

**Lessons Learned in Promoting  
Better Infant and Young Child Feeding:  
Experiences from Northern Ghana**

**By  
LINKAGES and Partners**

**February 2003**



## TABLE OF CONTENTS

- i. Acknowledgments**
- ii. Lessons Learned: The Background Story**
- iii. Conference Highlights and Lessons Learned**
  - ◆ **Working with the Radio**
  - ◆ **Expanding Opportunities to Promote Better Infant Feeding**
  - ◆ **Mother to Mother Support Groups**
  - ◆ **Challenges to Promoting Timely and Appropriate Complementary Feeding**
  - ◆ **Community Entry or “Getting Started”**
  - ◆ **Experiences from around the World**
- iv. Appendix**
  - ◆ **A. Themes and Presenters**

## **Acknowledgments**

A round of applause is extended to each and every one of the conference participants and the organizations they represent who participated in making this event the enormous success that it was. Special thanks are also extended to Dr. Agnes Guyon from LINKAGES-Ethiopia for her assistance in teaching us about VIPP and facilitating the process during this conference. To Dr. Victoria Quinn from the LINKAGES home office we say thank you for expanding our vision of nutrition to a more comprehensive program approach based on the Essential Nutrition Actions. To our international visitors from CARE-Atlanta and CARE-Ethiopia, thank you for your enthusiasm, participation and fresh perspectives. And to the LINKAGES-Ghana team we would like to acknowledge and congratulate you for your outstanding work and continued dedication to improving infant and young child feeding in Ghana and bringing these lessons learned to life.

## **Lessons Learned and Experiences In Promoting Better Infant and Young Child Feeding In Northern Ghana**

### **Lessons Learned: The Background Story**

An important component of the LINKAGES program in Ghana has been constant sharing and discussion among partners on approaches and experiences to promote better infant feeding practices. Beginning in December 2001, discussions were held at the annual LINKAGES' partner refresher meeting to identifying lessons learned since the program began in early 2000 and to select at least three themes that they felt would be the most useful to share with others beyond the north at the 2003 annual meeting. Other ideas were added following the meeting based on international input and results from the rapid appraisal survey conducted in 2002. Partners were contacted by phone and mail in October/November 2002 inviting them to volunteer ideas for presentations based on the selected theme areas. More than two dozen responses were received and accepted from UDS, The Ghana Red Cross Society, CRS, ActionAid with its partners, ACDEP, World Vision, UNICEF with the Savalugu-Nanton DHMT, and three local radio stations. Presentations were also made by individuals and teams representing CARE-Ethiopia, LINKAGES-Ethiopia and LINKAGES-USA.

The Lesson Learned/The Way Forward Conference took place in Tamale from February 17 – 20, 2003. Over 60 people attended the Conference representing more than a dozen partner organizations including the GHS. In addition, representatives from LINKAGES-USA, LINKAGES-Ethiopia, CARE-Atlanta, CARE-Ghana, CARE-Ethiopia, Project Concern International, and BASICS attended and participated in workshop activities. Six panel sessions were organized and presentations made on a range of themes from “Expanding Opportunities to Promote Better Infant Feeding” and “Working with the Radio as Partners” to “Improving Community Entry” and “Experiences from around the World.” (See Appendix A for a complete list of themes and presenters.) The Visualization in Participatory Planning (VIPP) methodology was used to solicit ideas from all participants and organize them in such a way so that everybody's ideas were expressed and shared in plenary. Following brainstorming sessions within the larger groups, participants were divided into smaller units to discuss “what they had heard” from their peers during the presentations as well as propose “something to be added” based on their experiences in the topic area.

The result was a dynamic and thoughtful sharing of ideas and lessons learned among individuals, organizations and the GHS based on years of experience in the north promoting infant and young child feeding. This report attempts to capture the richness of those discussions/presentations and provide readers with “food for thought” on what works well, areas for improvement, and new programming ideas to be explored and expanded so that we continue to improve infant and young child feeding in Ghana and elsewhere around the globe.

