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Notes

The paper describes the general situation with regard to breastfeeding in Brazil, which was declining, and suggests methods of communication to improve the situation. Against the background of the specific focus on the promotion of breastfeeding in Brazil, the paper provides an example of the thinking at the time of the role of communication, social marketing and related techniques in support of development projects, and the strategic planning of a PSC campaign.

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A DISCUSSION PAPER ON  
COMMUNICATION PROPOSAL TO PROMOTE BREASTFEEDING IN  
BRAZIL

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## I INTRODUCTION

Breastfeeding is only one aspect of the nutrition and health continuum in which the mother and her child must live. Strictly speaking, therefore, the promotion of breastfeeding should be addressed as a part of the total concept of infant and child feeding practices. However, immediate action can be taken in isolation for infants 0 to 4 months of age since their needs are fully met by breastmilk.

Communications are only one component in the effort necessary to beat the problem. They interact with many other components and can be negated by them and therefore not easily isolatable.

This proposal has forged on anyway because the programme is seen as a first step that can be taken relatively fast. Its modalities are relatively independent within a much larger and complex system.

The shape of the total programme necessary is known. All of the strategies recommended here keep the wider perspective constantly in focus. They might even be considered the inevitable test runs for later validation and upscaling.

It is hypothesised that the present breastfeeding "promotion" will facilitate the larger and later programme, deliver helpful benefits and data, and exploit opportunities immediately available in Brazil (especially on the media cooperation front).

## II THE SITUATION WE WANT TO CHANGE

There has been a marked decline in the percentage of mothers

breastfeeding their infants and, particularly, in the duration of breastfeeding in Brazil.

The consequences are grave at the personal, family, community and national levels in fields like the nutritional, health, child mortality, economic, psycho-social and conceptional.

A peculiarity in Brazil is that it is afflicted by the worst of two worlds - rural, neo-urban and lower income/social groups are joining more upscale city folk in a diminishing practice of human lactation. At the same time, "top" urbanites are not returning to breastfeeding as seems to be happening in North America and Europe (the USA, Sweden, etc).

Studies compiled by the National Food and Nutrition Institute (INAN) bear out the widespread nature of the problem:

In the sixties, breastfeeding was universal and lasted up to anything from 4 to 12 months. But, by 1975, a Recife study showed weaning before the infant was 1 month old in 53% of the sample - and this in a year when the Infant Mortality Rate was 50% higher at 198.8 (per 1,000 live births) against 124.2 in 1966.

A study in the same city has shown that 73% of deaths in the first year are of infants breastfed for less than a month or not at all.

By 1978, the number of mothers ever breastfeeding in Pernambuco had dropped to 75% and those doing so for 4 weeks and more had plummeted to 12%. So much for the more economically backward Northeast.

In the South and Southeast, the picture is no better. In Pello-

tas (Rio Grande do Sul), 73% of infants 2 months old were already on supplementary food. So were 50% of infants leaving the maternity hospital in Campinas. In São Paulo a study found that 77% of infants 1 month old in the sample had already been weaned.

A study on the nutritional status of São Paulo children between 6 and 60 months of age by the Institute of Economic Research and the Institute of Preventive Medicine showed an association, statistically significant, between breastfeeding and malnutrition in children 2 years old and younger. This is amply corroborated by the WHO study by Puffer and Serrano in 1973 of 13 Latin American projects, including São Paulo, Ribeirão Preto (both in the South) and Recife (Northeast).

The reasons for the sharp drop in breastfeeding here are: rapid urbanization (urban population 63% and growing); changes in structure of the family which make it less supportive of breastfeeding; industrialization and the changing status of women; a new feminine self-image bred by the mass media and the environment; the association of the bottle with modernity, convenience and the elite; endorsement of this by doctors; public health and hospital practice which misinform the mother, practice routines or separate lodgement for infants which do not encourage breastfeeding.

Three other factors deserve notice. The laws of the land and their enforcement help provide no creches, suitable leave/time-off rules or job security for working mothers.

There is heavy infant food advertising and promotion, unchecked in some places even in hospitals.

Finally, there is a grievous lack of education and the right information, to counter the negatives; school, medical and nursing curricula ignore the advantages of breastfeeding; the mother is left in the dark or confused.

The psycho-social and anti-conceptual implications are serious. Breastfeeding practitioners and periods are declining despite a wide acceptance among mothers and doctors that "breastmilk is best". There is a gap between claimed attitude and resulting behaviour. By far the most frequent reason given by mothers for early weaning is "insufficient/inadequate/weak/salty" milk. This response is indicative of the chain reaction really at work: hospital practices which effect the lactation reflexes in the mother-child dyad; unsatisfactory lactation; easy availability of well-promoted substitutes; medical and environmental endorsement. Most of this links up with the mother's pre-natal preparation. Even legislation does not really help her.

Taken together, these forces overwhelm her own positive views on breastfeeding. She acquiesces in artificial feeding. To harmonize behaviour with opinion, she comes up with rationalizations ("insufficient etc" milk) which are partly valid anyway; the milk flow does stop.

Economics, reflecting these realities, offer gloomy estimates of food loss. Considering that on an average a mother produces 500 ml of milk per day and that about 3.5 million infants are born each year we are talking in terms of about 300,000,000 litres of milk annually based on a conservative 6 month spell of nursing. Conserving even a part of it means a substantial saving in food loss, not to mention that mothers can breastfeed beyond the 6 month period with resulting saving in supplementary

food.

This is substantial for a country which has reduction of its foreign debt high on its list of national priorities. Some of the food loss certainly goes to swelling it.

In addition, the consumer prices of formula feeding can eat up some 30% of a low income family's budget for one child and mean insanitary dilution of the milk powder into lethal feeding of the infant.

This overall situation is universal and hallowed by time - and not perceived to be harmful.

It may be worth pointing out here that "industrialization and urbanization" are being discounted in recent writing as real causative factors. Latham, for instance, believes the causes to be more politico-cultural, pointing out that bottlefeeding seem as the inevitable accompaniment of development is a "dangerous" dogma.

Here, then, is an outline of what we are up against in the scene we want to change.

The importance of what we want to do:

One reality and three quotes may serve to stress this.

Breastfeeding is a desirable practice involving no extra cost to the family - in fact, it cuts family feeding costs. It predicates no major infra-structural or socio-economic changes.

Yet its benefits, especially to under-privileged groups, are immense.



"For the vulnerable infant and young child, an effective public effort to counter the current trend (of bottle feeding) may be of greater significance than any other form of nutritional intervention". Alan Berg (The Nutrition Factor)

"Perhaps one of the greatest advances in immuno-prophylaxis that we could achieve would be to convince mothers throughout the world to re-instate breastfeeding". FC Robbins (Immuno-prophylaxis in Infections Diseases).

Exclusive and prolonged breastfeeding is "a more effective method of fertility regulation worldwide than the use of other forms of contraception". International Planned Parenthood Federation, Medical Bulletin, 1977.

So what one is trying to do is of importance in Brazil. This is especially so when one applies the economic and social development criteria, not "GNP per capita", to its state of development. Also when you consider such things as the routine availability of hygienic water, of adequate housing and sewerage, or of sufficient coverage and quality by the public health services in Brazil.

We may perhaps also bear in mind the current status of thinking in population problems here and the role breastfeeding could play.

### III GOALS AND OBJECTIVES:

Our goal is to stop, then reverse the decline in maternal lactation.

