IYCF Practices, Beliefs, and Influences in SNNP Region, Ethiopia

September 2010
Alive & Thrive is a five-year (2009-2013) initiative to improve infant and young child feeding practices by increasing rates of exclusive breastfeeding and improving complementary feeding practices. The first two years provide a window of opportunity to prevent child deaths and ensure healthy growth and brain development. Alive & Thrive (A&T) aims to reach more than 16 million children under two years old in Bangladesh, Ethiopia, and Viet Nam through various delivery models. Learnings will be shared widely to inform policies and programs throughout the world. Alive & Thrive is funded by the Bill & Melinda Gates Foundation and managed by AED. Other members of the A&T consortium involved in the program in Ethiopia include GMMB, IFPRI, and World Vision. The main implementing partner for the A&T community-based approach is the Integrated Family Health Project, funded by USAID. In Ethiopia, A&T collaborates closely with the Federal Ministry of Health and its Regional Health Bureaus, the National Technical Working Group, the Ethiopia Health and Nutrition Research Institute, and UNICEF.

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**Abbreviations and Acronyms**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACIPH</td>
<td>Addis Continental Institute of Public Health</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>A&amp;T</td>
<td>Alive &amp; Thrive</td>
</tr>
<tr>
<td>AED</td>
<td>Academy for Educational Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>CBN</td>
<td>Community-based nutrition</td>
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<tr>
<td>CMAM</td>
<td>Community-based management of malnutrition</td>
</tr>
<tr>
<td>DALYs</td>
<td>Disability adjusted life years</td>
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<tr>
<td>ENA</td>
<td>Essential nutrition actions</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>F-MOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>HEP</td>
<td>Health Extension Program</td>
</tr>
<tr>
<td>HEW</td>
<td>Health extension worker</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IFHP</td>
<td>Integrated Family Health Program</td>
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<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<tr>
<td>IYCF</td>
<td>Infant and young child feeding</td>
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<tr>
<td>OTP</td>
<td>Outpatient therapeutic program</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration salts</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PSNP</td>
<td>Productive Safety Net Program</td>
</tr>
<tr>
<td>SNNP</td>
<td>Southern Nations, Nationalities, and People’s (Region)</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCHP</td>
<td>Voluntary community health promoters</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aabila</td>
<td>Mixture of barley flour and milk</td>
</tr>
<tr>
<td>Atekana</td>
<td>Food prepared from bulla mixed with milk and butter (used in the southern parts of Ethiopia)</td>
</tr>
<tr>
<td>Besso</td>
<td>Food prepared from flour of roasted barley, with hot (not boiled) water; a thick version is prepared with salt and butter</td>
</tr>
<tr>
<td>Bulla</td>
<td>The white liquid extracted from the pseudostem of the enset (false banana plant)</td>
</tr>
<tr>
<td>Chiko</td>
<td>Food made of maize and wheat with kale</td>
</tr>
<tr>
<td>Enichela</td>
<td>Preparation from false banana</td>
</tr>
<tr>
<td>Enset</td>
<td>False banana plant</td>
</tr>
<tr>
<td>Fitfit</td>
<td>Mixture of injera and stew or tomato sauce</td>
</tr>
<tr>
<td>Fosese</td>
<td>Maize flour dough, shaped into a small ball and boiled with kale or a local leaf called aleko/shifera</td>
</tr>
<tr>
<td>Injera</td>
<td>A flat thin bread resembling a pancake prepared from teff/barley/sorghum</td>
</tr>
<tr>
<td>Injera fitfit</td>
<td>Mixture of injera with stew</td>
</tr>
<tr>
<td>Kinche</td>
<td>Cracked barley or wheat boiled and later mixed with butter/oil and salt</td>
</tr>
<tr>
<td>Kita</td>
<td>Unleavened flat bread prepared from teff/wheat/maize/barley</td>
</tr>
<tr>
<td>Kolo</td>
<td>Roasted cereals/legumes often made from barley, wheat, beans, chickpeas</td>
</tr>
<tr>
<td>Kotcho</td>
<td>Fermented food stuff from decorticated corm of the enset plant (false banana)</td>
</tr>
<tr>
<td>Kurikuфа</td>
<td>Similar to fosese, maize flour is shaped into a small ball and boiled with kale or a local leaf called aleko/shifera</td>
</tr>
<tr>
<td>Shiro wot</td>
<td>Stew prepared from flour of roasted beans or peas</td>
</tr>
<tr>
<td>Teff</td>
<td>Tiny grain used to prepare injera or unleavened bread, known for its iron content</td>
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</table>
Executive Summary

Alive & Thrive Ethiopia undertook formative research to better understand the infant and young child feeding (IYCF) practices in communities in Southern Nations, Nationalities, and People’s (SNNP) Region.

The guiding questions for the SNNP formative research, conducted in late 2009, were the following:

1. What are the beliefs and current practices for breastfeeding and complementary feeding of children in the study communities?
2. What key factors influence mothers and family members to adopt recommended IYCF practices?
3. Who influences mothers? What is the current role of family and community members to support optimal infant and child feeding practices?
4. What is the current role of health extension workers (HEWs) and other health providers to support optimal infant and child feeding practices?
5. What is the Health Extension Program (HEP) currently doing to support child feeding in communities? What opportunities exist to support frontline workers to optimize child feeding?

Prior to designing this formative study, A&T conducted a review of the existing substantial body of information concerning maternal nutrition, early initiation of breastfeeding, and exclusive breastfeeding in Ethiopia. Formative research, in the form of focus group discussions under the LINKAGES Project, provided additional information on child feeding practices that led to the development of Essential Nutrition Actions (ENA).

Much of the existing information from the literature review focused on the initiation of breastfeeding and complementary feeding practices in a general sense. More detailed information was thus needed to fully understand the issues of IYCF practices in the project areas, and to identify barriers, facilitators, people, and approaches that can influence change. The findings from the formative research will contribute to the design of effective strategies for improving breastfeeding and, especially, complementary feeding practices for young children. Findings highlight the potential role of health and community workers to support this behavior change, contributing to efforts to reduce stunting among young children in Ethiopia.

Key Findings

The SNNP formative research on infant and young child feeding identified the beliefs and current feeding practices for breastfeeding and complementary feeding of children, along with key facilitating factors to improve young child feeding. The study also assessed the roles of different groups, including family and community members, health extension workers, and voluntary community health promoters in supporting IYCF in their communities.

*IYCF practices and related beliefs and attitudes.* This study indicates that breastfeeding is widely practiced in the research communities and is expected of all mothers and valued in the community for its
contribution towards child growth and healthy development. Unlike the findings in related studies, mothers in the study areas seem to know the expected breastfeeding requirements such as: on-demand feeding, frequency of breastfeeding, and the need to feed from both breasts. Yet exclusive breastfeeding is not widely practiced in the study communities. Mothers commonly introduce water, fenugreek, or linseed water as early as 2 months. Mothers also use bottle feeding and consider this a good practice for feeding the child thin gruel, because the bottles are believed to keep the food covered and clean.

This study demonstrates that mothers and other family and community members are concerned that feeding a sick child extra food will cause further illness, diarrhea, and vomiting, or that it would stimulate the child’s appetite and develop a habit for eating more food than the family can afford.

In regards to complementary foods, the study indicates that the age for introduction of additional foods ranges from 2 months to 8 months, with a majority of mothers reporting that they had started giving foods at 6 months or earlier. Certain foods such as kale, enichila, banana, egg, pumpkin, carrot, and green vegetables are considered unsuitable and “too strong” for young children to digest before 1 year of age. Meat, in particular, is considered by mothers as too hard to digest. Most mothers recommend meat for children above 1 or 2 years old. Mothers also expressed that they need to have a good income to buy or feed their children such foods.

Regardless of this, study participants believe that children in their communities are doing well due to immunization services, improved access to health services, and improved child feeding practices.

**Community and family influences on mothers’ feeding practices.** The role of family members in influencing IYCF practices was also explored. Mothers are seen as the primary caregivers for children in the home, sometimes assisted by an elder daughter, mother, or mother-in-law. Husbands appear to influence child feeding practices indirectly, primarily in their role as provider and as the one who controls family finances. Family members’ and community elders’ advice on feeding is often followed, even though traditional practices sometimes run counter to the MOH recommended IYCF practices.

HEW and VCHP capacities. This study looked at perceptions of staff and volunteer capacity from their own point of view and from the point of view of the families they serve. Capacity includes both knowledge of recommended IYCF practices and the skills needed to teach, train or counsel.

The study confirmed that the HEP system is well established, with trained HEWs implementing many of the 16 key HEP packages. As a result, the HEW supervisors and HEWs believe that the overall health situation is improving in communities, and that morbidity and mortality have decreased. On the other hand, the potential burden of new initiatives on HEWs and VCHPs in terms of competing priorities and demands on their time was indicated as a challenge.

According to study participants, HEWs and VCHPs are well-known and active in the study communities. All of the HEWs have completed the 1-year HEW basic training program. They reported that they visit 40 or 50 households a week and also supervise 10 to 20 VCHPs.

Regarding BCC materials used in promoting IYCF, two previous USAID-funded projects, Essential Services for Health in Ethiopia (ESHE) and LINKAGES, have distributed these materials to area
communities as well as the guidelines for the community-based nutrition approach. Additional materials the HEWs receive through the Woreda Health Office include: the family health card and two types of posters, one with pictures of a well-nourished child and a child with malnutrition, and another with the feeding guidelines. Some of the HEWs say they are using the counseling cards. The HEWs say they find the family health card very useful in working with mothers and the posters are popular for working with community groups.

