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Strengthening What Works: Lessons from Community-Led Breastfeeding Support in Uganda

Introduction

Breastfeeding is one of the most effective, low-cost interventions for child survival. Yet in Uganda, one in five children under two are given something other than breast milk in the first three days of life, before their digestive and immune systems are ready for it. This brief highlights how CASCADE[1] (CAtalyzing Strengthened Policy Action for heAlthy Diets and resiliencE) community-led approaches are closing that gap in the Acholi, Tooro, and Karamoja sub-regions, and what the results mean for scaling this work nationally. It draws on CASCADE's implementing partners on this brief: Food Rights Alliance and Africa Innovations Institute (Acholi and Tooro sub-regions), and the Kyenjojo Association of Women Development Actors (Kyenjojo District) structured reporting on the breastfeeding interventions carried out, the results achieved, and the lessons learned.

Under this year's World Breastfeeding Week (WBW) theme "Breastfeeding for a Sustainable Start in Life: Strengthen What Works," this brief sets out the evidence-based pathways CASCADE has found to work so that national and district stakeholders can see what is already working, understand what it would take to replicate it in non-CASCADE districts, and act to embed it in national policy and practice.

Key insights at a glance

1. Peer counseling turns private struggles into solvable problems. Mothers spoke more openly with trusted, home-visiting "Breastfeeding Champions" than in clinic settings addressing poor attachment, painful nipples and low milk supply before mothers gave up.

2. Role Model Men are the missing multiplier. Once men understood that rest and diet drive milk supply, they took over household chores and food purchases, turning breastfeeding from "her issue" into a shared family role.

3. Integrated approaches strengthen nutrition outcomes. Combining nutrition education with cooking demonstrations helped communities understand, observe and practice appropriate feeding and shifted harmful myths around pre-lacteal feeding, maternal diet and complementary feeding alike.

4. The 12–23 month mark is where breastfeeding breaks down. Even where early practices are strong, women's return to farm and market labour is outpacing community structures built to protect breastfeeding time.

5. Trusted, trained existing structures move faster than new ones. Village Health Teams, Local Council leaders, health assistants and Care Groups gave CASCADE's approaches instant community credibility.

[1] CASCADE (2022–2027) works to improve food security, reduce malnutrition, and strengthen resilience among women of reproductive age and children across Benin, Ethiopia, Kenya, Mozambique, Nigeria, and Uganda. Funded by the Ministry of Foreign Affairs of the Netherlands and implemented by CARE Nederland, CARE USA, and the Global Alliance for Improved Nutrition (GAIN), the programme applies a food systems approach to support stronger nutrition policy implementation, promote multi-sectoral coordination, engage the private sector, and address structural and gender-related barriers to healthy diets.

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Why Community-Led Breastfeed Initiatives Matter?

The World Health Organization recommends that infants be breastfed within the first hour of birth, exclusively breastfed for the first six months of life, and continue breastfeeding alongside adequate complementary foods up to two years of age or beyond. When done well, breastfeeding protects children from infection and malnutrition in their most vulnerable months, supports healthy brain development, and lowers the risk of stunting later in childhood.

Uganda has demonstrated remarkable progress in promoting optimal breastfeeding practices. The 2022 Uganda Demographic and Health Survey (UDHS) reported that 96% of children born in the two years preceding the survey had been breastfed at some point, with 82% initiated within the first hour of birth. Furthermore, the survey highlighted a substantial increase in exclusive breastfeeding rates among infants aged 0–6 months, reaching 94%, a significant leap from 66% recorded in the 2016 UDHS. More recently, the Ministry of Health (2024) reported that the national exclusive breastfeeding rate, based on routine programmatic monitoring, currently stands at 87%. While this rate remains substantially above the 2025 global nutrition target of at least 50% set by the World Health Assembly, the apparent decline from the 94% survey-based estimate underscores the critical need to sustain and strengthen national breastfeeding promotion efforts to prevent backsliding and ensure continued progress.