To do this, we must identify the causes of the problem, analyse how they interrelate and effect breastfeeding - then set up

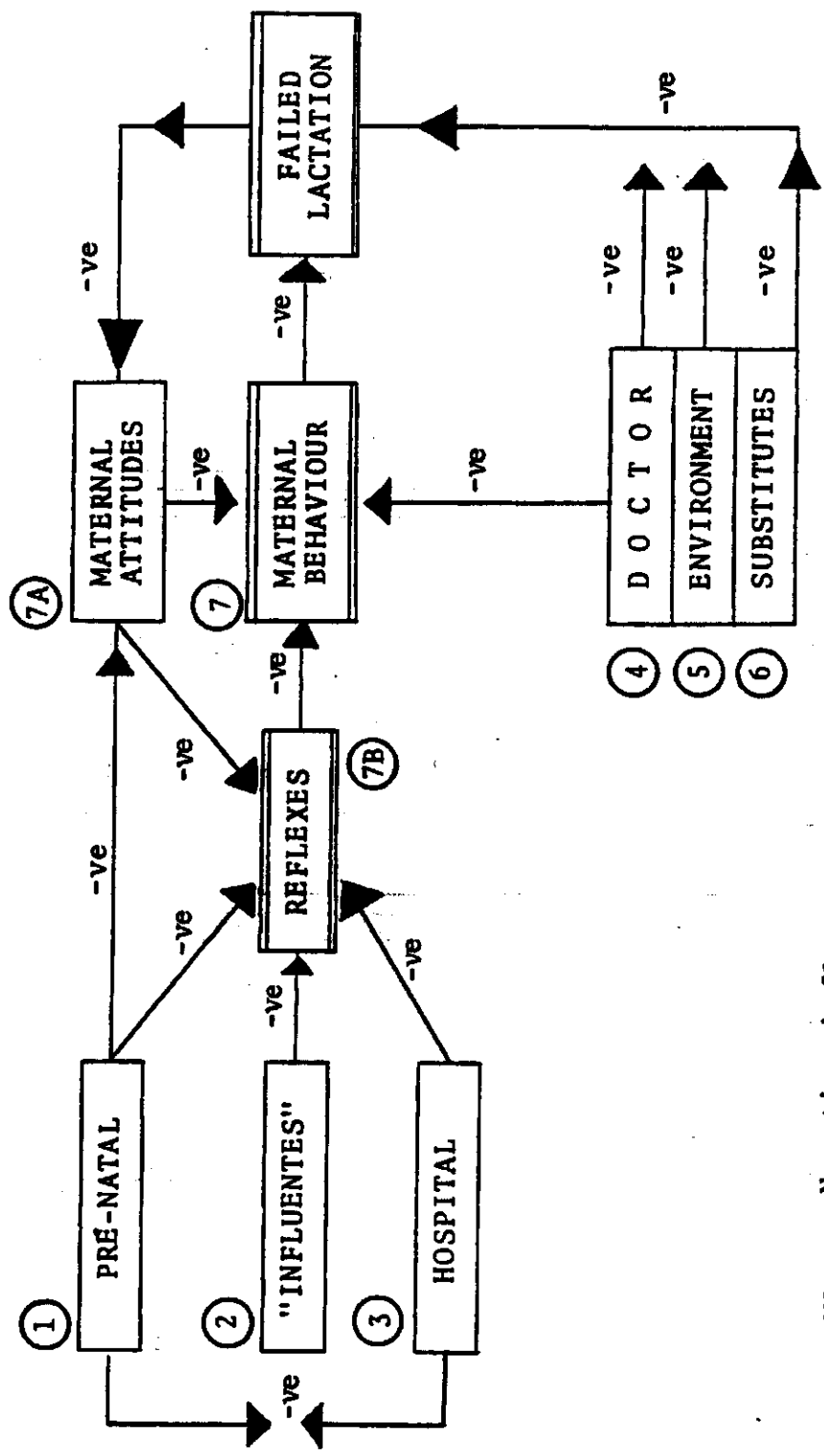


FIGURE I

objectives in each "cause" area.

Figure I attempts this. It depicts the influence of various factors on the mother and her attitude and, more importantly, on her physiological mechanism of lactation.

1. Pre-Natal: The mother is left uninformed on matters effecting breastfeeding. Therefore, we must...

DO ALL POSSIBLE TO MAKE HEALTH CENTRES (AND OTHER RELEVANT PARTS OF THE PUBLIC HEALTH NETWORK) EDUCATE THE MOTHER SUITABLY.

2. "Influents": These are the family, doulas, and neighbourhood (and other) opinion-formers who impact the mother. They are, if anything, more important than the pre-natal, which not all mothers do anyway. This influence is negative because the group is poorly or wrongly informed. Therefore, we must...

REACH THE RIGHT STORY TO THIS INFLUENTIAL GROUP, SO THEY WILL, IN TURN, ADVISE THE MOTHER CORRECTLY.

3. The Hospital: Philosophies and systems here are hostile to breastfeeding. They damage lactation. Therefore we must...

DO ALL POSSIBLE TO SET UP IN HOSPITALS AND MATERNITIES SUCH SYSTEMS AND ATTITUDES AS WOULD SUPPORT BREASTFEEDING. ALSO, EDUCATE HEALTH PERSONNEL.

What needs to change is known. It needs Government approvals and involves costs. This may seem to put it out of the realm of pure communications. But the necessary political/executive decisions are unlikely unless the decision-makers are properly informed and motivated.

4. The doctor: Though he is aware that breastmilk is best his

*Education  
School*

attitude and advice are, in the main, unhelpful as a result of faulty preparation, intensive bottlefeeding projection and a lack of breastfeeding "promotion". Therefore, we must...

INFORM THE DOCTOR ON HOW TO INVOLVE HIMSELF IN THE CAMPAIGN AND START THE ATTEMPT TO MODIFY MEDICAL CURRICULA SUITABLY.

(This involves the Government, too).

5. The environment: Family structures, facilities for the mother (especially the working woman) and the images of breast/bottle-feeding are negative to human lactation. Not all these factors could yield to direct communications treatment. But where they would not, media and message could play a key link note. Therefore, we must...

ENCOURAGE FAMILY AND SOCIAL STRUCTURES TO SUPPORT THE BREAST-FEEDING OPTION.

UPGRADE THE IMAGE OF BREASTFEEDING.

CONVINCE GOVERNMENT, STATE/LOCAL BODIES, EMPLOYERS AND SOCIAL GROUPS TO TAKE THE STEPS THAT ARE NECESSARY TO FACILITATE BREASTFEEDING. (Creches, job/factory rules etc.).

6. Substitutes: Infant food propaganda and marketing activities have a strong and directly negative effect on the doctor and on maternal practices and attitudes. They must be checked, within a formal system. Therefore, we must...

ENCOURAGE SELF-REGULATION BY PRIVATE MANUFACTURERS, WITHIN A CODE.

CONVINCE GOVERNMENT TO TAKE THE RIGHT LEGISLATIVE AND EXECUTIVE ACTION TO CONTROL SUCH COMPANIES.

Various guidelines are available. A WHO/UNICEF set of recommendations, to which the Brazilian Government subscribes,

exists. There is experience elsewhere to be drawn on.

- 7.7A & 7B. Maternal attitudes (psychological set, confidence, stress etc.), her behaviour and the crucial reflexes of the mother-child dyad are very much a function of factors (1) to (6) above. But, of course, the mother would be far from helpless if she knew precisely what is happening to hurt her and her child. A decrease in milk or failed lactation due to various causes identified will only speed up the mothers attitudinal and behavioral changes favouring early weaning even if she had started with intentions to breastfeed. Therefore, she must know. But the channels to her (factors (1) to (6) are unhelpfully choked. Therefore, we must...

LEAP-FROG THE ROUTINE CHANNELS OF CONTACT WITH THE MOTHER, IF POSSIBLE, AND REACH THE TRUTH TO HER IN A SYSTEMATIC WAY.

#### IV STRATEGY TO ACHIEVE OBJECTIVES

To attain the objectives set out in the previous section, what is needed, in summary, is mass information and communication, changes in system and the setting up of certain facilities and control mechanisms.

Looked at from a communication point of view, these developments specify the use of both mass media and interpersonal contact.

