away and how they can breastfeed when they're home after work.

*Remember to stick with a **few** simple messages, preferably in the form of suggestions rather than commands. It's easy to overwhelm people with too much information. **Also remember** to include marginalized groups—such as ethnic or religious minorities and people with disabilities—and children as key participants in all phases of planning, and listen to what they have to say.*

Box 5. Fitting communication channels to participants and messages

Channels that allow for customized messages and maximum interaction are best suited for shifting **mixed** breastfeeding to **exclusive** breastfeeding. Examples include counselling, using role models, trial with feedback and question-and-answer formats. Non-interactive methods such as radio jingles, TV spots and brochures are **not**

always suited to programme objectives. In finding communication channels that are accessible to women, low literacy rates and limited mobility are factors to consider. (Channels suited to simpler messages can be used for secondary participants, because they are supporting EBF, not doing it.) Appropriate channels are those that have broad reach, convey a few simple messages and can promote positive social norms that are important to the supportive role of secondary participants.

In Madagascar, multiple communication channels—interpersonal counselling, community mobilization and dialogue and mass media—conveyed messages that were clear, consistent and focused on feasible actions. These channels and message were found to be important in changing behaviour.

In Ghana, continuous and integrated communication was especially valuable in the community. The local songs (sticky messages) become a part of the social fabric. They remain long after those who introduced the concept are gone and remind the community regularly of the expected behaviour.

Chapter 4. Exclusive breastfeeding: Integrating C4D into programme monitoring and evaluation

Monitoring and evaluation, often referred to as ‘M&E’, are an ongoing process of data-gathering and analysis of the data you gather to determine success in meeting the objectives you and your partners defined during the planning stage. Monitoring and evaluation help programme officers:

- Highlight what is working with the different participant groups
- Identify problem areas and why they are not working as planned
- Correct problems before the programme ends to improve results (mid-course corrections)
- Provide feedback that is essential for continuing progress—sustaining and improving gains (see Chapter 5, ‘Maintaining Change Through Social Transformation’)

Common components of M&E are a baseline survey (where you started), ongoing monitoring mechanisms and evaluation of monitoring data (where you are) and a post-intervention survey (where you ended). Together, these activities drive continuous improvement in the programme and make it possible to allocate resources where they are most needed. M&E resources and funds should be included early on in the programme’s budget. While there is not an established rule on the overall cost of M&E, a reasonable cost may be 5% to 10% of the overall programme’s budget.

Outcomes and impact

Ideally, monitoring mechanisms track not only the rates of exclusive breastfeeding (behaviour of primary participant groups) **but also** the results of C4D-based activities involving primary, secondary and tertiary participant groups to measure transformative changes across a larger social and political landscape. This is a different scope of change, and it calls for different measurements. For this reason, the C4D approach is widening the focus of M&E beyond *traditional indicators* of outcome and impact to include *additional indicators* that acknowledge individual and community empowerment, human rights and social transformation for long-term change. Table 4 shows traditional indicators of behaviour monitoring plus the broader C4D indicators. C4D includes a well-developed M&E component, which is being finalized with the help of outside experts. Further information on C4D M&E process and methods is included in the C4D webinar module as well as 5-day C4D Learning workshop.

Table 4. Shifts in measurement of outcomes and impact

Traditional indicators	Plus C4D indicators
<ul style="list-style-type: none"> • Reach of media and information • Increased knowledge and awareness • Improved and new skills • Increased delivery and demand for products and services • Improved service delivery (technical quality) Improved national government policies • Changes in behaviour and practices 	<ul style="list-style-type: none"> • Improved service delivery and interaction of service provider and client • Changes in attitudes, social norms and power relationships • Enhances self-esteem and self-efficacy • Changes in community perceptions, engagement, empowerment • Adherence to basic human rights principles

An IYCF programme should have the flexibility to respond to changing circumstances that affect local contexts, national policies and behaviours of participants and partners, such as altered breastfeeding practices, urbanization patterns, emergencies and civil unrest. This means that routine monitoring needs to be a long-term commitment, built into the programme’s structure and supported by adequate resources. The ability to adapt the programme to

ongoing feedback from participant groups as well as in response to M&E findings helps sustain the results of successful interventions and inform how we go about measuring how we are doing.

