YEMEN NATIONAL STRATEGY FOR SOCIAL AND BEHAVIOR CHANGE IN NUTRITION 2018-2021

September 2018

Technical Rapid Response Team

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List of abbreviations

ANC	Ante Natal Care
BMS	Breastmilk Substitute
CMAM	Community-based Management of Acute Malnutrition
CHV	Community Health Volunteer
EHA	Essential Hygiene Actions
ENA	Essential Nutrition Actions
FB	Facebook
IEC	Information, Education, and Communication
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
LAM	Lactational Amenorrhea Method
MTMSG	Mother to Mother Support Group
MNCH	Maternal Newborn Child Health
PLW	Pregnant and Lactating Women
PNC	Post Natal Care
SBC	Social and Behavior Change
SMS	Short Message Service
Tech RRT	Technical Rapid Response Team
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
YNDHS	Yemen National Health and Demographic Survey

CHAPTER 1. Introduction and situation analysis

1.1 Objective

This chapter aims to provide overall understanding of current IYCF practices in Yemen, main barriers, enablers, and motivations influencing optimal behavior adoption. The objective is to provide key information to design an effective nutrition "social and behavior change" (SBC) strategy developed in chapter 2 and to contribute to the national IYCF strategy 2017-2021.

Yemen National IYCF strategy 2017-2021

GOAL: Reduction of undernutrition related mortality and morbidity amongst children under 2 years of age through optimal feeding of infants and young children.

MAIN OBJECTIVE: Appropriate infant and young child feeding practices are protected, promoted and supported.

Key Indicators (Baseline 2013- target by 2021)

% newborns breastfed within 1 hour after birth (53% -75%)
% of children 0-5 month exclusively breastfed (10% -35%)
% infants given introduction of food at six months (65%-85%)
% of children 6-23 months receiving the minimum acceptable diet (15%-40%)
% of caretakers with knowledge on IYCF

1.2 Nutrition context in Yemen

Before the conflict started in 2015, Yemen's nutrition situation was poor with 47% of children under five years being stunted, 16% acutely malnourished, and 5% severely acutely malnourished (YNDHS, 2013)[1]. One-third of children under 5 years showed symptoms of diarrhea in the 2 weeks before the survey. Estimated anemia prevalence in children aged 6-59 months is 86%. Regarding women's nutritional status, 25% are underweight and 24% of the women are overweight or obese, overweight being more frequent in urban settings, and 71% of pregnant and lactating women suffer from anemia. Geographical access to health services is difficult, with 50% of the overall population having access to health care[2], and only 30% in rural areas. The current crisis is bringing additional challenges such as a deterioration of access to safe drinking water, poor sanitation, dysfunctional health services, insecurity, lack of food, and adoption of negative coping mechanisms.

1.3 Overview of Infant and Young Child Feeding Practices (IYCF)

Early initiation of breastfeeding has slowly increased over the past decades. In 2003, 53% of infants were breastfed within one hour of birth, and 76% began breastfeeding within one day of birth. One third of newborns in Yemen received pre-lacteal feeds. Although 97% of children are breastfed at some time, only 10% of infants under six months are exclusively breastfed and 44% are fed using a bottle, indicating high rates of infant formula use. The use of infant formula was widely accepted in Yemen prior to the crisis, and several studies suggest that infant formula is seen as possible solution for feeding infants[3]. The median duration of breastfeeding is 18 months.

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[1] Ministry of Public Health and Population (MOPHP), Central Statistical Organization (CSO) [Yemen], Pan Arab Program for Family Health (PAPFAM), and ICF International (2015). *Yemen National Health and Demographic Survey 2013.* Rockville, Maryland, USA: MOPHP, CSO, PAPFAM, and ICF International.

[2] Health Systems Profile-2010, Yemen Regional Health Systems Observatory- EMRO

[3] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.

Regarding complementary feeding, half of children aged 4 months already receive solid food while by the age of 6-9 months, only 65% were given complementary foods, showing both issues of late and early introduction of food.[4] Overall, only 15% of children ages 6–23 months reach the minimum acceptable diet.

In the last decade, the use of unprotected water sources increased, increasing the risk of contamination since treatment of drinking water is not a common practice.

Qat leaf chewing is common in Yemen, and while not considered to be seriously addictive, its consumption is associated with low birth weight, and with a history of child mortality[5]. Among women, 28% of women chew qat, and qat is believed to give strength to women after delivery. In some families the consumption of sugar is very important. In some cases, people buy more sugar per week than rice and flour. Sugar consumption can be related to qat consumption. Very often people are eating sweets or drinking soft drinks when they chew.

A number of structural factors and constraints hinder efforts to implement effective IYCF programming in Yemen[6], such as the limited sectorial coordination, the lack of national IYCF strategy and weak enforcement of existing legislation and guidelines, the health workforce not being sufficiently trained on IYCF, the lack of dedicated human resources, the low implementation of the Baby Friendly Hospital Initiative (BFHI), the pressure from infant formula industry on health workers, and frequent violations of BMS code.

1.4 Factors influencing adequate nutrition during pregnancy

Increasing food intake during pregnancy (having an extra meal)[7] is associated with the availability of and access to food, and availability of time, feeling that they are able and have the means to increase intake (perceived self-efficacy), being confident that the child will not get malnourished (perceived control), access to social support and perceived approval from relatives (grandmothers, sisters, and husbands). In the view of pregnant women, the main advantage of eating an extra meal during pregnancy is the benefit for their own health and their baby's health: the mother will not get malnourished and the child will grow well, move well, and get immunity.

