KINGDOM OF CAMBODIA
NATION RELIGION KING

# CAMBODIA NATIONAL MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN) SOCIAL AND BEHAVIOR CHANGE COMMUNICATION (SBCC) STRATEGY 2020-2025

## Foreword

Cambodia has successfully reduced stunting rates and made improvements to maternal, infant and young child health and nutrition status over the past decade. However, stunting rates remain high relative to the level of economic development, and at a rate that threatens the continued growth and sustainability of meaningful economic and human development. Addressing stunting is critically necessary for Cambodia to meet its Sustainable Development Goal (SDG) targets by 2030. According to 2013 research by the Council for Agriculture and Rural Development (CARD), UNICEF and World Food Program (WFP), malnutrition is estimated to burden the Cambodian national economy by more than $266 million annually (1.7% of GDP), with stunting being the largest contributing factor. This significant loss is partially attributable to the barriers many Cambodians face in obtaining nutritious food, high rates of infectious diseases, suboptimal water, hygiene and sanitation practices, and unsuitable feeding practices.

Cambodia's Infant and Young Child Feeding (IYCF) policy is one of the most important components of the Ministry of Health's National Nutrition Program (NNP) and its Fast-Track Road Map for Improving Nutrition in Cambodia (2014-2020). Since the year 2000, the NNP—together with key partners and stakeholders—has made demonstrable progress in this area through a strategic mix of interventions, activities, and social and behavior change and communication (SBCC) approaches that incorporate training, service delivery education, and mass media.

The overall goal of the Cambodia National Maternal, Infant and Young Child Nutrition (MIYCN) Social Behavior Change and Communication Strategy 2020-2025 is to advance nutrition, health, and general wellbeing of all Cambodians, particularly women and young children, through optimal MIYCN practices. The strategy will directly support Component 1 (promote nutrition during pregnancy including nutrition counseling) and Component 5 (maternal, infant and young child nutrition behavior change communication focused on 1,000-day window of opportunity) of the Fast-Track Road Map 2014-2020. It outlines the key SBCC approaches targeting all women of reproductive age, pregnant women, and mothers with children younger than two years, along with key influencers of MIYCN such as family caregivers, grandparents, husbands, healthcare providers and Village Health Support Groups (VHSG). This strategy will be led and implemented by the Ministry of Health (MoH), with implementation relying on close and solid collaboration between the MoH, key relevant line ministries, and a range of other development partners. Furthermore, the MIYCN SBCC Strategy will seek to strengthen linkages with other policy and strategic frameworks in the areas of food security and nutrition, including the National Strategy for Food Security and Nutrition 2019-2023 and existing platforms such as the Technical Working Group on Food Security, Nutrition and Social Protections and the Sub-Technical Working Group for WASH-Nutrition. It also highlights the importance of the MoH increasing efforts to collaborate with sectors beyond health through advocacy and the development of partnerships in areas relevant to nutrition.

The Ministry of Health strongly believes that with active participation and support from all stakeholders, as well as effective implementation and monitoring by health workers, the implementation of the MIYCN strategy will be a great success, resulting in benefits for all Cambodians for generations to come.

## Acknowledgements

On behalf of the Ministry of Health, the National Maternal and Child Health Center and the National Nutrition Program, we would like to express our deepest appreciation to all those who have supported the development and finalization of the Cambodia National Maternal, Infant and Young Child Nutrition (MIYCN) Social Behavior Change and Communication (SBCC) Strategy 2020-2025.

The Ministry of Health is especially grateful for the financial and technical support extended by Helen Keller International (HKI), UNICEF, the World Bank and other members of the Steering Committee (see Annex 1). With sincere commitment and hard work, these organizations have contributed their time and resources in full capacity in support of the development of this document.

In addition, we would like to thank all members of the National Nutrition Working Group, who have been fundamental in driving efforts to improve child nutrition in Cambodia. Since 2000, there have been significant improvements in training and educational materials that have resulted in the successful promotion of breastfeeding in Cambodia. Together, with continued efforts, our hope is to achieve Sustainable Development Goal 2 of Zero Hunger in Cambodia.

-

## List of Abbreviations

| | |
|---|---|
| ANC | Antenatal Care |
| BF | Breastfeeding |
| BFCI | Baby-Friendly Community Initiative |
| BKKK | *Bobor Khab Khrub Kroeung* |
| BMS | Breast Milk Substitutes |
| CCWC | Commune Committee for Women and Children |
| CDHS | Cambodia Demographic Health Survey |
| CF | Complementary Feeding |
| CMAM | Community-Based Management of Acute Malnutrition |
| COMBI | Communication for Behavioral Impact |
| DCWC | District Committee for Women and Children |
| EBF | Exclusive Breastfeeding |
| ECCD | Early Childhood Care and Development |
| GDP | Gross Domestic Product |
| GMP | Growth Monitoring and Promotion |
| HC | Health Center |
| HCD | Human-Centered Design |
| HCS | Health Center Staff |
| HKI | Helen Keller International |
| iDE | International Development Enterprise |
| IPC/C | Interpersonal Communication and Counseling |
| IYCF | Infant and Young Child Feeding |
| MAD | Minimum Acceptable Diet |
| MCH | Maternal and Child Health |
| MIYCN | Maternal, Infant and Young Child Nutrition |
| MoH | Ministry of Health |
| MUAC | Mid-Upper Arm Circumference |
| NCHP | National Center for Health Promotion |
| NGO | Non-Governmental Organization |
| NMCHC | National Maternal and Child Health Center |
| NNP | National Nutrition Program |
| NWG | Nutrition Working Group |
| OD | Operational District |
| PHD | Provincial Health Department |
| PNC | Postnatal Care |
| RGC | Royal Government of Cambodia |
| SBCC | Social and Behavior Change Communication |
| SDGs | Sustainable Development Goals |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VHSG | Village Health Support Group |
| WASH | Water, Sanitation and Hygiene |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |

# Table of Contents

# I. Background and Context

## A. General overview of maternal, infant and young child nutrition in Cambodia

In the past two decades, Cambodia has made significant progress in improving reproductive, maternal, infant, and young child health and nutrition outcomes. The maternal mortality rate decreased from 442 per 100,000 live births in 2005 to 170 in 2014, and under-five mortality rate decreased from 83 per 1,000 live births in 2000 to 35 in 2014 (1). Maternal and young child malnutrition are known contributors to morbidity and mortality, and in Cambodia nearly one-third of overall child mortality – an estimated 4,454 deaths annually – is linked to undernutrition (2).

Maternal and young child nutrition remain among priority health outcomes; however, progress is lagging. Malnutrition has declined in Cambodia over the past twenty years but remains a significant public health and development concern for women of reproductive age and children under age five. Nearly one quarter (24%) of under-fives are underweight and 10% experience wasting – especially those living in rural areas. Fourteen percent (14%) of women of reproductive age are underweight and 18% are overweight and obese. Though child stunting declined from 59% in 1996 to 32% in 2014, prevalence remains "high," as one of the most common forms of malnutrition in Cambodia, according to the World Health Organization's (WHO) public health thresholds (1).

The health and nutritional status of children and their mothers are closely linked. Optimal nutrition during the first 1,000 days window between conception and a child's second birthday can have a profound impact on the child's overall health, growth, and development. Despite this, many Cambodian women of reproductive age are malnourished – often underweight or anemic – thereby increasing the risk of maternal mortality, pre-term and/or low birth weight deliveries, perinatal mortality, and longer-term impairments to a child's cognitive and motor development.

Improving the nutritional status of young children and women of reproductive age is necessary for Cambodia to meet its Sustainable Development Goals (SDGs) by 2030, address issues of inequality, health and poverty, and achieve education outcomes for the current and future generations. In 2013, the Council for Agriculture and Rural Development (CARD), UNICEF and the World Food Program (WFP) estimated that malnutrition represents a burden to the Cambodian national economy of more than $266 million annually (1.7% of GDP) with stunting being the largest contributor (2). While stunting is not treatable, there is global consensus that the first 1,000 days of a child's life offer a critical window of opportunity for improving cognitive and physical development, which has the potential to make lasting impacts on a country's health and prosperity (3). Scientific research has shown that interventions to prevent and reduce stunting, such as the promotion of optimal infant and young child feeding (IYCF) practices, increase overall economic productivity and are among the most cost-effective development actions (4).

