I declare that this research report has not been submitted for a degree in this or any other university.

Thesis
MWA
1998

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Acronyms and Abbreviations

BFHI	-	Baby Friendly Hospital Initiative
CP	-	Community Participation
MCH	-	Maternal and Child Health
MSG(s)	-	Mother Support Group(s)
NFNC	-	National Food and Nutrition Commission
NRDC	-	Natural Resources Development College
UNICEF	-	United Nations International Childrens' Emergence Fund
WHO	-	World Health Organization

Table of Contents

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That said, responsibility for errors and omissions, of which there must be many, is mine and mine alone.

May, 1998

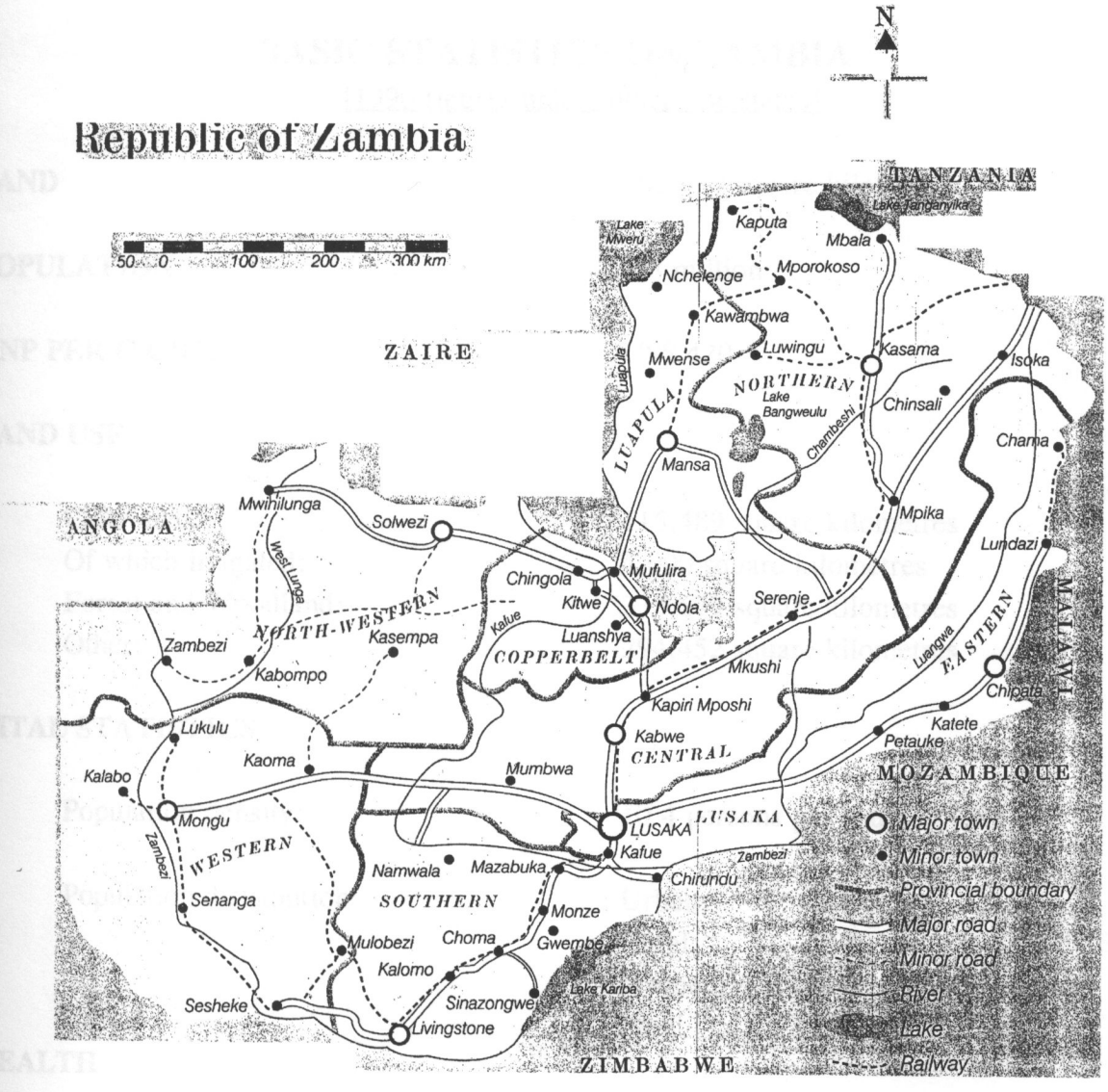
List of Figures

List of Maps

Glossary of Meanings

Community participation	-	A social process in which specific groups of people with shared needs, living in a defined geographical area actively pursue identification of their needs; take decisions and establish mechanisms to meets these needs.
Mother	-	Any woman who has or looks after a breastfeeding child in her household.

To my wife Mary, and our children: Max, Moses and Dingase



Map*1*: *The Republic of Zambia*

BASIC STATISTICS ON ZAMBIA

[1990 figures unless otherwise stated]

LAND	752,620 square kilometres	
POPULATION	7.8 million	
GNP PER CAPITA	US$ 420	
LAND USE		
Cultivated:	115,489 square kilometres	
Of which irrigated:	4,000 square kilometres	
Forest and Woodland:	338,679 square kilometres	
Other:	294,452 square kilometres	
VITAL STATISTICS		
Population density:	10.4 persons per square kilometre	
Population distribution:	Urban:	42%
	Rural:	58%
	Women:	51%
	Men:	49%
HEALTH		
Infant mortality rate:	79/1000	
Life expectancy at birth:	Female:	57.5 years
	Male:	55.4 years
Access to safe water (1987-90)	Urban:	76%
	Rural:	43%
	Overall:	59%
Access to Sanitation (1987-90)	Urban:	77%
	Rural:	34%
	Overall:	55%
Population per doctor (1988):	6.7/10000 people	
Population per hospital bed (1988):	3.2/1000 people	

EDUCATION

Net school enrolment	Primary:	1,446,847	
	Secondary:	161,347	
	Tertiary:	10,875	
	Adult literacy rate:	Male:	81%
		Female:	65%
		Total:	73%

ECONOMY

Real Growth in GDP:	0.1%
Annual average Growth rate (1989-90):	-1.8%

GDP by main activity based on current prices

Agriculture:	17.5%
Industry:	39.4%
Services:	34.1%
Mining:	9.0%
TOTAL GDP:	100.0%

GDP Expenditure based on current prices

Public consumption:	15.5%
Private Consumption:	67.5%
Investment:	12.0%
Imports minus exports:	5.0%
TOTAL GDP:	100.0%

BALANCE OF PAYMENTS

(US dollar millions)

Exports				
Metal:		1154.7		
Non-Metal:		88.4		
Total Exports:		1243.1		
Imports:		1112.1		
Services				
Factor Services (net)	(-)	427.8		
Non-Factor (net)	(-)	119.6	(-)	547.4

Private transfers:	(-)	42.9
Current Account Balance (excluding interest payments):		314.3
Official grants:		145.0
Official capital:		294.0
Private capital:		32.0
Total debt stock:		6,807,285
Long/medium-term:		6,137,981
Short-term:		669,304
Public and publicly guaranteed:		6,136,025
Debt-service ratio		65.8% (excluding payments of arrears)
Principal Exports:		Copper, Zinc, Lead, Cobalt and Tobacco
Principal Export Markets:		China, USA, Japan and U.K
Infrastructure		
Roads:		20,782 km
Railways:		1,743 km
Electricity:		1,637 MW (of installed capacity)
Currency:		Kwacha
Exchange Rate (August 1992):		Official US$=ZK 185.26
		Market US$=ZK 214.65

Sources

- World Development Report 1992, World Bank, Washington D.C
- Economic Report 1990 &1991, NCDP, Lusaka
- 1990 Census of Population and Housing and Agriculture, Preliminary Report, Central Statistical Office, Lusaka
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- Bank of Zambia

Abstract

This report is based on the writer's experience with the breastfeeding project which is being funded by the National Food and Nutrition Commission (NFNC) and implemented by the Maternal and Child Health (MCH) wing of the Chainama Hills Hospital in Kaunda Square Stage II and the Natural Resources Development College (NRDC) residential areas in Lusaka.

The report makes a comparative assessment of community participation in the promotion of breastfeeding in the two communities. Specifically, the report examines issues relating to the recruitment of the members of the support groups, the training they received, as well as their role and effectiveness in the communities they serve. The report also makes recommendations to the authorities on how to enhance community participation in the breastfeeding programme in the two communities.

