SOCIAL AND BEHAVIOR CHANGE COMMUNICATION IMPLEMENTATION KIT:

To Support Faith-Based Organization-Led Breastfeeding Interventions

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HEALTH COMMUNICATION CAPACITY COLLABORATIVE

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ACRONYMS

ANC	Antenatal Care
BFHI	Baby-Friendly Hospital Initiative
CHW	Community Health Worker
DHS	Demographic and Health Surveys
EBF	Exclusive Breastfeeding
ENC	Essential Newborn Care
EWEC	Every Woman Every Child
FBO	Faith-Based organization
ICT	Information and Communication Technologies
IPC	Interpersonal Communication
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organizations
ORS	Oral Rehydration Solution
PPP	Public Private Partnership
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled Birth Attendant
SBCC	Social and Behavior Change Communication
SMS	Short Message Service
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

INTRODUCTION

Welcome to the Social and Behavior Change Communication Implementation Kit to Support Faith-Based Organization Breastfeeding Interventions. This Implementation Kit (I-Kit) includes:

- This program guide.
- Social and behavior change communication (SBCC) strategy templates.
- Case studies.
- Examples of breastfeeding communication materials used by faith-based organizations (FBOs) and others.
- Sample sermons.
- Excerpts of religious texts.
- Monitoring and evaluation (M&E) guidance.
- Links to child survival organizations and programs and a variety of web-based resources.

This I-Kit provides SBCC practitioners with straightforward guidance and interactive tools to assist in developing breastfeeding SBCC programs. While this program guide was designed with FBOs[1] in mind, any type of organization seeking to improve breastfeeding practices can use it.

About this I-Kit

This I-Kit introduces users to the building blocks for an SBCC strategy for breastfeeding. It links the SBCC strategy development to FBOs assets such as religious leaders and religious texts. It includes basic information about breastfeeding and the role of FBOs, religious leaders and faith communications in improving child survival.

Each step includes activities to help users develop all of the elements of a well-planned SBCC strategy. It may be used as a starting point for developing an SBCC strategy and generating ideas and approaches for new programs. They can also use it as a resource for revising and refocusing an existing strategy, program or set of activities.

Who Can Use this I-Kit?

A range of audiences can use the guide and I-Kit. It is aimed primarily at FBOs whose staff want to use SBCC to increase the use of breastfeeding to improve child health. Staff might be:

- Program managers, designers and implementers who work (or want to work) in child survival or maternal, newborn and child health (MNCH).
- Program managers, designers and implementers who want to incorporate SBCC in their work.

And they might work in:

- FBOs interested in child survival/MNCH.
- Child survival/MNCH organizations.
- SBCC-focused organizations.
- Ministries of Health (MOHs), child welfare, women, Social Services and others.

Programs should use the Kit as an adaptable tool to provide a quick-start foundation create SBCC strategies tailored to their context. The Kit uses an evidence-based approach to SBCC strategy development and can inspire local and national SBCC strategies. It is intended for users in low-resource settings.

What Does this I-Kit Contain?

The Kit may be used as a starting point for developing an SBCC strategy and generating ideas and approaches for new programs, or it may be used as a resource for revising and refocusing an existing strategy, program or set of activities.

This program guide is the foundation of the I-Kit. The guide introduces users to the building blocks for developing an SBCC strategy for breastfeeding.

- **Introduction** provides context for developing a breastfeeding SBCC strategy. It includes basic information about breastfeeding and the role of FBOs, religious leaders and faith communities in improving child survival.
- **Part 1. SBCC Strategy Structure and Guidance** explains concepts and steps in developing an SBCC strategy.
- **Part 2. An Illustrative SBCC Strategy for Breastfeeding** provides an example of the completed steps using global-level data.
  - Use Part 1 and Part 2 together to complete SBCC templates in **Appendix A**.
- **Appendix B** has additional information on breastfeeding basics.
- **Appendix C** provides sample questions for conducting a situational analysis.

[1]Faith based organizations are organizations that are associated with or inspired by religious institutions or religious beliefs and operate as registered or unregistered non-profit institutions.

- **Appendix D** provides additional sample messages for promoting optimal breastfeeding.
- **Appendix E** provides additional sample indicators for measuring SBCC efforts related to optimal breastfeeding.

Each step of a six-step process includes activities to help users develop all of the elements of a well-planned SBCC strategy. The six steps and the estimated time for completing them are outlined below. The estimated timeframes will help you plan your strategy development.

Step	Estimated Timeframe
Step 1. Define a Vision	½ day
Step 2. Analyze the Situation	2 weeks
Step 3. Analyze the Audience	3 weeks
Step 4. Define a Message Strategy	2 weeks
Step 5. Determine Activities and Interventions	2 weeks
Step 6. Plan for Monitoring and Evaluation	2 weeks

The Kit also provides links to resources for users who want more information and examples. The full Kit is available online [www.healthcommcapacity.org/implementation-kits/faith-community-led-breastfeeding-interventions/] and has been designed with the connectivity and context of end-users in mind.

Best Practices for Using this Kit

Program managers should plan for an estimated 11 weeks to complete the six-step process from beginning to end, longer if formative research is conducted. It is highly recommended that these steps be completed by a team of people with various technical strengths, including knowledge of breastfeeding practices, knowledge of local cultural and faith practices in different regions of the country where you will work, and experience with monitoring and evaluation. These could consist of program managers, nurses and/or midwives, social and behavior change communication professionals, monitoring and evaluation professionals, religious leaders, and others. It is also recommended that teams develop a schedule of when to meet each week and assign different roles and responsibilities to the team members for completing the various tasks.

Below is an illustrative schedule for completing the strategy within the 11-week timeframe.

Activity	Weeks 1-2	Weeks 3-5	Weeks 6-7	Weeks 8-9	Weeks 10-11
Read **Introduction**. Fill out **Step 1. Vision Template** from **Appendix A.** • Refer to *Adaptable SBCC Strategy, Step 1. Define a Vision.* • Refer to *Illustrative SBCC Strategy, Step 1. Define a Vision.* • Refer to *Appendix B. Breastfeeding Basics* for more information about optimal breastfeeding practices. Fill out **Step 2. Situation Analysis Templates** from **Appendix A.** • Refer to *Adaptable SBCC Strategy, Step 2. Analyze the Situation* for guidance. Where possible, use the country-level data sources mentioned in this section. • Refer to the *Illustrative Analyze the Situation* for sample information. • Refer to *Appendix C. Breastfeeding Situation Analysis Questions.*					
Fill out the templates in **Step 3. Analyze the Audiences** from **Appendix A.** • Refer to *Step 3. Analyze the Audience* for guidance. • Refer to the **Illustrative Analyze the Audience** for sample information					
Fill out the template in **Step 4. Define a Message Strategy** from **Appendix A.** • Refer to *Part 1, Step 4. Define a Message Strategy* for guidance. • Refer to the *Illustrative Define a Message Strategy* for sample information. • Refer to *Appendix D. Key Messages for Breastfeeding.*					
Fill out the template in **Step 5. Determine Activities and Interventions** from **Appendix A.** • Refer to *Part 1, Step 5. Determine Activities and Interventions* for guidance. • Refer to the *Illustrative Determine Activities and Interventions* for sample information.					
Fill out the **Step 6. Plan for Monitoring and Evaluation** Template. • Refer to *Part 1, Step 6. Plan for Monitoring and Evaluation* for guidance. • Refer to the *Illustrative Plan for Monitoring and Evaluation* for sample information. • Refer to *Appendix E. Indicators.*					

What Do We Mean by SBCC and an SBCC Strategy?

SBCC is the practice of using the most powerful and fundamental human interaction—communication—to positively influence knowledge, attitudes and social norms. SBCC capitalizes on opportunities for change and addresses obstacles to change to help people change behaviors. SBCC recognizes that, while individuals have choice and responsibility, social context also influences behaviors. The social context can include the family, the community, values, and the environment in which change must take place. Structural considerations also matter, such as whether facilities and policies support the change or are barriers to change. For example, if we want pregnant women to get antenatal care (ANC), we must:

- Get women to want ANC and spend the time, energy and money needed to get it. (Individual)
- Get male partners and other family members to support women's seeking ANC services. (Social)
- Make getting ANC the normal thing to do in that

community—everybody does it, so everyone is expected to do it, and rarely does anyone seriously consider not doing it. (Social)
- Promote and provide ANC as part of workplace health programs. (Social and Structural)
- Advocate for having an ANC provider or facility within a reasonable walking distance for a pregnant woman or reachable with adequate transportation. (Structural)
- Advocate for policies that promote, enable and ensure adequate ANC staffing (including technical and interpersonal skills), equipment and supplies. (Structural)

What is the Role of A Promise Renewed in Child Survival?

Globally, the number of child deaths has dropped from nearly 12 million in 1990 to 6.9 million in 2011. Many countries have greatly reduced their very high child death rates. [1] While this is great progress, most of these 6.9 million children die from causes that we have the power to prevent, and from diseases that we can treat. We can do better.

In June 2012, more than 700 representatives from government, civil society and the private sector met to advance the Child Survival Call to Action. Evidence shows that most countries can make it so that fewer than 20 of every 1000 children born die before age five. To make this happen, governments and partners are uniting under the banner of A Promise Renewed to support joint action to reduce child deaths.

To help translate the Promise into action, partners in Religions for Action made "Ten Promises to Our Children" [www.apromiserenewed.org/files/Interfaith_Pledge_Child_Survival.pdf], focused on promoting, encouraging, and advocating for priority interventions and behaviors in health, nutrition, and other key areas related to child survival. The first promise on that list is to promote, encourage, and advocate for exclusive breastfeeding for the first six months of life.

The* Promise *in A Promise Renewed refers to Millennium Development Goal (MDG) 4, the world's promise to reduce under-five mortality by two-thirds between 1990 and 2015.* A Promise Renewed *is based on the idea that child survival is a shared responsibility.

What is the Role of Religious Leaders and Faith Communities?

In this I-Kit, "religious leader" refers to leaders within religious groups, and "faith communities" refers to people who belong to a religious group.

Religious leaders and faith communities are the largest and best-organized civil institutions in the world, claiming the allegiance of billions of believers and bridging the divides of race, class and nationality. More than any other civil society representatives, religious leaders have the experience of establishing and working with international partnerships. Their expertise can greatly benefit the global breastfeeding effort.

Religious leaders are often the most respected figures in their communities. Buddhist monks and nuns, imams, pastors, priests, punjaris, and leaders of other faith communities play a powerful role in shaping attitudes, opinions and behaviors because their members trust them. Community members and political leaders listen to religious leaders.

Especially at the family and community level, religious leaders have the power to raise awareness and influence attitudes, behaviors and practices. They can shape social values in line with faith-based teachings. At these levels, religious leaders can:
- Become aware of optimal breastfeeding practices and motivate their congregations to promote mothers' right to breastfeed.
- Motivate and educate followers to adopt other healthy behaviors that are compatible with religious teachings.
- Model appropriate and supportive behaviors. For example, women leaders with infants or young children can breastfeed, and male leaders and "mothers of the church" can support their wives and daughters in breastfeeding).
- Facilitate communication within families to create a more supportive environment for the woman who is breastfeeding.
- Remind families of the husband's responsibility to support the wife before and after childbirth.

- Influence communities and families to support women to only breastfeed for the first six months and to continue breastfeeding for the child's first two years.
- Establish breastfeeding support groups.
- Create space in their facilities for women to breastfeed in private during services and events if that is the norm or mothers' preference.
- Share messages about the benefits of breastfeeding and risks of sub-optimal feeding practices to parents.
- Connect with religious leaders and others to create a movement to support optimal breastfeeding practices.

Religious leaders also have the power to promote and support public policy that protects the health of mothers, children, and families. In the advocacy arena, religious leaders can:

- Magnify the voices of the poor where laws and policies are made.
- Influence the Ministry of Labor to make it easier for working women, for example, to exclusively breastfeed for six months.
- Influence the MOH to put in place policies to keep the mother and child together in the hours after birth so breastfeeding can begin right away.
- Advocate to the relevant Ministries not to distribute formula to mothers of children under six months old who do not really need it.
- Make it harder for companies to market infant formula to women who do not truly need it.

Religious leaders and faith communities can and do speak out for children. They are well placed to add their moral and spiritual leadership to the local and global effort to save lives by improving breastfeeding practices.

What Are the Breastfeeding Basics?

Breastfeeding's Impact on Child Survival
Breastfeeding in the first hour of life could prevent almost one million deaths every year.[2] Optimal breastfeeding of infants under two years of age has the greatest potential impact on child survival of all preventive interventions, with the potential to **prevent over 800,000 deaths (13 per cent of all deaths) in children under five** in the developing world (Lancet 2013).[3]

Breastfed children have **at least six times greater chance of survival** in the early months than non-breastfed children. The potential impact of optimal breastfeeding practices is especially important in developing countries that have a high burden of disease and low access to clean water and sanitation.

But non-breastfed children in industrialized countries are also at greater risk of dying. A recent study in the United States found a 25% increase in deaths among non-breastfed infants. In a UK survey, six months of exclusive breastfeeding was associated with a 53% decrease in hospital admissions for diarrhea and a 27% decrease in respiratory tract infections.[4]

Recommendations for Optimal Breastfeeding
UNICEF and WHO recommend that:

- Breastfeeding begin within one hour of birth.
- Babies receive only breast milk (not even water) for the first six months.
- Mothers actively breastfeed their babies (i.e., feed at least 10 times a day) for the first six months.
- Breastfeeding continue with safe, nutritious foods and drinks from 6 months until the child is at least two years old.

In addition, to breastfeed optimally, mothers need to keep up their strength. They should eat two extra meals a day of diverse, nutritious foods until the child is 2 years old and they stop breastfeeding.

More information about the benefits of breastfeeding and the risks of less-than-optimum breastfeeding practices can be found in Appendix B – "What are the Breastfeeding Basics?" [http://www.healthcommcapacity.org/hc3resources/appendix-b-breastfeeding-basics-1/].

Some Definitions and Helpful Terms

These definitions will help ensure a common understanding of terms used in this Kit.

Active breastfeeding: Responding to the child's hunger cues and encouraging the child to breastfeed.

Artificial feeding: Infant is fed only on a breast-milk substitute.

[2]Uruakpa, F. "Colostrum and its benefits: a Review". Nutrition Research, 2002, 22, 755-767, Department of Food Science, University of Manitoba, Winnipeg, Manitoba, Canada
[3]UNICEF – Nutrition – Breastfeeding, http://www.unicef.org/nutrition/index_24824.html
[4]UNICEF – Nutrition – Breastfeeding, http://www.unicef.org/nutrition/index_24824.html

Baby-friendly household hospital initiative (BFHHI): Launch by WHO/UNCIEF in 1991, this initiative ensure that all birthing hospital and centers become "centers of breastfeeding support." For more information, see https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/bfhi-worldwide.