Monitoring: answering the central question

Monitoring and evaluation answer the pivotal question: “How are we doing?” It is important not to confuse **how** you are doing with **what** you are doing. The “what” can be a simple tally of activities, such as number of training sessions for health workers, number of visits made by representatives of mother support groups, number of meetings held with policy-makers. The measure that matters is the actual change that results from those training sessions, visits and meetings, for example, changes in:

- *Social norms and social processes* (e.g., increased social support for involvement of fathers in child care, participatory approach to the definition of most needed community services in support of EBF)
- *Power within different levels of society* (e.g., increased number of women from marginalized populations who recognize EBF as a human right and feel entitled to ask questions and demand services that would support EBF knowledge and practices and behaviors)
- *Policies and practices* (e.g., workplace policies that provide support and resources for women who breastfeed, such as with dedicated refrigerators for breast milk, a breastfeeding room, etc.)
- *Knowledge and skills* (e.g., knowledge on correct breastfeeding positions, understanding that mixing breast milk with other fluids may cause harm)
- *Health and social behaviours* (e.g., more women who breastfeed do not introduce water or other liquids during the first six months of the infant’s life; increased number of district directors of health allocate adequate human, material and financial resources to implement district-level IYCF communication activities)

These are the transformative changes necessary to increase rates of exclusive breastfeeding—the ultimate outcome behavior—and sustain those changes over time. Further guidance on C4D M&E process is included in the C4D webinar module as well as part of the 5-day C4D learning workshop.

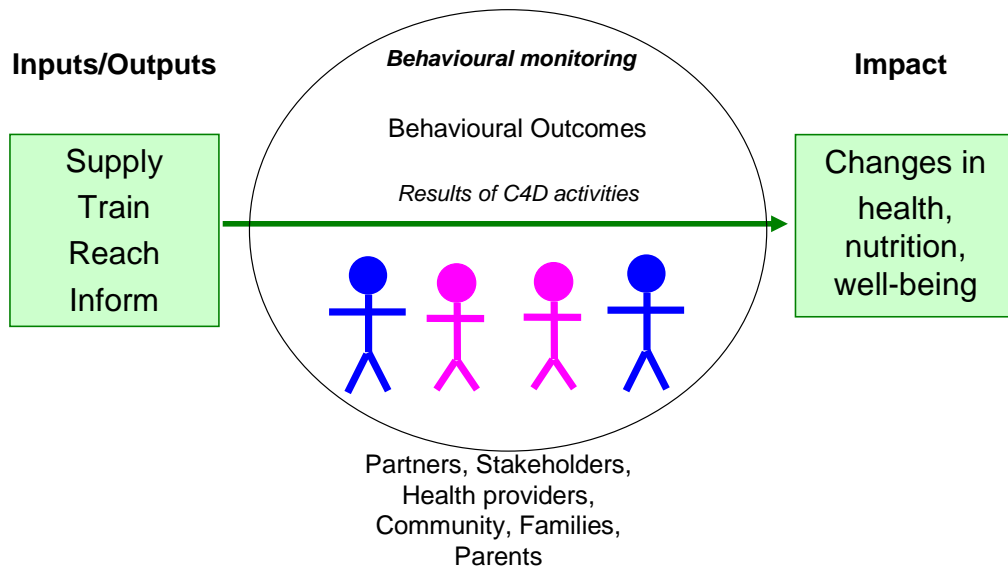
Behavioural monitoring

Programmes routinely monitor inputs and outputs such as designing and distributing communication materials and training health workers and community volunteers in counselling skills. Behaviour monitoring is part of the monitoring plan and goes a step further to track results or **outcomes** of C4D-based activities:

- Changes in behaviours, social norms, policies and practices, knowledge and skills that lead to improved EBF rates.
- Improved EBF rates that ultimately lead to better survival, growth, nutrition and overall health and well-being of infants less than six months old—and therefore to better physical, mental and emotional health and well-being as those infants move through adolescence and into adulthood (and to better health outcomes for breastfeeding mothers).

Evaluation at the end of the programme focuses on these long-term changes in behavior and their **impact** on health and development goals, sometimes from a wider perspective than the programme’s objectives (Figure 4 and Table 3). Other desirable impacts, such as reduced use of the health system and associated reduced costs for families, health care facilities and employers, may not be quantified in programme goals. Behavioural monitoring as well as the focus on behavioural results are already well-established principles of other planning frameworks and integrated models, including UNICEF Behavior Change Communication model, WHO’s Communication for Behavioral Impact (COMBI) and the P-Process framework of John Hopkins University.