The main barriers[8] to adequate food intake during pregnancy include not having appetite, morning sickness, fatigue, not having money to buy food, not having different foods at home, lack of support, and difficulty remembering to eat more. Other inhibiting factors are the fear of a difficult delivery if the baby is too big, and in urban area specifically, the fear of becoming too fat and not being able to move around. Other difficulties and challenges mentioned were vomiting and nausea when eating too much, stomach problems (gas, acid), feeling that the baby is pushing, and that there is not enough space for food in the stomach.

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[4] Ministry of Public Health and Population (MOPHP), Central Statistical Organization (CSO) [Yemen], Pan Arab Program for Family Health (PAPFAM), and ICF International (2015). *Yemen National Health and Demographic Survey 2013.* Rockville, Maryland, USA: MOPHP, CSO, PAPFAM, and ICF International.

[5] MIA et al. The effect of qat chewing and other factors on breast-feeding and child survival in a Yemeni society. Sudan J Paedi 2011;11(2).

[6] Yemen National IYCF strategy 2017-2021

[7] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.

[8] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.

Regarding communication, the key nutritional message "eating an extra meal during pregnancy" seems to not be an adequate message to convey the recommendation to increase food intake and may not be the most practical and feasible action for pregnant women suffering from nausea. Indeed, pregnant women understand that they should eat one large quantity extra meal per day, while the goal of increasing food intake can be achieved more easily through eating small additional snacks several times a day.

1.5 Factors influencing early initiation of breastfeeding

Several type of barriers or reasons[9] delay early initiation of breastfeeding, among them, environmental and access factors (lack of timely counselling[10], lack of social support, lack of ANC, and availability of BMS due to donations); individual factors (mother fatigue, sickness after delivery, lack of self-confidence); and tradition and beliefs (fear of harming the baby with colostrum, tradition of giving drops of cow's milk to make the baby strong, belief that the child cannot immediately hold the breast, belief that the mother should wait and rest in order to make sure that her milk will be good and abundant). In addition, social pressure discourages the mother to initiate optimal infant feeding practices (e.g. (encouragement from relatives or health staff to give infant formula). Indeed, infants born in health facilities are more likely to be given pre-lacteal feeding and to be breastfed after 1 day of life compared to those born at home[11].

Factors enabling early initiation are the access of social support and health staff support, the mother's belief that the child needs to be immediately breastfed, and the perception of relative approval. Access to information is also a key determinant of behavior change[12].

1.6 Factors influencing exclusive breastfeeding

Current evidence indicates that skin to skin contact shortly after birth and early initiation of breastfeeding is associated with successful breastfeeding and maintenance of exclusive breastfeeding[13],[14]. Factors associated with exclusive breastfeeding[15] are access to social support, counselling from health staff, feeling relatives approve of this practice, and the mother's self-confidence: feeling confident in her own ability to provide enough and good quality breastmilk for the baby, perception that breastfeeding is not difficult, being confident that her child will not get malnourished or get diarrhea, believing that breast milk only is enough for the child[16] and will prevent the child getting stomachache. In the perspective of women who practice exclusive breastfeeding, the main advantages of this practice are: the milk is always ready, free, and clean, the baby will be more intelligent, as breastmilk is good for brain development, and breastmilk protects the baby from diseases. Using messages based on fear (e.g. fear of child disease) does not seem to be an effective motivator. Regarding culture, some traditions are supportive of good feeding

[9] Juriew (2013). Yemen Anthropological study report. PU-AMI.

[10] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.

[11] Ministry of Public Health and Population (MOPHP), Central Statistical Organization (CSO) [Yemen], Pan Arab Program for Family Health (PAPFAM), and ICF International (2015). *Yemen National Health and Demographic Survey 2013.* Rockville, Maryland, USA: MOPHP, CSO, PAPFAM, and ICF International.

[12] Assabri et al. The Power of Counseling: Changing Maternal, Infant, and Young Child Nutrition and Family Planning Practices in Dhamar, Yemen. The Maternal and Child Health Integrated Program (MCHIP) and The Maternal and Child Survival Program (MCSP).

[13] Moore ER et al. Cochrane Database of Systematic Reviews. 2016; Issue 11. Art. No.: CD003519.

[14]Jaafar SH, Ho JJ, Lee KS. Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD006641

[15] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.

[16] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.

practices: “Elders used to say colostrum is important for the child” and "fill your stomach, and you will get milk in your breasts[17]."

According to women who practice exclusive breastfeeding, practical factors facilitating breastfeeding are not feeling stressed or not having problems at home, the child refusing formula milk or bottle feeding, and not having money for formula milk. These last findings suggest that they would have used formula milk, which is seen as the first choice, if their baby had not refused it or if they had the money.

Indeed, exclusive breastfeeding is not always considered a feeding practice[18]. Although breastmilk is perceived as nutritious and good, and most mothers usually breastfeed on demand[19], women feel it does not cover the hydration needs of babies. Water, water with sugar, tea, sugar biscuit, cow’s milk or infant formula are used to complement breastfeeding when mothers are not sure that the baby has enough, believe the baby needs hydration, to prevent or cure child stomachache[20] or when they are questioning the quality of their milk. The main barriers to exclusive breastfeeding[21] were the lack of support and recommendations from relatives to give additional foods, perceived disapproval from relatives, bad health of the mother, breast pain, fatigue, not having enough food for the mother, stress, problems at home, working outside the home, not having time for breastfeeding, not having enough milk, the child refusing the breast, child “crying all the time,” other caretakers giving foods, and the lack of information on breastfeeding. In addition, regarding nutrition of lactating women, access to food is a major concern, and people tend to eat fewer meals or to eat the same type of food every day.