##### Mass Media Because:

- a) it is the only way of reaching a strong and real story to the woman, quickly. All channels to her are otherwise blocked by ignorance, wrong practices, entrenched environmental negatives etc. "Unblocking" them will take time. The price of delay is high;
- b) the use of such media creates a "campaign effect" - a by-product of which is a softening of resistant systems;
- c) they are fast, low-cost-per-head, and wide reach (this is a

"mass" problem and, therefore, in the simplest sense, demands "mass" treatment):

- d) they deliver a standard message, always the same and therefore avoids confusion:
- e) they permit inexpensive repetition,
- f) they are quickly started up and involve no complex organizational/training problems;
- g) the mass media in Brazil are highly developed and offer excellent coverage of our potential target groups;
- h) soft-ware skills are abundant and
- i) we have media owners here well-disposed to assisting us at no or discounted cost.

But mass media has these shortcomings:

- a) they lack authority and can only use simple messages;
- b) they permit no dialogue or feedback;
- c) they cannot be precisely tailored to key individuals and small groups;
- d) they involve high start-up and total (not per-head) costs and
- e) they are more effective in knowledge/attitude change, less effective in behavioural change.

Therefore, we need inter-personal contact too. This because:

- a) they are essential in behavioural changes;
- b) they are flexible and ideal for individuals, small groups and, most importantly, for training;
- c) they have high credibility and authority;
- d) have dialogues, so difficulties can be handled at once and feedback is facilitated.

Communications alone will achieve only a part of the job. A lot

will depend on the support and sympathetic action in several other key fields.

A case in point is the whole area of harnessing the public health network and using this outlet to promote and encourage breastfeeding. These objectives require specific actions in the health system and likely to be delayed in realization. However, there is no reason why, to start with, the campaign could not conscientise health personnel or use the health centre to hospitals as "redistribution" points for campaign material.

Hopefully, the skilful use of mass media will lubricate the wheels of change and facilitate cooperation (policy makers, administrators, nursing staff). It also may win collaboration from the volunteer groups (women's organizations) and the established societal structures (e.g. the Churches) that the Campaign needs.

How the strategy works depends on what messages are designed, how target groups are selected and how media are deployed.

#### Notes on the Basic Message

A look at Figure I will show that standing between what a mother is now doing and what she should be doing (indeed, may want to do) is a combination of resisting forces.

To achieve our target result - nursing for at least 4 months - we must obviously do three things: (It is understood that the ideal target is to prolong nursing as long as possible but with proper supplementation after the age of 4 to 6 months).

a) strengthen her own impulse: therefore, inspire more confidence

in her ability to nurse her child adequately, heighten her motivations to doing so and reduce the effect on her of bad example by bottlefeeders;

- b) eliminate/reduce the resisting forces: therefore, educate her and tackle/neutralise/"positivise" the forces working against her;
- c) heighten the value to her of prolonged breastfeeding, therefore, show that she gains much more than the verifiable benefits of breastfeeding.

Our problem is not really getting women to breastfeed. It is holding them, once they start, and having them nurse four to six months. Surveys suggest that, before delivery, 90% women (and all doctors anyway) claim that they know "breast milk is best" and nursing should last four to six months.

The reason they behave differently is that they are ignorant of the physiology of lactation, of the real value of breastfeeding/evils of the bottle and lack confidence in themselves. This may be why they do not fight to nurse.

Therefore, we need an educational campaign, above all.

To "add value" to breastfeeding, we may need to inter-lay the education with what is known as "testimonial" advertising. This means featuring, in the communications, women who are following the recommended practice, and explaining why - using women in "status" roles/positions.

Anyway, there is much sense in sharing with mother(s)-to-be, or nursing mothers, the actual experience of women who "have done it already". Which is what "testimonial" means.



It may be important to note that our story, therefore, is not merely that "breast milk is best". The mother already accepts this. Or that she must breastfeed her child. She does - for a bit.

It is a much more complex story and task, as outlined above.

(SEE UNDER "GENERAL NOTES ON CAMPAIGN AND STRATEGY" FOR ELABORATION ON MESSAGE DESIGN).

#### V CHOICE OF TARGET GROUP

Women, specially mothers, are obviously our main target. But socio-economic and educational differences make them a very heterogeneous group.

In communications terms, the main differentiating factors are education/literacy and income. Therefore we would refine "mothers" into these two main target groups: less affluent/educated and more affluent/educated. (We are making the assumption here that the Campaign is going to be an urban/metropolitan one and therefore demands no further urban/rural break-up).

Current studies indicate that the practice of breastfeeding is in inverse ratio to income/education. But this does not necessarily make the upper income/better educated mother our prime target.

This, because the practice is nowhere near satisfactory in the lower socio-economic strata, even though it may be better than in the other. The problem is aggravated here. The better-off groups are protected from the worst effects of premature weaning by the availability of piped water, sewerage, medical

facilities, a better family diet, etc.

Therefore, the real problem lies among less affluent, neo/non literate mothers - who should therefore be the prime target of our communications. The problem that we will have to surmount here, however, is the relative inaccessibility of such a group in media terms. Most importantly, we must assume that the typical mother here is a poorer reader, if not illiterate. We have a complicated story to tell her. Television and radio, which do reach her, will not be able to carry it with the force that is required.

The only other medium available for this type of task with this type of mother is word-of-mouth. Therefore, if we choose her and her type of woman as our prime target, word-of-mouth communications will be compulsory. Such communications are essential anyway if we seek behavioural change.

These communications mean the use, for instance, of Church and other community channels, the public health infrastructure etc., that will enable us to address the women face to face.

Of course, such contact will take place under the umbrella of a mass media Campaign - so the contact will be facilitated, enriched and benefitted by the authoritative "echo" that mass media provides.

This strategy assumes that word-of-mouth channels will be available to us before or at the start of, or early in the Campaign.

It is submitted here that the strongest possible effort should be made in this direction, or the most vulnerable and neediest group will be left virtually uncovered.

It is also the most numerous group. In Grande São Paulo, households with a family income of 3.5 minimum salaries and less represent nearly 60% of the total households in the City.

Roughly the same is true in Rio de Janeiro. The figure for Recife is nearly 70%.

If such interpersonal media cannot be quickly and effectively organized/used, there is a strong argument for not reaching mothers in the lower socio-economic group as our prime target. We would be lacking in the ability to convince her properly.

With this possibility in mind it is necessary to have the more accessible group (more affluent and better educated) as one of our prime targets. We would have to look for positive results of our Campaign - hoping for a "trickle-down" benefit in the other group. (This will, of course, be a delayed effect).

On the other hand, practical difficulties may stand in the way of our doing an adequate job with the most obvious group. In which case, we shall be compelled to choose the "reachables" as our prime target, using them as "influentials". But this will be a second-best.

It may be worth mentioning here that concentration on upper-income, better-educated mothers has some positive aspects too:

- a) Such mothers have, in a sense, determined the current images of breastfeeding and bottlefeeding, to the detriment of the former. Breastfeeding is seen as old-fashioned and troublesome, bottlefeeding as something modern and an elite practice. Therefore, any substantial improvement in the nursing practices of this group will favourably influence the balance in the longer-term.

- b) In our use of radio, television etc., we would depict upper-middle environments, women and homes - not the less privileged type. This, to exploit the concept of "the reference group" so familiar in advertising. What this means is that the persuasion impact of message improves when it asks a particular socio-economic group to identify with a higher, not a peer, group.

Therefore, communications clearly directed at upper income groups will not be without effect in the lower.

- c) The cost of the operation will come down. Also, the cost-benefit is likely to be better. The coverage of target group per cruzeiro spent may be higher in mass media.

Nonetheless, the recommended prime target group is the lower income/less educated mother for the reasons set out above: 3.5 minimum salaries family income and less.