## B. Contributors to poor MIYCN-related outcomes

Effective breastfeeding promotion has been one of the most significant public health achievements in Cambodia over the last several years. Rates of exclusive breastfeeding and early initiation of breastfeeding increased significantly from 2000-2010. Nationally, however, exclusive breastfeeding has declined from 73.5% in 2010 to 65% in 2014, most prominently in urban areas. Only 37% of children are continuously breastfed until age two as recommended by WHO (1). The reversal of these positive trends is particularly concerning as children under 6 months who are only partially breastfed have an increased risk of mortality, especially from diarrhea.

Unlike breastfeeding, optimal complementary feeding of children aged 6-23 months is a persistent challenge. Many Cambodian children older than 6 months are not fed complementary foods of sufficient quality or quantity. Only one-third (30%) of children age 6-24 months are fed a minimum acceptable diet (MAD) consistent with the three main practices (food group diversity, feeding frequency, and consumption of breastmilk or other types of milk). Less than half of children in this age group (48%) receive foods from at least four food groups. In addition, many children do not have adequate access to or make use of available health services, with the quality of such services often not as good as they could be. Such services include growth monitoring, malnutrition screening and counseling. Infection and zinc and iodine deficiencies are added risks to children, with more than half (56%) of children under five in Cambodia being anemic (1).

Though the proportion of malnourished women in the country has declined over the last two decades, 14% of women aged 15-49 years are still undernourished (body mass index less than 18.5), with rates being the highest among adolescents aged 15-19 years (27%) (1). Nutrition during adolescence, time of conception,

and pregnancy are particularly important for maternal health and survival, fetal growth, and early childhood survival, growth and development (5).

Determinants of undernutrition include poverty, food insecurity (including insufficient food consumption, unhealthy food consumption or imbalanced diet, inappropriate mealtimes), low maternal education, infectious diseases, and gender inequities (6). Maternal anemia remains a serious problem in Cambodia, with 53% of pregnant women anemic and the overall prevalence of anemia not having changed significantly since 2005 (1).

Formative research conducted in the country points to these factors as contributors to poor MIYCN-related outcomes that can be addressed through social and behavior change communication (SBCC) interventions.

### Maternal Nutrition

Many women of reproductive age in Cambodia have poor eating habits before and during pregnancy and while lactating. While a lot of women and men know what women should do during pregnancy, including eating healthy foods and attending at least four antenatal care (ANC) visits, they do not know what constitutes healthy foods for pregnant women, how much to consume, and the importance of weight gain during pregnancy (7). This may be due to women not receiving proper nutrition counseling during ANC at the health centers (7) (8). In addition, pregnant women living in rural areas tend to have fewer ANC visits and start them later in their pregnancy than those living in urban areas (1). Many pregnant women often eat less to avoid having a difficult delivery by having a big baby (7) (8). Gender disparities also potentially influence maternal undernutrition. Culturally, especially in poor families, men get the best food at mealtimes and eat before children and women, who serve themselves last. This can not only lead to maternal undernutrition, but also impacts adolescent girls and their reproductive health later in life (6).

### Breastfeeding

In Cambodia, only 63% of children are breastfed within one hour of birth. Early initiation of breastfeeding is more common among children who are delivered in a health facility, in rural rather than urban areas, and differs widely among provinces (1). Pre-lacteal feeds (something other than breastmilk during the first three days of life) are quite common, especially among women living in urban areas (1). Many women and family caregivers have misconceptions about why pre-lacteal feeds are important (8).

While the practice of exclusive breastfeeding remains quite high in the country, especially in rural areas, many mothers stop breastfeeding early, before the baby is two years old. Reasons for this include misguided beliefs about babies needing water, mothers not having sufficient milk, and social or work pressures (8). Many mothers also do not feed their babies for sufficient time during each breastfeeding session (i.e., taking 2-3 minutes to pacify their child, rather than 10 minutes) (9).

Weak enforcement of the Sub-Decree on Marketing of Products for Infant and Young Child Feeding (No. 133) and Joint Prakas 061, along with the growing promotion and sale of breast milk substitute products, contributes to the decline in breastfeeding rates, especially in urban areas. A recent study found that 86% of mothers observed commercial promotions for breast milk substitutes, and 43% of children under five months consumed breast milk substitutes (10). Many mothers and family caregivers, especially in urban areas, believe that formula milk leads to healthier, “chubbier” babies, and is more nutritious when the mother’s own diet is not good enough (8).

### Child Nutrition

Nutrition care-seeking behaviors are low, with mothers mainly bringing children to health facilities for vaccinations and sick childcare. Few mothers and hardly any grandmothers who are primary caregivers take their children for monthly growth monitoring and promotion (GMP) visits (9) (7). Cambodians tend to assess the health of their children by two parameters – weight gain and how often he or she is sick. Height measurement is not always part of the equation (8).

Stunting rates increase in children around nine months, and while not treatable, can be prevented through continued breastfeeding practices and appropriate complementary feeding for children 6-24 months. Currently, those preventative measures are not practiced in line with global or national recommendations. Almost 70% of Cambodian children aged 12-24 months, and 84% of 6-8 month old’s, especially in rural areas, are not receiving the minimum acceptable diet (1). This is largely attributable to a lack of dietary diversity rather than the number of meals received (11). After 6 months of age, many children are fed watery porridge with little animal-sourced protein or vegetables, as family caregivers believe that these foods are “too hard” and cause choking. In addition, the quantity of food given is inadequate and children are often fed non-nutritious packaged snacks as they are conveniently accessible to caregivers, who believe they are healthy and easy for children to eat (9) (8).

Handwashing before preparing food, eating food and leaving the toilet is important to protect against many diseases. While most households have a place for handwashing (93% urban, 83% rural), 22% of rural households have only water but no soap (1). It is also a regular occurrence that family caregivers and mothers do

not wash children's hands before eating or snacking (8), or wash children's hands but not their own (9).

### C. Lessons Learned on MIYCN SBCC in Cambodia

Since 2000, Cambodia has made demonstrable progress in MIYCN through a strategic mix of approaches. These include training, service delivery improvements, education, and social changes. Different SBCC media channels and communication materials have been developed and used nationwide by different agencies, both governmental and non-governmental. Several operating units are involved in nutrition and maternal, infant and young child health-related SBCC design coordination and management, including the National Nutrition Program (NNP), National Center for Health Promotion (NCHP), and the National Maternal and Child Health Center (NMCHC). The efforts of these stakeholders have often been independent and are not as collaborative as they could be. The NNP developed the Fast-Track-Road Map for Improving Nutrition (2014-2020), aimed at achieving two overarching outcomes: i) Scale-up optimal use of nutrition-specific interventions, and ii) remove barriers to efficiently implement nutrition-specific services.

The Communication for Behavioral Impact (COMBI) Campaign to Promote Complementary Feeding in Cambodia 2011-2013 was developed by the NCHP, NNP, and NMCHC in close collaboration with development partners. The first main objective of COMBI was to encourage mothers and family caregivers to cook and feed the multi-ingredient porridge called *Bobor Khab Krub Kroeung* (BKKK) to their children aged between 6 and 24 months. The second main objective was to ensure that mothers and caregivers hygienically provided three groups of food in appropriate frequencies and quantities to their babies during feeding (12). It was anticipated that mothers and caregivers targeted by the COMBI strategy would adopt and maintain improved complementary feeding behaviors based upon the principle of "the right food, given in the right way, and at the right time to the young child."

The mid-term assessment of the COMBI strategy showed that while most caregivers of young children understood the importance of BKKK for children's growth and development, many were unable to follow the instructions to cook and feed their children with the multi-ingredient porridge. This was due to time-intensive preparation, the taste, and the relative expense of including all of Cambodia's three food groups (13). As a result, despite the country's economic growth and the COMBI strategy, the quality of young children's (aged 6-24 months) diets has remained a concern.

## II. Rationale for the MIYCN SBCC Strategy

Improving maternal, infant and young child nutrition is aligned with the priorities set out in Cambodia's overall national development objectives and with those of Cambodia's health sector. The Rectangular Strategy for Growth, Employment, Equity and Efficiency Phase 3 and National Strategic Development Plan (2014-2018) reaffirm the Royal Government of Cambodia's (RGC) strong commitment to sustainable development and poverty reduction, including improved health, nutrition, and sanitation, particularly among the poor and the vulnerable.