The study also revealed that HEWs feel they have a need to learn more about child feeding in order to effectively counsel mothers on IYCF. Several pointed out that they need more detailed information about additional foods, types of foods, and best approaches for preparing food for young children, with follow-up mechanism.

Besides the HEWs, the role of the VCHPs was also identified. The VCHPs work more in sanitation and hygiene and family planning than in IYCF. Though not formally trained in nutrition, many of these VCHPs spoke of providing basic advice on child feeding to families during home visits, especially about breastfeeding. Most said they learned about child feeding by reading the family health card, which they believe is the most important resource for their job. Similar to the HEWs, the VCHPs suggested the need for training in giving consistent messages and feeding recommendations to avoid IYCF misconceptions and to promote optimum IYCF practices in the community.
1. Background

In Ethiopia, A&T's goal is to reduce death, illness, and malnutrition caused by sub-optimal feeding of infants and young children:

- Increase exclusive breastfeeding by 25 percent (from 49 percent to 61 percent) among infants 0-5 months old
- Prevent stunting in 333,000 children

The aim is to design, implement, and test strategies which can have a substantive impact on complementary feeding practices and that can readily be adapted and scaled up all over the project area. To achieve coverage at scale, A&T is partnering with Integrated Family Health Project (IFHP), World Vision, and other organizations that support the Government of Ethiopia delivery system to effect changes in IYCF through three main strategies: improving IYCF policy and regulatory environments, shaping IYCF demand and practice (community-based approaches), and increasing supply, demand and use of fortified complementary foods and related products.

One of the major platforms for program implementation to shape IYCF demand and practice is through existing programs which address community-based nutrition. The strategy is to support and strengthen the government's community-based Health Extension Program which utilizes HEWs and VCHPs to mobilize their communities, deliver key preventive messages, and provide counseling to promote optimal IYCF behaviors. A key question which A&T seeks to answer through this approach is the level of improvement in IYCF that can be achieved at scale, largely through the government’s health program using the health extension workers to catalyze change.

The Federal Ministry of Health in Ethiopia has made significant progress in support of IYCF in the last decade. A National Strategy for Infant and Young Child Feeding was developed in 2004 which provides detailed feeding recommendations and guidelines. A National Nutrition Strategy was developed in 2005-06, and a National Nutrition Program for implementing this strategy on a national scale was introduced in July 2008.

In 2005, under the USAID bilateral project and AED’s LINKAGES project, key messages on the essential nutrition actions to improve the nutrition of women and young children in Ethiopia were developed and disseminated. Using the favorable policy environment created, considerable work was done in the area of IYCF by government and nongovernmental organizations. Alive & Thrive is building on these efforts.

2. Rationale, Objectives and Research Questions

Ethiopia is a large country with diverse cultures reflected by different food habits and traditional practices. To ensure that program strategies are effective in a diverse culture, information is needed to better understand various IYCF practices at community and household levels as well as the factors which influence child feeding practices. Further research was needed to fully understand the IYCF
practices and the barriers, facilitators, people, and approaches that can influence change for optimal IYCF practices. A&T offers an opportunity to expand on earlier IYCF work and to focus on children under 2 years of age towards preventing malnutrition. To reduce stunting, A&T focuses on improved complementary feeding. The research findings will be used to support effective strategies for improving complementary feeding practices.

2.1 Objectives of the formative research

The general objective of the study is to understand infant and young child feeding practices and the role of service providers in the study communities. Specific objectives are:

- To describe current IYCF practices
- To identify barriers and facilitators for recommended IYCF practices
- To identify people and approaches that can influence optimal IYCF change
- To explore strategies for improving complementary feeding practices for young children
- To explore the potential role of health and community workers to support IYCF behavior changes and thus reduce stunting in young children

2.2 Research questions

The following research questions were formulated to identify the gaps in IYCF, especially on complementary feeding, in the study communities:

a) What are the beliefs and current practices for breastfeeding and complementary feeding of children in the study communities?

b) What key factors influence mothers and family members to adopt recommended IYCF practices?

c) Who influences mothers? What is the current role of family and community members to support optimal infant and child feeding practices?

d) What is the current role of health extension workers (HEWs) and other health providers to support optimal infant and child feeding practices?

e) What is Health Extension Program currently doing to support child feeding communities? What opportunities exist to support frontline workers to optimize child feeding?

3. Methodology

3.1 Study area

The formative research was conducted in three zones of SNNP Region: Gamgofa, Hadiya and Dawiro. Research communities were selected from three woredas which were selected from the three zones, and includes Mareka, Misha and Chenicha. The three locations were chosen to capture differences in breast feeding and complementary feeding practices within the region.
3.2 Sampling techniques

**Site Selection:** Communities were purposefully selected by the A&T program team to capture varying factors, such as staple food, access to market, women’s employment patterns, and tribal and language composition. All of the study areas are currently served by a government health extension program and are within the current IFHP program areas.

**Selection of Respondents:** Prior to any data collection, discussions held at Woreda Health Offices assisted the program team in gaining permission to enter sample communities. Respondents were randomly selected in each area from a list provided by the health post, and the study interviewers also went door to door to identify households with children in the required age group. Since there was no better method to get a list of children under 2 years of age in selected communities, the health post immunization registry book was used to select participants. Selection was based on the age of the child and the willingness of the family to be observed.

**Maternal interviews and observations:** Household visits were conducted when the majority of residents were expected to be home. Observations were also conducted in the same households where mothers of the eligible children were interviewed.

**Focus group discussions:** Focus group discussions (FGDs) were held with fathers and grandmothers or mothers-in-law. Respondents for focus groups were selected from the same village where the women interviewees were residing. Only one member of the household was selected, in order to avoid mutual influences in the responses. Focus group discussions were also held with village leaders and women’s group leaders. These participants were identified by village leadership and HEWs.

**Interviews with service providers:** Interviews were also conducted with HEWs and VCHPs, as they are the individuals providing advice to mothers on child feeding and treatment of illness. The two HEWs serving each of the respective study communities were interviewed; in addition three more HEWs were interviewed from neighboring communities. (In one site, an additional two were interviewed.) Discussions were conducted at the Woreda Health Office, which also assisted the program team in gaining permission to enter sample communities. HEW supervisors supporting the interviewed HEWs were also identified and interviewed. The overall study design used for this formative research is presented in Table 1.

3.3 Data gathering instruments

The mothers’ questionnaire and observation guide were adapted from the *ProPan Manual: Process for the Promotion of Child Feeding*¹, developed by the Pan American Health Organization (PAHO). Focus group guides had been adapted from formative research previously conducted in several countries under the LINKAGES Project.

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Table 1. Study participants and data collection methods, SNNP formative research

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Method</th>
<th>Number per site</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers with children 6 to 23 months old</td>
<td>Semi-structured interview</td>
<td>15-17</td>
<td>47</td>
</tr>
<tr>
<td>-with children 6-8 months</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>-with children 9-11 months</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>-with children 12-23 months</td>
<td></td>
<td>5 +2 in Mareka</td>
<td></td>
</tr>
<tr>
<td>Maternal Observations</td>
<td>Observation tool</td>
<td>2-4</td>
<td>11</td>
</tr>
<tr>
<td>-with child 6-23 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fathers with children 6 to 18 months old</td>
<td>Focus group discussion</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Grandmothers of children 6 to 18 months</td>
<td>Focus group discussion</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Women’s leaders and community health committee members</td>
<td>Focus Group discussion</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Voluntary community health promoters</td>
<td>Semi-structured interview</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Health extension workers</td>
<td>Semi-structured interview</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Health extension worker supervisor</td>
<td>Semi-structured interview</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

3.4 Data collection

One team of eight interviewers was established with four responsible for focus group discussions, one for interviews with health personnel, and the remaining for interviews with mothers. Three individuals were selected from those who were doing the mother interviews and assigned for opportunistic observations.

The data collection process took seven days per site, including transportation to the study sites and initial visits to obtain the necessary permissions to enter the community. Partners in the study sites facilitated the field work by identifying study participants. Experts from ACIPH, including two field supervisors, stayed on the field for the whole duration of data collection to ensure accuracy and completeness.

3.5 Data quality assurance

To assure the quality of data collected, the following steps were taken:

- The data collection instruments were adapted from previous studies
- Data collectors were trained with the data gathering protocol
• Evening discussions were held to identify the key findings, challenges, and other issues raised by the interviewers.
• A summary matrix was developed in advance and the interviewers completed this matrix for each interview with mothers to summarize and discuss findings with supervisors.

### 3.6 Ethical considerations

Ethical approval was received from Addis Continental Institute of Public Health’s Institutional Review Board (ACIPH IRB). Permission to undertake the survey was obtained from the study sites and woreda authorities. Informed consent was obtained from the study participants after explaining the purpose of the study. Participation of all respondents in the study was on a voluntary basis and emphasis was given to assure the respect, dignity, confidentiality, and freedom of each participating individual in the study. Interviewers were also trained on the importance of obtaining informed consent and avoiding coercion of any kind.

### 3.7 Data processing and write-up

Data from FGDs was transcribed in the language of the interview and then translated into English for analysis. Notes from in-depth interviews were the main data for analysis of important and common concepts related to the main themes of the study. Data analysis was done mainly based on the interpretative approach that involves eliciting meanings from the collected information. "Open Code" Computer program was used for sorting transcribed information, looking for patterns, similarities, differences or contradictions.