There are other important targets. Further in this document is a fuller listing. Suffice it, at this stage, to emphasise the following:

1. Doctors: The medical professional is seen in much literature on this subject, and is shown in many Brazilian surveys, as probably the main facilitator of the move to bottlefeeding.

His authority over the pregnant and lactating mother is nearly total. His influence over pre-natal, delivery and post-natal systems is immense. The way he uses both wreaks failed lactation, the declining trend in breastfeeding, the spread of formula-feeding and an undesirable structure resistant to change.

He acts this way because his medical formation does not give

sufficient importance to breastfeeding and the evils of the alternative; because this formation in any case understresses preventive medicinal effects of nutrition and human lactation and because he is, therefore, vulnerable to baby food marketing activities-which are intense and use him as their prime target.

He ends up an unconscious instrument of failed lactation, acquiescing in it too easily and, therefore, not supporting her adequately in the pursuit of maternal nursing.

There can be no substantial change in the unhappy canvas we behold without a massive involvement of the medical profession. In fact, the degree of such involvement may be a measure of our Campaign's success.

2. Government: Official policy and decisions are critical because they determine public health and hospital practice, and because only Government has the resources and stamina to make a real dent in this huge problem, to say nothing of its ramifications. And, in a callous sense, they would be the main beneficiaries of any favourable change.

All this apart, Government's agency is vital on two other fronts: legislative/executive action to support human lactation, especially among working women, and to control/ban certain marketing activities of formula and "bottle" paraphernalia companies.

At the moment, the burden of official policy/decisions does not support breastfeeding. The cause is a lack of awareness in the problem, and therefore the system is not sufficiently motivated.

Tackling this group poses many challenges because of the complexity of Government organization and functioning. But, as a target, it is even more important than the doctor - or, yet, the mother herself.

This, because without unstinting Government support the Campaign could not start, could not run or be extended; the poorly educated mother could not be properly reached and all our efforts to "prepare" the woman would come to grief at a health center or maternity hospital.

Within Government, a high priority at Federal and State levels is the Health apparatus. To start with, this will need to be the focus of our efforts in Brasilia and the State Capitals.

3. "Enabling" Groups: Of these the main ones are:
  - a. as mentioned, community channels of education and information, which means women's and neighbourhood organizations; the Churches; also, the public health network;
  - b. industrial/commercial organizations as redistribution points of information and material to working women/fathers, as targets to set up and allow supportive facilities and to provide funds/resources for the Campaign;
  - c. the media, to provide the indispensable access to their vehicles at no cost to the Campaign promoters (there would be some 30 organizations we need to move).

## VI MEDIA AND THEIR USE

There follows below a crude listing of media that we shall need



8) Audiovisual:                   for top people in Brasilia/States  
                                  for media owners/printers  
                                  for funding organizations  
                                  for top levels in the Churches, LBA,  
                                  women's organizations etc.  
                                  for selected firms/Government Corpora-  
                                  tions/banks  
                                  a special audio visual for possible use  
                                  in health centres, mothers'/women's/  
                                  neighbourhood clubs, parish groups

- 9) Non-Formal:
1. Use of events (church feasts, neighbourhood dances etc) to put up material, use loud-speakers.
  2. Traditional media (especially in the northeast-equivalents elsewhere?); repentistas, literatura de cordel, clubes de frevo, música de maracatu, caboclinhos. All these are used for political Campaign.
  3. Electricity bills/lottery tickets.
  4. Use of closed circuit TV at Rodoviárias, some praças in northeast.
  5. Use of stalls at major feiras.
  6. Use of audiovisual devices in supermarkets.
  7. Car-stickers.
  8. Use of medical conferences - (stall).
  9. Essay contests, painting contests.
  10. Create a special lyric. Use over radio.
  11. Run joint promotions with related media e.g. ("Pais e Filhos", children's magazines etc)
  12. Consider donating prizes, trophies that commemorate Campaign theme.



13. Tie up with fashion-house around a theme of "the right things to wear" by a new-mother.
14. Incorporation of main Campaign ideas in tele-novelas (TV) and the printed novelas.
15. House-to-house propaganda and/or distribution of print material.

A final view of just which media should be used, and how, will be possible only after we have clear ideas of actual budget, what degree of support will be offered by media-owners and printers, what the views of the advertising agency and research are.

Later in this document, an attempt is made to match media broadly to various target groups and messages.

Appendix A outlines the types of mass media available, their coverage with what weights and at what cost.

## VII BASELINE DATA

The success of a programme like ours can depend on having the right type and quality of informational inputs. These are lacking and must be created by Research.

A blank area, for instance, is the relative strengths of the factors in successful/unsuccessful lactation e.g. are hospital systems more or less of an influence than baby food propaganda or the doctor's advice? On the answer depends the weighting of our efforts in an important area.

The only researches that exist seem to be of the more "medical" than "behaviour/attitude" type. They tend really to affirm the

problem, report mothers' claimed reasons for behaviour, often use biased samples and techniques not suited to our task.

And then, of course, we lack quantitative studies that could give us baselines or benchmarks pertaining to the whole population of a city, region or the country. So we could not really measure the impact of any "change" Campaigns.

All this seriously affects message design, evaluation, media planning and effort breakdown. Perhaps most seriously, we could end up with a faulty basic approach because we wholly lack data on the psychological frameworks in which we must work. Also, it complicates the task of recommending to Government a longer-term programme of adequate weight.

Just as seriously, the lack of a proper data base makes the expenditure of major resources irresponsible.

For all these reasons, a substantial investment in data is recommended here. It would pay for:

- a) A systematic compilation of existing data.
- b) Surveys/operations to help message design (qualitative).
- c) A survey to establish benchmark attitudes among major target groups in test areas, practices, images, influencing factors etc. by geographical and demographic breakdown (quantitative).
- d) A monitoring survey in test areas after the Campaign has run a while (for six months, in a year's Campaign)-(quantitative).
- e) An evaluative survey, after the Campaign, among exposed groups (quantitative).

This means seeking specialists to design and implement the

research programme (ALSO SEE UNDER "GENERAL NOTES ON CAMPAIGN AND STRATEGY").

### VIII GENERAL NOTES ON CAMPAIGN AND STRATEGY

It is hypothesised that a communications program, using both mass and interpersonal media, can materially benefit breastfeeding practices in Brazil if it is run continuously for something like two years.

Our basic strategy is to select the right target group(s), design the right message(s), select the right mix of mass and word-of-mouth channels, run the Campaign in test areas and then extend the operation. Communications Research will be used to reduce uncertainties at all stages and to monitor/evaluate results. These are some essentials of the Campaign:

1. It must have a single theme, that is run unchanged for the whole Campaign period. More than one basic message or more than one way of developing the same theme invariably leads to confusion or lower output. Thus, we should have a simple verbal formulation of our basic message (headline, or "slogan", or visual presentation/signature, etc.) that runs through all our communications. It will be the job of the Campaign promoters and the advertising agency to evolve this theme.
2. The theme must be a simple one because the main effect of this Campaign is going to come from its repetitive character. Such repetition will come from use of radio and TV. But these messages will be brief. Therefore, they have to be simple-ideally single-point.

The press (newspapers and periodicals) will allow more detailed elaboration of the story. So will folders and leaf-

lets and perhaps direct mail.

Talks and features over the radio and television could also tell the full story. But they could not be repetitive. It is important to understand that our staple diet in this Campaign is radio/TV and, therefore, the short, simple, high frequency message. The rest is supportive. This is the trade-off we must accept to benefit from the out-reach of these mass media.

3. When using mass media, it is vital to have one "Basic Proposition" as the Campaign message. This is the essence of what we want to say, chosen from among several options. This Proposition could yield different treatments as advertisements and commercials, with different degrees of effectiveness.

The Basic Proposition is not the "slogan" or "wording" of the advertisement or television/radio spots. It is formulated as "Desired Behaviour Plus Benefit"Appeal".