The methodology used for data collection is outlined in the appropriate section of this report. Although the menfolk have a significant role to play in the success of any project involving women, their participation in the breastfeeding programme in the two communities is beyond the scope of this report.

The data on which much of this report is based was collected during the writer's practical attachment in the Kaunda Square Stage II and the NRDC communities between 9 January, 1998 and 9 April, 1998. The International Questionnaire (IQ) development software was used to design a computer-based worksheet on which the data was entered after it was coded. The data was analyzed in the Lotus 1-2-3 and the Statistical Package for the Social Sciences (SPSS) software.

There is evidence of community participation in breastfeeding in the Kaunda Square Stage II and the NRDC communities. Members of the support groups are eager to enhance breastfeeding in their respective communities. However, a lot needs to be done in order to bring awareness and mobilize the community to join the support groups. This report has given recommendations on how community participation in breastfeeding can be enhanced in the two communities.

1.0 Country Background

The Republic of Zambia is situated in South Central Africa, lying between latitudes 8 degrees and 18 degrees South and between latitudes 22 degrees and 34 degrees East. It is a large landlocked country with an area of 752,620 square kilometres, most of which forms a plateau lying between 1,000 and 1,600 metres elevation. The highest parts of the country are in the north east, with the plateau gradually sloping to the south-west. It is bordered by Malawi to the East, Mozambique to the South-East, Zimbabwe to the South, Botswana and Namibia to the South West, Angola to the West, the Democratic Republic of Congo (formerly Zaire) to the North, and Tanzania to the North-East.

The country's sub-tropical climate is characterized by three seasons: the hot dry season from September to October; the rainy season from November to April with temperatures ranging from 27 degrees Celsius to 38 degrees Celsius; and the cool dry season from May to August with temperatures ranging from 16 degrees Celsius to 27 degrees Celsius. Mean annual rainfall ranges from 710 mm in the southern parts of the country to 1475 mm in the north.

The vegetation in the plateau is mainly woodland savannah consisting of a mixture of trees, tall grass, shrubs and other woodlands of deciduous types. It covers about 80 per cent of the country. In the low valley regions the vegetation is dominated by Mopane tree and short-lived annual grasses.

Zambia's livestock wealth is significant. In 1991, the total national livestock population was 3.1 million. However, the drought that hit the country in 1991/92 season and the prevalence of endemic diseases resulting in high mortality adversely affected performance of this

subsector in 1992. There was also increased off-take by farmers to reduce losses and generate cash income for other household requirements, especially food. Cattle population, for instance in the traditional rearing region of Southern Province, declined by 22.6 per cent in 1992. The situation was similar in other cattle rearing provinces of Lusaka and North-Western provinces.

The country possesses about 6 per cent of the world's reserves of copper ore and is the third largest producer of cobalt in the world. The country is also a minor producer of lead and coal. Other minerals include zinc, coal, selenium, silver, gold and gemstones.

Zambia has four rivers, namely the Zambezi, Kafue, Chambeshi-Luapula and Luangwa. The first three have been harnessed to produce some 1608 megawatts of hydro-electric power annually.

The country also possesses extensive game reserves of which the Luangwa and Kafue National Parks are the largest.

2.0 Introduction

In order to put mother support groups (MSGs) into context, it is worthwhile for the reader to understand and appreciate the ideals of the Baby-Friendly Hospital initiative (BFHI) as they are the corner stone for the establishment of MSGs. In 1991, the United Nations Children's Emergence Fund (UNICEF) and the World Health Organisation (WHO) began an intensive effort to transform practices in maternity hospitals as a compliment to community-based efforts to protect, promote and support breastfeeding. The BFHI brought a structured programme to breastfeeding support and in just six years, has helped transform over 12,700 hospitals in 114 countries into centres of support for good infant feeding. These baby-friendly hospitals are havens of protection for breastfeeding, where women are not subject to advertising and promotional activities for infant formula or feeding bottles, and where they can receive effective and well-informed help for a sound start to breastfeeding.

Through a WHO-UNICEF training programme that has been translated into the official languages of the United Nations and into many others, the professional staff of maternity hospitals are trained in lactation management and support. Staff members, along with the directors or managers of their health facility, make a commitment to fulfill the initiative's "Ten Steps to Successful Breastfeeding."[1]

The BFHI activities in Zambia started soon after the Innocenti Declaration of 1992 to promote, protect and support breastfeeding. The objectives behind these activities have been: (i) to transform hospital and maternity facilities into Baby Friendly institutions[2] through the implementation of the Ten Steps to Successful Breastfeeding; (ii) to establish in-service training in lactation management, and (iii) to enact necessary laws, regulations and procedures

The activities mentioned above have been undertaken under the auspices of the National Breastfeeding Program, formally established in 1993 to facilitate the attainment of the BFHI and to build up a resource centre to sustain BFHI activities. Based at the National Food and Nutrition Commission (NFNC) since 1994, the program has received and continues to receive tremendous financial, technical and other support from UNICEF, the Ministry of Health, the World Health Organisation as well as several local and international non-governmental organisations. Among the programme's notable successes have been the declaration of 40 health facilities (31 hospitals and 9 maternity units) as Baby-Friendly, the drafting of a National Breastfeeding Policy and the development of a National Code of Marketing of breast milk Substitutes. Step 10 of the BFHI calls for setting up breastfeeding support groups that new mothers can rely on for information and advice on breastfeeding and infant health.

3.0 Statement of the Problem

Available literature indicates that there has been a steady decrease in the number of women practising breastfeeding world-wide (Ministry of Health, 1992:5 ; http://www.geocities.com). The main reason for the decline is that because of pressing demands on women's time, most mothers abandon breastfeeding when children are still very young. The other reason for the decline is the conflicting messages that health professionals have given.[3]

There has been renewed interest in breastfeeding worldwide lately. In Zambia, the interest in breastfeeding is as a result of the realisation by the Ministry of Health that the high rates of child mortality and morbidity are closely related to the high incidence of avoidable environmentally-related illnesses, such as diarrhoea, and to the poor intake of nutrients in children's diets.

Health centres, through their Under Five clinics, have played and continue to play a very significant role in promoting breastfeeding among mothers throughout Zambia.[4] However, it is acknowledged that not all mothers benefit from the wealth of information provided by the clinics because not all of them attend the clinics. It has, therefore, become necessary to involve the community in the promotion of breastfeeding through the establishment of breastfeeding support groups in all communities served by baby-friendly hospitals and clinics[5].

As a baby-friendly hospital, therefore, the Chainama Hills Hospital through the Ministry of Health and with the support of the NFNC, identified, recruited, and trained some of the female members of the Kaunda Square Stage II and the NRDC community with the view of promoting breastfeeding among the mothers in the community. These trainees or MSGs have since been

the focal point of all the activities of mother support groups in their respective communities. However, it is yet to be seen whether the members of the support groups have played an effective role in promoting community participation in breastfeeding in the two communities.

4.0 Objectives

The objectives of this report are to make a comparative assessment of the role of the MSGs in the promotion of breastfeeding currently being implemented by the MCH wing of the Chainama Hills Hospital, in Kaunda Square Stage II and NRDC. Specifically, the report examines issues relating to the recruitment of the MSGs or facilitators, the training they received, their role in society, as well as their effectiveness in the promotion of breastfeeding within the communities they work. The report also examines the extent of community participation in the promotion of breastfeeding in the two communities with the view of making recommendations to the authorities.

5.0 Methodology

This project was carried out among members of the MSGs and the mothers in Kaunda Square Stage II and the NRDC. Interviews were conducted based on two questionnaires: one for the mothers (Appendix 1) and the other for the members of the MSGs (Appendix 2) in the two residential areas. The residential areas were chosen primarily because they were among those being served by the Chainama Hills College Hospital. The other reason was that they were convenient to the researchers. The questionnaire for the members of the community was initially to be administered among twenty mothers in each of the communities while the one for the MSG was to be administered among ten members. However, twenty six mothers in Kaunda Square Stage II and fourteen mothers in the NRDC were interviewed. More mothers

in Kaunda Square Stage II were interviewed because initial results from the survey seemed superfluous[6]. Nine members of the MSG actually returned the completed surveys in Kaunda Square Stage II while eight at the NRDC did so.

