Establishing Innovative Community Engagement Approaches in Baby Friendly Community Initiatives Project

Baby Friendly Community Initiative: A Desk Review of Existing Practices

July 2013 – December 2014

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Summary

Breastfeeding is an effective method of ensuring child health and survival and breastfeeding indicators are useful tools for monitoring the success of maternal, infant and young child nutrition projects. Several models have been tested for promoting exclusive breastfeeding in Kenya. This review focuses on the Baby Friendly Community Initiative (BFCI) while also highlighting the counselling of mothers and peer counsellors model and the Baby Friendly Hospital Initiative (BFHI) model. The purpose of this review is to draw lessons from successful BFCI projects with a view of informing similar projects and programs in the country. Mention has been made to a few examples of the outcomes of the counselling and the BFHI models while the BFCI has been covered in greater detail. Lessons are drawn from pilot projects in Kenya, Gambia and Cambodia and a summary of lessons on the implementation of BFCI is included.
Acknowledgements

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### Table of content

Summary .................................................................................................................. 2  
Table of content ..................................................................................................... 4  
List of acronyms .................................................................................................... 5  
1.0 Background ...................................................................................................... 7  
2.0 Breastfeeding counselling models .................................................................... 8  
3.0 Baby Friendly Hospital Initiative ...................................................................... 9  
4.0 The Baby Friendly Community Initiative (BFCI) ............................................ 12  
4.1 Main features of the BFCI .............................................................................. 13  
4.2 Benefits of BFCI ............................................................................................ 13  
5.0 Case studies of BFCI implemented in low and middle income countries ....... 14  
6.0 Kenyan examples of community based initiatives ........................................ 14  
6.1 Outcomes of this implementation of the BFCI in Bondo ............................. 14  
6.2 Formation of the Mother-to-mother support groups in Wajir .................... 15  
7.0 Gambia ........................................................................................................... 16  
7.1 Background .................................................................................................... 16  
7.2 Methodology .................................................................................................. 17  
7.4 Results ............................................................................................................ 18  
7.5 Challenges of BFCI in the Gambia: .............................................................. 20  
7.6 Lessons learnt in the Gambia: ..................................................................... 20  
8.0 Cambodia ....................................................................................................... 21  
8.1 Background .................................................................................................... 21  
8.2 National level .................................................................................................. 22  
8.3 District level .................................................................................................... 22  
8.4 Community level ............................................................................................ 23  
8.5 Methods used to encourage breastfeeding and BFCI in Cambodia ............. 24  
8.6 Setting up of the Mother support groups (MSG) ......................................... 25  
8.7 The role of the community health worker in the BFCI in Cambodia ............ 25  
8.8 Print and mass media .................................................................................... 26  
8.1 Summary of the key interventions .................................................................. 26  
8.10 Results ........................................................................................................... 27  
8.11 Lessons Learned from the Cambodia example .......................................... 27  
8.12 Monitoring of the BFCI in Cambodia involves: ......................................... 28  
8.13 Challenges of implementing BFCI in Cambodia ......................................... 28  
9.0 Lessons learnt and proposed approach for BFCI in Kenya ......................... 28  
10.0 Likely challenges to setting up a new BFCI framework ............................... 29  
References .......................................................................................................... 30
## List of acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>BBC</td>
<td>British broadcasting</td>
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<td>BFCI</td>
<td>Baby friendly community initiative</td>
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<td>BFHI</td>
<td>Baby friendly hospital initiative</td>
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<td>CCSS</td>
<td>Cambodia child survival</td>
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<tr>
<td>CDHS</td>
<td>Cambodia Demographic and Health Survey</td>
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<tr>
<td>CHW</td>
<td>Community health workers</td>
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<tr>
<td>C-IMCI</td>
<td>Community integrated management of childhood illnesses</td>
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<tr>
<td>CMDG</td>
<td>Cambodia millennium development goals</td>
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<tr>
<td>HINI</td>
<td>High impact nutrition intervention</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IMCI</td>
<td>Integrated management of childhood illnesses</td>
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<tr>
<td>IYCF</td>
<td>Infant and young child feeding</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>LAM</td>
<td>Lactation amenorrhoea method</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<td>MCHIP</td>
<td>Maternal and child health integrated program</td>
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<td>MDG</td>
<td>Millennium development goals</td>
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<td>MIYCN</td>
<td>Maternal, infant and young child nutrition</td>
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<td>MOH</td>
<td>Ministry of health</td>
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<tr>
<td>MoPHS</td>
<td>Ministry of public health and sanitation</td>
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<td>MSG</td>
<td>Mother support group</td>
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<td>MTM</td>
<td>Mother to mother</td>
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<tr>
<td>MTMSP</td>
<td>Mother to mother support group</td>
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<tr>
<td>ORS</td>
<td>Oral rehydration salt</td>
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<tr>
<td>PHO</td>
<td>Public health officer</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
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<tr>
<td>RACHA</td>
<td>Reproductive and health alliance</td>
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<tr>
<td>SITAN</td>
<td>Situation analysis</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States agency for international development</td>
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<tr>
<td>VHSG</td>
<td>Village health support group</td>
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<td>VSG</td>
<td>Village support group</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1.0 Background
Breastfeeding is an effective method of ensuring child health and survival. World Health Organization (WHO) recommends exclusive breastfeeding during the first 6 months of life as a source of nourishment for infants and young children (1). In-order to meet the infant’s needs for growth, health and development, breastfeeding should continue for at-least 2 years of life combined with appropriate complementary feeding that is introduced at 6 months. It is estimated that 1.4 million child-lives could be saved by improving breastfeeding practices (2). The rates of breastfeeding are generally high in Kenya with a reported 97% of children ever breastfed while initiation of breastfeeding is 86% within one day of birth (3). However, exclusive breastfeeding rates are still very low in the country estimated at only 32% of children age 6 months (3). Exclusive breastfeeding rates vary widely across the country with even lower rates of up to 2% reported in informal settlements in Nairobi (4). The main reasons given for discontinued breastfeeding and early introduction of complementary feeding includes mother’s retuning to work, not having enough breast-milk and advice by health professionals (5). The Baby Friendly Community Initiative (BFCI) has been recommended as an appropriate method of promoting and supporting breastfeeding at community level (6).