Figure 4: Monitoring C4D results



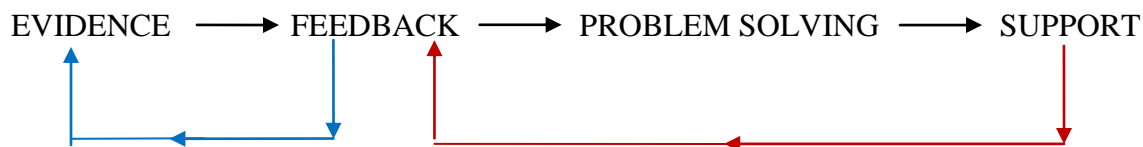
Chapter 5. Maintaining change through social transformation

For IYCF programmes to have a positive effect on the survival, growth, health and well being of infants and children, improvements in breastfeeding practices must be sustained over the long term. In fact, hard-won gains in breastfeeding practices can slip away¹¹. For example:

- **Bolivia's** programme began with modest gains, but within three years, EBF rates grew from 54 per cent to 65 per cent. Three years after the programme ended, an assessment showed a sharp decline in exclusive breastfeeding in programme areas. Resources were not available to investigate the reasons.
- In **Madagascar**, the largest gains in exclusive breastfeeding were achieved during the period of the most intense community activities, nearly doubling from 46 per cent to 83 per cent within one year. Later on, the focus of programme activities changed from the community and district level to the provincial level. The EBF rate dropped in the following years.

Building in sustainability

Sustainability should be built into the Communication for Development strategy throughout the planning stage. Although conditions that affect sustainability—resources, opportunities, obstacles and constraints—vary by country, the following four elements apply everywhere and are possible everywhere:



Creating a **cycle** of evidence, feedback, problem-solving and support at local levels will help maintain the high degree of participation that is needed to ensure continuing support of optimal breastfeeding practices. Communication for Development's continued attention to the social norms that underlie those practices is another important element in sustainability. In addition, the C4D communication strategy should include ways to help counterparts, partners and fieldworkers have productive, evidence-based dialogue, for example, by:

- Packaging data to be user-friendly,
- Improving group facilitation and advocacy skills and
- Disseminating information about successes.

It's important to know well in advance that the process of gathering and analyzing information requires time and resources. M&E data are a valuable part of maintaining gains in EBF rates. The Mali IYCF programme found that community leaders and resource persons are more likely to support recommended breastfeeding practices when they know that those practices are based on evidence and have a low cost and high impact. By reporting on data on behavioural outcomes and their impact on health and nutrition (**evidence**), national programmes can celebrate successes, address weak spots (**feedback** and **problem-solving**) and advocate for resources (**support**) to continue supporting the social transformation process that should give voice to mothers, family members and communities on EBF and related issues.

¹¹ WHO, 2008, op. cit.

Keeping partners and participants engaged

Sustainability also requires (1) *attention to the operation of systems* (e.g., collecting and analyzing monitoring data, continued service delivery) and (2) *engagement of implementing partners and secondary participants* (e.g., government officials and health care providers, NGO field staff, community volunteers, local political leadership and others—and true sustainability requires government to take the lead throughout the process, not merely as an implementing partner). It is their behaviour and actions that will support women’s breastfeeding practices over time.

Participatory monitoring methods are one way for partners and participants to evaluate their own performance and see how this is affecting mothers’ breastfeeding rates. For example, it is often difficult to keep community volunteers or mothers’ support groups involved, and that, in turn, often makes it difficult to sustain recommended breastfeeding practices. Madagascar’s IYCF programme found that women who belonged to a group or association were more likely to be dynamic volunteers than unaffiliated women. Moreover, they also learned that the programme’s nutrition volunteers needed support and recognition from local authorities, heads of health centres and community members to continue their work. In fact, involving these important participants regularly in tracking their own activities (***evidence***), reviewing the findings (***feedback***), modifying their activities (***problem-solving***) and gaining recognition (***support***) may go a long way toward holding their interest and continuing their interactions with breastfeeding mothers.