6.0 Literature Review

Community participation (CP) is a matter on which there is considerable disagreement among the development scholars and practitioners (Paul, 1987:12). Some use the term to mean active participation in political decision-making. For certain activist groups, participation has no meaning unless the people involved have significant control over the decisions concerning the organisation to which they belong. Development economists tend to define participation by the poor in terms of the equitable sharing of the benefits of projects. Yet others view participation as an instrument to enhance the efficiency of projects or as the co-production of services. Some would regard participation as an end in itself, whereas others see it as a means to achieve other goals. These diverse perspectives truly reflect the differences in the objectives for which participation might be advocated by different groups.

There are two types of participation: pseudo-participation and genuine participation . People's participation in development in which the control of the project and decision-making rests with planners, administrators, and the community's elite is pseudo-participation. Here the level of participation of the people is that of being present to listen to what is being planned for them and what would be done for them. Genuine participation comes about when the development bureaucracy, the local elite, and the people are working cooperatively throughout the decision-making process and when the people are empowered to control the action to be taken (White, 1993:17). This distinction between genuine and pseudo-participation is necessary as it points to the necessity of an in-depth analysis of just how the concept of participation can be

transformed into action in the development process.

In the development context, CP may be thought as an instrument that serves five objectives. One of the objectives has already been alluded to above, and that is, it may be thought as an instrument of empowerment. According to this view, development should lead to an equitable sharing of power and to a higher level of people's, in particular the weaker groups', political awareness and strengths. Any project or development activity is then a means of empowering people so that they are able to initiate actions on their own and thus influence the processes and outcomes of development.

Second, CP may serve a more limited objective of building beneficiary capacity in relation to a project. Thus beneficiaries may share in the management tasks of the project by taking on operational responsibility for a segment of it themselves. For example, beneficiaries can play an active role in monitoring.

Third, CP may contribute to increased project effectiveness. Effectiveness refers to the degree to which a given objective is achieved. CP tends to enhance project effectiveness when the involvement of beneficiaries contributes to better project design and implementation and leads to a better match of project services with beneficiary needs and constraints.

Finally, CP is the desire to share the costs of the project with the people it serves. Thus beneficiaries may be expected to contribute to labour, money, or undertake to maintain the project. CP may thus be used to facilitate a collective understanding and agreement and cost sharing and its enforcement.

Paul (1987:3) observes that while CP can be used for any or all of these objectives, it may vary in the intensity with which it is sought in a particular project or at a particular stage of a project. The nature of a project and the characteristics of beneficiaries will determine, to a large extent, how actively and completely the latter can practice CP.

There are four levels of CP (Ibid.,1987:4-5). The first level is information sharing. At this level, project designers and managers may share information with beneficiaries in order to facilitate collective or individual action. Though it reflects a low level of intensity, it can have a positive impact on project outcomes to the extent it equips beneficiaries to understand and perform tasks better. In family planning or nutrition programs, for instance, such information sharing may in fact be critical.

The second level is consultation. When beneficiaries are not only informed, but consulted on key issues at some or all stages in a project cycle, the level of intensity of CP rises. There is opportunity here for beneficiaries to interact and provide feedback to the project agency which the latter could take into account in the design and implementation stages.

The third level involves decision making. A still higher level of intensity may be said to occur when beneficiaries have a decision making role in matters of project design and implementation. Decisions may be made exclusively by beneficiaries or jointly with others on specific issues or aspects relating to the project. Decision making implies a much greater degree of control or influence on projects by beneficiaries than under consultation or information-sharing.

The fourth level involves the initiation of action. When beneficiaries are able to take the initiative in terms of actions/decisions pertaining to a project, the intensity of CP may be said to have reached its peak. Initiative implies a proactive capacity and the confidence to get going on one's own. For instance, when beneficiary groups are engaged in a health project to identify a new need and decide to respond to it on their own, they are taking the initiative for their development. This is qualitatively different from their capacity to act or decide on issues or tasks proposed or assigned to them.

Yoon (http://www.idrc.ca) observes four different ways of participation in most development projects claiming to be participatory in nature. One way includes participation in implementation. Here people are actively encouraged and mobilized to take part in the actualization of projects. They are given certain responsibilities and set certain tasks or are required to contribute specific resources. The second way is participation in evaluation. This involves inviting people to critique the success or failure of a project upon its completion. The third involves participation in benefit. Here people take part in enjoying the fruits of a project, such as water from a hand pump, medical care, a truck to transport produce to market, or village meetings in the new community hall. The final way is participation in decision-making. This means that people initiate, discuss, conceptualize and plan activities they will do as a community.

There are, however, two very important points to consider as we examine the issue of CP. For instance, Yoon (Ibid.,http://www.idrc.ca) points out that the apparently opposing concepts of "participation" and "manipulation" can be viewed from many perspectives. The interventionist who attempts to "sell" solutions to a "target population" may be accused of being manipulative, and may also be bringing along a whole set of alien cultural premises.

However, the participatory social communicator may also enter a village with a particular picture of reality and set values, hoping the people will come to perceive their situation the way he or she sees it. This may be equally manipulative. This point is particularly relevant to the breastfeeding programme as we shall see later.

Yoon (Ibid.,http://www.idrc.ca) points out that the price people have to pay for taking part in participatory processes is often overlooked. It is often assumed that the villager has nothing to do with his or her time. He further observes that for every hour spent "participating" there is an opportunity cost: that is, the fact that the villager may be foregoing more productive activity if the participatory process does not lead to benefits either in the long or short term.

Kumar (1993:76) observes that participation cannot be imposed from above. It has to take root slowly in individuals, in a cultural group, and gradually become part of the community. The foregoing underscores the fact that there ought to be genuine participation at all levels by the people themselves to ensure that developmental issues are not forced down their throats. Mere consultation of the people should not be considered sufficient, nor should participation be limited to the implementation of activities previously defined from outside (Libercier and Schneider, 1996:14).

White (1993:16) points out that it is relatively easy to say that participation is an important component of development and that 'involving' the unempowered poor is fundamental to development, which leads to the eradication of poverty and injustice. However, she argues, mobilizing people at grass roots to participate is neither a small task, nor is it a simple task. There is no way to brush aside the concerns and complexities regarding the concept of participation.

7.0 Women in Development in Zambia

The term Women in Development is used to identify and describe initiatives undertaken on behalf of women, focussing on changing women's social, economic and political positions. Enhancing women's participation in development is essential not only for achieving social justice but also for reducing poverty. Worldwide experience shows clearly that supporting a stronger role for women contributes to economic growth, it improves child survival and overall family health, and it reduces fertility, thus helping to slow population growth rates. In short, investing in women is central to sustainable development (World Bank, 1994:1). And yet, despite these known returns, women still face many barriers in contributing to and benefitting from development.

Zambia begun to address the "problem" of integrating women in development only during the past ten years, since the UN Decade for Women began. Before Women's Year in 1975, there was little concern shown in Zambia for women's issues and needs. For the most part, "women in development" in Zambia has meant "special projects" focussing on "home economics" activities (i.e, cooking, sewing, child care, home crafts, etc.) which cater to women's domestic role as wives and mothers. This approach has its roots in Zambia's colonial history, when mainly churches, non-Zambian women, and community development officers began to organize rural and urban women in women's clubs (Hurlich, 1986:21).

Women's lack of effective participation in development in Zambia can also be attributed to poverty. Poverty has disempowered females by reducing their access to education and forcing them to adopt desperate coping strategies. The impact of structural adjustment, especially poverty and unemployment, have tended to affect women and girl children more severely than males. One immediate impact has been to further increase females' workloads in order for the

household to earn enough money to cover its basic needs and make ends meet. Typically this has involved married women having to engage in coping strategies such as petty trading, which must be undertaken in addition to their normal responsibilities for running and caring for the household.

