COMMUNICATION FOR DEVELOPMENT REPORT

DADAAB REFUGEE CAMPS

FUNDED BY UNICEF
ACKNOWLEDGEMENT.
The finalisation of this report was made possible by the efforts of many individuals through their expert advice and tireless engagement in planning of the various activities such as design of the Formative research TOR, research tools, training, data collection, collation and analysis, report writing, peer review of the various drafts as well as facilitation of the logistical requirements. The role played by ACF, UNICEF, UNHCR and our partners (IRC, IRK, KRCS, MSF) is commendable.

Special thanks go to the ACF team of Evans Bett, Doris Mwendwa, nutrition officers and incentive staff in each of the five Dadaab refugee camps led by Jacob Korir and Alisia Osiro, their Nutrition Managers, Francis Kidake: Nutrition Officer, UNICEF Dadaab, Field Office who all worked on planning, execution of the Formative Research and writing of this report.


Special recognition goes to the ACF management and technical units are also recognized with special mention of Joy Kiruntimi: Deputy Country Director and Geoffrey Olunga: Field Coordinator, Dadaab Base - ACF Kenya Mission for their unwavering support.
# Table of Contents

ACKNOWLEDGEMENT .................................................................................................................. i
List of Tables ................................................................................................................................ iii
List of Figures ............................................................................................................................... iv
List of Appendices ......................................................................................................................... iv

ACRONYMS AND ABBREVIATIONS ......................................................................................... v

1. EXECUTIVE SUMMARY ........................................................................................................ 1
   1.1. DEFINITION OF COMMON TERMS .............................................................................. 4

2. INTRODUCTION .................................................................................................................... 5
   2.1. Background of MIYCN programming in Dadaab ....................................................... 5
   2.2. Trends in Nutrition status in Dadaab refugee camps .................................................. 6
   2.3. Health and Nutrition benefits of optimal MIYCN practices .................................... 9

2. PURPOSE AND SCOPE OF THE FORMATIVE RESEARCH .............................................. 10
   2.1. Purpose of the Assessment ......................................................................................... 10
      2.1.1. Specific Objectives ............................................................................................. 10
   2.2. Formative Research Methodology ............................................................................ 11
      2.2.1. Study Design ...................................................................................................... 11
      2.2.2. The Target Population ..................................................................................... 12
      2.2.3. Sample size determination and sampling procedure ......................................... 12
      2.2.4. Data Management ............................................................................................ 13
         2.2.4.1. Data collection procedure and data collection tools .................................. 13
         2.2.4.2. Qualitative data management and analysis ................................................ 14
   2.3. Implementation of the Formative Research ................................................................. 14
      2.3.1. Coordination ..................................................................................................... 14
      2.3.2. Training of the Survey Teams ......................................................................... 14
      2.3.3. Formative Assessment Teams .......................................................................... 15
      2.3.4. Limitations of the survey ................................................................................ 15

3. FINDINGS AND DISCUSSION .............................................................................................. 17
   3.1. General Care Practices affecting MIYCN in Dadaab refugee camps ..................... 17
      3.1.1. Early pregnancy ................................................................................................. 17
      3.1.2. Late Pregnancy .................................................................................................. 20
      3.1.3. Labour and Delivery ......................................................................................... 21
3.1.4. 0–6 months ........................................................................................................... 22
3.1.5. 6–23 months ....................................................................................................... 22
3.2. Maternal Infant and Young Child Feeding Practices ................................................. 23
   3.2.1. Early pregnancy ............................................................................................... 24
   3.2.2. Late pregnancy ............................................................................................... 25
   3.2.3. Labour and delivery ....................................................................................... 25
   3.2.4. 0–6 months .................................................................................................... 26
   3.2.5. 6–23 months ................................................................................................. 27
3.3. Decision makers in MIYCN practices .................................................................... 28
   3.3.1. Decision makers during pregnancy ............................................................... 28
   3.3.2. Decision makers during labour and delivery .................................................. 29
   3.3.3. Decision makers at 0–6 months ................................................................. 31
   3.3.4. Decision makers at 6–23 months ............................................................... 32
   3.4.1. Channels and messages ............................................................................... 34
   3.4.2. Relevance and effectiveness of messages .................................................... 35
   3.4.3. Challenges in passing MIYCN messages ..................................................... 36
   3.4.4. Support and coordination of MIYCN ........................................................ 36
4. CONCLUSION ............................................................................................................. 37
   4.1. General care practices and health seeking behaviour ........................................ 37
   4.2. Maternal and young child feeding practices ...................................................... 38
   4.3. Decision makers on MIYCN practices ............................................................... 39
   4.4. MIYCN Messaging ............................................................................................. 39
   4.5. Coordination of MIYCN .................................................................................... 40
5. RECOMMENDATIONS .............................................................................................. 40
6. BIBLIOGRAPHY ........................................................................................................ 42

List of Tables
Table 1: MIYCN Core indicators - UNHCR 2011/2012 SENS nutrition survey results ............ 9
Table 2: Formative research qualitative sample size for the camps .................................... 12
Table 3: Data collection plan ........................................................................................ 13
Table 4: Team composition .......................................................................................... 15
Table 5: Maternal Infant and Young child Feeding Practices ............................................ 23
List of Figures

Figure 1: Trends in weighted average of acute malnutrition rates in the refugee camps..........................7
Figure 2: Trends in Anaemia among children 6-23 months of age in Dadaab refugee camps: 2008-2012.8
Figure 3: Trends in Anaemia among women of reproductive age in Dadaab refugee camps: 2008- 2012.8
Figure 4: Role played by decision makers (Pregnancy to delivery).................................................................30
Figure 5: Roles played by decision makers (0-23 months)3.4 MIYCN Messaging...........................................33

List of Appendices

Appendix 1: Data collection Tools..................................................................................................................43
### ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACF</td>
<td>Action Contre La Faim</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
</tr>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>BSFP</td>
<td>Blanket Supplementary Feeding Programme</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for Development</td>
</tr>
<tr>
<td>CHWs</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>EBF</td>
<td>Exclusive Breast Feeding</td>
</tr>
<tr>
<td>FANC</td>
<td>Focused Antenatal Care</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>GFD</td>
<td>General Food Distribution</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>GAM</td>
<td>Global Acute Malnutrition</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IMC</td>
<td>International Medical Corps</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>IRW</td>
<td>Islamic Relief Worldwide Kenya</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge Attitudes and Practices</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td>KRCS</td>
<td>Kenya Red Cross Society</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MIYCN</td>
<td>Maternal Infant and Young Child Nutrition</td>
</tr>
<tr>
<td>MSF</td>
<td>Medecins Sans Frontiers</td>
</tr>
<tr>
<td>MTMSGs</td>
<td>Mother to Mother Support Groups</td>
</tr>
<tr>
<td>PLW</td>
<td>Pregnant and Lactating Women</td>
</tr>
<tr>
<td>SC</td>
<td>Stabilization Centre</td>
</tr>
<tr>
<td>SENS</td>
<td>Standardized Expanded Nutrition Survey</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WASH</td>
<td>Water Sanitation and Hygiene</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. EXECUTIVE SUMMARY
Communication for development (C4D) approaches are used to facilitate linkages that increase knowledge & awareness; builds community and government human resource capacities; change behaviour and practice; shift attitudes and social norms; enhance self-esteem and self-efficacy in and among communities (UNICEF). The main aim is to create a level playing field where dialogue allow every child, woman, family and community to access information, skills, technologies, and processes they need to generate their own solutions and reach their full potential. This report highlights not only the varied care practices and behaviours but also the factors that predisposes, reinforces, facilitates or inhibits these behaviours and practices in the Dadaab refugee camps.

The report focuses mainly on Maternal Infant and Young Child Feeding practices while delving into cross-cutting influences arising from other sectors such as health, protection, Water Sanitation and Hygiene among others. This is in recognition that nutrition outcomes are a factor of multiple determinants as highlighted by the UNICEF conceptual framework of malnutrition. Optimal MIYCN practices are critical to maternal child health and development. Studies show that the period from birth to two years of age is particularly important because of the rapid growth and child’s development. Early initiation of breastfeeding within an hour of birth, exclusive breastfeeding for 6 months and timely initiation of complementary foods with continued breastfeeding for at least two years are necessary to ensure proper growth of a child.

This formative research reviewed existing data from surveys, assessments, monthly reports and data from the UNHCR Health Information System (HIS). This secondary data was strengthened by collection of primary data at community level through conducting focus group discussions and key informant interviews. The target groups comprised of direct beneficiaries - the pregnant and lactating mothers. Indirect beneficiaries - mother in laws, grandmothers, MIYCN supervisors and counsellors and community health workers. In the key informant interview, health and nutrition partners working in the different camps were sampled and mostly included MIYCN focal points and health and nutrition coordinators from the health implementing partners per camp. A total of 25 FGDs and 32 KIIIs were conducted across the 5 camps.

The report observes that there has been significant improvement in most of these key MIYCN indicators in the camps over the past years which could be attributed to increased knowledge
on MIYCN at camp level from the continuous sensitization session and four day MIYCN trainings the ACF team has been conducting targeting the community through UNICEF funding and technical support. However, an in-depth analysis of existing data from annual health and nutrition assessments show consistently high anaemia rates among children under five with the most affected being children 6-23 months of age whose rates of anaemia are way above the critical threshold of 40%. Concurrently high stunting rates have also been observed among this age group further revealing the existing gap in translating nutritional knowledge into appropriate practices for improved health and nutrition outcome.

Further, these findings indicate that for general care practices, the community takes good care of their pregnant women. The period of pregnancy to delivery is considered sacred and several religious ceremonies are conducted during this period. Once confirmed to be pregnant mothers are not allowed to carry heavy loads and more often someone will be sent to stay at home with the mother during pregnancy. In most cases the mother in law or grandmother will be the one who stays with the mother. However, most mothers either discover late that they are pregnant delay to access the health facilities for routine ante natal care. The mothers also rarely take the iron/folate supplements provided at the clinics as per the health worker’s prescription, a practice which further aggravates their HB level status. Myths around maternal nutrition in pregnancy were also listed as restricted energy intake for fear of delivering big babies. Mothers are encouraged by health workers to deliver at home however some still prefer to deliver at home with the assistance of their mother in laws or traditional birth attendants, a practice considered to hinder safe delivery. These practices are believed to contribute to higher rates of neonatal mortality and poor nutrition.