The underlying idea is that people consider modifying their behaviour, or attitude, only if there is a perceived benefit for them in the transaction. This benefit may be a concrete one (better performance of a product or lower price) or a basic human appeal (like social approval/emulation, or ego satisfaction, or the need for recognition and reward, or the need for an improved self-image, etc.).

A close look at successful advertising and mass communication efforts will show that this is the basic technique being used.

In our Campaign to stimulate the practice of breastfeeding we are not selling a product in the ordinary sense. In

Product marketing, advertising merely seeks to influence preference for a particular brand after the consumer has decided that he wants to make a purchase within the product group. It sells "Cassy Lever" to people already in the market for soap.

In our Campaign we do not know precisely what mothers "are in the market for". Our communications will be expected not merely to "take her to the shop, to choose correctly" (after which the product itself takes over). They must influence basic behaviour, not just attitudes, without the help of "product performance in use".

Such behaviour change involves the identification of basic motivations, psychological resistances that may exist and the woman's needs to which we must appeal to overwhelm the negative factors. All this much more deeply than in marketing communications.

The solution does not lie in providing rational reasons and information only. The Campaign also needs a strong emotional content. This may even be the Campaign's cutting edge. So it is of the utmost importance to choose the emotional appeal that will best persuade our target group to behave the recommended way.

In support of this it is worth recalling that most mothers claim that breastmilk is best and that nursing should last at least four to six months. Yet, they do not do this. Something causes them to acquiesce in the external advice to move to bottle-feeding, and accept what they know to be "second best". What is it?

Is it only the effect of hospital systems? Why does the

mother not confront them better? Is it only her lack of "education"? What is her psychological mental set? How should it be met?

These questions emphasise the importance of the creative idea that will inform our Campaign materials and the communications research that must precede message design.

This Campaign must be a qualitative step ahead of those that have preceded it: it must combine education (facts) with motivation (feeling). We do not know enough at this stage ~~to know~~ which element is more important for the mother. We may know more after the right prior research, Campaign and evaluation operation have been run.

This is another reason why the Campaign and its materials should be centrally created and controlled, not left, in any of its aspects, to different creators or creative interpretations.

4. A lot of the effect of our efforts in radio, TV and print vis-a-vis mothers, doctors and opinion-formers may be wasted if public health and hospital philosophies do not support these efforts. To draw a parallel, our communications may take a woman, well-disposed, to "the shop" - only to find the shop shut, or out-of-stock.

Therefore, it is important that we create as receptive a frame of mind and system as possible in the Health Centres and hospitals. Ideally, we should start efforts to achieve this before the Campaign breaks in media. They must certainly run in parallel with the mass media programme.

These efforts would be: increasing awareness among health

professionals of the problem, the causes and their role in them, what correction is necessary and how the mother should be educated and handled.

5. Our use of mass media would be strictly to plan, not left to the owners of the media. A detailed schedule is envisaged which TV, radio, newspapers etc. would be expected to follow. There is much evidence that prepared materials left to media owners to schedule as they please yield poor, if any, results.

This needs to be clearly borne in mind when the approach for cooperation is made to media.

Only in this way will we know precisely who we are covering, and the extent of coverage, and have a means of forecasting possible impact. This would be important not just for Campaign effect, but also for monitoring and evaluation purposes.

6. There are two key specialist resource groups that must be built into Campaign preparation at once and into Campaign management later - as must be clear by this point: an advertising agency and research organization.

The advertising agency has the highly specialised infrastructure and talents to:

- a. create the precise formulation of words and images that will best motivate/inform our target group - while being comprehensible, credible and culturally relevant.
- b. design the most effective media strategy/plan and schedules for the selected communications, objectives, target groups and type of message - within a given budget.

- c. coordinate all the planning, creative, media, production, research and Campaign management activities that will be required.
- d. collaborate in the research/monitoring/evaluation activities, organization and running of support communications.

The research organization has the specialist resources we need to:

- a. collect and analyse data that will be necessary for theme and creative design.
- b. provide the quantitative "benchmarks" study against which we will judge Campaign impact after 12 months' running.
- c. do the 6 month monitoring study.
- d. run the final evaluation survey.
- e. supply guidance in Campaign planning.
- f. collaborate in desk research to compile existing information.

## IX MATCHING OBJECTIVES, TARGET GROUPS, MESSAGES AND MEDIA

In Appendix B an attempt is made to detail who we need to address, with what objectives, with what type and content of message, by types of media and material.

The following points must be borne in mind:

1. Each target group needs to know a great variety of things. But a selection must be made and priorities defined. In fact, a successful mass media programme concentrates on only a single "selling" idea.

For our main target groups - mothers and fathers - a Basic Proposition has been defined. It will determine the creative idea in a television commercial or radio spot or press advertisement.



The information contained under the head "What She/He Must Know" is the total story. Detailed study by the Campaign promoters and selected advertising agency, as well as some research, will be necessary before we decide on prioritisation and distribution of messages over media used.

In other words, the Basic Proposition and informational content set out in the following pages will be covered through a judicious use of the media mix. Each medium or piece of material cannot contain everything, except perhaps for press/leaflets and audio visual in some cases.

2. The notes in Appendix B are by no means exhaustive. They are meant as notes for the people who will create the detailed Campaign materials (radio/TV commercials, advertisements, leaflets etc.). These notes are meant for a briefing meeting and cannot replace such a meeting.

It is strongly recommended that no persons or agencies should be allowed to produce Campaign materials on the strength of this written brief, without an intensive face-to-face meeting.

3. The way that a medium is used and the type of material produced depend very much on local conditions and the type of channel used e.g. "literatura de cordel" makes sense in Recife, not in São Paulo; a volunteer group may not be able to use audio-visual material, so a particular form of printed word may need to be considered; posters may or may not be worthwhile, depending on where they are to be put up and the degree of supervision that will be available; the number and quality of people who will be available to run community or public health channels are not known - so, detailed thinking on the material they need, or could use, is not possible at this stage.

4. The next stage is: a) creation/production of the actual Campaign materials and the formal media strategy and b) initiation of the Research activities (these are necessary not just for evaluation and monitoring of the Campaign, but also for professional design of the materials themselves). This involves selection of an advertising agency and a research organization. Discussions with them may alter some of the ideas on the following pages.

X LOCATION OF TEST AREAS

The following considerations would be relevant in choice of test areas (more than one is assumed):

1. They would be urban because the problem is more urban than rural.
2. They would be metropolitan because such areas are a convenient way of addressing a good cross-section of families; the problem is acute, especially in the periferias; useful infrastructures exist, they are efficient units from the media-use standpoint; they cover substantial affected populations; they have a strong exemplary influence.
3. They would, as far as possible, sample the northern and southern regions of Brazil.
4. One city would act as a "control" area.
5. A test area will be determined by the reach of radio/TV, not municipal limit, and therefore could not be too small.

The cities we have been talking about are Grande São Paulo,

Rio de Janeiro and Recife. We have also talked about using media in Brasilia. The first three cities account for something like a quarter of the total households in Brazil.

In planning the weight of the Campaign, we must remember that it must bear relation to what would be feasible if the Campaign were ever to run nationally. We must not do "in small" what would be too costly or difficult to organise or a large-scale.

## XI COST

The assumption on which we have been proceeding is that the promoters of the Campaign should meet the start-up costs (Research and planning/production for audio-visual, TV, Radio and press advertisements) - but not the running costs of the Campaign in media.

The source of funds for the latter which includes costs of writing, designing, artwork for print material and printing should be identified. It is possible to have part of this cost gifted.

Given below is not a costing but an order of cost magnitudes for some items, and for the first year of the Campaign. The weight of effort and, therefore, the costs in the second year would be lower.

A detailed costing will only be possible after there is agreement on the broad outlines of this strategy, the advertising agency as well as the research organization have been appointed and we know just what type of spots/ads we need to produce.