The Third Health Strategic Plan (2016-2020) sets out four key health development goals, one of which is 'improving reproductive health and reduction of maternal, newborn and young child mortality and malnutrition.' The National Strategy for Food Security and Nutrition (2014-2018) further affirms the national commitment to improving human capital, social sector development, and nutrition, as does the Rural Water Supply and Sanitation Strategy (2014-2018) the Five-Year Strategic Plan for Gender Equality and Women's Empowerment (2014-2018); and the Social Protection Policy Framework (2016-2025), among others.

The Ministry of Health's (MoH) Fast-Track Roadmap for Improving Nutrition (2014-2020) highlights '*Behavior change communication focused on 1,000-day window of opportunity'* as one of eight components for accelerating progress on improving maternal and young child undernutrition. This is because SBCC has demonstrable effects on improving infant and young child feeding practices, nutritional status, and other health behaviors (14).

Given the high rates of malnutrition in Cambodia and persistent gaps in optimal MICYN behaviors, there is an urgent need for a comprehensive SBCC strategy and associated action plan for the country. Strong evidence points to the positive impact of SBCC on improving infant feeding practices, nutritional status and other health behaviors (14).

The challenges facing mothers, families, and communities on MIYCN are different and more complex than the messages and solutions currently being offered. There are significant capacity building and provider-focused behavior change efforts required to enable health providers to deliver updated MICYN counseling and help caregivers problem solve. Also, it is necessary to create widespread awareness and counteract social pressures against mothers and caregivers to practice optimal MIYCN behaviors. This strategy will set out pri-

ority areas for communication support and interventions to harmonize approaches across government ministries and development partners and create an enabling environment for improved MIYCN behaviors among the Cambodian population.

### Process Used to Develop the Strategy

This strategy was informed by a combination of primary and secondary data collection and synthesis conducted by iDE in collaboration with NNP, Helen Keller International and UNICEF. Formative research was conducted using Human Centered Design (HCD) to describe the experience of the feeding journey during the first 1,000 days window. Formative research was conducted with pregnant women, mothers of children aged 0-23 months, family caregivers, health staff, and Village Health Support Groups in four provinces and Phnom Penh in order to better understand the barriers and enablers to MIYCN-related practices in the country. In addition, iDE interviewed key stakeholders and experts on this subject. A desk review of existing MIYCN-related background materials, documents, experiences, and campaigns, as well as other health communication campaigns implemented in Cambodia, complemented the assessment of barriers and motivators of optimal MICYN behaviors and deepened the understanding of effective implementation approaches.

Findings from the formative research were presented to the core members of the National Nutrition Working Group (NNWG) and key nutrition stakeholders in the country to seek input and feedback on the strategy (see Annex 1). Objectives were prioritized through a consultative review of the formative research and draft strategy. In addition, the draft strategy document was reviewed by members of the NNWG.

## III. The Maternal, Infant and Young Child Nutrition Social and Behavior Change Communication Strategy

### A. Overall Goal

The overall goal of the National Maternal, Infant and Young Child Nutrition Social and Behavior Change Communication Strategy (2020-2025) is to improve nutritional status, health, and wellbeing of Cambodian women and children through optimal maternal, infant and young child nutrition practices.

### B. Strategic Objectives

Specifically, the MIYCN SBCC Strategy frames Cambodia's updated approach to MIYCN around four key strategic objectives, focused on the first 1,000 days window:

**1. Maternal Nutrition**
To achieve optimal nutrition status among pregnant/lactating women through increased dietary diversity and adequate protein and energy intake, micronutrient supplementation, and appropriate weight gain during pregnancy and while breastfeeding.

**2. Breastfeeding**
To further advance and sustain optimal breastfeeding practices for Cambodian children, including early initiation of breastfeeding, exclusive breastfeeding during the first 6 months and continued breastfeeding until at least two years of age.

**3. Complementary Feeding**
To ensure consumption of a timely, adequate, safe and appropriate diet for infants and young children 6-24 months, including age-appropriate quantity and diversity of foods, especially animal-sourced foods and healthy snacks.

1. HCD utilizes an ethnographic approach to understand users and stakeholder needs and combines this with design methods and expertise from product design, service design, and marketing strategies. The result is a market-based solution that is desirable, accessible, usable, and affordable to consumers, in addition to being technically feasible and economically viable for stakeholders in the market system.

### 4. Monitoring and Promotion of Child Growth and Development

To achieve optimal infant and young child growth and development through regular monitoring of child growth, promotion of nurturing care, and awareness-raising on the long-term benefits of nutri tion to encourage uptake of optimal nutrition-related practices.

## C. Conceptual Framework & Strategic Approach

The MIYCN SBCC Strategy is based on the Pathways to a Health Competent Society Model (see **Figure 1**). This model shows how sustainable nutrition outcomes are grounded in underlying social, political, and economic conditions. Communicating behavior change occurs through three different channels:(1) between individuals within communities; (2) through health service delivery systems; and (3) within the socio-political environment. While the model suggests a causal pathway, the process of communication and behavior change is not always linear.

Initial outcomes, such as political will, improved counseling at the health facility level, and changes in individual beliefs and attitudes, are what facilitates behavioral outcomes. This results in improved nutrition, health, and wellbeing of Cambodian women and children at the population level. These interventions are based on the underlying conditions influencing MIYCN-related behaviors.

Our strategic approach includes harmonization of the goals and actions of key nutrition stakeholders in Cambodia (see "MIYCN Alliance" Section V).

## D. Target Audiences

Formative research has highlighted three necessary sets of target audiences for MIYCN SBCC interventions at the community/individual, health service delivery system and socio-political stakeholder levels.

### Primary Audience

The primary audience group consists of individuals who are primarily responsible for the nutritional outcomes of the target population of mothers and children under age 2. The primary target audience for this strategy is comprised of:

- Pregnant women
- Mothers and other caregivers of children aged from 0 to 24 months old (i.e., grandmothers, aunts, fathers/fathers-to-be living in urban and rural areas)

### Secondary Audience

The secondary audience includes the key population groups that may influence our primary audience with regards to the behaviors being promoted and removing barriers to create an enabling environment. Our secondary target audience includes immediate influencers such as:

- Primary health service providers (nurses, midwives, doctors)
- Family and community members
- Members of Influential Community Groups: Village Health Support Groups (VHSG), commune councils including Commune Committee for Women and Children (CCWC), and District Committee for Women and Children (DCWC)

### Tertiary Audience

The tertiary audience group comprises stakeholders who can mobilize or allocate resources, impact policy in various sectors related to MIYCN (e.g., health, education, food security, agriculture, livelihoods and poverty reduction, gender), and influence the primary and secondary audience groups by addressing barriers and creating an enabling environment for MIYCN-related behavior change. These stakeholders include:

- MoH leaders at all levels, as well as other relevant ministries

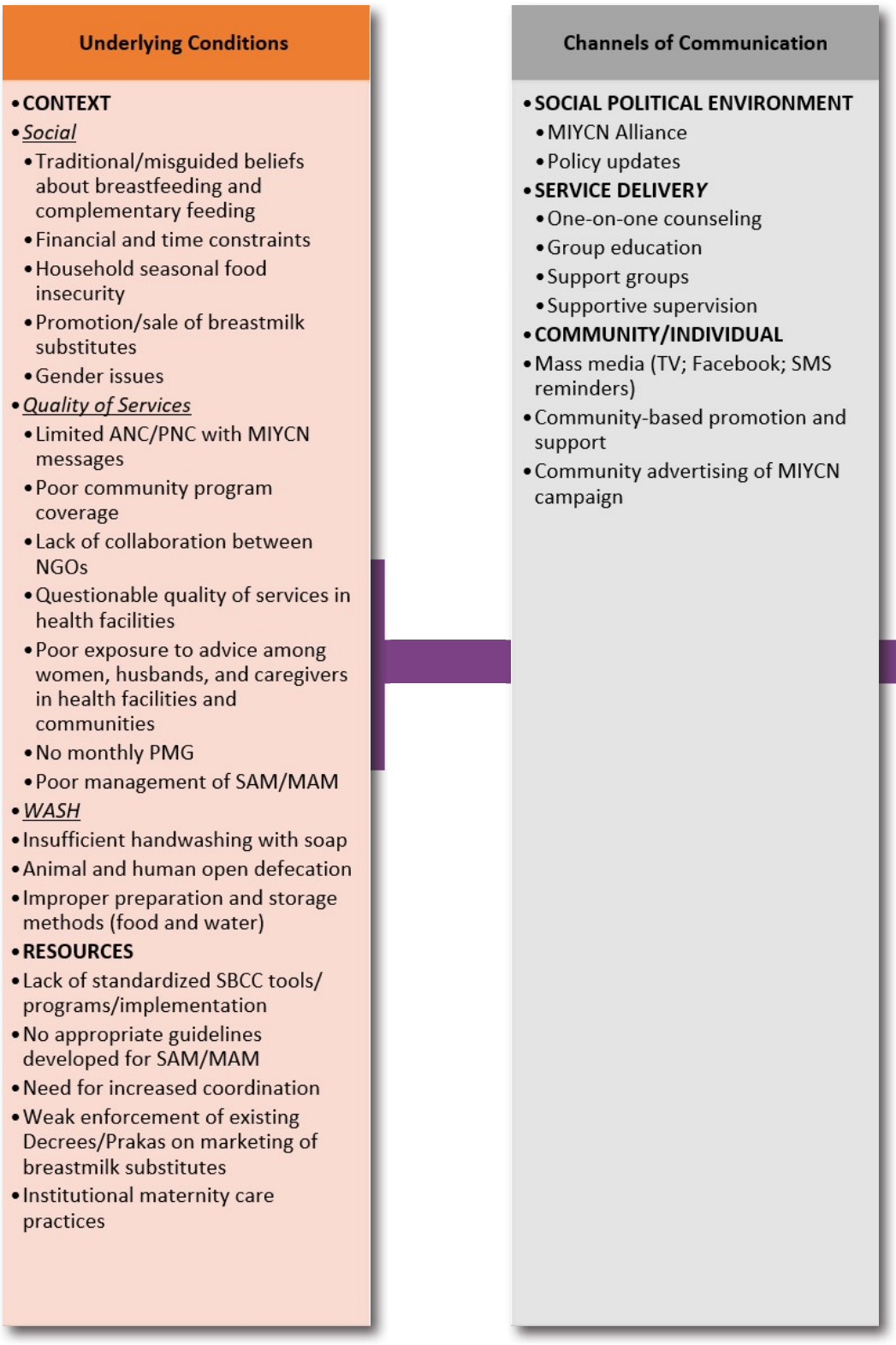
2. The Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs originally developed the Pathways Model as the organizing framework for USAID's Health Communication Partnership.

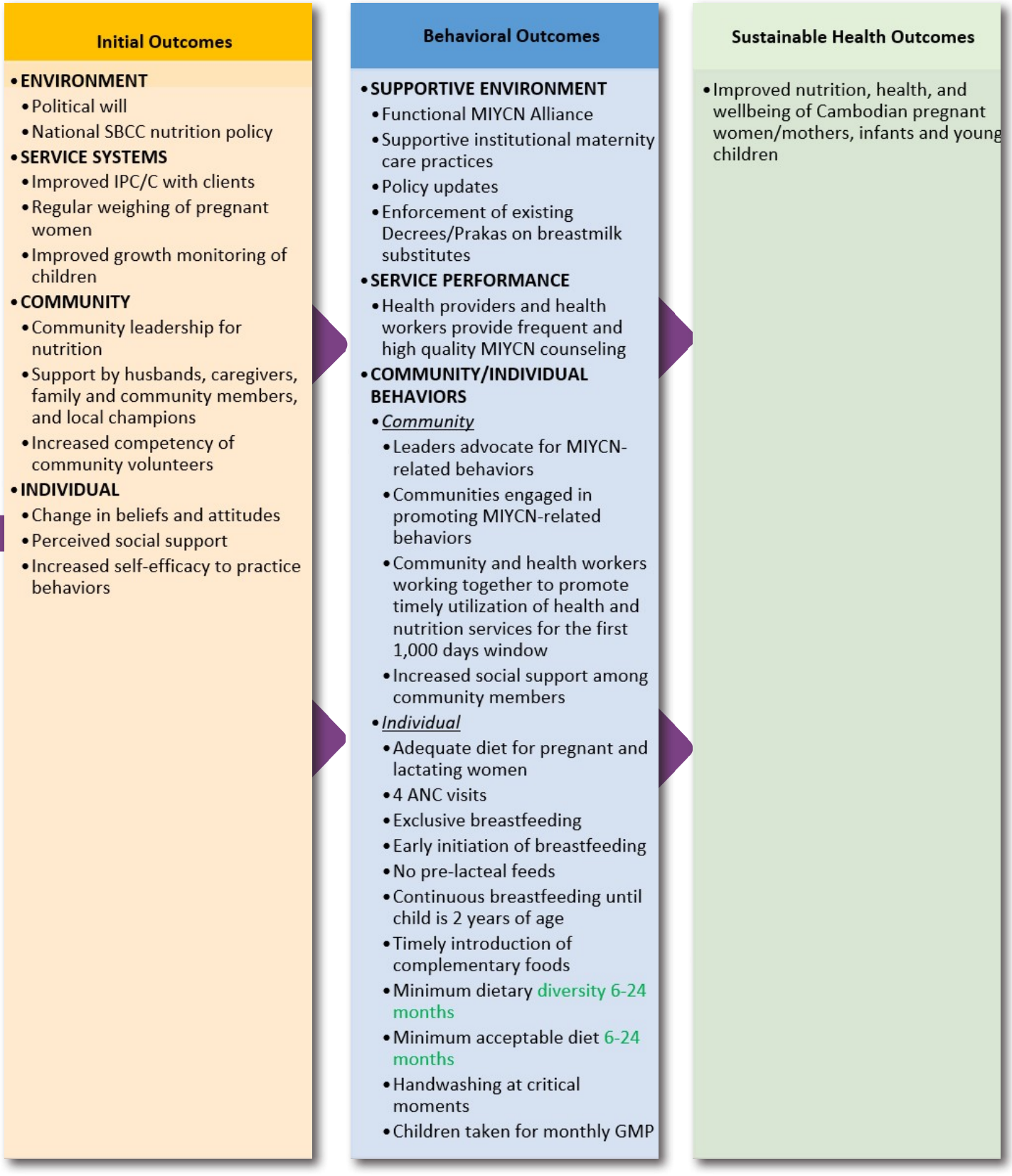
- Provincial and district governments and village chiefs
- Pagodas and religious leaders
- Other stakeholders such as employers, professional Councils, and associations and higher education institutions

## Audience Segmentation

Considering distinct differences in rural and urban areas of Cambodia, the adaptation of messages and delivery channels, and channel mix by area of residence will be explored based upon formative research as needed.

***Figure 1:*** Pathways framework for improved nutrition, health, and wellbeing of Cambodian pregnant women/mothers, infants and young children






## IV. Key Barriers, Facilitators, and Communication Objectives for Priority MIYCN Areas

Based on the existing research, the following key barriers and facilitators were identified as influencing the SBCC strategy's priority behaviors. From this, the behavior and communications objectives were defined.