Decision-making regarding breastfeeding and weaning[22] tends to belong to female roles. Grandmothers on both sides give advice and orientation to the mother. The oldest daughter is expected to take care of her younger siblings when the mother is busy or absent. The husband is a key support to access sufficient food for his lactating wife, facilitate time to rest and breastfeed, to take care of other children, and to access health facilities and counselling.

Availability of IYCF counselling is scarce. Access to health facilities is difficult due to distance, opening hours, and the obligation for women to be accompanied by a male relative to leave the house. Health workers are not always trained in counseling. They have a high workload and tend to prioritize curative services; some don’t perceive promoting IYCF practices as a priority or as one of their tasks[23]. In addition, some health staff are encouraged by companies to promote infant formula and receive incentives to do so.

As highlighted in the IYCF and IYCF-E strategies, several beliefs and reasons contribute to inhibiting breastfeeding, among them: “Colostrum is seen as expired milk”; “breastfeeding during pregnancy is bad for both the unborn baby and the child being breastfed, this can cause the child to have diarrhea”; “infants with diarrhea need extra water”; “malnourished mothers cannot produce enough breastmilk”; “mothers

[17] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.
[18] Juriew**,** 2013. Yemen Anthropological study report. PU-AMI.
[19] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.
[20] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.
[21] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.
[22] Juriew (2013). Yemen Anthropological study report. PU-AMI.
[23] IYCF Strategy and Barrier analysis report.

who are ill should not breastfeed"; 'stress prevents mothers from producing milk"; "breastfeeding (not exclusive) can prevent a new pregnancy".

Finally, in several documents[24,25], difficulties like "not having enough milk" and "stress preventing mothers from producing milk" have been labelled as "misconceptions" implying that women are "wrong" when the biomedical discourse says that "every woman can breastfeed." Some health staff demonstrated poor interface with patients by being judgmental or rude, and holding mothers responsible for children's illnesses[26]. These considerations highlight the need to develop more empathy within the discourse of professionals, to genuinely listen to women's experiences, to recognize that breastfeeding can be difficult, and to recognize existing good practices. Guiding documents should set the tone.

1.7 Factors influencing complementary feeding

Main factors enabling diet diversity[27] are food availability, knowledge, access to counseling, mother self-confidence and perceived skills, ability to adapt food to child motricity (finger food), positive interaction during meals such as father and mother encouraging the child to eat and praising him/her, access to social support and the approval of close relations (mother, husband, sister) and health workers. Positive motivation like believing that their baby will not get malnourished is associated with good feeding practices, whereas fear of disease is not an effective motivator. From the point of view of mother, the main advantages of a diverse diet are it protects the child from disease, provides good immunity and good growth.

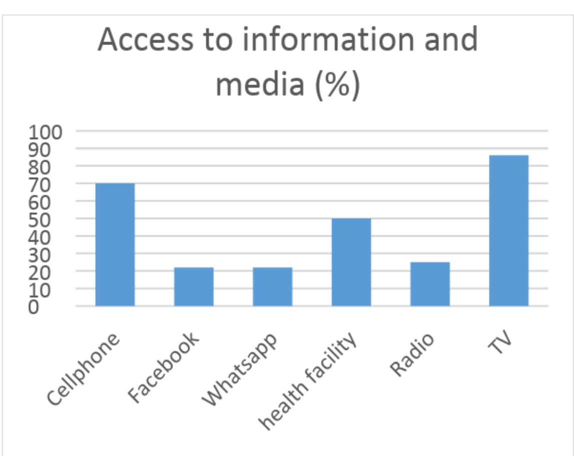
Main barriers to minimum dietary diversity[28] were not having money to buy a variety of foods, not having enough time to prepare meals and feed the child, the child not having appetite, the child being sick, lack of support, lack of access to diverse foods, lack of interaction with the child during meals[29], belief that the child should not eat too much, and difficulty remembering to give a variety of food groups.

Regarding the communication of diet diversity recommendation, the quantities needed from each group are unclear and some people tend to believe that big quantities are needed, perceiving the goal as unachievable. In terms of quantity, children's food intake is not monitored.[30] The meals are taken in common in the same dish. The children can be helped by an adult or eat by themselves. Small children have difficulty selecting diverse foods by themselves from the common dish. Children eat what they want, when they want, and how they want. Adults do not control them. Children and infants eat a lot of sweets when these commodities (biscuits, candies) are available in the house. Toddlers take food from the leftover pots and play with it before eating it. There is no systematic hand-washing before meals even when water is available.

[24] IYCF Strategy, E-IYCF strategy.
[25] Esther Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.
[26] Juriew (2013). Yemen Anthropological study report. PU-AMI.
[27] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.
[28] Busquet (2018). Barrier analysis of infant and young child feeding and maternal nutrition behaviors in urban and rural Yemen. Tech-RRT/Yemen Nutrition Cluster.
[29] The Feeding and Caring Practices of Under Two Years Children, Pregnant Women and Lactating Mothers in Four Districts of Yemen, Soul for development, 2015.
[30] Juriew **(**2013). Yemen Anthropological study report. PU-AMI.

1.8 Access to mass media and social media

Radio and TV plays an important role in people's lives and can trigger behavior change.[31] An estimated 19% listen to the radio every day and 86% watch TV on a daily basis. Local radio stations are commonly referred to as "**kitchen radio**" because women generally listen to them while they are cooking.