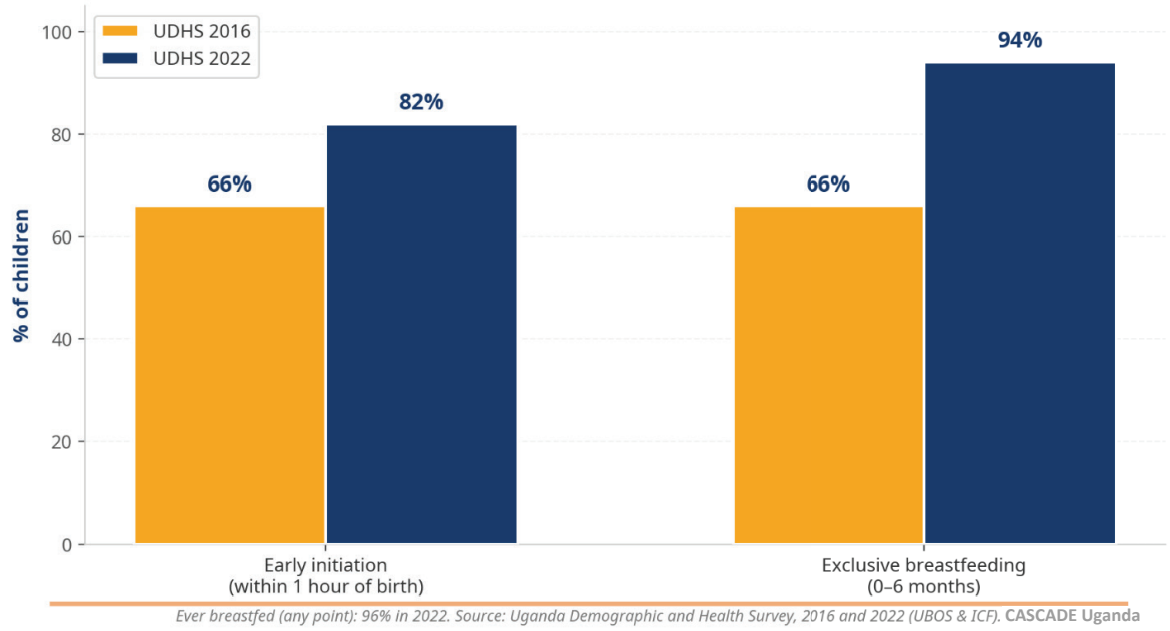

Figure1: Breastfeeding statistics —Trend 2016 to 2022

Breastfeeding and complementary feeding cannot be treated as separate issues. While breastfeeding performance was relatively strong, the transition to complementary feeding from six months emerged as a major gap, captured by the Minimum Acceptable Diet (MAD) indicator, which combines meal frequency, dietary diversity and breastfeeding status into a single measure of adequate nutrition. UDHS 2022 data show that only 7% of children aged 6-23 months met MAD; although breastfed children performed far better on meal frequency than non-breastfed children (76% versus 28%), dietary diversity remained very low (9%), so only 8% of breastfed children achieved MAD overall (Figure 2). The evidence is clear: getting a child breastfed is not, by itself, enough adequate diets ultimately depend on household food access and economic capacity.

This practice of early mixed feeding, not whether mothers breastfed at all, was the real challenge CASCADE partners set out to address. CASCADE sought to explore if mothers were supported to breastfeed exclusively through those first fragile days, when family pressure and old beliefs about "settling" a newborn were strongest. Project field reports consistently identified the same barriers: mothers-in-law encouraging the premature introduction of cow milk, mothers lacking a clear understanding of the importance of colostrum, and women managing a poor latch or perceived low milk supply without adequate support

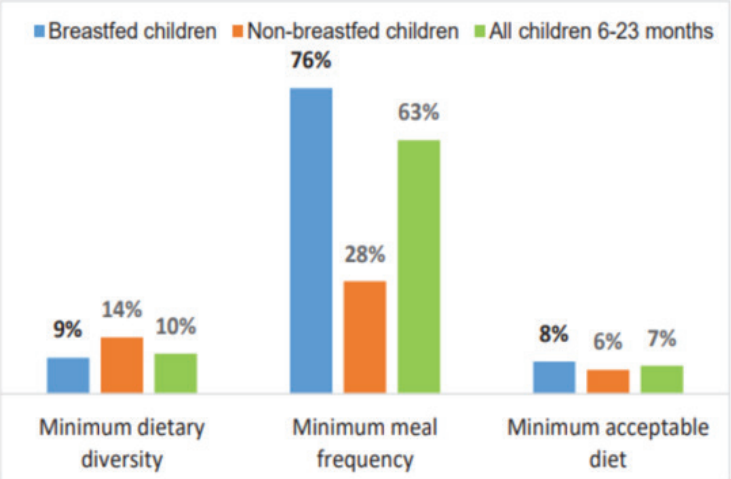

Figure 2: Infant and Young Child Feeding indicators (Source: UDHS 2022 Report)