## **Conference Highlights and Lesson Learned:**

### **1. Working with the Radio**

**Overview:** LINKAGES and its partners have worked with the radio for several years, involving journalists and producers from the three northern regions of Ghana in all aspects of program planning, strategic design, message and materials development, and behavior change communication workshops, including training of trainers for MtMSGs. LINKAGES' collaboration with the media includes networking, technical updates, skills building, and packaging of nutrition messages so that they address specific needs and appeal to northern audiences. This close working relationship has been satisfying for everyone involved. Listeners continuously send letters to radio stations expressing satisfaction with the programs and urging repeat broadcasts and more pieces on similar topics. Humorous serial dramas combined with call-in programs to a "panel of experts" are extremely popular and often result in lively and animated discussions.

Another advantage of involving the media as an active partner in all elements of program design and technical updates is that professionals can craft entertaining and technically accurate programs that they know will appeal to listeners. To quote T.T. Wubunto from URA Radio in Bolgatanga, "Unless the program is of value to the listener, he tunes out or skips to another station, so even in seeking listenership, we negotiate." (Note: Negotiation here is meant as working to develop programs that are meaningful for listeners and that keep them engaged.) Results of the RAP 2002 survey indicate that approximately 70% of mothers, 87% of husbands, and 59% of grandmothers listen to the radio. Of those listeners, 89% of mothers, 94% of husbands, and 91% of grandmothers had heard at least one message on child feeding.

### **Lessons Learned:**

- ◆ **Keep the broadcasts lively.** Producers clearly listen to feedback from their audiences and give them what they want. Producers use a wide range of formats to present their material so the audiences have no chance of being bored. Songs, stories, poems, jingles, quiz programs, drama, magazine format programs that mix messages and music, personal testimonies, and interviews with local leaders and "believers" are used. The radio stations make programs especially interesting and appealing by broadcasting in languages familiar to local audiences and using journalists those audiences can identify with. Locally produced radio programs that reinforce messages with complimentary on-the-ground activities such as MtMSGs; group sessions using counseling cards, songs, and skits; and home visits where people can learn, discuss, and negotiate the messages and new behaviors that they have heard about on the radio with their family and peers can be a powerful and convincing tool for nutrition behavior change promotion.

- ◆ **Make sure the source of information is credible.** In general listeners believe that what they hear on the radio is the truth. Journalists and producers have a responsibility to be ethical and to deliver up-to-date and accurate programs. Collaboration among radio and health partners is one way to ensure sound broadcast content and appealing programs. The infant and young child feeding messages that health workers share with mothers and communities need to be in line with national policy and match what is aired on the radio. According to Mrs. Adamu Musa Aidu, a journalist with Radio Savannah in Tamale, “There is still a lot of work to be done training and updating current health workers so that all information sources are ‘singing the same song.’” Initiatives such as the Nutrition Preservice Curricula Reform and Training Strategy being implemented with the Human Resources Division (HRD), LINKAGES, and the national Baby-Friendly Hospital Initiative should improve this coordination.
  
- ◆ **Broaden listenership.** Communities should be given opportunities to create their own programs. When people hear people “just like themselves” describe their experiences or ideas in a common language, they are inclined to listen and perhaps even try new behaviors. Some communities report that the radio is the only source of information on infant and young child feeding for some men and has even prompted them to share the information with their wives. Because FM stations have defined boundaries, radio presenters can make periodic visits to areas where coverage is limited to record one-on-one discussions, local dramas, role plays, and songs. Making the recordings available to the communities through nongovernmental organizations (NGOs) or the GHS would encourage information sharing among rural communities and keep interactions interesting. Partners such as Catholic Relief Services (CRS) and the Ghana Red Cross have begun this kind of activity, sometimes buying radios and audiocassette players for distribution to the MtMSGs so that the groups can independently tune in to educational radio programs and do their own recording.

Radio listening clubs would also increase the number of people tuning in to health promotion radio programs and discussing issues. Another way to get more people to listen would be to include practical information linking nutrition with income generating ideas on radio programs and to air broadcasts when the majority of people are listening. Peak time is usually the early evening, but this is also the most expensive time to broadcast. Opportunities exist, however, to negotiate with LINKAGES’ partner producers to air programs at peak time when cost is an obstacle to sharing and broadcasting information.