| 1. Maternal Nutrition | |
|---|---|
| Primary Audiences | Pregnant women; lactating women |
| Secondary Audiences | Husbands; mothers/mothers-in-law; local elders; members of influential community groups; health service providers. |
| Key Barriers | • Women are often not provided high-quality counseling on maternal nutrition during pregnancy or lactation<br>• Women often do not receive counseling from health staff on adequate weight gain during pregnancy and may even receive messages to keep weight gain minimal.<br>• Health workers focus primarily on diagnosis and treatment but do not assess mid-upper arm circumference (MUAC) to screen women for at risk pregnancies.<br>• Health workers lack interpersonal communication skills essential for prevention of maternal malnutrition.<br>• Women feel ashamed to ask health professionals for advice.<br>• High consumption of sugar and sugary snacks among pregnant women.<br>• Women do not eat regularly (e.g., skip meals) or eat insufficient quantities during pregnancy, as many don't want to gain too much weight in order to have an "easy," fast delivery and postpartum recovery.<br>• Women are concerned with beauty and afraid of becoming fat after delivery.<br>• Women in Cambodia have strong morning sickness (chanh), which may be related to poor habits, lack of nutrition knowledge, and lack of correct advice during ANC visits.<br>• A lot of women and men know what women should do during pregnancy, including eating healthy foods and attending at least four ANC visits, BUT they do not know what constitutes healthy foods for pregnant women, how much to consume, and the importance of weight gain during pregnancy. |

| | |
|---|---|
| Key Facilitators | • Women of reproductive age and mothers of children aged 0-24 months know about the negative health effects of maternal, infant, and young child malnutrition including stunting, and know about actions that can be taken during pregnancy and the first two years of life to prevent it.<br>• Pregnant and lactating women, husbands and caregivers know about the additional nutritional needs including quantities of food needed by pregnant and lactating women.<br>• Husbands and caregivers support pregnant and lactating women to eat regularly, four times a day, as well as increase the quantity, quality, and diversity of food.<br>• Community workers, community volunteers and support groups have the skills and capacity to counsel pregnant and lactating women for improved nutrition behaviors in the first 1,000 days window.<br>• Health care providers have the capacity to provide high quality tailored counseling to women of reproductive age, pregnant women and mothers with children aged 0-24 months about the importance of a healthy diet, the different types of foods, and the amounts needed in a healthy diet.<br>• There is high ANC attendance, with most pregnant women beginning ANC care in the first trimester and attending at least 4 ANC visits.<br>• Elders are an intergenerational source of positive information on traditional nutrition-related beliefs.<br>• Pregnant and lactating women know to eat 4 meals a day, adding animal source foods (fish, meat, egg), beans and tofu, and green and orange vegetables. |
| Behavior Objectives | • Increase percentage of pregnant and lactating women consuming a healthy diet consisting of five different food items from Cambodia's three food groups in each meal<br>• Increase percentage of women who have appropriate daily energy and protein intake in order to achieve optimal weight gain according to the needs in each trimester of pregnancy and during lactation. |
| Communication Objectives | • Increase the quality of nutritional counseling offered to pregnant and lactating women through ANC and PNC at health facilities, community sessions, and/or home visits, as well as the frequency at which it is accessed.<br>• Increase the competency (knowledge, skills and abilities) of health workers to provide counseling about the importance of a healthy diet and dietary requirements during ANC visits.<br>• Increase the competency of health workers to provide counseling on optimum weight gain, as well as to measure and record the weight and nutritional status of women during ANC visits.<br>• Increase the competency of community volunteers to advocate and counsel for early and at least four ANC visits, healthy eating, micronutrient supplementation and weight gain.<br>• Increase knowledge and skills for pregnant and lactating women and practice dietary diversity with five different food items providing energy, protein, and micro-nutrients and increase appropriate meal frequency. |

| 2. Breastfeeding | |
|---|---|
| Primary Audiences | Pregnant women; mothers of children aged 0-24 months |
| Secondary Audiences | Caregivers of children aged 0-6 months, including fathers; family members; members of influential community groups; health service providers |
| Key Barriers | • Misinformation and misconceptions regarding false benefits of formula milk, baby needing water and mother not having sufficient milk.<br>• High use of pre-lacteals because of the belief that a mother's milk does not fully come in until 1-2 days after birth.<br>• Mothers not feeding their baby for sufficient lengths of time during each feed.<br>• Growing promotion and sale of breastmilk substitutes, weak enforcement of Sub-Decree 133 and Joint Prakas 061 on marketing of these products, and some health professionals promoting these products and giving inappropriate advice.<br>• Women stop breastfeeding to go back to work and the child stays with relatives.<br>• Women and caregivers do not know that infants can be breastfed from birth until 24 months old. |
| Key Facilitators | *Early initiation of breastfeeding (without pre-lacteal feeds)*<br>• Family members, caregivers, and health care providers are supportive of promoting and facilitating skin-to-skin contact between mother and child immediately after birth, baby getting colostrum, and no pre-lacteal feeds. *Exclusive breastfeeding/continuous breastfeeding until at least 2 years of age*<br>• Create breastfeeding-friendly workplaces.<br>• Increase the availability of appropriate length maternity leave and incentives for employers to encourage employees to breastfeed.<br>• Enhance beliefs among the general public, pregnant and lactating women, husbands and caregivers regarding exclusive breastfeeding for 6 months leading to healthier children.<br>• Family and community support for exclusive breastfeeding is increased.<br>• Lactating women are confident that they can exclusively breastfeed, known for what length of time to breastfeed during each session, and understand that breast milk can supply all the baby's liquid and nutrient needs during the first 6 months of life.<br>• Health workers are skilled in counseling, have access to accurate counseling materials, and have the capacity to provide high quality tailored counseling to pregnant and lactating women about the importance of and how to exclusively breastfeed.<br>• Community health volunteers are skilled to support mothers to exclusively breastfeed (including position, attachment, how to express breastmilk, how to maintain milk supply, feeding during illness, and the risks of supplemental feeding) and are better equipped with information and resources to give advice. |

| | |
|---|---|
| Behavior Objectives | • Increase percentage of mothers who perform skin-to-skin contact with their newborn immediately after birth.<br>• Increase percentage of mothers who begin breastfeeding their newborn within the first hour after birth.<br>• Decrease percentage of newborns who receive pre-lacteal feeds within three days of birth.<br>• Increase percentage of infants 0-6 months of age exclusively breastfed.<br>• Increase percentage of mothers who continue breastfeeding until at least 2 years of age. |
| Communication Objectives | • Increase competency of health workers and community health workers to provide high quality, tailored lactation counseling and support to pregnant and lactating women. Counseling includes immediate skin-to-skin contact after birth, breastfeeding within the first hour after birth, no pre-lacteal feeds, exclusive breastfeeding for the first 6 months, and continued breastfeeding until at least 2 years. It also includes a variety of core elements of breastfeeding such as position and attachment, how to express breastmilk and maintain milk supply, and the risk of breastmilk substitutes.<br>• Increase awareness and knowledge among pregnant women, partners, and family caregivers, health workers, and community volunteers about the benefits of breastfeeding for children's growth and development. This includes benefits of skin-to-skin contact, breastfeeding within the first hour after birth, colostrum, and exclusive and continued breastfeeding.<br>• Increase perceived self-efficacy among women that they can exclusively breastfeed their child for 6 months and continue to breastfeed for at least 2 years.<br>• Increase knowledge among women, partners, and family caregivers about breastfeeding supply and demand, and how to provide support so that woman can breastfeed.<br>• Dispel misconceptions among pregnant women, caregivers and health staff surrounding breastfeeding, for example: about formula milk being better than breast milk, the need for pre-lacteal feeds, that women cannot breastfeed after a C-section, needing to give water to babies less than 6 months old, and mothers not having enough milk to breastfeed exclusively.<br>• Improve perceived acceptability and norms about expressing breastmilk.<br>• Change social norms to normalize breastfeeding as something that is aspirational and modern. |

| 3. Complementary Feeding | |
|---|---|
| Primary Audiences | Mothers and caregivers of children aged 6-24 months, including fathers |
| Secondary Audiences | Mothers/mothers'-in-law (of primary audience); family and community members; members of influential community groups; health service providers |
| Key Barriers | • There is confusion about when to give complementary foods, what foods to provide, what foods are nutritious, and the amount of food to provide.<br>• Mothers and caregivers think that making solid complementary foods – including BKKK – is complicated, time-consuming and requires too much money.<br>• Grandparents in urban and rural areas often help raise children. They often look after multiple family members and don't have enough time to prepare nutritious food, and lack knowledge about what food is nutritious.<br>• Mothers and caregivers give snacks to the children as a pacifier, leading to high consumption of convenient yet processed snack foods.<br>• Mothers and family caregivers often wrongly give rice porridge to children as a complimentary semi-solid food, believing it is nutritious enough to promote growth and avoid sickness.<br>• Low consumption of animal-sourced foods during the complementary feeding period.<br>• Use of formula milk until child is two or three years old. The main reason is that the baby is not eating enough solid food, so mothers compensate the lack of food with formula milk.<br>• Confusion between complementary feeding and formula feeding, where formula is used in place of solid/semi-solid complementary foods.<br>• Traditional beliefs including: Babies' stomachs are too small and therefore only need a little food; baby should only have porridge if they have no teeth.<br>• Mothers and caregivers do not wash hands before feeding children. |
| Key Facilitators | • Families are enabled to appreciate and act on specific age-appropriate child care and feeding requirements.<br>• Mothers, fathers and caregivers understand that specific nutrient-dense foods, particularly animal-sourced, are critical for young children to grow at a healthy rate. Facilitate their availability and the caregiver's daily consumption of these foods (gardens, preservation, collecting wild-foods).<br>• Communities and health workers work collaboratively to promote timely utilization of health and nutrition services by families in the first 1,000 days window.<br>• Mothers and caregivers are knowledgeable about food portion sizes and feeding frequency, know which animal-sourced foods can be easily added in which ways, at what age, and know how to feed sick children.<br>• Health care workers are skilled in counseling, have access to accurate counseling materials, and provide counseling to mothers on how to appropriately feed children from 6-23 months.<br>• Community health volunteers are skilled to support mothers in age-appropriate child care and feeding, including food cooking demonstrations of locally obtainable foods, and are better equipped with information and resources to give advice. |