Making changes commonplace

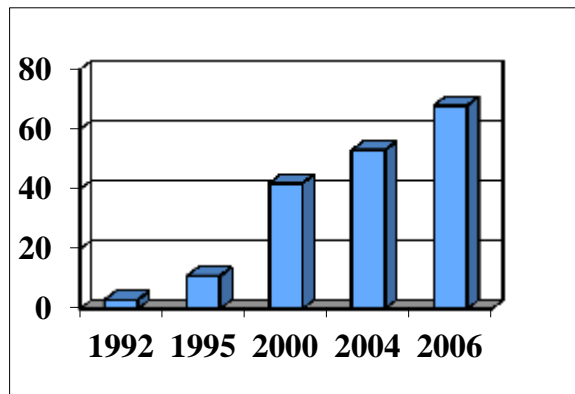
When sustainability is designed into the programme, it is possible to keep gains in EBF rates and continue progress toward optimal breastfeeding practices. This could be achieved by:

- Maintaining the desired behaviours through *personal and community empowerment in all program phases, in part by ensuring a plurality of voices, including vulnerable populations and—whenever possible—children as key agents of change*
- Strengthening systems—political, social, economic, support services and community, among others—through institutional (including public and private sectors) and government commitment to create *system shifts and make possible a long-term process of social transformation* and
- Strengthening the commitment and skills of people who support the behaviours through *reinforcement and training*.

Ultimately, the goal of all these activities—of every aspect of an IYCF programme designed by integrating C4D values—is to make most changes in individual and institutional behaviours and cultural and social norms ***commonplace***, so that exclusive breastfeeding becomes the expected and accepted practice rather than the exception. When this happens, the beneficial consequences in the form of positive short- and long-term outcomes for infants, mothers, communities and the health care system at large will reverberate throughout the society. This is the process that Communication for Development envisions and hopes to facilitate by integrating an approach based on human rights and social transformation within communication planning.

Annex I. Example of a comprehensive approach to breastfeeding programming: Malawi

Exclusive breastfeeding rates in Malawi, 1992–2000



Malawi is one of the countries that have succeeded in significantly increasing their rate of exclusive breastfeeding (EBF) among children less than six months old, as shown in these graphs.

Factors for success

Strong leadership. At all levels—national, provincial and district—the programme had strong leadership in support of infant feeding and well-articulated policies and guidelines because of the national commitment (including District Health Management Teams).

Global Strategy for IYCF harmonized and mainstreamed. Nutrition is mainstreamed in five different government Ministries (Health; Agriculture; Office of The President and Cabinet; Gender, Child Welfare and Community Services; and Education), and infant feeding is integrated in various development and child survival programs, district implementation plans, curricula for Health Surveillance Assistants (HSAs), training for nurses and relevant policies and strategic plans.

Integration of services at community level. Infant feeding services are integrated (1) at the community level (through CIMCI, IECD, in which infant feeding is an integral part) involving HSAs and (2) with various key services that reach the same child to improve survival, growth and development and overall quality of life.

Advocacy, communication and social mobilization. National advocacy in support of infant feeding and intensive mass education on EBF using different channels (community drama, village shows, Nyavo dance, TV and radio programs, etc.) increased support for and knowledge of breastfeeding. The core message was promotion of EBF for first 6 months. The program also features involvement of (1) men in community mobilization; (2) non-clinical/support staff to provide education, counseling and follow-up services where clinical staff are overburdened and (3) HSAs at the community level as agents of communication and social change.

BFHI Implementation within IYCF, with links to HIV. If a facility has to be a site for prevention of mother-to-child transmission (PMTCT) of HIV, it must embrace the Baby-Friendly Hospital Initiative (BFHI) concept. Strong leadership and team work in the targeted BFHI facilities with involvement of all cadres and communities. Each of the health facilities has more than 80% of health workers trained in Integrated IYCF, HIV and AIDS counseling; at least five trained support groups with 10 members each; at least 50 or more trained community services providers of different age groups.

Lessons learned

- Partnering is key and often adds breadth and depth to programmes, but it is also a complex process that should call for partners' involvement early on in programme planning.
- Highlighting the importance of nutrition in health delivery at national and international levels is critical to all efforts.