The report observes that after delivery some mothers and caregivers continue to propagating practices considered harmful and a barrier to optimal nutrition such as delayed initiation of breastfeeding especially among women who deliver at home, giving of pre-lacteals such as sugar water or in some rare cases salt solution among others, practices which hinder achievement of exclusive breastfeeding. In addition, complementary feeding is delayed way after 6 months of age besides either restricting or having limited access to energy and nutrient dense complementary foods. Continued breastfeeding is further curtailed before the recommended two years minimum period especially when lactating mothers conceive too soon.
The report rates husbands as the major decision makers in the household in all matters including aspects that affect maternal, infant and young child nutrition yet they are not targeted effectively in behaviour and social change. At the community level traditional birth attendants, grandmothers and mother in laws were considered as key decision makers as most mothers trust them to help them deliver at home or accompany them to the hospital during labour and delivery. The TBAs, grandmothers and mothers in-law in particular are pointed out as the main influencers on choices made by the mothers on whether to deliver at home or in health facility.

It is clear that there have been major gains made in the refugee community in terms of improving maternal, infant and young child nutrition, this report highlights that there are still significant gaps in the design of the C4D strategy for behaviour and Social change communication. There are institutional inadequacies in terms of segmentation of messages, the channels and audiences as well as effective monitoring and evaluation in the whole planning and implementation cycle. However there are strong lessons learnt and opportunities identified for achieving sustainable programming in C4D. The report therefore recommends building on the identified good practices such as community support systems for pregnant women that reduce maternal work load, the value for children and the place of religion in reproductive health to champion for good care practices. The research identifies community dialogue that rides on interpersonal communication, use of mentorship, on the job- training and support supervision as more client sensitive approaches for C4D as opposed to passive audio and visual channels of engaging communities.

Going forward the report sets the stage for a design of a cross-sectoral C4D strategy that is systematic in achieving positive and holistic behaviour change in the refugee camps by leveraging from other sectors such as WASH, immunization, Health, Child Protection just to mention a few. **KEY WORDS: Communication for Development (C4D), Maternal Infant and Young Child Nutrition, Formative Research, Messaging, Care Practices, behaviour, social change.**
1.1. DEFINITION OF COMMON TERMS.

Communication for Development (C4D): Systematic, planned and evidence based strategic process that is intrinsically linked to programme elements; uses consultation and participation of children, families, communities and networks, privileges local contexts; and relies on a mix of communication tools, channels and approaches, to promote positive and measurable behaviour and social change.

Positive Deviance - An approach to behavioural and social change built on the principal and observation that in any community, there are people whose uncommon but successful behaviours or strategies enable them to find better solutions to a problem than their peers, despite facing similar challenges and having no extra resources or knowledge than their peers.

Behaviour Change Communication - This is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioural change or positive behaviour maintenance for a better quality of life...it is based on proven theories and models of behaviour change.

Mentorship - In this case we refer to a relationship in which more experienced and knowledgeable health workers, caregivers and mothers or opinion leaders in the community help/assist in guiding less experienced or less knowledgeable peers in adopting acceptable behaviour and practices.

Cohort - This research considered a cohort as a targeted group of people or individuals who have shared distinct characteristics such as an age-set, development milestones, same needs etc. they were grouped into early and late pregnancy, Children 0-5 Months of age and 6-23 months of age women, children below the age of one year, among other categories.

Exclusive breastfeeding - Refers to the form of nutrition where the infant receives only breast milk for the first 6 months of life without giving any other liquids or solids- not even water - with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines (WHO).
2. INTRODUCTION

There are about 567,228 refugees in Kenya, 90% are Somali refugees\(^1\). More than two thirds (402,000)\(^2\) of these refugees live in the 20-year-old Dadaab complex consisting of 5 refugee camps in Garissa County. A humanitarian crisis in the horn of Africa region in 2010/2011 characterised by drought, famine and protracted armed conflict triggered the influx of about 150,000 refugees from south and central Somalia into already overstretched camps in Kenya. This complex emergency resulted in adverse effects on the health and nutrition status of all refugees with acute malnutrition rates rising from 7.9% in 2010 to an average of 20% in 2011\(^3\). The emergency and sustained influx of Somali refugees further impacted negatively on the delivery of health, nutrition and water and sanitation services in the camps and the host community due to limited resources available.

2.1. Background of MIYCN programming in Dadaab

For the last 20 years several strategies have been promoted among all the communities in Dadaab to improve care practices and health seeking behaviour. In June 2005, CARE International initiated a program to support and promote appropriate Maternal Infant and Young Child Nutrition (MIYCN) practices in Dadaab Refugee camps following the low Exclusive Breastfeeding (EBF) rate of (4.1%) as reported in the nutrition survey of 2005\(^4\). Some of the objectives of CARE supported IYCF program were; to increase the technical knowledge and skills of staff required to support appropriate IYCF practices and related maternal nutrition in Dadaab, to integrate IYCF behaviour change activities into health and nutrition activities at hospitals, health posts and community level and to advocate for infant and young child feeding policies based on international standards among the agencies implementing in Dadaab\(^5\). The strategy employed by CARE included establishment of community level structures (mother to mother support groups), development of MIYCN messages and tools in different languages, supported development of a training curriculum for health workers and engagement in the operational research among other activities. The programme was later handed over to Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), in 2008

---

\(^1\) UNOCHA April 2013
\(^2\) UNHCR August 2013 progress report
\(^3\) UNHCR 2010/2011 Annual survey weighted averages
\(^5\) UNHCR/GTZ 2009 KAP survey of infant and young child feeding practices in Dadaab refugee camps
focusing on integration and sustainability of the strategies and structures that had been put in place. However, by the year 2011 the gains made in improving infant and young child nutrition among children under 5 years had been considerably eroded especially by the events of the horn of Africa crisis.

UNHCR and UNICEF approached Action Against Hunger (ACF) in 2011 with a primary goal of revitalizing dormant MIYCN structures and strategies. This was aimed at strengthening, integrating and sustaining MIYCN interventions within the mainstream health and nutrition programs of partner organizations. ACF has since been working closely with 5 health and nutrition partners across all camps (IRC in Hagadera/Kambioos, MSF in Dagahaley, KRCS in Ifo 2, IRW, in Ifo main) . Through this programme ACF has managed to form and sustain 774 MTMSGs across all the camps reaching an average of 8,200 pregnant and lactating mothers on monthly basis from a baseline of 286 MTMSGs in all camps by May 2012, all of which were in Hagadera camp.

2.2. Trends in Nutrition status in Dadaab refugee camps

The nutrition situation in Dadaab has improved significantly in the last 2 years in the camps. Nutrition survey results of 2012 showed Global Acute Malnutrition (GAM) of 10.3% ,13.1% ,15%\textsuperscript{6} for Hagadera, Dagahaley and Ifo 2 respectively with the prevalence of malnutrition in under five year old children falling below 15% (the level which denotes a public health emergency). In August/September 2011 the rate (GAM) was 17.2%, 22.4% and 23.2 %\textsuperscript{7} for Hagadera, Ifo and Dagahaley camps respectively while Dagahaley outskirts occupied by new arrivals (2011) reported GAM of 38.3%, see fig 1 below. However, GAM rate for Kambioos still fall above the WHO threshold. Improvements have been attributed to enhanced provision of basic needs and essential services, including water and sanitation, high coverage for supplementary feeding and therapeutic feeding programmes.

\textsuperscript{6} UNHCR 2012 SENS nutrition survey
\textsuperscript{7} UNHCR 2011 SENS nutrition survey
In addition, the annual health and nutrition assessments have consistently reported high anaemia rates among children under five with the most affected being children 6-23 months of age. See figure 2. The rates of anaemia are way above the critical threshold of 40%. Concurrently high stunting rates have also been observed among this age group. These results show that more needs to be done to translate nutritional knowledge into appropriate practices for health and nutrition outcome.

Figure 1: Trends in weighted average of acute malnutrition rates in the refugee camps

Figure 2: Trends in anaemia prevalence among children 6-23 months of age
Africa has the highest proportion of iron deficiency for pregnant women\(^8\). The results of anaemia prevalence in the Dadaab were consistent with this analysis, see fig 3. Anaemia in pregnancy affects foetal growth, stunting, poor cognitive development or mental performance among children under five and reduces overall productivity later on in life.

---


\(^9\) Ifo main results (2012) were nullified and no repeat survey conducted
### Table 1: MIYCN Core indicators - UNHCR 2011/2012 SENS nutrition survey results

<table>
<thead>
<tr>
<th>Camps</th>
<th>Hagadera</th>
<th>Dagahaley</th>
<th>IFO main**</th>
<th>Dagahaley Outskirts**10</th>
<th>IFO 2</th>
<th>Kambioos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early initiation of breastfeeding</td>
<td>82.8%</td>
<td>96.0%</td>
<td>78.2%</td>
<td>63.3%</td>
<td>90.1%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Continued breastfeeding up to 1 year</td>
<td>62.5%</td>
<td>63.4%</td>
<td>69.4%</td>
<td>60%</td>
<td>70%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Timely initiation of complementary feeding</td>
<td>83.3%</td>
<td>66.7%</td>
<td>82.1%</td>
<td>N/A</td>
<td>61.9%</td>
<td>65.9%</td>
</tr>
<tr>
<td>Child ever breast fed</td>
<td>99.3%</td>
<td>93.4%</td>
<td>97.2%</td>
<td>N/A</td>
<td>97.2%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Continued breast feeding up to 2 years</td>
<td>13.3%</td>
<td>22.9%</td>
<td>31.0%</td>
<td>13.2%</td>
<td>31%</td>
<td>31.6%</td>
</tr>
<tr>
<td>Child ever bottle fed</td>
<td>8.1%</td>
<td>3.1%</td>
<td>15.0%</td>
<td>5.2%</td>
<td>15.0%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

**IFO main 2012 survey results were nullified and the repeat survey (2013) not accomplished**

### 2.3 Health and Nutrition benefits of optimal MIYCN practices

Optimal MIYCN practices are critical to maternal child health and development. Studies show that the period from birth to two years of age is particularly important because of the rapid growth and child’s development. Breastfeeding exclusively for the first 6 months along with complementary feeding from 6 to 24 months of age is highly beneficial and is associated lower infant morbidity and mortality from diarrhoea and respiratory infections\(^\text{11}\). In 2011 alone, over 800,000 child deaths (11.6% of all deaths) were attributed to sub optimal breastfeeding\(^\text{12}\). Appropriate MIYCN practices (EBF and complementary feeding) have the potential to cumulatively prevent up to 13% of all child deaths\(^\text{13}\). These common childhood illnesses compromise optimal growth and development of children, especially when caretakers introduce fluids and solid foods before the age of 6 months. The WHO therefore recommends

---

\(^{10}\) Refugee population who were living in Dagahaley outskirt were resettled in IFO 2 camp


\(^{13}\) Jones E et al. Child survival study group (BCSS) How any deaths can we prevent?. The lancet 2003;362(9377): 65-71
exclusive breastfeeding for the first 6 months of life after which breastfeeding should be continued up to or more than 2 years by complemented with other sources of nutrition\textsuperscript{14}.

