TECHNICAL REPORT

ON

INFANT AND YOUNG CHILD NUTRITION BCC CAMPAIGN STRATEGY DEVELOPMENT WORKSHOP

HELD AT MIKLIN HOTEL
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REPORT

BY

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EXECUTIVE SUMMARY

In order to control the high prevalence and the increasing burden of anaemia among children in Ghana, the Ghana Health Service (GHS) with support from the Behaviour Change Support (BCS) Project has put in place four strategies to deal with the situation. These strategies has been integrated into other strategies and programmes of which the main ones currently being used are, Food Based strategy, Food Fortification strategy and Infant and young child feeding strategy as well as the School Health Education Programme. A number of Food Based strategies and Food Fortification strategies have already been put in place to reduce anaemia. However, the Infant and young child feeding strategy is yet to be launched. In view of this, a one day workshop was organised for all stakeholders to discuss strategies to deal with the anaemia burden among children in Ghana considering major contributory factors such as malnutrition, malaria and worm infestation.

The workshop was attended by stakeholders and partners working in the technical and key areas such as Maternal Newborn and Child Health (MNCH), Nutrition, Water and Sanitation, Malaria. A total of 47 representatives participated in the workshop. A combination of presentations and group work were used at the workshop. Each presentation was followed by discussion, comments, questions and answers. Some of the topics presented includes; An Overview of Nutrition BCC In 2010, Strategies/ interventions to control anaemia and iron deficiency in Ghana, Current anaemia figures in Ghana, the potential effects, the proposed rationale and key objectives for the campaign and key objectives and the state of rationale and proposed direction of the Nutrition Campaign.

After the presentations participants worked in groups to define specific messages around anaemia, malnutrition, worm infestation, water and sanitation.

At the end of the workshop, it was decided that a team would be built to work with an advertising agency to flesh out campaign concept, approaches, channels and materials. A campaign will then be launch on the Infant and young child feeding strategy. Participants were to share existing thematic related appropriate materials to enable the campaign to build on these materials. Finally participants were encouraged to actively participate in the campaign at various levels, from national to the community levels.

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ABBREVIATIONS AND ACRONYMS

BCS	- Behaviour Change Support
BCC	- Behaviour Change Communication
GHS	- Ghana Health Service
MNCH	- Maternal Newborn and Child Health
HIRD	- High Impact Rapid Development
MDG	- Millennium Development Goals
NACS	- Nutrition Assessment Counselling and Support
PML	- Princess Marie Louis
WHO	- World health Organisation
GAIN	- Global Alliance for Improved Nutrition
FDB	- Food and Drugs Board
MOFA	- Ministry of Food and Agriculture
IPT	- Intermittent Preventive Treatment
ITN	- Insecticide Treated Net
DHS	- Demographic Health Survey NFFA
UNICEF	- United Nations Children's Fund
NGO	- Non Governmental Organisation
SHEP	- School Health Education Programme
SMP	- Statutory Maternal Pay
IMCI	- Integrated Management of Childhood Illness
RBM	- Roll Back Malaria
FBO	- Food Based Organisation
CBO	- Community Based Organisation
TBA	- Traditional Birth Attendance
CHW	- Community Health Workers
CDW	- Community Development Workers
HIV	- Human Immunodeficiency Virus
AIDS	- Acquire Immune Deficiency Syndrome

LIST OF TABLES

1.0. INTRODUCTION

The Behaviour Change Support (BCS) Project is a four year USAID supported project being implemented in three coastal regions in the country – Greater Accra, Central and Western Regions. The purpose of the project is to support the Ghana Health Services (GHS) at the national, regional and district levels in its efforts to achieve the health and health related MDG targets. One of the five thematic areas for BCS (Behaviour Change Support) project is Child nutrition, the others being, Maternal, Neonatal and Child Health; Family Planning, Malaria, Water and Sanitation (Personal hygiene).

BCS uses two main approaches- the Integrated and Campaign. The integrated approach deals with all the thematic areas together and for a long time and the campaign approach highlights specific thematic area at a time and in detail. During the previous year the Project mounted a campaign on Family Planning- Life Choices and a Behaviour Change Support project dubbed "Good Life-Live it Well". The aim of the Good-life-Live it well campaign was to inform Ghanaians that good life, aspirations and goals in life can be attained when one is in good health. This year BCS is mounting a Child Nutrition campaign. In view of this, the department of Nutrition, Family Health Division with support of the Behaviour change Support project scheduled a day's workshop for stakeholders to discuss strategies to deal with the anaemia burden among children in Ghana considering major contributory factors such as malnutrition, malaria and worm infestation.

2.0. AIM OF THE WORKSHOP

The aim of this workshop was for stakeholders to discuss strategies for a successful behaviour change campaign.

2.1. OBJECTIVES

The main objective was to collectively evolve ways to effectively deal with the huge anaemia burden among children in Ghana considering major factors such as malnutrition, malaria and worm infestation.

2.2. SPECIFIC OBJECTIVES

a. To use the central theme for the Behavioural Change Strategy (BCS) campaign to urgently prevent anaemia in pregnancy and delivery, child growth and development;

b. To develop a conceptual framework for the campaign looking at anaemia as the central theme;

c. To build on previous anaemia BCS activities and highlight perceived threats of thematic areas to stimulate action;

d. To create an effective and useful balance between the multiples of key messages under each thematic area and the need for more simplified yet technically correct messages for care givers.

3.0. PARTICIPANTS

The workshop was attended by stakeholders and partners working in the technical/key areas (MNCH, Nutrition, Water and Sanitation, Malaria). A total of 47 representatives participated in a day's workshop. (Appendix 7)

4.0 METHODOLOGY

The BCS team and GHS staff responsible for Child Health and Nutrition coordinated and facilitated the workshop. A combination of presentations and group work were used at the workshop. Each presentation was followed by discussion/comments, questions and answers. After the presentations participants worked in groups to define specific messages around anaemia, malnutrition, worm infestation, water and sanitation etc. The Deputy Chief of Party, BCS, introduced participants and presented the specific objectives of the Planning workshop. Participants were officially welcomed by the Head, Nutrition Department, GHS, on behalf of the Director of the Family Health Division, GHS.

