Infant and Young Child Nutrition in Northern Uganda:

Informing the Design of a Behaviour Change Communication Strategy in a Community-based Nutrition Program- the case of Kitgum and Pader districts

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ACKNOWLEDGEMENT

This report would not have been possible without the contribution of various people. The reported is a joint product of the International Medical Corps (IMC), Mercy Corps (MC) in Uganda and the Food and Nutrition Technical Assistance II (FANTA-2) project managed by AED. Financial support was provided by USAID/Uganda. The report was based on results of a formative research conducted by the two programs in Kitgum and Pader Districts of northern Uganda. Members of the formative research team included Dr. Elialilia Okello (of Makerere University Department of Psychiatry) and Mr. Gad Ruzaaza (of Mbarara University of Science and Technology) who were the main consultants. Other research members included Ms. Brenda Shenute Namugumya (of Regional Centre for Quality of Health Care), Richard Kajura and Samuel Onegi (International Medical Corps). Comments were also received from team from Mercy Corps headed by Darius Radcliffe, the country director.

Technical input in design of the methodology and review were provided by Kavita Sethuraman and Robert Mwadime, FANTA-2 and Ms. Brenda Shenute, who also coordinated the activity.

This report is made possible by the generous support of the American people through the support of the United States Agency for International Development (USAID), through the Food and Nutrition Technical Assistance II Project (FANTA-2), managed by AED and Mercy Corps.

The contents are the responsibility of AED, IMC and Mercy Corps and do not necessarily reflect the views of USAID or the United States Government.

Published March 2010

ACRONYMS

AIDS	Acquired Immune Deficiency Syndromme
BCC	Behaviour Change Communication
CHWs	Community Health Workers
FGDs	Focus Group Discussions
HC	Health Centre
HIV	Human Immune Virus
HO	Health Officers
IDPs	Internally Displaced Persons
IGAs	Income Generating Activities
IMC	International Medical Corps
IYCF	Infant and Young Child Feeding
KII	Key Informant Interviews
LRA	Lords' Resistance Army
MUAC	Mid Upper Arm Circumferences
MYAP	Multi-Year Assistance Program
NGO	Non-Government Organizations
ORS	Oral Rehydration Salts
RTI	Respiratory Tract Infections
SBCC	Social and Behavior Change Communication
SSIs	Semi Structured Interviews
TFC	Therapeutic Feeding Centres
TIPs	Trials of Improved Practices
UDHS	Uganda Bureau of Statistics
UNICEF	United Nations Children's Fund
VAM	Vulnerability Assessment Mapping
VHTs	Village Health Teams
WFP	World Food Programme

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1 INTRODUCTION AND BACKGROUND

1.1 Introduction

This formative research was conducted to inform the design of a district-wide community-based nutrition program to reduce under-nutrition among women and children in two districts – Pader and Kitgum in northern Uganda. The research was undertaken by the Food and Nutrition Technical Assistance II (FANTA-2/AED) Project in partnership with International Medical Corps (IMC) that is currently implementing a PL480 Title II multi-year assistance program (MYAP) in partnership with Mercy Corps, funded by the United States Agency for International Development (USAID).

1.2 Background

For many years Northern Uganda was mired in conflict, and as of 2006, this region has experienced relative peace and stability. However for families and communities in the north, the transition of returning from internally displaced persons (IDPs) camps to resettle in their native villages continues to be slow. The challenge in this region is that with the advent of stability, many non-government organizations (NGOs) that were providing emergency services and food aid have pulled out of the region. By many accounts the withdrawal of emergency aid was swift, and this has left many communities struggling to meet their basic needs. Fundamentally, we understand little of the time needed and the nature of the transition for families and communities to move from IDP settlements to their native villages. Recent research in northern Uganda highlights the reality that many families face, returning to their native villages that have been destroyed, and with few amenities or infrastructure, many families are at various points along a continuum. Some have resettled, while others have established homesteads midway between their native villages and IDP camps, and other have yet to leave IDP camps. For those observing from outside, it seems as though a mentality of dependency has settled in that serves as a disincentive for people to return to their homesteads. But in fact the ground reality is more complex. Families lack income and resources to meet their daily needs. Food insecurity is extremely high, and aid programming in this context is a challenge.

The most recent DHS (UDHS, 2006) and vulnerability assessment (VAM) surveys (2006) find that malnutrition and food insecurity are the highest in northern Uganda. While previous surveys were not able to be representative of the northern region as a whole, it is clear that the prevalence of malnutrition in this region has consistently been the highest in the country, and progress continues to be slow. Malnutrition in the northern region is therefore a consequence of poverty, insecurity, food insecurity, and a lack of infrastructure and access to health services in addition to poor infant and young child feeding and care practices.

The purpose of the study was inform the development of a behavioural change communication (BCC) strategy in implementation of the IMC Healthy practices, healthy practices strong communities nutrition and health program. This report presents the findings of the formative research undertaken in the Pader and Kitgum districts of northern Uganda. Towards the end of the document based on the findings, the report identifies key messages, behaviors, perceptions and constraints and recommends a social and behavior change communication (SBCC) approach that should be implemented in tandem with complementary interventions and support services.

1.3 Objectives

The purpose of the study was to inform the design of a community-based nutrition program to reduce under-nutrition among women and children in Pader and Kitgum Districts in northern Uganda.

1.3.1. Specific objectives

- To identify the socio-cultural factors that affect maternal and child nutrition in Pader and Kitgum Districts
- To assess the knowledge, attitudes and practices concerning maternal and child nutrition in Pader and Kitgum Districts
- To assess the community perception of malnutrition as a problem in Pader and Kitgum Districts
- To assess the community perception of food security, food production, livelihoods, and income sources in Pader and Kitgum Districts
- To recommend a package of interventions and services needed to reduce under-nutrition among women and children in Pader and Kitgum Districts

2 Methodology

The study covered several maternal and child nutrition-related themes. Under each of broad themes, the study addressed the following specific themes:

- Community perceptions of: a) existing services and prioritization of needs, b) malnutrition, its perceived causes and consequences, c) food security; d) livelihood opportunities and income sources;
- Infant feeding practices particularly: a) exclusive breastfeeding and complementary feeding practices; and b) care of infant and mother;
- Management of malnutrition and illness particularly *child morbidity* and h*ealth-care seeking behavior*
- Maternal nutrition and gender considerations
- Social transitions, social networks and social capital
- Male involvement and role of/influence of grandmothers and other key family members

2.1 Study conceptual framework

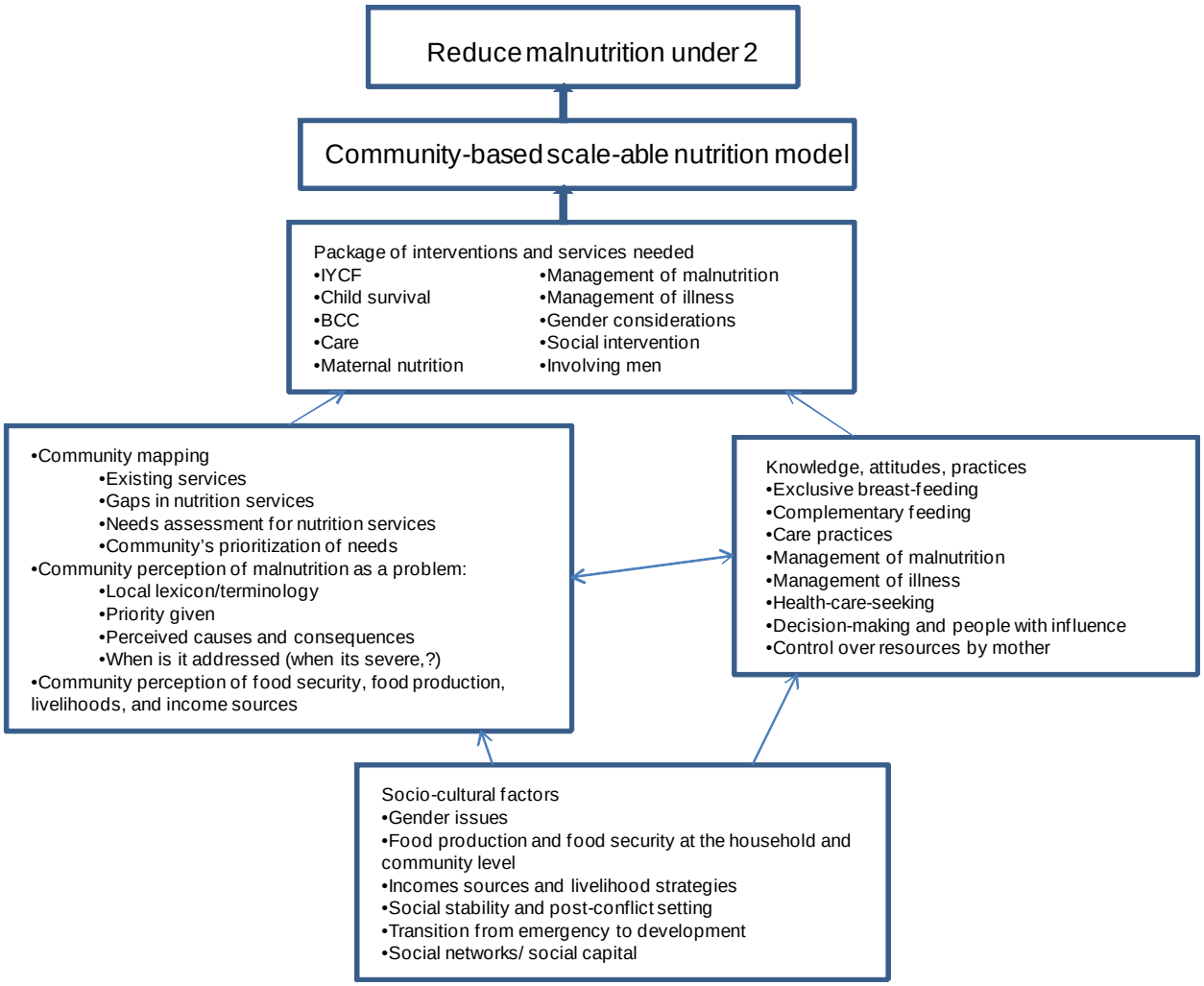

Figure 1: The study conceptual framework

2.2 Study sites

The study covered two districts, Pader and Kitgum that are largely similar socio-culturally and suggested that few study sites would suffice for the purpose of data collection because more data collection sites will not necessarily give more information. International Medical Corps (IMC)[1] operates in 4 sub-counties in Kitgum District and 2 sub-counties in Pader District and data collection was undertaken in the six sub-counties. The study sample included: health facility officials, community health workers, community leaders, mothers of children aged 0-6 months, mothers of children aged 7-23 months, fathers of children aged 0-6 months, fathers of children aged 7-23 months, grandmothers of children aged 0-23 months.

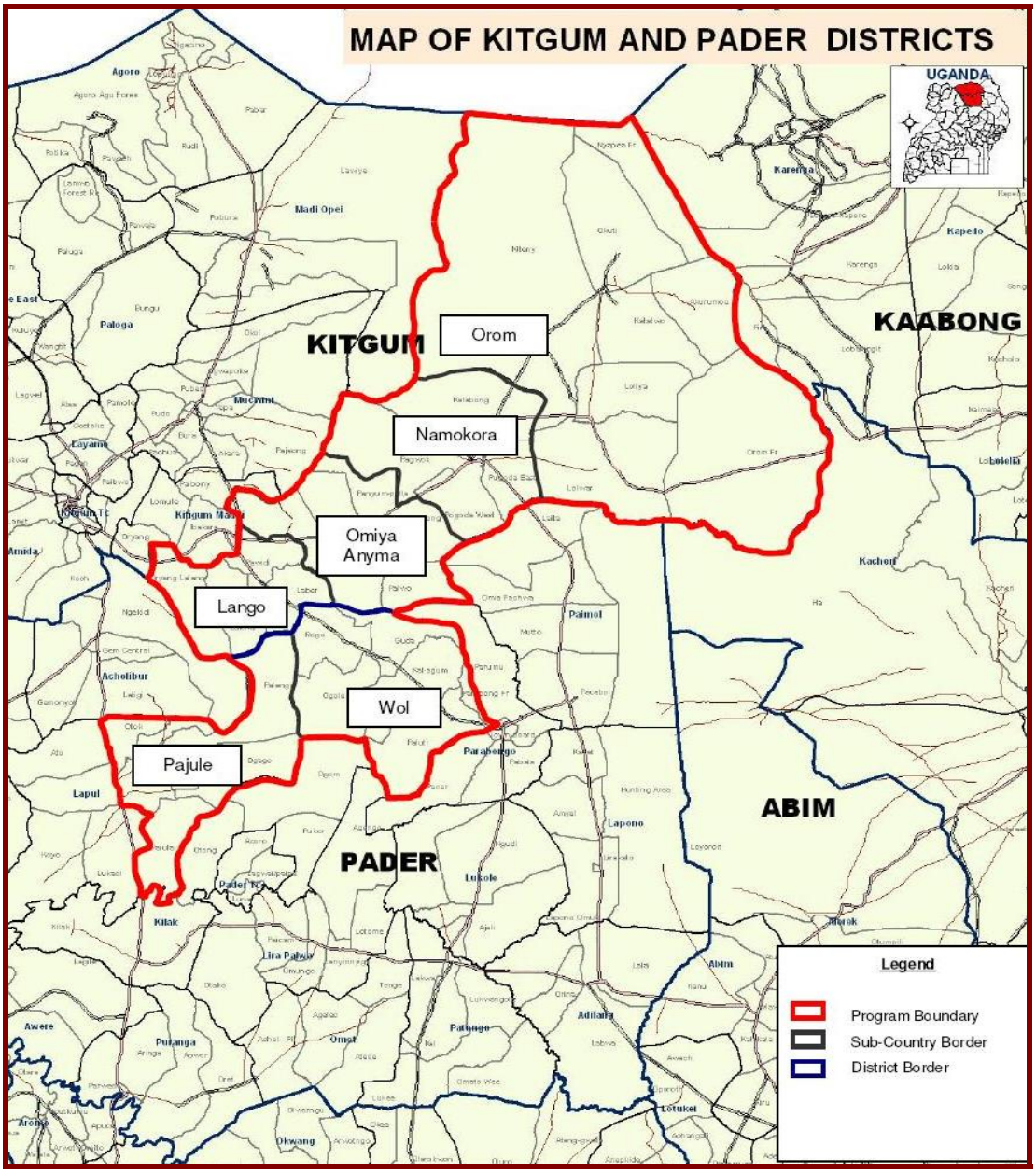

Figure 2: Map indicating the IMC activity subcounties in Kitgum and Pader at the time of the study

[1] IMC is the implementing partner for health and nutrition programs under the Healthy practices, Strong communities program.