Data from developing regions show that present practices are far from optimum, despite improvements in some countries. A systematic review of evidence based intervention for improvement of maternal and child nutrition in developing countries concluded that counseling or educational intervention increase exclusive breastfeeding by 43% at birth, by 30% till one month of age, and 18% for 1-5 months of age among infants. Although the results showed potential for scaling up none of these trials address issues of barriers and reinforcers for optimal care practices\textsuperscript{15}. The analysis further recommend that innovative delivery strategies such as social and behaviour change mechanisms by especially utilizing and scaling up community based delivery platforms, have the potential to reach poor population through demand creation at household level.

Having noted the many strategies and approached to social and behaviour change communication, UNICEF and ACF recognized that there were fundamental gaps in positively influencing appropriate care practices among the target beneficiaries in Dadaab refugee camps. This is evident in the poor nutritional status and health seeking behaviour despite the considerable investment done over the last two decades. A formative assessment was therefore recommended to better design a suitable communication for development strategy that builds on existing community and partner’s strengths.

2. PURPOSE AND SCOPE OF THE FORMATIVE RESEARCH

2.1. Purpose of the Assessment

The formative research was intended to assess factors that influence (predisposes, reinforces, facilitates or inhibits) Maternal, Infant and Young Child Nutrition (MIYCN) practices in Dadaab refugee camps. The information generated would inform the design of Behaviour Change Communication intervention, messages and monitoring of behavioural outcomes.

2.1.1. Specific Objectives

\textsuperscript{14} Global strategy for infants and young child feeding. WHO 2001. 54\textsuperscript{th} World Health Assembly A54/INF.DOC/4.WHO

\textsuperscript{15} Bhutta, A Z et al . Evidence based interventions for improvement of maternal and child nutrition: What can be done at what cost. The Lancet 2013 Vol 382 (9890): 462-467
1. To determine factors (social, cultural, economic, contextual, power structures etc.) that impact on MIYCN practices among the beneficiaries.

2. Determine nutrition care seeking behaviour of the target population

3. To determine the capacity of health care providers in supporting and strengthening communication at the health facility and community levels.

4. To integrate communication for social and behaviour change in other MIYCN related interventions in Dadaab refugee camps.

5. To identify existing communication channels and networks into which MIYCN communication for behaviour and social change can be integrated.

6. To establish benchmarks against which behaviour change communication outputs and outcomes would be measured.

7. To recommend health and nutrition partners’ feasible communication for development interventions/strategies to complement the on-going efforts in promoting appropriate MIYCN practices in the refugee camps.

2.2. Formative Research Methodology

2.2.1. Study Design

The formative research was mainly a qualitative study that employed participatory approach and was conducted in two phases. The first phase involved a desk review/secondary assessment of relevant documents which included: past nutrition surveys; Knowledge Attitudes and Practices (KAP) studies; monthly and quarterly progress reports, Baby Friendly Hospital Initiative (BFHI) reports; MIYCN training reports; community communication working group reports and assessments; Dadaab refugee camp health and nutrition reports; and other related health and nutrition reports. The literature review provided insights on past infant feeding practices that were experienced and also support the information collected in the second phase. The second phase involved the use of qualitative methods mainly Key Informant Interviews (KII)s and Focus Group Discussion (FGDs) to various target groups in order to obtain information around the MIYCN practices in the community as well as the barriers to such practices according to the set study questions.
2.2.2. The Target Population
The formative research assessment was conducted in the Dadaab refugee camps where ACF implements MIYCN programme. The study population comprised of: direct MIYCN beneficiaries (pregnant and lactating mothers); indirect MIYCN beneficiaries (mother in-laws, grandmothers); MIYCN supervisors and counsellors; Community Health Workers (CHWs); community leaders and religious leaders as they are believed to be the gatekeepers in the society. Sampled health and nutrition partners’ focal points and coordinators from IRW, International Rescue Committee (IRC) and Kenya Red Cross Society (KRCS) were also interviewed during the assessment.

2.2.3. Sample size determination and sampling procedure
The sample sizes used in the formative research to collect qualitative data were established by purposive sampling covering the 5 camps. The study adopted World Health Organization (WHO) 2005 cluster sampling. There were five (5) clusters which represented the camps (Kambioos, Hagadera, IFO Main, IFO II, and Dagahaley). Six (6) sub clusters representing different categories of respondents were purposively selected. Purposive selection was done to enhance representativeness; one block was randomly sampled in each camp for mother to mother support group members (pregnant and lactating) and mother in-laws and grandmothers. MIYCN counsellors, supervisors and community leaders were selected from each section. Religious leaders on the other hand were selected purposively based on their availability. A total of 25 FGDs and 32 KIIIs were conducted across the 5 camps. The resulting sample sizes for the study questions are shown in the Table 2 below.

Table 2 : Formative research qualitative sample size for the camps

<table>
<thead>
<tr>
<th>Sub category per camp</th>
<th>FGDs</th>
<th>KIIIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Pregnant and lactating women</td>
<td>5 (1 per camp)</td>
<td>-</td>
</tr>
<tr>
<td>b. Mother in-laws and grand mothers</td>
<td>5 (1 per camp)</td>
<td>-</td>
</tr>
<tr>
<td>c. Supervisors &amp; Counselors</td>
<td>5 (1 per camp)</td>
<td>5 (1 per camp)</td>
</tr>
<tr>
<td>d. Community health workers</td>
<td>5 (1 per camp)</td>
<td>5 (1 per camp)</td>
</tr>
<tr>
<td>e. Religious leaders</td>
<td>-</td>
<td>5 (1 per camp)</td>
</tr>
</tbody>
</table>
2.2.4. Data Management

2.2.4.1. Data collection procedure and data collection tools

The formative assessment collected key general and MIYCN feeding practices from the refugee community and barriers that hinder optimal MIYCN practices. The assessment adapted a cross-sectional study design using qualitative data collection methods; focus group discussions and in-depth key-informant interviews. Data collection tools were developed and covering pertinent questions highlighted in the research protocol. The tools were revised with inputs from the participants during the training before the start of the data collection process.

The FGDs were conducted to a cross-section of the community members to solicit their perceptions on factors influencing MIYCN practices in Dadaab refugee camps. FGDs targeted selected sample of; pregnant and lactating women, CHWs and IYCN counsellors. There were 8-12 participants in each FGD who were randomly selected by the counsellors prior to the assessment. Guidelines used in conducting FGDs were observed by the scribe, observer and facilitator during the discussions with the respondents. KII schedule were used to provide guidance in the interviews with the key-informants. The formative research assessment data collection process took a total of 3 days (11th - 13th June 2013) with one day for content analysis and data entry. The team were spread out as follows during the 3 day formative assessment.

Table 3: Data collection plan

<table>
<thead>
<tr>
<th>Team</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team 1</td>
<td>Kambioos</td>
<td>IFO</td>
<td>Dagahaley</td>
</tr>
<tr>
<td>Team 2</td>
<td>Hagadera</td>
<td>IFO II</td>
<td>Dagahaley</td>
</tr>
<tr>
<td>Team 3</td>
<td>Kambioos</td>
<td>IFO</td>
<td>Kambioos</td>
</tr>
<tr>
<td>Team 4</td>
<td>Hagadera</td>
<td>IFO II</td>
<td>Dagahaley</td>
</tr>
</tbody>
</table>
2.2.4.2. Qualitative data management and analysis

The data from both focus group discussions and key informant in-depth interviews were transcribed and content analysis conducted. Content analysis involved detailed exploration of common themes and assigning of labels to variable categories. The categories or themes were identified in advance, in line with the objectives and scope of the assessment. The coding consisted of searching for the common themes related to general practices, feeding practices, decision makers, MIYCN messaging, challenges and way forward. Information from FGDs were then inserted into each of the matching categories. The themes were clustered in a patterned order so as to identify variables that predict general concepts and isolate repetitions. Inferences were made from a particular dataset under each theme and conclusions drawn from the findings. The qualitative data drawn from the secondary data were used for triangulation of the findings and to complement the quantitative data obtained from reported interview information.

2.3. Implementation of the Formative Research

2.3.1. Coordination

The formative research was planned, coordinated, directed and implemented by ACF entirely with technical support from United Nations Children’s Fund (UNICEF) C4D and nutrition sections. UNICEF Dadaab nutrition officer, ACF MIYCN program manager, ACF nutrition manager and M&E specialist also ensured quality of the assessment and acted as technical point of reference for clarifying any technical issues arising from the assessment. At the field, partner staff together ACF MIYCN focal point at the camp took the lead in organizing, coordinating and availing the participants for KIIs and FGDs. ACF and UNICEF based in Dadaab worked closely in coordination with UNHCR health and nutrition partners to ensure they are fully involved in planning and data collection for this formative research.

2.3.2. Training of the Survey Teams

In order to enhance quality in data collection process, a one and half days training was conducted to the assessment team members by the formative research team overseeing the assignment. The assessment team was trained on qualitative data collection methods which focused on the objectives of the assessment, interviewing techniques, accurate recording of responses data entry and analysis of MIYCN practices. Since there was limited time for pilot testing of the tools, the team conducted simulation exercises to aid in understanding tools;
UNICEF Dadaab took lead in the exercise by listening and observing the assessment teams as they interacted. Observations made and issues raised were used to improve the tools.