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2 Addis Continental Institute of Public Health has an independent Ethical Review Board which is approved by the National Ethical Committee.
4. Findings

4.1 What are beliefs and current practices for complementary feeding of children?

Breastfeeding and complementary feeding practices

Breastfeeding is widely practiced in the research communities and is expected of all mothers. This practice appears to be valued in the community, with respondents in all three locations expressing the desirability for a mother to breastfeed, explaining that a breastfed child grows up to be a strong and healthy child. Mothers said that breastmilk gives energy and hastens growth, satisfies the child, and can protect against disease. When asked about practices in their communities, most HEWs and VCHPs mentioned breastfeeding, particularly their success in convincing some mothers to exclusively breastfeed.

**Breastfeeding frequency and on demand.** All mothers except two were breastfeeding at the time of the study, and mothers in all communities reported that they breastfeed frequently and on demand, both during the day and at night. It was difficult for some mothers to quantify how many times they breastfeed during the day and night, although when pressed, around half said they breastfed eight to ten times, even up to 13 times in the previous 24-hour period which included two to four times at night. Some mothers reported that they breastfed only three to seven times in the previous 24-hour period, including one who stressed that she can breastfeed only when she stays at home.

Women tend to breastfeed from both breasts, with many mentioning that they empty one breast before switching to the other. Many mothers explained their own way of knowing when one breast is empty and when it is time to change to the other, while some mothers rely on cues from the child such as pushing away or crying before switching breasts. A few mothers expressed concerns about feeding only from one breast, such as the breast becoming painful or the unused milk in the breast not being healthy if left overnight. Several mothers stressed that it was necessary to feed from both breasts to fully satisfy the child. Two mothers mentioned that one breast contains water and the other contains food, with one of these saying that she learned this from the HEW. Almost all mothers stressed that an adequate and varied diet is important in producing enough breastmilk for her child. Some mentioned that it is also important that the mother is in good health. One mother cautioned that if the child is not fed from both breasts, the unused breast will stop producing milk. No one else mentioned a link between the frequency of breastfeeding and the production of breastmilk.

**Duration of breastfeeding.** Of the mothers interviewed, only two women (with children 14 and 22 months old) had stopped breastfeeding. One stopped because she was pregnant and the other because she started on injectable contraceptives and was “busy with harvest.” Most of the mothers said they planned to continue breastfeeding until the child is 2 or 3 years old and some said even up to age 5 or 6 years. Many of the women plan to stop breastfeeding either when the child is old enough to eat on his or her own (around 3 years old) or when they become pregnant again. Some mothers fear that breastfeeding a child for more than two years is not good for the mother’s health. Several mothers stressed that they want to avoid pregnancy and that they believe that breastfeeding to 2 or 3 years is
important for protection. A few mothers admitted that they continue to breastfeed because they can not afford or do not have access to additional food for their child.

Many mothers and community members view breastfeeding up to 2 years and beyond as feasible while many also stressed that continued breastfeeding is important in ensuring that their children are healthy and protected from illnesses. Several mothers noticed that children who were breastfed for only a year were sick and weak, and not as strong as children who were breastfed for 2 years.

“I will continue breastfeeding for 2 years so that it will prevent pregnancy, make the baby strong and walk on her feet quickly and become fat. My first baby was breastfed for one and half years and she is sick and weak. My friend’s baby who was breastfed for 2 years is stronger than mine.” - A mother in Chenicha

Some mothers stated that they had been advised by the HEWs to breastfeed their child up to the age of 2 years, with one mother saying that she plans to continue breastfeeding her child for 2 years because the HEW had warned her that stopping before this time would lead to decreased thinking and learning capacity for her child.

Exclusive breastfeeding. While some mothers in all three communities give milk and nothing else to their children for the first 6 months, this is not widely practiced. Mothers as well as fathers and grandmothers in all three locales confirmed that the introduction of water, milk, thin gruels and other foods at 3 or 4 months is the customary practice. However, many mothers are aware of the recommendation to breastfeed exclusively, mentioning that HEWs routinely advise mothers to give only breastmilk and nothing else for the first 6 months. One mother heard this from her antenatal care (ANC) nurse at the local hospital and was convinced to try it.

Most of the mothers who said they are giving only breastmilk stated that they do so because of advice from a HEW. Several of these mothers said they had been told that breastmilk contains all the food a baby needs, or that a baby is too young and its stomach and intestines are not yet strong enough to digest food. Mothers also said that “the stomach will be clean,” that breastmilk is light and digestible and that it will not cause diarrhea or abdominal pain. One mother pointed out that she has enough breastmilk to breastfeed exclusively, and another said that she does not have enough additional food to feed her child anyway. Some mothers mentioned that they are convinced that breastfeeding exclusively contributes to the health of their children.

Mothers who do not exclusively breastfeed and introduce water and foods early do so for a variety of reasons. Many cited community traditions and advice from their mothers, grandmothers, mothers-in-law, and village elders. Many respondents said that breastmilk is not enough to sustain a child for the first 6 months. Some mothers voiced concerns about exclusive breastfeeding, saying that giving only breastmilk would hurt both the mother and the child, or that the child would be hungry and cry without other fluids or foods. A grandmother advised giving food because she believes giving breastmilk alone will cause constipation. One mother is concerned about constipation as well as the local tradition of burning the child’s stomach to relieve constipation. Others said that giving water and other foods and liquids does not cause any harm. A mother from Mareka said “even if I learned from HEWs that mothers should give only breastmilk for 6 months, I believe that my breastmilk wouldn’t be enough for the baby so I gave my
baby thin gruel prepared from millet, teff, macaroni, and barley at the age of 3 months in order to prevent the baby
from becoming ill and make her fat.” Another mother from Misha said, “Giving only breastmilk hurts the
mother as well as the child. The child will be hungry, weak and sick.”

Mothers commonly introduce water, fenugreek or linseed water early at around 2 months and
sometimes earlier. Some mothers are concerned that their baby needs water or liquids to quench his or
her thirst. Other mothers said that water is needed to dilute breastmilk because it is not easily digested,
too salty, or might cause stomach cramps. Mothers reported that elders recommend giving boiled
water to children. Giving fenugreek or linseed water to young children was recommended to avoid
abdominal cramps, prevent diarrhea and other illnesses, or when breastmilk is insufficient. Fenugreek
water is believed to help a child grow healthy and strong, and to be good for the skin.

Cow’s milk is commonly given to children starting around 3 months or sometimes earlier, especially
when it is readily available in the home. Mothers who give cow’s milk said that breastmilk alone is not
enough, especially for a 4- to 6-month-old child. One mother said that her child needs cow’s milk
between breastfeeds to obtain enough energy, and another observed that children that drink cow’s milk
grow bigger and stronger than those who drink only breastmilk. A mother with twins said that her
mother-in-law told her that her breastmilk is insufficient for two babies and that additional milk is
needed. Mothers reported that their mothers, mothers-in-law and village elders encourage the giving of
milk, boiled milk with butter, or home-made yogurt to the child. Milk is seen as important in ensuring
that a child grows strong and fat, and in fighting against illness.

When asked what advice they would give to a mother with a 4- to 6-month-old child, all of the VCHPs
and all but one of the HEWs reinforced the message of exclusive breastfeeding. Nonetheless, several
mothers stated that food should be introduced at 4 to 6 months, a message promoted as recently as
2003, and included in the original HEW training curriculum. One HEW said that introducing cow’s
milk is needed to provide additional food for the child, and one mother spoke of a community health
agent (who served before the HEW) who advised starting milk and food before 6 months. HEW
supervisors said milk is a common first food for infants, with one supervisor saying specifically that he
advises giving one part milk with three parts water as a first food. However, from what mothers said,
most health workers are now unified in support of exclusive breastfeeding. In one case, a mother
reported that she had been giving cow’s milk to her child, but that a nurse encouraged her to drink the
milk herself and give only breastmilk to her child.

Timely introduction of first foods. The age for introduction of additional foods ranged from 2 months
to 8 months with a majority of mothers reporting that they had started giving foods at 6 months or
before. Focus group discussions with other community members had similar findings. A tendency to
introduce foods early was reported in Mareka, where a couple of mothers said they started with fruit at
2 months, and others said they started with grain-based gruels at 3 to 5 months. One grandmother said
that food is normally introduced as early as 15 days. The primary reason given for introducing food
early is the concern that breastmilk is not enough for the child, and that additional foods are needed to
avoid hunger and ensure good growth and strength.

In Misha and Chenicha, many mothers said they started foods around 6 months, though some mothers
with children age 6 and 7 months they were still exclusively breastfeeding at the time of the study.
Other mothers in these areas with older children admitted that they did not start to give gruels or food other than liquid milk to their child until the ages of 7 to 9 months. This was also mentioned by a grandmother, and two mothers admitted not giving porridge or gruel until age 1 year. One mother of a 6-month-old plans to wait until her child is 7 months old and food is available from the harvest for making gruel, and another mother in Chenicha plans to wait to feed her child additional food until after the first year because she is afraid that “foods given to the child will bring illness to the child’s stomach.” She also said she has “no money to buy cereal,” and that she would have to arrange with neighbors or borrow money for food.

Many mothers and focus group participants (fathers, grandmothers, and community leaders) stated that the information from HEWs has made them change their feeding practices. Mothers noted that the early introduction of foods was previously the accepted practice and that HEW’s advice on exclusive breastfeeding is changing this practice.