2.3 Study methods

The study used qualitative methods of data collection. Convenience and purposive sampling methods were used to select study participants. Methods of data collection included focus group discussions (FGDs), key-informant interviews (KII), semi-structured interviews, and observations of infant feeding. Table 1 presents the study sample and data collection methods. A total of five FGDs were conducted. Three of the FGDs were conducted in Kitgum while two FGDs were conducted in Pader. An FGD was conducted in all but one sub-county. The size of a focus group ranged from 10 to 12 participants. Each focus group session lasted between one to two hours. Each FGD was be led by moderator assisted by a note taker. All FGDs and interviews were tape recorded. Oral informed consent was obtained from all study participants.

Table 1: Summary of data sources by data collection method

Method	Informant						
	HO	CHWs	Leaders	Mothers of children aged 0-6 months:	Mothers of children aged 6-23monthss:	Fathers	Grandmothers
KII	3	3	3				
Mapping		2	2	1		1	
FGD			1	2		1	1
SSI				16	16	8	8
Observations				6	6		

Data quality was ensured by:

- Recruitment of research assistants were male and female university graduates of nutrition, social sciences and related disciplines, with some experience in participatory data collection methods. Only individuals who were fluent in the Acholi language were recruited.
- Research assistants were trained during a four-day workshop. The first three days covered: introduction to the study objectives, sampling strategy, data collection tools, as well as training on qualitative interviewing skills through role playing/mock interviews. The fourth day of the workshop pre-tested the study tools in one of the sub-counties near Kitgum Town but outside the designated study areas.
- Field teams communicated and debriefed regularly to compare findings
- Research assistants were closely supervised through spot-checks and observation of interviews
- Data transcription, translation and preliminary analysis started immediately following the first field visits. This provided an opportunity to improve subsequent interviews

2.4 Data management, coding and analysis

The data was transcribed, translated, and cleaned. The recorded interviews were transcribed and merged with field notes to make final transcripts. Transcription began during data collection to enable supervisors to check the data and make corrections in a timely manner. Three assistants were trained to transcribe, translate and merge the data while the lead researcher supervised the process and did the data cleaning.

The cleaned data were coded using Atlas.Ti, a qualitative analysis software used for coding and analysis The process of data coding started with two lead researchers reading several transcripts independently and coming up with codes for different pieces of data. The researchers then met and discussed and agreed on the codes and developed a code list and code definitions. The researchers discussed the codes and code definitions with the coding team. The coding team was trained on how to code the data. Intercoder reliability was ensured by pairing coders to code the same transcripts, and sharing and discussing discrepancies in coding. This step ensured a common understanding of the code guide. The researchers coded some of the data and the coding team coded the rest of the data under supervision.

A data analysis plan was developed to guide analysis. The data analysis process involved identifying broad themes from the data and attaching different codes to these broad themes. These broad themes and codes were used to retrieve different segments of the data. Data analysis started with writing memos on the different segments of the retrieved data. For each theme the various types of data collected were compared and contrasted, to identify patterns and the range of variation in the data.

3 FINDINGS

Five themes emerged from the qualitative data: infant and young child feeding practices, malnutrition, and disease management; health infrastructure and services; rebuilding livelihoods; and social cohesion. This findings section is structured to highlight the infant and young child feeding practices. However, across the data it is clear that malnutrition and IYCF need to be considered carefully within the broader context. In terms of social cohesion, informants repeatedly indicated that the conflict in the north destroyed their traditional way of life, and as a result of having to live in camps, much of how families and communities interacted with each other was lost. In the past families and communities shared resources and supported each other. There was also a clear social hierarchy and social mores that guided families and communities. Now, informants reported how they are trying to reclaim their lost traditions. But significant changes persist in how people, young and old, interact with each other. The loss of this social fabric has also undermined the process of rebuilding livelihoods. Families lost access to traditional farm lands, and even when these lands are available for farming, the land still needs to be cleared to grow crops. In addition, men and women have access to few opportunities for income generation, and the basic infrastructure with functioning markets is absent. To compound this reality, the recent drought and the withdrawal of emergency food aid has left families highly food insecure. It is against this backdrop that infant and young child feeding practices and nutrition and health promotion for mothers and children will need to be implemented.

3.1 Knowledge, constraints, and perceptions about infant and young child feeding practices

Across the data, there are a range of infant and young child feeding practices. A few mothers know and practice exclusively breastfeeding for six months followed by the appropriate introduction of complementary foods. But many mothers for a variety of reasons are not exclusively breastfeeding. Some mothers do not feed their children colostrums, some offer pre-lacteal feeds in the form of sugar water, and some delay breastfeeding initiation ranging from a few hours up to three days. Similiarly, for complementary feeding, some introduce other foods and fluids early, others introduce foods late, and for the most part nutrient density and diet diversity are low for infant feeding. It is clear across the data, from mothers, fathers, grandmothers and the community at large that many do not have the knowledge of what appropriate infant feeding practices are at each stage. In addition, many mothers face significant constraints in terms of lack of time, resources, and support to adopt improved behaviors. Mothers, fathers, grandmothers, and community members have varying perceptions on infant and young child feeding practices. But there is a lot of variation in these perceptions and this suggests that not everyone has the same perspective on infant feeding. Moreover these perceptions do not appear to be deeply held beliefs; as such these perceptions are likely amenable to change. The time is ripe to have a common platform for behavior change that all families, communities, and health providers can learn from so that everyone will ultimately speak the same language when it comes to infant and young child feeding practices. The major challenge however is to enable behavior change in a setting that is so resource poor. As the data will show, in fact perceptions of IYCF practices while varied form the smaller part of the problem of poor IYCF practices. The greater challenge is identifying how IMC and its partners can strengthen the enabling environment so that mothers get both the support and resources to be able to adopt appropriate feeding behaviors.

3.1.1 Exclusive breastfeeding

As mentioned above, a few mothers reported exclusively breastfeeding. But many others did not exclusively breastfeed, and the most common reason was mothers' perception that they had insufficient milk. Because of this perception, mothers often introduced other foods and fluids early.

3.1.1.1 Initiation of breast feeding

Many mothers reported that they initiated breastfeeding within an hour of birth while others reported that they delayed breastfeeding initiation. Delayed initiation could be for a variety of reasons including delivery complications, advice from the traditional birth attendant or family member present at delivery to delay initiation, the perception of not having milk or that colostrums was bad for the baby. Many mothers are also aware that infants should not be given pre-lacteals partly because of the sensitization that has been taking place in the community to enhance the mothers' knowledge about breast feeding. However, in practice, many mothers give pre-lacteals to their newborns such as sugar solution, glucose water and olel (pasted sauce) three or four days after birth during the naming ceremony . Mothers reported that they gave pre-lacteals when they were advised to do so or they perceived that their milk had not yet come in, and most reported giving sugar dissolved in warm water:

> *"I gave the baby one tea spoon of sugar in water at a time… and I was told after three days to try him on the breast since there was some breast milk then… That is how the baby started on breast milk; but he suffered living on water and sugar for three good days"* (**Mother in Kadinga Village, Wol, Pader district)**

Often the traditional birth attendant, family member, or health provider would be the ones to give infants pre-lacteal feeds in the period immediately after delivery.

Discarding colostrums was not mentioned by many as a common practice. In fact, very few mothers reported discarding colostrums:

> *"I did not offer that [colostrum]. It was all expressed out and you know it was yellowish in colod and I felt no need in giving it to the baby because I believe it is not good for the baby and can cause sickness for the baby. So I did not give him."* **(Mother in Kadinga village, Lagoro, Pader district)**

The range of variation in breastfeeding initation suggests that some mothers are convinced that nursing their children immediately after birth is best and while others do not understand that nursing immediately after birth can help precipitate and establish a mother's milk supply. In addition, health providers and other community and family members often provide mothers with the wrong advice that results in delayed breastfeeding and the introduction of pre-lacteals. This highlights that fact that behavior change communication needs to target more than just mothers, and that health providers, including traditional birth attendants, and families need to understand the need for early initiation.

3.1.1.2 Length of exclusive breast feeding (including facilitating factors and barriers)

A majority of mothers reported breastfeeding their children for more than six months. Some mothers said that they have been taught that exclusive breastfeeding enhances the health of the baby and that the introduction of solid foods when the baby is below six months can cause illness such as diarrhea; and that before six months the child's stomach and the baby's system are not yet strong enough to handle solid food. However, exclusive breast feeding is not as common as desired for a variety of reasons. Some mothers begin supplementary feeding earlier than recommended because they perceive they are not able to produce

sufficient breast milk, which they largely attributed to lack of food. But it is also likely that mother's heavy workload and lack of time also undermine breastfeeding on demand. And missing feedings frequently during the first six months can also reduce a mother's milk supply. One other important factor that is likely implicated is poor positioning and attachment for breastfeeding which if not resolved in the early weeks can undermine breastmilk supply. Other mothers begin supplementary feeding early (e.g. at three months) because they believe that exclusive breast feeding weakens the child. The most common explanation provided however for early introduction of other foods or fluids was the lack of enough breast milk:

> *"I stopped exclusively breastfeeding when I did not have enough breastmilk after one month of feeding the baby only on breastmilk. I lack enough food that would increase breast milk and there was nothing I could do apart from giving him some porridge to supplement on the breastmilk. Also, my family members did introduce the child to taking some fluids like porridge. This was whenever I was not there with the child, and then the babysitters would give the baby some porridge whenever he was crying." Mother in Adak villager, Lagoro, Pader district.*

> *"I did not have enough breast milk by the time the baby made one month… I would dissolve some sugar in water and give to her. At about three months, since I still did not have enough milk, I started giving some little and light porridge; …but when she reached six months I started giving her enough porridge, still supplemented with breast milk"* **(Mother in Bolo village, Lagoro, Pader district**).

Some mothers also reported that their poor health prompted early cessation of exclusive breast feeding because they perceive they do not have the necessary energy and milk. Pregnancy when a mother is breastfeeding was often cited as a common reason to stop exclusive breastfeeding or breastfeeding altogether. Others stated that their child's poor health precipitated the introduction of other fluids such as sugar water, or the introduction of ORS to manage diarrhea then precipitated the use of other foods and liquids:
"I gave him breast milk immediately after birth and he suckled properly. After a week, the baby fell sick; he had a swollen throat and fever and I took him to the health centre… I was advised by the health workers there that I should dissolve some sugar in water and give to the baby; … that sugar solution would help give strength to the baby. I did that and after some few days, the baby recovered and gained strength and he started even breastfeeding normally" (**Mother in Kudeta Village, Wol, Pader district).**

> *"I was given medicine called ORS and that I should mix it in water. I told them … I have never given her water… I was told to give her very little because she lacked water in her body, yet there was no drip in the health centre… I came back home and followed their instructions…she liked it… I started giving her water. I would give her whenever she wanted… When she reached six months old, I started making for her some porridge"* (**Mother in Atem Village, Lagoro, Pader district**).

Some mothers also reported that health providers advised them that exclusive breastfeeding was needed for three months, indicating that at the provider level there is lack of knowledge and consensus on IYCF practices.

Fathers however, perceived that mothers needed adequate food to ensure sufficient milk supply, but at the same time they were not clear on the definition of exclusive breastfeeding or the length of time for which mothers should exclusively breastfeed. Some perceived exclusive breastfeeding should continue for up to a year, others thought three months was enough:

"I know that the mother needs to eat well first so as to provide enough breastmilk for the child…From birth to first year the child should be exclusively breastfed." (Father, Omiya anyima, Kitgum district)

"…What I can do as a man in the house is to provide enough food for the family such that the mother eats well and in the end gets enough breastmilk to feed the baby." (Father, Omiya anyima, Kitgum district)

Men widely felt that infant and young child was a mothers' realm and they did not feel they had a role in IYCF, they perceived their primary role as providing for mothers so they could adequately breastfeed.

3.1.2 Complementary feeding

3.1.2.1 Age of introduction of complementary foods

There is considerable variation in the data as to when infants are introduced to foods and fluids other than breastmilk. As noted above, many introduced water and dilute millet porridge to very young infants, some as early as three months. Many also started solid foods at the appropriate age of six months, while yet others introduced solids at ages older than six months (some as late as nine months). Regardless of the age from six months when complementary foods are introduced, the main issues appear to be low diet diversity, nutrient density, quantity, and frequency of feeding. Foods that are prepared for children come from what is prepared for the rest of the family, but the foods offered are often more diluted and not as nutrient dense. The broader issue however, is that families, themselves have very little diet diversity or nutrient density in their diets, so by extension infants diets are similar to that of their families.

While mothers, fathers, and grandmothers had perceptions of breastfeeding and when complementary foods should be introduced, they had much less knowledge on the dietary needs of infants from the standpoint of increasing calories over time, increasing diet diversity and nutrient density, and how the consistency of foods or even frequency of feeding should change over time. This suggests that they have not had an opportunity to learn, beyond the key messages of exclusively breastfeed for six months, and introduce complementary foods at six months, what complementary feeding consists of and how this needs to change over time.

In addition there is little understanding of looking for signs of readiness of when to let a child self-feed or being persistent with starting solid foods or trying new foods if a child refuses certain foods. There is also not the understanding that missing milestones of readiness can also make it more difficult for parents to introduce solids or new foods as children assert their independence as they get older.

The most common first foods are millet porridge, with gradual progression to *lacede* (small fish) soup, bean soup, *boo* (green vegetable) soup, and corn meal. Salt is added to the soups and is believed to good for the health of the baby. When sesame and ground nuts are available they are made into a paste and added to a child's meal, however with the drought this was not available regularly for children, as in the past. Over time, infants aged 6-12 months are gradually introduced to the foods the family eats, informants reported no special foods were usually prepared for infants. However the frequency of feeding, how the child is fed, the consistency and quantity of food all vary across households. And it is likely that parents have little knowledge of how or when to increase the quantity, quality, or frequency of food.

Observation data suggest that there are mixed perceptions on how to feed an infant aged 6-23 months. In some instances many younger infants aged seven to nine months were left alone with a plate of food to feed themselves while their mothers were elsewhere doing work. The challenge for mothers with many competing tasks such as farming and child care is having sufficient time to feed a young child frequently. As a result, many young children were left to feed themselves. Only in a few instances did mothers stay close to their children and encourage them to feed themselves. This suggests that mothers do not know what responsive feeding is. And with many other children to attend to, they are unable to dedicate the time needed to feed young children adequately.

Food safety is also a concern as many mothers reported keeping leftovers from the previous night and reheating it for their children the next day. Considering the lack of hygiene and access to safe water, it is likely that this practice may increase the risk of infection and diarrhea in young children. And this appears to be a particularly widespread practice.