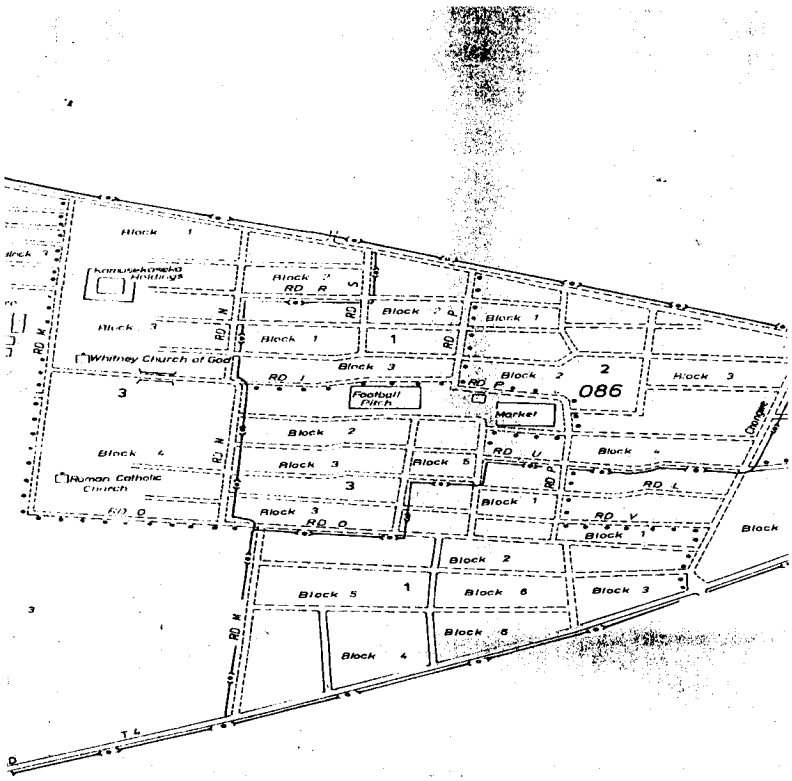
Government takes a bigger share of the blame for the lack of integration of women in development in Zambia. It is argued that increasing awareness of the problem of women has not resulted in their meaningful integration in the development process. It is further argued that as a result of unclear government policy, foreign agencies have found it much easier to address women's needs in a piece-meal fashion. Specific development efforts undertaken on behalf of women are largely structured by the concerns of lobbies far away from Zambia (Ibid, 1986:21). This has undoubtedly affected their effective participation in development programmes.

7.1 Women, breastfeeding, and support groups

Women have a need for one-to-one information and support from health care systems about breastfeeding. Many experienced breastfeeding mothers in other parts of the world have formed support groups to fill that need. As a necessity these groups train their members and ensure that they are updated with scientific and other knowledge related to infant health and breastfeeding. These voluntary groups work within health care systems and have proved an invaluable adjunct to the professional staff.

The reader is hereby reminded that the writer's practicals were conducted in Kaunda Square Stage II and the NRDC. What follow below are, therefore, the writer's impressions on the practicals in the two communities.

7.1.1 The MSG in Kaunda Square Stage II



Map.*2: Kaunda Square Stage II*

Kaunda Square is a site and service settlement scheme situated on the outskirts of Lusaka some eight kilometres from the centre of town. It has a population of 22,974 and it is divided between two areas, usually referred to as Stage I and Stage II[7]. Unless otherwise stated, information provided below refers to Kaunda Square Stage II.

The Kaunda Square Stage II support group started operating on 15 June 1996 prior to which the members had undergone a training course in breastfeeding management at the Chainama Hills Hospital. The group initially comprised of 18 mothers but this number has since dwindled due to some mothers going into formal employment and others getting stalls at the City Market[8].

The writer's practicals in this community commenced on 9th January 1998 and ended on April 9 1998. The first week of the practicals was spent at the MCH wing of the Chainama Hills Hospital in order for us to be acquainted with breastfeeding programmes. The MCH staff were receptive and friendly. This writer was introduced to the community in the second week of the practical attachment during which time the purpose of the practical was explained to the members of the support group.

This writer was warmly received by the community, though, a confession has to be made that the community thought the writer was among them either as an expert on the subject or as members of the MMD. To some extent, this affected the women's effective participation in the activities of the day during the initial stages of our practicals. Later, however, the women realised that this writer was a bonafide student on a practical attachment and that his interest in breastfeeding and desire to learn from them was the main reason why he had gone to work with them. This resulted in the members' uninhibited participation in subsequent meetings. The writer learnt a great deal about the operations of the support groups as he went from one community to another.

Some of the members of the Kaunda Square Stage II support group with a member of the MCH staff (front row standing, fourth from left)

Training for the members of the first support group in Kaunda Square Stage II was conducted at the Chainama Hills Hospital. The members were recruited from among some of the mothers who went to the hospital during antenatal clinics as well as from among those mothers who went there for breastfeeding related problems. The mothers who were attending the antenatal clinic were prime targets for the breastfeeding programme because the MCH staff wanted them to be peer counsellors in their community. They were, therefore, expected to teach the others based on their experiences with breastfeeding. It was felt that the involvement of the mothers in the promotion of breastfeeding would have greater impact in the community if the mothers themselves played an active role in teaching fellow women.

It should be pointed out here that the second group of the members of the support group was trained right within the community by the first intake of the members of the MSGs. The MCH staff only went into the community every Thursday afternoon to oversee the training sessions. Some of the members of the MSG handled the training sessions so well that the mothers had empathy for them.

A member of the Kaunda Square Stage II support group teaching fellow mothers (not in the picture)

A typical afternoon of lessons starts with the MCH staff and the mothers arriving at the established meeting place at about 14.00 hours. The training session starts as soon as a quorum is formed. It is a tradition in both communities to start the day's deliberations with a hymn and prayer. This is done in order to seek God's guidance during the day's teaching.

Some of the members of the MCH staff

This writer had the privilege of being present during the training sessions which were both participatory and interactive. The writer acknowledges and appreciates the fact that all training sessions were conducted exclusively in vernacular. No one dictated or took notes during these sessions. The only problem we noticed, though, was that almost all the members of the Kaunda Square Stage II support group who were involved in teaching had difficulties in translating some of the technical terms from English to vernacular, especially with regard to the anatomy of the breast.

7.1.2 The MSG at the NRDC

Map 3: Aerial view of the NRDC

The NRDC is Zambia's biggest college of agriculture. It is situated nine kilometres from the centre of town along the Great East Road. It is two kilometres from the main road and has a population of about three hundred and forty five people (excluding students)[9].

Practicals at the NRDC also commenced on 9th January 1998 and came to end on April 9. The reception accorded to us in this community was the same as described above. The MCH staff from the Chainama Hills Hospital and one or two members of the Kaunda Square Stage II support group used to go to the NRDC to teach the members of the new support group every Wednesday afternoon starting at 14:00 hours. Training was intense and culminated in the graduation of the NRDC support group on Friday, 13 February 1998. Like their Kaunda Square Stage II counterparts, the members of the NRDC support group are expected to teach and encourage fellow women to participate in the activities of the support group in the community.

Some of the members of the NRDC support group attending a seminar prior to their graduation

A typical afternoon of lessons in the NRDC support group also starts with the MCH staff and the mothers arriving at the established meeting place at about 14.00 hours. The training session starts as soon as a quorum is formed. Teaching is largely handled by a member of the support group from Kaunda Square Stage II previously identified by the MCH staff. Problems associated with teaching the anatomy of the breast were also observed in this community.

8.0 Main Findings

As stated above, the main objective of this report is to make a comparative assessment of community participation in the breastfeeding programme. This is done by examining the role of the MSGs in the promotion of breastfeeding in Kaunda Square Stage II and the NRDC.

Although the members of the mother support groups appreciate the importance of teaching others about breastfeeding, very few have actually done so since they finished their course on breastfeeding. In Kaunda Square Stage II, 1 respondent or 11 per cent[10] of the respondents have not attended to any mothers since they graduated in 1996. Four (4) respondents or 44 per cent have attended to at least five mothers while 3 or 33 per cent have attended to between 6 and 10 mothers.

At the NRDC, 2 or 25 per cent of the respondents have not attended to any mothers at all while only 1 or 13 per cent of the respondents have attended to between 6 and 10 mothers. Figure 1 below shows the number of mothers attended to by the members of the support groups upon their graduation in both communities.

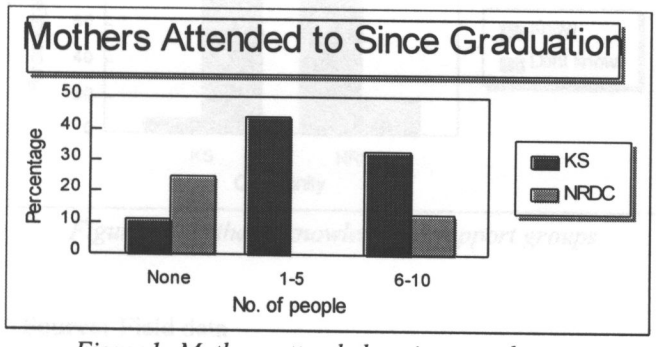


Figure1: Mothers attended to since graduation

Source: Field data

There also seemed to be a general lack of commitment to carry out duties in the community on the part of the members of the support groups. One reason for this is that household chores took most of their time and more often than not, they were unable to come for scheduled meetings on time. The reader is hereby reminded that the support group in Kaunda Square

Stage II has been in existence for over one year now. The writer feels that more mothers could have been visited by the members of the support group.