“Sometime ago, I believed that giving other foods before 6 months was good. I used to start giving food to the child at the second and third month. But now I have been educated and changed this practice. I was told by HEWs that the child will be sick if I give anything before 6 months, but I chose to give fenugreek since it will make the child gain weight and it may not cause abdominal pain like other cereals.” - A mother in Chenicha

“Giving additional food at 6 months makes the child healthy, and this habit came from the elders.” - A mother in Mareka

**Appropriate first foods.** In all three areas, porridge and gruel were typically the first foods given to children, with some mothers also mentioning mashed fruit, such as banana, papaya, avocado and orange. Focus group participants (grandmothers, fathers, and community leaders) agreed that gruel and porridge are often given, as are fruits. They mentioned that besso (porridge and gruel with a consistency of mashed banana), kocho (false banana), atekana (prepared from fenugreek, bulla, milk and butter), and bread are also given and as a first food.

Mothers listed many foods that are good for children, with gruel and porridge prepared from a variety of cereals mentioned as the best foods, across the three study sites. Almost all mothers suggested that gruel and porridge be prepared from at least two types of cereals, saying that these foods will facilitate the children’s mental and physical development and will help them grow. A mother in Misha had the idea that if children eat these foods, they will be better prepared to learn and be successful academically. The benefits of feeding children these foods were described as children “will be healthy and strong,” “will be able to start walking early” and “will be energetic and will be protected from diseases.”

“*If children don’t get these foods their bodies will swell and they will also lose weight. Children who get these foods will not cry, will be happy and be able to start walking soon.*”

-A mother in Chenicha
### Table 2. Foods suggested by mothers as best for children 6 to 12 months and above 12 months old

<table>
<thead>
<tr>
<th>Study areas</th>
<th>List of first foods suggested by mothers</th>
<th>Children above 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chenicha</td>
<td><em>besso</em> (porridge and gruel with a consistency of mashed banana)</td>
<td><em>apple</em></td>
</tr>
<tr>
<td></td>
<td>bread</td>
<td><em>besso</em> (made of barley)</td>
</tr>
<tr>
<td></td>
<td>cabbage</td>
<td><em>barley</em></td>
</tr>
<tr>
<td></td>
<td>carrot</td>
<td><em>boiled bean</em></td>
</tr>
<tr>
<td></td>
<td>cow’s milk</td>
<td><em>bulla</em> (prepared from the root of false banana)</td>
</tr>
<tr>
<td></td>
<td>egg</td>
<td><em>egg</em></td>
</tr>
<tr>
<td></td>
<td><em>gabilia</em> (mixture of barley flour and milk)</td>
<td><em>enichela</em> (prepared from false banana)</td>
</tr>
<tr>
<td></td>
<td>gruel (from lentil, linseed, barley, peas, beans, and maize)</td>
<td><em>kinche</em> (barley or wheat, which is crushed and boiled mashed potato, different cereals)</td>
</tr>
<tr>
<td></td>
<td>kale</td>
<td><em>kocho</em> (false banana) with tea</td>
</tr>
<tr>
<td></td>
<td>mango</td>
<td><em>peas</em></td>
</tr>
<tr>
<td></td>
<td>orange</td>
<td>porridge from maize</td>
</tr>
<tr>
<td></td>
<td>papaya</td>
<td>unleavened bread prepared from <em>kocho</em>, potato, <em>kurikufa</em> (similar to <em>fosse</em>, maize flour is shaped into a small ball and boiled with kale or a local leaf called <em>aleko/shifera</em>), and kale</td>
</tr>
<tr>
<td></td>
<td>tea</td>
<td></td>
</tr>
<tr>
<td>Mareka</td>
<td><em>avocado</em></td>
<td><em>avocado</em></td>
</tr>
<tr>
<td></td>
<td>banana</td>
<td>banana</td>
</tr>
<tr>
<td></td>
<td>bean barley</td>
<td>bread made of maize and sorghum</td>
</tr>
<tr>
<td></td>
<td>egg</td>
<td>gruel made of barley, teff, macaroni, and lentil</td>
</tr>
<tr>
<td></td>
<td>gruel from sorghum</td>
<td><em>injera</em> (of teff, an iron-rich grain) with <em>shiro</em> (prepared from powder of beans or peas with sauce) prepared with butter, porridge, and gruel, and mixed with yogurt/milk and butter <em>teff</em></td>
</tr>
<tr>
<td></td>
<td><em>injera</em> (of teff, an iron-rich grain) with <em>shiro</em> (prepared from powder of beans or peas with sauce) prepared with butter, porridge, and gruel, and mixed with yogurt/milk and butter <em>teff</em></td>
<td>“wet” (stew) of <em>shiro</em> (prepared from powder of beans or peas with sauce)</td>
</tr>
<tr>
<td></td>
<td>maize</td>
<td><em>kita</em> (unleavened bread) made of teff or false milk</td>
</tr>
<tr>
<td></td>
<td>mango</td>
<td></td>
</tr>
<tr>
<td></td>
<td>milk</td>
<td></td>
</tr>
<tr>
<td>Misha</td>
<td><em>atekana</em> (prepared from fenugreek, <em>bulla</em>, milk and butter)</td>
<td><em>atekana</em> (prepared from fenugreek, <em>bulla</em>, milk and butter)</td>
</tr>
<tr>
<td></td>
<td>beetroot</td>
<td>butter and milk</td>
</tr>
<tr>
<td></td>
<td>bread with tea</td>
<td>bread from wheat and maize</td>
</tr>
<tr>
<td></td>
<td><em>bulla</em> (made of false banana, orange, mandarin)</td>
<td>honey</td>
</tr>
<tr>
<td></td>
<td>carrot</td>
<td>kale</td>
</tr>
<tr>
<td></td>
<td><em>chiko</em> (made of maize and wheat with kale, chicken, gruel from different cereals, eggs, mango, and avocado)</td>
<td><em>kiniche</em> (crushed and boiled wheat or barley)</td>
</tr>
<tr>
<td></td>
<td><em>injera fitfit</em> (made of teff, wheat bread, butter, egg, papaya and avocado)</td>
<td><em>kocho</em> (false banana)</td>
</tr>
<tr>
<td></td>
<td><em>kocho</em> (false banana) and butter</td>
<td><em>injera fitfit</em> (made of teff, wheat bread, butter, egg, papaya and avocado)</td>
</tr>
<tr>
<td></td>
<td>porridge prepared from <em>bulla</em>, barley, sorghum, peas, beans, and lentils</td>
<td>meat, including chicken</td>
</tr>
<tr>
<td></td>
<td>porridge or gruel from <em>bulla</em></td>
<td>meat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>stew prepared from lentils</td>
</tr>
<tr>
<td></td>
<td></td>
<td>thick porridge prepared from <em>bulla</em>, barley, sorghum, peas, beans, and lentils</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unleavened bread made from <em>kocho</em> and maize</td>
</tr>
</tbody>
</table>
Consistency of foods. Children are being fed various gruels and porridges, although observations showed that these mixtures are often thin and liquid. Opportunistic observations showed that children are eating gruels and porridges from multiple grains, milk, and chiko (maize flour, kale, fenugreek). The porridges and gruels are typically made from barley and rye, with peas, beans or lentils. One mother added sugar and another added butter to the gruel. In two cases of younger children, the gruel was thinned with breastmilk. Two of the older children were given only kocho softened with milk or godere (a variety of taro/colocasia).

Mothers in all three areas agreed that special foods need to be prepared separately for young children because they are too young to digest family food and need special food to grow healthy. There appeared to be some difficulty differentiating between semi-solid and liquid foods and many children were being fed very thin gruels. Though most mothers interviewed said that food with the consistency of mashed banana should be given to children, during observations, gruels were found to be thin, with one mother in Chenicha preparing gruel as thin as milk. Many mothers said that thick porridge should be given to a 7-month-old child, although some completely disagreed with the idea. The reasons not to give thick porridge were: the porridge is not easily digestible for a child at this age, it is heavy for this age, and the child may choke or have abdominal illness. In all three areas, there were mothers who said thick foods such as gruel and porridge should be given only after the child is 1 year old.

"Thick foods stay in the child’s stomach for a longer time and make the baby fat.” -A mother in Chenicha

"I would not recommend that a mother give thick porridge to her 7-month-old child because this kind of porridge is heavy and will not be digested easily at this age. The child also can’t chew and swallow this food. Instead I would advise her to give gruel." -A mother in Chenicha

Most mothers talked of preparing food separately for the child. There was little mention of taking food prepared for the family and mashing it to make a soft food for the child.

Transition to family foods. In addition to feeding young children gruels and porridge, mothers said that after children are 1 year old, they could eat from family food. Mothers stated that it is not appropriate to give family foods to children younger than 1 year old since these children have no teeth to chew the foods. Focus group discussion responses varied about the age at which children can start sharing family food. Some informants from Chenicha said the child could be served the family food at 1 year or when it starts walking, while others said 2 to 4 years or even up to 5 or 6 years, in Mareka.

During interviews and focus group discussions, participants said that a child can share family food when they are old enough to sit with family members for a meal. At this point, the child eats the same food, from the same dish as the family. When asked about family foods that are not good for children, root crops were often mentioned; more specifically, godere was commonly mentioned in Mareka and tseguram dinich (hairy potato) in Chenicha.