- Integration must start at the national level, or otherwise mixed messages could make the job of the health worker at local level very difficult.
 - Improving nutrition is possible if there is a high-level coordinating unit/structure such as Office of the President and Cabinet where the Nutrition Department has been placed for soliciting high-level commitment and support.
 - Be cognizant of opportunities that exist—recognize and strengthen existing Government structures and community resources, including traditional leaders, because they can lend valuable support to interventions targeted at infants and young children.
 - Strengthen existing support systems and mother-support groups and form new ones to address specific issues at community level.
 - Advocate for integrated nutrition interventions, not vertical approaches.
- Involvement of traditional and other influential leaders and community-based service providers is important for sustaining support for effective implementation of nutrition interventions.
- To address new challenges emerging in infant and young child nutrition, undergraduate training for health professionals needs to be addressed and capacity building in nutrition is required.
 - Infant feeding counselling is beginning to be appreciated as an important intervention in PMTCT, but staff shortages and perception of counselling as an extra responsibility make implementation of IYCF programmes a challenge.
 - Building the capacity of an identified national Institution to conduct training helps ensure sustainability of the programme.
 - Support for EBF among the general population is one way to reduce MTCT.
 - An integrated approach to IYCF interventions has been key to sustaining support for optimal infant feeding for all while addressing the special needs of HIV-positive mothers.
 - BFHI as a separate initiative cannot continue to stand on its own; an integrated approach is needed for implementation of BFHI, especially in the context of HIV/AIDS and IYCF, PMTCT, IMCI, RH. In addition, integration will achieve standardization of messages, materials and human resources.
 - Knowing the practices of communities is the cornerstone to any programme. Community members will be able to accept any changes to improve food preparations and living standards if they are involved and can easily identify the problem and how it can be solved. Leaders can convince community members how the new approaches work.
 - Development of food and nutrition surveillance systems that will provide continuous data in a timely manner is critical for planning, monitoring and evaluation of infant and young child nutrition programmes.

Overview of lessons learned:

- There is need to address the challenges in a more comprehensive manner by bringing all the issues of nutrition together with a preventive focus and gender perspective.
- The combined scientific and epidemiological evidence and the accumulated programmatic experience do provide a solid technical basis for continuing concerted national and community level action.
- Community involvement and empowerment is critical so that communities realize that they can also help themselves in a sustainable manner.
- In every country where breastfeeding and related complementary feeding have improved, there has been political commitment and an active decision made that saving children's lives is worth the time and energy to support women and families to make an informed and unbiased choice in feeding their children, and then providing them with the support they need to succeed.
- In some settings, the government led the way and endorsed harmonized policies; in others, there was a gradual social revolution of behaviour change. In all cases, to achieve sustainable results, support must continue. The institutionalization of protection, promotion and support into law, health, and social norms will presage real change.

Annex II. Exclusive breastfeeding—a success story: Cambodia

The rate of exclusive breastfeeding (EBF) for children under six months increased from 11 per cent in 2000 to 60 percent in 2005. This dramatic increase is the result of an integrated approach involving many partners in Cambodia.

Lessons learned

A multi-faceted, integrated approach can have a rapid impact because of sustained support and commitment through behavior change. The high-level commitments of government, development and other partners in reducing child mortality and promoting breastfeeding were essential in creating a legal framework to regulate infant and young child-feeding products, while the engagement of health staff, community volunteers, media, mothers and community leaders ensured optimal outreach to families. Although the majority of babies in Cambodia are born outside of hospital facilities, community-based support groups bring breastfeeding skills to pregnant women and mothers in their local environment. Additionally, the Baby-Friendly Hospital Initiative (BFHI) interventions, although limited in scope because of the low number of hospital deliveries, allowed mothers who did deliver in BFHI facilities to receive the best opportunity to establish good breastfeeding practices.

Strategy and application

Optimal breastfeeding in the first year of life is one of the most important strategies for improving child survival. Increasing breastfeeding for the first six months of life could save the lives of many Cambodian children under five years of age. The Cambodia Demographic and Health Survey (CDHS) in 2000 showed that while 96 per cent of children were breastfed at some point, only 11 per cent of children less than six months of age had been exclusively breastfed.

Recognizing the impact of breastfeeding on reducing child mortality, the Government and its health development partners, WHO, UNICEF, USAID and NGOs under the Technical Working Group on Infant and Young Child Feeding (IYCF), launched an aggressive breastfeeding promotion campaign in early 2004, which is still ongoing. It is clear that mothers need support to initiate and sustain optimal breastfeeding and complementary feeding practices. This support needs to come from the family, community, the workplace and the health system.

The approach developed took into consideration the following factors:

- 89 percent of births take place at home, of which 66 percent are assisted by traditional birth attendants with no formal training. Mothers who receive antenatal or postnatal care are a minority.
- 85 percent of Cambodia's population lives in rural areas.
- Mass media can reach a large proportion of the population: in 2004, every other household had a radio and access to television.
- An extensive network of community health volunteers, working in all villages, exists in Cambodia.

A multi-pronged strategy was pursued and included the following elements:

High-level advocacy. In June 2004, a high-level consultation on Child Survival was conducted between the Government and health development partners comprising WHO, UNICEF, ADB, CIDA, DFID, EC and World Bank. Promoting and supporting breastfeeding was adopted as the highest priority among the 12 key interventions stipulated in the Cambodia Child Survival Score Card Interventions.