Breast milk substitutes: Any food represented as a partial or total replacement for breast milk.

Breastfeeding week: A week (August 1-7) every year that is celebrated worldwide as a time for promoting optimal breastfeeding practices.

Child mortality rate: For every 1000 live births, the number of children who die before age 5.

Complementary feeding: From age six months, the child receives both breast milk and appropriate solid (semi-solid or soft) foods until the child is two years old. The type, amount and consistency of food will vary based on the child's age during this time.

Colostrum: Colostrum is the first milk from the mother, usually thick, sticky and yellowish. Colostrum should be fed to the baby after delivery. Colostrum is rich in protein and contains antibodies to protect babies from disease.

Exclusive breastfeeding: Giving only breast milk (not even water), whenever the baby wants to eat, at least 10 times each day. If needed, exclusively breastfed infants can be given ORS, medicines, vitamins and minerals.

Formative research: Research done before designing a project, strategy, or materials in order to inform the design. Formative research for developing an SBCC strategy must include qualitative research that sheds light on not only what audience members do but also why they do it. Qualitative research allows for a more in-depth understanding of people and their behaviors.

Formula: Artificial milk for babies made out of things such as sugar, animal milk, soybean, and vegetable oils. They are usually sold as a powder, to be mixed with water.

Gatekeepers: People who control or strongly influence what others can do. Gatekeeper for new mothers might include the mother's partner/husband, parents, and parents-in-law, for example.

Immune system: Immunity is the ability to resist something harmful. The human body has natural defenses against infection and diseases. These defenses are called the human immune system.

Innocenti declaration: A declaration designed by participants of a WHO/UNICEF policy-makers' meeting in 1990 that protects, supports and promotes breastfeeding. For more information, see: http://www.unicef.org/programme/breastfeeding/innocenti.htm.

Infant: A child under one year old.

Initial breastfeeding: The first time a baby is breastfed. Initial breastfeeding should take place within the first hour after delivery. Colostrum should be fed to the baby during this time.

International Code of Marketing of Breast-milk Substitutes: The World Health Assembly adopted this code to promote and protect breastfeeding. It states in part that there should be no promotion of breastmilk substitutes, bottles and teats to the general public; that neither health facilities nor health professionals should promote substitutes and that free samples should not be given out. Since 1981, 84 countries have enacted legislation implementing all or many of the provisions. For more information, see www.who.int/nutrition/publications/code_english.pdf.

Nutrition for breastfeeding mothers:
Breastfeeding mothers should eat two extra meals per day. All of her meals should consist of nutritious foods from seven food groups[5]:

1. Grains, roots and tubers
2. Legumes and nuts
3. Dairy products (milk, yogurt, cheese)
4. Meat, fish, poultry and liver/organ meats
5. Eggs
6. Vitamin A-rich fruits and vegetables
7. Other fruits and vegetables

Mixed feeding: Infant receives both breast milk and

[5]IYCF Guidelines, 2011

any other food or liquid including water, non-human milk, and formula before 6 months of age.

Optimal breastfeeding practices: The baby is fed colostrum (and nothing else) in the first hour after birth, is exclusively breastfed for the first 6 months, receives complementary feeding starting at 6 months, and is breastfed at least until age 2.

Pre-lacteal feed: Giving the newborn water, tea, herbs, formula or any substance other than colostrum after birth and before the first breastfeed.

Sub-optimal breastfeeding practices: artificial feeding, mixed feeding, pre-lacteal feed, withholding breast milk when the infant is hungry.

Religion and Breastfeeding

Every religious tradition emphasizes the beauty, sanctity and value of children.[6] Most of the world's religions place particular emphasis on the total care of the child. This care begins before birth. Once a child is born, one of the most important things a mother can do is breastfeed, and many religious texts treat breastfeeding as a right and responsibility and as an act of love, sacrifice, and kindness. For example:

- The mothers shall give suck to their offspring for two whole years… (The Holy Qur'an – s. Baqara [2:232])
- Like newborn infants, long for the pure spiritual milk, that by it you may grow up into salvation (Holy Bible, Peter 2:2)
- As he said these things, a woman in the crowd raised her voice and said to him, Blessed is the womb that bore you, and the breasts at which you nursed! (Holy Bible, Luke 11:27)
- Because of your father's God who helps you, because of the almighty who blesses you, with blessings of heaven above, blessings of the deep that lies below, blessings of the breast and the womb. (Holy Bible, Gen 49:25; Proverbs 10:22).
- Drink deeply of her glory even as an infant drinks at its mother's comforting breast" (Holy Bible, Isaiah 66:11)
- So she stayed home and nursed the boy until he was weaned, (Holy Bible, Samuel 1:23b)
- Yet you brought me safely from my mother's womb and led me to trust you at my mother's breast, (Holy Bible, Psalm 22:9)
- May four oceans, full of milk, constantly abide in both your breasts, you blessed one, for the increase of the strength of the child! Drinking of the milk, whose sap is the sap of immortal life divine, may your baby gain long life, as do the gods by feeding on the beverage of immortality!" (Susruta, III, 10)
- Whenever you want to do a bodily action, you should reflect on it: 'This bodily action I want to do — would it lead to self-affliction, to the affliction of others, or to both? Would it be an unskillful bodily action, with painful consequences, painful results?' If, on reflection, you know that it would lead to self-affliction, to the affliction of others, or to both… then any bodily action of that sort is absolutely unfit for you to do. But if on reflection you know that it would not cause affliction... it would be a skillful bodily action with pleasant consequences, pleasant results, then any bodily action of that sort is fit for you to do. (Ambalatthika-rahulovada Sutta)[7]

The following text also points to the role of faith leaders in communicating appropriate messages based on knowledge about child survival strategies:

- My people are destroyed from lack of knowledge. Because you have rejected knowledge, I also reject you as my priests because you have ignored the law of your God, I also will ignore your children. (Holy Bible, Hosea 4:6 NIV)

[6]Religions for Peace, Ibid.
[7]http://www.familybuddhism.com/buddhism_children.php

PART 1. SBCC STRATEGY FOR BREASTFEEDING: STRUCTURE AND GUIDANCE

This section provides a detailed overview of the steps in developing an SBCC strategy. Depending on the step, it provides definitions, reasons the step is important, advice on how to carry out the step, links to resources, and examples. **Templates used in the illustrative examples at the end of each step can be found here for download:** http://www.healthcommcapacity.org/hc3resources/appendix-kit-templates/.

Step 1. Define a Vision

The vision will help you frame the communication strategy by stating what the program hopes to achieve. It is what the "world" looks like when the projector program is complete. The stakeholders involved in the strategy design process should agree on the vision so that they all share the same one. This shared vision is a short statement that spells out what is important. It also shows what is desired in the future and guides the strategy development process.

The true vision should be realistic, concrete, and inspiring. It should provide direction, communicate enthusiasm, and foster commitment and dedication. Some organizations call the vision the "Goal" or the "Primary Objective." All other steps in the process should reflect and draw on the vision for guidance and inspiration.

Step 2. Analyze the Situation

What is a situation analysis?
A situation analysis is the systematic collection and study of information to identify trends, forces and conditions related to the problem you are trying to solve. In SBCC, it will help you gain a deeper understanding of the opportunities, challenges and barriers to change.

A situation analysis studies:

- The people affected and their needs.
- Social and cultural norms.
- Potential constraints on individual and collective change.
- Potential facilitators of individual and collective change.
- Audiences' access to and use of communication channels (such as brochures, television, and SMS).
- The status of the behavior in question, including the knowledge and practices of the audiences as well as policies that impact the behavior.

In short, the situation analysis describes where we are now.

The situation analysis should help you answer five big questions:

1. *What is the child health situation here that demands a breastfeeding intervention?*
2. *What are the current breastfeeding practices in this community/country?*
3. *Where, with whom, and to what extent do feeding practices need to be changed?*
4. *Who and what influence breastfeeding practices in the community/country?*
5. *What are the best ways to reach priority groups with breastfeeding messages and interventions?*

***F**BOs will want to be sure to identify faith-related assets they can use, such as religious texts and teachings, religious groups and leaders, groups within religious institutions such as women's groups, men's groups, religious broadcasts, and other available assets.*

Why conduct a situation analysis?
A good situation analysis provides a detailed picture of the current state of the health problem or behavior you want to address. This information is crucial for making decisions about what the SBCC strategy will entail and how it will be implemented. Ultimately, it affects how successful the strategy is.

How to Conduct a Situation Analysis
First, decide on a framework for presenting findings

in a useful way. We have used a simple framework to help focus the search for information:

Health and Breastfeeding Context
- Health Context
- Breastfeeding Context

Audience and Communication Analysis
- Individual Family and Community Level
- Health System Level
- Societal and Political Level

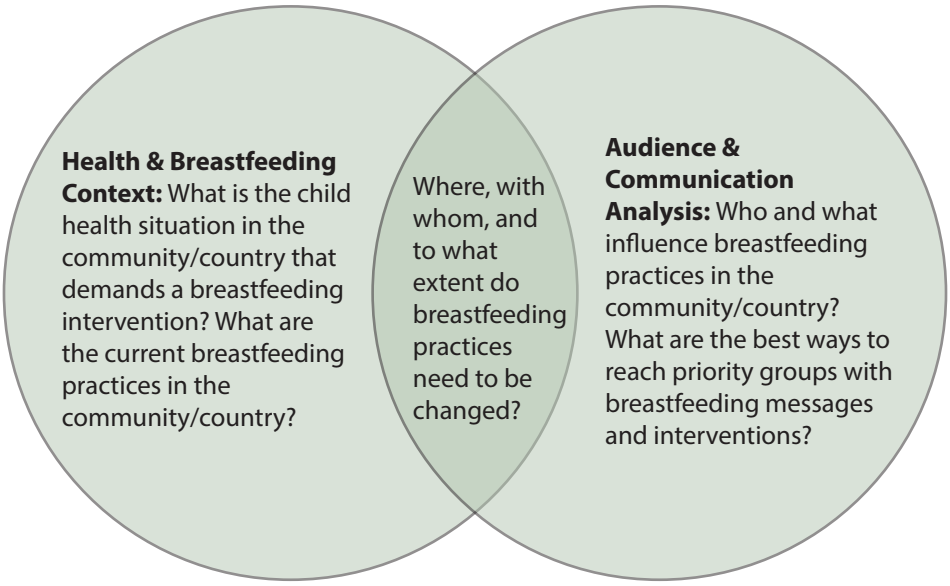

Figure 1. Situation Analysis Structure for SBCC for optimal breastfeeding practices.

Appendix C contains a comprehensive list of questions showing the type of information you need in order to develop a successful SBCC strategy. When considering your own national or sub-national situation analysis, keep in mind that you should carefully select questions that meet the particular needs of the program and the region. It is not necessary to use all of the sample questions listed.

Where to Find Information

Next, look at the information you already have or that is available from known sources. Save the Children's *Superfood for Babies* (www.savethechildren.org) and UNICEF's *Breastfeeding on the Worldwide Agenda* (www.unicef.org/eapro/breastfeeding_on_worldwide_agenda.pdf) provide global perspectives on breastfeeding issues and some country-specific information. Infant and young child feeding (IYCF) and RMNCH policies and guidelines might provide information and analysis of the breastfeeding situation.

Demographic and Health Surveys (DHS) (www.measuredhs.com/) and Multiple Indicator Cluster Surveys (MICS) (www.unicef.org/statistics/index_24302.html) should also have country-specific information. Some countries or country programs have employed national nutrition assessments that include breastfeeding. Also look for quantitative and qualitative research conducted by NGOs, Demographic Surveillance Sites, or private sector market researchers, such as Nielsen (www.nielsen.com/us/en.html).

How to Find Missing Information through Formative Research

Now decide if you have all the information you need, especially on the social and behavioral drivers of infant and young child feeding practices in your area. If you do not, decide how you will get the missing information. Typically, this can involve formative research through a stakeholder consultation, focus groups and interviews with members of primary and influencing audiences and/or facility surveys (health, social service, religious or other facilities). Interviewing priority audience members and

influencers is especially helpful in identifying local beliefs and practices as well as the reasons for them.

Formative research is an activity conducted at the beginning of the SBCC project design process. It is used to gain insight into the health issue or behavior the project intends to address; relevant characteristics of primary and secondary audiences; communication access, habits and preferences; and the main drivers of behavior. Formative research is critical to developing program materials, tools and approaches that are culturally and geographically appropriate. For tools and more information on how to conduct formative research, see the How to Conduct Qualitative Formative Research here: http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research. The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices provides formative research guidance and sample research tools.

How to Use the Situation Analysis

Organize the situation analysis findings in a way that makes them easy to use and helps you focus on the most important information, as in Table 1, below. (You can do this as you gather the information.) Factors associated with optimal and suboptimal breastfeeding practices can be individual, family, community, and structural. (Please note that Table 1 is included in the templates in Appendix A, but is not in the Illustrative Strategy since this is just an organizing structure for the information gathered within the situation analysis).

Table 1. Framework for organizing situation analysis findings

Audience	Current Behaviors	Factors Associated with Suboptimal Breastfeeding Practices	Factors Associated with Optimal Breastfeeding Practices
Primary Audience			
Mothers			
Grandmothers			
Influencing Audience			
Fathers			
Religious Leaders			
Faith Communities			
Community Health Workers			

Finally, select only a few key factors from Table 1 that the SBCC strategy will address. While it is tempting to address all factors, successful communication programs focus on the factors that will have the biggest impact given available resources. In your setting, where are you likely to have the most impact? Household beliefs and practices? Breastfeeding mothers busy working at home and on the farm? No (or not enforced) active breastfeeding policy in health facilities? Breastfeeding knowledge and counseling skills of health staff and volunteers? Another area/topic?

Table 2 offers a series of questions to guide the selection of priorities to address. It helps you think through what your findings mean and what you can do about them. As you think about your core problems, continue to ask "why" these problems exist. For example, if one core problem to optimal breastfeeding is that, "Women with the heavy workload stop breastfeeding after 2-3 months," ask why that is the case, and for each answer, ask "why" again until the root causes of the problem are clear. Note: Table 2 is included in the templates within Appendix A, but it is not included in the Illustrative Strategy – a brief example is included on the next page instead.

