ORIE Nutrition Research in Northern Nigeria

Improved infant and young child feeding (IYCF): Lessons from the WINNN programme

Key messages

- **While political support for IYCF services has increased since baseline, more needs to be done to sustain and scale up the services** at health facilities and in communities.
- **Effective implementation of facility-based IYCF counselling requires considerable health worker time.** This is a challenge in the Nigerian context, given the inadequacy of human resources for health.
- **Engaging community leaders in IYCF counselling is critical** for both community acceptance of CVs' work and uptake of the IYCF recommendations.
- **A family-centred approach to IYCF,** including targeted messaging toward fathers and grandmothers, is important for achieving behavioural change.
- **Finding ways to reach adolescent mothers is especially important,** since they have particularly limited autonomy in infant feeding decisions in northern Nigeria.
- **Community members' fears about not giving water to infants is a key challenge for exclusive breastfeeding.** Further work is required to develop effective messages that address this concern.

Northern Nigeria has a high prevalence of child malnutrition, with around 10% of children (aged 6–59 months) acutely malnourished, one-third underweight, and over 50% stunted.[1] This brief summarises learning from an IYCF intervention implemented in three Local Government Areas (LGAs) in five states in northern Nigeria (Jigawa, Katsina, Kebbi, Zamfara and Yobe) with the support of the Working to Improve Nutrition in Northern Nigeria (WINNN) programme.[2]

WINNN increased the proportion of mothers who knew that:

5% It's OK to feed a young baby under six months whenever he/she wants

11% No water should be given to children under 6 months

14% more women knew that the baby should start breastfeeding immediately or within the first hour in focal than control LGAs at endline

WINNN promoted the integration of IYCF counselling into routine government primary health care (PHC) services, by supporting government planning, training, supportive supervision, and monitoring and evaluation. WINNN also trained community volunteers (CVs) to provide counselling in communities, promoted the development of legislation for IYCF services, and pursued advocacy to promote political commitment and public funding.

WINNN-supported IYCF counselling is provided to pregnant women and caregivers with a child under the age of two. It promotes the early initiation of breastfeeding (within 30 minutes of birth), exclusive breastfeeding for the first six months, and good breastfeeding techniques. For children over six months of age, mothers are educated on continued breastfeeding and the introduction of solid foods (complementary feeding), and are provided with food demonstrations using locally available foods. The counselling also promotes an adequate diet during pregnancy, good hygiene practices, and the use of antenatal care (ANC) services.

Context

At baseline, government officials in the WINNN focal states had fairly low appreciation of the need for IYCF services and saw it as a lower priority than other nutrition interventions, such as community management of acute malnutrition (CMAM). Only 17% of infants in Nigeria are exclusively breastfed during their first six months, and only 18% of children aged 6–23 months are fed a minimum acceptable diet.[3] Colostrum is commonly expressed and discarded for the first three to seven days after birth.

Key findings

There were positive trends in several IYCF indicators in the WINNN focal LGAs, from 2013 to 2016, including increases in the proportion of children breastfed within 24 hours of birth and exclusively breastfed, and the proportion of children with minimum dietary diversity.[4] This was underpinned by improvements in some aspects of mothers' IYCF knowledge. The evaluation found evidence that WINNN had an impact on mothers' knowledge about not giving water to children under six months and breastfeeding 'on demand', and on the practice of breastfeeding within 24 hours.

Despite some positive improvements in key knowledge and practices, overall levels of appropriate feeding behaviour remained low at endline. The qualitative evaluation identified difficulties affecting the translation of knowledge into practice. These included strong fears related to not giving water to babies, and the influence of older women and husbands over a mother's ability to adopt IYCF recommendations.

What worked well?