Rural subsistence farming households bore the heaviest burden of poor infant feeding practices; where mothers often returned to domestic care work soon after delivery; and feeding decisions were strongly influenced by other family members. Young, first-time mothers with limited income and decision-making power were most vulnerable. These were the households where CASCADE's community structures and women's empowerment approaches proved most relevant, providing trusted local support to navigate both early breastfeeding challenges and the food-access, and norm barriers shaping complementary feeding after six months.

CASCADE'S Approach

The project implemented a multi-level, multi-stakeholder social and behaviour change approach to address the poor infant and young child feeding practices found in Acholi, Karamoja and Tooro sub-regions from early mixed feeding in a newborn's first days to weak dietary diversity once a child reached six months. Rather than a single activity, this was a connected package working at every level of the system at once, from district structures down to the household.

Men participating in a cooking demo. Through CASCADE-supported cooking demonstrations, men and caregivers are empowered with knowledge and skills to prepare diverse, nutritious meals that contribute to improved maternal, infant and young child nutrition outcomes.

The approach comprised three interconnected strands, each reinforcing the others:

Nutrition education

Nutrition education was the entry point for changing feeding practices at household level. Evidence showed that poor practices were driven less by a lack of knowledge of "what to do" and more by deeply entrenched beliefs about what was safe or appropriate. For instance, mothers-in-law often encouraged the premature introduction of cow milk, had limited understanding of the importance of colostrum, and there were long-standing taboos around what a lactating mother should eat after birth, such as prohibitions on consuming protein-rich foods like eggs and groundnuts, restrictions on certain vegetables believed to cause infant colic, and beliefs that specific foods could reduce milk supply. To address this, CASCADE delivered nutrition education through trained facilitators and health assistants directly at community level and deliberately paired each session with practical cooking demonstrations. This ensured messages were not left abstract: caregivers could see, taste, and practice appropriate feeding rather than simply hear it described. This combination of instruction and hands-on demonstration accelerated the shift away from harmful feeding myths, not only around pre-lacteal feeding and postnatal maternal diet, but across complementary feeding practices more broadly.

Men participate in a cooking demonstration session, gaining practical knowledge on preparing nutritious meals to support improved household nutrition practices.

Social and Behaviour Change (SBC)

The SBC approach was shaped directly by evidence. A barrier analysis and gender analysis conducted in collaboration with Kyambogo University identified the specific social dynamics standing in the way of good feeding practices, including the exclusion of men from infant feeding decisions and the influence of older female relatives over early feeding choices. Rather than targeting mothers alone, CASCADE's SBC work intentionally brought fathers and grandmothers into community dialogues, turning breastfeeding from an issue mothers were expected to manage alone into a shared family responsibility. This is reflected most clearly in the male engagement results: when fathers understood that a mother's rest and diet directly drive milk supply, many took over household chores and food purchases, reframing breastfeeding as a shared role rather than "her issue." The approach was reinforced through peer-to-peer support the "Breastfeeding Champion" model, which combined home visits with maternal support circles (locally known as breastfeeding support groups). This created a private, trusted space for mothers to raise problems like poor latch or low milk supply before they led to premature discontinuation.

Revitalization of District Nutrition Coordination Committees

Revitalizing District Nutrition Coordination Committees (DNCCs) was key to addressing suboptimal feeding practices. Based on the premise that community-level behaviour change could not be sustained without a functioning coordination structure above it to plan, track, and hold sectors accountable, CASCADE facilitated the orientation of DNCC members at all levels and walked them back through their own nutrition work plans, reviewing what had been committed to against what had been done. This was particularly important for breastfeeding because it prevented the issue from being confined to a single "health sector" silo. DNCCs bring multiple sectors together, and CASCADE's advocacy ensured those sectors acted together on infant feeding rather than in parallel. From district level, CASCADE followed the same structures down through sub-county and parish level, connecting them directly into the community, so that a decision made at district level had a visible, working line down to the household. Village health teams, local council leaders, and health facility staff linked this community sensitization to clinical referral and to existing tools such as MIYCAN cards, so problems identified at home could be escalated when needed.