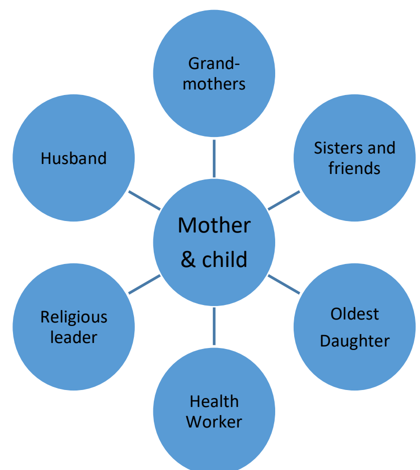


In 2016, an estimated 70% of the Yemeni population owned a mobile phone (17 million mobile phone subscriptions[32]), meaning they could receive **SMS, voice messages**, and reach or be reached via a **hotline.**

Internet is increasing in Yemen, with 25 %[33] access to internet, mainly by social media. Most people access internet via smartphone; 93% of the population who access Internet use **Facebook**; 92% have **Whatsapp**; 41% use **Youtube**. Facebook is popular among illiterate people because of its sharing pictures features.

1.9 Enabling factors for behavior change

- Parents value education and knowledge and have a strong interest in learning.
- Family values and parenthood are important. Children are culturally, socially, and religiously valued. Their wellbeing is a strong motivator.
- Islam's religious principles support good health and balanced diet, breastfeeding children until 2 years, and promote mutual support while encouraging spontaneous aid.
- Rich and diverse existing social support networks including the mother's husband, older daughter, mother, and mother-in-law, sisters, cousins, and friends.
- Formative research suggests that listening to information on media (TV, radio) can trigger behavior change in the Yemen context, and that Facebook is a powerful social media in Yemen.
- The MIYCN-TIPs research[34] found promising results regarding the ability of women to change the way they were eating and how they were feeding their children. Approaches involving couples, based on adult dialogue, discussing options and goal-setting can motivate women to try new practices.
- Horizontal support is very important between sisters, sisters-in-law, cousins and close friends and this suggests that peer support groups are an effective way to promote behavior change.



Social support network

[31] Juriew (2013). Yemen Anthropological study report. PU-AMI.
[32] Statistica 2018
[33] Battaglia (2018) Yemen - Media Landscape, European Journalism Centre.
[34] Assabri et al. The Power of Counseling: Changing Maternal, Infant, and Young Child Nutrition and Family Planning Practices in Dhamar, Yemen. The Maternal and Child Health Integrated Program (MCHIP) and The Maternal and Child Survival Program (MCSP).

1.10 Key influencers

Male partner/husband/father: Men are knowledgeable in some areas of nutrition and health. They have a larger social network and greater access to information than women, higher literacy level and greater access to phones. Men are the ones going to the market and shopping for food. They take care of children when needed and they accompany their wives to the health center because women cannot go to public spaces alone. This contact between health facilities and fathers is an opportunity to reach them and involve them in health and nutrition activities.

Grandmothers: Grandmothers on both sides give advice and orient the mother; infant care information and practices are transferred from women to women. Lessons learned from project experiences suggest that it is more suitable to refer to the role of "grandmothers", rather than "mother-in-law" as in many cultures, this term may carry some negative perceptions.

Health workers, community midwives, community educators and community health volunteers: they are the first contact with patients and can have a strong influence on facilitating behavior change, in particular regarding timely initiation of breastfeeding and exclusive breastfeeding.

Religious leaders: Religious leaders are influential as spiritual and sometimes political leaders. The Friday prayer is an important time in the community life. People listen to the advice of Imams and respect their speech. The Koran provides support for many optimal practices, such as breastfeeding and healthy and balanced diet, and these practices could be conveyed by the religious leaders.

1.11 Platforms for delivering information and support

Health facility-based platforms: Baby Friendly Hospital Initiative, maternal services (ANC/PNC) and family planning, IYCF corners, CMAM, vaccination campaigns and outreach activities such as immunization campaigns. Note that to better integrate nutrition behavior change within the health system, it is relevant to consider behavior change as a general package and to combine IYCF practices together with ENA and EHA.

Health community-based networks: mother-to-mother support groups (MTMSG), fathers' groups and peer education via men leaders ("Father" champions), health, hygiene and CMAM community volunteers.

Global events: Global Hand Washing Day[35] and World Breastfeeding Week[36].

Private health structures: Private health sector is quite developed and represents 30-50% of care-seeking choices. Although more focused on curative and for-profit, private sector should be targeted as well to ensure respect of BMS code and promotion of IYCF practices.

[35] October 15th
[36] August

CHAPTER 2. Social & Behavior change strategy

2.1 Objectives

This document aims to provide guidance on how to implement a social and behavior change (SBC) strategy to national, governorate and district level health and nutrition government actors, as well as key partners and program implementers. It contributes to the national IYCF strategy 2017-2021, complementing the IYCF-E strategy, advocacy strategy, as well as nutrition guiding policies[37].

