1 Communication that Improves Nutrition

This chapter first confronts two common beliefs concerning reducing malnutrition, then delineates how a behavior-focussed approach can facilitate effective interventions. It then describes the role that behavior-change communication plays in a program.

Two Myths

Myth 1: If the problem is malnutrition, the solution is making more food available.

Clearly, malnutrition is a complex problem with numerous political, economic, social, and cultural causes. In 1992, a UNICEF causal model for under-nutrition gained widespread acceptance for its recognition of three underlying, immediate causes: food insecurity, poor health, and inappropriate caring practices (UNICEF). The appropriate emphasis to place on addressing each cause varies by country and regions of a country. Some malnutrition cannot be remedied without significant investments in distributing food, augmenting household income, or otherwise making food more available or accessible and/or in improving the quality and availability of health care.

Yet in most developing countries, the bulk of the nutritional problem lies in mild and moderate malnutrition. Half or more of young children in many countries are affected by these forms of malnutrition which contribute significantly to their risk of death. (Pelletier). *In most families, mild and moderate malnutrition can be eliminated or controlled through simple changes in dietary and food hygiene practices that are amenable to change through well-planned and executed behavior-change strategies*. For young children, it is usually a matter of feeding an additional 200 to 300 calories per day, providing access to vitamin A capsules, or improving recuperative feeding. Most families—except in situations of war, famine, or extreme poverty—do not require extra-familial food inputs to control malnutrition in their children.

Box 1. Cost-Effectiveness of a Behavioral Approach to Nutritional Improvement

A cost-effectiveness study conducted on the Nutrition Communication and Behavior Change Component (NCBC) of the first World Bank loan to Indonesia for community nutrition showed that the successful nutrition communication component (which provided educational inputs only and which significantly improved the nutritional status of 40% of the children), if expanded nationally, would cost about 0.15% of the national budget. This would be one-tenth the cost of an institutional feeding program and one-twentieth the cost of consumer food subsidies (Ho; Berg).

It is possible during project planning to estimate what portion of a population can do significantly more on their own and what portion will require higher-investment interventions. The multi-country Weaning Project (1985–1989) was successful in improving weaning practices, nutritional status, and growth in a variety of countries. One phase of planning each country project was household trials of proposed changes in practices (TIPs), which allowed planners not only to fine-tune practices and behavior-change strategies but also to gain a realistic picture of where poverty and/or lack of coping skills were so significant that the mother, family unit, and community could not change their practices enough to have significant nutritional impact (Griffiths, 1993).

- In a district in East Java, Indonesia, almost all families (90 percent or more) could and would provide resources and change practices enough to significantly improve young child feeding, i.e. the additional 200–300 calories per day.

- In Ghana (except for the north) and in parts of Swaziland, around 80 percent of the families had sufficient resources to improve nutrition through behavior changes.

- Fewer families in the Extreme North Province of Cameroon and the high Sierra of Ecuador had sufficient resources to improve child nutrition on their own.

Credit and income-generation activities, as well as investments in basic education (all directed to females), generally have a positive impact on family health and nutrition, particularly if accompanied by behavior-change communication. But even in the absence of (or while establishing) such activities, much can be done to enable people to better use existing resources.

Myth 2: Changing nutrition practices is extremely difficult, takes a long time, and is hard to measure.

A mother in Indonesia explains that she does not add green leafy vegetables to her child's rice because they are difficult for a baby to digest; she knows, because when she tried they made her baby's stool green. Fifteen months later, however, after hearing advice from a doctor on the radio and being counseled by her local community health worker and given a take-home reminder sheet, she feeds her child a mixed "weaning" food with green leaves and oil. So do 85% of the mothers in this province. As a result of mothers' following this and other advice related to improved child feeding, the typical decline in nutritional status seen about the fourth or fifth month of life is delayed by two months and is less severe; 40% of children under two years of age significantly improve their nutritional status.

A young woman in São Paulo, Brazil, states that she could not possibly breastfeed her baby—she does not have milk that is good or abundant

enough to satisfy the child. She says she knows this without even trying to breastfeed. All her friends feed their babies with a bottle, just as they see rich ladies doing. Also, the doctor gave her some free milk to take home after her child was born. During the next 18 months, however, a program convinces policy makers that breastfeeding could help reduce a tremendous drain on their foreign exchange, launches a national mass-media program, and hospital norms change to promote breastfeeding. More women begin breastfeeding and do so longer; hospitals report that child abandonment is dramatically reduced in Recife; and, after five years of breastfeeding promotion, researchers attribute 12% of the reduction in infant mortality in São Paulo to improvements in breastfeeding practices.