The major reason given by the members of the NRDC support group for the small number of mothers attended to was that they were not sure of what to teach their colleagues because they had not yet completed their training programme. A similar survey in future could reveal whether the assertion made above is correct.

Although the MSG has been in existence for almost two years in Kaunda Square Stage II, only 2 or 8 per cent of the twenty six mothers interviewed knew about it. Twenty-four (24) or 86 per cent did not know that a support group existed in their community. This finding contrasts sharply from the data obtained from the NRDC residential area where 11 or 79 per cent of the mothers knew about the existence of the support group in their community. Only 3 or 21 per cent of the mothers said they did not know. Figure 2 below is a summary of the responses.

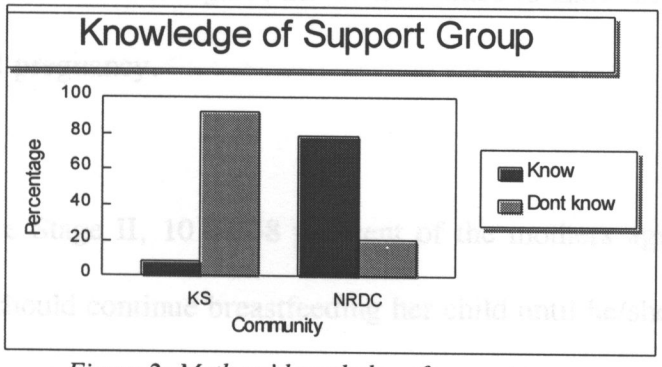


Figure 2: Mothers' knowledge of support groups

Source: Field data

In order to find out the attitude of the mothers on exclusive breastfeeding, the writer asked them what their opinion was on the issue. Eleven (11) or 42 per cent of the mothers in Kaunda Square Stage II agreed that a child between 0-6 months should be fed exclusively on breast milk while 14 or 54 per cent did not agree. At the NRDC, 12 or 86 per cent of the mothers agreed while 2 or 14 per cent did not agree. These responses are presented in Figure 3 below:

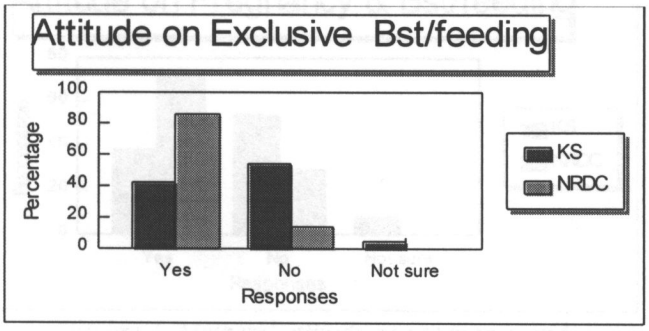


Figure 3: Mothers' attitude on exclusive breastfeeding

Source: Field data

A closer look at the figures indicates that 43 per cent of the respondents who had a negative attitude on exclusive breastfeeding in Kaunda Square Stage II belonged to the 30 - 40 age group and had an educational background of between grades 1-9. None of the people in this category of respondents belonged to the 30 - 40 age group at the NRDC.

The role played by the older and more experienced mothers in influencing opinion in the respective communities can not be ignored. More often than not, they are the role models to whom the younger and inexperienced mothers usually go for advice especially on issues relating to motherhood. In this regard, the writer wanted to know what the mothers felt about breastfeeding and pregnancy.

In Kaunda Square Stage II, 10 or 38 per cent of the mothers agreed that a lactating and pregnant mother should continue breastfeeding her child until he/she is six months old while 14 or 54 per cent of the mothers did not agree. Only 2 or 8 per cent of the mothers were not sure. At the NRDC, 10 or 71 per cent of the mothers agreed and only 4 or 29 did not agree. Figure 4 below presents a summary of the mothers' responses:

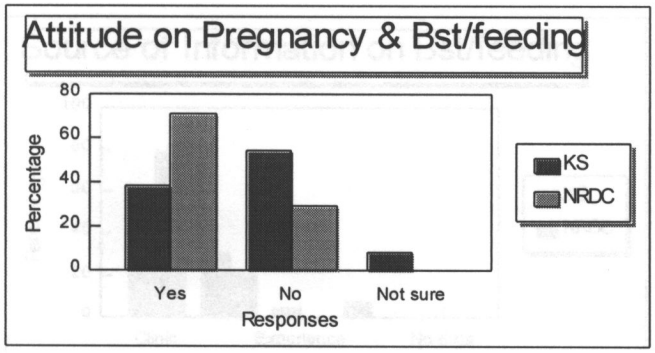


Figure 4: Mothers' attitude on pregnancy and breastfeeding

Source: Field data

These figures are significant as the attitudes/values the mothers have will almost certainly influence the type and nature of CP, and consequently, the success of the programme in the two communities. The members of the support groups in both communities, therefore, need to pay particular attention to the beliefs and attitudes of these people during teaching in order to change their attitude/values on exclusive breastfeeding.

In order to assess how effective the MSGs were in their respective communities, this writer asked the mothers to state where they obtained information on breastfeeding. Fifteen (15) or 58 per cent of the mothers in Kaunda Square Stage II cited the clinic as their source of information on breastfeeding while 8 or 31 per cent stated that they obtained this information from their relatives. Only 1 or 4 per cent of the mothers got it from their experience. This question was not applicable to 2 or 8 per cent of the respondents. At the NRDC, 11 or 79 per cent reported that they got information about breastfeeding from the clinic while 21 per cent said that they got this information from their relatives. It is interesting to note that none of the mothers interviewed mentioned support groups in their communities as their source of information on breastfeeding. These responses are summarised in Figure 5 below:

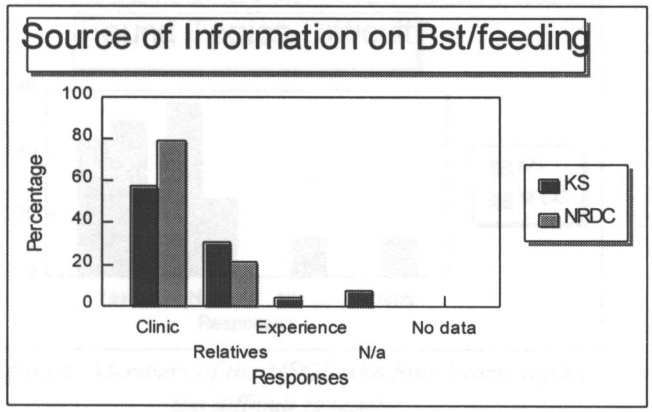


Figure 5: Mothers' source of information on breastfeeding

Source: Field data

The writer also wanted to know how conversant the members of the MSG were in terms of the topics they taught. It was necessary for them to state if they found some of the topics too difficult to teach. This was important because a member of the support group can only teach others effectively if they were themselves well informed on the various topics.

In Kaunda Square Stage II, 4 or 44 per cent of the respondents had problems in teaching certain topics. Of these, 22 per cent had gone up to Grade VII at school.5 or 56 per cent did not find any topic too difficult to teach and these had completed Grade IX at school. At the NRDC, 2 or 25 per cent found some topics too difficult to teach but declined to state how far they had gone at school. Four (4) or 50 per cent did not find any topic too difficult to teach and these too had completed at least Grade IX. This question did not apply to 1 or 13 per cent of the respondents while 1 or 13 per cent of the respondents did not respond. Of those who found some topics too difficult to teach, 3 or 43 per cent said they had problems in understanding the "Ten Steps of Successful Breastfeeding". Figure 6 below is a summary of the responses to the question.