“If a child is above the age of 1 year he can eat family foods like bread prepared from maize, and also godere three times a day. But children younger than 1 year old can’t chew and swallow thick, hard foods.” -A mother in Mareka
Frequency and quantity of feeding. Table 3 compares feeding frequency responses from mothers with the recommended practice.

<table>
<thead>
<tr>
<th></th>
<th>Recommended feeding frequency</th>
<th>Actual feeding frequency (including snacks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Chenicha</td>
</tr>
<tr>
<td>6-8 Months</td>
<td>2-3 meals per day plus 1-2 snacks (3-5 times)</td>
<td>1,2,6</td>
</tr>
<tr>
<td>9-11 Months</td>
<td>3-4 meals per day plus 1-2 snacks (4-6 times)</td>
<td>Chenicha</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,3,3,5,5</td>
</tr>
<tr>
<td>12-24 Months</td>
<td>3-4 meals per day plus 1-2 snacks (4-6 times)</td>
<td>Chenicha</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3,4,4,5,5</td>
</tr>
</tbody>
</table>

Mothers reported that they feed food to their children frequently, ranging from one to six times a day. A significant portion of children are being fed according to the recommended minimum frequencies for each age group, at least three times for children 6-8 months old, at least four times for children 9-11 months old, and at least five times for children age 12-24 months. However, some children are being fed less frequently. In Chenicha, some children aged 6-8 months are being fed as little as one or two times a day. In two of the three woredas, there are some children age 9-11 months who are being fed just two or three times a day, and in all areas there are children over 1 year old who are being fed only three times a day.

FGD participants confirmed these findings and clarified that this frequency either includes the additional snack given between meals or that no snacks are given. Mother respondents explained that giving snacks to children is not a common practice. Even if mothers give snacks, the food is typically the same as that fed during mealtimes.

Observations found that all mothers are feeding their children using a variety of utensils and that it is difficult to estimate the quantity of foods consumed. Children are fed using bottles filled with gruel, using cups and spoons, or plates and bowls, or using the mother’s hand. Children are fed until the quantity finish the amount of food served, or until they are satisfied or stop eating. Unconsumed food is set aside for future use. In the observations, two cases were reported where mothers stopped feeding the child even though the child appeared to want to continue. Only one mother mentioned feeding a specific quantity of food to her child. The mother of a 10-month-old child in Misha said that she gave 1½ coffee cups of food in a day and that to give more would be too much and would make her child sick.
In the mother interviews, some mothers who are feeding their children below the recommended frequency expressed willingness to increase frequency if told by a health worker to do so. These mothers think that the advice from a health worker is useful and a child will be healthy, strong and protected from illnesses if food is increased. Some mothers, however, are not willing to increase the feeding frequency or quantity, even if told to do so by a health worker. Several said that it is difficult to get enough flour or grains to make the gruel, or that increasing food is not easy because the family has low income, does not have the grains available, and cannot afford to buy more food. Others are concerned about over-feeding their child; they are worried that feeding their child more would cause sickness, diarrhea, and vomiting, or that it would stimulate the child’s appetite and develop a habit for eating more food than the family can afford. Focus group participants in Chenicha mentioned repeatedly that increasing the frequency of feeding according to the age of the child is difficult and not affordable for many families in their area.

“I think giving the child food three times a day is enough. Giving the child too much food is a bad habit because if they stay for some time without food, they can’t survive. Too much food may also predispose them to illnesses.” - A mother with a child above 12 months of age in Mareka

“Increasing the frequency of feeding when the child gets 8 months is not possible. Sometimes feeding a child twice a day is hard because mothers stay outside their home as children are getting older”. - Community leader in Chenicha

HEWs, however, are convinced that mothers will feed their children the correct amount and frequency if they have the correct information and advice. However, some of the HEWs and VCHPs in two locales were skeptical that families would have enough food to feed the children as required.

**Food quality and diversity.** Interviews with mothers suggest that women are widely aware of the need to feed a variety of foods to their child. When asked what they fed their child yesterday, the majority of mothers talked of feeding gruel or porridge made with two or three types of cereals, with many including pulses (various types of lentils, beans and peas) in the mixture. Mothers also said that they enhance the gruel by adding other foods, such as milk, and in a few cases, egg and pumpkin. Other food mixtures given to young children are shiro wet (a stew prepared from peas or bean powder), atekana (cheese, milk, and butter), fosese (maize, kale, potato and kocho), kocho softened with milk, as well as injjera, egg, and fruits and vegetables such as avocado, banana and mango. Hand-held foods such as kocho, sugarcane, enichila, boiled potato, godere, and bread made of maize are also given but often to older children.

The variety of food actually given to the child, witnessed during opportunistic observations, was more limited. Children are fed with grain-based gruels and porridge, milk, and chiko (a preparation made from maize, flour, kale, fenugreek and oil). Some of the gruels are made with multiple grains and grain/pulse mixtures with many ingredients.

Some mothers believe that kocho is not digestible for children and that oil causes constipation. Other foods mentioned as unsuitable for younger children are kale, enichila, banana, egg, pumpkins, and carrot. Focus group discussion participants explained that foods for young children must be soft, chewable, and
digestible. They also explained that texture is important and that some foods such as kolo (a roasted cereal usually prepared from barley, wheat, maize and chickpea), toasted cereals such as barley, kocho and unleavened bread are too hard for young children. Some mothers do no give their children soft kocho, boiled godere, and sometimes kale, because they believe these foods are too hard to digest that they likely cause gastro-intestinal problems.

Many mothers said they add milk, butter, and oil to foods because these foods are available and they give children energy and help them grow healthy and strong. Several mothers have cows so milk is readily available. Others said they do not have cows and access to milk, and although they sometimes buy milk in the market, several are concerned that the milk from the market is not good. Many mothers in Misha and Mareka said that they have fruits and vegetables in their gardens or near their homes and could easily give these. Mothers stressed that fruits are important for the child’s health and one mother had heard from a neighbor that it is good to give avocado, papaya, and orange. Another mother was told during her ANC visit that fruits and eggs are very important foods for children. Green vegetables are not often given to children, and kale in particular was considered by some as unsuitable and too strong for young children to digest. In Misha, mothers only feed cabbage to children over age 2 because they are concerned about worms.

Pumpkin is seen as a possibility and is given by a few mothers. One mother remarked that it is easy to give pumpkin because it is soft, and another had been advised by an HEW that pumpkin is good for her young child. Another mother, however, said that pumpkin is not good for children under age 1, yet she still feed it to her child since that is what she has. Several other mothers also said that a child needs to be at least 1 year old before foods like pumpkin, carrot, and egg are appropriate.

In all three communities, some mothers are already feeding eggs to children. This is mainly in households where chickens are being raised. Other mothers pointed out that they have eggs available at home and could feed them to their children. There were a few mothers who said that eggs are not safe to give to children under 1 year old because they might make them sick; and in Mareka, egg was considered suitable only for children above 3 years old. Others expressed willingness to feed eggs if these were available, but added that this requires money, and that other foods or items would need to be sold to buy eggs. In some households, eggs are available but are being sold so that the family could buy grains and other needed commodities. Eggs were seen by many as a luxury item and too expensive to be given on a daily basis.

Flesh foods, such as poultry, meat, and fish, are not easily available and are rarely given to children. When asked about these foods, most mothers responded that they are not available in the home and that they did not have enough money to buy them. For many, meat is eaten only on holidays or during special festivals. Mothers also pointed out that poultry, fish, or meat is not commonly given to young children in their communities. Children are considered too young to chew and digest these foods. Meat, in particular, is considered by mothers as too hard to digest and is recommended for children above 1 or 2 years old in Chenicha and Misha, and above 5 years old in Mareka.

“Children start eating egg after the age of 1 year. It predisposes the child to diarrhea and vomiting if given before this age.” -A mother in Mareka
“To feed the child meat, fish, and egg I have to get a job and earn money. The government should create a job opportunity for me.” -A mother in Chenicha

“I never feed the child meat because it is not available here. Even if it is available, we don’t give meat to children below the age of 5 years. If children start to eat meat at an earlier age, they will share with adults and want to eat more. We get meat once a year during the Mesikel holiday.” -A mother in Chenicha

Most of the HEWs in Mareka and some in Chenicha and Misha said that the children in their communities are not getting a variety of foods for a number of reasons, the biggest reason being financial constraints. Families do not have the ability to buy various types of fruits, vegetables and cereals, so families just prepare food from what is available at home. HEWs also said that mothers do not have adequate knowledge on child feeding practices.

“I don’t think children in this community are getting enough food, because foods like egg, banana, mango, avocado, and papaya are not easily available here and mothers also can’t afford to buy them. Mothers are trying their best to feed their children, but they are economically poor. Previously mothers used to think that giving only milk is enough for children. But after we provide education, they sell some milk and buy fruits and cereals.” -HEW in Mareka

Some HEWs in all areas said that children are getting enough food in some cases, when foods were available in the household and when other family members provided help and support to the mother. The VCHPs in Mareka and Misha also feel that children are getting enough food.

“…children are getting enough food because families are producing adequate vegetables, fruits, and cereals. They also buy foods that are not available at home from the market. Other family members give advice and money to buy food items from market.” – VCHP in Misha

All the HEWs and the VCHPs said that while they agree with the feeding recommendations to add animal flesh foods to a child’s food on a daily basis, they did not feel that this was realistic since these foods are expensive and not readily available. Some did agree that giving children eggs might be a possible action.