3.1.2.2 Good infant feeding practices

Across the data several good infant feeding practices are apparent:

- Many mothers offer their infants colostrums, because they know its nutritive value, and they received information from health providers to do so and they follow through on this advice, however this is not consistently practiced by all mothers
- Infants are usually breastfed on demand throughout the day and night
- When available simsim paste or ground nut paste are added to an infant's meal
- Many mothers continue breastfeeding even after they have introduced complementary foods, up until the child is two years of age
- Some mothers try to keep the water safe by adding "water guard"
- Many mothers try to feed their children themselves, to ensure their child eats well
- Many mothers try to ensure that their young infants are always with them, by carrying them to their farm, or instructing older children or caregivers to bring her child to her promptly when he/she cries to be breastfed

Work, especially garden work interferes with breast feeding. Nevertheless, mothers try to mitigate this. Some mothers go with the babies to the gardens so that they can breast feed them as often as needed. In case the mother is working far from home and her baby is not with her, she tries to make up for missed feedings by feeding the child frequently before leaving home and upon return home. *"When I return from the garden, the first thing I do is to breast feed him. Before I leave for the garden I breastfeed him; and as I am preparing food for the family, I give him the breast. I make sure he breastfeeds before I finish grinding the sorghum"* (Mother in Kudeta Village, Wol, Pader district).

Many mothers breast feed their children too infrequently both during the day and at night. Farming away from home is the main factor during the day. At night on the other hand, some women reported being unable to wake up to breastfeed their children.

3.1.3 Support provided to mothers for breastfeeding and complementary feeding

Across the data, grandmothers are seen as having a positive influence on mothers and an overwhelming majority of mothers regarded their interactions with grandmothers on IYCF practices as positive. In addition, some grandmothers who have had access to good health information also report a basic understanding of appropriate IYCF practices. The support grandmothers provide mostly takes the form of advice they give to their daughters-in-law, such as upholding child spacing and avoiding early pregnancy to prolong lactation, which they believed also helps to mitigate malnutrition in children. There is a strong belief in the region

that early pregnancy is a major factor in infant and young child malnutrition. Grandmothers also provide advice on feeding, health seeking and general care for children. If she has a garden or can buy food, a grand mother can give food to the daughter-in-law to cook for the grandchildren:

> *"…On a market day when we have some money, I also go and buy "lacede" (small fish) and make sure the mother prepares it for the child and that the child eats….That is what I do for the children"* (**Grandmother, FGD participant, Wol, Pader district)**

Grand mothers also take care of their grandchildren, providing mothers with support, including carrying, playing with, and feeding the baby. At times a grandmother can sometimes take full custody of a grandchild if she feels her daughter-in-law is too busy, especially in situations of frequent child births and poor health of the mother. But, perhaps more influential than grandmothers, is the support mothers get from fathers, that varies considerably in the data. One mother reported:

"What helped me mostly in following the advice was my husband who stood by me and firmly encouraged me to do as I was instructed. He supported me a lot by providing for my needs especially buying good food to help me increase my milk for the baby" (Mother, FGD participant, Orom, Kitgum district)

While many other mothers report receiving no support from their husbands. Fathers also perceive their role in supporting their wives to breastfeed as providing enough food for mothers to eat to have a good milk supply. Many felt this was an important responsibility they needed fulfill, but they felt challenged given the prevailing circumstances of poverty and food insecurity.

"I am satisfied that I am trying my level best to ensure that my family is provided for. But things are very difficult because of poverty and drought…What brings me happiness is when the entire family members are healthy and this comes about when they have enough food to eat and that comes as a result of successful farming." (Father, SSI, Namokora, Kitgum district)

It is important to note however that in many families in the study sample there are no grandmothers as they died during the conflict, and many fathers are absent also, leaving mothers to fend for themselves with little support or access to resources – and this trend exacerbates the problem of malnutrition in this region. In cases where grandmothers are near or with families, they themselves reported that they lack the resources, financial or otherwise to support mothers.

3.1.4 Decision making about infant feeding

Across the mothers and fathers interview data, there is a continuum, with some couples cooperating and deciding together on the needs of their child, while at the other end of the spectrum fathers are absent altogether. Among households where fathers are present, there is variation in the extent of cooperation between couples. In households where there is more cooperation, it appears that there is greater consensus on meeting a mother's and child's needs despite the prevailing resource constraints. Whereas in households where cooperation is low, it appears to be more difficult to meet mothers and children's needs.

Some couples discuss together how to feed the baby as soon as he/she is born. The father openly indicates that taking care of the children is a joint responsibility for the couple. Such couples discuss the child's health and feeding and they also do the family's financial and material resource budgeting together; the decisions are mutually arrived at. Some fathers are

responsible and supportive with regard to child care. Such a father plays with the baby, carries the baby around, feeds the baby when food is ready, buys for the children some snacks when he goes to the market, endeavors to bond with the children as a father, advises the mother to take the child to the hospital in case of illness, provides transport for the mother and child to go to hospital, provides the basic necessities for the mother and child, and works with the mother in the garden.

On the other hand, many men are not supportive to their wives with regard to child care and child feeding. Some men openly declare that they have nothing to do with the feeding of their children, leaving it entirely to the mothers even when it is evident that the mothers are struggling. They do not help to feed the baby; they do show concern whether the children are sick or hungry; they consider child feeding to be a dirty job that is not suitable for a man but for the mother; they do not support schooling for older children; they do not buy the basic household needs like salt and soap; and they do not support the mothers in seeking health care for the children. The relationship between the couple concerning child care and feeding is characterized by remarks such as: *"find what they will eat, I have nothing to do for the children", "they are your children", "the baby will make me dirty with her food",* and *"take your child to the hospital if she is sick; don't disturb me"*. Alcoholism and polygamy are also common in such relationships:

> *"Just imagine somebody leaving you alone with the responsibility of taking care of six children with no resources… There is no help he is giving me. He runs away incase there are problems here… to the other wife of his …. At times he stays there for even two months without thinking about his children here…whether they are sick, or they have eaten or not. He gives all the help to his other family"* (**Mother in Atem Village, Lagoro, Pader district)**.

In many cases, men and women share responsibilities and control of household resources. However, the dominant pattern is that the women control the home-maker resources such as food crops in the garden, food in the granary, and the kitchen with its food, tools and utensils. Men on the other hand largely control the valuable household resources such as land, furniture and livestock. However, in many of the households, income from the resources is usually used for the benefit of all the household members in terms of school fees, school uniform, and health concerns. But it is also clear that some mothers are resigned to the fact that in reality men control all the household resources, revealing the gender bias that persists: *"In the real sense the man controls everything in the home including me. He has overall say over me as his wife and I ought to listen to him when he speaks"* (Woman in Bolo village, Lagoro, Pader district).

3.1.5 Barriers to good infant feeding practices

Food aid that used to be distributed to the people in the camps was suddenly stopped as people transitioned from the IDP camps to their homes of origin. The area also experienced a long drought to which the farmers lost virtually all their crops. These led to a decline in both the quantity and quality of food available to households According to some of the study participants, most mothers are aware that they are supposed to exclusively breast feed for six months but circumstances drive them to contrary behaviors.

> *"One of the problems I have is of getting sugar; no proper food and at times no breast milk for the baby. We only have same type of food here – mostly green vegetables like malakwang… and sometimes I eat food without salt… It is not good food really"* (**Mother in Kadinga Village, Wol, Pader district).**

> *"I did not have breast milk... until after three days… the baby suffered and could cry all the time… I really don't know why there was such a problem with this child. For the rest of the children, I have been having enough breast milk"* **(Mother in Kadinga Village_Wol, Pader district).**

After introduction of the complementary foods, many mothers are not able to provide the right kind of foods for the children. Some children also refuse certain foods and mothers are not sure what to do to get the child to eat: *"He sometimes refuses to eat all green vegetables; he wants only good food that I cannot afford"* **(Mother in Kudeta Village, Wol, Pader district).**

When a family member or child falls ill, resources are usually diverted to buy medicines, and this affects food availability in the household and by default what is available for a child to eat. Many mothers have limited income and are unable to buy the necessities such as food, salt and sugar, toiletries, domestic utensils, and clothes for their young children and families. Many women are overworked so they have little time to care for and feed their children, and with each mother having many children, their ability to provide optimum care is extremely limited. As a result some children eat too infrequently. Water shortages in the home are a significant strain for mothers who have to walk up to two miles to get to the nearest water source. Some mothers are in poor health. Many mothers also have few inputs for agriculture and as a result their crop yields are low. Pregnancy while a mother is breastfeeding commonly leads to breastfeeding cessation. The LRA insurgency in the region and raids by the Karimajong worriers claimed the lives of many men, leaving behind many widows some of whom have no other social supports and are not able to properly fend for their children.

> *"I can say no body is there to help me. I am struggling alone to take care of the children. My husband was recently this year killed by the Karamajong… The children sleep hungry if I don't work hard; and as you can see I am even lame"* **(Mother Kudeta village_Wol, Pader district**).

Men are variously implicated in undermining infant feeding practices. Some men consume alcohol excessively, and this creates conflicts in households, and more importantly diverts much needed resources. This also leaves mothers with little support in feeding their children. Some men cannot support their wives because they spend most of their time away from their homes by virtue of their occupations (e.g. hunters); others have moved to other places in search of employment opportunities but do not remit any earnings home.

> *"He helps with decision making but he is he is never around…he is preparing to go back today. There is a time he stayed away for two years without coming to see me and the children. He came last year and I got pregnant; he went back for one year and he has just come this time because we lost a relative… He has another woman there, so he does not care about these children… they don't know him and sometimes they think that he is visitor at home when he comes. How can a child know him when he is never here?"* (**Mother of six children in Rucurucu Village, Lagoro, Pader district).**

Many men are in polygamous marriages and that makes them unavailable to support their children's mothers with child care duties. Some men are disrespectful of their wives and therefore do not consider their views on family matters including child feeding and management of family resources; women in such marriages are also too intimidated to express themselves about family matters. Many men are opposed to family planning, which leads to frequent child births and large families that make it difficult for the mothers to properly feed their children; the mother often stops breastfeeding as soon as she becomes pregnant thereby increasing the risk of malnutrition for that child:

"Besides the lack of support from my husband, there is no family planning here… the number of children is growing… Since there is no support and I am continuing to produce, I find it hard now. I told him we should either stop or I go on the pill but he refused…he told me that he wants the children…But you see he also has children with the other woman; so it is difficult for him to support us all… at the moment they are twelve children and yet he wants to continue producing" (**Mother of six children in Atem Village, Lagoro, Pader district).**

3.1.6 Facilitating factors to good infant feeding practices

Some of the fathers are now willing to care for their children while their wives are busy with other household duties or in the garden:

"…… when I have a lot of work to do in the home the father usually helps me by carrying her… He even sometimes bathes the baby when I am not around and takes care of her other needs. He provides for the family" **(Mother in Adak Village, Lagoro, Pader district).**

Fathers also describe how the community perceives men's roles as providers:

"Fathers should be able to provide food adequately for the family, buy clothes and any other family needs that are basic…[the community perceives that] fathers who actively participate in caring for their infants are responsible and fathers who do not actively participate in caring for their infants are irresponsible fathers…I am not very sure about what the community expects of me because sometimes when you care so much the other men will call you names. When you do not care at all they mock you. So it is like that you need to learn to balance…"

"The role of the father in taking care of the babies among the many include buying clothes for the children, sending children to school, guiding the children to grow up well with discipline…If you the father is actively involved in caring for the baby the community respects you and neighbors follow what you are doing for your family, such as keeping the children when their mother goes to the market, or fetching water. For me if my wife is not there at times I cook for the children as well…I take care of the child when I am available. I carry the child whenever the child cries, offer that love as a father to the child, unlike other father within the villages, I always play with my child because it is important for the growth of the child and the entire development."(Father SSI, Namokora, Kitgum district)

Both mothers and fathers reported that things have changed following the conflict. In some households, gender roles have changed favorably increasing cooperation and partnership between spouses towards a common goal of taking care of their family and rebuilding their lives. While in sharp contrast many households continue to experience conflict that affects the type of care and feeding infants receive.

As a result of IMC's sensitization, some men are more aware of infant and young child feeding practices – but their understanding is still at a very basic level, and not sufficient to provide mothers with real support. Men do not yet feel relevant in terms of behavior change, and are not clear on what their roles can be in improving IYCF practices. They are clear on broader social expectations of them from the community at large, but the supportive role they can play in IYCF has yet to be realized.

Another potential facilitating factor is that the region has great potential to produce a wide

range of foodstuffs that would make it possible for the mothers to ensure a balanced diet for their children after introduction of complementary foods. This is apparent from the variety of foods that the mothers reported giving their children currently, which are apparently largely produced locally. Common cereals included: sorghum, millet, and maize. Pulses included: ground nuts, simsim, cow peas (l*apena*) and beans. Green vegetables included eggplants, okra, green gram, *boo, otigo* and *marakwang*. The main tuber was cassava. Sources of animal protein included small fish (*lacede*) and meat occasionally.

3.2 Community perceptions about malnutrition

3.2.1 Priority given to malnutrition

The community members generally perceive malnutrition as one of the most serious health problems in the community and they consider it a priority issue that deserves attention. Families and communities clearly understand that malnutrition can lead to the death of a child. The communities perceive that lack of food and unplanned early and frequent pregnancies are among the major factors underlying malnutrition. However, there are still some members who believe that it is caused by witchcraft. There are also some community members who do not see malnutrition as a priority issue.

3.2.1.1 Local terms/Lexicon used by people to refer to a malnourished child

Community members used various common terms to describe malnutrition and malnourished children. The spontaneity with which the local terms were brought out by the study participants suggests that malnutrition is a recognized problem among the community members. The terms include: *tuwo netto*, meaning a malnourished child; *tuwo cam,* referring to sickness caused by lack of food; *La bel,* which means a child with wrinkled skin, *La goro*, meaning a weak child, and *La pwut*.

3.2.1.2 Ability of community members or households to identify malnutrition

The community members are generally able to identify severe malnutrition. This observation is based on the ability of the study participants in the community to correctly identify the signs of severe malnutrition, including the following: frequent illness suggesting low immunity, protruding stomach, small limbs, swollen cheeks, brown and soft hair, pale and dry skin, inactivity, physically wasting and bonny, disproportionately big head, sunken eyes, irritability, persistent low mood, diarrhea, low appetite at the peak of illness, and insatiable appetite during recovery.

> *"Normally we get to know a child who is malnourished when the child looks very weak and very thin; living like an orphan. Others develop body swellings and are not even fit to be called human beings; the hair is also brown in color. Also such a child looks like an adult with wrinkled face, sunken eyes and with a big stomach"* (FGD, Grand mothers in Wol, Pader district).

However, the named signs refer to severe malnutrition, suggesting that the community members are largely unable to identify signs of mild and moderate malnutrition; yet malnutrition can only be effectively managed at the family and community levels if it is identified in those early stages.

> *"People think the child gets malnourished only because of not having enough to eat. They cannot identify malnutrition when it presents alone. Many of them bring children to because of other health problems not because of malnutrition. The care givers are usually not able to link health problems of their children to malnutrition. Community can*

only identify malnutrition when it is very severe" (KII, health official in Namokora, Kitgum district).

Most parents do not realize they need to take action about their malnourished children until the signs and symptoms are obvious. The dominant perception is that it is only the trained medical personnel that can identify malnutrition. Moreover, malnutrition is usually identified with other illnesses such as malaria, diarrhea, mouth sores and respiratory infections.