These are just a few of the dramatic improvements in nutrition outcomes that can occur when programs focus on changing practices and fully involve both families and health workers and other implementers in designing program actions. There are more examples: a doubling of the daily consumption of green leafy vegetables among young children and women in western Sumatra, Indonesia; and a halving of severe and moderate malnutrition in the Dominican Republic through growth monitoring and education at a time when economic conditions were deteriorating. The careful design work undertaken by these programs meant that changes in practices were feasible for potential beneficiaries and that they saw the benefits. Measurable improvements were seen quickly, in under two years. Detecting changes was not difficult because baseline measures focussed on precise behaviors defined as part of the design work.

Appendix A summarizes the program examples above, and others. Appendix B summarizes lessons learned from a multi-national project to improve weaning practices, and Appendix C illustrates insights gained by employing a behavior-oriented approach to the challenge of reducing anemia among pregnant women in developing countries.

What is Communication for Behavior Change?

Social Marketing

The programs that produced these results derived from concepts of social marketing. Social marketing is a consumer-oriented approach to defining, promoting, and making accessible socially useful practices and/or products. The approach places an exceptional emphasis on formative (planning) research—with beneficiaries, major influencers on beneficiary behavior, and program implementers and supporters—in order to devise and implement an effective behavior-change strategy that will promote new or modified practices that will both have the desired nutrition and health impact and that are acceptable and feasible for most people.

Too often, health and nutrition programs establish services that are underutilized or not properly utilized, distribute iron supplements to women who stop taking them and/or do not return for re-supply, or give technically correct and easy-to-understand nutrition education messages that people do not put into practice because of their own beliefs or perceptions or those of people close to them, or because of some real or perceived practical problem. Following the social marketing methodology should minimize these dangers.

Social marketing sprang from the success of commercial marketing in both developed and developing countries, i.e. if particular audiences could purchase and use toothpaste, snack foods, and analgesics, why couldn't they use maternal child health services or the advice offered by government programs?

Over the last 25 years, many commercial advertising and marketing experts have joined forces with health, nutrition and population professionals, not to mention anthropologists, to derive a version of marketing that

serves social objectives. Some organizations and programs define social marketing as strictly a marketing operation often offering subsidies for "social" products, such as vitamins or contraceptives. Others have defined social marketing as the communication or advertising part of a product promotion. But social marketing principles are also commonly used when there is no real product to promote, supporting behavioral changes such as improving weaning and breastfeeding practices, increasing consumption of vitamin A-rich foods, correctly mixing and using homemade oral rehydration solutions, and supporting community actions such as construction and maintenance of lead-free play areas for children. If a program does promote obtaining "products" such as immunization, prenatal care, vitamin A capsules, iron tablets, the appropriate *use* of the products becomes a major behavioral objective.

This paper considers social marketing to be *a systematic, analytical methodology for strategic planning of activities that leads to real and sustainable behavior change*. Communications, training, policy change, and product development and marketing may all be part of the overall strategy. Social marketing managers, taking their cue from commercial marketing experience, manage the integration of behavior-change communications with service-delivery and other components of programs. This means that the health care system, including quality of service and customer satisfaction, become part of the social marketing strategic plan. This approach has led to significant improvements in service quality and use.

Communication components of programs have improved with the application of social marketing's techniques emphasizing both the benefits of new practices and giving key information to make new practices easier. Communication for behavior change goes beyond the traditional health education approach of providing only essential technical information to people. It addresses the multiple reasons why a behavior may not be practiced as revealed through formative research—whether they are

purely practical constraints, social norms, or cultural perceptions. Formative research with program participants also indicates convincing ways to overcome resistances and to motivate desired practices.

Experience has shown that the reasons why someone may take up a new behavior may not be readily apparent. For example, programs to improve consumption of vitamin A-rich foods have found that fear of blindness is a poor motivator. Program managers have had to search for ways to "position" vegetables as essential for the overall good health of a child before mothers would react positively to feeding their child more of them.

Although not always associated with social marketing, some programs have made extensive use of community-based counseling and communication networks, with or without the use of mass media; others have involved extensive use of mass media, either as a support to counseling or as the prime communication medium. Counseling is normally an essential element of programs intended to improve nutrition practices. Since there are often several ways to solve a feeding problem, counseling is most effective if it means that practices are "negotiated" with individual mothers based on their situation rather than simply instructing mothers to follow general program recommendations.