Breastfeeding is a complex process governed by psychological and physiological factors which are influenced by a wide spectrum of environmental, social and cultural factors (7). These factors have been summarised by Ochola (8) in a schematic illustration shown on Figure 1. Ochola, (8) argues that maternal psychological and physiological factors are affected by maternal socio-economic and demographic factors, contextual factors such as place of delivery, cultural factors and infant characteristics. The maternal psychological and physiological factors in-turn directly affects exclusive breastfeeding practices (Figure 1). This complexity of factors influencing breastfeeding practices requires a tactical approach in-order to increase the uptake of appropriate breastfeeding practices for optimal child growth.

Several models have been tested for promoting exclusive breastfeeding in Kenya. This review will highlight three main ones namely, the counselling of mothers and peer counsellors, Baby Friendly Hospital Initiative (BFHI), and the Baby Friendly Community Initiative (BFCI).
2.0 Breastfeeding counselling models

To a lesser scale, an intensive mother counselling strategy was been tested in the Kibera slums in Nairobi. Ochola (2008)(8) evaluated the effects of two counselling strategies promoting exclusive breastfeeding among HIV-negative mothers in Kibera slums. In this evaluation, mothers were randomly assigned to different counselling strategies during 34-36 weeks of gestation and followed up until 6 months postpartum. The home-based intensive counselling group received one counselling sessions prenatally and six sessions postnatally. On the other hand, those receiving facility-based semi-intensive counselling received only one counselling session prenatally. This study reported an exclusive breastfeeding rate of 23.6% at 6 months among mothers receiving home-
based intensive counselling which was significantly higher than for those mothers receiving facility based counselling (9.2%) and for mothers in the control group who received no counselling (5.6%) (8).

In Uganda, a community based peer counselling for support of exclusive breastfeeding was reported (9). Nankunda and colleagues (10) assessed the feasibility of training community based peer counsellors to support exclusive breastfeeding in a rural district in Uganda and found that the trainees appreciated the benefits of breastfeeding and identified the factors affecting breastfeeding. The peer counsellors were able to identify common problems affecting breastfeeding such as insufficient milk, sore nipples, breast engorgements, and poor positioning of the baby at the breast. This study did not report on breastfeeding rates following the peer trainers’ intervention but concludes that peer counsellors for the support of exclusive breastfeeding is a feasible intervention that could improve breastfeeding rates. Other examples of community-based breastfeeding counselling by health providers (11) and peer counsellors (12) show that community strategies to improve breastfeeding can be effective at small scales. The effectiveness of peer counselling has not been reported at a larger scale in resource constrained environments.

3.0 Baby Friendly Hospital Initiative

The Baby Friendly Hospital Initiative (BFHI) is the tool that was Launched in the 1991 by WHO and UNICEF following the 1990 Innocenti Declaration. The purpose of the BFHI is to promote breastfeeding in maternity wards worldwide. The Innocenti declaration advocated for governments to develop national breastfeeding polices and implementation systems to support, protect and promote breastfeeding. Baby friendly hospital initiative takes into consideration ten steps to successful breastfeeding as listed below:

1. A written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.

6. Give new born infants no food or drink other than breast milk, unless medically indicated.

7. Practise rooming-in - that is, allows mothers and infants to remain together - 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or pacifiers/dummies/soothers to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

In Kenya, the BFHI was adopted by the Ministry of Health (MOH) in Kenya, based on the joint WHO/UNICEF global strategy for infant and young child feeding developed in 2002. There were 232 Baby friendly health facilities in the country in 2002. Breastfeeding is adopted as one of the eleven high impact nutrition interventions priorities in-order to increase child survival and help to achieve MDG 4 on child mortality. The Kenya national strategy set out in the maternal and infant and young child nutrition strategy is to increase exclusive breastfeeding from 32% to 80% by 2017. An assessment done in 2009 involving 62 hospitals reported that only 11% of facilities in the country were certified as “baby friendly” and only 5.7% of hospitals and maternity facilities that provide maternity services were designated as “baby friendly” based on global and national criteria (13). It is not known to what extent the BFHI has influenced exclusive breastfeeding rates in the country where hospital deliveries are few. An example of the success of BFHI was reported at Hola District Hospital that exclusive breastfeeding rate increased to 67% in 2012 against the national figures of 32% following introduction of BFHI (13).