- ◆ **Understand the limitations of radio.** Improved knowledge does not always translate into action. Radio messages have clearly played an important role in promoting better knowledge about breastfeeding and early initiation of breastfeeding, but actual practices still appear inappropriate for more complex behaviors such as complementary feeding and diarrhea management. Although radio is an effective tool for mass dissemination of information and messages, some behaviors, such as introducing thickened and enriched porridge to a six-month-old baby or offering oral rehydration solution (ORS) to a child with diarrhea, are best understood through

personal contact so that people will try and then adopt new or unfamiliar behaviors. This is why most BCC programs promote using a combination of mass and interpersonal media as a way of maximizing message reach and effectiveness.

- ◆ **Continue broadcasting stimulating programs.** Although much has been achieved, much more remains to be done. Development workers can never sit down and say that their work is finished. To again quote presenter T.T. Wobunto, “Of those won over, some are on the various stages of behavior change—awareness, contemplation, trial, adoption, etc. —and can easily slip back unless we continue stoking the fire constantly. The human mind by nature requires constant prompting.” We need to continue broadcasting accurate, engaging, entertaining, and thought-provoking programs on nutrition that entice people to try new ways to do things so that over time new social norms are adopted and maintained for improved infant and young child feeding.

## 2. Expanding Opportunities To Promote Better Infant Feeding

**Overview:** Science tells us that malnutrition—even moderate malnutrition—can significantly affect the development potential of a nation. Despite this evidence, the political will to turn this knowledge into action is still lacking. One reason for this inaction may be the view that nutrition is a woman’s problem to be dealt with in the kitchen. Another reason may be that political leaders lack access to clear information about nutrition and an understanding of practical nutrition actions that can be promoted to reduce common types of “hidden hunger,” including micronutrient deficiencies (iodine, iron and vitamin A) and stunting.

Another part of the problem may be that nutrition information is most often shared—apart from radio broadcasts—during growth promotion and monitoring sessions or in well-baby clinics and do not normally reach “household policy makers” such as mothers-in-law, older women, and fathers. These individuals often have an important influence—direct or indirect—on how a child is raised and fed. Nutrition messages need to reach both official and household policy makers for the development of the nation and the child.

### **Lessons Learned**

- ◆ **Promote the Baby-Friendly Community Initiative.** When entire communities are mobilized to promote exclusive breastfeeding, everyone gets involved. The experience from the Charia community in the Upper West Region shows that when breastfeeding matters stop being “feminized,” men are more likely to support women’s efforts to breastfeed. Men are encouraged to be advocates for breastfeeding by the chief and his family and at regular community meetings. The Charia experience began when one mother was convinced by a public health nurse to practice exclusive breastfeeding. She was so happy with the results that she convinced four more mothers to do the same. Now the women say that, “In this community water is not given to children under 6 months.” Their children are living

testimonies to the benefits of exclusive breastfeeding. Each section of the community has its own support group which meets on a monthly basis. A larger group is made up of members from each community group. Fully registered members must have attended meetings at least three times and paid a levy of 500 *cedis* to support the group's operations. People who miss three meetings have their names removed from the group register. It is believed that the structure helps build commitment and solidarity among group members. Traditional birth attendants, who are important community advocates for better breastfeeding and infant feeding practices, are encouraged to participate in both meetings and activities. The Charia experience needs to be shared so that more communities can experience being baby friendly and seeing healthy, bouncy babies everywhere.

- ◆ **Work with an array of stakeholders.** Traditionally nutrition and other health messages have been limited to forums where women with children gather for services such as immunizations, checkups, or growth promotion and monitoring. A wider network of “stakeholders,” including men and older women, and development sectors are clearly interested in knowing and understanding more about child feeding issues and what they can do to help. When they are given roles and responsibilities that make them feel important they can make important contributions by creating an enabling environment for better infant feeding at both household and community levels.

Periodic feedback and encouragement goes a long way toward keeping these stakeholders interested and involved. Groups such as district assemblies, credit schemes, and household livelihood security groups could be approached to find out whether they would be interested in becoming involved in the fight against malnutrition in Ghana. Given the association between access to water and diarrheal disease, which has important implications for child growth and nutrition, more could be done to link with groups that facilitate access to potable water at community level. Working hand in hand with reproductive health and family planning programs to increase awareness about maternal and child health issues, including maternal nutrition, early initiation of breastfeeding, exclusive breastfeeding, and child spacing, is also a good way to expand message and program reach.