Applying social marketing methods usually means there is a high degree of collaboration between the public and private sectors. Developing relationships between the commercial and social sectors has not been an easy task. Advertising and marketing managers have had to significantly adapt their experience in the commercial world to the far more complex needs of social programs, to sometimes frustrating government-approval processes, and to the importance of technical accuracy. Social-sector officials, too, have not found it easy to appreciate that the commercial world has a great deal to offer them, often distrusting their motivations. But where both sides have joined forces and adapted their unique experiences and skills, effective, new partnerships have been created.

Box 2. Reasons for Social Marketing Effectiveness

- Social marketing operates on the basis that new ideas, services, or products can best be introduced if the intended beneficiaries see them as fulfilling their own aspirations and well-being. People will not accept new ideas and technologies designed solely from the specialists' concepts.

- Social marketing follows a disciplined series of program-development and implementation phases, each with steps designed to learn from the community itself: conducting formative research to formulate the whole program's strategy; testing those strategies; designing, testing, and improving messages; designing, testing, and producing communication materials; monitoring and making necessary revisions in program strategies to better address people who have not tried or who have stopped desired practices. As the program matures and behavioral changes begin, the design of communication and other program elements should be revised and adapted to that change.

- The focus is on behavior—on understanding existing attitudes, perceptions, and practices and the social context in which these practices exist; and on the blocks or resistances that impede take-up of desired practices—social, cultural, cost concerns, availability, poor service, lack of appeal and so on—and how these constraints may be overcome.

- Social marketing takes a systems approach to managing behavior change—for integrating the technical (or clinical) aspects of the program with service or product delivery and with motivations for change. To truly address behavioral and development objectives, the social marketing process keeps in mind larger intersectoral processes as well.

- Social marketing appreciates that not all target audiences are the same and that even within an audience (mothers), there may be important segments (e.g. nursing mothers, mothers with children who "don't want to eat") that need to be identified and addressed differently.

- Rigorous discipline is enforced in the message development processes to ensure that messages always call for, and motivate, a desired action; resolve all known resistances convincingly; offer meaningful benefits; are memorable; and are presented by a convincing authority. Linkages with commercial advertising agencies may enhance this process and the presentation of ideas to identified audiences.

- Media strategies are based upon sound research to ensure that message reach and frequency are sufficient to achieve the required behavior-change objectives. Communication channels are chosen according to the locale and may include direct counseling from fixed sites or door-to-door, the generation of word-of-mouth within the community, traditional drama or singing troops or puppet shows, promotional events, point-of-sale display material, and innovative use available mass media.

- Special attention is given to service personnel (their training and morale) and to train them in sound counseling practice to be real motivators of behavioral change.

- Effective programs work to achieve a balance between centrally managed activities and locally developed initiatives within target communities themselves. This often means that project funds must be allocated in a decentralized fashion.

Communication for Behavior Change

A critical aspect of a social marketing strategy is the communication component, which this paper refers to as communication for behavior change (CBC). CBC overlaps with but is distinct from several other methods of nutrition education or communication—information, education, and communication (IE&C), project communications, nutrition or health education and social mobilization—mainly because of its consumer orientation and its requirement that all communication, education or training be "on strategy," i.e., be carried out only as they support the program's behavior-change strategy.

CBC means *strategic* communication designed to achieve specific behavior changes. But it is important for readers to keep in mind that CBC must work in tandem with other program activities. The overall program strategy may include activities related to legislation, product development and marketing, training, modifications in service norms, etc. While communication alone may not produce and sustain behavior change, as an integral part of a broad behavior-change strategy, CBC is a powerful tool.

In summary, the process put forth in these guidelines is a tool for:

- specifying the role and expectations for communication activities based on the program's behavioral objectives,

- defining the nutrition or health problem not only from the technical point of view but also from the clients' perspective,

- reviewing available resources and formulating a comprehensive behavior-change strategy—and its communication elements—that responds to the resistances and motivations of clients and of program implementers and supporters (e.g., community health workers, health staff, policy makers),

- implementing the program with the participation of clients and implementers,

- monitoring the program to adjust it to better support clients and implementers, and

- evaluating the contribution of all components of the program to improvements in health and nutrition.