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% of children 6-23 months receiving the minimum acceptable diet (15%-40%)
% of caretakers with knowledge on IYCF

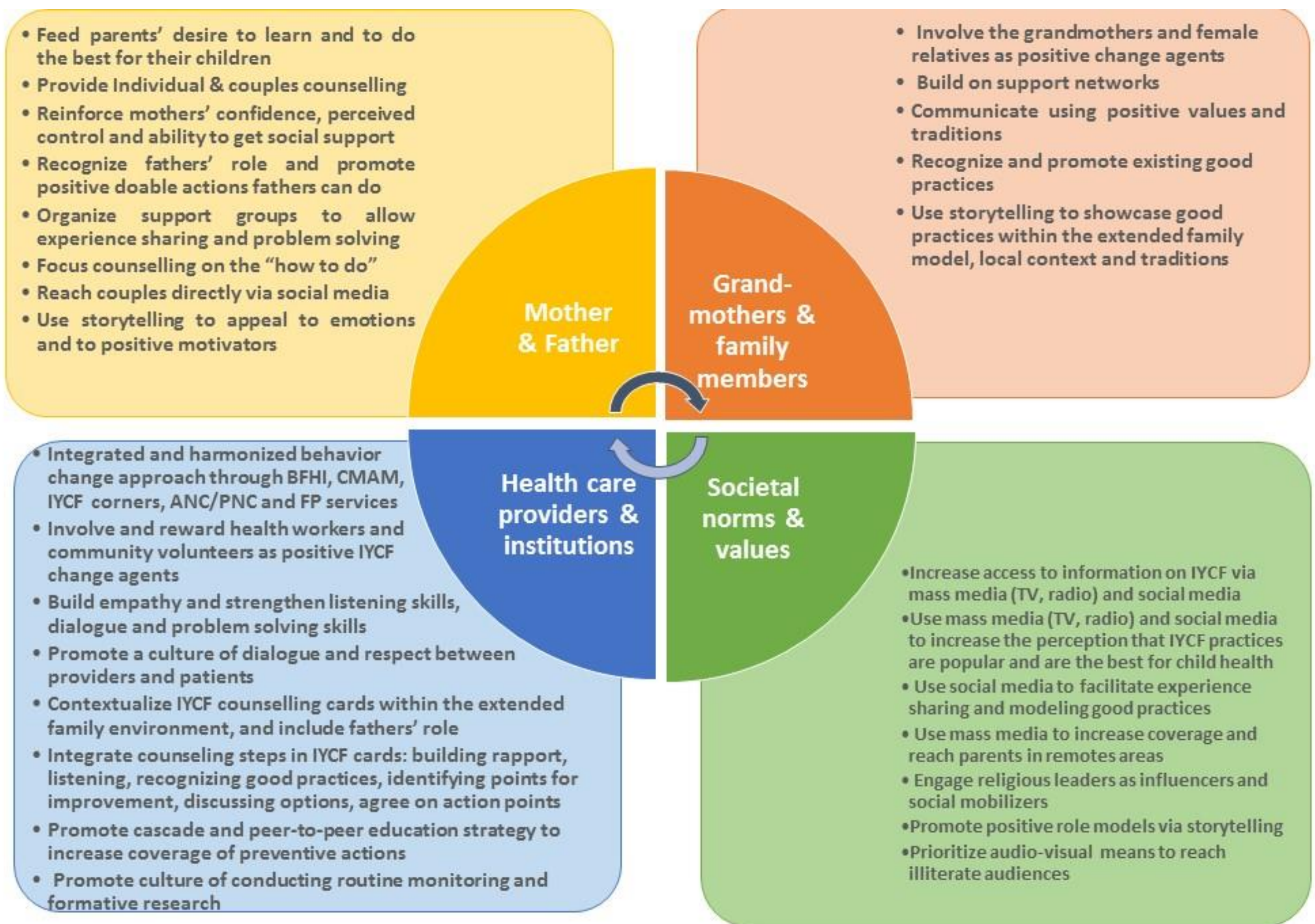
2.2 Key components

Objective: Motivate and accompany adoption of appropriate infant and young child feeding practices.			
Motivate Trigger nurturing and caring feelings Appeal to positive emotions Promote benefits (not only health benefit) Make parents feel that they are capable and skilled parents Promote positive motivators: child school success	**Engage dialogue** Create safe spaces for sharing experiences and asking questions Develop "Parent friendly" communication supports Encourage peer-support Increase access to evidence-based information	**Give options** Focus on "how to" Address common difficulties Enable informed choice by providing evidence-based information Enable individual/couple goal setting Support behavior change process	**Promote role models** Promote empowered figure of mothers and fathers Promote positive role model of grandmothers Promote positive role model of health staff Promote positive role model of religious leaders Develop father-centered interventions

[37] IFE Core Group Operational Guidance on Infant and Young Child Feeding in Emergencies (2007), The Sphere Project, IYCF Minimum Standards in Minimum Standards in Disaster Response (2011), WHO International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly Resolutions (1981), National Breastfeeding Legislation (2002) and Policy for implementation of Breastfeeding Legislation at Health Facility (2004).

2.3 Audience targeting and behavior change approach

Audience	Action
Primary audience	Pregnant women, mothers, or primary caretakers of children 0-2 years old.
Secondary audiences	Fathers of children 0-2 years old and partners of pregnant women, grandmothers, health staff (public and private practitioners, community volunteers), and religious leaders.



2.4 Develop effective behavior change communication material

Media	Action
IYCF visual aid: Counselling cards and posters	Integrate father figure in IYCF cards and show father modeling good practices Show positive role model of grandmother (e.g. grandmother protecting exclusive breastfeeding). Use photos to show complementary feeding recipes. Use photos to show happy, healthy and loving parents and baby. Promote information channels to request support (e.g. hotline, FB).