Globally, BFHI is reported to increase rates of exclusive breastfeeding while improving child health and survival (14). In developed countries, varying outcomes have been reported on BFHI. In Italy, a hospital staff training program based on the 18 hour UNICEF course on breastfeeding management and promotion, resulted in changing hospital practices, knowledge of health workers and improved breastfeeding rates (15). The training also led to improved hospital compliance to the ten steps of successful breastfeeding from 2.4 steps to 7.7 steps of compliance. The study also reported increased exclusive and predominant breastfeeding at three months resulting from BFHI (15). Improved exclusive breastfeeding rates have also been reported at baby friendly hospital initiatives in Scotland (16), and in Switzerland where the rate of exclusive breastfeeding infants 0-5
months was 42% in the Baby friendly hospitals compared with 34% for infants born elsewhere (17). A national survey in Baby friendly hospitals in the United States reported improved indicators of early initiation of breastfeeding at 83.8% in Baby friendly hospitals compared to 69.5% nationally and 78.4% exclusive breastfeeding rate during the hospital stay compared to 46.3% nationally (18).

A national wide breastfeeding prevalence survey in Brazil reported a positive impact of BFHI on several indicators of breastfeeding (19). Initiation of breastfeeding was more likely to occur among infants born in BFHs (9%) than those born elsewhere while exclusive breastfeeding rate was 6% times more likely among 6 months old infants born at BFHs than infants of the same age born elsewhere (19). There are some examples of successful Baby Friendly Hospital initiatives provided by (20). In Cuba, 49 out of 56 hospitals and maternity facilities are listed as baby-friendly and the rate of exclusive breastfeeding at four months almost tripled in six years - from 25 per cent in 1990 to 72 per cent in 1996. Another examples is at the central hospital of Libreville in Gabon where cases of neonatal diarrhoea fell by 15 per cent, diarrhoeal dehydration declined by 14 per cent and mortality fell by 8 per cent after the first two years of BFHI implementation. China has more than 6,000 Baby-Friendly Hospitals and the rates of exclusive breastfeeding in rural areas improved from 29 per cent in 1992 to 68 per cent in 1994; in urban areas, the increase was from 10 per cent to 48 per cent following the implementation of BFHI. Initiation of breastfeeding within the first two hours of birth increased at the Catholic University of Chile, Santiago upon adoption of BFHI in the teaching hospital. The exclusive breastfeeding at 6 months increased from approximately 20% to over 60% in the same hospital following a monthly hospital visit and an implementation of the 10-BFHI steps.

It is difficult to obtain the desired BFHI outcomes in the setting where more deliveries happen at home than in the health facility. The BFHI which is facility is limited in achieving the BFHI step ten that focuses on formation of community support groups. A well designed and implemented Baby Friendly Community Initiative (BFCI) which is an expansion on the BFHI is an important intervention that can possibly increase the exclusive breastfeeding rates by reaching out to the mothers in their own communities when they leave the hospital and even if they do not deliver at the hospital.
4.0 The Baby Friendly Community Initiative (BFCI)

Baby Friendly Community Initiative (BFCI) was developed to expand on the BFHI’s 10th step, focusing on support for breastfeeding mothers after they leave the hospital. This initiative also offers an entry point to address the nutritional and developmental needs of both the mother and the child. BFCI is a multifaceted program for community-based breastfeeding promotion which is complementary to the BFHI. The objectives for BFCI are to increase the percentage of babies who are breastfed, increase the duration of exclusive breastfeeding and sustain breastfeeding after 6 months alongside introduction of complementary foods (21). It addresses environmental sanitation, personal hygiene, and equity.

The BFCI aims to protect, promote and support breastfeeding for healthy mothers and babies through the implementation of a seven point plan and compliance to the International Code of Marketing of Breast-milk Substitutes. The BFCI seven point plan was developed based on the ‘BFHI’s 10 steps. The seven point plan as summarised by (22) as follows;

1. A written breastfeeding policy that is routinely communicated to all staff and volunteers.
2. Train all health care workers in the knowledge and skills necessary to implement the breastfeeding policy.
3. Inform pregnant women and their families about the benefits and management of breastfeeding.
4. Support mothers to establish and maintain exclusive breastfeeding to six months.
5. Encourage sustained breastfeeding beyond six months, to two years or more, alongside the introduction of appropriate, adequate and safe complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote collaboration among health services, and between health services and the local community.

The seventh step of the BFCI emphasizes the creation of community support groups and mother-to-mother support groups that encourage the inclusion of men, as they are the main influencers of feeding practices at household level. This initiative also includes introduction of sustainable income generating activities, such as kitchen gardens. Community level involvement in breastfeeding initiatives consists of health care professionals, multipurpose community health workers, family members, relatives and friends, peers, lay counsellors, community development,
extension workers, traditional health practitioners, breastfeeding advocates such as grandmothers, community and religious leaders and local media.

4.1 Main features of the BFCI

- Community involvement
- Breastfeeding, adequate complementary feeding maternal nutrition, early childhood development, and hygiene
- Formation and training of mother support groups at the village level
- Close links to the health facility
- Training messages are derived based on knowledge and practices of the community as identified through interviews with community members.

4.2 Benefits of BFCI

- Creating linkages between maternal and infant nutrition
- Creates linkages between the health facilities and communities
- Integrated with environmental, personal hygiene and sanitation practices
- Includes sustainable income generating activities
- Includes men as important actors of infant feeding decisions
- Involves a larger community integrated group
- Addresses the environmental issues that affect breastfeeding beyond the mother.
- Offers sustainability through community engagement. Members of the community are not likely to move away on transfer as do health care providers who are often transferred from one health facility to another which causes loss of follow-up and low sustainability of programs.
- Drawing resources of the entire community
- Provides governments with an entry point for other community development and health care policy frameworks and programs.
- Messages are developed based on traditional knowledge and practices of the local communities
5.0 Case studies of BFCI implemented in low and middle income countries

6.0 Kenyan examples of community based initiatives

The Kenya nutrition action plan 2012-2017 has listed baby friendly facility and community initiatives as one of the outcome indicators for the strategic objective 2 which is to improve the nutritional status of children under 5 years of age (23). The BFCI has been tested in a pilot project by USAID/MCHIP in partnership with the Division of Nutrition in Bondo District and other rural areas of Kenya involving tier two facilities and the community units attached to these facilities (MCHIP, 2013.) Only 44% of mothers are attended to by a skilled birth attendant and still those who deliver at hospital only stay for a day or less. The BFCI aims to improve maternal and infant feeding practices at the community level. Social pressure, along with traditional beliefs and practices in the home environment, strongly influence how mothers feed their infants.