- ◆ **Combine credit with education.** Credit can contribute to food security; however, additional income does not necessarily translate into good nutrition. Providing women with credit coupled with appropriate education can be a powerful tool to enhance the nutritional status of children and families. Income generating activities are another good way to keep groups active and increase the likelihood that parents will have more resources, understand the value of investing in good food choices for their families, and take concrete actions. Groups that work with credit schemes are convinced that women are the best “investment” because they have proven more reliable at repaying loans. Creating opportunities for men to join credit schemes and peer support groups and including awareness of how to translate improved income into better family nutrition in income generating activities might be another way to involve entire communities in tackling malnutrition. Mechanisms to ensure

repayment of loans should be included in the design of such initiatives. FFH has built scale-up and exit strategies into its credit programs.

- ◆ **Involve district assemblies.** All too often, programs fail to thrive because of lack of funding. In Ghana, however, decentralization has put more resources in the hands of district assemblies who have power to invest in activities and initiatives that they understand and believe in. Advocacy work at this level could result in more resources being released for local initiatives to improve nutrition. One suggested activity would be to involve district assembly members in nutrition workshops and program planning so that they appreciate the issues and can actively participate in program implementation.

### **3. Mother To Mother Support Groups**

**Overview:** Although mother-to-mother support groups (MtMSGs) and mothers' clubs organize themselves differently and engage in different activities depending on their organizational affiliation, they share a common purpose of providing a safe environment where women can learn from one another, exchange experiences and concerns, and support one another in a variety of ways. MtMSGs affiliated with the GHS' Baby-Friendly Hospital Initiative (BFHI) are committed to improving infant and young child feeding practices and maintaining formal links between health institutions and communities. ActionAid collaborates in the Damongo District with more than 50 active MtMSGs committed to improving breastfeeding practices through peer support and education. The mothers' clubs working with the Red Cross Society pay a registration fee and monthly dues in return for training on income generating activities such as basket weaving and off-season gardening, as well as basic skills in first aid, care of sick children, home hygiene, breastfeeding, and complementary feeding. Community service and leadership are also important elements of the work of the Red Cross groups. The mothers' group model promoted by World Vision empowers women to help themselves and their families lead fuller, more productive lives through peer education on topics such as home hygiene, family planning, breastfeeding, malaria, and HIV/AIDs. Microcredit schemes through community fundraising events are also included in the World Vision approach.

#### **Lessons Learned:**

- ◆ **Involve the community.** Traditionally mothers do not decide how to feed their children in isolation. Often other family and community members, particularly mothers-in-law, sisters, neighbors and fathers either directly or indirectly influence the way a mother feeds her child. The experience in northern Ghana is that support groups and clubs comprised of women but also men, older women and grandmothers, and even on occasion mixed groups of interested community members regardless of age or gender seem to provide a comfortable, non-threatening forum to teach and support improved child feeding and other health care practices. When everybody in the household knows and understands infant feeding issues and trust is established

from the beginning, well-meaning family members are less likely to be able to “sabotage” a woman’s efforts to improve the care and feeding of her child.

- ◆ **Promote visits and sharing.** Support groups and clubs are often eager to receive visitors so they can share their accomplishments. Recognition by people from outside the community makes “leaders” who are ensuring improved child and family health feel important and motivates their involvement. Visits can be formal monitoring or supervision visits to improve performance or exchanges of ideas and praise and encouragement for group members.
- ◆ **Link women’s groups.** Communities and individuals value having and belonging to mothers’ groups and clubs. MtMSGs that extend or build on existing networks of women or local clubs seem to project a sense of club ownership. The most effective MtMSGs seem to have influential community women serving as group facilitators. World Vision in Nicaragua has had excellent experience linking group leaders from the community to the national level to create a National Council of Rural Women in Support of Breastfeeding. In Ghana linking groups to national health insurance initiatives and financial institutions should be explored as a way to motivate groups and promote sustainability.
- ◆ **Recognize and use club talent to promote messages.** Most women in the north of Ghana are non-literate. Trainers and facilitators encourage club members to compose and exchange songs and role plays to help them remember important health information and messages. Women’s clubs can collaborate with the media to record and broadcast songs with infant feeding messages. Working with local initiatives that entertain and educate people to adopt better infant feeding practices encourages the dissemination of messages using language and approaches tailored to community interests.
- ◆ **Recognize MtMSG members as effective development agents.** In many communities MtMSG members act as agents of change, improving the quality of life of families and communities. In addition to improving breastfeeding and infant feeding, the groups and clubs help address malaria prevention and treatment, immunization, vitamin A capsule distribution, family planning and reproductive health, and increased attendance at antenatal, postnatal and growth promotion and monitoring services. As one participant aptly put it, “The empowerment of women through MtMSGs is a social cohesion strategy which helps lead to development and community problem solving.”