Face-to-face: support group and individual counselling	Integrate storytelling and participatory activity during Mother-to-mother support group meetings and fathers' group activities (e.g. develop a card sorting exercise[38] using photos or drawings or tell a story orally and ask questions). Develop specific visual material and content for husband/father peer-to-peer activities. Review card instructions to make sure they do not stigmatize parents. Integrate counselling steps into the IYCF facilitator tools to guide the IYCF facilitator during home visit, one-to-one or couple counselling.
Mass media: Radio and TV	Use storytelling (video and audio) to convey health and nutrition topics, challenges and solutions; develop story and characters people can relate to; appeal to emotions and motivators and promote inspiring role models of mothers and key influencers (father/husband, grandmother, health staff and religious leader). Address specific challenges of breastfeeding and feeding practices identified during the formative research stage (e.g. What to do if you feel you don't have enough milk) through storytelling, success stories and testimonies.
Social media and internet	Relay audio and video content (testimonies, success stories, soap opera) on YouTube and Facebook to extend media coverage and facilitate information sharing and audience engagement. Create a website or Facebook page with a "parent friendly" FAQ section, section with information and tools for health staff, section for mothers, and section for family and friends. Use social media to disseminate existing IYCF videos for parents. Develop FB based mother-to-mother support groups (limited to 16 members, facilitated by a trained IYCF counselor). Develop FB and YouTube based training and coaching options and forum for IYCF promotors, managed by trained experienced IYCF counselor.
Hotline and online support	Develop a hotline/online support by creating either a phone line, FB messenger, or WhatsApp info #.

2.5 Address specific barriers and challenges

Barrier/challenge	Action
"I don't have enough milk"	Conduct FGD with mothers to understand what they mean by "not having breastmilk." Develop video and audio stories based on mothers' experience of not having enough milk and propose possible action to address this issue (e.g. Monitoring child urine to evaluate milk intake, observing sucking and correct position if needed, encourage the mother to breastfeed more often, assess mother's food and water intake situation, discuss stressors and possible relaxing exercises, etc.). Promote existing audio-visual material addressing this issue (translate if needed).[39] Develop practical content with tips addressing this issue (how to check that my baby is suckling well; how to know if the baby is getting enough

[38] Examples of card sorting exercise can be found at: https://www.cawst.org/files/wavemakers/resources/3PileSortInternational-InstructionsCards.pdf

[39] Global Health Media videos: Is your baby getting enough milk? How to increase milk supply. Available at: https://globalhealthmedia.org/portfolio-items/is-your-baby-getting-enough-milk/

	milk; how to get more milk) and disseminate it via several media: IEC, website and social media. Address this specific issue during mother-to-mother support group meetings using participatory facilitation method, such as role play, storytelling, and interactive discussions and social support mapping. Train health staff on how to react when a mother says she does "not have enough breastmilk," how to listen and ask questions, analyze the situation, assess possible causes and propose tailored solutions.
"Breast milk is not enough to hydrate"	Promote evidence-based information regarding breastmilk hydration function. Develop story (audio or video) where mother is confronted with the challenge of hot weather and discuss hydration needs with family members. Promote concrete tips to monitor baby milk intake and hydration status (e.g. monitor urine, encourage the mother to drink more water). Develop participatory activities to discuss what to do during hot season. Consider realistic possible solutions for non-breastfed children. Develop didactic video and audio of health practitioner explaining why breastmilk meets the hydration needs of the baby. Address this specific issue during mother-to-mother support group meetings using participatory facilitation methods, such as role play, storytelling, and interactive discussions and social support mapping.
"How to know when the child is ready to eat food"	Use video to illustrate physical signs showing that the child is getting ready to eat complementary food. Translate and promote existing audio-visual material addressing this issue from Global Health Media[40] and Thousand days.[41] Build parents' responsive feeding skills and child development knowledge. Share evidence-based information and promote trustworthy information sources through social media. Develop participatory activities to discuss this question in mother-to-mother support groups; the facilitator should be aware of not blaming parents and not making them feel guilty for past suboptimal practices.
"My child refuses to eat"	Promote practical tips for parents to encourage the child to eat, prioritize available "super foods" to maximize food intake, and avoid force feeding. Promote attractive and nutritive recipes through mother-to-mother support group, radio, TV and FB. Encourage mothers to seek for nutrition counselling and care services to assess child health.

2.6 Reinforce and promote enablers

Enabler	Action
"Father or relative encourages the child to eat"	Promote the model of father and relatives supporting the mother (e.g. taking meal with the child, helping the child to eat, encouraging and praising the child, playing small games or singing songs). Showcase "positive interaction during meals" through videos and pictures (e.g. photos or drawings showing good practices).

[40] Global Health Media videos: When to start solid food?
[41] https://thousanddays.org/for-parents/

	Enable mother-to-mother experience-sharing about the possible ways to create positive interactions during meals at home, develop social support mapping and action plan with mother to support behavior adoption.
Interest in using breastfeeding as a family planning method	Integrate specific information in IYCF cards regarding the effect of exclusive breastfeeding as a family planning method (Lactational Amenorrhea Method, LAM), clarify what “exclusive” means (e.g. no water) and how to do it. Use storytelling (video, audio, oral) to promote the contraceptive benefit of exclusive breastfeeding and to explain how to do it properly.
Availability of social support network	Illustrate the role of fathers (e.g. taking care of older children, encouraging the child to eat, showing children how to wash hands) and contextualize the practices within the extended family and social network. Develop specific communication for family members and friends on how to support a pregnant woman and breastfeeding mother.
Islam supports continued breastfeeding and balanced diet	Conduct FGD and interviews with religious leaders to discuss the importance of good nutrition in the Koran, which verses support IYCF and the possible support or role religious leaders would be willing to play. Develop social mobilization strategies and sensitization activities based on FGD and interview findings. Promote the positive attitude of religious leaders toward IYCF through storytelling, by integrating a figure of Imam supporting IYCF in stories (audio, video, etc.).
Desire to be a good father	Integrate husband/father in counselling session when possible. Use the opportunity of fathers/husbands accompanying wives or children to the health facility to engage them as positive agents of change. Investigate fathers’ attitudes, practices, and beliefs toward nutrition, hygiene and health, and fathers’ influence on IYCF (e.g. food shopping practices, educating children to wash hands, feeding children, couple dialogue regarding spending and task sharing). Based on formative research findings, develop detailed father social mobilization or peer education strategies.
Interest in learning and doing the best	Develop self-assessment tool to monitor individual behavior change progress. Multiply channels of communication (radio, TV, face-to-face, FB) to increase access to information and promote trustworthy sources of information.