While men are important actors in infant feeding decisions, they are not usually targeted by breastfeeding intervention programs. Their involvement in this initiative as both information providers and information recipients is a formal acknowledgement of the important role they play. Mothers alone may find it difficult to take a decision on exclusive breastfeeding without the support of their husbands. With men as members of the support group, it is easier to convince their fellow men in the community as well as to support their wives.

6.1 Outcomes of this implementation of the BFCI in Bondo

- Attitudinal change towards colostrum (earlier referred to as bad milk and now referred to as the protective milk) or first immunization for the child.
- Awareness on the benefits of exclusive breastfeeding including benefits to mothers specifically Lactation amenorrhea method (LAM) as a method of family planning.
- Awareness of the importance of an enabling environment for breastfeeding mothers was raised through this initiative.
- Supported national breastfeeding weeks and improved assessment of BFCI and nutritional surveillance needs.
- Promote collaboration among health services, and between health services and the local community.
• Let’s talk breastfeeding, Kenya face book page has 1,024 likes

In Wajir county, a mother to mother support group initiative for breastfeeding formed in January 2012 reported marked improvement in MIYCN indicators when results are compared before and after formation of the Mother to mother support groups (24). Exclusive breastfeeding of infants aged 0 - 5 months during the previous 24 hours before the survey increased from 21.1% in July 2011 to 53.7% in February 2013. Initiation of breastfeeding within one hour after delivery improved from 45.3% to 67.3% between the two study periods while continued breastfeeding of children age 6-23 months improved from 45.3% to 64.2% (24).

6.2 Formation of the Mother-to-mother support groups in Wajir.
The MTMSGs were formed within a wider framework of the implementation of MIYCN project by save the Children through the emergency nutrition programs in Wajir county. Counselors were identified and trained for 4 days on breastfeeding and other aspects of MIYCN. The counselors then identified and trained 6 women each as facilitators of the MTM groups. The counselors conducted 3-day training for the recruited women who went and formed the MTMSP in their villages. The counselors and the women were selected by their communities. Community mobilization on the importance of the groups was done by elders, community leaders, Public Health Officers (PHO) and community leaders.

There are a total of 48 MTMSG in the Habaswein and Wajir south sub-counties of Wajir county. The program has expanded from mothers only to recruiting men into the care group. This development has led to change of name to care support groups with a large number of participants of up to 629 persons in total. The care support groups meet monthly to plan on how to improve the community’s uptake of MYCIN practices. Members are also trained on High Impact Nutrition Interventions (HINI), use of Oral Rehydration Salt (ORS), zinc sulphate for diarrhea management and creating community awareness on other micronutrients supplementation programs. Member of the MTMSG or the care groups are also trained on personal and food hygiene, kitchen gardening, poultry keeping, and other income generating activities. The community based initiative in the Siaya (Bondo) and Wajir counties in Kenya are ongoing and not much has been reported in regard to the outcomes and the challenges.
7.0 Gambia

7.1 Background
The Gambia is a country in West Africa which covers approximately 10,689 square kilometers. The total population of in Gambia is 1.3 million people according, of which 50.2% were female and 49.8% male (25). The population growth rate is 2.74%. Estimates put the population at between 1.7 and 1.8 million currently. According to the 2003 census, nearly 44% of the population is below 15 years and 19% is between the ages 15 to 24 while nearly half (49%) of the Gambia's population is below 18 years of age, with 19 per cent aged 15 to 24, and 22 per cent of women aged 15 to 49 (25).

In the Gambia as in many other African countries, 80 per cent of the total population is involved in the agricultural sector and women contribute 49 percent of the total agricultural produce. More than half (61.2%) of the population is classified as poor with an approximated 69% of the population being classified as below the poverty line. This high poverty rate implies a high level of disease vulnerability on the population and has serious implications for public health services delivery. In rural areas, 60 per cent of households are extremely poor. The leading causes of morbidity in children are malaria, acute respiratory infections, diarrheal diseases, helminthic infections and skin disorders. In adults, malaria, respiratory conditions, skin disorders, cardiovascular diseases (including hypertension), diabetes, cancers and trauma are the common diseases/conditions. Inaccessible and inadequate maternal health care services are responsible for increased maternal morbidity and mortality. These health conditions are responsible for over 75% of the out-patient and in-patient care delivered through the government’s health care system.