In the statement below full costs have been considered (not discounted or gifted resources). Detailed discussions with concerned organizations should take place to finalize activities that could be sponsored, subsidized or gifted.

National Costs (Three Cities, First Year)

	<u>Cr\$</u>
1. <u>Research</u> : message design: pre-tests; benchmark, monitoring, evaluation surveys	4.0 million
2. <u>Production</u> : three TV commercials, six radio spots, 2/3 press ads, medical press ad, writing and artwork of two folders/leaflets	4.0 million
3. <u>Mass Media (space/time)</u> : TV, radio, newspapers (see Appendix A for rough working - Alternative II)	20.0 million
4. <u>Not Included</u> : agency fees, if space/time is gifted; direct-mail (creation/production/fees); use of non-formal media; conferences; travel; audio-visual; posters; some print material; media costs in Brasilia; personnel	-
	<hr/> 28.0 million

NB: a) An annual expenditure of between Cr\$30 and 40 million would measure up to a medium-to-large national budget in

Brazil at the moment.

- b) Costs depend a lot on how many test cities we choose and which they are.

### Cost/Benefit

We are proposing a major, systematic and long-term Campaign. We are attempting to employ methods used for bottlefeeding over 50 years, very intensively - trying to see what just two years will yield.

The costs of our Campaign are modest, considered against this background, but quite high in absolute terms (and not just as money: effort and time costs will also be high).

But the benefits will be immeasurably higher. As stated earlier, the direct loss of unrealised breastmilk in Brazil is unlikely to be less than 300 million litres annually. Its value, calculated in terms of an equivalent volume of formula-feeding at March 1980 prices, is in the neighbourhood of Cr\$ 9 billion. This is substantially more than the whole PRONAN budget in 1979.

Apart from the fact that the consumer, often needy, has to find this considerable amount in his pocket, there is this implication: The Cr\$ 9 billion is worth some 200 million dollars. It is evident that not all can afford formula feed and the poorer people feed their infants with diluted formula and other simpler substitutes. Considering this reality the actual costs for substitutes would be less, however, even a fraction of the money involved is a considerable loss to the Brazilian economy. A proportion of this is undoubtedly making its contribution to Brazil's foreign debt since Brazil imports milk powder. Increase

in breastfeeding could release substitute milk for other purposes for which milk powder is imported.

The indirect costs are incalculable. Poor child health, often a result of formula-feeding, costs the State dearly. For instance, a calculation in Recife suggests that each recovery from severe malnutrition costs the public health services Cr\$ 469,000. This takes into account the large number of cases where treatment was not able to save lives.

The immunization effect of breastfeeding on other health aspects reduces the curative costs to treat illness.

Recent research links human lactation to mental development, aggressive behaviour in adulthood and the output of the economically active work force.

Wider spacing of children resulting from breastfeeding not only reduces the cost of family planning programmes but also keeps the mother healthy and avoids her treatment costs.

Finally, bottlefeeding, left unchecked, can only make further inroads into maternal lactation practices - which, in time, would aggravate the problem we confront today.

It is all this that lies between the lines of Alan Berg's view, in "The Nutrition Factor", that a shift of even a few percentual points in the duration and practice of breastfeeding would be worth "millions of dollars" to a nation.

This may be a sensible context in which to judge the real cost/benefit of the Campaign we propose.

## XII MANAGEMENT

It is hard, at this stage, to estimate the total manpower requirement and resources the Campaign will require. It is certain, however, that the following will be necessary at the coordinating level.

1. A coordinating cell to deal with Ministries and State Secretaries/other bodies at a sufficiently senior level. It will be abreast of Campaign plans, monitor how it goes, control budgets and expenditures and maintain high level liaison. The consultant or consultants provided by UNICEF will assist INAN in coordinating the programme.
2. The local Campaign in each test city will be coordinated by the consultant on Communication & Mass Media. Local action is key. It will organize support communications in neighbourhoods, health centres and hospitals, maintain contact with all local "enabling" target groups (e.g. women's organizations, volunteer groups, the Churches) also doctors, industrial houses and the like. Before the Campaign, many audio-visual shows will need to be organized and followed up. In addition to the above, press relations and some rudimentary PR; as well as liaison with the advertising agency and research will need to be maintained.
3. The role of other institutions and media organizations will be identified after detailed discussions with them.

BREASTFEEDING CAMPAIGN

TARGET POPULATION - Housewives - Mothers\*  
 Medical Doctors  
 Public Opinion Leaders

\* First priority: Mothers with family income up to  
 3.5 minimum salaries  
Second priority : Mothers with family income above  
 3.5 minimum salaries

LOCATIONS - Greater São Paulo  
 Greater Rio de Janeiro  
 Greater Recife

NUMBER OF TARGET POPULATION

LOCATIONS	HOUSEWIVES		
	Up to 3.5 salaries	From 3.5 to 6 salaries	Above 6 salaries
São Paulo	1.210.000	807.000	672.000
Rio de Janeiro	835.000	727.000	577.000
Recife	320.000	82.000	54.000

USE (%) OF MEDIA BY TARGET POPULATION

MEDIA	INCOME	Up to 3.5 salaries			From 3.5 to 6 salaries			Above 6 salaries		
	Location	SP	RIO	REC	SP	RIO	REC	SP	RIO	REC
Magazines		22	14	15	36	27	36	60	62	76
Radio		81	72	60	85	85	75	85	86	88
Cinema		10	15	10	19	19	20	36	41	44
Newspaper		11	21	18	26	48	33	57	80	79
Television		63	52	46	96	92	90	98	98	99



RADIO AND TV SETS OWNED (%) BY TARGET POPULATION

LOCATION/MEDIA	TELEVISION	RADIO
São Paulo	96	98
Rio de Janeiro	94	99
Recife	66	89

RECOMMENDED MEDIA

TELEVISION: Wide and forceful communication coverage

RADIO : Additional coverage of target population and reinforcing coverage of TV owners

MAGAZINES : Communication addressed to medical doctors and public leaders opinion

NEWSPAPERS: Additional effort in launching the campaign aimed at public opinion leaders.

MEANS OF COMMUNICATION

- Posters for Maternity and Health Centres;
- Posters for buses etc.;
- Information to medical doctors and high level health officials by direct mail;
- Participation in Paediatric Conferences;
- Promotional Campaigns for "Mothers' Day" and "Child's Day";
- Radio/TV commentators : Zé Betio/Gil Gomes/Xênia etc.;
- Football commentators.

MEDIA STRATEGY

ALTERNATIVE I

MEDIA	VARIABLES	SÃO PAULO	RIO DE JANEIRO	RECIFE	MONTHS	TOTAL
TV	GRP 30s	5.000	5.000	4.500	5	23.000.
	No. Commercials	250	200	180		
	% Coverage - Housewife	90	90	65		
	% Coverage Target Population	60	50	45		
	Cr\$000,	12.000..	9.500.	1.500.		
RADIO	GRP 30s	9.500	9.500	13.000	6/8	7.600.
	No. Commercials	900	810	1.440		
	% Coverage - Housewife	95	95	85		
	% Coverage Target Population	80	70	60		
	Cr\$000,	5.000	2.000	.600.		
MAGAZINES	General inserts	5	5	5		600.
	Special inserts	6	6	6		
	Cr\$000,					
NEWSPAPERS	Inserts	6	4	5		1.800.
	Cr\$000	700.	700.	400.		
TOTAL COST					Cr\$	33.000.