2.3.3. Formative Assessment Teams
The data collection team comprised of 4 teams; consisting of 3 members (table 3), who were drawn from both the ACF nutrition and WASH sectors. Each of the team constituted a scribe, observer and facilitator for FGDs while the team leader interviewed the key informants. At the field level, each team was assigned MIYCN supervisor/counsellor who was the field guide during the data collection.

Table 4: Team composition

<table>
<thead>
<tr>
<th>Team 1</th>
<th>Team 2</th>
<th>Team 3</th>
<th>Team 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M&amp;E manager (Team leader)</td>
<td>Nut Manager (Team leader)</td>
<td>Assistant Manager (Team leader)</td>
<td>MIYCN manager (Team leader)</td>
</tr>
<tr>
<td>MIYCN officer</td>
<td>MIYCN officer</td>
<td>WASH officer</td>
<td>MIYCN officer</td>
</tr>
<tr>
<td>WASH supervisor</td>
<td>HiNi officer</td>
<td>WASH supervisor</td>
<td>HiNi officer</td>
</tr>
<tr>
<td>MIYCN focal point, MIYCN supervisors and counsellors in each camp were charged with the responsibility of mobilizing target groups prior to the assessment and stood as focal points during the data collection</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3.4. Limitations of the survey
The formative research was accomplished on time and within budget however there were some challenges experienced.

1. Translation -
   i. The team members translate information in different ways therefore the end product may not reflect the views of the respondent. In other occasions information translated in English was too summarized yet listening to the participant/respondents dialogue had a lot of content.
ii. Challenges in the teams on how to translate questions. In some cases, the scribe and facilitator did not always agree on translation of the question leading to different versions of the same question

2. Missing information
   i. There are questions which went unanswered during some FGDs. Specific questions in FGDs with mothers, grandmothers and mothers in law were phrased differently when compared to questions in FGDs with incentive workers. As a result question 5c and part of question 5b in the incentive workers FGDs were not exhaustively answered
   ii. There was also information missing on specific roles played by some community members who were mentioned as actors in influencing the decision of mothers in MIYCN practices e.g. shopkeepers
3. FINDINGS AND DISCUSSION

The information in this section is mainly based on the perceptions of the community members who took part in the focus group discussions and experiences of various key informants working or living in different areas of the refugee camp. The section will highlight the general care practices given to mothers and children in the different cohorts, feeding practices, main channels of communication and sources of information on MIYCN at household and community levels. It will also point out how these practices and resources can be barriers to MIYCN or how they can be used to enhance MIYCN interventions.

3.1. General Care Practices affecting MIYCN in Dadaab refugee camps

The information represented in this section details the general and feeding practices in the community that affect maternal and young child well-being during the first 1000 days. It highlights how the community perceives the appropriateness of these practices, why they follow the practices and the challenges they face during this critical window of opportunity. Table 5 below shows general care practices that are observed during the first 1000 days.

3.1.1. Early pregnancy

One common practice that emerged in all the focus group discussions with mothers is that in the refugee population women usually do not realise they are pregnant until when they have missed at least two menstrual cycles. Most women will still be breastfeeding at the time of conception and therefore they do not notice the hormonal changes that occur in their bodies. This means that most women start attending ANC in their second trimester. Pregnant women identified the common signs of pregnancy such as lack of appetite, nausea, vomiting, pica and craving for foods such as lemon, salty foods. These women mostly visit the ANC when they need medical attention due to ailments they might be suffering from when pregnant while other ANC visits are triggered by the Blanket Supplementary Food (BSFP) food ration distributed to pregnant and lactating women at nutrition sites in health facilities twice a month. According to refugee health records, 85% of women in the Dadaab camps will have visited the ANC clinic at least once during pregnancy and only 60% will have achieved the four FANC visits by the time they give birth. During this period, most mothers do not take medications as prescribed at the hospital. Uptake of family planning services is also very low at average of 1% in all the camps thereby negatively impacting on MIYCN practices due to
poor child spacing [12]. Some mothers seek divine assistance when sick, through reciting the Quran and for some ailments she will be given hirsi.

At the ANC clinic pregnant women are given iron folate supplements by health workers. Iron folate supplementation is considered as one of the key High Impact nutrition interventions that have the potential to improve maternal and child survival during the first 1000 days. Iron deficiency anaemia is one of the most common nutritional deficiencies in the refugee camps as discussed above. Maternal iron deficiency has been associated with women giving birth to low birth weight babies (LBWs) and also increases risk of maternal death due to the potential increase of haemorrhage and infection during childbirth [13]. The Dadaab refugee camps nutrition survey report 2012 indicated that anaemia levels are very high in the refugee population, almost 1 out of 3 women of reproductive age were found to have haemoglobin level of <12 g/dL of blood [6]. Unfortunately, it emerged from the assessment that a significant proportion of pregnant women in the community do not take the iron and folate supplements because they believe that the supplements make mothers gain weight. The interviewed women associated iron-folate supplements with causing nausea. Moreover, they mentioned that pregnant women during this period are not allowed to conduct household chores or carry heavy loads chores as this is considered unhealthy for the unborn child. Pregnant women tie a string around the neck and read the Quran often as they believe it will protect them against evil spirits.

Table 5: General practices care practices among pregnant and lactating women

<table>
<thead>
<tr>
<th>Cohort</th>
<th>General child care practices and health seeking behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Pregnancy</td>
<td>• Women reported to often visit antenatal clinics once they notice to have missed two menstrual cycles.</td>
</tr>
<tr>
<td></td>
<td>• Majority of the mothers said they did not take iron folate supplements according to instruction provided by healthcare workers.</td>
</tr>
<tr>
<td></td>
<td>• Women are not allowed by key decision makers such as grandmothers/mothers in-law to carry heavy loads or do a lot of household chores once pregnant</td>
</tr>
<tr>
<td></td>
<td>• Some of the women practice tying of a string around their necks which is perceived to protect them from evil spirits</td>
</tr>
<tr>
<td></td>
<td>• Women are encouraged to read the Quran for spiritual nourishment and good tidings</td>
</tr>
</tbody>
</table>
Cohort | General child care practices and health seeking behaviour
--- | ---
**Late Pregnancy** | • Religious ceremonies are conducted which include animals being slaughtered to invoke ‘blessings’ to mothers in preparation for child birth.
  
  • Mothers visited a sheikh for Quran reading for further spiritual nourishment
  
  • Mothers reported that during this period a string is tied around a mother’s tummy as a measure of preventing ‘evil spirits’
  
  • Mothers are also encouraged by their husband and sometimes older mothers/grandmothers to perform light exercises and avoid heavy work load
  
  • Intimacy with husbands is forbidden during this period
  
  • Most of the mothers visit ANC clinics to access care and follow up by health worker.
  
  • Most of the mothers preferred to sleep outside at night

**Labour and Delivery** | • Health worker and leaders at the facility and community level encouraged mothers to deliver at the health facility. An ambulance (Mama taxi) has been provided for all pregnant mothers seeking delivery services in hospital.

  • However, home deliveries are considered normal as long as mothers can get support from TBAs, mother in law and grandmothers.

  • Mother who opted to deliver in hospitals were accompanied by their TBA

  • Relatives of mothers assisted them to carry out household chores
• Mothers interviewed said that they wash the breasts with ‘divine water’ after delivery.

<table>
<thead>
<tr>
<th>0 – 6 months</th>
<th>6 – 23 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The infant is cleaned immediately after birth using ‘divine water’</td>
<td>• A religious ceremony is conducted by slaughtering a goat to ward away evil from the child</td>
</tr>
<tr>
<td>• A Islamic prayer (religious) called <em>adhan</em> is offered to the new born</td>
<td>• Most mothers said they take their children to the health clinic for immunization and treatment of common childhood ailments.</td>
</tr>
<tr>
<td>• A child naming ceremony is conducted to welcome baby</td>
<td>• However, some mothers are still tying a ‘traditional rope’ around the waist of the child to prevent diseases including when they are sick.</td>
</tr>
<tr>
<td>• The new born baby and the mother remain indoors for 40 days after delivery.</td>
<td>• Most mothers to children born with a perceived ‘large’ head use a burning stick from a ‘medicinal tree’ to burn the head ‘back to size’ especially on the forehead.</td>
</tr>
<tr>
<td>• A special tree bark is used to smoke the child’s clothes to remove the smell of urine and stool</td>
<td>• Most caregivers reported to be removing false baby teeth with the help of medicine men and TBAs</td>
</tr>
</tbody>
</table>

### 3.1.2. Late Pregnancy

In this cohort, religious ceremonies are conducted just before delivery. As part of the ceremony animals are slaughtered as the community believes this will prevent evil and bring blessings to the mother, therefore pregnant women are expected to take part in this activity. During the religious ceremony, the respondents said that Sheikhs recite the Quran to the mothers and a string is tied around the mothers’ stomach. They also believe tying a string will
help the mother to deliver normally and reduce chances of associated complications. This is done to prevent evils spirits. Mothers are instructed to perform light exercises like walking and are expected to avoid heavy workload, noise, busy environment and sitting for long periods because at this stage the mother is considered to be weak and ‘heavy’. Mother in-laws and grandmothers believe that pregnant women should not be intimate with their husbands during late pregnancy. During this period, mothers said they prefer to visit health facilities for check-ups as they seek to know the progress of their pregnancy. At the facilities they are given iron and folate supplements for boosting haemoglobin level in order to improve their pregnancy outcome. Prayers are recited for the women at seven and nine months stage of pregnancy, most of them choose to sleep outside at this time and they stop taking multivitamins even if they were prescribed by a health worker.