In the Gambia, mothers are exposed to traditional and cultural care practices during and after pregnancy, delivery and after birth since most deliveries as in many other African countries take place at home. In addition, even mothers who delivered in health facilities only stayed there for 24 hours or less with a normal delivery (26). Late initiation of breastfeeding, giving water and fluids to newborns and early complementary feeding (as early as 3 months after birth) are examples of these practices. Some of these practices are a major cause of maternal and infant deaths. In addition, rural communities suffer high infant mortality rates during the neonatal period mainly due to malnutrition, infections and premature births.
In Gambia, only 41% of mothers practice exclusive breastfeeding for the first six months of life for their babies (27). In addition, about 48% of mothers initiate breastfeeding within the first hour of birth and 33% of children aged 6-9 months receive adequate complementary foods with continued breastfeeding. To promote the practice of exclusive breast-feeding, the National Nutrition Agency in 1993 successfully piloted a BFCI in 12 rural villages in the Lower River Division. It was an integrated approach, which included immunisation, water and environmental sanitation, personal hygiene, maternal nutrition, breastfeeding and literacy. The program covered 200 communities throughout the country in by 2004 and was projected to cover 400 primary health care within the next few years.

The BFCI concept was derived from the UNICEF/WHO BFHI, which emphasized exclusive breast-feeding from birth. The adaptation of this initiative to rural Gambian communities gave rise to the BFCI. The strength and success of the BFCI approach in The Gambia is based on two features: the development of messages based on existing knowledge and the ownership of the initiative by communities. Messages on a variety of issues: exclusive breast feeding, maternal and child nutrition, environmental sanitation, and personal hygiene were built on local or traditional communications derived from interviews with mothers and community members.

7.2 Methodology
Exclusively the communities conducted the selection of the members of the Village Support Group (VSG). The group is made up of eight people – a village health worker, a traditional birth attendant and six elected members, three of them men. The VSGs were fundamental and key to the success of the initiative.

The training methodology consisted of a combination of tools: Village meeting, village ceremonies, discussions, singing, dancing, drama, role-play and the use of humour groups locally known as “Kanyelengo”. These humour groups usually composed of women are well known and respected for their skills in transmitting important educational messages through entertainment activities to eradicate taboos and other traditional practices that impacted negatively on breastfeeding. The scope of training covers the 10 BFCI steps which are then passed on to pregnant and lactating women in
the villages together with their spouses. Peer to peer education and the use of opinion leaders were also exploited fully for maximum information sharing and behaviour change (28). The training model puts into consideration traditional beliefs and practices by incorporating community elders as part of the process.

Apart from theoretical information, the training emphasized practical solutions to simple problems that breastfeeding mothers may encounter. These included cracked or sore nipples and engorged breasts for which avoidable causes and simple solutions were identified. It was expected that such practical information would make the support groups more persuasive and credible in their communities.

The support groups are also taught about breast milk expression for mothers who have to be away from their infants for short periods. There was some initial reluctance to this based on their belief that breast milk can turn sour if not utilized for several hours. Even mothers who are away from their babies for a few hours, according to local tradition, were expected to express and throw away the first milk before breastfeeding.

Men are important actors in infant feeding decisions but are not usually targeted by breastfeeding intervention programs. They are both information providers and information recipients in this initiative. Mothers alone may find it difficult to take a decision on exclusive breastfeeding without the support of their husbands. With men as members of the support group, it was also assumed that it would be easier to convince their fellow men as well as to support their wives.

Support is given to accommodate women who spend most their time cultivating in the fields, by establishing the ‘Maaka’, a traditional shelter where these mothers care for their babies.

7.3 Monitoring of BFCI in the Gambia

- Monthly questionnaires on the 10 steps
- Mothers knowledge and practices on IYCF
- Supervision by the community nurses

7.4 Results

The results of this approach in Gambia were an increase from 60% to 100% in initiation of breastfeeding in the first day of life, and a decline in introduction of complementary feeding at four
months of age from 90% to nearly zero percent (29). In a rural community in Gambia named Sukuta, the BFCI has improved the community’s perception on caring for mothers, women have been relieved of heavy work load for three months before and six months following delivery which is a local law. Men are more supportive and there is support for a diversified diet for the pregnant women and attendance of prenatal care appointments.

Men’s involvement in the BFCI both as members of the support groups and as part of the target population may also have been a crucial element for success and sustainability of the intervention. Their involvement in an area, which in the past targeted only women, sent out a clear and strong message that maternal and infant nutrition concerned both men (fathers) and women (mothers) (30).

Reported benefits by the community members in the Gambia; cleaner environment, healthier pregnant women, healthier babies, community unity resulting from shared involvement and commitment in BFCI.

- The recognition that good nutrition after breastfeeding is equally important has resulted in establishment of community gardens to provide micronutrients.
- In Sukuta a rural community in the Gambia, BFCI has resulted in the community introducing a local law that relieves women of heavy work for three months before and six months following delivery. This was born out of community members acknowledging the need to care for mothers.
- The BFCI initiative has also led to men being more supportive as well as making sure that pregnant women have a more varied diet and attend prescribed prenatal appointments.
- Due to its success in getting the entire community involved, BFCI has been used as a model for other community based activities such as the Gambia Early Childhood Development (ECD) for an effective entry point and to enhance smooth implementation at the community level. The BFCI training manual has been adapted as an ECD manual, with additional emphasis on psychosocial care and early learning and stimulation for children aged 0-8 years. The training program for the VSGs has also been expanded to include early stimulation and learning, the importance of interaction between other family members and children, ensuring birth registration, promoting clean and safe environments for children, and protecting against abuse and exploitation. The number of BFCI communities sensitized on the ECD approach increased from 39 in 2002 to 68 in 2004. More than 10,000 caregivers,
the majority of whom were women (mothers and grandmothers), have been sensitized on
difficult ways to actively assist in the survival and development of their children. As of 2005, more
than 20,400 children were benefiting from the BFCI approach in these rural communities.