4.1. PRESENTATION 1

An Overview of Nutrition BCC in 2010 was presented by Wilhelmina Okwabi who is the Deputy Director, Nutrition Department of the Ghana Health Service (GHS).

4.1.1. GOAL

The goal of the Nutrition BCS campaign was to ensure that all persons living in Ghana are well nourished.

4.1.2. OBJECTIVES

In order to achieve this goal the GHS focused on the following objectives:

a. Improving awareness and knowledge in nutritional issues including skills in appropriate infant and young child feeding and maternal nutrition;

b. Promoting improved nutrition in special situations including management of malnourished children and persons living with HIV & AIDS;

c. Preventing/controlling micronutrient deficiencies due to iodine, iron and vitamin A;

d. Improving maternal nutrition to reduce anaemia.

4.1.3. THE PROBLEM/PREVALENCE

The major nutritional problems of which women and children are mostly affected were outlined as follows:

a. Protein energy malnutrition: According to the Ghana Demographic Health Survey,2008, 28% of children under five are stunted that is too short for their age, with 9% wasted (too thin) and 14% underweight (i.e. with low weight for their height);

b. Micronutrient deficiencies: Iron deficiency, Vitamin A deficiency and iodine deficiencies are the major micronutrient deficiencies observed in Ghana.78% of preschool children

   65% of pregnant women and 59% of women of child-bearing age (15-49years) are iron deficient. 72% of these children are vitamin A deficient. Out of 27 districts surveyed, 9 districts had serious iodine deficiency problems;

c. The two major nutritional problems now co-exist with diet related non-communicable diseases such as obesity, overweight, diabetes, hypertension etc.

With these statistics, the presenter clarified the need for a high impact rapid development (HIRD) approach to curb these deficiencies in order to meet the target set by the Millennium Development Goals 4 (i.e. Reduce child Mortality) and 5 (To improve maternal health).

4.1.4. INTERVENTION STRATEGIES

The Ghana Health Service has therefore put various interventions in place in order to control and prevent protein energy malnutrition and micronutrient deficiencies. Some of the strategies adopted in the control of these deficiencies were as follows:

a. The supplementation of various micronutrients. Example is supplementation of iron and folate for pregnant women and lactating mothers, vitamin A supplementation for children 6 months and above once every 6months until the child is 5years;

b. Fortification of some selected flour and vegetable oil has also been fortified with vitamin A and there is the fortification of salt with iodine;

c. Other public health interventions strategies have also been taken in collaboration with other stake holders. Some of which are the promotion of good hygiene and sanitation, de-worming, malaria control and immunization;

d. There has also been a new healthy paradigm- regenerative nutrition which seeks to promote healthy eating lifestyles among Ghanaian. In view of this radio and television jingle on healthy eating lifestyle is advertised occasionally.

4.1.5. ACHIEVEMENTS

With these interventions, some achievements were made. These were outlined as follows:

a. Supplementary Feeding Programme: This programme provided health and nutrition education, growth, monitoring and promotion, deworming, Vitamin A supplementation, immunization and food to children under five, pregnant and lactating women in 26 districts in the 3 Northern regions. About 14,000 children 6-24 months old, 60,000 children 2-5years and 10,000 pregnant and lactating women were covered;

b. Food Fortification: At the moment all wheat flour and about 84% vegetable oil has been fortified with vitamin A. A legislative instrument has also been developed for the amendment of the food law submitted for approval by cabinet;

c. Micronutrient Deficiencies: For iodine deficiency, a market sensitization has been conducted in Greater Accra region. Other activities such as TV documentaries and radio programs have also been planned;

d. For iron deficiency /anaemia, there is a radio spots on anaemia control in pregnancy translated in local languages and aired on 16 radio/FM stations nationwide. While School age children have been dewormed and Guidelines developed and piloted for school aged children in collaboration with stakeholders and partners;

e. For Vitamin A deficiency, consumption of foods rich in vitamin A is being promoted. There is distribution of vitamin A capsules for children 6-59months with 80% national coverage. In addition to this there is an on-going distribution of Vitamin A capsules for lactating women within 8weeks after delivery;

f. Nutrition and HIV/AIDS: Adequate nutrition is a co-therapy for HIV/AIDS. Good nutrition is required to boost the compromised immune system in HIVAIDS patients. For this reason, dietary guidelines have been developed for people living with HIV/AIDS. In addition a training material on Nutrition assessment, counselling and support (NACS) has also been developed. These have been implemented in three initial facilities in Greater-Accra region (Ridge, PML, and Korle-Bu teaching Hospitals) and two facilities in central region (Agona, Swedru and Assin Fosu Hospitals).

4.1.6. CHALLENGES

These achievements as reported came about with lot of challenges. The key challenges faced are as follows:

a. There is a large fund gap for implementation of programmes and planned activities;

b. There are no adequate staffs at national and district levels in particular. There is no nutrition staff at sub-district levels;

c. It is also difficult to secure district assembly support for programme/activities at the community level;

d. Collaborators do not fully commit to programmes;

e. There is therefore the need to develop a comprehensive and integrated nutrition communication strategy as well as a National Nutrition Policy.

4.1.7. PLAN OF ACTION FOR 2011

a. Build capacity to promote growth at regional, district/ sub-district and community levels to implement the new WHO growth standard that will intensify nutrition BCC in all program areas especially complementary feeding;

b. Develop easy to use counselling cards to facilitate the health workers counselling sessions at the health facilities, since health workers tend to advice and not counsel mothers;

c. Support micronutrient food fortification in collaboration with Global Alliance for Improved Nutrition (GAIN) and FDB (Food and Drugs Board);

d. Develop a National Nutrition Policy.