#### **4. Challenges to Promoting Timely and Appropriate Complementary Feeding**

**Overview:** Promoting better and timely complementary feeding beginning at six months and continuing through two years involves special challenges. Timely initiation of breastfeeding and exclusive breastfeeding are less complex behaviors than complementary feeding. Optimal breastfeeding behaviors are easier to adopt, and the results are easier to see. In addition to advising and negotiating with mothers on how

often, how much, at what age, and how to feed their young children, programs promoting improved complementary feeding confront issues such as hygiene, poverty, food security, access to water, and work load. When mothers return to work, a caretaker—often an older sibling or grandparent—charged with feeding children may not know about optimal food handling, food preparation, hygiene, or coaxing a child to eat. These caretakers are not normally included in nutrition education activities. In addition, possibly because of high rates of illiteracy in the north, mothers often need to rely on other people to interpret the correct age of their children. This makes giving age-specific messages about complementary feeding a special challenge. Communicating clear and believable messages about complementary feeding is also challenging because many people have not received training in complementary feeding. Moreover, messages on complementary feeding have frequently changed. Mother-to-mother support group leaders must have up-to-date training in appropriate complementary feeding in addition to breastfeeding issues and skills.

### **Lessons Learned:**

- ◆ **Harmonize complementary feeding messages.** Complementary feeding messages need to be consistent and coordinated. Different interpretations of messages by well-meaning health providers have tended to confuse mothers. Some teach that complementary feeding begins at around six months, others after six months, while WHO is saying that it begins at six months or 180 days. Some mothers understand that they should begin introducing water at six months and soft and mushy foods later, with the result that some young children are not introduced to solids or semisolids until they are more than seven or eight months old. The challenge for programs is to speak with one voice. In Ghana the message for starting complementary feeding follows the WHO recommendation of beginning feeds at six months and continuing to breastfeed through at least two years. Indicators for complementary feeding also need to be improved to allow for better monitoring and understanding of how changes in infant and young child feeding behaviors impacts on improved nutritional status.

Alongside messages about when to start offering soft and mushy foods should come practical suggestions on feeding frequency, adequacy (amounts and consistency), nutrient density, and the body's utilization (FADU) of foods being offered. Active feeding is another important message. These messages should be introduced and negotiated not only with mothers, but with a variety of influential people at the community level.

- ◆ **Make negotiation a key element of complementary feeding counseling.** An aspect of complementary feeding that has not received enough emphasis is that introducing complementary foods requires patience. Mothers should be told to expect challenges. The gap between knowledge about complementary feeding and its practice is a concern. In Bongo in the Upper East Region, health workers begin counseling mothers when their children approach 6 months old so that they understand how important complementary feeding is, what is involved, and how it is done, with

practical sessions on preparing soft and mushy foods for children. Working and negotiating with mothers and other family members so that they know how to enrich porridges and other easily prepared foods is important. This should include messages on how often to feed, how much to give, how to handle food, and how to coax a child to eat.