3.2.2 Perceived causes and consequences

3.2.2.1 Causes of malnutrition

Childhood malnutrition is attributed to several factors in the community. Some girls begin child bearing before they become mature enough to face the challenges of childbearing and rearing; the adolescent mothers usually lack both the resources and the knowledge; and the men responsible for such pregnancies often deny their relationship for fear of being caught by the law of defilement. The adolescent mothers often relinquish the child caring role to their mothers who are most often already weak and with no means of properly feeding the babies. Some mothers bear children too frequently for them to properly feed the young children, moreover with limited resources. Frequent pregnancy often leads to early weaning of the child.

> *"When the mother has a small child and she gets pregnant, that child will not have enough food… There is no other cause of malnutrition; it is caused by pregnancy when the mother of the child is still breastfeeding"* (**FGD, grandmothers in Wol, Pader district**).

3.2.3 Consequences of malnutrition

3.2.3.1 Consequences to the child

Malnutrition is perceived in the community to have physical and psychological consequences on the child. The child's appetite goes low, the body becomes weak, the child becomes easily irritable and often sad; the child's immune system is compromised, hence it can not fight diseases, leading to frequent illnesses; the intellectual growth of the child impaired, which may affect its school performance; and many of the malnourished children who are not attended to in time die as a result.

> *"The health of the child is greatly affected. A malnourished child takes long to start walking; such a child is generally weak… Malnutrition weakens the immunity of a child...the weight of a malnourished child is less, compared to a well nourished child. The last consequence of malnutrition to a child if not managed, may lead to death of such a child"* (**FGD, Community Leaders, Namokora, Kitgum district).**

3.2.3.2 Consequences to the family

Focus group participants explained how malnutrition can have far reaching consequences on the affected family. From their perspective, they said it aggravates poverty levels in the family because a lot of productive time and resources are lost in caring for the malnourished child; parents have to forego other activities such as farming and house chores in order to attend to the sick child; a lot of money is required to buy the recommended food and other necessities for the child and to meet transport costs of going to the hospital, which may sometimes compel the family has to sell off some of their household items and livestock:

"It is a priority issue because most households affected lose a lot of money to treat or take care of the child. It is expensive because you have to buy food for the child all the time, medication, constant movement from the home to the hospital and long queue at the hospital in order to get treatment becomes a very big problem. There is also the problem of time, that is wasted in doing the same thing through out." (**FGD, community leaders in Namokora, Kitgum district**).

It breeds conflict within the family because of the stress and social stigma associated with having a malnourished child in a family; for instance the mother will be at the hospital with the child for an extended duration and the other family tasks will not be attended to; there will be accusations and counter-accusations about the poor timing of pregnancies. The family of a malnourished child gets stigmatized in the community, sometimes to the point when the mother will want to deny the child is hers.

"Such a family where there is a malnourished child most often does not have peace. Quarrels may erupt any time among the family members because they don't agree on most issues. They get divided." **(FGD, community leaders in Namokora, Kitgum district)**

3.3 Management of malnutrition

3.3.1 Malnutrition and transition from the IDP camps

When people were living in the IDP camps, they largely depended on emergency food aid, which kept the problem of malnutrition low. However, most of the relief food distribution programmes ceased when people began to return to their original homes. The abrupt end to food distribution coupled with prolonged drought in 2009 left many people highly food insecure. The number of reported cases of malnutrition increased in the area and children were the most affected.

3.3.2 Management at community and household level

3.3.2.1 Remedial action at the family level

It is usually in the severe stage of malnutrition that parents take action. Although most parents take such children to the health centers for treatment, some parents still go first to the traditional healers and only seek appropriate care after realizing that the traditional healers are not solving the problem.

Once the problem is identified, the children are normally taken to the hospital for treatment. Parents or caregivers try to improve the child's diet by providing nutritious foods such as soup from small fish locally known as *lacede* in Acholi or *Mukene* in Luganda.

3.3.2.2 Remedial action by the community and health services sector

Nutrition and health services are provided by government and NGOs in both the health centers and the communities. Much sensitization has been done at the health centers and in the communities; hence many people are beginning to take malnutrition as a serious health problem. IMC, through the VHTs, has been particularly instrumental in this respect in areas such as Lagoro and Ogole where it operates. Health and food security education activities have been conducted in the communities. Children's health and growth as well as the health of pregnant women and lactating women are monitored at least monthly. There are also monthly screening sessions for malnutrition at different service centers; VHT were trained and have been playing a key role in the screening and monitoring services. Food rations are

provided for the malnourished children, and sometimes pregnant mothers and lactating mothers (e.g. by IMC in Namokora on a monthly basis). Severe cases of malnutrition are referred to the higher grade health centers. As a long term preventive strategy against malnutrition, there has been family planning campaigns in some areas (e.g. Orom Sub-county) spearheaded by agencies such as the Mercy Corps.

3. 3.3 Factors that may facilitate management of malnutrition

Several factors were identified that may facilitate the management of malnutrition. Continued sensitization and education of the community (that is currently done by IMC in areas such as Lagoro) will increase people's knowledge and awareness of malnutrition. There have been high levels of attendance at nutrition sensitization and food distribution activities for moderately malnourished children, pregnant and lactating mothers. Availability of food in the community as people continue to re-settle and cultivate their land will help in reducing the problem of malnutrition in the community. Availability and proper operation of health centers as well as VHTs has been critical in the management of malnutrition.

The study findings show an emerging and growing trend of shared responsibilities between men and women as well as increasing involvement of women in household decision making. Transition to original home areas has seen widespread emergence of social network groups in the community such as dance groups, saving schemes, farming groups which will impact positively on livelihoods in general and nutrition in particular. The prominent view in some areas (e.g. Omiya Anyima) was that most fathers know their roles in maternal and child care and indeed provide for their families in terms of food, clothes and health care, which can help mitigate malnutrition.

3.3.4 Barriers to managing malnutrition

The study identified several factors that contribute to malnutrition and act as barriers to management of malnutrition and access to health care. Most households did not produce enough food and were highly food insecure, which was compounded by the prolonged drought in the area that destroyed most gardens. Many mothers did not practice basic hygiene and sanitation practices, and distance to water sources contributed to this. As people resettled in their villages, accessing health centers involved longer distances and greater transport costs that were beyond the reach of many poor households. Income generation opportunities were limited; hence many people lacked money to buy most of the prescribed drugs. The relationship between the health center staff and the service seekers was said to be poor. The health centers did not have enough drugs; hence the people were forced to buy the drugs prescribed. The health centers were overwhelmed by large client numbers because they are under-staffed. The few available health center personnel did not live at the health centers, which rendered them largely inaccessible.

Many community members were still unaware of the problem of malnutrition; hence they often take inappropriate or delayed actions. Management of malnutrition is hampered by the continued preference of traditional healers by some community members. Alcoholism has adversely affected malnutrition: it has fuelled poverty by diverting resources, hence the inability of many households to pay for the basic needs or manage malnutrition; it has also contributed to less male involvement and less support for mothers in managing malnutrition. Even without alcohol, many men are not fulfilling their roles and responsibilities in caring for their children and women; hence male involvement in the management of malnutrition is still low (e.g. in Orom). Many women are left alone to face the challenges of seeking health care such as walking long distances, lack of money, lack of drugs at the health centers and the long queues at the service centers. Whereas the insufficient male involvement in family health

and nutrition can be blamed on male factors such as cultural attitude, personal negligence, ignorance and alcoholism some men are simply limited by the lack of income generating opportunities.

Lack of family planning services, low adoption of family planning and the associated poor spacing of births whereby mothers conceive before sufficient breastfeeding of current children contribute to the problem of malnutrition. Poor feeding practices by some mothers coupled with the lack of knowledge of good nutrition in many areas (e.g. Lagoro) contribute to malnutrition and complicate its management. The implicated practices include: giving children cold leftover food, too few meals and irregular meals. The common co-occurrence of malnutrition with other illnesses poses additional and special management challenges.

3.4 Management of illness

3.4.1 Common childhood illnesses

Many children often fall ill; sometimes the illnesses are as frequent as weekly. Several childhood illnesses were cited including: malaria and other fevers, flu, diarrhea, respiratory tract infections (RTI), mouth sores, tonsillitis, sore throat, skin rashes, vomiting, cough, intestinal worm infestations; eye, ear and nose infections, malnutrition, psychological trauma, pneumonia, and anemia. In all, the most common illnesses are: malaria, diarrhea, vomiting, and RTI.

3.4.2 Health seeking behavior

The dominant view is that the effort to seek health care is usually made as soon as the parent realizes that the child ill; parents perceive that the child is weakened by disease if they delay to seek help. Health care is mostly sought from the modern health care providers in the health centers as opposed to the traditional healers. There is a common perception that some of the childhood illnesses are by their nature only manageable in the modern health sector. Mothers also endeavor to improve their children's diet to the extent possible within their limited means once they detect illness.

On the other hand, there were divergent views as to why proper health care is sometimes sought late when the illnesses are already severe or treatment is not sought at all, sometimes leading death of children. Attempts are sometimes made by mothers to manage the children's illnesses from home, such as using a wet cloth to lower the sick child's body temperature and even administration of medicine. Some mothers seek initial remedy to the children's illnesses from the traditional healers and only turn to the modern health sector when they realize that traditional methods are not working. Other parents are unaware about childhood illness signs and symptoms such that they do not promptly detect and respond to the illnesses.

The lack of help seeking was also related to constraints beyond the control of many families such as the long distances to health centers and the lack of drugs in health centers. Some families are still strongly attached to traditional practices such that they are always inclined to seek help from the traditional sources. It was further noted that a family's choice between the traditional healers and the modern health sector largely depends on their interpretation of the cause of the child's illness. If they think the illness is traditional such as mouth sores (*Tuwo Lango* meaning illness from Lango), they will seek help from a traditional healer; but if it is perceived as one of the common childhood illnesses such as diarrhea, malaria or fever, the family is more likely to seek help from a health facility.

Mothers play a central role in management of childhood illness. It is the mother that usually

takes the child for treatment and she is most often unaccompanied when seeking health care for the child. Men rarely participate in management of their children's illnesses. However, there were some contrary views suggesting that men are increasingly getting closely involved in management of childhood illness. Some husbands accompany their wives to the health center especially when the child is severely ill and may require admission. Relatives also sometimes accompany the mother to the health center. Such can be the woman's brother, a brother-in-law, a sister-in-law and a mother-in-law. Single men and men whose wives have just delivered or are seriously sick are known to take children to the health center themselves. *"It is the mothers who usually bring sick children to the hospital, and they are rarely accompanied. If you see a man bring a child to the hospital, then either he is a single parent or the wife has just delivered"* (KII with a health official, Orom, Kitgum district).

3.4.3 Perception about quality of care

The quality of health care is generally rated poorly for several reasons. Shortage of drugs in the health centers features prominently. There were also assertions that the health centers sometimes issue expired medicines.

> *"For us here, the health centre lacks medicine and we are referred to go and buy from the clinics. Sometimes they even go up to the extent of breaking Paracetamol into two pieces to give to your patient! This explains to me how serious the problem of drug supply in our health centre is…definitely the quality of treatment is affected…the people who have money now prefer not to waste their time going to the health centre… they instead go direct to a private clinic where they get better services"* (**SSI with a mother, Pajule, Pader district**).

Negative attributes further include long distances to the health facilities, low staffing levels in the health facilities, and poorly motivated health workers. There are quite a lot of negative sentiments about health workers. There are reports of poor reception and mistreatment of patients by the health care providers. *"If your child falls sick repeatedly and you go the health center frequently the health workers can chase you away, saying that you are finishing the medicine"* (SSI with a mother, Pajule, Pader district). The health providers sometimes abuse and even slap the women. The health workers sometimes leave patients unattended especially when it comes to lunch time.

On the contrary however, some isolated voices were also captured that rated the quality of services highly. Two reasons were cited for the positive rating. Drugs are sometimes available for free in the government health centers, which greatly relieves the poor who would otherwise not access the services. Some of the health care providers have demonstrated great dedication to serve the people.

> *"The quality of treatment is fairly okay though there are moments when there are no drugs in the health centre… The health workers try their level best but there is nothing they can do when the drugs are out of stock. The patients are referred to the clinics where they have to buy the prescribed drugs"* (SSI with a father, Nomokora, Kitgum district).

3.4.4 Challenges that families face in obtaining health care for their children

Accessing health services involves several challenges most of which are linked to the widespread poverty in the communities. Drug stock outs are too frequent especially in the government health facilities. Some of the prescribed medicines are too expensive in the private clinics. *"They prescribe and refer us to buy drugs from clinics…only cheap drugs are*

available at the government hospital. For the expensive ones, the health worker gives you a prescription to go and buy" (SSI with a father, Namokora, Kitgum district).

The child sometimes falls sick at the same time with the mother, leading to delays in help seeking. Some mothers especially the young ones lack knowledge of childhood illnesses and their management, sometimes to the extent of fearing the sick child. Some of the patients are from child-headed homes where the family head lacks the experience, knowledge, skill and the means to manage childhood illness. Because many people are poor they lack the money to meet the costs of seeking health care. Many families are poor; yet when the patient gets admitted the family is required to provide the basic needs such as a blanket, a mosquito net, clothes, sugar and food because the health centers are unable to provide those items. Some families are unable to follow through with health care instructions because of the lack of money; for example some families can not follow through with referrals that entail admissions because the families can not financially support the caregiver and the child in hospital.

> *"The success rate in following instructions is very low; …people do not have the means to follow through with instructions. For instance the success rate of referred cases of malnutrition is very low because mothers rarely have means to support themselves in the hospital for therapeutic feeding"* (KII with a health official, Pajule, Pader district).

The health facilities are characterized by long queues and congestion that are largely due the facility understaffing and large patient numbers. Consequently, parents spend a lot of time when they go the health centers, and that tends to discourage potential help seekers.

> *"The quality of health and nutrition services at the health centers is severely affected by the inadequate number of staff. Namokora…Health Centre IV is planned to have forty - eight staff in total but…there are only twenty-one staff. Given the big number of patients …it becomes difficult to fully serve the population"* (FGD with community leaders, Namokora, Kitgum district).

Means of transport are limited for some families. Many families move long distances, sometimes up to 20km to reach the health units.

> *"The main challenge that the family faces in help seeking is distance from sources of care and money although the health services in government hospitals are supposed to be free. Health centers are often faced with stock outs thereby making government health facilities mere prescription centers. People sometimes come and wait for hours only to receive prescriptions because the health facility has no drugs"* (KII at Namokora, Kitgum district)

3.4.5 Challenges particular to women

Women as a group face several challenges in seeking help for sick children. Food is often not enough for the family, the child and for the mother. Women perform multiple and competing roles as mothers and wives. *"When my wife goes to the hospital …back at home there will be nobody to take care of the children who have remained; there is no body to cook for them. She comes back home tired"* (SSI with a father). Many women lack support from other family members including the children's fathers. Male involvement in management of children's illnesses is generally low. Many families lack the money to pay for transport and to buy medicine and the other basic necessities of health care. The lack of money for transport is exacerbated by the inability of some mothers to ride a bicycle, which is the main means of transport in the area*. "She does not know how to ride a bicycle; so when I am not around she*

has to walk the long distance to the hospital" (SSI with a father, Namokora, Kitgum district).