Together, these three strands produced impact beyond numbers reached. Functional DNCCs meant breastfeeding and infant feeding were actively tracked and discussed from district level down to community level, not left to community volunteers alone. Community-level models shifted real household behaviour, including a measurable, deliberate shift in male engagement in a domain often treated as "women's work." In Tooro alone, CASCADE's approach reached 3,961 people 3,251 women and 710 men at village level, but the more significant result was structural: a working line from district nutrition planning through to the mother receiving a home visit, with breastfeeding treated as everyone's responsibility along that line, not one sector's alone.

What We Learned?

The project's community partners identified four connected insights that explain why some approaches to breastfeeding support worked better than others and what would need to be true for these to work on a national scale.

Home-based peer counselling

The strongest lesson was that mothers need more than information; they need timely, practical support to address breastfeeding challenges as they arise. While community sessions raise awareness, home visits enable counsellors to identify specific barriers, engage key family influencers and provide tailored guidance within the mother's real-life environment.

The home-based breastfeeding champion model emerged as the most effective approach. Mothers were more willing to discuss issues such as poor attachment, perceived low milk supply and emotional stress with trusted community peers, while champions could identify problems early and facilitate referral for complications when needed.

This highlights the value of peer counsellors as an extension of, not a replacement for, the health system. For scale-up, districts should prioritize clearly defined catchment areas, simple case-tracking systems, strong referral pathways and regular supervision to ensure consistent, high-quality support.

Fathers and grandmothers as primary intervention partners

Breastfeeding outcomes improve when family influencers are engaged alongside mothers. Fathers and grandmothers play a key role in household decisions and feeding practices, helping families reject harmful newborn-feeding practices and supporting adequate maternal diets, breastfeeding time and childcare.

This support is particularly critical when women return early to farming, market work or informal employment. Father engagement is most effective when it leads to practical actions such as sharing household chores, protecting maternal rest, enabling feeding breaks and reducing family pressure that undermines breastfeeding.

Programme design also matters. Framing activities as family nutrition, child growth and household wellbeing, rather than breastfeeding or cooking alone, can increase male participation and make engagement more socially acceptable through the involvement of male peers and community leaders.

Integrated nutrition learning across the first 1,000 days

The integrated approach also improved efficiency by using existing platforms such as community outreaches, care groups, growth-monitoring sessions and cooking demonstrations to reach the same target groups. However, integration should not come at the expense of technical quality. Facilitators still require practical breastfeeding counselling skills, including support on positioning, attachment, expressing breastmilk and managing common difficulties.

A key lesson was the need to strengthen support beyond the first six months. While early initiation appeared relatively strong, continued breastfeeding after 12 months and the transition to complementary feeding remain challenges. Future programming should therefore provide age-specific counselling and follow-up throughout the child's second year, particularly during critical transition points such as returning to work, introducing complementary foods and declining family support.

Leveraging existing community structures with sustained support

The interventions achieved strong community acceptance and reach by building on existing structures such as village health teams (VHTs), community facilitators, local leaders, faith institutions and health facilities. Health workers provided technical guidance and referral support, while community actors ensured regular engagement and trust.

This model is scalable because it leverages existing systems rather than creating new ones. However, community-based support is not cost-free. Champions require refresher training, supervision, counselling materials, follow-up support and clear referral mechanisms to maintain quality and motivation.

A further lesson is the importance of local adaptation. Since myths, workloads and household decision-making dynamics vary across regions, districts should assess local barriers before scale-up. A national approach should therefore combine core standards with flexibility for locally tailored messages and community engagement strategies.

Strong district coordination strengthens community action

Revitalized DNCCs ensure that breastfeeding remains a multisectoral priority, linking planning, implementation, monitoring, and accountability from district level to households. Effective coordination enables community interventions to be resourced, institutionalized and sustained.