3.1.3. Labour and Delivery

Mothers are encouraged to deliver at the health facility. However, some still prefer home deliveries since they can get assistance from their mothers’ in-law, TBAs and relatives. The latter practice poses as a barrier to ensuring safe delivery in hospitals. On average, 80% of women deliver in health facilities in Dadaab refugee camps [12]. Agencies encourage deliveries at health facilities by facilitating safe transportation of mothers in labour to health facility for delivery in time and also by providing a baby package which varies with organizations. During day time, these women have the option of calling the agency’s ambulance to take them to the facility and at night, when a woman is in labour she can call mama taxi, a service that will be paid for by the agency working at the specific refugee camp. At labour and delivery, safe motherhood promoters previously known as TBAs who often conducted deliveries either at home have been given the role of escorting mothers in labour to the health facilities in time. The role of the string around the waist changes in this cohort - it is now considered to aid in reducing birth pains. Health workers provide support to mothers in labour through massaging the woman’s stomach, encouraging them to walk or exercise because they believe this will aid in safe delivery. The grandmothers and mothers in law mentioned that in cases where the baby is not positioned properly, mothers are asked to lie on their bellies as a way of achieving proper positioning of the foetus before delivery. Others shake the mothers vigorously to make them deliver faster and conveniently to avoid caesarean section. Normal household chores such as cooking and other tasks are forbidden, the mother gets assistance from grandmothers and relatives. The community believes if a mother cooks then the food will harm the baby.
3.1.4. 0-6 months
Upon delivery, the baby is bathed in ‘divine water’ to protect the child against evil. A religious leader offers prayers called *adhan* which are recited on the right ear and *qama* - recited on the left ear of the child to ensure the child adopts family’s religion from the first day. The Quran is also recited as it is the *suna* of prophet Mohamed. A child naming ceremony is then conducted as a way of welcoming the baby to the world. Following safe delivery, the mother and the baby are expected to stay in the house for the first 40 days as the community believes this prevents the child from contracting airborne diseases. This is a potential practice for reinforcing breastfeeding since during this time the mother gets ample time to bond with her infant especially when given adequate support.

However, due to the changing lifestyles in the camp and a substantial number of female headed households, some mothers break the 40 days practice to venture out since they are the sole breadwinners. Some of the social-economic activities mothers engage in such as running small businesses become barriers to breastfeeding as they interrupt breastfeeding on demand.

Traditional ointment made from herbal tree called *malmal* is applied on the baby to hydrate his/her skin. The infant is bathed in warm water and covered to keep him/her warm. In some discussions, the participants mentioned that the baby is taken to the clinic/facility to receive BCG vaccination a practice the community found to be appropriate as it reduces the risk of diseases.

3.1.5. 6-23 months
The grandmothers reported that in this age bracket, an animal such as a goat is again slaughtered to prevent the child from evil. They also added that the mother and infant are expected to minimize movement as the baby may inhale scents from herbal trees in their immediate environment called ‘*hildid*’ or ‘*lubadin*’ that are believed to cause diarrhoea. The grandmothers strongly believe that these practices are very effective in preventing child morbidity. Caregivers/mothers said that they take their children to health facilities early in life for immunization as well as to seek medical advice and attention where necessary. They believe this will help the baby to be healthy and strong. Some of the other practices mentioned as appropriate included tying the child with a ‘traditional string’ which they believe will prevent diseases. In most cases, communities in the camp especially the Somali and Somali Bantu tribes, practice traditional ‘head burning’. They believe this prevents the
head of the child from enlarging e.g. the hydrocephalus condition. The Quran is also recited for sick children to help them recover divinely. Traditional birth attendants and medicine men remove ‘false’ teeth of infants, a remedy believed to prevent diarrhoea. These two practices are harmful to the health and well-being of young children by predisposing them to infections and unnecessary torture.

3.2. Maternal Infant and Young Child Feeding Practices
Studies have continuously shown that good nutrition early in life is essential for the development of the child. New evidence from the lancet series of maternal and child nutrition reinforces the importance of the nutritional status of women at the time of conception and during pregnancy both for the health of the mother and for ensuring healthy foetal growth and development. Improvements in rates of exclusive and continued breastfeeding can contribute to the reduction of child mortality inequalities in developing countries. Active promotion of breastfeeding can prevent a large proportion of child deaths and disease burden [14]. Table 6 below highlights feeding practices in the Dadaab refugee community from early pregnancy all through to the second birthday of children (the first 1000 days).

Table 5: Maternal Infant and Young child Feeding Practices

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Common feeding practice among the refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Pregnancy</td>
<td>o Most of the women said they eat less food due to nausea and vomiting</td>
</tr>
</tbody>
</table>
| Late Pregnancy     | o It was stated that women are discouraged against eating high protein foods to protect them from allergies and ensure the foetus doesn’t grow too big  
                     | o Women are also discouraged from taking cold drinks and salty foods by grandmother and mother in-laws    
                     | o Most women reduce amount of food they consume.                                                        |
| Labour and Delivery| o Mothers are encouraged to drink lots of water, hot tea and porridge                                       
                     | o Upon delivery, mother drinks ‘divine water’                                                             |
0 – 6 Months

- Some mother initiate breast feeding 1 – 3 days after delivery especially for home deliveries.
- Salt solution given to the new born baby. This practice is also slightly common among mothers who deliver at home.
- Sugar solution, and a mixture of honey and aloe vera is given to new born babies,
- Divine water is also given to the baby

6 – 23 Months

- The girl child is not given liver as it will make her foolish. However, in some Somali clans all children are not given liver as it makes them delayed developing speech.
- Most mother cease from breastfeeding once they discover they are pregnant.
- Most of the mother said they breastfeed consistently for just about 8 months

3.2.1. Early pregnancy

In early pregnancy women make a lot of changes in their diet and this will depend on the family's financial status. As it was pointed out by the KII’s, in this cohort, women are fed on nutritious food which the community calls ‘special food’ - kidneys and liver. They believe this is important in improving the health of the mother. However, some community leaders reported that during pregnancy women do not get nutritious food, they are of poor health and at times some women borrow food from their neighbours because they cannot afford to buy food. Pregnant and lactating women confirmed that the main motivation for attending the antenatal and post natal clinics is to get a chance of being enrolled in the blanket supplementary feeding /fresh food voucher program.

On the other hand community leaders said that most of their women were suffering from iron deficiency anaemia as confirmed by the results of the nutrition surveys [6] from 2008 to date, see fig 3 above. Currently the pregnant and lactating are being enrolled in the WFP funded Fresh Food Voucher program which was rolled in July 2013. One of the secondary objective of the program is to provide an avenue for diet diversification which will by extension help
improve maternal nutritional status once the right information and skills are given to women on utilisation of the fresh foods.

In our FGDs, Community Health Workers (CHWs) said that pregnant women who suffer from nausea and vomiting tend to eat less food therefore they often buy tinned fish and salty foods available in the market to help them increase their appetite. They also develop craving for certain kinds of foods, porridge being one of them. Mothers also eat meat, anjera, kales, cabbages pepper, popcorns, fruits, honey, tree leaves, and locally available cereals. Others take tea without sugar, milk, vinegar, sour milk and cold drinks as they believe these beverages don’t contribute to excessive weight gain in pregnancy. They claim that the fear of pregnant women to adding weight helps them avoid giving birth to a big baby. However, this is one of the negative beliefs in the community that could interfere with adequate maternal nutrition necessary for growth and development of the foetus due to the increased nutrient demands during pregnancy.

3.2.2. Late pregnancy

In all the FGDs conducted, it was stated that pregnant women are fed with nutritious foods to ensure good health of the mother and the baby but they are advised against eating foods with high proteins such as meat, cow peas and beans. The mothers in-law and grandmothers believe avoiding protein protect mothers from allergies and help prevent the unborn child head from growing big. The mothers are also advised to avoid taking salty foods, fatty foods and cold drinks as it can cause miscarriage. Consumption of mashed potatoes, porridge, milk, white rice, anjera, cabbages, kales, eggs, liver and fruits is encouraged but only if these foods are taken in small portions. However this information received from mothers in-law and grandmothers contradicts the information given in the pregnant and lactating mothers, and CHWs FGDs where participants reported that during late pregnancy the mother is not restricted to eating certain types of foods. They are allowed to eat any locally available foods although the number of meals is reduced especially for foods rich in proteins for fear that the child will grow big and bring complications during delivery. This conflict in messages reaching mothers can become barriers to effective social and behaviour change communication. The recurrent issue of weight gain in pregnancy as a measure to avoid giving birth to a big baby is a harmful community belief that acts a major barrier to achieving good nutritional status of women during the pregnancy cycle.

3.2.3. Labour and delivery
Mothers at this stage are encouraged to drink a lot of water, hot tea or porridge. The community believes that drinking water facilitates delivery with ease while hot tea and porridge provides energy needed during labour and delivery. Mothers are also encouraged to take milk, soup, mashed potatoes, *anjera*, meat and fruits. By providing the foods that the community highlighted is good practices for optimal maternal nutrition, however there was a misconception in role played by increased intake of water during labour and delivery. Nevertheless knowledge on the need for more energy intake is a good message that needs to be reinforced in the community.

3.2.4. 0 - 6 months

Immediately after delivery, the infant is cleaned and the mother is given ‘divine water’ to drink and wash her breasts with the same while salt solution, oil, honey, or juice squeezed from dates are given to the new born. The community believes giving the infant something sweet ensures good health. A small portion of this mixture is put on the baby’s tongue. The community also believes this is going to make the child taste the harshness and sweetness of the world he has been born into and become resilient. The practice goes against early initiation of breastfeeding where infants benefits from colostrum. Breastfeeding begins earlier for some mothers as reported in one of the FDGs conducted with mothers’ in-law and grandmothers. However in a different FGD with a different set of mothers in-law and grandmothers they termed the first breast milk as unclean and believed the infants should not be breast fed for the first 3 days. In such instances, sugar solution is given to the child.

In some of the FGDs, it was said that a Somali child is expected to have received animal milk (camel & goat), goat soup, sugar water solution and water by the time he/she reaches 6 months. Mothers and their advisors still believe breast milk alone is not enough. The mothers mentioned the following as some of the common foods and drinks given to children who are introduced to other foods before 6 months. These include: mashed potatoes, bananas, *anjera*, liver, fish, eggs, *tamu*, formula milk and porridge. The CHWs refer malnourished children in this age cohort to the facility for admission in the outpatient therapeutic feeding program. The MIYCN counsellors pointed out that mothers exchange their general food ration for meat and vegetables. These are cultural practices harmful for the new born as they interfere with successful exclusive breastfeeding for the first six months of life. When good breastfeeding practices are not established during the first few days after delivery, it often becomes difficult to attain breastfeeding success and compromising the overall health of the new born.
The information generated in this study is consistent with a KAP assessment conducted in 2008 in the camps [5] which implies there has been little change in the mind-set of the beneficiaries around this subject, some of key bottle necks that this assessment seeks to identify.