- ◆ **Address constraints to complementary feeding.** A possible reason for the reported divide between knowledge and behavior is poverty. According to Edward Adimazoya of CRS, “Unfortunately we have learned with pain that the mothers know all the messages; they know what type of food to give to the child, e.g., the thickness of the food, the need to fortify the foods, and add vegetables and fruits, but they are constrained by poverty to put the messages into practice. The challenge is to introduce income generating activities and make sure that women have the resources to put into practice what they have learned.” Many also believe that because of heavy work load and fatigue, women feel they do not have the time or energy to breastfeed exclusively and thus introduce complementary foods much earlier than they know they should. On the other hand, appropriate complementary feeding does require more time, effort, and commitment than breastfeeding. If not done well or initiated too early, complementary feeding could result in diarrhea or illness that requires money for medical help and time lost from work. In some areas, community nutrition shops have been introduced, with ties to income generating schemes such as weanimix production. These initiatives both facilitate local access to good foods for young children and create opportunities for women to earn money. Social obligations such as funerals drain scarce money and resources needed for food for the family. Community education is essential for helping families deal with these delicate and often difficult situations.

## **5. Community Entry or “Getting Started”**

**Overview:** The way a project approaches or communicates with a community for the first time can either make or break a program. Appropriate community entry, although critical to good development work and program design, is an art that must be learned. It requires time, patience, and negotiation skills. Often busy timetables and agendas rush communities into participating in a program that may not fit their needs or interests. Community members may not fully understand what the donor or sponsoring organization expects from them nor have they been given the opportunity or time to communicate how they would like to participate or contribute. A number of techniques are used by organizations to facilitate understanding, communicating, and working with communities. The more popular techniques include Participatory Rural Appraisal (PRA), Participatory Technology Development (PTD) from the agricultural sector, and the UNICEF “Triple A” approach (assessment, analysis, and action). The key to these approaches and to community entry is, as one organization puts it, “learn to listen, listen to learn” or “talk less, listen more!” Understanding and building on indigenous knowledge and working in harmony with traditional and political structures are likewise

important. Community entry is rarely a one-time event; it is instead a process and in almost all instances it must be participatory to be successful.

### **Lessons Learned:**

- ◆ **Build strong bridges and find doors to the community.** Architects know that both bridges and doors require a good foundation or frame to stand the test of time. Effective development agents appreciate and respect the local “architecture” of a community, which is grounded in sociocultural, economic, attitudinal, mental, and spiritual matters. No two communities are exactly alike. No blueprints, road maps, or recipes guarantee successful community entry. Likewise, no two people will ever do community entry in exactly the same way. An important first step for community entry is understanding the “bridges” between programs and community needs and knocking on the appropriate “doors” (including those of chiefs and elders, teachers, public health nurses, religious leaders, unit committees, district assemblies, assemblymen, and community-based volunteers). Sometimes even listening to local jokers or jesters can unveil important knowledge that may not be ordinarily expressed by the local population but is critical to understanding the dynamics of a community to meet its needs.
- ◆ **Be flexible, willing to adjust, and open-minded.** Community entry is a dynamic process requiring patience and diplomacy. Occasionally the ideas of opinion leaders must be double checked with others in the community. Understanding the local dialect or language or working through a good interpreter is essential for obtaining important “pre-entry” information, such as the success of previous interventions in the community, conflicts, relationships between key opinion leaders, governance structures, food habits, and religious leanings. Being aware of community dynamics and knowing and respecting local norms and customs is key to avoid creating a “cultural shock” that may unknowingly damage or derail a program’s start-up. Entering a community as the expert and publicly questioning the ideas or opinions made by local leaders can damage start-up. Unanticipated non-verbal messages can be sent by dressing inappropriately for a meeting or event. Being mindful of one’s attitude, understanding the local culture, and identifying oneself with the community enhances the probability of success in program entry and implementation.
- ◆ **Follow other practical tips.** Programs should identify and solve problems as they go along and always in collaboration with the community. No community activity or behavior should be disparaged. Instead, especially where food and infant feeding practices are concerned, community members should be encouraged to learn and practice the art of negotiation, build local awareness and skills, and encourage people to try new or unfamiliar behaviors such as putting the baby immediately to the breast after birth or enriching foods commonly given to young children. Avoid starting community entry with gift giving. This may set a precedent that could inadvertently interfere with future relationships. When appropriate, consider integrating development issues or programs that address child survival, maternal health, agriculture, poverty reduction, and food security, and build on what exists rather than

starting something brand new. When planning programs, remember that good community exit is as important as good community entry and should be considered from the beginning of a program. Program ownership and sustainability are often the cornerstones of a well thought out exit strategy. Finally, design a program to make adequate time, financial resources, and skilled staff available from the onset. Skimping on this critical stage of program design and implementation would be “penny wise and pound foolish.”