Table 2. Selection of strategic priorities			
What? (Core Problems)	**Why?**	**So What?**	**Now What?**
Data Collection: Key facts collected during the situation analysis.	**Root Cause Analysis:** Key facts collected during the situation analysis.	**Data Analysis:** Implications that the facts may have on the SBCC strategy.	**Strategic Priorities:** Identify which problems to address in the SBCC strategy. Limit to 3-5 strategic priorities in order to focus the plan.
Examples for breastfeeding:			
Women with a heavy workload stop breastfeeding after 2-3 months.	Why? Families expect them to work. Why? Husbands don't know about the importance of breastfeeding. Families need the extra income for food.	Interventions are needed to foster a support system within the family to help relieve a mothers' workload and support her breastfeeding practices.	Inform women and families of the child's need to breastfeed. Encourage family members (e.g., husbands and mothers-in-law) to help relieve mothers of their household responsibilities so they can practice optimal breastfeeding.
Source: Population Services International The DELTA Companion: Marketing Planning Made Easy. (http://www.psi.org/sites/default/files/publication_files/DELTA%20Companion.pdf)			

Step 3. Choose Intended Audiences

Segment the Audiences

Segmentation is the process of identifying groups of people who share similar interests and needs relative to the behavior you want to change. Sharing common characteristics makes the group members more likely to respond similarly to the SBCC activities. Segmenting allows for targeted use of limited resources. Segmenting allows you to focus on the groups that can create the most change. It also helps ensure that you choose activities that are the most effective and appropriate for specific audiences and helps you develop customized messages and materials.

The first step in audience segmentation answers the question, "Whose behavior must change in order to change the health situation?" The answer should be found in the key findings collected from the situation analysis.

Primary audiences are the key people to reach with messages. These may be the people who are directly affected and who you want to practice the desired behavior. Or they may be the people who make decisions for those who would benefit from the behavior. Primary audiences can be further segmented into sub-audiences. For breastfeeding, pregnant women and mothers of children under 2 years old are likely to be a primary audience.

Influencing audiences are people who can impact or guide behaviors of the primary audience. Influencing audiences can include family members and people in the community. They include people who shape social norms, influence policies, or affect how people think about the behavior. It is crucial to prioritize influencing audiences by how much they are likely to be able to impact change. For example, male partners are likely an influencing audience, but the level of influence (low, moderate, strong) may depend on country context or the behavior you want to change. Stakeholders should help prioritize influencing audiences. A table like the one below can be helpful.

Table 3. Sample prioritization of influencing audiences based on situation analysis findings			
	Primary Audience Influenced	**Estimated Power of Influence (Low, Moderate, Strong)**	**Current Attitude Towards Optimal Breastfeeding Practices**
Influencing Audience 1: Paternal Grandmothers (mothers-in-law)	Mothers with children under 2 years of age/ mothers-to-be	Strong	Supports nutrition for breastfeeding mothers but also advises pre-lacteal feed and early supplemental feeding. Helps relieve workload.
Influencing Audience 2: Husbands/Partners	Mothers with children under 2 years of age	Moderate	Supports breastfeeding for a few months only

Develop Audience Profiles

Audience profiles are key in an SBCC strategy. Audience profiles help bring to life each audience segment. This helps guide messaging and activity planning. The profile should show the characteristics of the audience. It should tell the story of an imagined person who is typical of the intended audience. Basing decisions on what could be a real person allows for better-defined and better-focused communication strategies. Consider that:

- The profile helps ensure the messages are tailored to members of this audience segment.
- If messages are tailored correctly, the key audiences will see themselves in the messages.
- Seeing themselves in the messages helps motivate them to take action.

Develop audience profiles for each audience segment using the information collected in the situation analysis. The profile typically starts with information such as age, income level, religion, sex, and where the person lives. It then adds details on current behaviors, motivation, emotions, values, and attitudes. The profile should mention the primary barriers to the desired behavior faced by the audience segment. (For example, the profile for a working mother of a 4-month old could indicate that her heavy workload in and outside of the home interferes with her ability to breastfeed exclusively.)

The profile can include a name and photo that represents this person. This helps staff see who this person is and understand his or her story. It is important to keep in mind that:

1. No two audience profiles look the same since the characteristics and behavior change factors vary for each audience segment.
2. The best profiles use qualitative research as a source.
3. Profiles are living documents that should be updated when new information becomes available.

If the information gathered in the situation analysis lacks detail on any audience segments, conduct additional research to address the gaps. For example, for all health provider audiences, it may be especially important to research provider attitudes and other factors that drive their behavior (such as policies, training, supervision, or resources). Use this information to better inform the audience profile and the strategy.

Step 4. Define a Message Strategy

The message strategy is one of the most important elements of a communication strategy. It ensures synergy, consistency, and coordination of objectives and messages across all stakeholders and partners. Each primary and influencing audience needs a message strategy. The message strategy includes (a) communication objectives, (b) positioning, and (c) key messages. Refer to audience profiles to ensure the objectives, positioning and key messages are appropriate for that representative individual. As the strategy is drafted, reviewed, and revised, verify that the message strategy and audience profile still match.

It is extremely important that all messages be pretested on the intended audience before they are

used more widely in order to make sure they the audiences understand them and like them. It will also ensure the you have the right cultural references and intent.

(a) Objectives
Communication objectives are measurable statements that clearly and concisely state what the target audience should think, feel, and do, as well as the timeframe required for the change. "SMART" objectives are Specific, Measurable, Attainable, Relevant, and Time-bound. The available evidence on the factors that drive the behavior of the selected audiences should determine what the communication objectives are. These measurable objectives help to determine whether or not the goal of the program was achieved.

(b) Positioning
Positioning is the heart of the SBCC strategy. Positioning identifies the most compelling and unique benefit that the behavior offers the audience. Effective positioning appeals to the emotions of the audience. Positioning presents the desired behavior in a way that is both persuasive and appealing to the audience. It shapes the development of messages and helps programs determine what communication channels to use. Positioning ensures that messages have a consistent voice and that all planned activities reinforce each other for a cumulative effect.

As part of the positioning, you will identify a key promise that highlights the main benefit associated with the proposed change. People change behavior, policies, and social norms only because they see a benefit to the change. That benefit must outweigh the personal cost of the change. An accompanying support statement, also called a "reason to believe", describes why the audience should believe the promise. This could be based on data, peer testimonials, a statement from a reliable source, or a demonstration. The key promise and support statement should include both emotion and reason.

(c) Key Messages
Key messages outline the essential information you will convey to audiences in all materials and activities. Messages cut across all channels and must reinforce each other across these channels. Effectiveness increases when all SBCC materials and activities communicate harmonized key messages that are expressed in different ways and build on each other.

Well-designed messages are specific to the audience. They also clearly reflect both positioning and a specific thing that drives or inhibits behavior (a behavioral driver). Key messages clearly describe the behavior the audience can and should do. Key messages are not the text that appears in print materials (including taglines), or the words that are used to define a campaign (slogans). They are the ideas those words convey.

Key messages are often included in a creative brief, which is a document developed for creative agencies or internal teams that guides the development of materials, media products and campaigns more broadly.

When developing key messages:
- Base them on country-specific formative research.
- Tailor them to each specific audience based on that audience's needs and characteristics.
- Address known drivers of behavior and barriers to behavior change in your community.
- Pre-test them with the audience and refine them based on audience feedback.
- Use non-technical language for non-technical groups.
- Emphasize doable actions for all groups.
- Emphasize positive immediate results of optimal breastfeeding while recognizing constraints for the mother and family and say how they might be overcome.
- Listen and learn—don't repeat the same messages and approaches that did not work well in the past, as you are unlikely to get different results.

Step 5. Determine Activities and Interventions

Activities and interventions allow for programs to convey key messages through a variety of communication approaches and channels (mothers' groups and mass media are two examples of channels for behavior change). Decide on messaging and channel selection together in order to effectively communicate with the intended audiences. Carefully

select activities based on the type of messaging, ability to reach the intended audience through channels they use, timeline, cost and available resources.

Use findings from the situation analysis to guide selection of activities and interventions.

A "Theory-Based Framework for Media Selection in Demand Generation Programs" [http://sbccimplementationkits.org/demandrmnch/ikitresources/media-selection/] can help inform channel selection decisions based on communication theory. Table 4, below, is an overview of strategic approaches. Any SBCC program should include activities across a range of different intervention types and communication channels. All selected interventions and channels should communicate mutually reinforcing messages. It is also important to link with other programs and systems. The following are examples of potential areas for linkages when designing an SBCC program for breastfeeding:

- Other FBOs, NGOs, and civil society organizations.
- Other MCH programs that may or may not currently emphasize breastfeeding.
- Nutrition programs, especially IYCF programs.
- Women's ministries and support programs (e.g., mothers' groups, men's groups, prayer groups).
- Quality of care improvement initiatives for service providers/clinics.
- Pre-service education, continuing education, and in-service refresher training initiatives for clinical and non-clinical providers.
- Labor rights initiatives.
- Other cross-sectoral programs (e.g. child welfare, education, economic empowerment).

Table 4: Overview of Strategic Approaches that can be used in SBCC
Advocacy: Advocacy operates at the political, social, and individual levels to mobilize political and social commitment for social change and/or policy change. Advocacy aims to create an environment to ask for greater resources, encourage fair allocation of resources, and remove barriers to policy implementation. **A Guide for Advocates and Journalists for Helping Advance Infant and Young Child Nutrition in Ethiopia** (http://www.aliveandthrive.org/sites/default/files/Women%27s_Association_Guide-2014.pdf) provides resources for raising awareness and engaging stakeholders in addressing nutrition-related gaps in policy.
Community Mobilization: Community mobilization is a participatory process through which individuals, groups, or organizations plan, carry out, and evaluate activities to improve lives of community members. A successful community mobilization effort not only solves problems but also increases the capacity of a community to identify and address its own needs. It can include activities such as rallies, public meetings, folk dramas, folk songs and sporting events. FBOs could think of their sermons and prayer meetings as a type of community mobilization. For guidance on community mobilization, see Tearfund's Mobilizing the Community: A PILLARS Guide (http://www.thehealthcompass.org/sbcc-tools/mobilising-community-pillars-guide) and Mobilizing the Church: A PILLARS Guide (http://www.thehealthcompass.org/sbcc-tools/mobilising-church-pillars-guide).
Interpersonal Communication/Counseling: Interpersonal communication and counseling is on one-to-one communication and is often done with a trusted and influential communicator such as a religious leader, counselor, teacher, health provider or even volunteer. Counseling tools or job aids are usually produced to help improve these interactions. Those who will use the tools and aids should be trained to use them effectively. The Linkages Project web site has links to breastfeeding counseling information as well as counseling cards developed in several countries http://www.linkagesproject.org/tools/ccards.php.
Distance Learning: Distance learning provides a learning platform that does not require attendance at a specific location. Rather, the students access course content from channels such as radio or the Internet and interact with their teacher and classmates through letters, telephone calls, SMS texts, email, chat rooms or internet sites. Distance learning courses can train clergy, lay leaders, communication specialists, community mobilizers, health educators, and service providers. Additional information on eLearning can be found at Global Health eLearning Center and PEPFAR eLearning Initiative.

Information and Communication Technologies (ICTs): ICTs are platforms for enabling communication and promoting the exchange of information through technology. ICTs include computer technologies, mobile phones, and the use of SMS and social media such as Facebook, Twitter, Linked In, blogs, e-Forums, Springboard, and chat rooms. This approach also includes web sites, e-mails, listservs, eLearning, eToolkits, and message boards. Digital media can disseminate tailored messages to the intended audience on a large scale while also receiving audience feedback and encouraging real-time conversations, combining mass communication and interpersonal interaction. "A Theory-Based Framework for Media Selection in Demand Generation Programs" and "Utilizing ICT in Demand Generation for Reproductive, Maternal, Newborn and Child Health: Three Case Studies and Recommendations for Future Programming" [http://sbccimplementationkits.org/demandrmnch/ikitresources/utilizing-ict-new-media/] are useful resources for program managers looking to utilize ICT in SBCC activities.
Mass Media: Mass media can reach large audiences cost-effectively through radio, television, and newspapers. According to a review of mass media campaigns, those that follow the principles of effective campaign design and are well executed can have a small to moderate effect not only on health knowledge, beliefs, and attitudes, but on behaviors as well (Noar, 2006). Given the potential to reach thousands of people, a small to moderate effect will have a greater impact on public health than would an approach that has a large effect but only reaches a small number of people.
Social Mobilization: Social Mobilization brings relevant sectors such as organizations, policy makers, networks, and communities together to raise awareness and empower individuals and groups for action. It also allows them to work together towards creating an enabling environment and effecting positive behavior and/or social change.
Support Media/Mid-Media: Mid-media's reach is less than that of mass media but can be useful in supporting SBCC. It includes posters, brochures, billboards, and other materials

Other helpful tips for designing SBCC interventions:

- Engage target audience members and other stakeholders in the design of interventions to ensure their views and realities are reflected.
- Design interventions that allow target audiences to discover for themselves rather than just be told what is right. One example is facilitated discussions using cue cards.
- Design interventions that stimulate discussion of barriers and how to overcome them.

Step 6. Plan for Monitoring and Evaluation (M&E)

Monitoring and Evaluation (M&E) is a critical part of any program activity because it tells you if you are doing what you said you would do and if what you are doing is working. It can also tell you why it is (or is not) working. It is important to develop an M&E plan before beginning any monitoring activities so that there is a clear plan for what questions about the program need to be answered. It will help program staff decide:

- How they are going to collect data to track indicators.
- How monitoring data will be analyzed.
- How the results of data collection will be distributed both to the donor and internally among staff members for program improvement.

Remember, M&E data alone is not useful until someone puts it to use! An M&E plan will help make sure data is being used efficiently to make programs as effective as possible. For more information on how to develop an M&E plan, see the How to Develop an M&E plan. For more information on identifying objectives and output, see How to Develop a Logic Model.

Some planning for M&E should be included in the communication strategy, such as identifying the indicators that are directly related to the SBCC objectives. The objectives and indicators should be developed based on formative research. Measuring them should tell you whether the key messages and interventions are having the desired effect on the target audience. A full M&E plan should then be developed as a separate program document. Guidance on developing an M&E plan and for developing indicators is available in the online I-Kit.

A full set of how-to documents for planning and conducing M&E are available.

Indicators

M&E indicators should include process, output, outcome and impact indicators. The process/input indicators are what was done. The output is who was reached. The outcome is what affect that reach had. And the health impact is the higher-level result of the campaign—how much breastfeeding interventions contributed to improved child health.

In other words, process indicators track how the implementation of the program is progressing. They help to answer the question, "Are activities being implemented as planned?" Some examples of process indicators are:

- Number of trainings held with health providers.
- Number of outreach activities conducted at youth-friendly locations.
- Number of condoms distributed at youth-friendly locations.

Outcome indicators track how successful program activities have been at achieving program goals. They help to answer the question, "Have program activities made a difference?" Some examples of outcome indicators are:

- Number and percent of youth using condoms during first intercourse.
- Number and percent of trained health providers offering family planning services to youth.
- Number and percent of new STI infections among youth.

Table 5 describes these different types of indicators. For more information about creating indicators, see How to Develop Monitoring Indicators. For sample indicators for measuring optimal breastfeeding practices, see Appendix E.