4.1.8. COMMENTS & QUESTIONS FROM WORKSHOP PARTICIPANTS

a. How do we approach fortification with iron, when most people eat locally grown foods which may not be possible to be fortified?

b. Behaviour Change Communication (BCC) should focus on improving the consumption of locally available foods, and not encourage use of micronutrient powders and other supplements.

c. As part of BCC, nutrition interventions should take a good look at the curriculum in schools and school age children.

d. Malnourished Children eat more flour products (ex. Bread, puff loafs etc…), hence the fortification of flour. However, home based fortification of local grains such as maize, and millets should be encouraged. This is in the pipeline, even though it is difficult to get done, it is being built on gradually.

4.2.0. PRESENTATION 2

Another presentation was made by the focal person for anaemia, **Kate Quarshie** from the Nutrition Department, Ghana Health Service. She presented on the "Strategies/ interventions to control anaemia and iron deficiency in Ghana".

4.2.1. OBJECTIVES

The objective of the Anaemia Control Strategy is to reduce the prevalence of aneamia by 25% in pre-school children; school aged children and pregnant women in 5 years.

4.2.2. THE PROBLEM

The prevalence of anaemia at the time of developing the strategy is as follows; 76% of preschool children, 65% of pregnant women and 42% of women 15-49years were anaemic (DHS 2003).

4.2.3. INTERVENTIONS

The interventions adopted 5 key strategies:

a. Food Base Interventions: This includes dietary diversification and food fortification strategies. For dietary diversification, there is the need to promote increase production and consumption of iron-rich, vitamin A and C foods in collaboration with MOFA. Promote consumption of fruits with meals and promote exclusive breast feeding and timely and appropriate complementary feeding in collaboration with the Infant and Young Child Feeding strategy. For food fortification, there is the fortification of wheat flour produced and imported into the country with Vitamin A, iron, zinc, folic acid, B-vitamins 1,2,3 and 6 and industrially produced /imported vegetable oil with Vitamin A. This must be done in collaborations with the Food and Drugs Board and National Food Fortification Alliance (NFFA) and other partners;

b. Micronutrient Supplementation: : Iron and folic acid supplementation for the period of pregnancy and until 6 weeks after delivery (In the Safe Motherhood Programme);

c. Malaria Control and IMCI: Intermittent Preventive Treatment(IPT) for pregnant women, promoting the use of insecticide treated net (ITN), improving home-based care for malaria, and getting appropriate and prompt treatment for malaria and anaemia particularly in children as part of IMCI

d. Helminthe Infection Control (intestinal worms): Promoting twice yearly de-worming of children aged 2 years and above. Promote good hygiene and environmental sanitation practices;

e. Nutrition Information and Communication: This targeted pregnant women, caregivers and school-age children. For each target group identified, problem behaviour, desired behaviour, barriers, objectives, strategies for achieving the objectives and activities were identified.

4.2.4. SOME PROBLEMS/BEHAVIOURS IDENTIFIED

a. Caregivers do not exclusively breastfeed their infants for the first 6 months of life;

b. Caregivers introduce complementary foods either too early or too late.
c. Care givers do not deworm their children every 6 months they either deworm too frequently or not at all;

d. Care givers have poor knowledge, production, availability of iron, Vitamin A and C rich/fortified foods as such do not give adequate food rich in these nutrients;

e. Children do not sleep under treated bed nets;

f. Caregivers do not properly treat malaria to help prevent anaemia, and lack of good personal and environmental hygiene practices.

4.2.5. SOME TARGETED OBJECTIVES TO EFFECT CHANGE WITH THESE PROBLEMS/BEHAVIOURS

a. By the end of 5 years caregivers in RBM/IMCI districts will give their children a fruit with one meal/day, be aware of the need for deworming their children twice a year, and deworm their children twice annually;

b. 60% of children will sleep under treated nets, and those with malaria will receive prompt and correct treatment. Advocate for provisions of environmental health facilities by district assemblies and development partners;

c. Incorporate anaemia issues in pre-service and in-service training curricula and train health workers to provide adequate counselling on anaemia and its related issues to caregivers.

4.2.6. SOME TARGETED STRATEGIES USED TO EFFECT CHANGE IN THE OBSERVED BEHAVIOURS AND PRACTICES

a. Policy Level: There should be advocacy for the provision of environmental health facilities by district assemblies and development partners. There should also be advocacy to ensure the availability of dewormers, antimalarial drugs, and insecticides treated nets and chemicals for retreatment.

b. Community Level: Improve knowledge of Food Based Organisation (FBO), Community Based Organisation (CBO), Traditional Birth Attendants (TBA), Community Health Workers (CHW), Community Development Workers (CBW) on all the issues related to anaemia control so they could educate caregivers appropriately.

c. Institutional/ Organizational level: Incorporate anaemia issues in pre-service and in-service training curricula. Train health workers to provide adequate counselling on anaemia and its related issues to caregivers. Improve knowledge of teachers, health and other extension workers.

d. Interpersonal: It is important for families and friends to reinforce health messages. Health workers and other extension workers should provide adequate counselling on anaemia and its related issues.

e. Primary Target Level: Improve knowledge and practices of care givers of children and make treated nets affordable and available through targeted subsidies and exemptions for paupers.

4.2.7. COMMENTS FROM WORKSHOP PARTICIPANTS

a. There is an ongoing effort to have the cottage industry made products like Palm kernel and palm oils fortified as well.