ALTERNATIVE II

ADROIT USE OF MEDIA WITH REDUCED COVERAGE					
<u>AREAS</u>	<u>SÃO PAULO</u>	<u>RIO DE JANEIRO</u>	<u>RECIFE</u>	<u>MONTHS</u>	<u>TOTAL</u>
TV: GRP 30s	1.500	1.500	1.500	5	
No.Commercials	75	60	60		
% Coverage -					
Housewife	80	80	70		
% Coverage					
Target Population	55	50	40		
Cr\$000,	5.500.	3.400	600.		9.500.
RADIO: The same as for Alternative I					7.600.
MAGAZINES: Only special inserts (Medical)					300.
NEWSPAPERS: The same as for Alternative I					1.800.
TOTAL COST			Cr\$		19.200.

ADROIT USE OF TELEVISION: use of a wide audience programme (soap opera)

APPENDIX B

PRIMARY TARGET

I Target Group

Mothers (A)

II Demographics

- Family income of 3.5 minimum salaries and less.
- Non/neo literate.
- 18/45 years of age.
- Metropolitan.

III Objectives

- To get more of the Group to breastfeed.
- To get them to breastfeed for as long as possible and, in any case, for at least 4/6 months.

IV Basic Proposition

(Desired Behaviour Plus Benefit/Appeal)

BREASTFEED FOR AT LEAST SIX MONTHS...

(only one of the following to be chosen after pre-test)

- a) ... BECAUSE THAT WAY YOUR ASPIRATIONS FOR YOUR BABY HAVE THE BEST CHANCE OF BEING REALIZED. (Ambition/Reward).

- b) ... BECAUSE THAT WAY YOU WILL BE A REAL MOTHER TO YOUR BABY.  
(Self-Esteem)
- c) ... BECAUSE THAT WAY YOU WILL DO FOR YOUR BABY AS THE "TOP"  
MOTHEPS DO FOR THEIRS. (Social Emulation)
- d) ... BECAUSE THAT WAY YOU WILL EXERCISE YOUR PRECIOUS RIGHT  
TO DECIDE WHAT IS BEST FOR YOUR BABY. (Ego Satisfaction)
- e) ... BECAUSE ANY OTHER WAY YOU WILL FAIL YOUR BABY AND  
YOURSELF. (Ambition/Reward/Self-Esteem, stated negatively)

V What She Must Know

1. How nature provides every mother with the ability to nurse her baby.
2. That there is no such thing as "a lack of milk".
3. That nursing is a reflex in mother and baby.
4. How these reflexes work and can be damaged.
5. That it is worth doing everything possible to breastfeed the child because breastmilk is best and babies need nothing else for 4/6 months.
6. Why breastmilk is best.
7. Why prolonged breastfeeding is beneficial both to the baby and mother.
8. That babies should be fed "on demand".
9. How to prepare for breastfeeding; nourishment during pregnancy; breast preparation; hand-expression of colostrum in the last three months of pregnancy, etc.
10. How to deal with breastfeeding problems (rejection of the breast, or milk, by the baby, crying, etc.).
11. That bottle feeding is dangerous, expensive and can affect lactation reflexes and why.

12. That nursing does not normally transmit disease, that breast milk is sterile, always at the right temperature, and has the right taste for baby.
13. That the sooner she starts breastfeeding after delivery the better (30 minutes later is recommended).
14. How and when to start supplementary feeding.
15. That breastfeeding does not affect breast aesthetics and that it returns a mother to normalcy quickly (uterus and weight/measurements).
16. That a weight-gain of 8/10 kilos during pregnancy is normal, necessary and happens for breastfeeding.
17. That breastfeeding creates an important psycho-biological bond between mother and child.
18. That permissive breastfeeding has an anti-conceptional effect.

#### VI Desired Attitudes

1. Desire to breastfeed exclusively for at least 4/6 months.
2. Confidence in her ability to breastfeed adequately.
3. Willingness to protect her right to breastfeed vis-a-vis the doctor, in the hospital and in the home.

#### VII Required Skills

Knows how to prepare herself for breastfeeding, knows the right position for nursing, etc.

### VIII Media/Material

1. Radio (commercials; spoken word support by broadcasters; special programs; mention in regular features).
2. Television (commercials; interviews; special programs, especially the launching of the campaign).

(Media Forums could be attempted using Canal  
Cultura with Church/volunteer animators.

Radio Cultura could also be used the same way)

3. Word of mouth/Activities/Events (through community channels, through the doctor, public health personnel, opinion-former); supporting charts and audio visual.
4. Lottery tickets, electricity bills (message printed on the back) and other non-formal media.
5. Posters at Postos/Centros de Saúde, audio-visual support.
6. Home-to-home distribuiton of material/contact: there are organizations that specialise in such contact e.g. Singer (who have a vast propaganda fieldforce).  
One or more such organizations may be willing to cooperate.  
This avenue should be explored.

PRIMARY TARGET

I Target Group

Mothers (B)

II Demographics

- Family income of more than 3.5 minimum salaries.
- Literate/Educated.
- 18/45 years of age.
- Metropolitan.

III Objectives

- same as for Mothers (A) and ...
- to act as an exemplary reference group.

IV Basic Proposition

- same as for Mother (A).

V What She Must Know

- same as for Mothers (A).



**VI Desired Attitudes**

- same as for Mothers (A).

**VII Required Skills**

- same as for Mothers (A).

**VIII Media/Material**

- same as for Mothers (A).

- in addition, general press, leaflets/folders.

I Target Group

Fathers (A).

II Demographics

- Family income of 3.5 minimum salaries and less.
- Neo/non literate.
- 20/50 years of age.
- Lower order employment
- Metropolitan.

III Objectives

- To support and reinforce pregnant/lactating mothers in the breastfeeding option.
- To support better nutrition of the pregnant women.

IV Basic Propositions

- Same as for Mothers (A).
- (Selection of proposition from among the alternatives must keep the father in mind).

V What He Must Know

- he must participate in all that the mother should know, if not, be the vehicle of information,
- in addition, he must appreciate the economic advantages of breastfeeding.

VI Desired Attitudes

- be a supporter of the mother in the breastfeeding option because he recognizes the economic, health and family benefits of it.
- empathise with her better in her maternal role, especially within the household in the first six months.

VII Media/Material

- same as for Mothers (A).

I Target Group:

Fathers (B).

II Demographics:

- Family income of more than 3.5 minimum salaries.
- Literate/Educated.
- 20/50 years of age.
- Higher order employment.
- Metropolitan.

III Objectives:

- same as for Fathers (A).

IV Basic Proposition:

- same as for Fathers (A).

V What he must know:

- same as for Fathers (A).

VI Desired Attitudes:

- same as for Fathers (A).

VII Media/Material:

- same as for Mothers (B).
- the only difference is the possibility of a more intensive exposure to the media and the messages.

I Target Group:

Doctors (top consultants, especially Pediatricians/Obstetricians/  
Gynecologists).

II Demographics:

- Class "A" and "B" socio-economically.
- Metropolitan.

III Objectives:

- to elicit their active support of the breastfeeding vis-a-vis the mother and among other doctors.
- to have them influence public health and hospital systems as recommended.
- to pass on the right guidance to their patients on breastfeeding.
- to resist propaganda/marketing activities that are in conflict with the WHO/UNICEF Geneva declaration.
- to participate in/and initiate special professional events through medical bodies.

IV Basic Proposition:

- THE DOCTOR IS THE PRIME AGENT IN THE MOTHER'S RESOLVE TO BREASTFEED HER CHILD: HIS ADVICE/ACTION CAN MAKE THE DIFFERENCE BETWEEN SUCCESSFUL AND FAILED LACTATION.