Despite this observation, the MIYCN counsellors and Community Health Workers reported that some mothers are practicing early initiation of breastfeeding as per recommendations. Majority of the women are breastfeeding their children as they believe this will protect the infant from infections and reduce chances of diarrhoea. In the 2011 and 2012 nutrition survey, (see table 1) the rate of exclusive breastfeeding in the camps was substantially high. An in-depth review of these outcome suggested that this is an indication of the knowledge that mothers have gained over time and not a reflection of actual practices in the camps. From the FGDs, it came out clearly that exclusive breastfeeding is hindered by cultural and religious practices such as giving pre-lacteal (honey and aloe vera) to the new born baby. Bottle feeding was also mentioned as a feeding practice in one FGD.

3.2.5. 6-23 months

In the UNHCR 2012 survey, children in this age cohort emerged as the most vulnerable group, they recorded very high anaemia levels. In Hagadera 63.4% of children 6 - 23 months have anaemia, 63.4% in IFO 2 and 66.5%, see fig 2 above. This situation is made worse due to the fact that initiation of complementary feeding occurs very late across all camps [6]. Complementary feeding at this age in the camps includes giving the child soft foods so that the child can grow well. Porridge is the complementary food of choice for most mothers. This is a diet deficient in iron, vitamins and micronutrients necessary to enhance iron status of children less than two years of age. Most of the Somali communities do not give liver to the girl child at this stage because they believe liver will make the child foolish. Others believe if liver and eggs are given to the child, he/she will have a delayed speech development milestone, a practice that has no scientific justification. Common foods recommended by FGDs and KII for children in this age cohort included: mashed anjera, animal milk, powder milk, mashed potatoes, bananas, fruits, formula milk, tea, mashed rice, porridge, beef stew, beans, sukuma wiki, biscuits and herbal medicine. However, there still gaps in access to these foods at house hold level due to social economic variables. Thus health and nutrition partners may need to change the complementary feeding strategy used at community level to advocate for adequate nutrition among the young children.
In terms of continued breastfeeding, two very different opinions came out during the FGDs. Some CHWs said that women continue breastfeeding for two years even if the mother discovers that she is pregnant but it was also pointed out that some mothers stop breastfeeding once they discover they are pregnant. Some mothers reported to be breastfeeding exclusively for 8 months as they believed this will make the child stronger. This practice could be contributing to the low rates of timely initiation of complementary feeding at the age of six months across all the camps.

### 3.3. Decision Makers in MIYCN practices

#### 3.3.1. Decision makers during pregnancy

All the participants in the FGDs rated husbands as the major decision makers in the household on matters that affects the mother. Husbands provide basic needs and occasionally perform other domestic chores, functions that can be explored to reduce on maternal workload during pregnancy. Currently there are sensitizations targeting fathers in the community and health and nutrition partners should be encouraged to take the responsibility of forming father to father and father to mother support groups. This is meant to influence fathers to support mothers in adopting appropriate MIYCN practices. It was also reported that the mothers together with mothers in-law and grandmothers have equal stakes in decision making during the first trimester of pregnancy. Their role is to order for necessities that the mother is craving for and also assist in household work. They are a key target group for successful social and behaviour change in improving maternal and child nutrition.

At the community level, several people influence the decision of the mothers during this period. TBAs are considered as the main decision makers because they are trusted by most mothers. They encourage mothers and constantly implore them to visit ANC. This could be attributed to the fact that they are targeted in trainings and sensitizations to help them understand the importance of facility delivery. Other influencers at the community include MTMSG leader’s mentor’s mothers, community leaders, MIYCN counsellors, elderly neighbours, health committee members and shop keepers. These key decision makers have distinct roles that qualify as credible channels for optimal social and behaviour change. MTMSG leaders and mentor mothers have proved to function well as positive deviance theory which an effective strategy to influence change among peers. The community and religious leaders have been effective in social mobilization and sensitization along themes they have
embraced. Shop keepers’ in particular are an asset in influencing access to nutritious food by building on the current fresh food voucher program platform supported by WFP.

3.3.2. Decision makers during labour and delivery

The grandmothers, TBAs, husbands and mothers in-law emerged as the major decision makers during this period each having specific roles which included TBAs/CHWs calling for an ambulance/ mama taxi, accompanying mothers to the health facility, and burying placenta after delivery. The TBAs, grandmothers and mothers in-law in particular have been known to influence the choices made by the mothers on whether to deliver at home or in health facility. They are key target channel for effective behaviour change communication. Religious and community leaders were said to be handy during delivery especially when health workers are faced with life threatening birth complication that require unpopular medication decision such as caesarean section to be conducted.

A summary of the functions of the key decision makers include;

i. The CHWs follows up with mothers at the block level to encourage them to deliver at the facility and provide information on importance of immunization after delivery

ii. MIYCN counsellors together with MTMSG leaders provide information before and after delivery at the MTMSG meetings, at water points and at the facilities

iii. TBAs and husbands have the responsibility of calling the ambulance at day time (TBAs) and night (husbands)

iv. Mothers in law prepare tea or porridge to be carried by mother when going to the hospital

v. At the health facility nurses conduct the delivery and help mothers initiate breastfeeding immediately after birth

vi. MIYCN Counsellors working at the maternity provide further support on breastfeeding to the mother with more information and counselling. Their activities include supporting mothers with common breast feeding problems such as breast conditions (mastitis, cracked/inverted nipples etc), too little breast milk, mothers caesarean section scars among others.
Figure 4: Role played by decision makers (Pregnancy to delivery)

**FAMILY**
- Grandmother
- Husband
- Mother in-law
- Siblings

**COMMUNITY**
- TBAs
- CHWs
- Block/Section Leaders
- Religious leaders
- Neighbours
- Health committee

**ACF**
- MIYCN Counselors
- MTMSGs Leaders

**HEALTH CARE SYSTEM**
- Qualified health workers

**TRADERS**
- Shopkeepers
- Sell nutritious food items/products

**MOTHER**
- Qualified staff
  - Provide counseling on MIYCN
  - Nurses conduct delivery
  - Initiate breast feeding immediately after birth

**Grandmothers**
- Perform household chores

**Husband**
- Provide basic needs
- Help in household activities
- Call ambulance at night

**Mother in-laws**
- Accompany mother to the clinic
- Perform household chores
- Prepare tea/porridge for use in hospital

**TBAs**
- Call ambulance during the day
- Provide health info on importance of visiting ANC
- Create Awareness on safe delivery

**Religious leaders**
- Conduct prayers

**CHWs**
- Give health talks
- Conduct HHs visits
- Counsel on MIYCN practices
- Provide info on importance of immunization

**Community leaders**
- Solving disputes

**MIYCN counselors**
- Counsel mother on MIYCN practices
- Follow up & support mothers
- Provide breast feeding support in maternity

**MTMSGs/Mentor mothers**
- Provide health info on importance of visiting ANC clinic
- Act as positive deviants
- Follow up and support to mothers
3.3.3. Decision makers at 0 - 6 months

Pregnant and lactating women need to be empowered to make healthy decisions that are best for themselves and their babies. In the discussions held, the findings show that the main decision makers of MIYCN at household level during this age cohort are the mothers, husbands, grandmothers & mothers in law, neighbours, friends, TBAs, aunts and elder siblings. In all the FGDS the mother, grandmother and mother in laws came out as the main decision makers of MIYCN at this level. Husbands, TBAs, aunts and neighbours were mentioned as the next important decision makers. Elder siblings were mentioned in one FGD as part of the decision makers.

In the community MIYCN counsellors, CHWs, MTMSGs came out as the strongest influencers. This was also evident in the 2008 and 2012 KAP assessment where MIYCN counsellors, CHWs, MTMSGs were found to be the most knowledgeable on MIYCN. Community health committee and religious leaders were also mentioned in some FGDs as influencers, while TBAs and health workers were mentioned in at least one FGD as decision makers at community level. Their key roles were as follows:

- The husbands purchase or buy milk for the baby. The husbands may also help mothers to do household activities. Further understanding is recommended on why husbands prefer to buy baby food rather than support breast feeding.

- The grandmothers stay with the child and may at times give sugar solution and water to the child. They act as barriers to successful breast feeding.

- The CHWs, IYCN counsellors and MTMSG support mother in early initiation of breastfeeding, exclusive breastfeeding, educate on importance of breastfeeding and advise her on proper hygiene practices

- MIYCN counsellors largely give information on MIYCN practices. Noting that high knowledge has been achieved in MIYCN among caregivers the next strategy that emerges is to translate knowledge into practice.

- The TBAs ensures that the mother stays indoors for 40 days and give traditional medicine if necessary
o Religious leaders participate in performing some rituals believed to heal sick infants. This practice might obstruct appropriate health seeking behaviours among caregivers.

3.3.4. Decision makers at 6 - 23 months
At household level, the child’s parents were mentioned in all the FGDs as the main decision makers but other individuals such as grandmothers, grandfathers and CHWs were mentioned in only one or two FGDs. At community level the MTMSGs and health workers came out strongly as decision makers. Other groups mentioned included the CHWs, MIYCN counsellors and religious leaders. The heath workers are respected for providing technical advice to mothers visiting health clinics and at the community level for passing health and nutrition messages including the importance of breast feeding and complementary feeding. MTMSGs leaders and mentors mothers share experiences that other mothers can identify with on issues of infant and young child feeding for instance strategies that worked for them. As bread winners, fathers play a huge role in the type of food consumed by children 6 - 23 months while mothers determine food preparation methods used that contribute to nutrient intake.
Figure 5: Roles played by decision makers (0-23 months)

**Family**
- Grandmother
- Husband
- Mother-in-law
- Siblings

**Community**
- TBAs
- CHWs
- Block/Section Leaders
- Religious leaders

**Health Care System**
- Qualified health workers

**Qualified staff**
- Pass key health messages
- Encourage mothers to attend clinics

**MOTHER**
- Grandmothers
- Husband
- Mother-in-law
- Siblings

**TRADERS**
- Shopkeepers
- Sell formula, products and other milk

**Grandmothers**
- Give sugar solution and water to child
- Baby sitting

**Husband**
- Purchase milk for the baby
- Help in household activities
- Provide food for the family

**All**
- Naming of the child

**TBAs**
- Ensures mother stays indoors for 40 days
- Give traditional medicine

**Religious leaders**
- Pray for healing
- Offer spiritual nourishment

**CHWs**
- Support EBF
- Support early initiation of BF
- Educate on the importance of BF
- Educate on proper hygiene practices

**MIYCN counselors**
- Support EBF
- Support early initiation of BF
- Educate on the importance of BF
- Educate on proper hygiene practices

**MTMSGs**
- Discuss complementary feeding
- Demonstration on preparation of feeds.
3.4 MIYCN Messaging

3.4.1. Channels and messages

The main sources of infant feeding information identified in the community through this assessment include MTMSGs, health workers, MIYCN counsellors, community health workers and hygiene promoters. The sources of information for caregivers were less diversified only limited to the role played by health care provider. This provides for cross sectorial collaboration leveraging on diverse strengths that exist in each sector for improving health and nutrition outcomes. The channels they use in passing these messages include sensitization forums in the community, home visits, trainings, group health talks at the health facilities and at tap stands, cooking demonstrations, using mentors mothers who share their success stories, posters and discussions at MTMSG meetings. The KII s mentioned that community based structures like MTMSGs have been effective channels of messaging on appropriate MIYCN practices owing to the fact these groups encourages social and emotional connection, foster peer learning in an interactive and participatory manner. The positive deviance strategy by utilizing mentors and MTMSG leaders provide a fertile ground for cultivating good practices and discarding the negative ones. As the role models/mentors share information on infant feeding successes in their own perspectives, other peers are most likely to be convinced and adopt them.