## **6. Experiences from around the World**

**Overview:** Nutrition and food security programs from Bolivia, Ethiopia, Ghana, Madagascar, and other countries face important challenges in their efforts to improve nutritional status. “Hidden hunger” is often linked to micronutrient deficiencies associated with vitamin A, iron, and iodine, as well as chronic mild malnutrition. Although less obvious and less dramatic than the hunger seen during famines and drought, hidden hunger may not receive the attention and funding it deserves because it is perceived as a less “interesting” or “sexy” donor or government investment. Even mild malnutrition, however, carries important development and cost burdens for countries because of its debilitating effects on productivity and cognitive development and its links to recurring illness, infection, and even death. Another challenge in nutrition programming is vertical, stand-alone programs that address only one intervention, such as a single micronutrient or breastfeeding, in isolation of other interventions such as complementary feeding and maternal nutrition.

We now know that a focused but comprehensive approach is the best investment to tackle malnutrition in a meaningful, sustainable, and action-oriented way. A unifying approach that is now being supported by a number of countries is the Essential Nutrition Actions, or ENA. Given the important links between breastfeeding and other “popular” interventions such as child survival and reproductive health, the ENA approach is used as an entry point or bridge to build interest and support for nutrition in other health and development sectors, including emergency relief and household food security.

### **Lessons Learned:**

- ◆ **Consolidate efforts and work on the essentials.** The ENA framework helps program planners and managers hone in on a battery of integrated actions proven effective in enhancing the nutritional status of women, children, and their families. The ENAs are based on seven key areas for behavior change promotion: breastfeeding, complementary feeding, feeding of the sick child, women’s nutrition, control of vitamin A deficiency, control of anemia, and control of iodine deficiency disorders. Opportunities to address these areas are integrated with existing community- and facility-based health programs. The six key contact points include prenatal visits, delivery, postnatal visits, immunizations, well-baby sessions, and sick child visits. Broadening the conceptual framework of the ENA so that it articulates roles for men and older women in promoting improved nutrition could make this

approach even more dynamic and effective. Forging national level and multi-agency partnerships with governments to promote ENA will be essential for this work to be carried out effectively and for messages and information to be consistent and services accessible to all who need them.

- ◆ **Consider new paradigms.** Nutrition is an evolving science with critical public health implications. Only recently was it discovered that health status late in life may be determined by the nutritional state of the mother during pregnancy and even in conception. Although breastmilk is generally said to have everything a growing infant needs through six months of age, exclusively breastfed children whose mothers are deficient in vitamin A probably lack this vital micronutrient. To address this common problem in many developing countries, providing the postpartum mother with one or two doses of vitamin A within two weeks of delivery is recommended, depending on national protocols. Other areas of interest for program managers and nutrition advocates are not food based but have important implications for improving nutritional status and public health. These include deworming of pregnant women and children, malaria control and treatment, and family planning. It seems that wherever breastfeeding is successful, late initiation of complementary feeding becomes an issue. Appropriate feeding of the sick child during illness and recuperation is also a recurring problem that merits increased attention in Ghana and elsewhere.
- ◆ **Share information, monitor progress, and learn from others.** One way to increase the consistency of messages is to update all senior health managers on behavior change communication and infant feeding and nutrition. Another is to encourage the development of guidelines, including health education policies to standardize nutrition messages, accompanied by regular supervision and monitoring of approaches and progress. Avenues should be created for regular learning and sharing of ideas and lessons learned among stakeholders. Experiences and approaches from other countries should be adapted to broaden the dissemination of messages and engage different target audiences. This can be done through intra- and inter-country study visits, Web sites and newsletters for BCC and nutrition, regular FM radio broadcasts, and even the use of popular singers such as Poopy in Madagascar. At Wageningen University in the Netherlands, the Ghana experience is being used to train food and nutrition security workers from Africa, Asia, and South America on the art of using formative research to tailor convincing BCC messages and approaches for improved nutrition.