4.3.0. PRESENTATION 3

The third presentation was done by Mr. Ian Tweedie, Chief of Party, BCS Project.
The presentation dealt with the current anaemia figures in Ghana, the potential effects, the proposed rationale and key objectives for the campaign and key objectives and the state of rationale and proposed direction of the Nutrition Campaign

Some key points from the presentation are as follows:

4.3.1. OBJECTIVES

a. Increase threat perception of anaemia and the contributory factors such as malaria, malnutrition, poor hygiene behaviours, worm infestation and identify priority barriers specific to each behaviour;

b. Simplify detailed and at times confusing information on child nutrition into an easy to remember and doable messages, including reasons why it is important to take action and the benefits of doing them;

c. Review WHO Food Groups categorization (7), that of Ghana (3)for Young Child Feeding;

d. Identify possible ways to simplify the messages for age appropriate feedings a day- i) to reduce the number of age groups which would in turn reduce the confusion in messages. ii) Streamline all the different numbers and, iii) Illustrate the stages in a way that is memorable and easy to understand;

e. Ghana's food pyramid not fully established and categorized to help caregivers understand what categories of foods would be recommended per day and this should be done.

4.3.2. COMMENTS & QUESTIONS FROM WORKSHOP PARTICIPANTS

a. Mothers do not take into consideration the itemized groupings of nutrients on the food groups;

b. Emphasizing only enriched porridge for 2 – 5 year olds is not the best. The child should partake in other family foods;

c. Age group should be divided into three instead of four. Technically it makes things simpler for caregivers and health workers. Include advocacy component in the media (Radio stations are not communicating the correct messages;

d. Breastfeeding should be discussed in the context of before and after the child walks;

e. It is important to look at other target groups of caregivers (e.g. other family members, house helps, aunties, uncles) that also matter when it comes to providing the proper nutrition for the target group of under 5;

f. Mother-to-Mother support groups should be strengthen. They should be involved as a target group to support breastfeeding (these groups are community based). CHO's and community health workers can provide them with up to date information to share with mothers- information with regard to child nutrition, particularly in the area of complementary feeding.

5.0 GROUP SECTION

Participants went into groups to define answers to some critical questions that help to define the BCC strategy for anaemia, malnutrition, diarrhoea and worm infestation. Group 1 was made up of the Anaemia Group, Group 2- Malnutrition, Group 3- Infection and Infestation and Group 4-Food Preparation.

5.1. GROUP 1

5.1.1. ANAEMIA

Question 1:
Why should anaemia control be a matter of urgency in the country?

Answer:
a. Due to its high and persistence anaemia prevalence in Ghana;
b. Anaemia contributes to Maternal & Child deaths and illnesses;
c. It may lead to poor productivity and poor mental health development.

Question 2:

a. What is the level of public recognition of the threats of anaemia to the development and growth of children under five years and pregnant women?

b. What is the public's level of appreciation of the benefits of effective control measures at the family level?

Answer:
a. The Level of public recognition of the threats of anaemia to children's development and safe pregnancy is quite low;

b. The Benefits of effective control of anaemia and its contributory factors are not appreciated due to inadequate knowledge (e.g. De-worming and malaria control and prevention of malnutrition is not linked to anaemia).

Question 3:

a. What are the major contributory factors to anaemia in the country?
b. Are there any region specific contributory factors?

Answer:
The major contributory factors to anaemia in the country are as follows:

a. Poor nutrition and dietary practices
b. Malaria

c. Worm infestations
d. Poor sanitation/Hygiene
e. Inadequate knowledge
f. Seasonality of foods

These contributory factors cut across all regions, tribes and socio-economic levels.

Question 4:
What is the level of public knowledge of these factors as contributing to anaemia and their preventive response?

Answer:
There is a low level of public knowledge and preventive response is inadequate

Question 5:
How can the campaign build on existing anaemia related BCC interventions to improve public action on anaemia and its contributory factors?

Answer:
a. The burden should be made known to the public;
b. There should be an improvement upon the communication on iron/Folic supplementations in order to improve compliance;
c. Also the anaemia prevention should be integrated into malaria control;
d. Exclusive breastfeeding in addition to prolong breastfeeding up to 2 years should be encouraged.

Question 6:
List the local names of anaemia as expressed by communities and which are the most popular ones that should be used in this campaign?

Answer:
a. Akan – Mogya-wee
b. Ga – La nii faa
c. Dagaare – Nxieng bare
d. Ewe – Esu mele efe la meo
e. Hausa – matagynee

Question 7:
Identify at least 5 key messages on anaemia that should be communicated in materials for the campaign

Answer:
Some key messages are as follows:

a. To prevent anaemia; Eat Fruits with your meals;
b. Eat Dark Green Leafy Vegetables;
c. Sleep under ITNs (Insecticide Treated Net);
d. Wash hands with Soap and Water at the five critical times;
e. De-worm children aged 2years once every 6 months;

f. Eat beans, nuts and pulses regularly.

5.2.0 GROUP 2:

5.2.1. MALNUTRITION

How can the links between malnutrition and its contributions to aneamia be targeted in the overall strategy to combat aneamia, its effects on pregnant mothers, and children under 5 years?

Question 1:
Suggest 5 Key BCC messages targeted at expectant mothers on "Nutritional Status during Pregnancy"

Answer:

a. Eat a variety of foods including liver and other organs. Meat, leafy green vegetables etc;
b. Eat citrus fruits after meals;
c. Take Folic- acid supplement;
d. Sleep under Insecticide Treated Net;
e. Visit ante natal clinic and take Intermittent Preventive Treatment (IPT).

Question 2:
Suggest 5 key BCC messages "Infant/Child feeding targeted at caregivers on the benefits of proper diet at the transitional stages.

Answer:

a. Exclusive breastfeeding from birth to 6months;
b. Start complementary feeding at six months – feed the child a variety of family foods;
c. Increase quantity and frequency as child grows;
d. Observe good hygiene, like washing your hands;
e. Practice active and responsive feeding;
f. Mothers should be patient with children especially at feeding times. It takes time for a child to begin to accept other foods.