Partner policy frameworks. Two follow-up national-level workshops on child survival were held, which led to partners re-aligning their programmes with the Cambodia Child Survival Score Card Interventions. Promotion of breastfeeding was integrated with all initiatives and services affecting infant and young child health and

development. WHO and UNICEF took the lead role in the IYCF working group to provide technical assistance in rolling out these activities. UNICEF provided a total of \$417,800 for breastfeeding-promotion activities between 2004 and 2006, the highest contribution among the stakeholders.

The legal framework. A sub-decree on the marketing of infant and young child products, aimed at ensuring appropriate industry and retail codes and practices to safeguard breastfeeding, was adopted in November 2005. Nationwide dissemination campaigns were held, involving line ministries, development partners and milk companies.

Accreditation of “breastfeeding-friendly” sites. A Baby Friendly Hospital Initiative accreditation programme was carried out, focusing on national-level maternity public hospitals and provincial referral hospitals. Since 2004, eight hospitals have been accredited as baby friendly. Mothers’ support groups were formed to pay home visits to pregnant women and provide counselling and support on breastfeeding at the village level. Each support group includes the village chief, two mothers who have experience in breastfeeding, one traditional birth attendant and one village health support group member, and all are trained by health centre staff. This “Baby Friendly Child Initiative” has been launched in areas where the BFHI has been implemented. To date, 2,012 villages are implementing the initiative with support from UNICEF and NGOs.

Participatory communication strategy. A participatory communication strategy was developed, focusing on the use of mass media to incorporate breastfeeding messages into popular TV and radio programmes; training journalists on key messages about breastfeeding; and national-level advocacy campaigns, including the launch of World Breastfeeding Week involving the Prime Minister and other high-level officials and community-level events advocating the importance of breastfeeding.

Results

The preliminary results of CDHS 2005 have shown significant improvements in breastfeeding practices. Exclusive breastfeeding is becoming a more common practice in Cambodia, with 60 per cent of children less than six months having been exclusively breastfed in 2005. This is a significant increase from 11 per cent in 2000.

This positive behaviour change in breastfeeding is in line with improvements in the nutritional status of children and the significant decline in infant and under-five mortality rates, which have been stagnant for the last 10 years. The results are also consistent with the findings from the knowledge, attitudes and practices survey conducted by the BBC World Service Trust, which showed that knowledge of the benefit of breastfeeding immediately after birth increased from 39 per cent in 2004 to 71 per cent in 2006. The same study has also seen a decline in the percentage of the population which believes that the mother or the caretaker should give the baby substances other than breast milk in the first six months, from 60 per cent in 2004 to 18 per cent in 2006.

Next steps

Given the numerous and complex determinants of breastfeeding, maintaining the current level of achievement to obtain universal coverage will be very challenging for all actors in the next few years. The final report of CDHS 2005 will provide insights into social, cultural and economic factors and determinants that the Cambodian society has experienced in the last five years. Careful assessment of these changes will serve as a basis for fine-tuning and scaling up ongoing interventions nationwide.

Resources

See also in WHO, 'Learning from large-scale community-based programmes to improve breastfeeding practices,' Annex I. Resources for community-based breastfeeding programme

Breastfeeding programmes – general information

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UNICEF. Generic community based infant and young child feeding counselling package. 2010
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How to read breastfeeding area graphs

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Exclusive breastfeeding in emergency situations and selected C4D methodology and tools

'Behaviour Change Communication in Emergencies: A toolkit', UNICEF, South Asia Regional Office, Programme Communication, 2006. (available on UNICEF intranet, Communication for Development)

Planning process

'Advocacy for Policy Change: Guidelines for developing an action plan'. Action for West Africa Region, USAID. (found in Advocacy Guidelines AWARE Brochure, pdf)

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Participatory Rural Appraisal (PRA) methodology. (available at: http://portals.wi.wur.nl/ppme/?Participatory_Rural_Appraisal)

Roberts, Ann, et al., 'A toolbox for building health communication capacity,' 1995. Academy for Educational Development, Washington, D.C. (available in Adobe PDF at www.globalhealthcommunication.org)

'Towards better programming: A manual on communication for water supply and environmental sanitation programmes', UNICEF Technical Guidelines Series, 1999 (available on the UNICEF intranet, WASH, General advocacy and communication publications) (*including message and materials development*)

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