Implications for Policy and Practice

Table 1 below outlines the call to actions on how to translate this community evidence into national action requires clear ownership across four groups:

Stakeholder	Call to Action
Government / Ministry of Health & Local Government 	**Institutionalize What Works- Community Based Breastfeeding Support** • Recognize and formalize the "Breastfeeding Champion" peer-counselling cadre within the Village Health Team system, with defined roles, referral pathways, and a national supervision structure. • Adopt standardized father-inclusive mobilization language and male-engagement targets in national IYCF and Baby-Friendly Community guidance. • Champion community-based childcare and workplace breastfeeding accommodations for the informal and agricultural sectors, where existing maternity protections do not reach.
District Nutrition Coordination committees 	**Strengthen DNCCs to improve multisector nutrition programming** • Map and use existing care groups, women's organizations, faith platforms, local councils and community meetings rather than creating parallel committees. Include breastfeeding actions, coverage and follow-up in district nutrition workplans and review meetings. • Combine community mobilization, social and behaviour change, nutrition education, frontline health services, and district governance. Future investments should strengthen these interconnected systems creating an enabling environment where optimal breastfeeding can be sustained and scaled nationally.
Donors & Development Partner 	**Fund continuity, not one-off activity** • Prioritize multi-year financing for refresher training, supervision, and recognition of community-level cadres; peer counsellors who are highly effective early risk losing motivation without ongoing support. • Support formative, district-specific research on local breastfeeding myths before scale-up, rather than funding a single national message set: what works in Acholi may not work in Tooro.
Private Sector & Employers 	**Make workplaces part of the solution** • Extend breastfeeding-friendly practices, paid breaks, on-site or nearby childcare, and flexible market/trading hours for lactating women into agricultural cooperatives and informal-sector associations, not only formal workplaces.
Civil Society and Implementing Partners 	• When scaling to other districts, replicate the full package of peer counselling, father engagement, and demonstration rather than a single component in isolation; the evidence suggests it is the combination, not any one activity, that drives results. • Anchor new interventions in existing, trusted structures (VHTs, Local Council one Chairpersons (LC1),, Care Groups) rather than creating parallel committees, to accelerate uptake and reduce cost.

Priority Actions for Scale

Table 2 below outlines the priority actions for scaling the CASCADE approach, identifying the key interventions, the support required to implement them, and the measurable signals that would indicate successful scale.

Strengthen What Works	Support Required	Scale Signal
Breastfeeding champions and home visits	Training, supervision, referral links, basic transport/airtime	Every pregnant and lactating mother has a named community contact
Father and grandmother engagement (care giver support)	Male-peer mobilization, family dialogue tools, local leader endorsement	Households report concrete workload and feeding support
Integrated outreach and demonstrations	MIYCAN job aids, practical lactation skills, age-specific follow-up	Breastfeeding remains visible from birth to 24 months
Health-community linkage	Clear referral protocols and routine joint review	Complications are identified early and closed-loop referrals are documented

Conclusion

The findings from community experience shows that Uganda does not need to reinvent breastfeeding support; it needs to strengthen what is already working. Trusted peer counsellors, engaged fathers, practical demonstrations, and existing community structures form a proven, low-cost model for protecting breastfeeding from birth through the critical second year of life.

As Uganda and the global community mark World Breastfeeding Week 2026 under the theme “Strengthen What Works,” CASCADE's contribution is a clear, evidence-based pathway: recognize and resource community cadres, bring fathers in by design, pair every message with a demonstration, and follow mothers past the first birthday, not just past the first hour. Replicated with fidelity and backed by sustained investment, this model offers a genuinely scalable route to a sustainable start in life for children well beyond all districts in Uganda.

References

Food Rights Alliance, Africa Innovations Institute, & Kyenjojo Association of Women Development Actors. (2026). Structured partner field activity reports. CASCADE Uganda.

Kyambogo University, Department of Nutritional Science and Dietetics. (2025). Barrier analysis on the adoption of appropriate food production, access, preparation, and consumption practices among women of reproductive age and children under five years of age in six sub-regions of Uganda. Prepared for the CASCADE Project and UNICEF Uganda.

Uganda Bureau of Statistics, & ICF. (2024). Uganda Demographic and Health Survey 2022.

World Alliance for Breastfeeding Action. (2026). Breastfeeding: A sustainable start, strengthened by support.

World Health Organization. (2023). Exclusive breastfeeding for optimal growth, development and health.

World Health Organization, & UNICEF Uganda. (2025). Joint statement on World Breastfeeding Week.

Mirriam Atimango (standing right), a CASCADE staff, leads a food demonstration session at Mahani Health Centre in Rwamwanja Refugee Settlement equipping mothers and caregivers with practical knowledge on preparing nutritious meals to support optimal maternal, infant and young child nutrition alongside breastfeeding.

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