Question 3:
What are the perceived challenges of the communities and caregivers in translating or transforming basic staple foods that are available in the regions (ex. Maize, Rice, and others) into nutritious meals for children?

Answer

a. Perceived lack of time;
b. Food preparation process is cumbersome;
c. Inadequate knowledge of nutritious local foods and inadequate knowledge on how to prepare them;

d. Child care is not a priority;
e. Culturally, cooking is reserved for dinner;
f. The cost of preparing baby's food alone.

Question 4:
What is the current community perception and understanding of the four main food groups and how can we approach this with BCC strategy?

Answer:

a. Messages on the food groups are not well articulated, caregivers do not understand why they need to give certain foods;
b. Mothers do not go to the Child welfare clinic around 9 months so miss the messages on nutrition;
c. Group education does not always centre on the food groups.

Approach:

a. Address it from 2 levels – facility and community;
b. Inadequate number of staff is a challenge that hinders the possibility of one-on-one counselling at health centres;
c. Collaborate with private institutions;
d. Facilities/communities should be equipped with DVDs to show BCC videos on various topics;
e. Community theatre and drama at all levels.

Question 5:
In reference to the recently updated Child Health Record Book, Feeding a Healthy Child (**Pgs. 12 & 13)** on the current feeding recommendations and appropriate age groups:

a. In your opinion, how can the age ranges after 9 months be consolidated based on the feeding requirements listed?
b. Combine 9 month -12 months and 12 months -2 years making it 9 months -2 years; maintain or highlight the messages that are critical for the 9 months-12months age group;
c. Suggest 3 alternative ways to present the stages of growth and appropriate feeding.

Answer:

a. Alternative ways to define stages of growth are; Sitting, Crawling, Standing & Walking;
b. Appropriate feeding should emphasize the functions of the various food groups in relation to stages of growth: Energy giving foods (carbohydrates- roots and tubers, oils, fats, margarine and cereals), Body building: (eggs, meat, fish, beans and poultry), Protective foods: (fruits and vegetables).

5.3.0. GROUP 3

5.3.1. INFECTIONS AND INFESTATION, HYGIENE PRACTICES/ HYGIENE ENVIRONMENT/ DE-WORMING PRACTICES

Question 1:
What are the key strategies/ messages for preventing worm infestation for children under two?

Answer
a. Hand washing with soap and running water should be promotion. *Wash your hand those of your child hands with soap under running water at critical times. (5 critical times);*
b. Encouraging good personal/environmental hygiene- *keep child's environment clean, ensure child wears clean clothing and footwear, keep child's finger nails short, clean child's toys, dispose of feces properly;*
c. Promotion of Breastfeeding - *Exclusive breast feeding for the first six months continued to 2 years.*

Question 2:
Young children are most likely to put many things in their mouths leading to infection and worm infestation.
a. What messages can be given to caregivers to prevent this? Identify at least 5 messages.
b. What are the key strategies for prevention of worm infestation in children above two years of age?

Answer
a. Promotion of hand washing - *Wash your/child's hands with soap under running water at critical times. (5 critical times)*
b. Promotion of good personal/environmental hygiene – *keep child's environment clean, ensure child wears clean clothing and footwear, keep child's finger nails short, clean child's toys, dispose of feces properly, safe water- Ensure drinking and bathing water is safe*
c. De-worming children – *De-worm your child twice every year. Parents, Guardians and caregivers should participate in mass de-worming exercises- (School programmes, child welfare exercises)*

Question 3:
What role can the school de-worming programme play? (SHEP)

Answer:
a. Advocate for provision of safe water, hand washing and toilet facilities should be made;
b. Educate- PTAs, pupils, food vendors should be educated on personal hygiene, sanitation, hand washing, prevention of worm infestation & infections;
c. Monitor – There should be regular inspection of school environment and the de- worming programme should be monitored.

Question 4:
How can the existing hand washing strategies be integrated into this campaign?

Answer:
a. Work with existing groups – Media, Women groups, etc;
b. Identify existing strategies and strengthen them;
c. Involve all stakeholders in the implementation of the campaign- SHEP, UNICEF, NGOs, GHS, etc.

Question 5:
a. Has the five critical stages of hand washing (before eating, before preparing food, after using the toilet, before breast feeding, after cleaning the child) been integrated into previous GHS campaigns?
b. Are these the accepted 5 critical stages? Are there others that should be included?

Answer:
a. Yes, the 5 steps have been integrated into GHS materials (Child health, regenerative health, other NGOs, UNICEF);
b. YES, these are accepted. Other critical stages could vary between target groups- Caregiver vs. a mother handling refuse, children under 5yrs.

5.4.0. GROUP 4

5.4.1. FOOD PREPARATION

Question 1:

Please refer to the Child Health Record Book and the list of Complementary Foods provided by the focal points for nutrition in Greater Accra, Central, and Western regions: What is the current perception and community understanding of the four main food groups in your specific regions?

Answer:
a. The perception is that community members know specific foods and what they do for the body (e.g. fish helps the child grow), but they may not be able to conceptualize the food group idea;
b. There are misconceptions about certain foods (e.g. plantain gives iron, and kwaunsusua has iron);
c. Food taboos may also affect community perceptions.

Question 2:
a. Do these foods provided meet the standards for recommended complementary family foods?
b. What is the nutritional quality standard expected from each meal?

c. From your specific communities/regions, are these preparation instructions provided correct? If preparations are not included, please provide instructions on how to prepare recommended meals.

Answer:
Group members could not give answers to the first two questions because of time constrains. For the complementary food list provided (see Appendix 7), the comments are as follows:

a. Greater Accra Region - D*etailed additions and modifications was annotated on the list;*
b. Greater Accra list – Meals such as Aprapansa, Banku and Kenkey with stew can be added to the list;
c. Central Region - More details on preparation of the foods need to be provided;
d. Western Region- Some of the snacks are suitable only for children above 2 years. To feed fufu would depend on the soup that accompanies it. More details are needed on the preparation of the various meals.