Table 5. Types of M&E Indicators

Process Indicators	Program Output Indicators	Behavioral Outcome Indicators	Health Impact Indicators
Measure what was done through the program	Measure who was reached through the program activities	What affect that reach had on behaviors	Measure changes in health outcomes
Example: Number of counseling training workshops held for MCH nurses	Example: Number of key audience members counseled by MCH nurses	Example: Percentage increase in number of mothers of 0-6 month olds who are exclusively breastfed among populations exposed to the intervention and populations not exposed to it	Example: Percentage of under-5s found to be malnourished according to a standard measure of malnutrition

PART 2. AN ILLUSTRATIVE SBCC STRATEGY FOR BREASTFEEDING

Step 1. Define a Vision

Early and exclusive breastfeeding for the first six months is the norm in our communities. Women and families provide the right foods at the right time. Breastfeeding mothers eat at least two extra, nutritious meals a day. And more and more mothers practice active breastfeeding for at least two years. Families, service providers, congregations, businesses, faith-based texts and sermons and government and industry polices support these actions.

Importantly, the examples we provide are intended to demonstrate a wide range of possibilities that could be used. Individual programs need to decide what works best within their country context based on their situation or audience analysis, and budget and resource constraints.

Step 2. Analyze the Situation[8]

Health and Breastfeeding Context

Most of the information in this section is a global-level analysis for purposes of illustration. The country-specific situation analysis should focus on the local health and breastfeeding context.

Health Context: Since 1990 there has been huge global progress in reducing child mortality. Five million fewer children died in 2011 than in 1990. It is starting to look like we can end preventable child deaths. But making that happen requires quite a bit more change.

Malnutrition still is a major factor in one-third of child deaths. This means we are not reducing malnutrition fast enough. Unless malnutrition is solved, it will continue to hold back progress in other areas of child health. Also, while overall child death rates are falling, more of those deaths now occur within the first month of life.

Breastfeeding Context: Breastfeeding saves lives. There is no doubt about it. One can argue that it is the single best way to reduce child malnutrition and save newborn lives. Breast milk contains all the food and water the baby needs in the first six months of life. Really. The first milk the mother produces is called colostrum. Colostrum is the most powerful natural immune system booster known to science.[9] It is so helpful to the newborn that some people call it "liquid gold". Almost a million newborn deaths could be prevented every year if all infants were given breast milk in the first hour of life.

The benefits of breastfeeding for babies continue even after that critical first hour. Infants fed only breast milk for the first six months are protected against major childhood diseases. A child who is not breastfed is 15 times more likely to die from pneumonia and 11 times more likely to die from diarrhea.[10] Breastfeeding could prevent around one of every eight young child deaths.[11,12]

But breastfeeding is not valued nearly as much as it should be. Progress made in raising breastfeeding rates in the 1980s has slowed, stopped, or even reversed in some countries. Globally, only 43% of children are breastfed within the first hour of life and only 37% of children are exclusively breastfed for the first six months.[13] Progress is possible: 27 countries have increased their exclusive breastfeeding rates by more than 20 percentage points in 10 years.[14] Other countries are experiencing stagnation and even declines in exclusive breastfeeding. According to recent national data, two-thirds of the 92 million children who are not exclusively breastfed are in just 10 countries, and seven of those countries (India, China, Nigeria, Indonesia, Philippines, Ethiopia and Vietnam) have very high child mortality rates.[15] Common practices (to be discouraged) include:

- Denying the newborn colostrum.

[8]Much of the content in this section is adapted from Superfood for Babies: How overcoming barriers to breastfeeding will save children's lives. Save the Children, 2013.
[9]Uruakpa, F, 'Colostrum and its benefits: a review', Nutrition Research, 2002, 22, 755–767, Department of Food Science, University of Manitoba, Winnipeg, Manitoba, R3T 2N2, Canada.
[10]UNICEF, Pneumonia and Diarrhoea: Tackling the deadliest diseases for the world's poorest children, 2002
[11]Mullany, L, Katz, J, Yue M Li, Subarna, K, Khatry, S, LeClerq, C, Darmstadt, GL, and Tielsch, JM, 'Breast-feeding patterns, time to initiation, and mortality risk among newborns in southern Nepal', Journal of Nutrition, March 2008, 138(3): 599–603
[12]UNICEF, Pneumonia and Diarrhoea: Tackling the deadliest diseases for the world's poorest children, 2012
[13]UNICEF, The State of the World's Children 2012
[14]UNICEF, World Breastfeeding Conference, December 2012
[15]Save the Children, 2013

- Giving other foods or liquids before starting breastfeeding.
- Giving formula or milk instead of breastfeeding.
- Giving formula, water, teas, traditional mixtures or food in addition to breast milk within the first six months—in many cases, foods are given when the child is two or three months old.
- Feeding under-two year olds food that is too difficult to digest or not nutritious enough.

Sub-optimal feeding practices are even common in many settings where breastfeeding for the first two years (or longer) is the norm.

Audience and Communication Analysis
Decisions affecting breastfeeding are made at various levels: the individual/family/community level, the health system level, and the society or policy level. It helps to look at the factors affecting breastfeeding behaviors at each of these levels separately. For example, FBOs tend to be particularly well-placed to act at the individual/family/community level. They can also be quite good at impacting the other levels, especially if the FBO operates health facilities or has a high-profile leader who is able to influence policy and business. Many sources were consulted to provide this global breastfeeding situation analysis.

Individual, family and community level: Despite clear evidence that early and exclusive breastfeeding is the best way to care for newborns, many mothers are given bad advice, are pressured into harmful alternatives or do not have enough time to breastfeed exclusively because they have to return to work or household chores. Common reasons for sub-optimal breastfeeding practices are highlighted in Table 6.

Table 6. Common reasons given for sub-optimal breastfeeding practices

Harmful Practice	Common Reasons for It
Pre-lacteal feed	• To clean the newborn's stomach/intestines. • Belief that breast milk is not yet ready. • Belief that there is not enough breast milk. • To purge the first stool. • Traditional or religious beliefs or practices.
Withholding colostrum	Religious or traditional beliefs; belief that colostrum is old, unhealthy, unclean or hard to digest.
Non-exclusive breastfeeding in the first 6 months (mixed feeding or artificial feeding)	• Difficulty breastfeeding (Caesarean section, pain, not latching, cracked nipples, etc.). • Illness of mother or child. • Lack of knowledge about how and how often to breastfeed. • Lack of time due to chores or to work outside the home. • Belief that the mother does not produce enough milk to satisfy the child. • Belief that even infants need water in hot weather conditions. • Belief that formula is better than breast milk. • Shame of breastfeeding in public. • Belief that child is ready for other foods and drinks because they think it will make them stronger than breastmilk alone. • Belief that cow's milk or various foods will help the child grow better. • Lack of knowledge about or ability to safely express and store breast milk. • Lack of knowledge of the benefits of breast milk – including the antibodies and other protective substances it contains. • Fear that the child will become dependent on breast milk and not eat if the mother is away for any reason (for work, illness, death, other reasons.)

[16]Save the Children, 2013; Qiu et al. 2009; Yotebieng et al. 2013; Setegn et al. 2012; Egata et al. 2013; Inayati et al. 2012

Table 6. Common reasons given for sub-optimal breastfeeding practices	
Harmful Practice	**Common Reasons for It**
Inappropriate supplemental feeding in months 6-24	• Lack of knowledge about what foods are appropriate at what ages. • Belief that certain nutritious foods are harmful for the child. • Lack of resources to get appropriate foods. • Common practice for young children to eat what the rest of the family eats. • Traditional practice for fathers to be given the most nutritious foods.
Stopping breastfeeding before 24 months	• Many of the reasons mentioned above. • Belief that breastfeeding cannot be re-established if stopped for health or other reasons. • Taboos against sexual activity while breastfeeding. • Taboos against breastfeeding while pregnant. • Social status associated with infant formula. • Return to work.
Inadequate nutrition for breastfeeding mothers	• Tradition of limiting what breastfeeding mothers can eat. • Lack of knowledge of importance of extra and more nutritious meals. • Tradition of giving the most nutritious foods to the father. • Belief that certain nutritious foods can harm the mother or breastfeeding child. • Lack of resources to get more nutritious food.

In addition, many women are not free to make their own decisions about whether they will breastfeed, or for how long. Instead, in some countries and communities, it is often husbands or mothers-in-law who decide. Fear of passing HIV to the newborn can also reduce breastfeeding, but studies show that breast milk remains the healthiest alternative even when the mother is HIV positive.

At the individual, family and community level, several factors have been shown to improve breastfeeding practices:[17]

- Social, community and family support
- Positive social norms around breastfeeding
- Correct information
- Practical support from a knowledgeable and experienced person—relative, neighbor, health worker, religious institution member
- Maternities and workplaces with baby-friendly policies

Health system level: One-third of infants are born without a skilled birth attendant present.[6] As a result, the opportunity to support mothers to breastfeed in the first few hours can be lost. An analysis of data from 44 countries[7] found that women who had a skilled attendant present at birth were twice as likely to breastfeed within the first hour. However, it has also been found that many skilled birth attendants are unaware of the importance of breastfeeding within the first hour, give in to pressure from families to withhold breast milk, or actually discourage women from starting breastfeeding early (for example, because they feel the mother is too weak).[18]

Delivery room set-up and procedures, such as removing the infant from the mother right after birth for more than an hour, can discourage or prevent early breastfeeding. In addition, mothers having trouble breastfeeding before leaving the health facility might not get the support they need from overwhelmed nurses. Health systems have improved breastfeeding practices by:

- Having medical personnel, including community health workers and birth attendants, provide skilled support and correct advice.
- Having a companion (e.g., supportive family member) in the delivery room with the mother.
- Having maternities with "baby-friendly" policies such as the Baby-Friendly Hospital and Community Initiative, [http://www.who.int/nutrition/topics/bfhi/en/] launched in 1991 by WHO and UNICEF.
- Helping parents decide before delivery to exclusively breastfeed and create a plan to do so.

[17]UNICEF, C4D Orientation Webinar Series 2011-12, 2010 version
[18]Tawiah-Agyemang et al. 2008, Haider et al. 2010

Societal and political level: Returning to work after the birth of a child is difficult for any mother. Continuing to breastfeed can be very challenging for working mothers—even those who work at home or on the family farm.

For mothers who work outside the home, three areas of national policy play a key role in a woman's ability to breastfeed:

- Maternity leave.
- Financial protection to help maintain the family's income while the mother is not working.
- Workplace provisions to allow breastfeeding to continue once a mother returns to work.

To promote exclusive breastfeeding, women must receive enough paid maternity leave. Ideally this would be 14-18 weeks' leave with at least two-thirds pay. Most less-developed countries do not meet this standard. Back a work, there must be policies in place that require employers to provide paid breaks and private places where women can breastfeed or express milk.

Women in informal jobs also face problems in continuing to breastfeed when they return to work. They are often unable to take their children with them farm or to do household chores such as collecting firewood and water. For these women, state grants and social protection (such as social security payments or cash benefits) that do not depend on formal maternity leave are even more important.

FBOs can play a key role by:

- Organizing household and community savings plans that families can access in the months when the mother is working less in order to breastfeed more.
- Assisting with household costs or chores.
- Providing childcare that encourages women to express milk for feeding during the day.

It is true that certain infants need to be formula-fed. However, it seems that formula is marketed in a way that encourages mothers to prefer it even though their babies do not need it. Marketing images and mixed messages might not make it clear that formula can actually put children at risk.

Factors at the socio-political level that limit optimal breastfeeding practices include:

- Widespread promotion of breast milk substitutes
- No commercial advocate for breast milk, unlike infant formula
- HIV transmission

Factors at the socio-political level shown to encourage optimal breastfeeding practices include:

- Workplaces with appropriate mother and baby friendly policies
- 3-6 month maternity leave policies
- Limiting promotion of infant formula

Table 7 combines Tables 1 and 2, above, so programs can see how the situation analysis findings drive the choice of interventions.

Table 7. Strategic prioritization of situation analysis findings

Audience	Current Behaviors	Factors Associated with Suboptimal Breastfeeding Practices	Factors Associated with Optimal Breastfeeding Practices	So What	Now What
Primary Audience					
Mothers					
Grandmothers					
Influencing Audience					
Fathers					
FB Leaders and Communities					
Policy Makers?					
Community Health Workers?					

Step 3. Choose Intended Audiences

Potential audiences for improving optimal breastfeeding practices include expectant and new mothers, fathers, grandmothers and other caregivers, faith leaders and communities, other community leaders and the broader community, political leaders and others. (Note: The audience information in this example comes from studies from many countries. You will need to consult or conduct local research on breastfeeding beliefs and practices and health provider knowledge, attitudes, and practices about optimal and local infant/child feeding practices in your location. Use local research to define the primary and influencing audiences and to inform the audience profiles and strategy. The people who most influence infant feeding may vary by and within countries and communities.)

Primary and Influencing Audience Segments (with rationale for their selection)
PRIMARY AUDIENCES
Primary audience 1: Pregnant women and mothers of children 0–24 months old – Pregnant women and new mothers are the primary caretakers of infants. Unless a wet nurse or milk bank is used, mothers are also the only ones who can produce breast milk for their children. Women knowing and using optimal breast-feeding practices can improve their child's survival chances, health, and development. (Note: If needed, you can divide these women into even more targeted segments according to education, age, ethnic group, and other factors. Local research will show what characteristics matter for breastfeeding behaviors and what communication channels best reach them each segment.)
Primary audience 2: Grandmothers (of the child) and family members who provide newborn care –Grand-mothers and other relatives often help with feeding and care when the mother is away, resting or busy. Therefore, it is important to reach them with information about breastfeeding and the risks of introducing other food and drink too early. Mothers and fathers often also place a high value on the advice and knowl-edge of family elders when making decisions about feeding a new baby. Grandmothers in particular often have a strong voice in decisions about infant and child feeding. They can be a strong force in maintaining or changing social norms and cultural practices regarding infant feeding.
INFLUENCING AUDIENCES
Influencing audience 1: Fathers – While newborn care may be seen as "women's responsibility," the father of the child can have a strong influence on breastfeeding practices. If the father is supportive, the mother is more likely to continue breastfeeding and eat more nutritious foods more often while breastfeeding. If the father believes early supplementation is better for the child, the mother is more likely to add other food and drink early. And if the father supports the mother in getting antenatal and postnatal care, the mother is more likely to go. Also, if the father supports the mother in attending antenatal and postnatal visits, the mother is more likely to attend. As well, fathers can be supportive of reducing a mother's workload so they have time to practice active breastfeeding. Educating fathers and helping them to be supportive is crucial to increasing optimal breastfeeding practices.
Influencing audience 2: Faith communities – Faith communities can be recruited to help make optimal breastfeeding practices the normal things for their members and communities to do. They can show how important breastfeeding is using religious texts and traditions. They can foster safe discussions about barri-ers to breastfeeding and actions to overcome them within faith-based support groups. They can spread the word about the benefits of maternal nutrition, breastfeeding and the risks of mixed and artificial feeding. They can model appropriate behaviors—for example, they can look favorably on mothers who breastfeed on demand. They can support mothers who have trouble breastfeeding. They can encourage family mem-bers to support mothers—by helping reduce her workload, for example. They can encourage fathers to be supportive and helpful to breastfeeding mothers.
Influencing audience 3: The communities– Community norms play a large role in breastfeeding practices. Helping communities change their expectations and beliefs about breastfeeding can be crucial to sustaining improved breastfeeding practices over time.