- Men are now more supportive, and make sure that pregnant women have a more varied diet
and attend prescribed prenatal appointments.

7.5 Challenges of BFCI in the Gambia:

- Sustainability of the voluntary services by the village support group members.
- Some religious leaders remained with negative attitudes towards exclusive breastfeeding
despite the messages through BFCI
- There were difficulties in sustaining the training and integration of BFCI as part of an overall
community development strategy
- Sustainability of the voluntary service provided by the VSG members who are mainly young
people
- The voluntary nature of the approach is the greatest challenge since it depends on the
willingness of the communities to create VSGs who would be required to serve their
members without compensation.

7.6 Lessons learnt in the Gambia;

- Formation of village support groups:
- Training of village support group members on BFCI concept – This is a five day training
including maternal nutrition, complementary feeding, exclusive breastfeeding, environmental
sanitation, consumption of iodized salt and growth monitoring. Other factors influencing
breastfeeding practices such as peer and family pressure are discussed in the trainings.
Factors that cause some babies to refuse breastfeeding such as illness, sore nipples, sore
mouth, blocked nose or painful swallowing are also discussed.
- Involvement of men created a very strong message that maternal and infant nutrition is
everyone’s business and is a very important business.
8.0 Cambodia

8.1 Background
Cambodia is located in South East Asia, bordering Thailand to the West, Laos to the North, Vietnam to the East, and the Gulf of Thailand to the Southwest. Cambodia has a total area of 181,035 square kilometers and a population density of 75 persons per square kilometer. It is one of the poorest and least developed countries in Asia, with the gross domestic product per capita estimated at approximately 3.3 million Riel or $805 in 2010 (31). Currently, it is estimated that close to 30 percent of the total population lives below the poverty index. The main economic activity is agriculture. In 2010, the total fertility rate in Cambodia was 3.0 children per woman (31), a decline from 4.0 children in 2005 (32) and 3.4 children in 2002 (33).

Cambodia is recognized as one the countries that have made impressive and significant improvements in infant feeding and care practices with the United Nations recognizing Cambodia as a BFCI success story on millennium development goal 4. The Cambodian demographic and health survey (CDHS) in 2005 indicated a mortality rate of children aged less than five years of 83/1000 live births, which was an improvement from the CDHS 2000 estimate of 124.4/1000 live births. Infant mortality rate also improved from 95 deaths/1000 live births in 2000 to 65 deaths/1000 live births, in 2005 (32,33). Despite these general health improvements, child mortality remains high due to a high prevalence of malnutrition and communicable diseases, and around 60,000 children die every year mostly from a few preventable and treatable conditions.

The Government of Cambodia, recognizing the burden of child mortality, has worked in collaboration with development partners to set national Millennium Development Goals (MDG) targets and select high-impact interventions that are expected to make the greatest contributions to achieving the key targets of the child survival. The Cambodia Millennium Development Goals (CMDGs) include, reducing the under 5’s mortality rate to 65 per 1000 live births by 2015.

To achieve this, a number of cost-effective interventions to counter the causes of child mortality are currently implemented at national, district and community levels as follows:
8.2 National level
Key IYCF interventions identified as priority areas of attention were; promotion of early initiation of breastfeeding, exclusive breastfeeding and Complementary feeding. The Cambodian Royal Government adopted the national IYCF policy and launched a five year nutrition investment plan in 2002. This plan included policy formulation, communication, capacity building for health workers, curriculum development and support for the BFCl. The Ministry of Health formed an IYCF technical working group to coordinate the implementation of the nutrition related interventions. In 2004, breastfeeding was identified as one of the 12-high impact child survival interventions and endorsed by the Royal Government of Cambodia. The breastfeeding week was marked by wide social mobilization efforts, through local television and radio stations. The main messages for the social mobilization during the 2004 breastfeeding week was supporting exclusive breastfeeding and discouraging giving water to infants below six months. The breastfeeding week campaign was followed by a government’s approval of a sub-decree on marketing of products for IYCF in 2005. This sub-decree was disseminated through workshops and trainings on monitoring and enforcement with attention focused on the importance of protecting breastfeeding.

A multiple program framework was used to promote breastfeeding in the country. This framework included nutrition, child survival, Integrated Management of Childhood Illnesses (IMCI), Community Integrated Management of Childhood Illnesses (C-IMCI), maternal and child health activities such as reproductive health and ANC counselling, Prevention of Mother to Child Transmission of HIV (PMTCT) and use of mass media.

8.3 District level
Meetings were held at district level with representatives from the government agencies, donor agencies, training institutions, non-governmental organization and individuals. A working group with BFCl as the main agenda was formed. A plan of action for BFCl implementation and community involvement was also developed at the district level meetings. A health workers training program was implemented which included a capacity building program included training of more than 1,500 health workers on breastfeeding counselling and recruiting them into BFCl. Midwives received training on breastfeeding counselling and health Center staff were trained on IMCI and C-IMCl. Training of health care workers was supported by WHO and UNICEF and was aimed at
strengthening the linkages between health facility and community and to ensure consistent IYCF messages from health care workers and community health workers

8.4 Community level
Capacity building for community volunteers included training on oral rehydration therapy, diarrhoea management and breastfeeding. This part of the implementation was supported by CARE and included piloting of C-IMCI in 28 villages over 18 month’s period. The village health support groups and village health volunteers were trained on maternal and child health and nutrition and provided support on MCHN, immunization and ANC services. Mothers clubs were formed with a trained facilitator who held discussions with the mothers of children under five on exclusive breastfeeding and healthy family practices. The CARE MCH-community initiative reached about 285,000 people over six years. Community Mobilization meetings were held in the 32 villages where BFCI was first piloted, to introduce the initiative into the community.