The respondents felt that cooking demonstrations are strategic avenues which are popular with the mothers and the community at large for passing massages as the exercise is not limited to the groups but to any other interested members of the refugee population. This avenue can be exploited to deliver messages in strengthening optimal complementary feeding practices for children 6-24 months. However, the popularity has been seen to be largely in the activity itself but more evaluation of this strategy needs to be conducted on how replicable the strategy is at household level.

Another key community channel mentioned during the discussions was use of religious leaders for sensitization. The Quran support breast feeding practices and encourages breast feeding up to 2 years. Unfortunately listening to the community through the FGDs a distortion of messages was observed with many caregivers attributing some of their poor practices to their religion. The ‘Faith for life project ‘supported by UNICEF and the religious council of Kenya attempts to use religion to advance good nutrition and the rights of children as a whole within communities. Health workers, CHWs and MIYCN counsellors offer continuous education.
through group health talks and counselling sessions on MIYCN at the health facilities/posts including households which has provided opportunities for passing MIYCN information reaching over 9,000 participants as per May monthly report. A gap still exists between knowledge and practices attributed to culture and traditions which need a multi-faceted approach for effective social and behaviour change.

3.4.2. Relevance and effectiveness of messages

The assessment found out that the community feels there is good coverage of messaging on appropriate MIYCN practices due to the fact that it is integrated with other nutrition programs alongside clinical services though with minimal linkage and interconnection with CHWs and MIYCN counsellors. The mothers and mother in laws believe the messages they receive are relevant in promoting infant feeding practices as well as improving the health status of mothers in the community. This is evident when comparing the results of 2011 and 2012 UNHCR nutrition survey where rates of early initiation of breastfeeding were higher in 2012 than in 2011. Mothers in the Ifo 2 FGDs reported to have noted the health of their children improve in comparison than the previous years when they had less knowledge. The MIYCN counsellors and CHWs reported that mothers prefer pictorial messages over lectures and booklets and IEC materials should preferably be in their local language. In most cases, mothers receive this information at the MTMSGs meetings. The main challenge they face is inability to consistently attend the monthly meetings due to other competing activities such as household chores, collection of food from the General Food Distribution (GFD). In Kambioos for example, MTMSGs members lamented that their husbands did not see the value of them attending these meetings because no tangible items are provided. This is because the camp is new and inadequate livelihoods opportunities thus suggesting the need to vary strategies used across all camps.

Mothers noted that the messages given at different level have helped change some of their practices such as reducing honey and milk given to new born babies immediately after birth. However, some of the participants noted that the dissemination of messages mostly focused more on the infant and young child nutrition with less focus on the maternal nutrition which was a key element since mothers’ health plays a key role in ensuring good health of their children, gap also noted by 2012 KAP assessment findings.
3.4.3. Challenges in passing MIYCN messages

MIYCN counsellors and CHWs reported to experiencing different challenges when passing MIYCN messages to the community. Some of the challenges mentioned include:

1. Busy schedules of mothers, they do not have time to attend meetings or even fully concentrate on home visits

2. The mother always look at the short term, they prefer to be given tangible items as an incentive to attend the meeting, they do not always think about the long term benefit - which is to increase the chances of survival for their babies

3. The discussants felt that the messages given were complex and had too much content at once per session thus needed to be simplified further.

4. Inadequate counsellors and CHWs at community level making it difficult to reach all beneficiaries in the blocks with a specified time

5. In some cases mothers choose to ignore the messages given as they prefer to do what they have always been doing as they believe this is what their ancestors have been doing.

6. They do not believe in their ability to provide enough breast milk for their infants. There is also strong influence on MIYCN practices by grandmothers who come to provide support to the mothers after birth

3.4.4. Support and coordination of MIYCN

In-depth key informant interviews conducted with coordinators and partner staff revealed that strengthening MIYCN activities both at the health facility and community is essential in ensuring the refugee population receives adequate information regarding infant feeding. Partners reported that capacity building to different cadre of staff by ACF has contributed in supporting, promotion and protecting infant feeding practices. They are able to support women with breastfeeding difficulties, assist mothers to achieve correct breastfeeding technique and counsel women to build their confidence on achieving breastfeeding success. Trained incentive staff usually conducts camps level sensitizations sessions to different groups at the same time assisting MTMSGs leaders to reach out to pregnant and lactating mothers.
through health education during MTMSGs meetings. The informants acknowledged the existing MIYCN community component that supports mothers with breastfeeding difficulties, provide guidelines on optimal complementary feeding and create forum for discussions through MTMSGs meetings.

Interviewed partner staff and coordinator during the assessment felt that they have the necessary knowledge and skills to be able to provide technical guidance to the team on aspect of MIYCN. Yet, the limited human resources do not allow to reach all the beneficiaries of concern.

4. CONCLUSION

The nutritional status of children under five in the refugee camp remains a major concern often deteriorating in the face of cyclical emergencies and related shocks that often erode community capacities to cope. Review of the nutritional status over the last five years show that chronic malnutrition is prevalent especially with high rate of anaemia reported among children and women. This calls for more sustainable strategies to combat malnutrition in the refugee camp. This formative assessment was meant to identify gaps, opportunities and strengths that C4D provides in improving delivery of high impact nutrition interventions that have been proven to have the potential of contributing to child survival and development. It can therefore be concluded that:

4.1. General care practices and health seeking behaviour.

1. About half of the women delay to attend ANC. Pregnant women are also motivated by incentive (BSFP, FFV) rather than holistic health seeking behaviour.

2. The refugee camps have one of the lowest rates of family planning uptake (just 1% on average)

3. Uptake and utilization of ferrous/iron supplementation is low among pregnant women in the camp and the diet deficient in iron thus contributing to the high anaemia levels report.

4. Most of the women are exempted from heavy workload by their families during pregnancy.
5. Reproductive health (pregnancy and child birth) is considered sacred as shown by the involvement of religious leaders and ceremonies that characterise these milestones.

6. The 24 hour ambulance/mama taxi service together with a baby package, engagement of safe motherhood promoter formally referred to as TBAs through partner support has boosted facility deliveries.

7. Mother and their new-born babies especially in the Somali culture often spend the first 40 days indoors. This offers an opportunity to reinforce on breast feeding practices except for the single mother headed households.

8. A majority of Somali and Somali Bantu communities burn the forehead of new-born babies’ perceived to have a ‘big’ head and remove ‘false’ teeth of their infants/children.

4.2. Maternal and young child feeding practices

1. Energy and protein intake is restricted among pregnant women especially in the last trimester to curb ‘excess’ weight gain and giving birth to ‘big’ babies. The number of meals eaten in a day is also reduced.

2. Most of the diet of mothers and children is deficient in essential nutrients especially iron and vitamins.

3. Most pregnant women crave for pica.

4. In most of the families, improved/ special diet is provided to mothers during labour and delivery and shortly thereafter but it is not sustained during the entire lactation period when energy and nutrient requirement are at the highest level.

5. Most mother offer or are influenced to give pre-lacteals (honey, sugar water, aloe vera etc) to their new born babies especially among those who deliver at home.

6. Exclusive breastfeeding is not a common practice even though the knowledge level on its importance is high with initiation of breastfeeding being delayed for up to 3 days especially among women who deliver at home. Some breastfeeding mothers also delay to introduce appropriate complementary feeds at the right age of 6 months.

7. Access to and consumption of variety of complementary foods is a challenge in all the camps: porridge dominates the diet of children 6-23 months of age.
4.3. Decision makers on MIYCN practices

1. The husband is a major decision maker in all age cohorts on issues related to choice and access to food at household level, health care seeking behaviour of mothers among other key issues.

2. Mothers’ in-law and grandmothers play a major role in infant and young child feeding, and health seeking behaviour among both young and older mothers.

3. Religious leaders provide a good platform to marry nutrition, health and other cross cutting issues with religion through their elaborate engagements in pregnancy, child birth and general well-being of children.

4. Partners have redefined roles of TBAs who were once key decision makers in reproductive health by renaming them as safe motherhood promoters. This has provided an opportunity of engaging them more productively thereby reducing some of the major health issues such as maternal mortalities.

5. MTMSGs leaders and mentor mothers have positively influence infant feeding, mobilization of peer others and sensitization on key health and nutrition concerns.

4.4. MIYCN Messaging

1. There are diverse channels of messaging at community level but they are not segmented based on target groups/audiences.

2. Messaging strategies in use in the camps rely more on ‘telling’ and ‘showing’ without engaging communities in constructive feedback and active participation.

3. Messages provided so far have had a good coverage through community level structures of MTMSGs as well as other channels and the community is aware even though they may not necessarily practice.

4. Pictorial messages are preferred by the mothers.

5. There is over reliance on MTMSGs for messaging which is also affected by consistency in attendance by respective members.
6. Messages are biased to MIYCN, do not cut across sectors and overly target women leaving out other target groups such as fathers.