Question 3:
What other recommended local snacks and preparations should be added? What are the nutritional components and benefits of these snacks?

Answer
Local Snacks: Bofrot (doughnut, atwemo), roasted groundnuts, biscuits, plantain chips, sweetbad (rockbuns), bamfo bese, koose, waagashi, maasa, fula, kuli kuli, baked abodoo, moimoi, bread and groundnut paste, banana and groundnuts, duibal.

Question 4:
Based on your specific regions and communities are there other local ingredients, iron-rich vegetables and fruits (not listed) but are available and can contribute to boosting the dietary components of recommended family foods?

Answer:
Dark green leafy vegetables other than Nkontomire are as follows: Beans leaves, Pumpkin leaves, Baobob leaves, Moringa, Cassava leaves, Kwaunsusua, Aleefu

5.5.0.GROUP PRESENTATIONS

After the group discussions a representative from each group made a short presentation.

6.0 CONCLUSIONS/ NEXT STEPS

The meeting agreed on the following next steps:

1. A design Team made up of BCS inner team, GHS representatives at the national and regional levels as well as relevant partners will work with an Advertising Agency to flesh out Campaign Concept, Approaches, Channels and Materials;

2. Campaign launch- this would take place during the early months of the year, followed by regional launches, coupled with community mobilization;

3. Roles and Responsibilities- Participants were asked to share existing thematic related appropriate materials to enable the campaign to build on these materials. Participants were also encouraged to actively participate in the campaign at various levels, from national to the community levels.

6.1 RECOMMENDATIONS

a. The time allotted for the group discussion was very short hence relevant issues could not be addressed.
b. The workshop could have been held for two or three days so as to enable participant address the problems comprehensively.

7.0 APPENDICES

APPENDIX 1

AGENDA- CHILD NUTRITION BCC CAMPAIGN STRATEGY DEVELOPMENT WORKSHOP

VENUE: MIKLIN HOTEL

DATE: 11TH JANUARY, 2011

Table 1: Showing the Programme Outline for the Strategic Development Workshop

TIME	ACTIVITY	FACILITATOR
9.00am	Introduction and Welcome	Director Family Health Division
9.10am	Brief Remarks	USAID
9.15am	Objectives of Workshop	BCS
9.30am	Overview of Nutrition BCC Activities in 2010 (Anaemia)	Nutrition Dept.
10.00am	• Presentation: Rationale and Proposed New Directions for Anaemia BCC in 2011: • Building on previous activities/Current Status of Anaemia in the country • Major Contributory Factors – Interrelatedness, Threat Perception /Benefits of Prevention • Campaign Concept/ Approach • Plenary Discussions on Presentation	BCS
11.30am	**BREAK**	
11.45am	• Preparation for Break Out Groups: • Review of Discussion Questions • Form Groups • Group work areas- Anaemia; Malnutrition; Translating the Food Groups into Meals, Simplifying Nutrition messages for Care Givers, Infections and Infestations 9 Hand Washing),	BCS/Nutrition Department/Child Health Unit
12.00am	Group Work	
1.00pm	**LUNCH**	
1.45pm	Group Work (Continued)	BCS/Nutrition Dept./Child Health Unit
3.00pm	Plenary Presentations	Groups
4.00pm	Next Steps:Roles and Responsibilities; Timelines, Geographic Coverage	
5.00pm	Closing	

APPENDIX 2

Questions for Group work- Anaemia

1. Why should anaemia control be a matter of urgency in the country?

2. What is the level of public recognition of the threats of anaemia to the development and growth of children under five years and pregnant women?

   a) What is the public's level of appreciation of the benefits of effective control measures at the family level?

3. What are the major contributory factors to anaemia in of the country? Are there any region specific contributory factors?

4. What is the level of public knowledge of these factors as contributing to anaemia and their preventive response?

5. How can the campaign build on existing anaemia related BCC interventions to improve public action on anaemia and its contributory factors?

6. List the local names of anaemia as expressed by communities and which are the most popular ones that should be used in this campaign

7. Identify at least 5 key messages on anemia that should be communicated in materials for the campaign

APPENDIX 3

Questions for Group work- Malnutrition

1. How can the links between malnutrition and its contributions to aneamia be targeted in the overall strategy to combat aneamia, its effects on pregnant mothers, and children under 5 years?

   A. Suggest 5 Key BCC messages targeted at expectant mothers on "Nutritional Status During Pregnancy"
   B. Suggest 5 key BCC messages "Infant/Child feeding targeted at caregivers on the benefits of proper diet at the transitional stages.

2. What are the perceived challenges of the communities and care givers in translating or transforming basic staple foods that are available in the regions (ex. Maize, Rice, and others) into nutritious meals for children?

   A. What is the current community perception and understanding of the four main food groups and how can we approach this with BCC communication in the strategy?

3. In reference to the recently updated Child Health Record Book, Feeding a health Child (**Pgs. 12 & 13**) on the current feeding recommendations and appropriate age groups:

   A. In your opinion, how can the age ranges after 9months be consolidated based on the feeding requirements listed.
   B. Suggest 3 alternative ways to present the stages of growth and appropriate feeding.

4. How can the categories of available foods and proper nutritional intake requirements based on the GHS FOOD groups be clearly articulated to caregivers and health service providers?
   (Amount – Safety – Quality – Frequency)

   A. Suggest an appropriate framework to articulate structured feeding practices
   B. What are the Food group components? Which foods (based on local diet) fit in what group?
   C. What nutrient components in one meal would constitute the appropriate quality? What is the suggested/recommended nutritional quality in every meal for a growing child?

APPENDIX 4

Questions for Group work- Infections and Infestations

To reduce the infestation of intestinal worms among children-Hygiene practices/ Hygiene Environment/ De-worming practices.