The lack of money to manage children's illnesses is apparently the main challenge facing women. The lack of money is closely linked with the generally low support from men in management of children's illnesses. Men's less involvement in management of children's illness partly attributed to alcohol on which the men spend a lot of their money. The other setback is that the men largely control household income including money earned by the women especially from small businesses such as selling greens.

> *"She has to look for her own money because the man won't support her; he spends his money on drinks. He will ask for the money from her incase she happens to have sold some greens in the garden the previous day. He will say give me the money here because all the money you have here belongs to me your man…it is all my money… Everything belongs to me"* (KII with Mother in Pajule, Pader).

3.5 Community perceptions of existing services and prioritization of needs

3.5.1 Impact of transition on access to social services

People's health problems are said to have reduced as they transitioned from the camps and resettled in their villages. With the support from NGOs people are more actively involved in activities that improve health of their families especially children. However, the transition from the camp to the villages also came with reduced access to services that promote health such as clean water, food and money.

> *There are many changes as compared to the time when people were living together in the camps. People are no longer gathered together in a congested place. Health problems are reduced; people do not fall sick anyhow as it used to be in the camps…On the side of health this has affected people, in other places there is no proper access to water, food aid has stopped and on income earnings, people do not have money (***KII, Community Health Worker, Namokora, Kitgum district***)*

3.5.2 Existing health and nutrition services

The main providers of nutrition and health services are NGOs and the different levels of government health centers including the VHTs. The VHTs were portrayed as a crucial component of the health care system that plays various roles including: immunization activities in the community, sensitization of pregnant women on the importance of antenatal care, promotion of sanitation, sensitization of community about family planning as a long term measure against malnutrition, and participation in services offered by NGOs such as the food distribution to pregnant women and lactating mothers by IMC.

Health centers provide a fairly wide range of services; for example, the Namokora HCIV provided: illness and nutritional assessment of the children, advising the mothers about nutrition, referring difficult cases, treatment of common illnesses, and a community outreach program that offers a number of services (such as immunization, health education, follow up of TB patients, and water and sanitation program). In Pajule, there were outpatient nutrition services for mothers that were being run with the support of UNICEF through the Ministry of Health, which included: advice, health education on how to manage malnutrition at home, supplementary food, and follow-up through regular appointments, and referred to TFCs for cases that do not improve within certain period. The TFC program that was running with the help of WFP was stopped with the suspension of the emergency relief program. Services that were being provided in Wol included: sensitization through health education, supplementary

food given by IMC, sensitization on the prevention of malnutrition, preliminary screening for malnutrition using MUAC and weighing, and referrals for severe cases of malnutrition.

The other health and nutrition services available in the area include: child growth monitoring, food distribution to pregnant mothers and lactating mothers, and training of mothers about early childhood development. Health centers mainly provided nutrition services for children and not mothers due to the lack of capacity to provide comprehensive maternal and child nutrition services. Mothers were mainly provided with information about nutrition.

3.5.3 Problems with the health care system and services

The challenges that affect the quality of services that are available to the communities are in two broad categories – the health service systems or supply factors and the community or demand factors. The former include: low staffing levels,[2] inadequate qualified health and nutrition staff in the health centers, inadequate and inappropriate timing of the child nutrition counseling services for mothers which are provided as part of the general health education during antenatal and postnatal period due to the challenges of low staffing and large number of patients; lack of staff supervision from the district, lack of incentives and facilitation for the service providers, the lack of space in the heath facilities for providing specialized services such as ART clinic and clinic for Pediatric HIV, the lack of capacity to provide therapeutic feeding (e.g. at the Namokora HCIV), overcrowding (long queues) at the service centers, and recurrent shortage of supplies such as drugs, books for keeping records, detergents, and food for the people on supplementary feeding. The recurrent shortage of drugs in the government health centers was said have reduced the facilities to mere "prescription centers". The supply challenges further include: lack of funds and logistics to run and sustain services such as comprehensive maternal and child nutrition services and community outreach programs, high burden of disease that relegates nutritional activities to a secondary position, policy issues such as decentralization, and limited NGO coverage that sometimes does not exceed a parish. Due to the resource constraints, even the previously limited services for mothers such as the nutrition supplement for pregnant women and lactating mothers had been suspended in the health centers.

> *"The health care system has very many problems for example the Namokora Health has recurrent shortage of drugs; drug supply is very irregular, the hospital has very limited space we have no children's ward. There is no space for ART clinic, no space for pediatric HIV care. It is also very difficult to sustain the community outreach program because getting enough fuel is a big problem. The health centre does not have motorcycle (KII, HO, Namokora, Kitgum district)*
>
> *The quality of the health and nutrition services at the health centers is deeply affected by the inadequate number of staff. Namokora has a health centre and it is health centre IV initially planned to have forty - eight staff in total but on board there are only twenty-one staff. Given the big number of patients that visit the centre, it becomes difficult to fully serve the population. In order to improve on this, there is need to decentralize services to the parish level by possibly putting up health centre II at the parish levels. This would help ease the problem of having many people at the health centre (**FGD, Community Leader, Namokora, Kitgum District**)*

On the other hand, there are several demand factors or challenges. Women play multiple and competing roles in the homes and community such that every time they have a child to take to the health center for care, they have to deal with issues opportunity cost; for instance looking

[2] Staffing level at the Pajule Health Center was estimated at 40% with one person in charge of the general ward as well as nutrition services.

after other children. Some mothers still prefer the alternative sources of health care such as the traditional birth attendants. There is relatively low participation of men in the maternal and child nutrition activities such that the men do not give their women adequate support in addressing health and nutrition problems in the homes. Distance from home to the source of care is sometimes long and too costly for many of the mothers. Many families especially the women lack of the financial capacity in to follow through with advice and instructions given to them concerning management of malnutrition. This factor is implicated in the low success rate in addressing malnutrition especially referral because many families are unable to support a child in hospital for therapeutic feeding.

3.5. 4 Services utilized by the community

Utilization of the health and nutrition services was reported to be high, using the long queues of service seekers at the health centers as evidence.

3.5.5 Quality of services

Because of the service limitations outlined above, the quality of services was generally rated as poor from the care providers' point of view. Both the providers and the consumers had a low rating of service provision in the health centers.

> *The quality is poor because of the problems we get in accessing the medication. Sometimes there are no drugs at the health centre and we are referred to seek medication elsewhere and then the lack of money creates difficulties in improvement of the health of the child… The health centre staff are very few and the services they give to the patients is affected because the number of patients that each of the staff is to attend to is usually big. Sometimes they are treated in a rush because the staff wants to attend to all (***FGD, Mothers, Orom)***

A) 3.6 Community and household/individual perceptions of livelihood opportunities and income sources

3.6.1 Effect of conflict and transition to the camps

The conflict significantly affected people's livelihoods. Conflict and displacement to the camps denied people access to land for agriculture, the mainstay of their livelihoods. Farming was severely disrupted including the loss of livestock like cattle and goats, which were taken by the fighting forces. Not only was there less food in the markets but the people's purchasing power also plummeted because there were fewer opportunities for income generation. Consequently, people became dependent on humanitarian aid as a source of livelihood. Household food insecurity that was previously rare became widely prevalent because food aid was never enough especially for big families. Many of the families were unable to properly feed their young children; hence malnutrition increased among the children. Food insecurity was also implicated in family instability including divorce.

3.6.2 Types of livelihood activities for men and women

Agriculture is currently the main livelihood activity for both men and women in most of the areas. The agriculture activities include: food and cash crop growing, and livestock keeping especially poultry and goats. Apparently as a strategy to overcome the unpredictable weather conditions and to meet the pressing and urgent need for money and food, farmers have taken to growing of fast-yielding crop varieties. Most of the crops grown for food are the same crops whose products are sold for income. Given that the farming is still on a small scale, this can

be a recipe for food insecurity given the reports that the small quantities of food produced are sometimes all sold out before the next harvest.

Besides agriculture, families are now able to engage in a range of other income-generating activities such as: the ‘cash box’, small-scale business, casual labor including digging in other people’s gardens for money, charcoal burning, brick making, selling water, bodaboda riding (transport), and sand quarrying to sell to builders. Money thus generated is usually used to buy food, pay school fees for children, pay medical bills, and buy other basic necessities in the household.

Most of the farming activities take place during the rainy season. Different numbers of days are committed to different activities. For instance whereas charcoal burning is usually done about three times in a month, farming is a daily activity especially for women during the rainy season. Income also tends to vary seasonally in the region; September-February are the months in which people are least involved in IGAs while March to July is the time when people are most involved in income generating activities, sometimes for up 30 days in month.

The study findings highlight the gender roles in the production and management of household resources. Women tend to control crops while men control livestock; women grow crops for food and manage their storage while men grow crops to sell. Both men and women participate in tilling the land and planting the seeds; but the women do most of the weeding and harvesting. Men dominate the more paying activities such as commercial farming, keeping poultry, bee keeping and charcoal burning while women are more involved in less paying activities such as petty business (*awarawara*), alcohol brewing and the cash box. In terms of income, women earn less compared to men and the household income is largely controlled by the man. Yet the women put in more effort than the men; whereas men on average put in twenty days per month the women do farming activities almost daily although not necessarily for money. Women have less access to opportunities for income generation. The income earned is never enough to cover the needs of households. In terms of child care, the study findings highlight the dominance of the traditional patriarchal view. FGD male participants confessed that they had limited knowledge of infant and young child feeding and care, arguing that a man's role is to provide clothing, school fees, food and medical care. Heavy consumption of alcohol remained a major threat to the quality of relationship between men and women as well as household livelihood because many men still spend on alcohol all the money they earn instead of buying food and other life necessities of the family; others sell food items to buy alcohol while others do direct exchange of food for alcohol. Besides the death of many men during the war, there are other factors due to which many men still do not fulfill their social responsibilities such as alcoholism and migration to urban centers.

3.6.2.1 Barriers in accessing and engaging in income-generating activities

The study shows that the transition to the villages did not yield the anticipated positive change in people’s livelihoods because it involved several challenges concerning access to and engagement in income-generating activities as well as other means of livelihood especially farming. Although women were more disadvantaged, men and women basically faced similar challenges in accessing and engaging in income generating activities. The food security situation did not improve because food aid that had become an integral part of people’s livelihood was abruptly stopped before the people had settled enough to produce their own food. There was total lack of a livelihood anchor for the transitional period as the people began to rebuild their livelihoods. The food situation also did not improve because of the setback of prolonged drought; much as people started to grow their own food crops and they were able to grow variety of crops, virtually all the first crops that were grown dried up because of the drought. Income-generation opportunities were not readily forthcoming; there

was the indication that it was much easier to make money before the war when the people had a variety of sources of income especially crop and livestock farming.

Farmers lack farm inputs such as seeds, hoes, and pesticides. The lack of pesticides features due to the problem of crop diseases that threaten to cripple agriculture production in some areas. Prior to the war, farmers used oxen to plough their land but all the animals were lost during the war; hence most of the families reverted to the rudimentary hand hoe when they returned to their villages; but the tool is also not adequately available and it limits productivity. Access to modern farming inputs and knowledge of modern farming methods are still limited. Some families still do not have access to land especially those families that have not been able to reach their ancestral land for different reasons. The number of farming groups is still much lower than desired. Some of the people involved in brick making lack water and tools for the job such as wheelbarrows. The people who make charcoal complained of inadequate market for their product. Because most of the people do not have salaried jobs, the people generally lack stable income; some households have incomes coming in as irregularly as just twice a month. There are few exceptions involving people who work for government and NGOs.

Poor health has been as a major challenge in re-building livelihoods. This phenomenon is largely attributed to the war that left most of the social infrastructure in ruins. As people returned to the villages they found most of the amenities broken down; hence they had limited access to safe water, health care and road networks.

Compared to men, women are said to face more challenges because of their multiple household roles. A woman is much more likely than the man to forego income-generating activity in order to take a sick child to the health center. Women work through out the month but virtually all the work is not paid for.

3.6.3 Changing trends

The study noted that despite the shortfalls, the situation in the villages was better than in the camps. People began to access food varieties from their own gardens as opposed to the mainly one type of relief food they received in the camp. There was an improvement in income because more people got engaged in income-generating activities. There was an increase in crop farming as an income generating activity. There was less consumption of alcohol because people regained a sense of purpose. Social networks that historically formed the basis of many livelihood activities in the area were re-established. With access to land, people were regaining their ability to grow crops and produce their own food and they were hopeful that the food security situation and household income would improve in the area when the drought eventually ends. People were falling sick less often due to improvement in diet and decongestion of the living environment. Two NGOs – Mercy Corps and IMC featured prominently as having supported communities in the region in the process of rebuilding livelihoods. Mercy Corps was directly involved in rebuilding livelihood while IMC focused on food and nutrition.

The study also noted some positive developments in gender relationships following the transition to the villages. The men's support to pregnant and lactating mothers was currently not good but better than when they were in the camp because the men were now able to engage in some income-generating activities such as charcoal burning and casual labor like digging in people's gardens; hence they were earning more money to support their families. More men were supporting their wives to attend antenatal services. Women were increasingly getting consulted during the decision making concerning household livelihoods. Men were increasingly helping their women with household livelihoods activities. Some men had also

started venturing into roles that were traditionally the domains of women such as cooking, washing clothes and fetching water. There was noted some increase in participation of women in IGAs. In all, however, no significant changes were registered in income generating activities in the past one year.

3.6.4 Management of household income

The study depicts a mixed picture concerning the role of women in management of household income. Some study participants depicted a positive change that came with transition from the camps whereby women are now more actively involved in the decision making processes, their opinions are considered, their rights are respected, and they actively share in the control of resources in the household. Other participants depicted a sharp contrast concerning control, utilization and disposal of valuable property such as land and livestock; the woman is often just informed about a decision by the husband, which she cannot reverse. There still remain extreme situations where men control the household income even where they (men) have not made any contribution to raise the income.

The study presents a mixed picture with regard to decision making concerning child care; the practice seems to vary between households. One opinion is that the men make the final decision about child care. The second view is that decision making about child care is done by both men and women because raising children is seen a joint responsibility of the husband and wife. The third view is that the decision about infant and young child care is made by the mother because the mother spends most time with the young child and therefore decides on what and when to feed the child.

The role of older women (grandmothers and mothers-in-law) in household decision making has been changing. There is the indication that whereas older women are still powerful and able to influence the decision making process in households of young couples, the influence has been waning. The older women are now involved in fewer decision making processes and it is largely the young people who determine where to involve the older women. Household decision making powers mostly lie with the man who has the volition to involve or not to involve his wife.