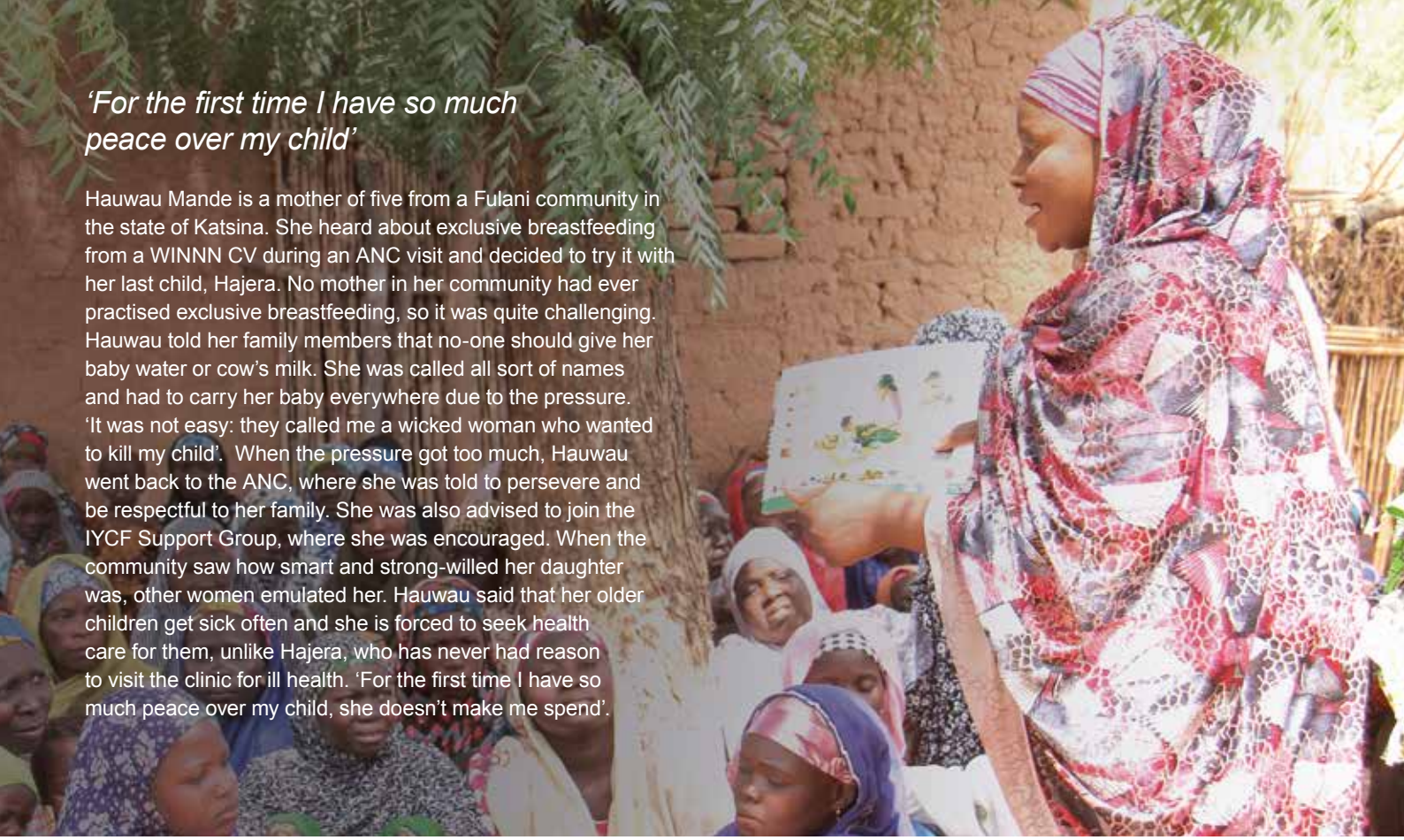
Advocacy promoting the importance and cost-effectiveness of preventing malnutrition led to increased political support for IYCF services in the WINNN-supported states. Engaging the wives of governors in IYCF events also raised the profile of appropriate IYCF. Three states moved from rhetoric toward concrete commitments, by approving or leveraging funds for the scale-up of IYCF services.

A harmonised national strategy for IYCF programming was developed by bringing together stakeholders from national, state and community levels to learn from different approaches. WINNN supported revision of the national Maternal, Infant and Young Child Nutrition (MIYCN) strategy and development of the national IYCF Social Behaviour Change Communication strategy through the National IYCF Task Force. This will help to improve the quality of IYCF programming at all levels.

WINNN has shown that IYCF counselling can be integrated into routine health services (Maternal, Newborn and Child Health Weeks, CMAM, ANC and postnatal care). Health workers widely appreciate the need to integrate IYCF promotion into routine services, and LGA staff and senior health officials are supportive of institutionalising the service. The qualitative research indicated that women usually trust the information provided at health facilities.

Community-based IYCF services can be rolled out on a large scale using CVs. A success factor in this regard was the development of gender-specific roles for female and male CVs, who provided counselling in community spaces. The establishment of supervision for CVs also strengthened the service by strengthening CV skills while also promoting community interest in IYCF. The supervision system links the community service into the PHC system and thus supports institutionalisation. WINNN's engagement of community leaders has been key to promoting community acceptance of the service.