2.7 Improve patient-practitioner interface and counselling quality

	Action
Build key counseling skills: empathy, active listening, problem solving	Build capacity of health staff by reinforcing key counselling skills: empathy, active listening, and problem solving. Integrate behavior change negotiation methodology within IYCF facilitator manual. Develop and disseminate training material (manual and videos) on good counselling practices. Develop a FB page or WhatsApp group for IYCF facilitators to share experiences and questions and get technical support from an experienced IYCF expert, and access training material and up-to-date information. Build the capacity of MTMSG facilitators on participatory methods, adult dialogue and group dynamics.

Promote the model of supportive health staff	Promote image of supportive health staff in mass media and social media. Develop audio and video of health staff sharing a positive opinion toward IYCF promotion and successful experiences of facilitating behavior change.
Mainstream respect and ethics in guidelines.	Review IYCF guidelines and tools to ensure that the perception, opinion and experiences of mothers are respected and valued, to avoid stigmatization and blaming language.

2.8 Create fictional characters and stories based on audience profiles

Urban Woman	Rural Woman
Urban, educated, some literacy, work outside of home, aspiration to modernity, better access to health services (private and public), rely on buying food, consumption habit influenced by Western model (consumption pattern in transition), religious, has a smartphone and access to social media and internet, collaboration with husband, watches TV when possible, reaches out to her friends when she has a concern.	Rural, remote places and limited access to health services, low education and literacy level, attached to tradition, listens to elders, strong religious values, stays home and participates in agricultural tasks like water and wood collection, may do home gardening, limited movement without a male relative, listens to kitchen radio when cooking, husband has a cellphone, watches TV when possible.

Generic Scenario: The mother is the "hero" of the story. She wants to do the best for her child, but she faces some challenges. On the way, someone (key influencer) helps her and finally, with the support of her family and friends, she succeeds in overcoming the challenge, and the child grows strong, healthy and happy.

The background of the story can include some messages addressing the issue of qat chewing. For instance, we can include in the scenario some family members encouraging the mother to breastfeed, to take care of herself and to avoid qat chewing, and some neighbors debating on the effects of qat chewing and other way to deal with stress. Although the objective will be to discourage the practice, the messages need to be positive and should not stigmatize the mother as bad mother for chewing qat. They should encourage alternative practices to replace qat chewing and reward effort for avoiding qat chewing.

2.9 Examples and references

Communication Objective	Resource and reference
Integrating the father figure within IYCF visual aids	Ethiopia family scorecards of feeding actions, from Alive& thrive https://www.aliveandthrive.org/wp-content/uploads/2018/02/family-scorecards-of-feeding-actions_English.pdf
Developing specific messages and videos targeting fathers	SPRING Sahel, Table 1: List of Community Videos Produced and Description of Male Involvement Content https://www.spring-nutrition.org/publications/reports/father-factor

Communication Objective	Resource and reference
Developing "Parent friendly" content and videos	Thousand days https://thousanddays.org/for-parents/
Demonstrating good counselling through videos to train promoters	Global Health media The Nutrition Counselling Visit for Young Children https://www.youtube.com/watch?v=RBGZ44NbeoU
Promoting the image of the grandmother protecting exclusive breastfeeding (instead of having a negative influence)	Breastfeed4Ghana The Best Protection a Mother Can Give, page 5. http://breastfeed4ghana.com.gh/wp-content/uploads/The-Best-Protection-a-Mother-Can-Give.pdf
Producing stories in video to teach mothers how to maintain breastfeeding while working outside of home	Breastfeed4Ghana How to breastfeed when you work outside of the house https://www.youtube.com/watch?v=tT103Ns_fx4&feature=youtu.be&has_verified=1
Using photos to build an attractive recipe book for complementary feeding	FAO/EU Food Facility Project "Improve the Food Security of Farming Families Affected by Volatile Food Prices" https://camnut.weebly.com/uploads/2/0/3/8/20389289/2011_recipe_cf_job_aid_en.pdf
Share trustworthy information sources providing audiovisual educational material in Arabic for mothers and practitioners	Global Health Media Project https://globalhealthmedia.org/videos/videos-arabic/
Showing healthy and smiling babies, girls and boys, to trigger parents' emotions and motivations	Breastfeed4Ghana http://breastfeed4ghana.com.gh/wp-content/uploads/The-Best-Protection-a-mother-can-give.Complementary-Feeding.small-2.compressed-2-1.pdf
Focusing on "how to" to support behavior change	Thousand days Video: Is your baby ready to start eating foods? https://thousanddays.org/is-your-baby-ready-to-start-eating-foods/
Developing specific messages for family and friends to support mothers to breastfeed	Breastfeed4Ghana http://breastfeed4ghana.com.gh/resources/family-and-friends/
Developing a social media campaign using Facebook	Breastfeed4Ghana https://web.facebook.com/breastfeed4GH/?_rdc=1&_rdr
Developing behavior change activities to address specific barrier aor driver, e.g. promote practical advantages (free, clean, ready to use) of breastfeeding compared to using infant formula.	LHSTM/Gain alliance, EMO-DEMO activities, Time Competition and cost calculation, p7-9. https://blogs.lshtm.ac.uk/envhealthgroup/files/2015/04/Emo-Demo-Descriptions.pdf