At the community level, young women are becoming more visible in the local leadership roles, they were more able to influence decision, and they were increasingly freer to join mutual support groups and associations.

3.7 Socio-cultural factors that affect maternal and child nutrition in Pader and Kitgum Districts

3.7.1 Effect Conflict, transition and resettlement on Social Cohesion

3.7.1.1 Effect at the couple level

Cooperation

Many study participants reported that displacement to camps changed the relationship between men and women, often in adverse ways. Women and men alike reported that men often had affairs with other women in the camps and social values of marriage were lost. Men lost their sense of purpose as they no longer provided for their families in the same way, and men's alcohol consumption increased.
Couple cooperation has improved with transition from camp life. Many couples listen to each

other and decide together on matters of mutual interest such as education of their children. Many men involve their women in decision making although superficially sometimes.

> *"The woman is only involved at the last minute. Whether or not she agrees with him, he goes ahead to do what he has planned. So in a way, it looks like he is just informing her about his decisions"* (**FGD of VHT at Lagoro**).

Changing gender roles

Camp life disrupted the traditional Acholi gender role. Women performed roles that were traditionally male roles such as construction and roofing of houses, opening up of land and cultivation, buying clothes for the children, and paying school fees. But with the transition from camp life, the situation has partly reverted to what it was whereby men and women perform gender defined roles. For instance, many women continue to play a dominant role in decisions and activities concerning child welfare right from pregnancy through birth to infancy period of the child. They also still dominate in subsistence food production activities while the men dominate in livestock management and cash crop activities.

Following life in the camps, there has been some improvement in the situation for women. Increasingly, a few couples now share roles more or less equitably whereby the man and the woman work together in the garden; take children to the health center for treatment; the man accompanies his wife during antenatal care visits; share some of the household work such as tending, cooking, fetching water, collecting firewood, caring for children, and washing clothes. Many men now encourage their women to participate in community activities; they listen to their women's views when making decisions that affect the home.

In all, however, men remain the main decision makers in the household and still have an upper hand in control of household resources such as land, livestock and money. Women on the other hand mainly control home-maker things like the granary and part of the proceeds from the sale crops to get money to buy basic necessities in the home like salt and paraffin. It is mostly the men that decide on crucial matters such as the sale of household livestock and many husbands do not have to discuss it with their wives first.

Alcohol consumption and Conflict

Couple conflict was rife in IDP camps. Displacement to the camps and the congestion, frustration, idleness and alcohol consumption increased occurrence of quarrels, infidelity and domestic violence. But the problems are now less common after people moved back to their villages.

Alcoholism especially among men increased when families lived in IDP camps. Many men spent most of their time away from their homes and spouses drinking, which fuelled couple conflict. Some women are also consumed alcohol. Although the situation appears to have improved with the transition from the camps, alcohol consumption, illness, disability (such as the men whose hands were amputated during the insurgency) and poverty remain major stumbling blocks to men fulfilling their responsibilities.

> *"What is really acting as a big barrier here is alcoholism. Many of our people have engaged in serious drinking. It has become like their daily work now...they only think about it [alcohol] and forget to provide food for the family. A man will not know whether the family has food or not and goes he goes drinking the whole day."* **(FGD, community leaders, Namokora)**

3.7.1.2 Effect at the family level

Relationship between older women and younger women

There are mixed views concerning relationship between older and younger women. Whereas some FGDs and KIIs see improvement, the dominant view is that there has been a change for the worse. On the positive side, the relationship is said to be better than that between elder men and younger men and better than in the IDP camps when people lived by themselves and quarrels were common. Many young women respect the older women and some assist them in their livelihood chores. Some grand mothers and mothers-in-law are able to sit with and advise the younger women. Grandmothers advise the younger women about child care such as infant feeding and health care; they assist in taking sick children to the health center; they provide child care support of the older children and some take full custody of the children when the mothers have problems. Some mothers-in-law are key decision makers in the household and are able to directly influence the decisions of their sons' households.

On the other hand, some of the younger women do not value or respect older women as would have been expected in the past, and they do not seek or follow older women's advice concerning child care. They do not support the older women with household chores; they do not give them food; and they do not show them any respect, claiming that they are exercising their rights. *"She respects only the husband; full stop!"* (**KII with a HO in Pajule).** This often results in family conflicts. A grandmother is sometimes viewed with suspicion by the daughter-in-law who accuses her of fuelling marital discord by unduly influencing the son.

Conflict

Reduction in the level of food aid to the communities, alcohol consumption and disagreement in sharing of household income have been implicated in family conflicts:

"Stopping of the food aid has brought problems of divorce. The man is not working and has no ways of providing for the family and there is no food in the home. The woman has got to move around looking for food and this has often brought quarrels between spouses, sometimes culminating in divorce" (**FGD of community leaders in Namokora).**

> *"A man goes and works in the gardens where he earns say 2000 UGX. But he gives only about 500 UGX to the wife to feed the family while he keeps the larger portion for drinking. The 500 UGX is not enough; may be she has five or six children. So conflicts in the house are there all the time. But the situation has improved; there was worse conflict in the camps"* (**KII with a VHT in Omiya Anyima).**

Family teaching

The change to camp life destroyed the opportunity for family and community teaching of the youth by the elders. The camps were congested and children's peer group networks were large. However, with the transition from the camps, children have time with their parents and it is now possible for children to sit with elders and learn from them. In many communities, by-laws are in place to have evening stories and discussions around a fire, that was an old tradition called "*wang too"* that was widely practiced in the past.

Family livelihood

The transition from camps has given families a renewed sense of purpose, and many study participants reported that there have been positive changes in their families as a result of returning to their villages:

"The women are now settled. They have more time at their homes doing household duties. When she moves out, it is for some work to help build the family" (**FGD Fathers, Omiya Anyima)**

3.7.1.3 Effect at the community level

Cooperation

Displacement to the camps destroyed the social fabric and the spirit of cooperation upon which livelihoods previously depended. Everything became commercialized, including land for cultivation which had to be hired:

> *"There was a lot of sharing of resources among the community members; but things changed when the war started in the 1980s and we were moved to the camps and means livelihood became harder"* (**Community Leaders' FGD in Namokora**).
>
> *"Life changed when people went into the camps, mainly because of difficulty to get food. It is like people became jealous, selfish, and individualistic and urbanized whereby you live on your own. Your children could only eat if you had food; otherwise no one, even relatives would come to their rescue"* **(KII with a Health Official in Pajule**)

The transition back to villages is slowly allowing communities to reclaim their lost socio-cultural practices. Cooperation has been rekindled with the people's return from the camps. This is mainly evidenced by the burgeoning phenomenon of village-level mutual support groups or associations. The groups are usually formed to address specific problems. Through the groups, many women and men have been able to work together and solve many of their problems. The groups are mainly concerned with savings mobilization and income generation, food production, and sensitization on child health and nutrition. The groups include: traditional dance groups that entertain for money, savings groups in form of cash boxes where each member is obliged to make a monthly saving for the family, small-scale business groups (e.g. selling of small fish), female farmers groups that dig for food production to feed their families, digging groups that dig for money and have helped many to become productive and provide for the family, and mother care groups that sensitize fellow mothers on how to take care of their children.

Life is now less commercialized and less individualistic. People are getting back to sharing of property among different households. Community leaders are also becoming increasingly visible again. For example they are now actively encouraging people to send their children to school.

> *"We can now share things with the neighbors unlike when we were in the camps. In the village here, relationship between people is much better. You can walk to a neighbor's home and you are able to get some assistance if you have a problem… But it is not the same. Things were much better before the war; people were so close to each other and people were generous"* (**KII with a Health Official in Wol, Pader district).**

Community participation

Participation of community members in the maternal and child health and nutrition programme

activities was generally highly rated during the FGDs and in some KIIs. *"People are participating in the sensitizations and the family planning sessions. Even us who are old go to attend. People always attend in large numbers during the sensitization programmes… even the men do participate in the programs ... together with their women…* (**FGD for mothers in Orom, Kitgum district**).

On the other hand, some KIIs revealed low levels of community participation with regard to the nutrition programmes. *"Yes community members usually respond to mobilization; but they usually want to be at the receiving end as opposed to being part of effort to improve nutrition. The war has created dependency; people want to be taken care of instead of being active stakeholders"* (KII with a Health Official in Namokora, Kitgum district)

Community teaching

There have been two main actors in community teaching, namely: village-level mother leaders that were trained by IMC in some areas such as Namokora and community leaders. The mother leaders conduct peer education of fellow mothers about child feeding, health and early childhood development. The mother leaders also educate community leaders who now use their regular community meetings to pass on to the community members the child feeding and health care messages.

> *"When these women were trained, they came back and shared with us the local leaders the knowledge they had acquired. We decided to support them by moving with them to teach our mothers. We have not limited our education to the mothers but have even gone a step further to include their husbands who also ought to know what their wives are learning because it is for the good of their entire families"* (**FGD of community leaders in Namokora).**

Conflict

Although the criteria for selection of beneficiaries of the IMC food distribution programme were explained to the communities, the selection process remains a source of conflict among community members.

> *"Another gap is from us the mothers. When a mother's child has been weighed but the name happens not to appear among the eligible beneficiaries, she gets annoyed and starts to quarrel with those whose names appear on the list… So there are many quarrels and grudges between families"* (**FGD for mothers in Orom).**

Sharing of land has become a major source of conflict during the transition from camp life. *"There are several land-related wrangles that were not there before the conflict and displacement. As people returned home, there came land conflict and hatred involving many people. People have become selfish…"* (**KII with a Community Leader in Lagoro, Kitgum district**).

Relationship between elders and younger people

Prior to the transition to camp life, the relationship between elders and younger people was one in which there was a social hierarchy and norms of respect for elders that were accepted, so relationships between the elders and youth were good. For instance children obeyed and assisted the elders. The elders in turn taught the younger persons the cultural values especially through evening story telling at the fire place *(Wang Oo)*. However, the camp life distorted these practices and values - the children no longer listened to the elders; the youth

were out most of the time; the two groups had no respect for each other; young men started migrating from their parents' homes to distant places upon getting married; and the elders' traditional role of teaching the younger members morals including mutual respect between the two groups disappeared. But in the transition from camp life, these relationships are improving. Communities are reclaiming their past traditions and building social institutions such as the village councils:.

> *"There are changes because the elders now have time to teach the children at the fire place in the evening because the elders don't drink all the time the way it was in the camps. The children are also available at home most of the time because there is less loitering; when they go out they come back early. There is a lot of improvement now*" **(FGD for mothers in Orom, Kitgum district**).

On the other hand, camp life has left some permanent dents in the relationship between elders and youth. Many of the children were born in the camps and in rebel captivity; hence they never got the opportunity to learn the traditional Acholi ways of relating with elders. Many young men still spend much time in urban centers and bars quarrelling, abusing and fighting each other and even the elders:

> *"But now you will find them drinking, arguing, and dancing inappropriately together. No wonder that a young man can now dare fight an old man… simply because the old man does not respect himself. The elders themselves are to blame for some of those behaviors"* (**FGD of fathers in Omiya Anyima, Kitgum district).**

Relationship between men and women

There has been general improvement in the relationship between men and women. Change has especially occurred in the men's and women's work whereby a growing number of women are venturing into the traditional work domains of men such as burning charcoal for sale and doing piece jobs for income.

> *"Changes have occurred in gender roles especially during the current regime of President Museveni. Men and women performed different roles in the past but we now work together with the men at the same time in the same organizations. For example, when a sensitization workshop is to take place in Ogole, at least one in every three people invited to attend the workshop will be a woman. Such activities are no longer exclusively for men but for woman as well"* (**FGD of Grand mothers in Wol**).

4 DISCUSSION AND RECOMMENDATIONS

The study findings show that poor infant and young child feeding practices remain a widespread problem in the north, and this is exacerbated by poverty, food insecurity, and lack of resources. In addition, cultural traditions and social networks that were crucial to Acholi society were lost as a result of the prolonged conflict. As the transition from camps to villages of origin continues, communities in the north must be supported to recreate their social networks, and reclaim their traditions. Slowly, as the data show, this is happening, with the formation of community groups such as traditional dance groups and farming groups. Trust and social cohesion are essential to enable a shared sense of responsibility for maternal and child nutrition and health at the community and family level. The resource poor setting in the north make behavior change communication on IYCF particularly difficult.

Any BCC strategy that is implemented in this region will need to take extra steps and provide complementary messaging and support services that address some of the resource and social constraints. Based on the study findings, table 2 presents a matrix of key messages that need to be considered on exclusive breastfeeding and complementary feeding in the BCC strategy. As outlined in the matrix, while there are mixed perceptions on IYCF practices, these are few compared to the many household and individual constraints that impede good IYCF practices. There is also a significant knowledge gap at every level. Importantly, at the level of the health provider, some providers are still not providing consistent messages on IYCF. A first step to implementing a BCC strategy should be to develop a common platform and framework with providers to ensure that all health services be they government or non-government, provide the same consistent IYCF messages. Without this, family members will be confused on what they need to do and what the appropriate behaviors should be.

Fathers and grandmothers have a very limited understanding of exclusive breastfeeding and complementary feeding. Beyond stating that exclusive breastfeeding and complementary feeding are important, fathers and grandmothers do not appear to know what these terms mean, why these practices are important, much less what the stages and steps of IYCF are. Fathers mainly see their role as providing food for the mothers so they can breastfeed well. A BCC approach needs to include fathers and grandmothers – but more importantly as key actors in households they need to understand their role in exclusive breastfeeding and complementary feeding. They are not simply messengers carrying a message – they are key actors who need to themselves adopt new behaviors. BCC messages therefore need to be adapted for fathers and grandmothers so they see their role in behavior change (eg., the message on exclusive breastfeeding is not: the mother should exclusively breastfeed for six months, but rather: support the mother to exclusively breastfeed for six months by reducing/sharing her workload).

Mothers understand only a little more than fathers and grandmothers in terms of IYCF practices. Again, for mothers going beyond the messages will be important. For example with breastfeeding, the overwhelming feeling of insufficient milk is symptomatic of the larger problem of breastfeeding positioning and attachment. If in the very early days and weeks of breastfeeding initiation infants do not latch on properly, then a mothers' milk supply will plummet; targeted breastfeeding support that shows mothers how to breastfeed and helps them troubleshoot problems in the days following delivery will likely improve breastfeeding behaviors. Two important complementary messages or support activities will also be needed – one is to reduce mother's workload so they can breastfeed, and two is addressing men's alcohol consumption that diverts family resources. In addition, because many mothers do leave their infants in the care of their older children when they go to farm, a child to child approach that focuses on teaching older children about hygiene and hand-washing before

infant feeding and food safety with infant feeding may also be useful.