Primary and Influencing Audience Segments (with rationale for their selection)

Influencing audience 4: Policymakers – Policymakers can ensure Baby-Friendly Hospital programs are widely implemented. They can prioritize SBCC programs that increase breastfeeding. They can introduce policies to increase maternity leave so mothers can easily practice exclusive breastfeeding longer. They can ensure funding to temporarily supplement family income while a mother stays home to breastfeed. They can restrict marketing of infant formula. (Faith and other community leaders are often in a position to advocate with political leaders for such changes.)

Audience Profiles

PRIMARY AUDIENCE 1: PREGNANT WOMEN AND MOTHERS OF INFANTS 0-24 MONTHS

Halima, 34, expectant mother living outside of Abuja, Nigeria
Halima is pregnant, married, with 3 boys, ages 9, 6, and 4. She attended Qur'an school as a girl. Her first child died soon after birth, at home. She had her next child at the district hospital and the third one at home alone because the baby came too fast. The next time, she stayed with a relative who lived closer to the health center as her due date approached.

Halima keeps a small vegetable plot and owns a few chickens; she earns extra money selling vegetables and eggs. She wants her children to attend school, so she saves as much money as she can. Her husband has gone to the capital city to find better work. He comes home some weekends and sends money to her mobile phone when he can. Halima's house has an old latrine, and she gets water from a nearby stream.

Halima attends the community health talks when the health worker comes several times a year. She has been preparing for some time for the birth of this child. Even though she is six months pregnant, she has not yet had time to go to and wait at the ANC clinic. She plans to do so this month. The nearest health center is 10 kilometers away, and she plans to deliver there. She has breastfed all of her children for around two years, but has given them water almost from the beginning. She has given them porridge and whatever the family ate by the third or fourth month.

Sunita, 21, Lamjung, Nepal.
Sunita has given birth twice without her husband being there. Her first child was born when her husband was working abroad. Sunita was only 18 years old and had been married just one year.

She lived with her in-laws and assumed the traditional role of the daughter-in-law. This role included full responsibility for the household chores, even throughout her pregnancy. Unaware of the importance of antenatal check-ups or even the location of the nearest health post, Sunita never sought formal healthcare. When she felt ill, she consulted local traditional healers for advice.

She gave birth at home, assisted only by a few local women. Her first child died within fifteen days of birth. During her second pregnancy, she ate more regularly and was more cautious about straining herself doing household chores. She delivered a baby girl at home, who is now 4 months old, and has since resumed her heavy workload.

Sunita feeds her daughter a little porridge and some water because she fears her breast milk is not enough and her baby cries all the time. She also feels that she doesn't have enough time to breastfeed every time the baby is hungry.

Ria, 26 years old, Bawadesolo, Nias Island, Indonesia.
Ria is married and just found out she is pregnant with her 3rd child. Her first child died soon after birth, at home. She did not live long enough to be breastfed, as the custom is to throw away colostrum. She had her second child at the district hospital and was told to breastfeed right away. (She did not tell her mother-in-law that she gave the first milk to the newborn.) That child is now 11 months old.

Ria plans to stop breastfeeding now that she is pregnant again. She is worried about what the child will eat since her family is quite poor. In addition to managing her household she sells vegetables in the local market. She has heard from relatives in the city that infant formula is good for the baby and would give her more time to do other things. She wants to try it but is not sure she can afford it. Her mother and older sisters give her lots of advice.

Audience Profiles

PRIMARY AUDIENCE 2: GRANDMOTHERS AND FAMILY MEMBERS WHO PROVIDE NEWBORN CARE

Mrs. Tiwari, 57, grandmother, Deoghar District, Jharkhand State, India.
Mrs. Tiwari is very proud that her son is married, has one child plus a new one on the way, and that he has a job to provide for his family. Her daughter-in-law is respectful and is good at keeping the home. They get along well.

Mrs. Tiwari raised four healthy children by asking her own mother-in-law for advice and remedies, and she expects her daughter-in-law to consult with her on how to care for the new baby. Her family has a long tradition of feeding newborns a special tea just after birth and throwing away all colostrum. She is certain that this cleans the insides of the child and prepares it to breastfeed once the "normal" milk arrives. Mrs. Tiwari cares about her family's reputation but also wants the best for her family.

Ms. Tiwari listens to the radio and speaks to her friends at the temple each morning. They share stories about their families.

Miriam, 40, older sister, Kinshasa, DR Congo.
Miriam is 40 years old and has given birth to 7 children with the help of a traditional birth attendant. One of her children died within weeks of his birth. Another died before age 2. Some of her deliveries were difficult, but most of her children survived. She believes the old ways are good ways since they have worked for generations. All of her children were breastfed, and she started giving thin porridge when they seemed to need it, at 3 or 4 months.

When the government opened a health center in her village, she began taking her children for immunization. Nonetheless, she rarely seeks treatment at the government health center, preferring to seek assistance from her long-trusted healer. She is helping her much younger sister prepare for the birth of her first child and will be there when the child is born.

INFLUENCING AUDIENCE 1: FATHERS

Marco, married father, 30, Atauro, Timore-Leste.
Marco, married father, 30, Atauro, Timore-Leste. Marco has two children, ages 8 months and three years. He works in construction and has worked consistently for the past few years. He is happy and proud that his wife is expecting their third child. They do not normally discuss the pregnancy or what happens at her ANC visits – that is the women's domain. He does, however, comment on what the children eat and how well they are growing.

Marco is proud that his children are healthy and that he is able to support his wife so she can stay at home and take care of the children. He is responsible for making decisions for his family on everything from health care to education to regular purchases. Marco doesn't know much about breastfeeding except that almost all women do it at some point. He likes feeding his young children as soon as he can because it gives them quality time together. He finds his wife more attractive when she is not breastfeeding.

Thomas, 35, married father of one, living in Kadoma, Zimbabwe
Thomas is 25 years old with one wife. They are expecting their first child. A devout Christian, he believes it is his role to make all of the important decisions for his family after consulting with his wife. As is the tradition, family elders also have certain expectations and offer advice and wisdom. Both he and his wife must work long hours. His wife has mentioned that the ANC nurse told her she will need to buy infant formula when she returns to work. He has never accompanied his wife to the ANC clinic, but he is not sure that is good advice.

Audience Profiles

Haider, 40, married father of three, living in rural Chittagong, Bangladesh
Haider completed 7 years of formal education and works for a local merchant. His home has electricity, a tin roof and a toilet. He watches TV with neighbors but has his own mobile phone. A TBA delivered Haider's one-month old child. Haider's mother is staying with the family for the newborn's first 45 days. After that, his wife will have to resume all her normal chores. His wife did not attend ANC because he did not believe it was necessary and would have had to go with her. He believes all babies need water in addition to breast milk. He is proud to be able to buy tinned milk for his baby as well. Lately, the baby has been crying a lot and not sucking well. He hopes he will not have to take the baby and his wife to the health clinic, as that will cost him time and money.

INFLUENCING AUDIENCE 2: FAITH LEADERS AND FAITH COMMUNITIES

Moussa, 57, religious leader in Niamey, Niger.
Moussa is 57 years old and has four children. He serves as a religious leader in his village. The men and women in his community look to him for his knowledge and wisdom on life matters as well as religious matters. He welcomes opportunities to improve health in his area, and new health programs often consult him before starting. He has a healthy, hard-working family with a very productive farm. His first wife died in childbirth. The child was never breastfed and survived for only a few weeks. He knows first-hand how hard this was for him and his other children

INFLUENCING AUDIENCE 3: COMMUNITY LEADERS AND MEMBERS

Lin, female community leader, 40, Thanlyin township, Myanmar
Lin leads a local women's group and has five children. She wants to see the condition and position of women in her community improve. Her group holds monthly meetings where they discuss problems and what is going well. They also share solutions and things they have learned. Each month they focus on a specific topic. They also discuss whatever attendees are concerned about at that time.

Group members contribute a small sum of money each month to give to the member whose turn it is to receive. The women use this money for special purchases – seeds, equipment, preparing for a new child, health care, or large household items, for example.

Lin knows the life history of everyone in the group and regularly visits them. She listens and gives advice. She has seen too many babies in her village die within the weeks after birth. She believes in some traditional ways, but she also sees the value in modern ways, including modern health care.

Step 4. Define a Message Strategy

Reminder: It is important to remember that audiences respond better to "small doable actions" rather than requests to make big changes all at once. Similarly, it is important to note that fewer messages will have a greater impact and that providing too many messages runs the risk of losing and confusing your audience. Between three to five messages per audience is usually a good rule to follow. The sample messages here and in Appendix C provide a wide range of possibilities that could be used. Individual programs need to decide what works best within their country context based on their situation or audience analysis.

When deciding on your message strategy,	
Don't:	**Do:**
• Use generic messages with no discussion of WHY and no context. • Focus only on the benefits of BF & not on risks of artificial or mixed feeding. • Use messages that the audience will not see as important to them. • Expect single big events to be adequate on their own (e.g., World Breastfeeding Week).	• Discuss the "why" and context. • Design messages that can be used across multiple channels. • Only include objectives the program can measure. • Select positioning that will strongly appeal to the audience segment. • Emphasize benefits valued by the audience segment.

PRIMARY AUDIENCE 1: PREGNANT WOMEN AND MOTHERS OF CHILDREN 0-24 MONTHS
OBJECTIVES
From 2014 to 2019, increase the number or percentage of pregnant women and mothers of children 0-24 months, at all levels of parity and marital status, who: 1. Have seen or heard messages about how breastfeeding needs to start within the first hour and colostrum should be the first thing newborns are fed (target is 500,000). 2. Are aware that exclusive breastfeeding means giving the infant only breast milk for the first six months except medicine or ORS prescribed by a health care provider (increase to 95%). 3. Are aware that breastfeeding mothers need to eat two additional nutritious meals every day (increase to 80%). 4. Have asked for breastfeeding advice from health care providers (increase to 70%). 5. Have asked for breastfeeding advice from health care providers and women who have successfully breastfed their children (increase to 70%). 6. Start breastfeeding within the first hour and give colostrum to the newborn (increase to 70%). 7. Exclusively breastfeed for the first six months (increase to 70%). 8. Eat two extra meals a day of diverse foods that include some protein such as eggs, chicken, meat or fish while breastfeeding (increase to 65%). 9. Provide appropriate complementary foods according to WHO after six months and continue to breastfeed until the child is at least two years old (increase to 65%).
POSITIONING
Optimal breastfeeding gives your baby a good start in life. It is a given in our faith and in many ways a natural vaccine.
KEY PROMISE
Early and exclusive breastfeeding for the first six months and complementary feeding until age two will prevent all kinds of illnesses and could save your baby's life. Your child will be healthier and quite possibly smarter.

PRIMARY AUDIENCE 1: PREGNANT WOMEN AND MOTHERS OF CHILDREN 0-24 MONTHS

SUPPORT STATEMENT

All over the world and in communities like yours, babies who are breastfed are much less likely to get common childhood illnesses such as diarrhea and pneumonia. They are also much less likely to die. If all newborns were given breast milk in the first hour life, many more of them would survive that first critical month. Infants who are not breastfed until they are one or two days old can be three or four times more likely to die. Young infants given some foods and liquids in addition to breast milk can be four times more likely to die than exclusively breastfed young infants. Introducing water, tea, formula, and other foods too early can expose them to harmful bacteria. These foods also do not have all the nutrients and immunity-building properties that breast milk has. Feeding these foods to babies means that they consume less of the more beneficial breast milk than they need. Our religious texts have always recognized the importance of breastfeeding not only for food but also for comfort and closeness.

KEY MESSAGES

- Breast milk is the only thing your child needs for the first 6 months after birth. God designed breast milk specifically for the infant's best growth and development. Even HIV+ mothers should breastfeed.
- Feed your baby the first milk (colostrum) within one hour of birth. Colostrum contains many natural substances to protect your child's health—things not found anywhere else. Other foods or liquids can hurt the newborn's stomach and bowels.
- Breastfeed whenever your child is hungry—at least 10 times every day—emptying one breast before moving the baby to the other one. The more you breastfeed, the more milk you will produce. Keep breastfeeding even when the child is sick, to help him/her regain strength.
- Your religion supports and encourages exclusive breastfeeding, and so does your community.
- If you have any trouble breastfeeding, ask a trained counselor (from health facility, faith community, CHW, or other) for help.
- Eat more often than you normally would—one extra meal if you are pregnant and two extra meals when breastfeeding—and eat plenty of fruits, vegetables, legumes, eggs and meat/fish/chicken.
- Once your child has reached 6 months of age, continue to breastfeed whenever he or she wants it. Also give the child age-appropriate foods and clean water. You can stop breastfeeding when the child is 2 years old (but you don't have to).
- Continuing to breastfeed protects your child from illnesses and reduces the risk of malnutrition.

Reminder: *Key messages must be tailored to the specific context. Different regions or ethnic groups have different reasons for their breastfeeding practices and different beliefs about colostrum, what makes babies grow, and related issues. To be effective, messages must address relevant benefits, concerns, and practices. They should be based on evidence from well-conducted studies designed to shed light on people's breastfeeding beliefs and practices. In addition to highlighting benefits, breastfeeding messages should emphasize the risks of mixed feeding within the first six months and artificial feeding. Provide key information and actions audience members can take in a simple, easy-to-understand, non-threatening, respectful way.*

PRIMARY AUDIENCE 2: GRANDMOTHERS AND FAMILY MEMBERS WHO PROVIDE NEWBORN CARE

OBJECTIVES

From 2014 to 2019, increase the percentage/number of grandmothers and family members who:

1. Have seen or heard messages that colostrum improves newborn survival and long-term health and development (target is 300,000).
2. Have seen or heard messages that infants should be exclusively breastfed for the first six months (target is 300,000).
3. Have stopped encouraging lactating women to give other foods/liquids in the first six months after being exposed to messages about exclusive breastfeeding (60% of those exposed).
4. Have promoted exclusive breastfeeding to a new mother in the past year after being exposed to messages about exclusive breastfeeding (60% of those exposed).
5. Have encouraged mothers to breastfeed in the first hour after delivery and give colostrum to the newborn after being exposed to messages about colostrum (60% of those exposed).
6. Have taken some of the mother's workload so she has more time to rest and to breastfeed the baby at least 10 times a day (55% of those exposed).

POSITIONING

Ensuring early and exclusive breastfeeding from birth is the best and most natural thing families can do for their newest member to give them a good start in life. Our faith presumes this, and the whole world is re-learning it.