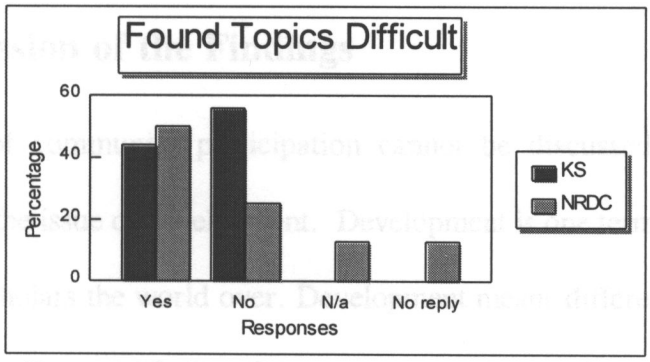


Figure 6: Members of the MSGS who found some topics too difficult to teach

Source: Field data

Finally, members of the MSGs were asked if they faced any problems as they worked in their respective communities. Eleven (11) or 65 per cent of the respondents in both communities reported that they faced problems as they worked in the community. One of the problems they cited was that they found it very difficult to convince older mothers on certain aspects of breastfeeding because they [the mothers'] argued that "the nurses do not tell the truth" especially on issues relating to exclusive breastfeeding. Another problem was that some mothers did not know how to look after their children. As a result of this, members of the MSGs had difficulties in teaching such mothers good family hygienic practices as they feared they would offend them if they did so. The other problem was that it was difficult for the members of the MSG to convince older mothers because some of them just had a negative attitude towards exclusive breastfeeding.

9.0 Discussion of the Findings

The concept of community participation cannot be discussed fairly without necessarily touching upon the issue of development. Development is one term which has been defined and redefined by scholars the world over. Development means different things to different people. Some see development as "freeing from nature's servitudes, from economic backwardness and oppressive technological institutions, from unjust class structures and political exploiters, from cultural and psychic alienation - in short, from all of life's inhuman agencies" (Melkote, 1991:193). Others define development as a process of social change which has as its goal the improvement in the quality of life of all or the majority of the people without violence to the natural and cultural environment in which they exist, and which seeks to involve the majority of the people as closely as possible in this enterprise, making them the masters of their own destiny (Ibid.,1991:193). Kasoma, however, defines development as the "improvement in the human life condition at individual and societal levels which is achieved through desirable but fluctuating changes or adjustments in the environment. Environment here means the sum total of all that goes into human life situation. It includes the physical and the psychological vicissitudes of the human life situation"(Kasoma, 1990:3). What is common in all these definitions is that man/woman is the focal point of development. It is, therefore, fair to say that any form of development that negates the centrality of man/woman is not beneficial to humankind at all.

One of the factors that has provided impetus to addressing the importance of community participation in development activities is that there has been some evidence in many development projects especially those commissioned by the World Bank in rural and population/health areas of the positive impact of community participation on project efficiency. Another is that local and national governments are finding it increasingly difficult to manage adequately the innumerable development projects and programs, thus paving the way for a

more prominent role for non-governmental and community organizations. The other is that non-governmental organizations and several development agencies including those of the U.N, have made it their development objective to empower the underprivileged populations by giving them greater control over resources and decisions in projects and programs affecting their lives.

CP is now generally seen as providing several benefits to project and programme managers, especially in times of budget distress and structural adjustment. First, it can lead to increased mobilization of financial and non-financial resources (labour, material, information, etc) by communities. Second, it can make for greater effectiveness in planning and implementation of development initiatives, by adapting them to local circumstances. Third, it can help to improve the maintenance of assets and infrastructure through local resource contribution and management. Forth, it can contribute to local experience in providing local services, and hence stimulate the development of other forms of local institutions. Finally, it can enhance accountability and more equitable distribution of benefits by making local administration accountable to a more representative community.

If development is to have any relevance to the people who need it most, it must start where the real needs and problems exist. It, therefore, goes without saying that people must be encouraged to perceive their real needs and identify their real problems.

Although the people of Kaunda Square Stage II and the NRDC did not initiate the breastfeeding programme, the two peoples are committed to its success. Admittedly, a lot needs to be done in order to enhance the level and extent of CP in the breastfeeding programme in general and in the activities of mother support groups in particular in both communities.

CP in the activities of the MSGs can only be possible if the members of the community are informed about the program. The results of this survey have shown that a good part of the Kaunda Square Stage II community does not know about the existence of the support group even though this was formed as far back as 1996. A lot needs to be done in this community to make the members aware of the activities of the support group. Only then will the community participate effectively in the breastfeeding programme.

Results from the survey have also shown that the NRDC community is more aware of the existence of the support group in its locality than its Kaunda Square counterpart. In a way, this can be attributed to the fact that the NRDC community is small and therefore its members tend to take more keen interest in what is going on around them. The support group at the NRDC community will, therefore, not have as many difficulties in mobilising the community for the breastfeeding programme as most of the members already know about the existence of the group. This, however, is not to suggest that members of the support group should relax in their membership recruitment drive.

The success of the breastfeeding programme in the two communities largely depends on the values and attitudes the members of the community have towards the programme. In this regard, the negative attitude shown by some of the mothers in Kaunda Square Stage II will certainly have a negative impact on the success of the breastfeeding programme in general and on exclusive breastfeeding in particular. A lot, therefore, needs to be done in Kaunda Square Stage II to change the beliefs and values which the older women have with regard to exclusive breastfeeding.

It can be observed from this survey that the members of the support groups have not played a very effective role in promoting the activities of the groups in their respective communities.

One way in which the members of the support group can promote their activities in their respective communities is by having some of their members assigned to specific areas of the community. For instance, certain members could be given a block of houses as their catchment area. These would be expected to recruit new members or address issues of common interest to the mothers in the community. The members of the support groups would then exchange notes with their colleagues as they meet on the days set aside by themselves for such meetings. This writer feels that in this way, the members of the MSGs will have the opportunity to share their experiences and problems as they work in their respective communities. Current efforts being made in this direction in Kaunda Square Stage II are noted. However, much more still needs to be done.

There seems to be a strong relationship between the level of education attained and the ability to comprehend topics taught by the members of the MSGs. Results from the survey indicate that those members of the MSGs who attained at least Grade IX have fewer problems in understanding some of these topics. The survey has shown that those members of the MSGs who are young and have only attained the level of Grade VII at school face even more problems when articulating critical issues in breastfeeding especially in the presence of the older and more experienced mothers. This was particularly true for issues relating to exclusive breastfeeding.

It should be appreciated that it is not possible for members of the MSGs to teach others effectively unless they themselves fully understand the material they are teaching. In the same token, it should be acknowledged that an audience cannot listen attentively to any instructor who lacks confidence while teaching. Such confidence, however, can only come about if the instructor is sure that she understands the subject matter. Perhaps this explains why the number of mothers reached by the members of the MSGs in both communities has generally

been low. This is especially true for Kaunda Square Stage II where the majority of the members have only been able to reach a dismal number of the mothers in the community.

CP in the breastfeeding programme can be greatly enhanced if health professionals are continuously consistent in their pronouncements on health issues. Perhaps the women who are now resisting exclusive breastfeeding are justified in doubting the advice given to them by the professionals. Who knows, may be one day the health professionals will "rescind" their current stand on exclusive breastfeeding and advise the women against the very practice they are promoting now. This is exactly what happened in the 1980's when problems of malnutrition were associated with late weaning. Health officials started a campaign to introduce porridge to the baby's diet at three months. Later, however, it became apparent that a lot of sickness and malnutrition was due to early weaning. Health professionals are now instead advising mothers not to introduce solids to their babies until after they are six months old [exclusive breastfeeding]. Suffice to say that inconsistent pronouncements made by the health professionals have had a negative impact on the promotion of breastfeeding in general and on the promotion of exclusive breastfeeding in particular.

10. Recommendations and conclusions

The breastfeeding programme currently being implemented by the MCH wing of the Chainama Hills Hospital Board of Management should be seen by the communities as their own programme. Effort should, therefore, be made to improve the level of CP in the programme by ensuring that as many community members as possible are involved in the activities of the mother support groups in both communities. This can be possible through an intensive awareness campaign, especially in Kaunda Square Stage II where a lot of people expressed ignorance about the existence of the mother support group. Strategies for such a campaign could include meetings, matches, theatre as well as radio and television discussions on the subject.

The members of the support group accompanied by a nurse, should pay more home visits in their respective communities in order for them to explain critical issues in breastfeeding. This would help influence and change current values and attitudes towards breastfeeding. The presence of a nurse among members of the support group would also help boost the communities' perception of the support groups.

Any programme or project that removes the beneficiaries from their communities during its implementation or execution is bound to be mistaken by the community for a programme that is imposed on the people from the outside. The MCH should, therefore, continue conducting training for members of the support groups in the areas where the beneficiaries live and not at the clinic. This would result in changing the community's perception of the breastfeeding programme so that they begin to regard it as their own.

The manual on breastfeeding is essential in the teaching programme of the MSGs. Having recognised this and the fact that the manual is to be used in all Baby Friendly Hospitals, this

writer strongly calls upon the NFNC to have it translated into the major vernacular languages. This would facilitate teaching and learning as the mothers meet in their respective communities.