If mothers' Support Groups are well targeted and regularly convened they can be a key space for counselling and peer support. Separate groups for adolescent mothers have helped to meet the specific needs of young mothers who have limited autonomy in child feeding decisions. In addition, WINNN-supported ceremonies to celebrate women who breastfeed exclusively



'For the first time I have so much peace over my child'

Hauwau Mande is a mother of five from a Fulani community in the state of Katsina. She heard about exclusive breastfeeding from a WINNN CV during an ANC visit and decided to try it with her last child, Hajera. No mother in her community had ever practised exclusive breastfeeding, so it was quite challenging. Hauwau told her family members that no-one should give her baby water or cow's milk. She was called all sort of names and had to carry her baby everywhere due to the pressure. 'It was not easy: they called me a wicked woman who wanted to kill my child'. When the pressure got too much, Hauwau went back to the ANC, where she was told to persevere and be respectful to her family. She was also advised to join the IYCF Support Group, where she was encouraged. When the community saw how smart and strong-willed her daughter was, other women emulated her. Hauwau said that her older children get sick often and she is forced to seek health care for them, unlike Hajera, who has never had reason to visit the clinic for ill health. 'For the first time I have so much peace over my child, she doesn't make me spend'.

for six months have helped to raise the profile of exclusive breastfeeding, and provided an incentive to breastfeeding mothers.

The sensitisation of fathers has been key. When men are convinced of the benefits of recommended IYCF practices they are more likely to support their wives, and may also persuade older women in the house to support those practices. Counselling for fathers promoted the Qur'anic teaching that men are responsible for family health, and emphasised the importance of nutrition for child health. The fathers' IYCF Support Groups, convened toward the end of the programme, have helped to promote male support for IYCF.

What more needs to be done?

While political support and public funding for IYCF services have increased since baseline, more needs to be done to sustain and scale up the services at health facilities and in communities. Ongoing advocacy regarding the importance of preventative measures will be important. ORIE evidence showing the cost-effectiveness of the WINNN-supported IYCF intervention (cost per disability adjusted life-years (DALYs) averted of £19 (US$30)[5] and cost per life saved of £706 (US$1,102) per life saved) can be used to support advocacy.

A key challenge for facility-based IYCF services has been the inadequacy of human resources for health. In busy CMAM and ANC sites, the services are often provided by CVs rather than health workers. This is a challenge for full institutionalisation. Human resource constraints also mean that IYCF counselling in facilities is often provided to large groups of women, or takes the form of very brief sessions, which are less likely to be effective.

There is a need for further development of the CV support model. CVs receive no financial incentives or reimbursement of expenses and there were signs of dwindling CV motivation in some communities at endline. Government officials and WINNN staff reported that CVs continue to anticipate financial incentives, and they see this as a key concern for the longer-term sustainability of IYCF services.

Fears that infants under six months of age will dehydrate and possibly die without water remain a key challenge. There is a need for further research on strategies and messages that work to intervene in relation to this fear and enable exclusive breastfeeding.

The evaluation found relatively limited improvement in complementary feeding practices in the focal LGAs. **Qualitative research found that mothers did not understand the concept of food groups, and that the availability and affordability of key foods were important barriers,** particularly for poorer households. WINNN supported the development of recipes

that use locally available foods, and has recently commenced food demonstrations. Since men often purchase household food, targeted sensitisation of fathers is also important.

The evaluation suggested that **adolescent, poorer and less educated mothers were less likely to attend community IYCF counselling and to practice early initiation and exclusive breastfeeding.** For adolescent mothers, this is affected by their weak mobility and decision-making power. Support Groups for adolescents and the Care Group model being piloted by WINNN, in which mother leaders in each neighbourhood work with all household members to promote dialogue and understanding, may help to reduce barriers amongst these women. **The evaluation also indicated the need to develop targeted communication strategies for grandmothers, who are very influential in child feeding decisions.**

References

[1]National Nutrition and Health Survey (NNHS) 2015. [2]WINNN is a six-year programme (2011–2017) funded by the UK Department for International Development. The Operational Research and Impact Evaluation (ORIE) project is a separate component of the programme, undertaking independent research around, and evaluation of, WINNN. The project is undertaken by a consortium led by Oxford Policy Management. This brief draws on evidence collected between 2013 and 2016. [3]A minimum acceptable diet is a combination of age-appropriate meal frequency and dietary diversity (see next footnote, on dietary diversity). [4]Children who receive food from four or more food groups. [5]This is well within the World Health Organization (WHO) threshold for cost-effectiveness (www.who.int/choice/costs/CER_levels/en/) Cost per DALY averted and per life saved are incremental cost-effectiveness ratios from a societal perspective. ORIE calculations have been converted from US dollars to British pounds using the average of representative rates for September 2011 to August 2016 (Source: IMF).

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