KEY PROMISE

The Qur'an, Bible, and other religious teachings highlight the benefits of breastfeeding. Grandmothers and other family members are practicing their faith when they take steps to ensure the best possible care of the newborn. In many communities, grandmothers and other family members help the new mother breastfeed successfully.

Early and exclusive breastfeeding for the first six months is one of the first and most important choices made for the newborn. Infants who are not breastfed until they are one or two days old can be three or four times more likely to die. Infants given some foods and liquids in addition to breast milk during the first six months can be four times more likely to die than exclusively breastfed young infants. Caregivers who help encourage breastfeeding and discourage mixed feeding have a very positive impact on their families.

SUPPORT STATEMENT

All over the world and in communities like yours, babies who are breastfed are much less likely to get common childhood illnesses such as diarrhea and pneumonia. They are also much less likely to die. If all newborns were given breast milk in the first hour life, many more of them would survive that first critical month. Infants who are not breastfed until they are one or two days old can be three or four times more likely to die. Young infants given some foods and liquids in addition to breast milk can be four times more likely to die than exclusively breastfed young infants. Introducing water, tea, formula, and other foods too early can expose them to harmful bacteria. These foods also do not have all the nutrients and immunity-building properties that breast milk has. Feeding these foods to babies means that they consume less of the more beneficial breast milk than they need. Our religious texts have always recognized the importance of breastfeeding not only for food but also for comfort and closeness.

PRIMARY AUDIENCE 2: GRANDMOTHERS AND FAMILY MEMBERS WHO PROVIDE NEWBORN CARE

KEY MESSAGES

Key messages for grandmothers and other caregivers should emphasize the benefits of breast milk and the risks of formula and mixed feeding.

- Help ensure your grandchild's best health, growth and development by supporting his/her mother to give only breast milk from birth until the child is 6 months old. Help her make this decision while she is still pregnant. Breast milk–including the first milk (colostrum)–has all the food and water the child needs for the first 6 months.
- Except for medicine from the clinic, anything else given to the baby makes the mother produce less milk and increases the chances that the child will be malnourished and get sick in the first 6 months.
- Do whatever you can to help ensure the mother has the time and energy to breastfeed as often as the child wants it—including helping with housework and ensuring she eats lots of healthy food.
- Breastfeeding is also good for the health of mothers – it is economical and safe. It increases bonding.

INFLUENCING AUDIENCE 1: FATHERS

OBJECTIVES

From 2014 to 2019, increase the percentage or number of fathers who:

1. Has seen or heard messages about optimal breastfeeding practices (target is 300,000).
2. Can recite at least three health benefits of breastfeeding (80% of those exposed).
3. Can recite at least two ways that husbands can support breatfeeding mothers (65% of those exposed).
4. Can recite that one of those ways is to help with her workload (65% of those exposed).
5. Has advised mothers to exclusively breastfeed for the first six months (55% of those exposed).
6. Has assisted the mother with chores and child care so that she is able to breastfeed on demand (50% of those exposed).
7. Support their breastfeeding mother to eat two extra meals a day by allowing her to eat a variety of food during mealtimes, including proteins (55% of those exposed).
8. Encourage the breastfeeding mother to eat larger portions of food during mealtimes (55% of those exposed).

POSITIONING

Given how important your child is to you, exclusive breastfeeding, complementary feeding starting at 6 months, and continued breastfeeding for 2 years can be your family's only choice. It's what God intended and it gives your child the best, healthiest start in life.

KEY PROMISE

Early and exclusive breastfeeding for the first six months and continued breastfeeding with complementary feeding from age 6 months to 2 years greatly improve your child's chances of surviving childhood, being healthy, and developing the abilities he or she is meant to have. You will feel pride knowing that you are providing the best for your children and family, and giving your children the best start in life and a better future. You will be happy knowing you acted responsibility as a father, making the right choices and seeing them through.

INFLUENCING AUDIENCE 1: FATHERS

SUPPORT STATEMENT

Religious teachings highlight the benefits of breastfeeding. The Qur'an specifically states that:

- Children should be breastfed for 2 years.
- The mother and father together should decide when to wean the child.
- The father must support the mother and child.
- The mother should not be mistreated because she is doing what is best for the child.

Modern studies support the importance of breastfeeding. These studies show that children who are breastfed according to global guidelines are more likely to survive than children who are not. They are also healthier in general and get diarrhea and respiratory infections a lot less. Studies also show that mothers are more likely to breastfeed if the father is supportive and encouraging. Your role is more important than you know.

KEY MESSAGES

Key messages for fathers should focus on their roles, the benefits of breastfeeding, and the risks of mixed and formula feeding.

- You play a crucial role in helping your partner decide to give your baby only breast milk for the first six months.
- Breastfeeding is not only the best and most inexpensive feeding, exclusive breastfeeding for the first 6 months can reduce the chance of your partner getting pregnant again too soon.
- You can support your partner by helping out with household tasks and child care so she has have more time to breastfeed.
- Breast milk is far superior to infant formula in nutrition, protective effects and safety.
- Breastfeeding improves your child's chances in life by helping ensure his or her best health, growth and development.
- After six months and until the baby is at least 2 years old, support your partner to continue breastfeeding while also feeding nutritious foods.
- You and your wife don't have to abstain while she breastfeeds. Intercourse has no impact on breast milk.
- Fathers can feed the baby milk expressed from the mother if they want to help feed babies less than 6 months.

INFLUENCING AUDIENCE 2: RELIGIOUS LEADERS

OBJECTIVES

From 2014 to 2019, increase the percentage or number of faith leaders who:

1. Have seen or heard messages about the links between optimal breastfeeding and faith (target is 10,000).
2. Can recite at least one religious rationale for breastfeeding (80% of those exposed).
3. Can recite at least three health benefits of breastfeeding (60% of those exposed).
4. Can recite at least two risks of mixed feeding or of not breastfeeding (60% of those exposed).
5. Has promoted optimal breastfeeding practices in at least one sermon or religious publication (target is 7,000).
6. Since being exposed to messages, has encouraged fathers and other family members to assist mothers with chores and child care so that she can breastfeed on demand (80% of those exposed).
7. Oversee at least one breastfeeding promotion activity (target is 5,000).

POSITIONING

God intended for women to breastfeed their children and mandated that we care for the most vulnerable. Given the emphasis on children in our religious texts and traditions, religious leaders have the moral authority to help families adopt optimal breastfeeding practices.

INFLUENCING AUDIENCE 2: RELIGIOUS LEADERS

KEY PROMISE

Early and exclusive breastfeeding for the first six months and continued breastfeeding with complementary feeding from age 6 months to 2 years greatly improve children's chances of surviving childhood, being healthy, and developing the abilities God meant them to have. Doing everything you can to support optimal breastfeeding can help you fulfill your mission.

SUPPORT STATEMENT

Religious teachings highlight the benefits of breastfeeding. The Qur'an specifically states that:

- Children should be breastfed for 2 years.
- The mother and father together should decide when to wean the child.
- The father must support the mother and child.
- The mother should not be mistreated because she is doing what is best for the child.

Modern studies support the importance of breastfeeding. These studies show that children who are breastfed according to global guidelines are more likely to survive than children who are not. They are also healthier in general and get diarrhea and respiratory infections a lot less. Studies also show that mothers are more likely to breastfeed if they receive support from society and those around them.

KEY MESSAGES

Key messages for religious leaders should focus on their roles, the benefits of breastfeeding, and the risks of mixed and formula feeding.

- Breastfeeding is natural and important part of God's plan—make it easy for mothers to breastfeed wherever and whenever the child is hungry, even at temple/during services.
- Breast milk is God's gift to newborns and young children. It provides all the food and water the child needs for the first 6 months. It protects the child from illness and malnutrition. It comforts the child and strengthens the mother-child bond.
- Teach about the benefits/importance of breastfeeding and allow others to do so—through sermons, visitation, mothers' groups, and other activities.

Many faith communities have more than one level of leadership. The following messages are for those who have more direct contact with members than the most senior leader might.

- Your leadership role puts you in a good position to help improve breastfeeding practices and by doing so improve health and save lives in your community.
- Giving young babies formula or anything else instead of breast milk increases their risk of infection, malnutrition, and mental deficiency.
- Plan and implement care groups, prayer groups, and workshops that teach and support optimal breastfeeding practices.
- Support families to exclusively breastfeed for six months and continue breastfeeding at least until the child is two years old.
- Encourage family, including fathers, and community members to take some of the mother's workload so she has more time to rest and breastfeed. This helps ensure that the baby is a healthy addition to your community.

INFLUENCING AUDIENCE 3: FAITH COMMUNITIES

OBJECTIVES

From 2014 to 2019, increase the percentage or number of faith community members who:

1. Have seen or heard messages about the benefits of breastfeeding (target 500,000).
2. Can recite at least two health benefits of breastfeeding (75% of those exposed).
3. Can recite at least two risks of mixed feeding or of not breastfeeding (75% of those exposed).
4. Have encouraged fathers and other family members to assist the mother with chores and child care so that she is able to breastfeed on demand (65% of those exposed).
5. Have encouraged families to ensure that breastfeeding mothers get two extra meals each day (65% of those exposed).
6. Have organized or participated in at least one breastfeeding promotion/support activity (60% of those exposed).

POSITIONING

God intended for women to breastfeed their children and mandated that we care for the most vulnerable. Given the emphasis on children in our religious texts and traditions, faith communities should want to help families adopt optimal breastfeeding practices.

KEY PROMISE

Early and exclusive breastfeeding for the first six months and continued breastfeeding with complementary feeding from age 6 months to 2 years greatly improve children's chances of surviving childhood, being healthy, and developing the abilities God meant them to have. Doing everything you can to support optimal breastfeeding can help you fulfill your mission.

SUPPORT STATEMENT

The Qur'an, Bible, and other religious teachings emphasize the benefits of breastfeeding. The Qur'an specifically states that:

- Children should be breastfed for 2 years.
- The mother and father together should decide when to wean the child.
- The father must support the mother and child.
- The mother should not be mistreated because she is doing what is best for the child.

Modern studies support the importance of breastfeeding. These studies show that children who are breastfed according to global guidelines are more likely to survive than children who are not. They are also healthier in general and get diarrhea and respiratory infections a lot less. Studies also show that mothers are more likely to breastfeed if she receives support from society and those around her.

KEY MESSAGES

Key messages for faith communities should focus on their roles, the benefits of breastfeeding, and the risks of mixed and formula feeding.

- Breast milk is a free gift from God. It provides all the nutrition and water a baby needs for the first six months. It helps protect children from illness. It strengthens the mother-child bond.
- Your close relationship with others in your faith puts you in a good position to help improve breastfeeding practices. By doing so improve the health and wellbeing of children in your community.
- Giving babies formula instead of breast milk increases their risk of infection, malnutrition, and cognitive impairment (mental deficiency).
- Support families to exclusively breastfeed for six months and continue breastfeeding at least until the child is two years old.
- Support mothers so they have more time to rest and breastfeed. This helps ensure that the baby is a healthy addition to your community.

Step 5. Determine Activities and Interventions

SBCC approaches, activities and illustrative examples are presented here as potentially appropriate choices for communicating with audiences about breastfeeding. These suggestions are a starting point—you might think of others that fit your situation well. Include in your strategy only the approaches and activities you have the resources and experience to carry out successfully. Close collaboration with communication and creative professionals can help ensure that design and execution are innovative and compelling.

Please note that FBO messaging about breastfeeding should be consistent with national and local efforts. It can be integrated into essential newborn care, IYCF, MCH, and SBCC efforts.

Reviews from many successful countries have shown that success on breastfeeding can be achieved by:

- Doing all of the right things (comprehensive, evidence-based package, based on assessment of needs and situation).
- At all levels (national, health system, community, communication).
- In the right way (applying best practices, using effective strategies, providing appropriate training & supervision).
- For everyone (national scale and ensuring equity).
- All the time (sustained, ongoing implementation, fully institutionalized).

Some FBOs might need substantial support to plan and implement such a comprehensive program, so it is important to find out what others are doing (or willing and able to do) to increase optimal breastfeeding and to collaborate and coordinate with them when possible. For example, if a larger NGO or the MOH is implementing a mass media campaign, the FBO might:

- Implement peer support through mothers' groups, prayer groups or other supportive groups.
- Use religious services to deliver breastfeeding messages that reinforce the mass media effort.
- Train and send experienced mothers to maternity wards to support women just learning to breastfeed.
- Organize community dialogues on the importance of optimal breastfeeding and risks of not breastfeeding.
- Organize workshops or one-on-one sessions where women learn how to practice optimal breastfeeding, including correct positioning and active feeding.
- Organize workshops where women learn what, when, and how to prepare appropriate foods for complementary feeding.

If the FBO has a health facility, it should also institute the Baby Friendly Hospital Initiative (BFHI) [http://www.who.int/nutrition/topics/bfhi/en/] and ensure appropriate staff are trained and doing what they are supposed to do to promote and facilitate early and exclusive breastfeeding. FBO health facilities can also ensure breastfeeding counseling and materials are provided to anyone seeking MCH services.

Key breastfeeding interventions proven to be effective include:

- Legislation to protect breastfeeding
- Institutionalizing the BFHI/10 Steps
- Counseling & support through primary health care (integrated IYCF counseling)
- Counseling & support by trained community cadres (integrated IYCF counseling)
- Mother to mother support groups in the community
- Implementation an evidence-based comprehensive communication strategy

Depending on country context, it may also be important to have interventions that address policy and practice (including pre-service education), supply, and monitoring.

Mass Media			
INTERVENTION AREA	**ILLUSTRATIVE ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**

Local mass media	• Develop sermons that promote breastfeeding. Disseminate them by radio, TV, CD/DVD, web.
	• Develop radio and TV spots on breastfeeding. For example:
	  • Real women breastfeeding and talking about how it improves their and their child's life.
	  • Grandmothers sharing what they have learned and witnessed about the benefits of colostrum, exclusive breastfeeding, and supporting the workload.
	  • Women of all social strata who breastfeed instead of giving formula; emphasis on how much nicer, cleaner, and safer it is.
	