Table 3 outlines the audience for messages, potential channels, and the approach that would be useful to implement a BCC strategy based on these study findings. Training all health providers including traditional birth attendants will help create a common understanding of appropriate IYCF practices and messages. At the community level, because preventing malnutrition is seen as a priority issue, community leaders can serve as champions for maternal and child nutrition, focusing on supporting mothers to have time to engage in good IYCF practices. Grandmothers and fathers will also benefit from receiving messages through various channels, and for fathers with young children, more directed activities such as fathers groups or one- on-one counseling would also be needed, using an approach such as Trials of Improved Practices (TIPs) for example. Mothers should be grouped by physiological age of the child, so pregnant mothers are grouped, mothers with infants 0-6 months are grouped, mothers with infants 6-12 months are grouped, and finally mothers with children 12-23 months are grouped. In this way mothers will interact with peers and get the most relevant information for feeding their child – at each growth stage. For pregnant women, there is clear evidence that mothers make infant feeding decisions at this time; learning about exclusive breastfeeding, and when to start complementary feeding, for both the mother and father are key to ensure good IYCF practices in the future. Antenatal care sessions should cover topics of maternal care, family planning, and delivery, and exclusive breastfeeding and complementary feeding.

As the study findings show, there is a lot of variation in the types of households in the study areas. In some households both infants' mothers and fathers are present, while in others mothers are alone with their children. Households where husbands and wives cooperate and work in partnership seem to be better able to meet the needs of their children, while in households where this type of cooperation is absent - things appear to be more challenging. Households that are female headed, or households where resources are diverted for alcohol consumption are highly vulnerable to malnutrition and food insecurity. In addition, many households are still transitioning back to their villages, and many also settle somewhere in the middle between the camp and their native villages so they can access amenities such as schools more easily. It will be important for providers and leader mothers to be empowered to problem solve with mothers on how they can manage their resource constraints and still ensure good complementary feeding for their infant. But at the same time, considering the variation in the types of households and the varying resource constraints, it would be useful to develop some criteria of which types of household are more able to adopt new IYCF behaviors and which ones are not. For example, extremely poor households may not be able to adopt new behaviors simply because they do not have the resources to do so, and identifying different ways of working with them will be important.

The range of variation in the perceptions around infant feeding indicates that there are not many predominant practices that a majority practices. This, in fact, serves as an opportunity to engage in behavior change communication to promote ideal IYCF behaviors. Tables 4 and 5 present the BCC messages that have been developed based on the findings from the formative research. Because of the range of variation in practices seen in the data, this set of messages reflects ideal IYCF behaviors that should be promoted. For example while many mothers reported providing colostrums, some mothers discarded colostrums. This indicates that the practice of giving colostrums is not yet universal, and some BCC messages are needed to reinforce this behavior. As a result the range of messages included in these tables seek to reinforce existing positive practices as well as orient family members on new and ideal IYCF behaviors. These messages are tailored for fathers, mothers, and grandmothers, and in many instances there are overlaps in the messages that are intended to ensure all the key actors in a household develop a common understanding of the ideal behaviors for good IYCF

practices. As a part of the BCC approach, fathers and grandmothers should be clear about what is needed for the child, but also be clear on their role in supporting and enabling mothers to practice good IYCF practices.

The most significant threat to successfully implementing this package of BCC messages is the current socio-cultural context in which gender based violence and the consumption of alcohol remain widespread practices. These two also interact with each other, in that alcohol consumption often escalates household conflict and gender based violence. Identifying approaches to manage these two factors will be key to being able to promote good IYCF practices and prevent malnutrition.

Research suggests that gender based violence tends to cluster in communities and becomes a normal way of life where there are no strong social norms that condemn this form of conflict resolution. Family or community intervention can help mitigate violence. Strong leaders and community gatekeepers or champions can also help reduce gender based violence by leading by example and promoting zero tolerance for violence. There is also a need to enable men to find other coping mechanisms for the challenges they face. A current intervention in Ethiopia is demonstrating early successes in reducing gender based violence by engaging men through a male mentoring program. The design of this program suggests that it could be replicated in other developing country settings, and this approach itself could tackle both gender based violence and alcohol consumption. Adapting this approach could present an opportunity to develop a comprehensive male involvement approach that would enable men to learn how to resolve conflict without resorting to violence, as well as learn about the needs of their children to prevent malnutrition, and better understand how they can support mothers to adopt ideal IYCF practices.

Also in this setting, it is perhaps more important that beneficiaries from the maternal and child health component of the Title II program also benefit from the other livelihoods activities of the Title II program, or be supported in farming, agriculture, livelihood diversification where possible. In general supporting communities to increase agriculture and food production of both subsistence crops and cash crops will be important to facilitate food security. However – these activities also need to happen in tandem with ensuring that resources gained are directed to the household and not diverted to other things (such as alcohol). This is particularly important considering women have much less access to and control over resources in this region, and access to farm land may be difficult for women who are alone, and they may only be able to produce small quantities because they have less access to inputs and labor to work the land. Men have much greater access to larger tracts of land, inputs, and labor, but if the resources men gain are not directed to their households, the situation of malnutrition is likely to remain precarious. Clearly partnership and cooperation from the family level to the community and even district level will need to be emphasized.

There is a strong demand for family planning services, and IMC could provide mothers and fathers with information and knowledge on family planning, and referral to government services or other health providers to ensure couples can access family planning services. If services are absent, there is a need to advocate with the government or other health providers to bring this service into the region. At every level in health, nutrition and behavior change activities – male involvement is critical, and learning to work with them will be important to gain ground on preventing malnutrition.

Study participants clearly identified improving the quality of health services as a core issue. There is the need to ensure steady and sufficient stocking of drugs in the health facilities. Partnership between government and NGOs should be established and strengthened to train the specialized service cadres and to provide logistical support for nutrition services provision.

Such partnership is said to have previously worked well for other services such as HIV/AIDS, particularly the PMTCT program. VHTs need training in areas such as child growth monitoring, weighing of children and promotion of family planning as a way of improving and taking services closer to people. In view of the generally low levels of staffing and the lack of qualified staff especially in the health centers there is need for government and development partners to recruit and train more health and nutrition personnel for the area. Existing staff in the health centers need refresher courses. Because there are multiple factors that impact on nutrition which need to be taken into account when addressing nutrition problems, a joint health and community model is strongly recommended to deliver the services. Health centers should be provided with nutrition assessment tools such as MUAC tapes. There is need to open both supplementary and therapeutic feeding programs. Prevention strategies such as family planning should be emphasized in the community malnutrition programs. Given the strategic location of VHT at the grassroots level, maximum use should be made of them in disseminating important health information to the community – while also not overloading them with to many activities, but rather identify a core set of key health and nutrition issues that they should focus on.

Taken together, despite the many challenges communities face in the north, this is also an extremely hopeful time. It will be important to harness this spirit in programming and with a shared vision work together to reducing and preventing malnutrition in children and improving maternal nutrition.

What		Why	
Key messages	**Key behaviors**	**Perceptions**	**Constraints**
EXCLUSIVE BREASTFEEDING			
Encourage and support mother to exclusively breastfeed for six months Help mothers to initiate breastfeeding within 1hr of birth Do not offer prelacteal feeds Offer the baby colostrum Feed the baby on demand Teach and support mothers on positioning and attachment	Early introduction of foods and liquids Late initiation of breastfeeding Introduction of prelacteal feeds Discarding colostrum Perception of insufficient milk	**Mothers:** Perceived milk insufficiency Milk came in late Prelacteals give baby strength Give pre-lacteals while waiting for breastmilk Colostrum is not good for baby Mixed perceptions on whether to give colostrum or not Mothers perceive they feed the baby on demand	**Mothers:** Mother's lack of time Poor attachment and positioning affecting milk supply Lack of family support Advice from medical providers and others to give other liquids and foods early Lack of knowledge Delivery complication Mixed message Lack of time Working long hours on the farm away from baby Mother/baby have trouble with latch-on Lack of hands on guidance on how to breastfeed Lack of follow up on how breastfeeding is progressing
		Fathers Fathers perceive mother should be well fed to have enough breastmilk Feeding the baby especially breastmilk is mothers work Mixed perceptions on how long mothers should exclusively breastfeed Upon delivery mother should be fed well to increase milk supply Fathers perceive no role for themselves to support mother's breastfeeding except to provide food	**Fathers** Lack of money Poverty Lack of food Lack of knowledge
		Grandmothers Grandmothers perceive breastfeeding as extremely important	**Grandmothers** Lack of understanding of definition of exclusive breastfeeding Lack of money, food, resources to provide and help with grandchildren Lack of knowledge on initiation, and colostrum

		Health provider Health providers have mixed perceptions on how long a mother should exclusively breastfeed Providers have mixed perceptions on when to initiate breastfeeding, whether to provide colostrum	**Health provider** Lack of knowledge Lack of time Lack of training in interactive counseling skills and problem solving

Table 2. Key messages, behaviors, perceptions and constraints on exclusive breastfeeding and complementary feeding

What		**Why**	
Key messages	**Key behaviors**	**Perceptions**	**Constraints**
COMPLEMENTARY FEEDING			
Introduction to solids at 6 months of age Increase quantity of food over time (calories triple) Provide child with a variety of foods – vegetables, fruit, meat, fish, eggs Offer child food frequently at regular intervals Offer food persistently and consistently Offer food at regular intervals even if child refuses	Late introduction to solid foods Small quantities of food offered over time, almost no increase in quantity of food Low nutrient density Inadequate frequency of feeding Lack of knowledge on what to do if child refuses food Lack of responsive feeding Lack of knowledge on hygiene and hand washing before	**Mothers:** Perception that baby cannot digest certain foods When child refuses food once mothers perceive that child is not ready for food or does not want food Mixed perceptions on when child can feed itself Mothers perceive they should have something ready to feed the children the next day as soon as they wake up Child refuses food so liquids are enough **Fathers** Mixed perceptions on when others foods should be introduced – some suggest very early, others late, and others at six months Fathers perceive feeding frequency should be 3x a day plus breastmilk Mixed perceptions on complementary feeding Fathers perceive they do not have a role in complementary feeding	**Mothers:** Lack of food in house Baby refuses food Lack of knowledge on: how much to feed baby what responsive feeding is type and consistency of food to offer baby how and when to gradually increase quantities and variety over time the importance of variety and diet quality how frequently to feed child being persistent with offering child food on many occasions handwashing with soap before feeding a child food safety and infections feeding the child when is sick Lack of variety in household and family diet No special foods for the child due to lack of food resources Child gets what child can eat within what is prepared for family like soup or porridge Lack of time to engage in responsive feeding Instructing older siblings to feed and care for child

Interact with child and feed child up until 8 months When child shows signs of readiness – good motor skills in picking up food and feeding self – sit with child and encourage and feed child frequently Wash hands with soap and clean water before feeding a child or child feeds self Offer a child freshly prepared food Feed a sick child during and after illness	feeding child or child feeds himself Lack of food safety – warming up left over food for children the next day Lack of knowledge on feeding the sick child	**Grandmothers** Mixed perceptions on when others foods should be introduced – some suggest very early, others late, and others at six months **Health provider** Mixed perceptions on what complementary feeding is, age when to start	while siblings do not know how to care for child Lack of water and soap to maintain hygiene practices Lack of resources to buy soap Lack of sufficient clean water Lack of time **Fathers** Lack of knowledge on what complementary feeding is and what steps it consists of Lack of money and food **Grandmothers** Grandmothers lack money, food, or any other resources and are unable to provide for grandchildren Lack of knowledge on what complementary feeding means and consists of, what steps are included **Health provider** Lack of knowledge of what complementary feeding consists of Lack of training Lack of time with mothers

Who	When	How
Audience	**Contacts/Channels**	**Approach**
Health provider		
Health providers	Training	Provide all health providers across the continuum of facility-based to community-based providers including traditional birth attendants with training on IYCF, hygiene, and food safety practices, and provide refresher trainings subsequently
Community		
Community champions	Community events Community level champions training	Provide key community leaders and elders with basic information on IYCF and help them identify roles to support and champion good IYCF practices, especially supporting positive role models for fathers.
Family		
Grandmothers	Community events Interaction during home visits with grandmothers when present	Use grandmothers groups, similar to mother-support groups, or courtyard sessions, to provide grandmothers with accurate information on IYCF practices, and help them identify/strengthen the supporting role they can play when they interact with mothers
Fathers	Fathers groups meeting One-on-one counseling Community events Mass media Health visits Health campaigns	Use fathers groups, to promote positive role models for fathers, help fathers identify a role for themselves in helping mothers, and provide them with accurate information on IYCF practices Positive role models for fathers: Fathers reducing mothers work burden Father doing household chores and child care Fathers providing resources for adequate food and health needs
Older children	Child-to-child	In households where fathers are absent, or mothers rely on older children for child care, use a child to child approach focusing messages on hygiene, hygiene before feeding, complementary feeding, and food safety, for children to learn and practice
Primary caregiver		
Mothers	Group meetings Leader mothers Home visits Peer-to-peer support Ante-natal care Health visits Health campaigns	Group mothers by physiological age of baby eg (group pregnant mothers, mothers with infants less than 6 months, mothers with babies 6-12 months, mothers with babies 12-23 months, provided these targeted groups with messages relevant to the stage of the child (eg. With pregnant mothers discuss exclusive breastfeeding, and some sessions on infant feeding at six months; with mothers with infants aged 0-6 months discuss breastfeeding difficulties, milk supply, etc) Provide mothers with intensive peer to peer support immediately following delivery – peers can be identified by leader mothers as mothers who have successfully breastfed and have a baby gaining

		weight, and who do not complain of insufficient milk (indicative of good positioning and attachment) Train peer mothers in basic breastfeeding support on positioning and attachment techniques, to provide hands on support.