Food preparation and hygiene. Mothers take the primary responsibility for preparing food for children, sometimes helped by a daughter. In Chenicha, there were also a few cases where the grandmother decides what to prepare and feeds the child. When mothers are away from the home during the day, food is most often prepared ahead of time and left with another family member to feed the child. In one case in Chenicha, the mother said that her husband would prepare the food and feed the child in her absence. In the observation households, all of the mothers were seen preparing the food, with the husband and grandmother looking after the child in a few cases while the mother was busy.

During the observations, almost all mothers were observed washing their own hands before preparing food but with water only and not soap. Children’s hands were not washed even though many had their hands in the food or were trying to feed themselves. Dishes, pots, utensils, and bottles were all washed
with just water. In most households, food was cooked in part of the hut, often near to where cattle and animals are kept, and flies were commonly seen resting on children’s faces and on utensils. Mothers cooked over open fires, sometimes putting utensils, and in one case, kale, on the dirt floor. This raised concern from observers about hygienic conditions in the household. Left-over food for the child was covered and stored for later use.

**Support and motivation during feeding.** During observations, almost all the children were fed at a separate time from the rest of the family, with the family eating earlier or later, and in a few cases, not having lunch at all. Some village mothers were not willing to be observed and appeared to be embarrassed that they did not have any food in the house to prepare or that they were not planning to feed their child. Mothers sat with their children, interacted and fed them using their hands as a cup. In one location, two children aged 10 and 13 months, were fed very thin gruel using bottles.

Bottle feeding was reported and observed in all three communities. When asked why bottles are used, mothers explained that bottles are good because they are clean and keep food covered. They stated that using a hand to feed is not hygienic and that young children are not able to drink from a cup. Mothers said that bottles make it easy for others to feed the child and that they are easy for the child to handle, with one mother saying that “a bottle feels like the mother’s breast to the baby so the child goes to sleep easily when given a bottle.” Some mothers interviewed, in all three areas, stated that they use bottles when the child is under 1 year old and that they use spoons, cups, and their hands after they are one year old. Mothers note that thin gruels are most appropriate for young children and that bottles works best with these gruels.

“Before 1 year of age the child takes liquid foods. Bottle is better than my hand in terms of hygiene since it has a cover. Also, if I am not around I store the gruel in it and others feed the child easily. After one year the child eats thick foods and other family foods.” -A mother in Misha

“Bottle feeding is not good for the baby. If the bottle is left uncovered it could be exposed to flies and children will be sick with diarrhea”. -Another mother from Misha

Mothers also reported that they use a traditional way of feeding with a cup, in which the mother holds the child, supports the child’s chin in her hand, and pours the gruel or other liquid into the child’s mouth from a plastic cup. Traditional cups made of clay, korana and bute, were also mentioned for child feeding in Mareka and Misha.

When mothers were asked about their child’s appetite, there was a mixed response. Mothers explained that they feel their child has a good appetite if their child eats all the food given to him or if they see that their child is healthy, fat, and growing well. Mothers mentioned that children have poor appetites when they have health problems or a cough. Some mothers stated that younger children are not able to eat much food and are expected to have a poor appetite.

“Because the child is young I have no method of knowing when the child is hungry. If the child stops eating it means that he is satisfied because a child can’t stop eating unless satisfied. If children are not satisfied they will cry.” -A mother in Mareka
When mothers were asked how they encourage their child to eat, many said they do not do anything special to encourage eating. Other mothers spoke of methods such as changing the food to something the child likes, adding butter to the food, demonstrating to the child how to eat, playing with the child, or waiting a while and trying again later. A few mothers mentioned and two were observed hitting the child and trying to force feed the child to eat more. During observations, some mothers were seen actively encouraging their children to eat more by talking with the children, smiling, nodding, and giving gruel again after some time. However, others did nothing to encourage the child and removed the food once the child stopped eating.

**Feeding during mother’s absence.** Many mothers reported leaving their homes occasionally during the day. They said they do so once or twice a week to go to the market, to the mill or to funerals, but that they often take their young child with them. Other mothers, in all three areas, said that they rarely leave home or leave their child in the care of another person. For those who leave the family compound, most say they prepare foods in advance, such as gruel, porridge, chiko, atekana, beso, and milk, and that they leave the food stored in a cup or a bottle for a family member to feed the child later. Children are cared for by fathers, grandmothers, neighbors, and sometimes older siblings, who are sometimes very young children. Many mothers who leave the home say that they check the food upon their return to see what the child has eaten, while some said that they have no way of knowing that the child was fed in their absence. For this reason, some mothers in Mareka and Chenicha said they do not leave any food for the child, preferring instead to feed the child before they leave and again after they return.

“I go to the market two days a week, and at this time I will prepare porridge and fosese (prepared in parts of southern region from mixture of maize, kale, potato and kocho), and the elder sister, who is 4 years old, will feed the child. I have no way of knowing how much the child ate because other children could eat his food. So when I come back I will give the child food.” – A mother in Chenicha

**Feeding during illness.** According to mothers, most young children suffer through one or more episodes of diarrhea cough or fever and are given various treatments such as herbal medicines at home, or taken to traditional healers or to health facilities. One mother in Mareka mentioned that she gives her children one dose of a medicine called *tetra*, purchased from a local shop, a practice also discussed by grandmothers in the Focus group participants who take children to the local pharmacy for *tetra*. Only one mother, from Chenicha, mentioned giving Oral Rehydration Salts (ORS) for diarrhea. Focus group participants said that children are often taken to the health facility for illness, and that for diarrhea, they are typically given ORS and fed more.

Mothers did not mention any special foods for feeding during illness, and they said they give the same food as when the child is not sick. Focus group participants, fathers, grandmothers, and community leaders, however, said that families do give foods or antibiotics specifically to stop the diarrhea. In Mareka, grandmothers said *kocho* is a good food for diarrhea.

“If a child has diarrhea we give lentils and kocho in a soft form. We also give Kocho for the treatment of diarrhea even for adults; kocho treats diarrhea.” – A grandmother in Mareka
Mothers in all three sites increase the frequency of feeding during illness to enable the child to recover quickly and to stay strong. Some in Misha and Chenicha explained that they give more food during diarrhea because this helps to replace the fluid lost from the child’s body. However, some focus group participants in Chenicha said that they do not give more fluid or food to sick children, and that they reduce the amount of fluids instead.

Mothers say they follow advice from HEWs, elders, in-laws and neighbors about feeding during illness. This advice at times was consistent with current recommendations, such as the mother in Mareka who was advised by her mother-in-law to keep giving the usual gruel to the child during diarrhea. However, at other times, HEWs and community members gave conflicting advice, such as the case of a mother in Misha who was told by the community elders to give only herbal drinks for treatment of a cold.

“The HEW told me to increase the frequency of feeding when the child is sick” - A mother in Mareka

“My neighbors advised me to give more food even if the child was not willing to eat. They told me that it will make the child strong and recover quickly.” - A mother in Chenicha

“When the child had a cold the community elders told me to give the child herbals in a drink form. But I didn’t accept their advice because the HEW has told me to give porridge and hot drinks frequently when the child has a cold.” - A mother in Misha

When told about the recommendation to increase the frequency of fluids and continue feeding during illness, some mothers disagreed, giving reasons such as, “the child has already lost his appetite and is not ready to eat more, the child will have vomiting if more food is given and if more fluids are given it will exacerbate diarrhea.” One mother in Misha agreed with the recommendation, saying that the next time her child has diarrhea she plans to give more solid foods than liquid ones, since it helps to cure diarrhea.

Focus group participants were more receptive and convinced of the need to give additional fluids during diarrhea and agreed that children should be fed more than usual when ill. They explained that the child loses more body fluid when they are sick and that if fluids are not replaced the risk of death is high.

“We usually give more food to replace what has been lost for diarrhea; if the child develops vomiting we usually take the child to health facility.” – A father in Misha

“When a child develops diarrhea we take the child to the health facility and they usually give him ORS; we give more food and ORS. Sometimes we give milk if the child has a good appetite; otherwise we didn’t give him special food that is not given when he was well but we try to give him more foods than usual because when child is sick he gets thin and liable to die so giving more food is important.” – A father in Mareka

**Feeding during recovery from illness.** When asked about feeding during recovery, some mothers said they increase the food given during recovery while others said that they return to the same amount that they were feeding before the illness. Mothers who increase feeding said that they increase both the frequency and the quantity compared to what they give during the illness mainly because children have regained their appetites. Mothers offered specific explanations for giving more food, such as: “the body was weakened by the disease and will be strengthened if children get enough food,” “it helps the child to grow fast
and gain weight,” “the child wanted to eat more,” and “feeding more food will hasten the recovery.” Other mothers said that they keep on feeding children the same way they did when the child was ill and explained that they do this because ill children do not have a good appetite and are unable to eat more. They were concerned that the child would vomit if forced to eat more. Some mothers reported that they breastfeed their recovering child more frequently but are not willing to give other foods. A mother in Mareka explained that she breastfeeds frequently because she wants to see her child “cured completely, become strong and look beautiful.”

When told that the recommendation is to increase the amount of food for two weeks after an episode of illness, many mothers, in all three areas, said they are willing to do so if advised to by a health worker. Almost all of the FGD participants agreed that giving a child more food during the recovery period makes sense and would help a child to restore what had been lost during the illness.

4.2 What are key factors? How can mothers and family members be motivated to adopt recommended practices and improve young child feeding?