	(A successful TV spot in Viet Nam showed babies talking about the benefits of breastfeeding and one baby asking its mother to breastfeed only).
	• Integrate breastfeeding and other newborn care topics into a multi-episode radio serial on MNCH.
	• Produce radio call-in shows with breastfeeding as a health and nutrition topic.
		• Increase awareness and knowledge of benefits.
		• Increase acceptability of optimal breastfeeding practices.
		• Depict role models practicing desired behaviors; stimulate social dialogue about everyone's role in protecting maternal and child health.
		• Answer listener questions to further dispel myths and provide accurate information.
		• Shift social norms around breastfeeding.
			• Pregnant women/ new mothers
			• Grandmothers and other caregivers
			• Fathers
			• Faith communities
			• Broader communities
			• Spots will also reach some health providers, faith leaders, and political leaders

Print media	• Develop/adapt take home brochures/ leaflets on breastfeeding, stickers to remind women to seek help if they are having trouble breastfeeding. • Posters • "Overcoming the barriers" action cards • Circulars with religious justification, sermon excerpts	• Increase awareness about breastfeeding benefits and formula/ mixed feeding risks. • Reminder audiences of key messages.	• Pregnant women/ new mothers • Fathers • Faith communities
Digital media and mHealth	• Produce SMS service on breastfeeding benefits, breastfeeding tips, reminders of when and where to go for help, encouragement (including religious references). • Develop SMS messages reminding pregnant women to decide to breastfeed, and to give the first milk. • Host infant and young child feeding hotline (phone and/or SMS-based). • Where appropriate, social media pages on breastfeeding. • Develop short video clips and short FAQs that model breastfeeding promotion and education (accessible on basic and smart phones).	• Increase awareness. • Stimulate social dialogue. • Increase knowledge and skills.	• Pregnant women/ new mothers • Fathers • Faith communities

Community-Based Services, Outreach and Community Approaches			
INTERVENTION AREA	**ILLUSTRATIVE ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**
Traditional birth attendant (TBA) outreach	• Train TBAs to advise giving colostrum, assist with positioning child for initial breastfeeding, and recommend exclusive breastfeeding for the first six months and continued breastfeeding from 6-24 months. • Develop/adapt materials and job aides (practice dolls, flipbooks, pictorial checklists, etc.) to provide guidance for counseling on breastfeeding. • Develop certificate or laminated card showing TBA as having completed breastfeeding/IYCF training.	• Improve knowledge and skills. • Improve linkages with faith community and health system. • Acknowledge TBA value.	TBAs
Community Health Worker (CHW) outreach	• Train CHWs to conduct community-based breastfeeding education and counseling. • Establish CHW radio listening groups for distance learning program. • Develop/adapt materials and job aides (practice dolls, flipbooks, pamphlets, checklists, referral cards, etc.) to provide guidance on breastfeeding and IYCF counseling including problem solving. • Develop songs, logos, buttons, badges, and other items that support the central positioning and promotion of acceptability.	• Improve knowledge and skills. • Provide peer-supported learning opportunities. • Ensure quality counseling, education and referral. • Promote optimal breastfeeding practice as the new norm. • Provide incentive.	CHWs
Community approaches	• Promote healthy lifestyles including optimal breastfeeding, and hygiene, into spirituality during sermons or other religious teachings. • Hold awareness raising campaigns around optimal breastfeeding during Breastfeeding Week (August 1-7 every year). • Hold community dialogues around newborn health, especially breastfeeding using breastfeeding mothers, grandmothers, fathers, and other family members as key advocates. • Invite respected clergy and health professionals to speak and answer questions. • Incorporate breastfeeding as a key topic for faith-based women's groups. • Organize support groups for mothers. • Organize discussion groups for grandmothers, other family members and community leaders as appropriate. • Use FBO events to promote optimal breastfeeding practices. • Organize community events that promote optimal breastfeeding practices as the norm—perhaps in conjunction with other MNCH or nutrition practices—such as community theater, world breastfeeding week events, etc.	• Encourage social dialogue on relevant breastfeeding topics • Increase social. support for optimal breastfeeding practices. • Decrease social support for mixed and formula feeding. • Create/improve environment for cultural shift. • Increase breastfeeding prevalence and duration.	• Pregnant women • Grandmothers • Fathers • Communities • TBAs

Community-Based Services, Outreach and Community Approaches			
Peer Educators/ Champions	• Find satisfied mothers to use as community advocates. • Coach peer educators/champions on key messages. • Identify "everyday heroes" - grandmothers in the community who support optimal breastfeeding practices and are helping to ensure the health of their families. • Celebrate them at community events and through community and mass media. • Identify women and family members who have suffered the loss of a newborn or constant childhood illness and are now using optimal breastfeeding practices to save other families from such both. Have them speak at community meetings, in mass media, at work where appropriate, and one-on-one with their neighbors.	• Encourage social dialogue on preventing neonatal deaths. • Increase social support for optimal breastfeeding practices.	• Women • Grandmothers and other caregivers • Fathers and communities

Structural			
INTERVENTION AREA	**ILLUSTRATIVE ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**
Policy and guidelines	• Advocate to public and private sector leaders to adopt and enforce policies and procedures that promote and allow for optimal breastfeeding practices (e.g., breastfeeding rooms, etc.). • Distribute up-to-date breastfeeding guidelines for use at all health facilities. • Distribute policy/guidelines to companies that produce or market infant formula. • Update monitoring and supervision tools to include breastfeeding counseling, baby-friendly delivery rooms, and other BFHI indicators. • Twitter feed on international, national, and local impact of breastfeeding; FBO breastfeeding activities, progress and lessons learned; and other relevant information. • Allowing breastfeeding in religious institutions and/or during religious services/celebrations.	• Increase knowledge. • Ensure appropriate guidelines. • Ensure practice matches policy.	Health district and facility decision-makers and implementers
Pre-service, in-service, on-the-job, and refresher training	• Integrate optimal breastfeeding practices and counseling into pre-service, in-service, on-the-job and refresher training at all FBO institutions (for all providers including doctors, nurses, midwives, physician assistants, CHWs, and pharmacists).	Increase awareness and practice.	Health providers

Structural			
Digital/distance learning	• Develop short video clips and print FAQs that model education and counseling that can be disseminated via video, smartphones, tablets and online. • Use Twitter or other social media as a discussion forum to share program implementation ideas, problems, and solutions.	Increase and refresh knowledge and skills.	• ANC providers • Skilled birth attendants • Supervisors of CHWs
Other continuing education	• Offer breastfeeding counseling workshops and online courses that include up-to-date guidelines and best practices. • Distribute updated breastfeeding job aids.	Increase awareness and improve practice.	Professional associations for health providers

Step 6. Plan for Monitoring and Evaluation

The following indicators are examples of the types of things your program will want to monitor and evaluate. Base your indicators on your SBCC objectives and plan. Select only indicators that are feasible to measure and will tell you whether or not you are succeeding.

Pregnant women and mothers of children 0-24 months

- Proportion of women in 3rd trimester who say they plan to exclusively breastfeed.
- Proportion of women who say they believe colostrum is good for the newborn.
- Proportion of mothers of children 0-24 months who report giving their newborn colostrum.
- Proportion of women who correctly define exclusive breastfeeding.
- Proportion of women who know how long to exclusively breastfeed.
- Proportion of mothers of children 0-24 months who report they exclusively breastfeed/ breastfed.
- Length of time mothers of children 0-24 months exclusively breastfed.
- Proportion of women who know who to ask for breastfeeding advice.
- Proportion of mothers of children 0-24 months who continue to breastfeed while providing complementary foods from six months until 2 years of age.
- Proportion of mothers of children 0-24 months who know to continue breastfeeding even when the child is sick.
- Proportion of breastfeeding mothers of children 0-24 months who know about needing to eat 2 additional nutritious meals daily from the 4 food groups until they stop breastfeeding.
- Proportion of breastfeeding mothers of children 0-24 months who consume 2 extra meals daily while breastfeeding.
- Proportion of mothers of children 0-24 months who report seeing/hearing breastfeeding messages on radio/TV.
- Proportion of mothers of children 0-24 months who report they would recommend breastfeeding to other women.
- Proportion of mothers of children 0-24 months who believe optimal breastfeeding leads to healthier babies.
- Proportion of mothers of children 0-24 months who have discussed optimal breastfeeding practices with friends or family.
- Proportion of mothers of children 0-24 months who recall program messages and materials on optimal breastfeeding practices.

Fathers of children 0-24 months

- Proportion of fathers of children 0-24 months who know at least three health benefits of breastfeeding.
- Proportion of fathers of children 0-24 months who say they believe that breast milk is all the nutrition and water a baby needs for the first six months.
- Proportion of fathers of children 0-24 months who say they encouraged and supported the choice to exclusively breastfeed for the first six months.
- Proportion of fathers of children 0-24 months who report they helped the mother with chores and childcare.

Grandmothers and other caregivers

- Proportion who are aware that colostrum improves newborn survival and long-term health and development.
- Proportion who report they allow the feeding of colostrum to the newborn.
- Proportion who are aware that breast milk is enough for the first six months.
- Proportion who report no use of formula or mixed feeding in the first six month.s
- Proportion who report providing appropriate complementary foods to infants in their care after six months.
- Proportion who say they approve of breastfeeding for at least two years.
- Proportion who report recommending exclusive breastfeeding and other optimal breastfeeding practices to family members at least once.

Religious leaders and faith communities

- Proportion who can quote at least one religious rationale for breastfeeding.
- Proportion who know at least three health benefits of breastfeeding.
- Proportion who know at least two risks of mixed feeding or of not breastfeeding.
- Proportion who promote optimal breastfeeding practices in at least one sermon or religious publication.
- Proportion who encourage fathers and other family members to assist the mother with chores and child care so that she is able to breastfeed on demand.
- Proportion who encourage families to ensure that breastfeeding mothers get two extra meals each day.
- Proportion of faith leaders and faithful who oversee, organize or participate in at least one breastfeeding promotion/support activity.

BREASTFEEDING RESOURCES ON THE WEB

General

Alive & Thrive, an initiative to improve infant and young child nutrition by increasing rates of exclusive breastfeeding and improving complementary feeding practices.
http://www.aliveandthrive.org/

Every Newborn, an action plan to end preventable deaths, focuses attention on newborn health and identifies actions for improving survival, health and development.
http://www.everynewborn.org

Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) promotes healthy environments, identifies practices that protect children from disease, and advocates for access to appropriate measures to prevent and treat pneumonia and diarrhea.
http://www.who.int/maternal_child_adolescent/documents/global_action_plan_pneumonia_diarrhoea/en/

Healthy Newborn Network, an online community dedicated to addressing critical knowledge gaps in newborn health. HNN is a platform for organizations and professionals to exchange experiences; disseminate information; and increase coordination, collaboration and co-generation of knowledge to advance newborn health.
http://www.healthynewbornnetwork.org/topic/breastfeeding

La Leche League International, seeks to help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information, and education.
http://www.lalecheleague.org/ links to country programs and information by language.
http://www.llli.org/toolkit has 1-2 pagers for mothers, family members, and other caregivers on various topics, including breastfeeding problem-solving)

Scaling Up Nutrition (SUN), is founded on the principle that all people have a right to food and good nutrition. It unites people—from governments, civil society, the United Nations, donors, businesses and researchers—in a collective effort to improve nutrition. *http://scalingupnutrition.org/*

Superfood for Babies, Save the Children
http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SUPERFOOD%20FOR%20BABIES%20ASIA%20LOW%20RES%282%29.PDF or access the link from
http://www.savethechildren.org/site/c.8rKLIXMGIpI4E/b.8565981/k.141A/Superfood_for_Babies_Breastfeeding_Report.htm?msource=pcolpbfr0213

Ten Commandments of Breastfeeding
http://www.alternamoms.com/nursing.html

World Health Organization (WHO)
http://www.who.int/topics/breastfeeding/en/

Advocacy

Breastfeeding on the Worldwide Agenda, UNICEF
Executive Summary: *http://www.unicef.org/eapro/breastfeeding-worldwide-Executive-Summary.pdf*
Full report: *http://www.unicef.org/eapro/breastfeeding_on_worldwide_agenda.pdf*

A Guide for Advocates and Journalists for Helping Advance Infant and Young Child Nutrition in Ethiopia:
http://www.aliveandthrive.org/sites/default/files/Women%27s_Association_Guide-2014.pdf

Religions for Peace, Day of Prayer and Action: ABC for Action & Advocacy
http://www.dayofprayerandaction.org/take-action/abc-for-action-advocacy

World Alliance for Breastfeeding Action (WABA), a global network of individuals and organizations concerned with the protection, promotion & support of breastfeeding.
http://www.waba.org.my/index.htm
WABA Men's Initiative: *http://www.waba.org.my/whatwedo/mensinitiative/index.htm*
Links: *http://www.waba.org.my/resources/usefullinks.htm* (includes other languages)

World Breastfeeding Week: Theme, objectives, and ideas to highlight the importance of breastfeeding.
http://worldbreastfeedingweek.org/

Counseling

Counseling Cards on Breastfeeding and Related Behaviors, Linkages. Contains links to counseling cards developed in several countries as well as Tips for Communicators and advice on developing and adapting counseling materials.
http://www.linkagesproject.org/tools/ccards.php

Timed and Targeted Counseling, a Community Health Worker/Volunteer approach to extending primary health care counseling to the household level World Vision.
http://www.wvi.org/health/timed-and-targeted-counseling-ttc

ICT and Online Learning

Mobile Alliance for Maternal Action (MAMA), an international public-private partnership that develops SMS messages that can be sent directly to mothers to educate and encourage them, including messages on breastfeeding. MAMA also offers online learning courses to assist organizations to localize SMS messages. The modules cover topics such as the principles of behavior change, localization, and how to handle cultural beliefs. Both of these resources can be downloaded at:
http://www.mobilemamaalliance.org/tools-and-resources
http://www.mobilemamaalliance.org/sites/default/files/1772-MAMA-Spotlight-September-v3-JH.pdf highlights a program in Malawi that operates an information hotline and sends pregnant women and mothers of infants tips and reminders via SMS.

Community Mobilization

Mobilizing the Church, Tearfund. Ideas to encourage church members to widen their vision. It contains material on the role of the church, leadership, Bible study groups, planning, working within the community and maintaining the vision of the church.
http://tilz.tearfund.org/en/resources/publications/pillars/mobilising_the_church/

Mobilising the Community, Tearfund. An exciting process of encouraging and supporting communities to analyse their own situations and to take steps to work together to make changes for the better.
http://tilz.tearfund.org/en/resources/publications/pillars/mobilising_the_community/

Umoja Facilitator's Guide and Coordinator's Guide, Tearfund. Tearfund helps church leaders and their congregations work with the local community to bring about positive change. It helps churches and communities build on the resources and skills they already have, and it inspires and equips people with a vision for determining their own future with their own resources.
http://tilz.tearfund.org/en/themes/church/umoja/

Howard-Grabman, L. & Snetro, G. (2003) How to Mobilize Communities for Health and Social Change, available at *http://www.jhuccp.org/resource_center/publications/field_guides_tools/how-mobilize-communities-health-and-social-change-20.*

Successful Community Nutrition Programming: Lessons from Kenya, Tanzania, and Uganda, Linkages, outlines key lessons and success factors for mobilizing communities to improve infant and child nutrition.
http://www.linkagesproject.org/publications/Successful-Community-Nutrition.pdf

Formative Research/Situation Analysis

The Basics: Planning for Formative Research for Infant and Young Child Feeding Practices
http://iycn.wpengine.netdna-cdn.com/files/IYCN_planning_formative_research_083111.pdf provides formative research guidance and sample research tools.