While it is the desire of the MCH staff to recruit more women attending the antenatal clinic into the support groups, efforts should be made to recruit only those mothers who have attained at least Grade IX. Biology, a subject which is taught at this level, seems to provide a good background for understanding such topics as the anatomy of the breast, a topic which the members of the MSG found too difficult to teach.

Much as the voluntary nature of support groups is appreciated, incentives should be given to the members of the groups once in a while as a way of acknowledging their participation in the promotion of breastfeeding in their respective communities. For instance, in addition to the chitenge material and T-shirts which the members receive, the Chainama Hills Hospital Board of Management could also consider exempting those members at the focal point of the MSGs from paying user fees (medical scheme).

Some of the problems being encountered by the members of the MSG in both communities could be alleviated if the National Food and Nutrition Commission, through the Ministry of Health assisted the members by providing for some of their needs. This writer wishes to suggest that some of the money given to the MCH at the Chainama Hills Hospital be used to meet some of the direct needs of the members of the MSGs. For instance, the MCH could spend some of the money on notebooks and pencils which some of the members could use to keep a record of activities in their respective communities.

Although advocates of CP maintain that the involvement of the beneficiaries in the identification of their needs and priorities is a major tenet for the success of any community project, the breastfeeding programme in Kaunda Square Stage II and the NRDC has demonstrated that community participation is still achievable even when the problems of the community are identified by people who are not necessarily members of the beneficiary community.

It should be acknowledged that CP is a social process that springs from preexisting set of social relations. It requires leadership and organization, attributes that must be created within the community and that, ultimately reflect its values and goals. It should also be understood by all the stakeholders that the success of CP in the breastfeeding programme greatly depends on the vision and cooperation among all the staff of the MCH wing on the one hand, and the understanding and support from the members of the community on the other. It is important that both the staff of the MCH and the members of the support groups in both communities work hand in hand to explain the objectives and rationale for the existence of the support groups to the members of society. This in itself is no easy task for it requires all the stakeholders to have unity of purpose in their continued desire to promote breastfeeding in Zambia.

11. Feedback From the Field

This writer went back to the field on 21 May 1998 and held discussions with the MCH staff at the Chainama Hills Hospital and the members of the support groups at Kaunda Square Stage II and the NRDC. The discussion were centred on the findings from the field and the recommendations that were made in order to enhance breastfeeding in the two communities. The writer is pleased to report that most of the recommendations made have been well received by both the MCH staff and the members of the support groups.

One of the recommendations made was that the NFNC, through the Ministry of Health, should assist the MSG by providing for some of their needs. It has been suggested in the report that some of the money given to the MCH should be used to meet some of the direct needs of the MSGs. This writer is pleased to report that the suggestion was well received and that right now the members of the MGS in Kaunda Square Stage II have been given notebooks and pens which they use in keeping a record of the progress they are making in the community.

The report also recommended that MSGs assign themselves catchment areas as this would ensure that information and advise on breastfeeding and infant health reaches as many members of the community as possible. This writer is pleased to note that the first group of the MSGs has implemented this recommendation and that members of the subsequent support group in Kaunda Square Stage II no longer meet in the community hall as was the case in the beginning. Members now meet in homes of fellow members from where they go door to door helping mothers with issues related to breastfeeding. This writer feels that the present strategy is going to be more effective than the previous one which required that the members meet in the community hall. The writer feels that the strategy will reduce the opportunity cost which the mothers incur when they take part in the activities of the support group in their community. For instance, some mothers could not find time to walk and see member of the MSGs in the community hall because they

did not have time to do so as they were too busy at home. This will not be the case any more as the members of the MSGs will now meet the mothers in their own homes.

The first group of the MSGs in Kaunda Square Stage II and the NRDC community is the core of the support group in the respective communities. The two groups now organize the mothers themselves. In other words, the two support groups have been empowered to make their own decisions on how best they can enhance community participation in breastfeeding in their respective communities. The MCH staff at the Chainama Hills Hospital are only consulted if the support groups come across issues which the support groups can not handle. The decision by the MCH to empower the support groups is, therefore, highly commendable.

Some of the recommendations, however, could not be implemented by the MCH staff alone as they required the attention of the NFNC. For instance, the writer recommended that members at the core of MSGs could be given some incentives in order to encourage them to work even harder in the promotion of breastfeeding in their respective communities. The MCH staff spoken to felt that while they appreciated the rationale for the suggestion, they were not in the position to make any decision on the issue. This writer strongly urges the NFNC to look into this issue.

One of the recommendations made by this writer was that the manual which the MSGs use for teaching should be translated into vernacular so that some of the members of the MSGs and the mothers could easily understand the topics. As earlier indicated, it was mainly the MSGs who had attained less than nine years at school who found some topics too difficult to teach. The study has recommended that members at the core of the support groups should only be those who have attained nine years at school. This recommendation was accepted in principle by the MCH staff but required the full endorsement of the NFNC.

12. Executive Summary and Main Recommendations

This report is based on the writer's experience with the breastfeeding project which is being funded by the National Food and Nutrition Commission (NFNC) and implemented by the Maternal and Child Health (MCH) wing of the Chainama Hills Hospital in Kaunda Square Stage II and the Natural Resources Development College (NRDC) residential areas in Lusaka.

The report has attempted to make a comparative assessment of the extent of community participation in the promotion of breastfeeding in the two communities. The report has examined issues relating to the recruitment of the members of the support groups, the training they received, as well as their role and effectiveness in the communities they serve. The report has also made recommendations to the authorities on how to enhance community participation in the breastfeeding programme in the two communities.

The methodology used for data collection has been outlined in the appropriate section of this report. Although the menfolk have a significant role to play in the success of any project involving women, their participation in the breastfeeding programme in the two communities was beyond the scope of this report.

Summary of the Findings

Although the members of the MSGs appreciate the importance of teaching fellow women about breastfeeding in their respective communities, very few have actually done so since they finished their training course on breastfeeding. This could be attributed to the difficulties MSGs have had in finding time to attend to the activities of the support groups in addition to their daily household chores. This was quite often manifest in their inability to come for scheduled meetings on time.

Although the MSG has been in existence for almost two years in Kaunda Square Stage II, only 8 per cent of the mothers interviewed knew about its existence. Ninety (92) per cent of the mothers did not know that a mother support group existed in their community. This finding contrasts sharply from the data obtained from the NRDC residential area where 79 per cent of the mothers knew about the existence of the support group in their community. Only 21 per cent of the mothers said they did not know.

Fifty-eight (58) per cent of the mothers in Kaunda Square Stage II cited the clinic as their source of information on breastfeeding while 31 per cent said that they got this information from their relatives. Only 4 per cent of the mothers got this information from past experience. In the NRDC, 79 per cent of the mothers reported that they got information about breastfeeding from the clinic while 21 per cent said that they got this information from their relatives. It is interesting to note that none of the mothers interviewed mentioned support groups in their communities as their source of information on breastfeeding.

In Kaunda Square Stage II, 38 per cent of the mothers agreed that a lactating and pregnant mother should continue breastfeeding her child until he/she is six months old while 54 per cent of the mothers did not agree. Only 8 per cent of the mothers were not sure. In the NRDC, 71 per cent of the mothers agreed and only 29 per cent did not agree.

Forty-two (42) per cent of the mothers in Kaunda Square Stage II agreed that a child between 0-6 months should be fed exclusively on breast milk while 54 per cent did not agree. In the NRDC, 86 per cent of the mothers agreed while 14 per cent did not agree. These figures are significant as the attitudes/values the mothers have certainly influence the type and nature of community participation, and consequently, the success of the programme in the two communities.

Main Recommendations

The Kaunda Square Stage II and NRDC community should regard the breastfeeding programme currently being implemented by the Maternal and Child Health wing of the Chainama Hills Hospital Board of Management as their own. Effort should, therefore, be made to improve the level of community participation in the programme by ensuring that as many community members as possible are involved in the activities of the mother support groups in the two communities. This can be possible through an intensive awareness campaign, especially in Kaunda Square Stage II where a lot of mothers expressed ignorance about the existence of the support group. Strategies for the campaign could include meetings, theatre, matches as well as radio and television discussions on the subject. Efforts currently in place in this direction are acknowledged.

Members of the support group in the company of a nurse should pay more home visits in the respective communities in order to explain critical issues in breastfeeding. The presence of a nurse among members of the support group would help boost the standing of the support groups in the community.