## V What He Must Know

- He knows why breastfeeding is best. But this theoretical knowledge needs to be reinforced by the most recent and detailed supporting evidence; the evils of bottle feeding and the action required of him must be underlined in detail.
1. Pregnant mothers' nutritional needs, existing food tabus and how to conquer them.
  2. Local foods that could be part of the diet.
  3. That the bottlefeed can never be the equal of breast-feeding and why.
  4. That public health/hospital systems as well as medical advice could well be the main causes of failed lactation and therefore of "desmame precoce".
  5. That special attention needs to be paid to mothers likely to have breastfeeding problems.
  6. That the following should be avoided: unnecessary caesarian deliveries, sedation, episiotomy, lactation suppressants, etc.
  7. That the let-down reflex is damaged by delayed initiation of breastfeeding after delivery, pre-lacteal feeds and anxiety in the mother.
  8. That a relaxed atmosphere in the maternity ward, visits by family, permissive (not rigid) breastfeeding schedules, etc. are all helpful.
  9. Evidence that "rooming-in" has marked advantages over the "berçário" system.
  10. The importance of colostrum.
  11. That the mother needs to be educated, as recommended, during pregnancy and after delivery, on breastfeeding.
  12. Why no complementary feeding is indicated during the first 4/6 months of life and bottle feeding must be avoided, even as "mixed" feeding.

13. That the mothers' nutritional status during lactation must be as high as possible - yet that this status has only a negligible effect on the quality of breastmilk.
14. Up-to-date information on the contraceptive effect of breastfeeding.
15. That medical curricula need urgently to be modified: they must include the right preparation on maternal/child nutrition and breastfeeding.
16. That the decline in breastfeeding is a national problem for Brazil.

VI Desired Attitude:

1. Willingness to support the right educational practices in the pre-natal period.
2. Willingness to support modifications in public health/hospital practice to promote breastfeeding.
3. Resistance to propaganda, marketing and sampling activities by baby food Companies.
4. Willingness to throw their weight behind revision of medical curricula and research programmes.

VII Type of Message

- Exposure to general educational/motivational Campaign directed to mothers and opinion-formers.
- Exposure to professionally framed information on the scientific/medical basis of our story.
- Exposure to information on the Campaign itself.



VIII Media/Material:

- General Press, TV; Radio, audio-visual exposure.
- Medical Press.
- Direct Mail (3 shots in the year)
- Personal Contact (the possibility of enlisting the support of a pharmaceutical company and its detailing men needs to be explored; if available, this would be a channel for contact with and distribution of material to the doctor and of distributing posters/print meant for the mother).
- Associations (professional): use of their mailing channels/activities (to be created, and discussed with sympathetic medical professionals).

NB: The "Doctor" group is heterogeneous. Refining the group, it covers sub-groups like the cream of the profession, at National and State levels, the General Practitioner, the doctor in the Health Services and hospitals, doctors employed in pharmaceutical companies and private firms, doctor-journalists etc. Modifications for each may be necessary in the general lines of action set out for the group as a whole.

I Target Group:

- Government decision-makers and policy formulators.

II Demographics:

- A small group of "top" people in Brasilia and the States.

III Objectives:

- To get them to appreciate the problem in its national and socio-economic aspects.
- To win their acceptance of the broad lines of our strategy to tackle the problem.
- To have them cooperate in implementing the strategy, in detail, by framing the right long-term policies and issuing appropriate executive instructions in the short-term (especially on making government structures and resources available for the Campaign and its extension; as well as, on reviewing/reframing/policing relevant/legal provisions).
- To get agreement to forming a suitable coordinative mechanism.

IV Breakdown of Target Group

- The President and his lady.
- His principal aides in the "Casa Civil".
- The Planning Minister and his principal aides.

- The Finance Minister and his principal aides.
- The Health Minister and his principal aides.
- The Education Minister and his principal aides.
- The Justice Minister and his principal aides
- The Social Communications Secretary and his principal aides.
- The Industries and Commerce Minister and his principal aides.
- The personnel of the LBA.
- Governors and their Cabinets in test States.
- Governor's wives in test States and relevant "Palacio" organizations e.g. Fundo de Assistência do Palácio in São Paulo.
- Concerned Secretaries and Secretariats in the test States (Planning, Finance, etc.).

#### V What They Must Know

1. The problem as set out in the main audio-visual.
2. That the causes lie principally in areas they control and flow from past acts of omission and commission (mother/family's lack of information, inappropriate preparation of the mother in her Pre-Natal, unhelpful obstetrical and hospital systems, unhelpful medical advice, unhelpful medical curricula, the unhelpful circumstances of the working woman, inadequate liaison/control of activities by baby food Companies, especially vis-a-vis doctors and distribution of milk powder).
3. That reversing the declining trend in breastfeeding offers valuable and concrete socio-economic pay offs.
4. That the problem has been tackled and beaten elsewhere.
5. That bringing back breastfeeding is a real contribution to the family economics and health of high priority groups.
6. That this contribution has no inflationary implications and exacts no high price in funding, infrastructural change or

allocation of scarce resources.

7. The main lines of our strategy (detailed elaboration for each appropriate group).
8. Their role in the strategy and the action/cost this implies for each group.
9. Why extension nationally and long-term Campaign is necessary.
10. Detailed information and action points will be necessary for Ministry, Secretariat and Government Agency. The type of content envisaged is exemplified in Appendix C (what the Health Ministry/Secretariats need to know and do).

#### VI Type of Message:

In addition to the general exposure they may get to the mass media Campaign itself, special contact techniques will be necessary. These would be designed for small groups and convey highly tailor made information (facts and detailed action required by particular Ministries).

#### VII Media/Material

General Press, TV, Radio, Direct Mail, Special Audio visuals, Personal Contact.

#### VIII Desired Attitude:

- Disposition to cooperate in strategy in general and particular, at top and middle levels.
- Willingness to act on recommendations of WHO/UNICEF

Joint Meeting and Ministry of Health/INAN symposia.

NB: It will be important to feature that Brazil is officially part of the WHO/UNICEF Geneva declaration and that the action recommended there forms part of several Ministry of Health/INAN documents and meetings.

Other Target Groups

(To be examined in the way used on the preceding pages)

- Voluntary organizations (women's groups: neighbourhood/social service bodies etc.)
- The Churches (also Ubanda etc.)
- Industry (Chambers, Selected Houses, Baby food Companies)
- Media (owners, donors)
- Funding Organizations
- Medical Colleges
- The Schools System
- (Reviving) La Leche International, Brazil

APPENDIX C

I	<u>PRACTICE</u>	<u>EFFECT</u>
	1. Delaying first breastfeed. Sedated newborn (excessive maternal anaesthesia)  Supplying pre-lacteal and complementary feeds.  Regular, limited feeds  Separation of mother and infant (nurseries)  Automatic free supply of formula and industry literature	Limitation of sucking and prolactin secretion.
	2. Leaving mother poorly informed or confused  Tiring mother (no food/drink)  Routine episiotomy (pain)  Weighing before and after (test feeds)  Restricting visitors  Unsympathetic health staff  Automatic free supply of formula and industry literature	Anxiety and interference with the 'let-down reflex'.

II HEALTH SERVICE

MODIFICATION

1. Prenatal Care  
Information on breastfeeding (preferably from breastfeeding mothers). Breast preparation. Maternal diet. Emotional preparation for labour.
  
2. Puerperal Care  
Avoid maternal fatigue/anxiety/pain: allow eating in early labour: avoid unnecessary episiotomy; allow relatives and visitors; encourage privacy and relaxed atmosphere; organise the day with breastfeeding in mind.  
  
Stimulate lactation: no prelacteal feed; first breastfeeding as soon as possible; avoid unnecessary maternal anaesthesia; permissive schedule; rooming in.  
  
Lactation consultants: preferably women who have breastfed; adequate lying-in. In hot weather, extra water to baby by dropper or spoon.
  
3. Premature unit  
Use of expressed breastmilk. Contact between mother and child with earliest possible return to breastfeeding.
  
4. Children's ward  
Accommodation in hospital (or nearby) for mothers of breastfed babies.



5. Home Visiting

Encourage, motivate, support.

6. Health Centre

Supplementary food distribution according to defined local policy.

7: General

Supportive atmosphere from staff. No infant foods. Minimal bottlefeeding policy. Health education on 'biological breastfeeding'.