FGD Guide: Breastfeeding & Complementary Feeds, MATERNAL CHILD HEALTH PROJECT, Andhra Pradesh [located in dropbox under FBO Materials]

Mass Media

Strategic design of Viet Nam breastfeeding mass media campaign:
http://www.fhi360.org/resource/strategic-design-mass-media-promoting-breastfeeding-vietnam

Religious Texts/Justification

Muslim Khutbah Sermon Guide, MCHIP. Pages 32-34 contain information, scriptures, and a sample sermon on breastfeeding
http://www.mchip.net/sites/default/files/Muslim%20Khutbah%20Sermon%20Guide_English.pdf

SBCC

Self-Paced SBCC Online Training Modules, JHU/CCP/HC3. A more in-depth course for individuals who want to learn more about SBCC.
https://learning.healthcommcapacity.org/sbcc/default.asp

UNICEF's **Improving Breastfeeding Practices Through Using Communication for Development:** UNICEF webinar Series 2010-2012.
http://www.unicef.org/nutrition/files/C4D_for_breastfeeding_webinar_presentation.pdf
http://www.unicef.org/nutrition/files/C4D_in_EBF_manual__6_15_2010_final.pdf

WHO/UNICEF/AED/USAID. **Learning from Large-Scale Community-based Programmes to Improve Breastfeeding Practices: Report of ten-country case study.** 2008.
http://www.unicef.org/nutrition/files/Learning_from_Large_Scale_Community- based__Breastfeeding_Programmes.pdf

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Faith Communities' Promise Renewed: Ending Preventable Child Deaths and Supporting Mothers. World Faiths Development Dialogue, Washington, DC, 2013. http://repository.berkleycenter.georgetown.edu/140102WFDDCIFAFaithCommunitiesPromiseRenewedBackgroundReport.pdf

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WHO. Multi-Country Study of Medicine Supply and Distribution Activities of Faith Based Organizations in Sub-Saharan African Countries, 2006

WHO. HIV and Infant Feeding Technical Consultation held on behalf of the Inter-agency Task Team (IATT) on prevention of HIV infections in pregnant women, mothers and their infants in Geneva on October 25-27, 2006 (2007)

Iannotti L and Gillespie S. Successful Community Nutrition Programming: Lessons from Kenya, Tanzania, and Uganda. The Linkages Project, Academy for Educational Development, Washington, DC, 2002. http://www.linkagesproject.org/publications/Successful-Community-Nutrition.pdf

Linkages Project. Counseling Cards on Breastfeeding and Related Behaviors, http://www.linkagesproject.org/tools/ccards.php

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Yotebieng M, Chalachala JL, Labbok M and Behets F (2013). Infant feeding practices and determinants of poor breastfeeding behavior in Kinshasa, Democratic Republic of Congo: a descriptive study. International Breastfeeding Journal 2013 8:11. doi:10.1186/1746-4358-8-11

Setegn T, Belachew T, Gerbaba M, et al. (2012). Factors associated with exclusive breastfeeding practices among mothers in Goba district, south east Ethiopia: a cross-sectional study. International Breastfeeding Journal 2012 7:17. doi:10.1186/1746-4358-7-17

Egata G, Berhane Y and Worku A (2013). Predictors of non-exclusive breastfeeding at 6 months among rural mothers in east Ethiopia: a community-based analytical cross-sectional study. International Breastfeeding Journal 2013 8:8. doi:10.1186/1746-4358-8-8

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APPENDIX A: I-KIT TEMPLATES

Step 1. Vision Statement Template

See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for a global-level sample vision statement.

Vision Statement

Vision	Yes	No	Suggestions/Notes
Does the vision statement:			
• Describe the best possible outcome?			
• Inspire people to want to help/participate/act?			
• Point to what the program hopes to achieve in the long run?			
• Show that the program is excited about the work?			
Is the vision statement:			
• No more than 2-3 sentences?			
• Realistic in the long term?			
• Something people can believe in?			
• Concrete?			
• Worth committing to?			

Step 2. Situation Analysis Templates

The situation analysis should give programmers and stakeholders a clear, detailed understanding of (a) the current status of breastfeeding practices in the country and (b) the factors most likely to influence optimal breastfeeding practices within each audience of target users or target influencers. These may include perceived benefits of breastfeeding, knowledge of optimal breastfeeding practices, and perceptions and social and cultural norms that may encourage or discourage optimal breastfeeding practices and behaviors. Typically, national-level stakeholders would use formative research and other national-level data to complete their situation analysis. See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for a global-level example situation analysis for breastfeeding. That global-level situation analysis can be adapted to the national/local level based on national/local level data.

Barriers and Facilitators Template			
Audience	**Current Behaviors**	**Factors Associated with Suboptimal Breastfeeding Practices**	**Factors Associated with Optimal Breastfeeding Practices**
Primary Audience			
Mothers			
Grandmothers			
Others (?)			
Influencing Audience			
Fathers			
Faith Communities			
Community Health Workers			
Others (?)			

See an Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide for a global level example.

Analysis Aid Template			
What?	**Why?**	**So what?**	**Now what?**
Data Collection: Key facts collected during the situation analysis	**Root Cause Analysis:** Key facts collected during the situation analysis	**Data Analysis:** Implications that the facts may have on the SBCC strategy	**Strategic Priorities:** Identify which implications to address in the SBCC strategy. Limit to 3-5 strategic priorities in order to focus on the plan
	Breastfeeding:		

See an Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide for a global level example. This global level situation analysis can be adapted to the local level based on local level data. Once you have completed the tables above, you can write your situation analysis using the table below, to include information on the national-level breastfeeding context, including your audience analysis.

Country-level Situation Analysis Tool
Breastfeeding Context
Audience and Communication Analysis

Situation Analysis	Yes	No	Suggestions/Notes
National data sources checked			
• Demographic and Health Survey			
• Multiple Cluster Indicator Survey			
• National Breastfeeding Policy			
• National Breastfeeding Strategy			
• National Child Health Policy (or RMNCH)			
• National Child Health Strategy (or RMNCH)			
• Infant and Young Child Feeding Policy, Strategy, or Guidelines			
• National Nutrition Survey			
• National and international organizations working in MNCH			
• Nielsen surveys			
• Other national marketing surveys/companies (List here _____)			
Local data sources checked			
• NGOs working in the target areas			
• Demographic Surveillance Sites			
• Published academic or programmatic research (online search)			
Formative research conducted			
• Stakeholder consultation			
• Focus group discussions			
• Audience member interviews			
• Health facility surveys			
• Membership surveys			
• Intercept interviews			
Local health context described			
Local breastfeeding context described			
Potential audiences identified			
Local practices documented			
Root causes of key problems identified			
Do you know what percentage of children 0-6 months in the target area get only breast milk?			

Step 3. Audience Segmentation Template

See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for global-level sample audience segments.

Primary and Secondary Audience Segments (with rationale for segment selection)
In each country or sub-national context, choices will have to be made between primary audiences and influencing audiences. Targeting SBCC to specific audiences, such as pregnant women, mothers of children under 2 years of age, grandmothers/mothers-in-law, fathers, faith-based leaders and others, can have impact and be cost effective in either generalized or concentrated settings.
PRIMARY AUDIENCES
Primary Audience 1:
Primary Audience 2:
Primary Audience 3:
INFLUENCING AUDIENCES
Influencing Audience 1:
Influencing Audience 2:
Influencing Audience 3:

Ranking Influencing Audiences by Level of Influence			
	Primary Audience Influenced	**Estimated Power of Influence (Low, Moderate, Strong)**	**Current Attitude Toward Optimal Breastfeeding Practices**
Influencing Audience 1: *<Name audience>*			
Influencing Audience 2: *<Name audience>*			
Influencing Audience 3: *<Name audience>*			

Develop profiles of these audiences. See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for global-level sample audience profiles.

Audience Profiles
PRIMARY AUDIENCE 1: PREGNANT WOMEN AND MOTHERS OF INFANTS (1-24 MONTHS)
PRIMARY AUDIENCE 2: <NAME THIS AUDIENCE>
PRIMARY AUDIENCE 3: <NAME THIS AUDIENCE>
INFLUENCING AUDIENCE 1: <NAME THIS AUDIENCE>
INFLUENCING AUDIENCE 2: <NAME THIS AUDIENCE>
INFLUENCING AUDIENCE 3: <NAME THIS AUDIENCE>

Audience Segmentation	Yes	No	Suggestions/Notes
Can the program effectively reach all of the audiences selected?			
Of the potential priority audiences/segments identified, which 2 are the most important to reach?			
• Why?			
Of the potential influencing audiences identified, which 3 are the most important to reach?			
• Why?			
What happens if Audience X, Y, or Z is not reached?			
How much will it cost to reach each audience with effective messages and activities?			
Audience Profiles			
Profile developed for each audience segment			
Each profile sourced from local information			
Each profile reflects a specific audience segment			
For each profile:			
• Photograph			
• Name			
• Age			
• Religion			
• Employment type			
• Income			
• Region/town/village			
• Marital status			
• Number of living children			
• Number of children deceased before age five			
• Pregnancy status			
• Current behavior related to infant and young child feeding			
• Potential drivers for target behaviors			
• Barriers to optimal breastfeeding practices			
• Indication of emotions related to IYCF and child care			
• Indication of values relevant to breastfeeding			

Step 4. Message Strategy Template

See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for global-level sample audience segments.

PRIMARY AUDIENCE 1: PREGNANT WOMEN AND MOTHERS OF CHILDREN UNDER 2 YEARS OLD
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

PRIMARY AUDIENCE 2: <NAME AUDIENCE>
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

PRIMARY AUDIENCE 3: <NAME AUDIENCE>
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

INFLUENCING AUDIENCE 1: <NAME AUDIENCE>
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

INFLUENCING AUDIENCE 2: <NAME AUDIENCE>
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

INFLUENCING AUDIENCE 3: <NAME AUDIENCE>
OBJECTIVES
POSITIONING
KEY PROMISE
SUPPORT STATEMENT
KEY MESSAGES

Message Strategy	Yes	No	Suggestions/Notes
Objectives			
Does every objective have at least one corresponding message?			
Will the program be able to measure achievement of every objective?			
Is every objective essential to measure?			
Which are the most important 3 objectives?			
Which are the least important 3 objectives?			
Are there more than 5 objectives for any audience?			
If so, consider dropping at least the 3 least important.			
Do you know how each objective will be measured?			
Are there any extra (unnecessary) words in any of the objectives?			
Does every objective state what the target audience should think, feel, or do?			
Does every objective reflect a challenge raised in the local situation analysis?			
Does every objective contribute significantly to achieving the program goal?			
Is every objective SMART?			
• Does it focus on a Specific thought, feeling, or action?			
• How will it be Measured? What amount of change represents success?			
• Can it be Attained? Is it achievable?			
• Is it Relevant and worth achieving?			
• What are the start and end dates?			
Positioning			
Does the positioning statement express a unique benefit that is highly important to the audience segment?			
Does the positioning statement have a strong emotional appeal for the audience segment?			
Is the positioning statement likely to appeal strongly to the audience segment?			
Can staff develop messages and approaches around the positioning statement?			
Does the positioning statement make breastfeeding stand out for the audience segment?			
Does the positioning statement reflect how the program wants the audience segment to feel about breastfeeding?			

Message Strategy	Yes	No	Suggestions/Notes
Key Promise			
Does the key promise highlight the main benefit of optimal breastfeeding practices?			
Will the audience segment agree that it is the main benefit for them?			
Will the audience segment feel that the chosen benefit is worth the cost?			
Support Statement			
Is the support statement credible?			
Does/will the audience segment respect the sources quoted? If not, what sources will the audience segment respect?			
Will the audience find the reasons and data compelling?			
Does the support statement contain an emotional element that will speak to the audience segment?			
Key Messages			
Are there more than 5 messages for any audience segment? (The general rule is 3-5 messages per audience)			
Does each message address a behavioral driver identified in local research for the audience segment?			
Is the message relevant for the regions and ethnic group where it will be used?			
Is the message about something the audience can actually do?			
Is the message believable?			
Is the message easy to understand?			
Is the message framed in a respectful way?			
Does the message convey something essential for the audience to know?			
Does the message convey something that is nice to know but not essential? (Is so, drop it.)			
Does the message support to the positioning statement?			
Does the message stand out?			
Is the message simple and direct?			
Is it clear what benefit the audience receives if they take the action?			
Are all messages consistent?			
Can the message be conveyed across different channels?			

Message Strategy	Yes	No	Suggestions/Notes
Is the message credible?			
What source will make the message most credible?			
Does the message use emotion, as well as logic and facts?			
Does the message clearly communicate what the audience should do?			

Step 5. Activities and Interventions Template

See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for global-level sample activities and interventions.

MASS MEDIA			
INTERVENTION AREA	**ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**

COMMUNITY-BASED SERVICES, OUTREACH AND COMMUNITY APPROACHES			
INTERVENTION AREA	**ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**

STRUCTURAL			
INTERVENTION AREA	**ACTIVITIES**	**PURPOSE**	**INTENDED AUDIENCE**

Activities and Interventions	Yes	No	Suggestions/Notes
Have at least two interventions been selected for each audience?			
Does the local situation analysis support the selection of interventions for each audience?			
Are the selected channels used by the audience for which they have been selected?			
Can the program effectively implement all of the selected interventions at the same time?			
If not, is there a logical way to stagger the interventions? What is it?			
Has a timeline been established for each intervention?			
Have collaborators been identified to undertake interventions as appropriate?			
Can the key messages for each audience be effectively conveyed through the interventions selected for each audience?			
Has a reasonable and realistic cost been attached to each intervention?			
Does the program have the human resources needed to implement the interventions?			
Does the program have the financial resources needed to implement the interventions?			

Step 6. Measuring & Evaluation Template

See an "Illustrative SBCC Strategy for Breastfeeding in the Implementation Kit to support FBO-led Breastfeeding Interventions: Program Guide" for global-level sample activities and interventions.

Hierarchy of objectives	**Performance indicators** *Disaggregated by target audience, gender, age, and partner type/marital status as appropriate*
HEALTH IMPACT:	Sample Source: National surveys, e.g. Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS)
Global example: Reduce mortality rate of children under 5 years of age by 2/3rds (MDG 4.1)	Global example: Child mortality ratio (MDG Ind. 4.1 and 4.2)
PROGRAM OUTCOME – OPTIMAL BREASTFEEDING PRACTICES	Source: Program-specific surveys of audiences / geographical areas targeted by demand creation interventions
INTERMEDIATE OUTCOME – INCREASED KNOWLEDGE OF AND SUPPORT FOR BREASTFEEDING	Source: Program-specific surveys, unless indicated

M&E	Yes	No	Suggestions/Notes
Does each indicator match one of your objectives?			
Is each indicator feasible to measure given the program's human, financial and technical resources?			
How will each be measured?			
Does each indicator tell you if you are succeeding?			