• Mothers and community members already recognize the connection between good feeding practices and healthy, growing children

Interviews and FGDs in all three communities revealed a high value placed on having healthy, growing children, and an existing understanding of the connection between child feeding and growth and health. Those who perceive children as doing well and growing strong in their community were asked for reasons. In unprompted responses, improved child feeding was ranked in third place, following immunization and improved access to health services. Children were thought to be healthy because they are fed a variety of nutritious foods and specific foods, such as mixtures of grain, milk, and eggs. Similarly those mothers who said that children in the community are doing poorly mentioned poor feeding practices or lack of specific foods as one of the main reasons. Mothers expressed a strong desire for children to be healthy and to grow up “strong and fat,” and many mothers mentioned this desire as one of the main motivators for recent changes that they had made to improve feeding of their child. In addition, several mothers also spoke of the importance of child feeding for good mental development and of a desire for children to grow up intelligent, become educated and have a good future.

Illness in the communities, especially malaria and diarrheal diseases, were also mentioned by many as reasons for poor growth in children. In addition to immunizations, medical care, and good hygiene, feeding the child well and feeding of specific foods are seen as key strategies to protect children from illness. Many mothers mentioned specifically that good food helps children fight illness.

• Many mothers are well aware of key breastfeeding messages, but less aware of specific messages and recommended practices for complementary feeding

Most of the mothers interviewed know the key messages for breastfeeding and spoke specifically about breastfeeding on demand, the number of times to breastfeed, and breastfeeding for at least 2 years. They stressed the importance to giving only breastmilk for the first six months. Many of those who are
following recommended practices were able to explain the justification for doing so and mentioned that they tried the new practices after learning from a HEW or a clinic health worker.

Most mothers know to start introducing foods at 6 months and are able to recite the reasons not to give other fluids or start solid foods too early. Many mothers also know to prepare soft foods and gruels for their child, with some mentioning specifically the importance of using several grains and pulses. A few mothers are aware of the need to add other foods to enhance the gruel, mentioning oil, butter, milk or vegetables. Mothers and community members also know of the recommendation to feed a variety of foods to the child, with many mentioning giving their child specific fruits, vegetables, milk products, eggs and animal products. Most of the understanding, however, appears to be focused on the ideal situation, with mothers less confident about identifying healthy options that could easily be prepared at home.

Fewer mothers appeared to know key messages related to feeding frequency, quantity and feeding during illness. Only a few mothers know how many times it is recommended to feed children of different age groups. Even though educational materials and posters illustrate the recommended quantity of food (in terms of coffee cups) for each meal, there was no mention in any of the discussions about food quantity. There was also some confusion with messages about increasing fluids and continuing to give food during illness, and there was very little mention of increased feeding after illness for recovery.

- Mothers already prepare special foods for young children and feed them separately

Mothers in all three areas customarily prepare and feed gruels and porridge for young children. Although observations showed that food preparations are often more of a liquid than a semi-solid form, at least the basic practice is in place and can be built on and improved. All HEWs stressed the need to educate mothers about adding nutritious foods to porridge.

- Common practice of bottle feeding and challenge of feeding child while mother is away

Bottle feeding was identified, in all three communities, not so much as a substitute for breastfeeding, but as a preferred way to serve liquids and thin gruels to young children. Bottle use appears to be one of the major reasons why gruels are made too thin. While cup and spoon feeding is recommended for children, mothers rarely mentioned using spoons for feeding children (during interviews) and they rarely practiced this behavior (during household observations). Mothers, fathers, grandmothers, and community leaders explained that the traditional method of feeding young children is to use a cup and the mother’s hand, and that there is some concern in the community that using the hand for feeding in this way is unhygienic. Feeding from a bottle is perceived as a more hygienic option in the community, even by one VHCW, who said he promotes bottle feeding for this reason. In addition, because the food is thin and liquid, bottle feeding is also seen as a clean way to feed with less spillage.

Bottles are also viewed as a convenient and clean way for storing infant foods for later use. Mothers commented that it is easy for family members to feed a child with a bottle during their absence. HEWs are already convinced of the problems associated with bottle feeding but say that VCHPs and many community members do not yet see this as a problem.
• **Some mothers are already giving specific foods to children thought to be healthy**

Many mothers and community members are already aware of the importance of a varied diet and the need to feed children fruit, vegetables, and protein foods. During interviews mothers often spoke of specific foods and how good they are for the health of their child. Mothers talked of adding milk, butter, and oil to gruels to make their children “fat and beautiful.” Fruits and eggs are also seen as good for young children and important for their health. Mothers say they had heard these messages from HEWs, ANC, clinic nurses, and in one case, from a neighbor. A few mothers are giving pumpkin, adding kale to food, and giving eggs to their children because they had learned that this was good for the child, and they want their children “to grow physically and mentally strong.”

Other mothers are not giving these foods but expressed a willingness to do so if the food were more easily available. HEWs said that if mothers were aware that they should be giving these foods, more would do so. Most of the HEWs confirmed that many of these foods are already available in the community and in households and could feasibly be given, although there is some concern about the availability of the more expensive items, such as eggs, poultry and meat.

• **Availability of food in the home and willingness to overcome access issues**

Information from interviews and FGDs suggest that there is a good variety of foods available in these communities, with the exception of Chenicha, where food choices appear to be more limited. Many families have small gardens and fruit trees around their homes, and some have additional plots nearby for growing grains, root, crops, and pulses. During interviews mothers mentioned many types of fruits and vegetables that they are either already feeding their child or that are at least are available in the community. Some families have cows and chickens, and are already giving butter and milk, and others expressed a willingness to give eggs to children. Though there are beliefs that certain foods are not appropriate for children under age one, the fact that some mothers are already adding these foods to their child’s porridge suggests that this is a feasible practice that could be further promoted. The barrier of limited availability of food most often refers to eggs, poultry, and meat.

HEWs are convinced that availability of different food items and support from family members are key factors in making sure that children are getting enough food. When told of the recommendations to feed vitamin-A rich foods to children or to try to give meat, poultry, fish, or egg each day, many mothers said that something could be done by the family or in the community to make this possible. Some mothers expressed their willingness to work harder to improve access to foods, saying “if advised, then I will give,” “I should work hard and the father should work hard to get more money,” and “my husband and I will work harder to give a variety of foods.” Mothers said that they could sell some grain or other items to raise money for food, or that their husband could grow some of these foods or trade with other community members. Some also mentioned that it might be possible to organize some type of exchange in the community to improve access for families to the needed foods.

• **Family and community willingness to improve practices. Interest in learning more about child feeding and willingness to try something different**
All of the respondents spoke of recent changes in breastfeeding practices in the community, indicating that mothers are willing to try new practices. During interviews mothers expressed an interest to learn more about child feeding with many referring to positive changes they had seen after following breastfeeding advice. When feeding recommendations were discussed during interviews, many mothers were interested in the new information and wanted to learn more. Many said that they welcome the counseling sessions in the home and could have time for group meetings on this topic as well. FGD participants (fathers, grandmothers, and community leaders) also indicated an interest in learning more about child feeding and that they would be specifically interested to learn what they could do to better support mothers and families to feed children better.

All the HEWs and VCHPs agree that mothers want to learn more about child feeding, with many mentioning that a good approach would be to show women what could be prepared from food they already have. VCHPs also stressed that women are eager to learn and suggested that the best way to get the message across is “to educate with examples.”

- Seeing is believing – Mothers who already have had a positive experience with feeding advice

Many mothers explained that they have been convinced to try or maintain new feeding practices based on their own experience and observations. Some were convinced after seeing the positive changes in their own child after following HEW advice on breastfeeding, while other mothers observed how these practices led to healthier and stronger children for others. Exclusively breastfed children are seen as growing quickly and strong, and some mothers noticed that these children are sick less often. Many mothers spoke about exclusive breastfeeding and how their own experience or another mother’s experience convinced them of the merit of new practices, even ones that go against what is traditionally done in their communities.

HEWs and VCHPs are also motivated by success in changing some breastfeeding practices. They said that they feel good about their new knowledge and being able to suggest specific actions the mother can do, and they are encouraged that some mothers are receptive to try their advice. The positive reaction from the community to exclusive breastfeeding efforts provides an excellent foundation to add efforts related to complementary feeding.

4.3 Who influences mothers? What is the current role of family and community members and their potential to support optimal infant child feeding practices?

Household interviews and observations found that the mother is the primary caregiver for children in the home, and in almost all cases, is the person responsible for child feeding and food preparation. Sometime she is helped by an elder daughter, mother, or mother-in-law. Mothers mentioned that they learned about child feeding from their own mothers, and by watching other mothers in the community. Some mothers said that they are the sole decision maker in the household related to child feeding, while many other mothers reported that they make the decisions on what to feed the child together with their husband. A few mothers said that they have sole responsibility as their husband lives away from home.
Mothers explained that husbands are primarily responsible for work on the farm and bringing food home for household consumption, although some mothers said that they, too, go to the market to buy food. Food purchasing is often done by the father, but in many cases the fathers provides money to the mothers to purchase food from the market herself. The role of other family members appears to be to that of preparing food and feeding the child mainly during the mother’s absence. In most of the observations, the mother alone prepared food and fed her child, although in one case the mother’s mother and sister helped to maintain the cooking fire and prepare the food.