1. What are the key strategies/ messages for worm infestation for children under two?

2. What are the key strategies for worm infestation in children above two years of age?

3. How can the existing hand washing strategies be integrated into this campaign?

4. Have the five critical stages of hand washing (before eating, before preparing food, after using the toilet, before breast feeding, after cleaning the child) be integrated into previous GHS campaigns? Are these the accepted 5 critical stages? Are there others that should be included?

APPENDIX 5

Questions for Group work- Food Preparations

Please refer to the Child Health Record Book and the list of Complementary Foods provided by Greater Accra, Central, and Western regions:

1. What is the current perception and community understanding of the four main food groups in your specific regions?

2. Do these foods provided meet the standards for recommended complementary family foods?

   A. What is the nutritional quality standard expected from each meal?

   B. From your specific communities/regions, are these preparation instructions provide correct? If preparations are not included, please provide instructions on how to prepare recommended meals.

3. What other new local foods and preparations should be added or introduced to the list of complementary foods?

4. What other recommended local snacks and preparations should be added? What are the nutritional components and benefits of these snacks?

5. Based on your specific regions and communities are there other local ingredients, Iron-rich vegetables and fruits (not listed) but are available and can contribute to boosting the dietary components of recommended family foods?

APPENDIX 6

Complementary Foods

Table 2: showing the complimentary foods of the western region

Category	Food item	Dish/Meals	How prepared	Remarks
Energy giving foods	**Cassava**	Akyeke	Grated cassava is pressed to remove starch. End product is steamed and eaten with fried fish/soup	Eaten mainly by Nzemas
		Fufu	Cassava is peeled and boiled and pounded. Eaten with soup	Eaten in all districts
		Ampesi	Cassava is peeled and boiled	Eaten with stew especially kontomire stew
		Akutu/Yakeyake	Cassava grated fermented and pressed to remove water	Eaten with fried fish and pepper/stew
	Rice (local)	Awule Bolo(baked rice)	Soaked rice overnight and mill Water added to form paste and baked/boiled in leaves	Usually eaten without any stew/soup
		Awule Bolo(steamed rice)		Can be eaten with roasted groundnut
	Rice	Emo Ampesi	Rice cooked with water and Vegetable	Eaten with fresh pepper/tomatoes in Waasa Area
	Maize	Fonfon	Maize is steeped overnight and milled into dough. Dough made into balls, boiled in water. Boiled dough pounded mixed with raw dough and boiled.	Eaten with soup/pepper &fish/stew
	Maize / plantain	Apitsi	Ripe plantain is pounded and mixed with corn dough and baked in leaves	
Energy giving foods	Fresh corn	Boiled/roasted fresh maize		Eaten alone or with groundnuts
	Garden egg (Ntropo)		For soups and stews	Eaten with dry coconut
	Nsaman ntroba		For soups and stews	Could be eaten with boiled/ roasted groundnut
Vegetable				Also boiled, mashed and stained. Fluid is taken to treat aneamia.

Table 3: Complementary Foods of the Central Region

No	Complementary food	Ingredients	Remarks
1	Kooko (Maize Porridge)	Fermented maize dough	
2	Mashed kenkey	Fermented maize dough	Cooked half way before cooking into kenkey
3	Mpotompoto	Yam or cocoyam, palm oil, tomato, onion, iodated salt	
4	Apraprasa	Maize powder, fish powder, palm nut soup	
5	Banku and stew	Maize dough, cassava dough, stew	Soft
6	Rice and stew	Rice, stew	Soft
7	Waakye	Rice and beans	Soft
8	Kenkey and stew	Maize dough, stew	Soft
9	Rice water	Rice	Porridge
10	Mashed yam an stew	Yam, stew	
11	Weanimix	Roasted maize, beans, groundnut	Grounded into
Some mains staples used			
1	Maize		
2	Yam		
3	Sweet potato		
4	Rice		
5	Potato		
6	cocoyam		
7	Plantain		
8	Cassava		

1. MASHED YAM (NPOTONPOTO)/POTATOES)

- CARBOHYDRATES - YAM COCOYAM, SWEETPOTATOES
- PROTEINS - POWDERED FISH (ANCHOVIES)/SOYA FLOUR
- OILS - PALM OIL/MARGARINE OTHER FORTIFIED OILS/SHEA BUTTER
- VEGETABLES - TOMATOES, CARROTS/GREEN LEAVE VEGETABLES
- SPICES - SAILT, ONIONS

2. RICE AND STEW

- CARBOHYDRATES - RICE
- PROTEIN - EGG/FISH/MEAT
- VEGETABLES - CARROTS/TOMATOES/KONTOMIRE
- SPICES - SALT, ONION

- ❖ OILS - MARGARINE, PALM OIL /ANY FORTIFIED OIL

3. MILLET PORRIDGE

- ❖ CARBOHYDRATES - MILLET (POWDER)/MILLET DOUGH
- ❖ PROTEIN - EGG YOKE/KOOSE/GROUNDNUT PASTE
- ❖ CONDIMENT - SUGAR

4. MASHED RICE AND BEANS/KONTOMIRE(GREEN LEAFY VEGETABLE)

- ❖ CARBOHYDRATES - RICE
- ❖ PROTEINS - BEANS/ POWDERED FISH
- ❖ VEGETABLES - KONTOMIRE, TOMATOES/ ANY OTHER LEAFY VEGETABLE
- ❖ OILS - PALM OIL
- ❖ SPICE - SALT, ONIONS

5. MAIZE PORRIDGE

- ❖ CARBOHYDRATES - MAIZE
- ❖ PROTEIN - FISH POWDER/SOYA FLOUR/GROUND PASTE/MILK/MILK POWDER
- ❖ CONDIMENT - SUGAR, SALT

NOTE: AVOID SALT, SUGAR, AS MUCH AS POSSIBLE BEFORE 1 YR
ADD FRUITS TO ALL MEALS
FOR CHILDREN LESS THAN 12YR YOU CAN ADD EGG YOKE.
SOUP: LIGHT SOUP, OKRO SOUP