4.5. **Coordination of MIYCN**
1. Coordination, integration and harmonization of strategies and activities in C4D are important in achieving desired goals.

2. Functions/activities of level 1 worker (CHWs, hygiene promoters, safe motherhood promoters, MIYCN counsellors etc.) are not harmonized across partners/sectors.

3. Capacity building in MIYCN heavily relied on training without the added advantage of more practical approaches such as mentorship program, OJTs, support supervision exchange visits among others.

5. **RECOMMENDATIONS**

This report highlights significant gaps in the design of the BCC strategy for the refugee camp. These gaps are noted in the fact that despite the major achievements made in disseminating the right messages in nutrition and specifically MIYCN, appropriate practices are still lagging behind. There are also institutional inadequacies in terms of segmentation of messages, the channels and audiences as well as effective monitoring and evaluation in the whole planning and implementation cycle. However there are strong lessons learned and opportunities identified for achieving sustainable programing in C4D. This report therefore recommends:

1. Effective leveraging on cross sectorial programming to achieve broader targets i.e. positive holistic health seeking behaviour and social norms changes with regard to harmful practices such as ‘head burning’, which would benefit other sectors like family planning, immunization, child protection, etc., besides MIYCN component.

2. Build on good practices such as community support systems created for pregnant women to reduce on maternal work load, the value for children and the special place of religion in reproductive health to champion for good care practices.

3. There is need for a structure response to harmful practices such as ‘head burning’ to advance the right of children.
4. While supporting health and nutrition partner initiatives such as the reward mechanisms to mothers for facility deliveries and reassignment of TBAs with new roles and structures, sustainability aspects in these initiatives require collective attention given the high capital investment that is needed to maintain un-interrupted provision of these services.

5. A holistic approach is needed in addressing messages targeted at infant and young child nutrition through clear segmentation of audiences and channels. This would entail moving away from over reliance on MTMSGs to roping in other options such father to father support groups, father to mother support groups, use of mentor mothers etc. and generally the positive deviance theory.

6. Religious leaders should be strategically used as change agents given the strong religious environment within the camps as well as their role as gatekeepers.

7. The mothers in -law and grandmothers have a stake in child care practices and have to be targeted as primary influencers.

8. There is need to define the functions /activities and harmonize the work that level one worker perform at community level for effective social and behaviour change communication.

9. The partners require orientation on effective messages development skills.

10. Capacity building of health and nutrition workers and communities has to be diversified to other practical approaches such as mentorship, OJTs, support supervision, exchange visits among other strategies.

11. The C4D strategy has to be finalized and rolled out across all the camps.
6. BIBLIOGRAPHY.


5. UNHCR/GTZ (2009). KAP survey Report on Infant and Young Child Feeding practices in Dadaab refugee camps


10. WHO (2001). Global strategy for infants and young child feeding. 54\textsuperscript{th} World Health Assembly A54/INF.DOC/4.WHO


12. UNHCR (2012). Monthly and annual Health Information System report: Dadaab refugee camp


List of Appendices

Appendix 1: Data collection Tools

COMMUNICATION FOR DEVELOPMENT (C4D) FORMATIVE RAPID ASSESSMENT PRIMARY DATA COLLECTION TOOLS

CONSENT FORM

ACF, UNICEF, UNHCR and health and nutrition partners are conducting a rapid assessment to determine factors that influence Maternal Infant and Young Child Nutrition (MIYCN) practices in Dadaab refugee camps. The information generated would inform the designing of Behaviour Change Communication intervention and messages to influence positive behavioural outcomes. Kindly provide as much information as possible. The information you provide will be treated with confidentiality. With your consent, I will appreciate your participation in the FGD/KII. Thank you.

FGD AND KII TOOLS FOR VARIOUS TARGET GROUPS

1. FGD tool for pregnant & lactating women, mother in laws and grand mothers
   1. Please tell us about MIYCN practices in this community. (Probe for: breastfeeding & complementary feeding practices, Iron and folate supplementation, ANC & PNC attendance, linkage to mother support groups, facility delivery, family planning e.t.c. under the respective age cohorts- early pregnancy, late pregnancy, labour and delivery, 0-6 months, 6-23 months)
   2. Probe for appropriateness and inappropriateness of the MIYCN practices listed in question 1. (Probe for the reasons for response given why the mothers consider the practise as appropriate or inappropriate).
3. How do pregnant and lactating mothers, infants and young children normally fed in this community? (Probe for the reasons for response given).

4. Decision making on MIYCN at the household and the community level
   a. Who makes decisions on MIYCN and health in the household and the community?
   b. What specific role do the major decision makers play in MIYCN (what do they influence you to do)

5. Who/What are the sources of infant feeding information in the community? [Probe for role of; TBAs, CHWs, health facilities, family, friends, media, mother to mother support groups and other social networks in the communication network] [Rank with the order of importance]
   a. What are the common messages communicated on MIYCN? (what do they tell)
   b. Is the message relevant/useful to you? (Probe for responses).

6. What are the main challenges you face in providing good nutrition to children and mothers: (PROBE for: cultural, socio-economic, livelihood, mother’s workload, influence from decision makers in the household, access and utilization of health facilities services, breastfeeding issues, knowledge, frequent pregnancies, mother’s nutritional status e.t.c) Record responses based on the cohorts

7. Please make suggestions for the way forward in the efforts to improve IYCF practices in the community?

2. FGD tool for incentive workers (MIYCN counselors and CHWs)
   1. Please tell us about MIYCN practices in this community. (Probe for: breastfeeding & complementary feeding practices, Iron and folate supplementation, ANC & PNC attendance, linkage to mother support groups, facility delivery, family planning e.t.c. under the respective age cohorts- early pregnancy, late pregnancy, labour and delivery, 0-6 months, 6-23 months)
   2. Probe for appropriateness and inappropriateness of the MIYCN practices listed in question 1. (Probe for the reasons for response given why the mothers consider the practise as appropriate or inappropriate).
   3. How do pregnant and lactating mothers, infants and young children normally fed in this community? (Probe for the reasons for response given).
   4. Decision making on MIYCN at the household and the community level
a. Who make decisions on MIYCN and health in the household and the community?

c. What specific role do the major decision makers play in MIYCN?

5. How do you pass messages in the community? (probe the following channels; role models, mentors, IEC materials, cooking demonstrations, group health talks, sensitization sessions e.t.c)

a. How do you engage mothers to improve on their health and nutrition status and that of their children?

b. What challenges do you face in passing information and skills and effecting positive behaviour change in MIYCN and how can you overcome these challenges?

c. How do MTMSGs embrace/ like MIYCN messaging channels (probe the following channels; role models, mentors, IEC materials, cooking demonstrations, group health talks, sensitization )

6. What are the main challenges you face in engaging communities/mothers to improve nutrition of children and mothers: (Probe for: cultural, socio-economic, livelihood, mother’s workload, influence from decision makers in the household, access and utilization of health facilities services, breastfeeding issues, knowledge, frequent pregnancies, mother’s nutritional status e.t.c) Record responses based on the cohorts

7. Please make suggestions for the way forward in the efforts to improve MIYCN practices in the community?

4. KII tool for religious and community leaders

1. Please tell us about MIYCN practices in this community. (Probe for: breastfeeding & complementary feeding practices, Iron and folate supplementation, ANC & PNC attendance, linkage to mother support groups, facility delivery, family planning e.t.c. under the respective age cohorts- early pregnancy, late pregnancy, labour and delivery, 0-6 months, 6-23 months)

2. Probe for appropriateness and inappropriateness of the MIYCN practices listed in question 1. (Probe for the reasons for response given why the mothers consider the practise as appropriate or inappropriate).

3. How do pregnant and lactating mothers, infants and young children normally fed in this community? (Probe for the reasons for response given).
4. Decision making on MIYCN at the household and the community level
   a. Who makes decisions on MIYCN and health in the household and the community?
   b. What specific role do the major decision makers play in MIYCN

5. Who/What are the sources of infant feeding information in the community? [Probe for role of; Religious leaders, community leaders, TBAs, CHWs, health facilities, family, friends, media, mother to mother support groups and other social networks in the communication network] [Rank with the order of importance]
   a. Are they adequate in improving MIYCN practices? (Probe for reasons).
   b. What are the common messages communicated on MIYCN?
   c. Is the message relevant/useful to you? (Probe for responses).

6. Describe what the Koran says about feeding practices in the cohorts. What are other cultural beliefs that exist regarding MIYCN in this community (probe for myths and misconception related to MIYCN).

7. What are the main challenges that mothers and families in this community face providing good nutrition to children and mothers: (PROBE for; cultural, socio-economic, livelihood, mother’s workload, influence from decision makers in the household, access and utilization of health facilities services, breastfeeding issues, knowledge, frequent pregnancies, mother’s nutritional status e.t.c) Record responses based on the cohorts

8. Please make suggestions for the way forward in the efforts to improve MIYCN practices in the community?

5. KII for coordinators and partner staff
1. What is your role in supporting and coordinating MIYCN communication for development/behaviour change communication activities in your camp?
2. How would you rate the scale and effectiveness of messaging on appropriate MIYCN practices in the community? (Probe for level of coverage of mothers, fathers, the elderly, religious leaders, TBAs, CHWs, mother to mother support groups e.t.c).
3. In your opinion what is the status of pregnant & lactating women and caregivers health seeking behaviour during pregnancy and postpartum care in this community. Is it appropriate? (Probe for practices and for reasons).
4. What factors influence MIYCN practices?
a. Barriers/predisposers,
b. Reinforcers/ facilitators

(Probe for; cultural, socio-economic, livelihood, mother’s workload, influence from decision makers in the household, access and utilization of health facilities services, breastfeeding issues, knowledge, frequent pregnancies, mother’s nutritional status e.t.c)

5. In your opinion has information that you have been giving regarding MIYCN brought any changes in maternal, infant and young child feeding practices in this community? (for partners only)

6. In your opinion do you feel that you have the necessary knowledge and skills to effect positive MIYCN behaviour in the community? (Probe the responses) If not what is are the most feasible ways to ensure that you have the necessary knowledge and skills?

7. As a coordinator/partner focal point, what would you recommend to be done to improve communication towards adoption of appropriate MIYCN practices in the community?