| | |
|---|---|
| Behavior Objectives | • Increase percentage of mothers and family caregivers who feed age-appropriate quantities of diversified solid or semi-solid family foods (four different food items from Cambodia's three food groups) to children aged 6-24 months, including animal-sourced proteins and healthy snacks.<br>• Increase percentage of caregivers who wash their hands and children's hands thoroughly, with soap, before food preparation and feeding of children aged 6-24 months. |
| Communication Objectives | • Increase families' efficacy to carry out proper feeding practices for infants and young children.<br>• Increase knowledge among mothers and caregivers of children aged 6-24 months on optimal complimentary feeding, including feeding amounts and food diversity per age and feed.<br>• Increase knowledge among mothers and caregivers for healthy snack alternatives for children aged 6-24 months.<br>• Decrease misperceptions around when/what/how to feed complementary foods.<br>• Increase capacity of health care providers and VHSGs to provide high quality, tailored counseling to mothers with children aged 6-24 months regarding complementary feeding practices, including what to feed, quantities, where to obtain the food and the importance of providing animal-sourced proteins and healthy snacks. |

| 4. Monitoring and Promotion of Child Growth and Development | |
|---|---|
| Primary Audiences | Mothers and caregivers of children aged 0-24 months, including fathers and grandparents. |
| Secondary Audiences | Family and community members; members of influential community groups; health service providers |
| Key Barriers | • Cambodians tend to assess children's health by two parameters: weight gain and frequency of illness, but not height.<br>• There is little understanding of the relationship between child nutrition, health and growth.<br>• There is little understanding of early childhood care and development (ECCD) for children aged 0-24 months and its relationship to children's cognitive development. |
| Key Facilitators | • Health workers offer high-quality GMP and ECCD counseling to the caregivers of children aged 0-24 months at every point of service contact with the child at health facility or community level.<br>• Community leaders, mothers' support groups, local non-governmental organizations (NGO) and health volunteers promote the importance of regular monthly growth monitoring and ECCD. |

| | |
|---|---|
| Behavior Objectives | • Increase percentage of children aged 0-24 months receiving monthly growth monitoring and promotion.<br>• Improve provision and quality of GMP at health facility and community level.<br>• Increase responsive caregiving and stimulation of children aged 0-24 months.<br>• Increase the understanding of mothers, fathers, and caregivers of the importance of nurturing care in the first 1,000 days for health, nutrition, and development outcomes. |
| Communication Objectives | • Increase interpersonal communication and counseling skills of health workers during regular monthly GMP.<br>• Strengthen health workers' knowledge and skills to provide growth monitoring and quality counseling during regular monthly GMP.<br>• Increase skills of community leaders, groups, NGOs and health volunteers to encourage families to take their children under 2 years for regular monthly GMP<br>• Increase awareness and knowledge among mothers, fathers, caregivers and the community about the impact of child growth and ECCD on children's physical and cognitive growth and development.<br>• Increase knowledge and skills among mothers, fathers, caregivers, and communities on responsive caregiving and early stimulation of children aged 0-24 months |

## V. Communication Channels

We recommend that the key SBCC messages be delivered through the following communication channels. Differences in access to communication channels in urban and rural areas will need to be taken into consideration when planning the detailed implementation of the strategy, as well as gender-related factors (e.g., tailor community activities to men and women's different schedules, women's participation in public forums etc.) (15).

### A. Mass and Social Media

Mass and social media will be used to reach the primary target audience at scale, with targeted behavior change messages addressing maternal nutrition, optimal breastfeeding and complementary feeding practices, and child growth and development. Mass media messages will largely be provided through Facebook, radio, TV spots and SMS. Facebook is useful for targeting young urban audiences, while radio, TV spots and SMS messages are suitable for both rural and urban audiences.

**Facebook:** One-third of people in Cambodia use the internet and numbers are increasing. Percentages are higher in urban (45%) than rural (27%) areas, and higher among those with higher education levels (16). The

use of Facebook is rising dramatically in the country and it is well established as the choice social media platform, especially among 18-34-year old's. Usage increased by 2 million people, from 4.8 million in 2017 to 6.8 million in 2018 (60% men; 40% women) (17).

**Radio:** Almost half of Cambodian adults (48.5%) listen to the radio at least weekly, with listenership rates almost the same among urban (47.9%) and rural (48.2%) residents. 36% of those with no formal education listening on at least a weekly basis, compared to 64.2% of those with secondary school or high education, indicating that radio use rises in Cambodia with education level.

**TV:** TV is an effective means to reach a large national audience of all demographics. 66% of households own a television (91% in urban areas and 61% in rural areas) (1). 85% of Cambodians watch TV at least once a day, with urban audiences more likely to watch TV at almost any given time of the day (8).

**SMS:** Almost all (90%) households own a mobile phone (97% in urban areas and 88% in rural areas) (1). This provides an opportunity to use mobile phones and text messages as behavior message reminders, to provide information, or to reinforce information heard or seen elsewhere. Almost forty percent (39.5%) of mobile phone owners own smartphones, which are used more commonly than computers to access Facebook (16).

## B. Inter-personal Communication and Counseling/Community Social Mobilization

Interpersonal communication and counseling (IPC/C) will be used in conjunction with community mobilization to provide more frequent and reinforced messaging and to address social norms, gender norms and more local needs. Activities will focus on improving the quality and frequency of health and frontline worker nutrition IPC/C through one-on-one counseling, group education and peer support groups. Community mobilization activities will be used to increase the numbers of people who are mobilized to provide information on and communicate optimal nutrition behaviors.

Operational guidelines will be developed to harmonize the approach to enhancing IPC/C implementer competencies (including training, coaching, job aides, etc.), service delivery, materials and incentives.

### Health Systems

**One-on-one counseling:** We will provide health workers and frontline workers (VHSG, NGO staff) with the skills and capacity to deliver key messages to mothers and caregivers about maternal nutrition, optimal breastfeeding, complementary feeding, and child growth and development. To build health worker capacity in IPC/C, we will provide training as well as specific tools and materials for each level of health worker by developing standardized new or updated health communication materials.

**Group education:** Included in our strategy will be group health promotion sessions conducted by health care centers and NGO staff and accompanied by VHSG members. Group health discussions for elders and men can be especially useful and will also be included in the strategy.

**Support groups:** Peer-led caregiver (including mother and father) support groups will be established, or where already in existence, be brought to scale to encourage adoption and support of MIYCN-related behaviors.

**Supportive supervision:** Supportive supervision is important to institutionalize and strengthen IPC/C skills at health care facilities. To implement supportive supervision for IPC/C, different techniques will be used. These include observation of counseling sessions, role plays/vignettes and competency assessments. Materials and trainings are needed for implementation at different levels (provincial, district).

### Communities

Community-based communication channels help spread new behavior change ideas and encourage widespread support for MIYCN practices through social networks, especially among rural populations. These include commune councilors, CCWC, village chiefs, VHSGs and other volunteer groups, pregnant women and mother support group leaders, community agents, religious/public/local leaders, and local NGOs. Their roles will include supporting the MIYCN strategy and resulting campaigns at the community level with advocacy and funding; supporting their implementation and monitoring; leveraging village planning processes; supporting community mobilization to improve MIYCN; promoting key messages; facilitating establishment of the support groups; and/or endorsing and mobilizing local community events and media.