2.10 Additional communication considerations

Adapt language to local context: Spoken Arabic language is not homogenous in Yemen and local variations need to be taken into account when translating messages[42]. Consider the local accent for local radio programs.

Use photos rather than drawings to promote complementary food and recipes: Attractive photos of food trigger senses (taste, odor), appetite and souvenirs. A porridge recipe illustrated with a photo is much more appealing and more likely to motivate one to cook it.

Use photos of happy and healthy babies, active and smiling toddlers, caring and loving parents to appeal to positive emotions and nurturing feelings; it is easier for parents to relate to photos and identify themselves as fathers and mothers, similar to the proposed role model. Build on the experiences of popular commercial brands (soft drinks, cellphones) to identify the types of pictures people prefer. Remember that breastfeeding promoters are competing with commercial infant formula promotion campaigns.

Take time to test and refine the newly created visual aids and other communication material to ensure that it is understood as expected, it is appropriate and respectful of the culture, how much does it engage and motivate the audience, and it does address the communication issue as intended. The Health Compass[43] website provides a number of how to guides to develop a creative brief, proceed to audience segmentation[44], create and pre-test[45] communication material.

Use testimony and success stories to motivate people to practice, such as a father talking about how he encourages his 9 month old baby to eat new foods by eating with him/her and praising him/her; a grandmother proud of her daughter who is exclusively breastfeeding and the 4 month old baby is growing well, sleeps well and doesn't cry much; a young mother explaining what motivated her to make the decision to breastfeed and promoting its practical advantages (free, ready, clean); a mother sharing her concern about not having enough milk for the baby and explaining how she overcomes the challenge with support from her IYCF counsellor and family support, and giving concrete tips (small doable actions) that can be done to help having more milk.

Communicate from the parents' perspective (user-centered communication) and develop "parent friendly" communication tools. Focus on common challenges and questions parents often ask and provide concrete "how to" guidance: how to know if my baby is ready to eat complementary food; how to know if my child is suckling well; how to breastfeed a child when you work outside home; how to deal with morning sickness during pregnancy; how to know if my child is hungry or is full; how to prepare a healthy snack when I am busy; how to teach the caregiver to wash hands before feeding my child when I am not at home.

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[42] Juriew (2013). Yemen Anthropological study report. PU-AMI.
[43] Available at: https://www.thecompassforsbc.org/how-to-guides
[44] How to conduct audience segmentation for SBCC: https://www.thecompassforsbc.org/how-to-guides/advanced-audience-segmentation-social-and-behavior-change
[45]How to conduct a pre-test: https://www.thecompassforsbc.org/how-to-guides/how-conduct-pretest

2.11 Monitoring and evaluation

Formative research, pilot, refine and scale up intervention

Test new communication material to refine it before scaling up to a national campaign.

Conduct formative research to tailor interventions:

- Explore attitudes toward health and nutrition, willingness and opportunity for religious leader to support IYCF campaign.
- Explore attitudes of fathers and husbands toward health and nutrition, and build a strategy to involve them as change agents (e.g. social mobilization, peer education, etc.).
- Solve practical challenges to implement adequate diet diversity, for instance, develop a practical recipe book for feasible complementary feeding with locally available ingredients.

Progress monitoring

Progress indicators should be defined after the nutrition SBC strategy and implementation plan' validation, and might include, among others:

- Number of actors/partners committing to contribute to the nutrition SBC strategy
- Budget allocated to SBC strategy implementation for year #1, #2, and #3.
- % of PLW enrolled in mother-to mother support groups
- % of target audience reached through more than 1 media (radio, FB, M2MSG, hotline)
- Number of IEC material developed and pre-tested
- Audience reached or media coverage
- Number or % of health staff trained in counselling skills (W/M)
- % Attitude in favor of optimal IYCF practices (e.g. exclusive breastfeeding)
- % care takers with adequate Knowledge on IYCF practices (e.g. age to introduce complementary feeding)

Effectiveness evaluation and lesson learned capitalization

Midterm review evaluation: 2019

- Review of implementation and evaluation of the social and behavior change strategy and tools by stakeholders, health staff and IYCF promoters and parents of children 0-2 years old: effectiveness, appropriateness, relevance, cost and coverage.

Final review: 2021

- Measure outcomes by comparing key indicators at end line and baseline (DHS2013).
- Capture individual change process by trying self-evaluation tools, such as parent score cards for essential nutrition actions[46] and story of change (e.g. using the most significant change[47] method).
- Conduct lessons learned workshop to capitalize on experience and learning and make recommendations for the next nutrition SBC strategy.
- Integrate learning within the IYCF strategy evaluation.

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[46] Example of parent score card: https://www.aliveandthrive.org/wp-content/uploads/2018/02/family-scorecards-of-feeding-actions_English.pdf

[47] Information and guidelines available at: https://www.betterevaluation.org/resources/guides/most_significant_change