As part of a recent emphasis on CBC in World Bank programs (see, for example, *Communication for Behavior Change: An Overview*, 1996, by Cecilia Cabañera-Verzosa), this guide was prepared to assist World Bank Task Managers in planning social marketing/CBC components or activities. In hopes of improving nutrition and health outcomes, this guide aims to provide Task Managers and their national colleagues with the necessary concepts to plan, manage and supervise the social marketing/CBC activities in nutrition programs.

What Roles Can Communication for Behavior Change Play?

World Bank loans support an array of interventions designed to reduce malnutrition or otherwise improve nutrition in public health terms. Table 1 below indicates both these interventions and some general roles that CBC can play in making them more cost effective. Although CBC is always geared to promoting healthful behaviors, there are important distinctions depending on the target group and the type of behavior or action required. Some communication is tailored by and for mothers or their influencers (promoting individual, family, and community actions), some for communities motivating improvements in community conditions for nutritional well-being, some for health staff or other program implementers (improving services and counseling), and some for policy makers (advocacy to support the program).

Table 1. Roles of CBC in Support of Improved Nutrition

Interventions to Address Nutritional Problems	Illustrative Behavior-Change Activities [Strategic activities beyond communication are in brackets]
Nutrition education / counseling to improve dietary (feeding and eating) practices	Advocate for continued funding and support among decision-makers by communicating prevalence, cost-effectiveness, and impact information; increase public awareness of nutritional needs; promote family and community participation in growth promotion activities; train health workers to counsel more effectively; inform mothers about feasible, improved practices; negotiate specific practices with individual mothers; give important enabling information; motivate to adapt new practices; address fears and questions.
Fortified foods (especially with vitamin A, iron, iodine, protein)	Advocate for legislation or funding to improve compliance with existing laws; [negotiate with food manufacturers / processors];create awareness of benefits and importance of the fortified food; inform people where to get and how to use it; motivate to obtain and use; [develop an appropriate, efficacious and safe fortified product that is acceptable to the public; establish effective quality control and monitoring systems], package the food in quantities that meet consumers' needs and purchasing power.
Vitamin or mineral supplements (public and / or private sector distribution / sale)	Advocate for needed funding and changes in health system norms; train health workers in dispensing norms and counseling; create awareness of the need and importance of the supplement; inform people how and where to obtain; motivate to obtain and (esp. for iron tablets) to comply with instructions for use; inform on appropriate use and how to minimize side effects; [negotiate with and give support to private vendors; improve the public distribution system], package to resolve compliance and storage problems.
Growth promotion of young children	Advocate for program funds to support this activity in the community; train health workers and volunteers in the range of needed skills; create awareness of need to participate in regular weighing and counseling; inform people how and where to participate; negotiate specific practices with individual mothers; give important enabling information to facilitate following negotiated practices; [and, if appropriate, to participate in targeted actions such as health referral, food supplements or food stamps]; establish a system to give communities feedback on their children's growth in order to stimulate discussion and collective action.

Nutritional rehabilitation of malnourished children	Teach mothers how to participate in rehabilitation; discuss how children became malnourished and negotiate actions to help avoid it in the future; give important enabling information to facilitate improved dietary practices, provide follow-up in the home and community support.
Feeding poor or malnourished children, disaster victims, refugees	Advocate for support to the program; give essential logistical information on obtaining food; teach how to use food; motivate to obtain and use food as intended by age and condition of child; teach basic nutrition concepts for use after current emergency situation passes
Food stamps or price supports for staple foods	Advocate for legislation or funding to support program; inform about benefits, logistics of obtaining, and how to use as intended; promote improved feeding practices
Growing and / or preserving food for local consumption	Motivate people to do it, teach how; [give technical and materials assistance (seeds, water, etc.)]; teach / motivate use of food for children's nutritional benefit
Treatment of parasites among children	Make parents and children aware of harm of parasites, motivate cooperation by describing multiple benefits of periodic treatment; explain how to take medicine and handle possible side effects; motivate people to prevent re-infection (breastfeeding, hand washing, use potable water, etc.) and give enabling information
Birth spacing to benefit women of childbearing age and their children	Inform (men and women) of many advantages of spacing, of alternative ways to do it; motivate them to space; give logistical and other enabling information; address fears and question

Promoting Healthy Behaviors

The essential role of CBC is to foster behavior change—actions in the home, community, or health facility that will promote healthy living, prevent health problems, or cure or limit their impact. These actions are often individual, e.g. done by a mother, although influenced by others in the house or community. The influence of the community on individual behavior should not be confused with collective action (a group decision and effort), for example, organized child care while mothers harvest crops, communal grain storage for lean times, group gardens to supply a particular high-nutrient food. These community or collective practices require different communication activities and need to rely heavily on community participation expertise. These activities are critical supplements to individual actions. Examples of the types of individual behaviors to promote are:

- key practices in the home, such as exclusive breastfeeding for about six months, introducing soft and adult foods at the appropriate ages, appropriate use of contraceptives, hand washing, use of iodized salt, oral rehydration therapy, and ceasing certain practices such as withholding foods during illness.