6. RICE PORRIDGE

- ❖ CARBOHYDRATES - RICE
- ❖ PROTEIN - YOKE
- ❖ CONDIMENT - SALT, SUGAR

7. T.Z AND AYOYO SOUP/GROUNDNUT SOUP

- ❖ CARBOHYDRATES - T.Z (MAIZE) MILLET
- ❖ PROTEIN - FISH POWDER/BLENDED LIVER/ MEAT/CHICKEN
- ❖ VEGETABLES - AYOYO, TOMATOES, GROUNDNUT SOUP
- ❖ SPICES - ONIONS
- ❖ OILS - SHEA BUTTER/ PALM OIL

8. MASHED SWEET POTATO

- ❖ CARBOHYDRATES - SWEET POTATO
- ❖ PROTEIN - ANCHOVIES
- ❖ VEGETABLES - CARROTS/TOMATOES/MASHED GREEN

  LEAFY VEGETABLES

9. RICE AND SOUP

- ❖ CARBOHYDRATES - RICE
- ❖ PROTEIN - BLENDED LIVER/GOAT/SHEEP MEAT/FISH
- ❖ VEGETABLES - GARDEN EGGS, TOMATOES
- ❖ SPICES - GINGER, GARLIC AND ONION
- ❖ CONDIMENTS - SALT

10. WEANIMIX PORRIDGES

- ❖ CARBOHYDRATES - RICE/MAIZE
- ❖ LEGUMES - BEANS/GROUNDNUT/SOYA BEANS
- ❖ CONDIMENT - MARGARINE

11. SOUPS - GROUNDNUT SOUP/PALM NUT SOUP

- ❖ BASES - GROUNDNUT PASTE/PALMNUT/NERI SOUP
- ❖ PROTEIN - BLENDED LIVER, GOAT OR SHEEP BONES
- ❖ VEGETABLES - GARDEN EGGS, TOMATOES
- ❖ SPICES - ONIONS
- ❖ CONDIMENT - SALT

APPENDIX 7:

Names, Position and Organisation of Participants

1. Dr. Gloria Quansah-Asare	-	Family Health Division, GHS
2. Dr. Isabella Sagoe-Moses	-	Child Health Division, GHS
3. Ms. Kate Quarshie	-	Nutrition Division, GHS
4. Ms. Wilhelmina Okwabi	-	Nutrition Division, GHS
5. Dr. Nana Kwadwo Biritwum	-	Program Manager HQ, GHS
6. Ms. Eleanor Sey	-	Health Promotion Dept, GHS
7. Ms. Kafui Anyapi	-	Health Promotion Dept, GHS
8. Ms. Gladys Brew	-	S.M Program Officer, GHS
9. Ms. Barbara Mills	-	Nutrition Officer, RHD
10. Michael Neequaye	-	Program Manager, Nutrition, GHS
11. Ms. Esi Amoaful	-	Program manager, Nutrition, GHS
12. Ms. Hannah Adjei	-	Program Manager NMCCSP Nutrition, GHS
13. Ms. Gifty Donkor GAR	-	Regional Nutrition Program Officer (RHO),
14. Ms. Honesty Numetu GAR	-	Regional Health Promotion Officer (RHO),
15. Mr. Matthew Ahwireng C/R	-	Regional Health Promotion Officer (RHO),
16. Ms. Margaret Forson	-	DDNS/RCH, C/R
17. Ms. Marian Borden	-	Public Health Nurse, WR
18. Mr. Emmanuel Badiena W/R	-	Regional Nutrition Program Officer (RHO),
19. Mr. Edwin Kunbatazie W/R	-	Regional Health Promotion Officer (RHO),
20. Ms. Faustina Kargba	-	RCH/ PMO (PH), GHS
21. Ms. Mercy Kwafoa	-	Care International
22. Mr. Francis Yankey	-	Plan Ghana
23. Mr. Maurice Quaye	-	ProMPT Ghana
24. Ms. Mary Amoakoh-Coleman	-	ProMPT Ghana
25. Dr. Devine Atupra	-	FOCUS Health Project
26. Dr. Cecelia Bentsi	-	Coalition of NGO's in Health
27. Ms. Lois Ohene- Ayisi (DCoP)	-	Relief International
28. Ms. Margaret Owusu-Amoako	-	CHF International
29. Madam Abena Annobea Asare	-	Ministry of Women & Children Affairs
30. Mr. Sid Sidartha	-	UNICEF
31. Ms. Ernestina Agyepong	-	UNICEF
32. Ms. Mercy Nyamikeh	-	PATH/IYCN
33. Ms. Susan Wright	-	USAID
34. Ms. Julianna Pwamang	-	USAID
35. Ms. Ruth Pobee	-	CSIR-Food Research Institute
36. Ms. Mildred Suglo	-	Women in Agricultural Development
37. Ms. Alice Nkoroi	-	Nutrition Specialist, FANTA – 2
38. Ms. Beatrice Amponsah	-	General manager, BGMSL
39. Mr. Frederick Addo-Yobo	-	Regional Coordinator, BGMSL

40. Ian Tweedie	-	Chief of Party, BCS
41. Martha Osei	-	Deputy Chief of Party, BCS
42. William Adusei	-	Western Regional Coordinator, BCS
43. Evelyn Lamptey	-	Central Regional Coordinator, BCS
44. Shamwill Issah	-	Greater Accra Regional Coordinator, BCS
45. Hamid Yakubu	-	Media Program Officer, BCS
46. Geordie Woods	-	Media Program Officer, BCS
47. Ledor Igboh	-	PPA Program Specialist, BCS