**Appendix A: THEMES AND PRESENTATIONS**

<b>THEMES</b>	<b>PRESENTERS</b>	<b>INVITED CHAIR</b>
<b>1. WORKING WITH THE RADIO</b>	<ol style="list-style-type: none"> <li>1. Mr. Tennyson Wubonto, WRA Radio, Bolgatanga, UE/R</li> <li>2. Mrs. Adamu Musa Alidu, Radio Savannah, Tamale, N/R</li> <li>3. Mr. George Ramsey, Radio Progress, Wa, UW/R</li> <li>4. Mrs. Clara Weobong, CRS, Tamale, N/R</li> </ol>	Mrs. Theresa B. Nobiya, Ghana Red Cross
<b>2. EXPANDING OPPORTUNITIES TO PROMOTE BETTER INFANT FEEDING</b>	<ol style="list-style-type: none"> <li>1. Mr. Mahamma Saaka, GHS, Nutrition Officer, Wa, UW/R: <i>“Promoting Community Level BFHI”</i></li> <li>2. Mrs. Vida A. Abaseka, Ghana Red Cross, Bolgatanga, UE/R: <i>“Engaging Men and Grandmothers in the Promotion of Better Child Nutrition”</i></li> <li>3. Freedom from Hunger, Accra: <i>“Credit, Micro-enterprise and Improved Infant Feeding”</i></li> <li>4. Mr. Edward Samari, Catholic Family Health Project/ ACDEP, Walewale, N/R: <i>“Linking Improved Infant Feeding, Safe Motherhood and Reproductive Health Programs”</i></li> </ol>	Mr. Edward Adimazoya, CRS
<b>3. MOTHER-TO-MOTHER SUPPORT GROUPS</b>	<ol style="list-style-type: none"> <li>1. Mr. Moses Tibilla, GHS, Nutrition Officer, Tamale, N/R</li> <li>2. Mr. James Asedem, World Vision, Nadowli ADP, UW/R</li> <li>3. Mrs. Gilberta Akuka, Ghana Red Cross, Bolgatanga, UE/R</li> <li>4. Mr. Charls Wontewe and team: ActionAid, Damongo-DHMT, GUNSA, N/R</li> </ol>	Mr. Edward Adimazoya, CRS
<b>4. CHALLENGES TO PROMOTING TIMELY AND APPROPRIATE COMPLEMENTARY FEEDING</b>	<ol style="list-style-type: none"> <li>1. Mr. Moses Tibilla, GHS, Nutrition Officer, Tamale, N/R</li> <li>2. Mr. Eddie Adimazoya, CRS, Tamale, N/R</li> <li>3. Ms. Comfort Yankson and Ms. Sowdey Zackaria, DHMT-Savalugu Nanton, UNICEF/UDS/IFPRI, N/R</li> <li>4. Mr. John Abugri and team, Nutritionist, ACDEP and UNICEF, Bawku East, UE/R</li> </ol>	Mr. James Asedem, World Vision
<b>5. COMMUNITY ENTRY</b>	<ol style="list-style-type: none"> <li>1. Mr. Gaston Bozie, GHS, Health Education Officer, Bolgatanga, UE/R</li> <li>2. Prof Saa Dittoh, UDS, Tamale, N/R</li> <li>3. Mrs. Ernestina Armah, World Vision, Nadowli, UW/R</li> <li>4. Mr. Charles S. Nachinab, New Energy, Walewale, N/R</li> </ol>	Mr. Malex Alebikiya, ACDEP
<b>6. EXPERIENCES FROM OTHER PARTS OF THE WORLD</b>	<ol style="list-style-type: none"> <li>1. Dr. Agnes Guyon, LINKAGES-Ethiopia, Addis Ababa: <i>“Promoting Essential Nutrition Actions at the Community Level: The Madagascar Experience”</i></li> </ol>	Mrs. Gladys Gamor, UDS

	<ol style="list-style-type: none"> <li>2. Mr. Abdul Razak Abizari UDS, Tamale, N/R: <i>“BCC and Capacity Building: Lessons and Experiences from Wagenegen University in Holland”</i></li> <li>3. Dr. Solomon Tesfaye and team, CARE-Ethiopia, Addis Ababa: <i>“Experiences and Challenges from Ethiopia”</i></li> <li>4. Dr. Vicky Quinn, LINKAGES-DC, USA <i>“LINKAGES around the World: Challenges and Results”</i></li> </ol>	
--	--	--