The MCH should continue conducting training for members of the support groups in the areas where the beneficiaries live and not at the clinic. This would result in changing the community's perception of the programme. Training should place emphasis on changing current attitudes and practices on breastfeeding, especially among the older women in Kaunda Square Stage II. This would only be possible if they are persuaded to join support groups in their respective communities.

The manual used during the training of the members of the support groups should be translated into vernacular. This would facilitate teaching and learning as the mothers meet in their

residential areas.

Some incentives should be given to the members of the support groups as a way of acknowledging their work in the respective communities and society as a whole. One of the incentives, for instance, could be exempting these members from paying user fees or what is commonly known as "scheme" at the hospital.

While it is the desire of the MCH staff to recruit more women attending the antenatal clinic into the support groups, efforts should be made to recruit only those mothers who have attended at least Grade IX of school. This survey has shown that fewer problems in teaching fellow mothers were encountered by MSG members who had attained at least Grade IX at school than by those who had only attained Grade VII.

Notes

1. Joint WHO/UNICEF statement (WHO, 1989) and 'the Global Criteria for the WHO/UNICEF Baby-Friendly Hospital Initiative' (UNICEF, 1992).

2. Hospitals can be awarded 'baby-friendly' status only when specially trained independent evaluators have ensured that all the ten steps are met.

3. For instance, in the 1980's problems of malnutrition were associated with late weaning, so health officials started a campaign to introduce porridge to the baby's diet at three months. Later, however, it became apparent that a lot of sickness and malnutrition was due to early weaning. Health professionals are now instead advising mothers not to introduce solids to their babies until after they are six months old [exclusive breastfeeding]. For details see Carlise (1997:24).

4. Although breastfeeding is a old as the human race, Under Five Clinics have also been a source of information on breastfeeding.

5. For instance, the Chainama Hills Hospital caters for the Kaunda Square Stage II, NRDC, Minestone, Munali, Ester, Mtendere, and Ng'ombe communities. The hospital is expected to establish breastfeeding support groups in each of these communities.

6. For instance, out of the first 20 questionnaires administered in Kaunda Square Stage II, 16 respondents said that they did not know that there was an MSG in their community. We had to verify this by instructing the research assistant to administer ten more questionnaires and to take note of the house numbers of the respondents so we could independently countercheck the collected data. This was done and the result were confirmed.

7. Housing Project Evaluation Report, 1980

8. Oral interview with the Sister-in-Charge of the MCH at Chainama Hills Hospital

9. Oral interview with the Acting Vice Principal of the NRDC

10. Figures have been rounded off to the nearest whole number

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Appendix 1: Questionnaire for the mothers

Community: *Kaunda Square Stage II* [ ] *NRDC* [ ]
House No.: _____

1. Is the MSG necessary in your community?

   Yes [ ] No [ ] [ ] Not sure [ ]

2. Was it your idea as mothers to form the MSG in this community?

   Yes [ ] No [ ]

3. How long have you been a member of the MSG in this community?

   _____

4. Do you enjoy your work?

   Yes [ ] No [ ] Not sure [ ]

5. Do the mothers in your community appreciate your work?

   Yes [ ] No [ ] Not sure [ ]

6. How many mothers have you attended to since you graduated last year?

   None [ ] 1-5 [ ] 6-10 [ ] 11-15 [ ] 16-20 [ ]

7. Do you usually visit the mothers?

   Yes [ ] No **[ ](GO TO Q11)**

8. How often do you visit them?

   _____

9. When was your last visit?

   _____

10. Were you welcome by the mothers?

    Yes **[ ](GO TO 12)** No **[ ](GO TO Q12)**
    Not sure **[ ](GO TO Q12)**

11. Why do you not usually visit them?

    _____
    _____
    _____
    _____
    _____

12. Do you find the breastfeeding manual easy to use in your teaching?

Yes [ ] No [ ] Not sure [ ]

13. Do you find some topics too difficult to teach?

Yes [ ] No [ ]**(GO TO Q15)**

14. Which topic(s) do you find difficult?

i) _____
ii) _____
iii) _____
iv) _____
v) _____

15. Would you try to convince a mother who argues that exclusive breastfeeding is not healthy for the baby?

Yes [ ] No [ ] Not sure [ ]

16. Do you agree that a breastfeeding mother should continue breastfeeding her child even when she is pregnant?

Yes [ ] No [ ] Not sure [ ]

17. If there was a project in your community in which members were paid for their participation, would you continue working as a member of the MSG for no pay at all?

Yes [ ] No [ ] Not sure [ ]

18. Was the training you received sufficient for you to carry out duties in your community?

Yes [ ]**(GO TO Q 20)** No [ ] Not sure [ ]

19. Would you be interested in pursuing further training?

Yes [ ] No [ ] Not sure [ ]

20. Do you face any problems as you work in your community?

Yes [ ] No [ ]**(GO TO Q22)**

21. What are these problems?

_____
_____
_____
_____
_____

22. How far did you at school?

1. Never been to school [ ]
2. Sub A-B [ ]
3. Standard 1-6 [ ]

4.	Grade 1-4	[ ]
5.	Grade 5-7	[ ]
6.	Grade 8-9	[ ]
7.	Grade 10-12	[ ]
8.	College	[ ]
9.	University	[ ]

23. Would you say your age is between...

1.	10 - 20	[ ]
2.	21 - 29	[ ]
3.	30 - 40	[ ]
4.	41 - 49	[ ]

Appendix 2: Questionnaire for the members of the MSGs

Community:	*Kaunda Square Stage II [ ] NRDC [ ]*
House No.:	_____

1. How many children do you have?

_____

2. How old is the oldest child?

_____

3. What is the sex of the oldest child?

Male [ ] Female [ ]

4. Do you breastfeed your children?

Yes [ ] No [ ]

5. Do you think it is necessary to breastfeed them?

Yes [ ] No [ ] Not sure [ ]

6. Have you noticed any difference between breast milk and powdered milk?

Yes [ ] No [ ] Not sure [ ]

7. Do you know that there is a MSG in this community?

Yes [ ] No [ ]**(GO TO Q15)**

8. Would you say that the MSG is necessary in this community?

Yes [ ] No [ ] Not sure [ ]

9. Do the members of the MSG visit you?

Yes [ ] No [ ]**(GO TO Q13)**

10. How often do they visit you?

_____

11. Are their visits regular?

Yes [ ] No [ ]

12. When did they last come to visit you?

_____

13. Are all the members of the MSG in your community qualified to teach you how to breastfeed your children?

Yes [ ] No [ ] Not sure [ ]

14. What are your reasons for the answer you have given above?

_____
_____
_____
_____
_____

(GO TO Q17)

15. Where do you get information about breastfeeding?

Clinic [ ] Church [ ] Friends [ ]
Relatives [ ] Experience [ ]
None of the above [ ]**(GO TO Q17)**

16. Do you think that this information is accurate?

Yes [ ] No [ ] Not sure [ ]

17. Do you agree that a child below 6 months should exclusively be breastfed without giving him/her water at all?

Yes [ ] No [ ] Not sure [ ]

18. Do you agree that a mother should continue breastfeeding her child when she is in her early stages of pregnancy?

Yes [ ] No [ ] Not sure [ ]

19. How far did you go at school?

1. Never been to school [ ]
2. Sub A-B [ ]
3. Standard 1-6 [ ]
4. Grade 1-4 [ ]
5. Grade 5-7 [ ]
6. Grade 8-9 [ ]
7. Grade 10-12 [ ]
8. College [ ]
9. University [ ]

20. Would you say your age is between...

1. 10 - 20 [ ]
2. 21 - 29 [ ]
3. 30 - 40 [ ]
4. 41 - 45 [ ]
5. 46 > [ ]

Appendix 3: The Ten Steps to successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.

2. Train all heath care staff in skills necessary to implement this policy

3. Inform all pregnant women about the benefits and management of breast-feeding

4. Help mothers initiate breast-feeding within a half hour of birth

5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.

6. Give newborn infants no food or drink other than breast milk unless *medically* indicated.

7. Practice rooming-in-allow mothers and infants to remain together - 24 hours a day.

8. Encourage breast-feeding on demand.

9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.

10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital clinic.

In addition, facilities should refuse to accept free and low-cost supplies of breast-milk substitutes, feeding bottles and teats

Source: *Protecting, Promoting and Supporting Breastfeeding: The special role of maternity services:* a Joint WHO/UNICEF Statement (WHO, 1989) and 'The Global Criteria for the WHO/UNICEF Baby-Friendly Hospital Initiative'(UNICEF, 1992)