Breastfeeding promoting teams known as mother support groups (MSG) were established at the community level, each team comprising of:

- Two village health support group volunteers (a man and a woman)
- Traditional birth attendant (TBA)
- Two Model mothers
- The village elder

The Village leaders and the TBAs were recruited by the health care workers while the model mothers were elected by the community members.

Another part of the integrated framework was reproductive and child health activities. The Royal Government of Cambodia with USAID funding founded the Reproductive and Health Alliance (RACHA) in 1996. In 2000, RACHA joined the breastfeeding campaign and developed a poster on exclusive breastfeeding. This poster was used as a training tool by Nuns (religious workers) and grannies to promote good breastfeeding practices. The Nuns were trained to provide health education in the villages and grannies were selected to provide monthly small group health education sessions and make home visits to families with children less than five years of age.
The Baby Friendly Community Initiative was launched in 2004 by the MOH with support from WHO, UNICEF, RACHA and CARE. The programs are being facilitated by the regional WHO/UNICEF child survival strategy which was endorsed in 2005 following which the Cambodia Child Survival (CCSS) was developed for the period of 2006-2015. A score card by CCSS includes 4 nutrition interventions basically under IYCF’s components. A report presented by the Cambodian Ministry of Health, on Cambodia’s achievements from 2000 to 2005 indicated a 49% increase in exclusive breastfeeding, threefold increase in breastfeeding initiation within one hour (87% of new-born babies) and within one day (90% of new-born babies), and improvement in complementary feeding practices. BFCI coverage grew from 35 to 2000 villages. In 2007, the Cambodia Ministry of Health approved national expansion of the BFCI as part of its nutrition strategic plan.

8.5 Methods used to encourage breastfeeding and BFCI in Cambodia

- The BFCI model in Cambodia was established on the concept of “Mother Support Group” (MSG). Groups are made up of the village chief, a traditional birth attendant and two model mothers as well as local health volunteers who serve as the linkages between the villagers and health Center staff. Creation of mother to mother support groups which encourages sharing of knowledge and experiences among rural women in the support group.

- Group activities include regular informal discussions with pregnant women and nursing mothers in their own villages and also gatherings between several villages that gather for quarterly meetings at the local health Center to discuss on their experiences.

- Personal success stories by mothers who have successfully exclusively breastfed. This is referred to as the “model mother”. A model mother is a member of the support group with a positive breastfeeding experiences, is literate, respected in the community, has proper communication skills and motivated to participate. Her role is to try and reach out to pregnant women, new mothers and their families and explains to them the importance of breastfeeding as the best way to feed the babies and the least expensive.

- Involvement of other community members such as training of religious Nuns and grandmothers by the reproductive and health alliance of Cambodia. The Nuns were selected by colleagues to provide health education in the villages during religious ceremonies while the grandmothers were chosen by community members to provide small group health
education sessions and home visits. Roughly one granny was selected to cover 50 households.

- In Cambodia, the BFCI extends to industry level where enterprises are required to provide a functional and accessible lactation room at the workplace if they employ at least 100 women. This law is supported by the International Labour Organization, supported by the Government of Cambodia and the manufacturers association and unions.

8.6 Setting up of the Mother support groups (MSG)

1. Select Health Centres, build partnerships with Community councils and train all stakeholders.
2. Select BFCI villages.
3. Orient community leaders to BFCI
4. Orient the existing Village Health Support Group (VHSG) members to BFCI
5. Select and train BFCI volunteers

- Health Center staff facilitates the setting up of the MSG by organizing a village level meeting in partnership with the chief and help with the elections of model mothers. The health facility staff also provides capacity building, follow-up and supervision of the MSG activities.
- The role of the chief is to mobilize the community to attend meetings. MSG members receive a 3 day training on breastfeeding and complementary feeding, counselling and communication based on IYCF module of the C-IMCI. The key messages of the 3 day training is early initiation of breastfeeding, exclusive breastfeeding, continued breastfeeding to 2 years and beyond as well as appropriate complementary feeding starting at 6 months of age.
- Group activities also includes monthly meetings with the health Center staff. Quarterly meetings with the MSG and health Center staff are heald to offer an opportunity for refresher training, update on IYCF practices, discuss progress and challenges

8.7 The role of the community health worker in the BFCI in Cambodia
The community health workers are the 2 village health support volunteers, a TBA, the village Chief and 2 model mothers. Their main role is to provide health education to the group and attend the
monthly outreach meetings organized by the health Center staff in addition to individual counselling
during home visits. The main training they receive is a 3 day training on breastfeeding counselling
and support.

8.8 Print and mass media
Printed materials such as leaflets, booklets, flipcharts and posters were used to promote
breastfeeding in Cambodia. There was also an extensive mass media campaign focusing on early
initiation of breastfeeding and exclusive breastfeeding called; “do not give water” campaign. This
was started as a national communication strategy for promotion of IYCF developed for the period
March 2005-December 2007. The campaign was in partnership with the BBC world service that
developed maternal and child health project television and radio production as well as supporting
print materials to convey more than 50 essential health messages especially on breastfeeding. The
national wide breastfeeding week was highly publicized and supported by the mass media through
TV soap operas, call-in shows and roundtable discussions featuring breastfeeding. These mass media
messages were initiated around the 2004 breastfeeding week. Children recorded songs encouraging
breastfeeding that were very popular for mobile phone downloads. There were large billboards of a
breastfeeding woman and baby in towns and rural areas.