## C. Targeted Advocacy

Targeted advocacy includes local advocacy and coalition building with government and MoH leaders at

all levels, relevant ministries, partners and other stakeholders (e.g., employers, higher education institutions, professional associations and councils). This will help to ensure ownership of the strategy in the long term and enable an environment that supports the practice of recommended behaviors for good nutrition through legislative and institutional reinforcement.

**MIYCN Alliance:** The high number of nutrition stakeholders and limited program target areas in Cambodia has resulted in fragmentation and a lack of coordination and consistency in messaging and efforts. It is essential to unite all stakeholders under a common entity to improve the efficiency of the SBCC campaign, promote synergy among nutrition-related work being implemented by partners in the country, and create a much more visible and unique entity that will be the key (if not the only) nutrition resource in Cambodia.

The MIYCN Alliance will be a mechanism for key nutrition stakeholders in Cambodia, under the umbrella of the NNP, to operate cohesively at a national, provincial and district level. The focus of the Alliance will be to develop collaborative, clear and specific policy goals and actions to achieve the broader goals of Cambodia's MIYCN program as a part of the NNP operating under the MoH. Several key stakeholders will be involved in the Alliance, including RGC operating units, donors, donor organizations, private sector partners and NGOs involved in nutrition-related SBCC coordination, design, implementation, and management. The Alliance will be an important vehicle to drive institutional and legislative changes through policy reforms, acting as the front-line advocate for increased political and financial support for scaling up smaller nutrition projects and maintaining a successful NNP. It will deliver evidence-based recommendations to decision makers, stakeholders and/or those who influence them to adopt any effective decision on increased political and financial commitment to nutrition programs.

The new MIYCN Alliance will also work to create a distinctive image and/or branding with high visibility, so as to raise public awareness about the MIYCN campaign.

**Policy and Advocacy-Related Action:** As part of its work, the MIYCN Alliance will educate and motivate influential audiences—including policymakers and program managers—to act to support specific measures to advance nutrition causes. It will identify advocacy approaches based on circumstances, the exact need/unique barriers, goal or policy action. Examples of advocacy goals for child nutrition include adopting more pro-MIYCN national policies such as extended paid maternity leave; increasing funding and support for MIYCN promotion in healthcare systems and the community; improving monitoring and enforcement of Sub-Decree No. 133; and developing national strategies and action plans that are evidence based.

In addition, the MIYCN advocacy campaign should address inequity by bringing the issue of child nutrition disparities to the forefront of the agenda for decision makers. This can be achieved by building awareness, visibility and public momentum behind the issue, and by improving access to, cost of and the quality of programs and services for disadvantaged children and women. Central to our approach will be to obtain disaggregated data and evidence on who are the most disadvantaged and excluded, gain a deep understanding of the root causes of the nutrition problem, and create an enabling environment so that the problem can be addressed. This involves strengthening the accountability of decision-makers to support the most disadvantaged children and women in claiming their rights.

## VI. Implementation Plan

### A. Implementation and Coordination

The National Nutrition Program of the National Maternal and Child Health Center, Ministry of Health, will be the lead agency responsible for operationalizing the National MIYCN SBCC Strategy (2020-2025), including coordination, implementation and monitoring and evaluation. Successful implementation of the strategy and improving the nutritional status, health and wellbeing of Cambodian women and children requires making changes on all levels, from national to community, as well as engagement and coordination between various stakeholders and partners. These stakeholders/partners include:

**RGC:** Establish a supportive political environment through capacity building and improved coordination for SBCC for MIYCN and the strategy in key line ministries at national and decentralized levels. Identify and allocate human, financial and organizational resources for its implementation. Develop capacity, procedures and mechanisms to incorporate MIYCN SBCC into the local government planning process and integrate messages and delivery across relevant line ministries. Improve information management to include sex-disaggregated data and SBCC-related monitoring and evaluation.

**Health professional institutions and associations** (e.g., health training institutions, professional councils and professional associations): Provide pre-service training to health service providers in MIYCN and IPC/C and improve their understanding of existing MIYCN-related standards and guidelines. If needed, revise existing

guidelines to integrate pro-MIYCN practice and competencies for antenatal, postnatal, reproductive health, young child health, and nutrition services. Highlight institutions' responsibilities in enforcing Sub-Decree 133 and Prakas 061 on Marketing of Products for Infant and Young Child Feeding and in working together with community-level groups. Make use of training regarding the capacity building of health care providers to also address issues of gender sensitivity.

**Health facilities:** Provide high quality counseling on maternal, infant, and young child nutrition during contact with health providers. Integrate counseling into all points of contact with pregnant/lactating women and infant/young child caregivers (including men).

**Non-governmental organizations and community support groups, including religious organizations and women's groups:** Provide current information and skilled support for MIYCN in community-based organizations. Ensure that SBCC campaigns, messages, and materials are consistent with national strategy and are gender responsive.

**Employers:** Contribute to creating and maintaining maternal and breastfeeding-friendly workplaces.

**International organizations:** Support capacity-building at national and sub-national levels, advocate for human and financial support, and support policy and standards development and promotion.

A detailed implementation plan addressing activities, targets, responsibilities, and key behaviors to be addressed through different communication channels will be developed separately and coordinated by the NNP and National MIYCN Alliance

.

### B. Sustainability

Building sustainable solutions for MIYCN SBCC will involve: commitment and active engagement of all partners and stakeholders from the planning stage through to implementation and assessment stages; strengthening institutional capacity to manage and implement SBCC MIYCN programming at national and decentralized levels; ensuring all work of the SBCC MIYCN will be carried out on the basis of scientific evidence, including data, information and best practices; improving coordination and harmonization of MIYCN SBCC activities and materials; and enhancing the capacity of the MoH and local counterparts to implement and finance SBCC implementation.

## VII. Monitoring and Evaluation

The overall effectiveness of the MIYCN SBCC strategy implementation will be assessed through monitoring and impact evaluation.

Monitoring will be conducted throughout the implementation of the project activities. It will be led by the National Nutrition Program and will actively involve key stakeholders on national and local levels. As described below, monitoring and evaluation will take place on 3 different levels: Process evaluation, impact on the quality of services and counseling of health providers, and the impact on the target audiences' behaviors.

Its purpose will be to:

- Determine whether activities and outputs are proceeding and produced according to plan. If not, determine where necessary changes need to be made (i.e., development of communication materials for different participant groups and channels; use of a variety of mass media platforms).
- Ensure use of a harmonized set of messages and approaches by different stakeholders, scaled up and sustained over time.
- In addition, it will examine the strengths and weaknesses of the program activities. **Table 1** outlines mandatory data to be collected on an annual basis.

The National Nutrition Program oversees this monitoring, but as a part of the MIYCN Alliance formation and responsibilities, all partners from the alliance will be expected to report on their contributions to each of these indicators on an annual basis.

**Table 1. Process Evaluation: Data Type and Analysis Approach**

| Evaluation Questions | Data Type and Analysis Approach |
|---|---|
| Do the SBCC implementers have the capacity to deliver SBCC? | If any support has been dedicated to MIYCN building capacities:<br>• Number of people trained on MIYCN in the past year (disaggregate by type of deliveries)<br>• Numbers and types of health communication materials distributed to the newly trained (disaggregate by type of delivery) |
| Are the SBCC program activities being conducted as planned (quantity and quality)? | MIYCN activities:<br>• Number of health facilities supported<br>• Number of communities supported (disaggregate by villages or communes)<br>• Number of pregnant women who have received MIYCN counselling (disaggregate by level of service provision, e.g., community vs. health facility)<br>• Number of mothers of children aged 0-5 months who have received MIYCN counselling (disaggregate by level of service provision)<br>• Number of mothers of children aged 6-24 months who have received MIYCN counselling (disaggregate by level of service provision)<br>Material production:<br>• Numbers and types of health communication materials produced and distributed (state the location) |
| Is the population being exposed to mass media campaigns? | Summary of the number of target audience members exposed to the campaign interventions. For example,<br>• Number of mass media outlets used<br>• Number of individuals in each target group reached by each media (how to measure?) |

Impact evaluation will assess the net effect of the strategy on 1) the target audiences' behaviors and 2) the quality of the service providers, using both quantitative and qualitative research methods. **Table 2a and 2b** provide indicators for measuring both impacts.

The National Nutrition Program will ensure the appropriateness of the knowledge of the service provider. Those service providers should be tested after the training and at least every year or two years due to high turn-over. The National Nutrition Program will develop quality standards and integrate these into the nation-

al quality enhancement monitoring tool while the MIYCN alliance will support the assessment of VHSG.