- utilizing services appropriately—seeking curative care at appropriate times, giving permission and/or money to one's wife to visit a health facility, bringing children for weighing and counseling or to obtain a vitamin A capsule at the appropriate times, seeking prenatal care several times during pregnancy.

- complying with health workers' instructions to take a full course of iron pills or to return for an additional supply of pills or immunizations.

CBC can motivate, teach, and give enabling information through both interpersonal and mass media, but for those actions that depend on health services, the "supply" side must also be functioning: the food or

drugs must be available and affordable, and the referral site must be accessible and capable of handling the problems referred; and quality of care (from both a professional and client perspective) must be good.

Improving Nutrition or Health Services and Their Utilization

Too often, services are designed from a technical (physicians' or nutritionists') point of view, without considering client needs and preferences. CBC can both guide a process of making health, nutrition, and family planning services more "user friendly" and promote their appropriate utilization.

Many conditions of poor health are so common in developing countries that they are not recognized as abnormal. These may include mild and moderate malnutrition, anemia during pregnancy, low birth-weight in newborns, intestinal parasites, malaria, and even some complications of pregnancy. Often, a first step to increase service utilization is to make individuals and communities aware of these problems or of high-risk conditions that should be a cause for seeking services. In addition, mothers and/or communities may need their confidence and skills enhanced so that they feel that they themselves can take actions that will really make a difference (self-efficacy).

Once people recognize a problem or the need to prevent one, they need to know what they themselves can do at home and under what circumstances and where they should seek assistance. However, even if people recognize a nutrition or health problem and know when and where to go for help, they may not go. Through formative research, programs must gain an understanding of the barriers to women utilizing health services for themselves or their children. In addition to lack of self-efficacy, these may include:

- conflict with essential daily activities, including employment, water and fuel supply, food preparation, and child care;

- concern with their personal safety;
- husbands' resistance to women traveling or insufficient cash for bus fare, clinic fees, and drugs;
- cultural distance of women from clinic settings, norms and personnel;
- inappropriate clinic scheduling, including the separation of related activities such as family planning and child health;
- insensitive clinic staff, who criticize women or treat them with disrespect; and
- poor quality treatment, due either to deficient staff capabilities or lack of equipment, drugs, and other support.

Formative (planning) research can discover the clients' perspective by dissecting these barriers, suggesting needed modifications in the services themselves, as well as revealing key communication messages and strategies for providers of services to help overcome barriers. This may mean adjusting service hours, client flow, room temperature, privacy, etc. Services can also be "promoted." A program can let people know what to expect, the benefits of the services, and what is improved. This is particularly important for preventive activities such as growth promotion and is key in encouraging people to use services improved through the implementation of IMCI protocols.

Advocacy

CBC activities can persuade and motivate policy makers and opinion leaders to support programs. Television, newspapers, seminars, meetings, publications, etc. can be employed to make policy makers more aware of the magnitude of nutrition and health problems; of the many immediate and secondary (including economic) benefits of improving

nutrition and health; of the potential action taken by them such as supportive legislation, enforcement, or funding (e.g., to require breastfeeding breaks for nursing mothers during the work day, or day care facilities at the workplace) have on individual practices and on improving nutrition outcomes.

There are many examples of successful advocacy. For example, the Brazilian national breastfeeding campaign employed CBC strategies at the policy level. A video that addressed the health consequences and loss of foreign exchange that results when women do not breastfeed helped convince planners and legislators to support programs and legislation that encouraged breastfeeding. Legislation supporting salt iodization in Brazil was also facilitated by advocates taking around a photo album of persons suffering from goiter and cretinism. Exposing politicians and health professionals in Bangladesh to the costs of undernutrition in their country and to some clear actions to address it, helped to create acceptance for an innovative community nutrition scheme.