8.1 Summary of the key interventions
1. Government leadership played a key role in the success of breastfeeding promotion by
formulating and approving policy, supporting key interventions, political will and
supporting the breastfeeding initiatives.
2. Training: The ministry of health trains health staff in Integrated Management of
Childhood Illnesses (IMCI) which includes training on appropriate breastfeeding and
complementary feeding practices.
3. Community-based interventions in villages; in the communities BFCI works through
support groups at the village level and with close links to health centres.
4. Use of multimedia campaigns which are seen to be highly effective. e.g Television
advertisements, round table negotiations, print media and posters among others.
5. Involvement of other community members such as religious Nuns and selected grandmothers.

8.10 Results
Improved IYCF practices were observed between DHS surveys of 2000 and 2005. For example, initiation of breastfeeding within an hour of birth improved from 11% to 35% while exclusive breastfeeding rates improved from 11% to 46% between the two surveys (32,33). These indicators of breastfeeding rates were sustained in the CDHS 2010 with a 66% initiation of breastfeeding within one hour of birth and only 19% are reported to have received pre-lacteral feeding in the CDHS 2010 (31). The exclusive breastfeeding rate was reported to have improved from 46% in 2005 to 60% in 2010. Introduction to complementary foods like water to children less than six months during the hot seasons reduced from 64% in 2000 to 28% in 2005 and further decrease to 22% in 2010 (31-33). Although the results were from multiple interventions, community based breastfeeding activities are thought to have largely contributed to the success in increasing the rates of breastfeeding in Cambodia. In addition to the improved breastfeeding outcomes, infant mortality rate decreased from 95 per 1000 live births in 2000 to 66 per 1,000 live births in 2005 and further down to 45 per 1,000 live births in 2010. The under-five mortality rate also decreased from a high of 124 per 1000 live births in 2000 to 83 per 1,000 live births in 2006 and further down to 54 per 1,000 live births in 2010. The mother support groups in rural Cambodia have been associated with the improved child health indicators (34).

8.11 Lessons Learned from the Cambodia example
- Community-based activities, nationwide media campaigns and coordinated “do not give water” message emphasis set a strong foundation for positive behaviour change
- Multiple programme opportunities created by an integrated approach on promotion of breastfeeding, reproductive health, IMCI, PMTCT and nutrition education were effective in reaching women and children.
• Political commitment and involvement by the national governance through policy and advocacy activities together with other partners at district levels.
• Involvement and support from community leaders and decision-makers such as chiefs, elders, teachers, public health nurses, religious leaders and members of the local governance committees increased the uptake of BFCI activities
• Creating links with the health system through the involvement of the local health facility personnel in the mothers support group helped to facilitate supervision of the MSG and for monitoring of the BFCI program.

8.12 Monitoring of the BFCI in Cambodia involves:
• Supervision; Supervision of BFCI and other community models supportive of breastfeeding is done by someone associated with the government health programs.
• Follow-up and supervision after trainings
• Regular meetings for BFCI volunteers and health Center staff
• Refresher trainings
• Annual BFCI review meeting
• Reported changes in the CDHS

8.13 Challenges of implementing BFCI in Cambodia
• Logistical time and cost constrains often limit the supervision of community initiatives by the health workers.
• Follow-up
• Keeping the MSG members motivated
• Resources, time and logistical constraints by the health workers and the MSG members

9.0 Lessons learnt and proposed approach for BFCI in Kenya
1. Comprehensive approach involving formation of support groups. The support groups can take either of the two models discussed above name: the “mother-to-mother” model or the “village-support group” model. Based on the examples above, the village support group...
model engages a wider number of community members, may be harder to formulate but may provide higher levels of accountability and success once the groups are formed.

2. Other Volunteer supporters that should be considered for inclusion in the village support model are spouses, “older women”, “model mothers”, community health workers, organized women/youth group leaders and religious leaders.

3. The key partners in setting up BFCI must be carefully selected and should include local authorities in the devolved system of government.

4. Type of support and level of participation of the group should involve training of group members, based on the IYCF practices, BFCI elements and with an emphasis on the benefits of exclusive breastfeeding, challenges and how to overcome them.

5. Open discussion on how to deal with the possible hindrances of exclusive breastfeeding and involvement of the male partners may be incorporated in the training sessions.

6. Discussion of cultural beliefs and practices relating to breastfeeding

7. Inclusion of maternal nutrition as part of the training model provides a wider understanding of the importance of nutrition to the expectant mother and the lactating mother that improves the outcome of pregnancy and lactation.

8. Implementation must involve follow-ups as well as monitoring of the support groups

9. Community ownership is key in sustainability of the model.

10. A pilot of each of the two models on a smaller scale will give an indication of which model may be more successful in the urban low resource settings

10.0 Likely challenges to setting up a new BFCI framework

- Creation of village support groups or mother to mother support groups is a major challenge. This challenge is the most likely to face the setting up of BFCI in any community. The village support group members have to spend a lot of time serving the community as volunteers. The participants must be carefully selected with community involvement for ownership.

- Meeting the cost of continuous training and capacity building for the village or mother to mother support group members is also a major challenge to BFCI programs.
• Supervision of the village support groups through existing health care personnel is an added responsibility to an already strained health work force.

• Gaining the political support of local authorities and the community at large is a challenge that can be anticipated

References


34. UNICEF. Mother support group network promotes exclusive breastfeeding in Cambodia 2008.