Exclusive breastfeeding	
Audience (who): Fathers	
Messages (What)	
Support the mother to exclusively breastfeed Mothers need enough time each day to breastfeed the baby for the first 6 months of life: • Help the mother by doing some of her work for her (like childcare, farming, and household chores) so that she has enough time to breastfeed each day. • Help the mother get enough rest, food and water so she has enough breastmilk • If the mother complains she is not getting enough milk, get help from health providers or talk to elder women or other breastfeeding mothers to get help	
Why is this practice important	
Exclusive breastfeeding is the best way to ensure the baby has all his/her nutritional needs met for the first 6 months of life Exclusive breastfeeding reduces the risk of infection in young infants	
What is their role	
Fathers should understand why exclusive breastfeeding is important and their role in supporting exclusive breastfeeding. They should understand what they can do to help and support the mother so she can successfully breastfeed. More knowledge on exclusive breastfeeding can help fathers know: • what to expect from the mother when baby arrives • when to get help for the mother when she faces breastfeeding difficulties • how they can help the mother by helping with farming and household chores • how they can help by just providing for the mother, baby, and family	
When to give this message	**How give this message**
• Antenatal care • Around delivery • During the first 6 months of infants life	Use fathers groups and TIPS for fathers to help them understand their role and identify things they can do to support the mother for breastfeeding Provide fathers with messages at the health centres and in antenatal care

Breastfeeding initiation	
Audience (who): Fathers	
Messages (What)	
Ensure the mother is supported to give colostrums • Talk to those who will help her at delivery ask them: o to help put the baby to breast within 1 hour of the birth o to give the baby only breastmilk and nothing else	
Why is this practice important	
• Colostrum or the first milk is a yellowish liquid that the mother gets in small quantities. This is essential for the baby as it contains antibodies and protects the newborn against infection • Many mothers believe that their milk comes in late, but the more a baby sucks on the breast after delivery the quicker a mother's milk will come in.	
What is their role	
Fathers should understand the importance of giving only breastmilk immediately after birth and try to go to antenatal care with the mother and participate in planning for the delivery and talk with providers about breastfeeding immediately after birth and giving nothing else but breastmilk	
When to give this message	**How give this message**
• Antenatal care • Around delivery	Use fathers groups and TIPS for fathers to help them understand their role and identify things they can do to support the mother for breastfeeding Provide fathers with messages at the health centres and in antenatal care

Exclusive breastfeeding
Audience (who): Grandmothers
Messages (What)
Support the mother to exclusively breastfeed • Mothers need enough time each day to breastfeed the baby for the first 6 months of life: o Help the mother by doing some of her work for her (like childcare, farming, and household chores) so that she has enough time to breastfeed each day. o Help the mother get enough rest, food and water so she has enough breastmilk o If the mother complains she is not getting enough milk, get help from health providers or other successfully breastfeeding mothers
Why is this practice important

• Exclusive breastfeeding is best way to ensure the baby has all his/her nutritional needs met for the first 6 months of life • Exclusive breastfeeding reduces the risk of infection in young infants	
What is their role	
Grandmothers should understand their role in exclusive breastfeeding – what can they do to help and support the mother so she can successfully breastfeed? Grandmothers can talk to fathers and other family members to get help and support for the mother to have time to breastfeed.	
When to give this message	**How give this message**
• Around delivery • During the first 6 months of infants life	Use grandmothers groups similar to mother-support groups to discuss breastfeeding
Breastfeeding Initiation	
Audience (who): Grandmothers	
Messages (What)	
Ensure the mother is supported to give colostrums • Talk to those who will help her at delivery ask them: o to help put the baby to breast within 1 hour of the birth o to give the baby only breastmilk and nothing else	
Why is this practice important	
• Colostrum or the first milk is a yellowish liquid that the mother gets in small quantities. This is essential for the baby as it contains antibodies and protects the newborn against infection • Many mothers believe that their milk comes in late, but the more a baby sucks on the breast after delivery the quicker a mother's milk will come in.	
What is their role	
• If grandmother will be present at delivery or know those who will help the mother deliver, she should try to discuss the delivery with the mother and the birth attendants about breastfeeding immediately after birth and giving nothing else but breastmilk	
When to give this message	**How give this message**
• Around delivery	Use grandmothers groups similar to mother-support groups to discuss breastfeeding

Exclusive breastfeeding
Audience (who): Mothers
Messages (What)
Exclusively breastfeed your baby for the first 6 months: • While you are still pregnant discuss exclusive breastfeeding with those in your community who will help you deliver the baby

- Discuss with your family ways that they can help you have enough time to breastfeed
- Try to get rest, drink plenty of water, and eat well so you have enough breastmilk
- If you feel that you are not producing enough milk or that baby is struggling with breastfeeding get help from other breastfeeding mothers, health providers, or grandmothers
- If you have difficulty with breastfeeding get help immediately

Why is this practice important

- Exclusive breastfeeding is best way to ensure the baby has all his/her nutritional needs met for the first 6 months of life
- Exclusive breastfeeding reduces the risk of infection in young infants
- Both mother and baby have to learn how to breastfeed successfully. If the baby has trouble latching on the nipple or the mother has difficulty positioning the baby at the breast she can eventually have difficulty producing enough milk. Mothers need to be encouraged to get help early from health providers or other mothers who have breastfeed successfully.

When to give this message	How give this message
• Antenatal care • Before and immediately after delivery • During the first 6 months of infants life	Use mother-support groups, or the care model, peer to peer support

Breastfeeding initiation

Audience (who): Mothers

Messages (What)

Give your baby your first milk, and put your baby to the breast within one hour of birth:
The more you put the baby to the breast immediately after birth the more quickly your milk will come in. The baby sucking on the breast tells your body to begin producing milk.

- Before delivery, talk to those who will help you at delivery and tell them:
  - Once I deliver help me put the baby to my breast within 1 hour of birth
  - Once I have delivered, I want to give my baby only breastmilk and nothing else. Please help me do that

Why is this practice important

- Colostrum or the first milk is a yellowish liquid that the mother gets in small quantities. This is essential for the baby as it contains antibodies and protects the newborn against infection
- Many mothers believe that their milk comes in late, but the more a baby sucks on the breast after delivery the quicker a mother's milk will come in.

When to give this message	How give this message
• During the antenatal period • Before delivery • Immediately after delivery	Use mother-support groups, or the care group model, peer to peer support

Complementary feeding	
Audience (who): Fathers	
Messages (What)	**Why is this practice important**
When to start solid foods	
Support the mother to start solid foods from 6 months: • Babies should be introduced to the foods you eat in the home from six months and the mother should be supported to continue to breastfeed. • The mother still needs support to have enough time to breastfeed the baby and prepare and feed the baby solid foods. • Once the baby starts eating solid foods it is very important that everyone who feeds the baby washes their hands frequently – before preparing the baby's food, before feeding the baby, after feeding the baby, after going to the toilet. • Help the mother by buying soap for her • Help the mother by getting water and fuel for her so she has more time to feed the baby • Help the mother by doing some of the mother's work, like looking after the older children, getting water, fuel, food, preparing food, farming her land etc. • Help the mother by using water guard to keep the water clean and safe.	• At six month the baby's stomach is ready to use solid foods. Before six months breastmilk is best. • From six months babies also need more food to grow than what they get from breastmilk alone
What to give the baby	
• New foods should be introduced slowly. • Support the mother to increase the variety of foods your baby gets including local vegetables, eggs, meat, dairy, and fruits. • Help the mother of your baby by getting and giving her a variety of foods and not just staple foods	• Babies need vegetables, beans, fruit, meat, dairy and eggs to be strong and healthy and grow well
How often to feed the baby solid foods in a day	

• From 6 to 12 months of age babies need to gradually increase the number of meals and snacks they have in a day. Starting at 6 months with 2 meals and 1 snack per day and gradually increasing so that by 12 months having 3 meals and 3 snacks a day • Help the mother by doing some of her work so she has enough time to feed the baby. • Help the mother by taking care of the other children so she has time to prepare food for and feed the youngest baby.	• Babies have small stomachs so they need to eat small meals and snacks frequently so they get enough to grow • Continued breastfeeding is also important to help the baby grow and be healthy
How should this change over time as the baby gets older	
• The quantity of food given to the baby should increase from 6 to 12 months so that by 12 months the baby is eating more foods and having less breastmilk. • The variety of foods offered should continue to increase • The texture of the food should gradually change over time going from thin soups to thick gruels. By 12 months foods for a baby should no longer be diluted.	• Babies usually start with eating very dilute foods such as porridges and gruels, but very quickly they get ready to eat the same foods adults do. The consistency of the food needs to change so the baby can grow well
What is their role	
Fathers have very little knowledge of complementary feeding. But if they understand how important it is, what to do, when to introduce foods, and what role they can play in helping mothers with complementary feeding they can feel empowered to get involved and play a more supportive role. They should understand that a little help from them can go a long way in helping mothers improve practices. More knowledge on complementary feeding can help fathers know: • when, what, and how often solid foods should be introduced/given • when to get help for the mother when she faces feeding difficulties • how they can support the mother to continue breastfeeding • how they can help the mother by helping with farming and household chores • how they can help by just providing for the mother, baby, and family	
When to give this message	**How give this message**

• During the first year of life	Use fathers groups and TIPS for fathers to help them understand their role and identify things they can do to support the mother for complementary feeding Provide fathers with messages at the health centres

Complementary feeding	
Audience (who): Grandmothers	
Messages (What)	**Why is this practice important**
When to start solid foods	
Support the mother to start solid foods from 6 months: • Babies should be introduced to the foods you eat in the home from six months and the mother should be supported to continue to breastfeed. • The mother still needs support to have enough time to breastfeed the baby and prepare and feed the baby solid foods. • Once the baby starts eating solid foods it is very important that everyone who feeds the baby washes their hands frequently – before preparing the baby's food, before feeding the baby, after feeding the baby, after going to the toilet. • Help the mother by getting (or instructing older children or family to get) water and fuel for her so she has more time to feed the baby • Help the mother by doing some of the mother's work, like looking after the older children and preparing food.	• At six month the baby's stomach is ready to use solid foods. Before six month breastmilk is best. • From six months babies also need more food to grow than what they get from breastmilk alone
What to give the baby	
• New foods should be introduced slowly. • Support the mother to increase the variety of foods your baby gets including local vegetables, eggs, meat, dairy, and fruits. • Help the mother of your grandbaby when you can by providing or giving her with a variety of foods and not just staple foods – like simsim, peanuts, boo, etc.	• Babies need vegetables, beans, fruit, meat, dairy and eggs to be strong and healthy and grow well
How often to feed the baby solid foods in a day	

• From 6 to 12 months of age babies need to gradually increase the number of meals and snacks they have in a day. Starting at 6 months with 2 meals and 1 snack per day and gradually increasing so that by 12 months having 3 meals and 3 snacks a day • Help the mother by doing some of her work so she has enough time to feed the baby. • Help the mother by taking care of the other children so she has time to prepare food for and feed the youngest baby.	• Babies have small stomachs so they need to eat small meals and snacks frequently so they get enough to grow • Continued breastfeeding is also important to help the baby grow and be healthy
How should this change over time as the baby gets older	
• The quantity of food given to the baby should increase from 6 to 12 months so that by 12 months the baby is eating more foods and having less breastmilk. • The variety of foods offered should continue to increase • The texture of the food should gradually change over time going from thin soups or porridge at 6 months to thick gruels by 12 months. By 12 months foods for a baby should no longer be diluted.	• Babies usually start with eating very dilute foods such as porridges and gruels, but very quickly they get ready to eat the same foods adults do. The consistency of the food needs to change so the baby can grow well
What is their role	
Grandmothers can give mothers a lot of support if they can update their knowledge on complementary feeding. They have a lot of experience, so for many this will mean orienting them in what is best for the baby, and identifying ways they can help mothers. Grandmothers should know that they can help mothers feed their grandbabies well. More knowledge on complementary feeding can help grandmothers know: • when, what, and how often solid foods should be introduced/given • when to get help for the mother when she faces feeding difficulties • how they can support the mother to continue breastfeeding • how they can help the mother by helping with farming and household chores • how they can help by sharing their knowledge and bringing healthy foods for the baby when possible Grandmothers can also talk to father and family to provide the mother with support and help so the mother has enough time to prepare food frequently and feed the youngest child.	

When to give this message	How give this message
• During the first year of life	Use grandmothers groups similar to mother-support groups to discuss complementary feeding

Complementary feeding	
Audience (who): Mothers	
Messages (What)	**Why is this practice important**
When to start solid foods	
Your baby is ready to start solid foods from six months: • Introduce your baby to the foods you eat in the home from six months and continue to breastfeed your baby also. • It takes time to prepare meals and food for the baby often, try to get help from other family members with your work so you have enough time to prepare the baby's food and feed the baby. • Once the baby starts eating solid foods it is very important that everyone who feeds the baby washes their hands frequently – before preparing the baby's food, before feeding the baby, after feeding the baby, after going to the toilet.	• At six month the baby's stomach is ready to use solid foods. Before six months breastmilk is best. • From six months babies also need more food to grow than what they get from breastmilk alone
What to give the baby	
• Introduce new foods to your baby slowly • Slowly increase the variety of foods you give your baby, including local vegetables, eggs, meat, dairy, and fruits.	• Babies need vegetables, beans, fruit, meat, dairy and eggs to be strong and healthy and grow well
How often to feed the baby solid foods in a day	

• From 6 to 12 months of age babies need to gradually increase the number of meals and snacks they have in a day. Starting at 6 months with 2 meals and 1 snack per day and gradually increasing so that by 12 months having 3 meals and 3 snacks a day • It takes time to prepare food for your baby several times a day, so talk with your family to see how they can help. • If you have older children (older than 12 years of age), teach them how to prepare food for the baby in a clean and safe way. Also teach them how to feed the baby • It takes time for a baby to adjust to eating solid foods and new foods, be patient and keep trying to offer foods. • Offer your baby food frequently and at regular intervals in the day, while also continuing to breastfeed • Offer food to your baby, but if he/she refuses to eat, try again later	• Because a baby's stomach is small, babies need to be fed often throughout a day with small frequent meals. This will help babies grow well.

How should this change over time as the baby gets older	
• The quantity of food you give to your baby should increase from 6 to 12 months so that by 12 months the baby is eating more foods and having less breastmilk. • You should continue to breastfeed your baby, but by 12 months breastmilk will no longer be the baby's main food • The variety of foods offered should continue to increase • The texture of the food should gradually change over time going from thin soups to thick gruels. By 12 months foods for a baby should no longer be diluted.	• Babies have small stomachs so they need to eat small meals and snacks frequently so they get enough to grow • Continued breastfeeding is also important to help the baby grow and be healthy
How to feed the baby over time as the baby gets older	
• Sit with your baby and feed your baby • As your baby gets older your baby may start to pick up food him/herself, when your baby is ready help your baby learn to feed him/herself • Stay with your baby throughout the meal time, try to get others in your family to help with other duties at that time	• Babies usually start with eating very dilute foods such as porridges and gruels, but very quickly they get ready to eat the same foods adults do. The consistency of the food needs to change so the baby can grow well.
How to keep food safe and clean to feed baby	
• Try to offer your child freshly prepared food for each meal and snack, this can help prevent infections and illness from spoilt food • Keep the area where you prepare the baby's food clean before and after preparing food for the baby • Try to ask your family members to get you clean water and more fuel so you can prepare foods for the baby safely • Discuss with your family members the importance of hand washing with soap and clean water before and after preparing food, feeding the baby, or going to the toilet	• Foods that are not stored well or are stored for too long and fed to the baby the next day carry the risk of infection. Because food can spoil easily and hygiene is very important to prevent infection, providing a baby with freshly prepared foods is best.
How to feed your baby when baby is sick	

• When your baby is sick, he/she may refuse food, but to help your baby get better fast, keep offering to breastfeed, and keep offering food to your baby. As your baby starts to feel better, your baby will show more interest in food. • To keep your baby from getting more sick, handwashing with soap and clean water, and preparing food in a safe and clean way are very important at this time.	• Babies often are not hungry when they are sick, but it is important to continue to breastfeed the baby and give fluids. It is also important to give the baby solid foods. Even if the baby refuses, it is important to keep offering them.
When to give these messages	**How give these messages**
• During the first year of life	Use mother-support groups, or the care group model, peer to peer support