### Table 2a. Indicators for Measuring Impact on Quality of the Service Providers

| Evaluation Questions | Data Type and Analysis Approach |
|---|---|
| Is the service provider skilled enough to provide the correct MIYCN messages? | If any support has been dedicated to MIYCN activities:<br>• Number of health facilities assessed for their capacity to provide MIYCN counseling<br>• Number of service providers with the adequate knowledge to provide MIYCN messages |

The results of several of the above indicators (**Table 1 and Table 2a**) can be drawn from performance on vignettes integrated into the National Quality Enhancement Monitoring Tools (NQEMT).

Information will be drawn from existing sources by incorporating additional communication questions into existing surveys and or/specially commissioned studies to measure the extent of both short-term outcomes (i.e., increase in knowledge and attitudes) and longer-term behavioral outcomes.

### Table 2b. Indicators for Measuring Impact on Target Audiences' Behaviors

| Impact/Outcome Indicators | Source of Data |
|---|---|
| Stunting prevalence rate among children under five | CDHS & special survey |
| Wasting prevalence rate among children under five | CDHS & special survey |
| Underweight prevalence rate among children under five | CDHS & special survey |
| **Maternal Nutrition** | |
| % of pregnant women who visit health facility for at least 4 ANC check-ups | CDHS & Cambodian HMIS |
| % of pregnant women who receive nutritional advice on dietary diversity (consuming at least 5 food groups) and increased meal frequency during antenatal care | Special survey |
| % of pregnant women who receive correct information on weight gain during pregnancy | Special survey |
| % of women of reproductive age or pregnant/lactating women consuming an adequate diet according to the Minimum Dietary Diversity for Women (minimum 5 of 10 food groups), focused on meal frequency, quantity and diversity | Special survey |
| % of pregnant women with adequate weight gain during pregnancy | Special survey |
| **Breastfeeding** | |
| % of newborns who were breastfed within one hour of birth | CDHS & Cambodian HMIS |
| % of newborns who received a pre-lacteal feed within three days of birth | CDHS & special survey |
| % of infants 0–5 months of age exclusively breastfed | CDHS & special survey |
| % of children with continued breastfeeding at 2 years of age | CDHS & special survey |
| % of children 0-23 months of age who met the minimum meal frequency requirements according to age | CDHS & special survey |
| **Complementary Feeding** | |
| % of infants 6–8 months of age who receive solid, semi-solid or soft foods | CDHS & special survey |
| % of children 6–23 months of age who receive the minimum dietary diversity (four or more food groups) | CDHS & special survey |
| % of children 6–23 months of age who receive a minimum acceptable diet (other than breast milk) | CDHS & special survey |
| % of caregivers who wash their hands and those of children 6-23 months of age before food preparation and feeding | CDHS & special survey |
| **Growth Monitoring** | |
| % of children 0-23 months of age receiving regular growth monitoring and promotion | Special survey |

# Annex

## Annex 1. List of Steering Committee Members Who Contributed to the Development of the Cambodia National Maternal, Infant and Young Child Nutrition (MIYCN) Social and Behavior Change Communication (SBCC) Strategy 2020-2025

| Name | Institutions and Role | Role in the Steering Committee |
|---|---|---|
| H.E. Prak Sophonneary | Under-Secretary of State for Health, MoH | Senior Advisor |
| H.E. Prof. Tung Rathavy | Under-Secretary of State for Health, MoH | Senior Advisor |
| Dr. Chea Mary | Manager of NNP | Chair |
| Mr. Hou Kroeun | Deputy Country Director, HKI | Member |
| Mr. Un Sam Oeurn | Nutrition Officer, UNICEF | Member |
| Dr. Silvia Holschneider | Consultant, World Bank | Member |
| Mr. Chhoun Wathna | Nutrition Specialist, Plan International | Member |
| Dr. Arnaud Laillou | Nutrition Specialist, UNICEF | Member |
| Ms. Anne Provo | Nutrition Specialist, World Bank | Member |
| Dr. Phal Sano | National Professional Officer, WHO | Member |
| Dr. David Raminashvili | Technical Lead – Nutrition/ Health & WASH, World Vision International | Member |

## References


1. **National Institute of Statistics, Directorate General for Health, and ICF Internationa.** *Cambodia Demographic and Health Survey 2014.* Maryland, USA : Phnom Penh, Cambodia, and Rockville, National Institute of Statistics, Directorate General for Health, and ICF International, 2015.

2. **Moench-Pfanner, R., Silo, S., Laillou A.., Wieringa F., Hong, R. Hong, R., Poirot E., and Bagriansky J.** The Economic Burden of Malnutrition in Pregnant Women and Children under 5 Year of Age in Cambodia. *Nutrients.* 2016, Vol. 8, 5.

3. **de Onis M., Branca F.** Childhood stunting: a global perspective. *Maternal and Child Nutrition.* 2016, Vol. 12, 1, pp. 12-26.

4. **Shekar, Meera, et al.** *An Investment Framework for Nutrition : Reaching the Global Targets for Stunting, Anemia, Breastfeeding, and Wasting. Directions in Development--Human Development.* Washington, DC : World Bank, 2017.

5. **Black R., Victoria C., Walker S., Bhutta Z., Christian P., De Onis M., Ezzti M, Granthan-McGregor S.,Katz J., Martorell R., Uauy R.** Maternal and Child Undernutrition and Overweight in Low-income and Middle-income Countries, Maternal and Child Nutritio. *Lancet.* 2013, Vol. 382, 9890, pp. 427-451.

6. **Chhoun P., Pal K., Oy S., Collins C., Tout S., Yi S.** Social Determinants of Maternal and Child Undernutrition in Cambodia: A Systematic Review. *Int J Food Nutr Sci .* 2016, Vol. 3, 2, pp. 331-337.

7. **Save the Children.** *NOURISH Project Baseline Survey Report.* Phnom Penh : NOURISH Project, 2016.

8. **iDE.** *2016.* Phnom Penh : Melon Rouge Agency and iDE, The 1000-Day Feeding Journey of Infants and Young Children in Cambodia.

9. **Save the Children.** *NOURISH Project Social and Behavior Change Communication Strategy.* Phnom Penh : NOURISH Project, 2015.

10. **Pries A., Huffman S., Mengkheang K., Kroeun H., Champney M., Roberts M., Zehner E.** Pervasive promotion of breastmilk substitutes in Phnom Penh, Cambodia, and high usage by mothers for infant and young child feeding. *Maternal and Child Nutrition.* 2016, Vol. 12, S2, pp. 38-41.

11. **Som SV, Prak S, Laillou A, Gauthier L, Berger J, Poirot E, Wiering FT.** Diets and feeding practices during the first 1,000 days windows in the Phnom Penh and North Eastern districts of Cambodia. *Nutrients.* 2017.

12. **(COMBI), Communication for Behavioral Impact.** *Campaign to Promote Complementary Feeding in Cambodia 2011-2013.* Phnom Penh : National Nutrition Programme.

13. **Chhorvann, C., Sothea N. K., Bandeth, R.** *Assessment of the Complementary Feeding Communication Campaign for Children aged 6 to 24 months in Cambodia, 2013 - A final draft report submitted to UNICEF to undertake Qualitative Assessment of Child Nutrition Programmes in Cambo.* Phnom Penh : Cambodia Development Research Institute, 2013.

14. **Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING).** *Conference Report and Strategic Agenda for Nutrition SBCC. Designing the Future of Nutrition Social and Behavior Change Communication: How to Achieve Impact at Scale.* Washington, DC : s.n., 2014.

15. **Save the Children.** *NOURISH Gender Analysis and Integration Strategy.* Phnom Phen : NOURISH Project, 2016.

16. **Phong K., Sola J.** *Mobile Phones and Internet in Cambodia.* Phnom Penh : USAID and Asia Foundation, 2015.

17. **Cambodias 2018 Social Media Digital Statistics. [Online] Geeks in Cambodia. [Cited: March 13, 2018.] http://geeksincambodia.com/cambodias-2018-social-media-digital-statistics/.**

Published: 2021


unicef
for every child


USAID
ជំនួយពីពលរដ្ឋអាមេរិក

RTI
INTERNATIONAL

HELEN
KELLER
INTL