In terms of offering advice, mothers in all three communities overwhelmingly mentioned HEWs as their main source of information on child feeding. Within the home and community, mothers mentioned that they receive advice on feeding from their own mothers or mothers-in-law, especially advice related to breastfeeding and introduction of foods. Of the mothers who practice non-exclusive breastfeeding and early introduction of foods, most said that these practices are customary in their community and spoke of being influenced by their mothers, grandmothers, mothers-in-law, and sometimes village elders. Neighbors and other mothers were also cited as sources of advice in two of the communities.

Husbands appear to influence child feeding practices indirectly, primarily in their role as provider and as the one who controls family finances. While only two mothers mentioned their husbands as a direct source of advice, many who discussed giving or not giving certain foods explained that they do so based on their husband’s advice or approval. In some cases, mothers said they would be able to follow recommended practices, such as increased feeding frequency and quantity or giving specific types of food, if their husband provided the food or gave them money to buy food. HEWs are convinced that the availability of different food items and support from family members are the key reasons behind some children getting enough to eat.

When asked what more could be done to promote child feeding in communities, some mothers as well as fathers and grandmothers suggested that an effort should be made to increase involvement of fathers and other family members in supporting mothers in child feeding. Suggestions included providing the mother with more help in the home, as well as for fathers providing more food from farm land, selling farm products to purchase food, or bartering within the community to access more foods. VCHPs and HEWs all agreed that fathers and other family members could all play a larger role, and that they should be given more information on child feeding and being included in promotion activities.

The majority of mothers feel that HEWs are the best source of advice. Other mothers prefer receiving advice from their elders or mothers-in-law, who can share their own experience raising children, while others like to seek advice from promoters or an educated person living in their community.

“HEWs are the best to give advice. They are knowledgeable; they know more about feeding than community leaders. Traditional birth attendants and religious leaders and doctors know more than HEWs, but I prefer a person from the local area, who knows our local language and I am not afraid of them. They come to our house every time and we can find them easily.” –A mother in Misha

“There is one farmer in our village, his name is Melesse, and he is educated. He tells us how to feed children when we are gathering. The community elders and HEWs also give us advice” –A mother in Misha
4.4 What is the current role of health extension workers and volunteers and what is their potential to influence and support for optimal feeding?

**Health Extension Workers.** Mother interviews and FGDs found that the HEWs and community volunteers are well-known and active in the study communities. Five HEWs were interviewed in each of the three woredas, and all were women under age 30, most between 21 and 25 years old, with a high school education up to at least 10th grade. All of the HEWs completed the one-year HEW basic training program and all but one had graduated within the past three years. The exception was a HEW from Mareka who was trained with the first batch of HEWs when the national program was launched in 2006. These HEWs also received some short-term or refresher training related to child feeding and nutrition, such as the outpatient therapeutic program (OTP), screening and treatment of severe malnutrition, promotion of breastfeeding and prevention of malnutrition, community based nutrition (CBN), and one HEW mentioned training in essential nutrition actions (ENA). Most also were trained in cold-chain management and immunization, sanitation and hygiene, and community conversation, and a few had received refresher trainings in integrated family health guideline, trachoma prevention, HIV prevention, and reproductive health services. Most of the HEWs had been working in their current job and area for 2 to 4 years, with a few in their first year of work, and two who had been working as HEWs for more than 5 years.

HEWs described their work as routinely conducting home visits in their communities and giving advice on breastfeeding, family planning, hygiene, immunization and child feeding in general. They also supervise, teach, and give technical support to the VCHPs and traditional birth attendants, and they typically supervise around 10 to 20 volunteers in their areas. HEWs also talked of organizing group meetings twice a month in their communities, such as immunization sessions, community dialogue sessions on specific health topics, or community gatherings, such as coffee ceremonies, church gatherings, and school dramas.

HEWs explained that they typically visit between 10 and 30 households a week, with two saying that they visit 40 or 50 households. Almost all of the HEWs spoke of a focus on environmental sanitation and latrines, immunization, family planning, care of pregnant women and child feeding in general. When asked specifically about their work in child feeding, most HEWs mentioned individual counseling during home visits, with a focus on breastfeeding as well as introduction of soft foods at 6 months and general feeding for children from birth to age two. Two HEWs in Mareka spoke of being involved with screening for malnutrition and distribution of Plumpy’nut\(^3\) in their communities. One spoke of organizing a 6-day training for volunteers on prevention of malnutrition and said that the community was very interested and asked for more sessions. Another did a similar training in her community where she used posters and did food demonstrations for mothers, using the food and equipment she had supplied on her own. None of the HEWs seem to consider this work to be a burden, but instead they said it is important in ensuring the health of children.

Home visits from HEWs were often mentioned during mother interviews, with a majority of mothers referring to counseling sessions in their home and specific advice and health messages they heard from

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\(^3\) Plumpy’nut is a peanut-based food used to treat malnutrition in children.
HEWs. Most mothers who talked about changing their infant feeding practices said that they did so based on recommendations from HEWs.

“I got information on child feeding from HEWs. After the establishment of the health post we have changed our practice. Previously we used to prepare gruel only from sorghum but now we got advice and we use rye, lentil, macaroni, barley, sorghum, teff, linseed, and butter.” - A mother in Mareka

“The HEWs taught me about breastfeeding and additional foods. They advised me to give only breastmilk for the first six months and start additional foods after that. This was not the way I brought up my other children.” - A mother in Chenicha

However, the HEWs also said that they feel less confident that their advice is being followed. While many told of situations where they had been successful in persuading mothers to change a feeding practice, HEWs in all communities said there are challenges in getting mothers to follow advice. They explained that some mothers prefer the normal culture over the recommendation, saying that “we educate but they don’t practice,” “we teach but they resist,” and that they said that they feel that some mother’s don’t trust them.

Materials produced under two previous USAID-funded projects, Essential Services for Health in Ethiopia (ESHE) and LINKAGES, have been distributed to area communities as well as the guidelines for the community-based nutrition approach. HEWs in all three locations received materials from the health center or woreda health office, with only one HEW saying she had no materials. These materials included family health booklets and two types of posters, one with pictures of a well-nourished child and a child with malnutrition, and another with the feeding guidelines. Some of the HEWs also were and are using the counseling cards. HEWs find the family health booklets very useful in working with mothers and the posters appear to be popular for working with the community.

When asked about their own knowledge and skills for counseling, all of the HEWs expressed interest in learning more about child feeding. Most said that they have some knowledge but need training to develop more skills and confidence in advising mothers and families. Several pointed out that they need more detailed information about additional foods, types of foods, and best approaches for preparing food for young children. In interviews, HEWs demonstrated fairly good knowledge on feeding recommendations and appropriate messages and advice. However, most HEWs reported that children are not getting enough food or the right types of food, and they question whether families can adopt these practices because they have limited income and lack the ability to get or buy key foods. HEWs have the basic knowledge on feeding recommendations, and perhaps what is needed now is to focus on practical solutions that allow families to feed their children with what they have or what is easily obtainable.

Voluntary Community Health Workers. Though active in the community, VCHPs work more in sanitation and hygiene and family planning and were found to be less involved in IYCF. There are many types of community health volunteers in each community, including health promoters, latrine and sanitation specialists, reproductive health volunteers, health and disease prevention agents, and traditional birth attendants. Two VCHPs were interviewed in each community and all were male except for one young female reproductive health agent. Two VCHPs were men in their late 30s and
mid 40s who have been working in their communities for more than 10 years, and the rest were 20 to 23 years old and have been active from a few months to a year. These VCHPs have completed at least 6 years in school and the younger volunteers have all completed a basic training course for volunteers within the past two years. The VCHPs have been trained in sanitation, family planning, and some on HIV/AIDS, but all but one said that they have received no training in nutrition and child feeding.

VCHP activities are focused mainly on work with community meetings, giving group health education sessions, helping the HEW at the health post, and doing follow-up at the household level on sanitation, hygiene, and family planning. In one community the VCHP provided help to people living with AIDS. In Mareka one VCHP said they has been trained in care and support of children with malnutrition and has been involved in routine screening of children for malnutrition. Some VCHPs talked of visiting to two or three households a week, though two VCHPs said they average about 10 household visits per week, where they give counseling on child feeding, hygiene, and family planning. Though not formerly trained in nutrition, many of these VCHPs spoke of providing basic advice on child feeding to families during home visits, especially about breastfeeding. Most learned about child feeding by reading the family health booklet. Beyond this, none of the VCHPs said they are involved in activities to promote child feeding in their communities.

VCHPs in all communities mentioned using the family health booklets, with one saying that it is most effective when used while talking with families; however, another complained that it is not very useful since it is only in Amharic. In two communities, VCHPs said they have posters on child feeding and that these are useful when talking with the community.

Some VCHPs suggested more training for HEWs and more activities to promote IYCF practices in the community. One mentioned that educating the elders would be a good way to reach women, and another suggested that time should be invested with kebele cabines (decision makers at the local, kebele level) saying “when there is participation of higher officials, the power of information dissemination and acceptance becomes high.”

VCHPs could better spread messages on child feeding if these messages integrated into the work they are already doing. All CVHWs interviewed expressed interest in learning more about child feeding since they already interact with families. Many are already providing counseling on child feeding in the home, but training the VCHPs in feeding recommendations would give them a consistent message to reinforce within the community. Interviews also suggested that some VCHPs have misconceptions about feeding practices, for example, fearing that breastfeeding to two years is harmful to the mother, promoting the drinking of milk for infants, encouraging bottle feeding as a hygienic practice in one case, or encouraging introduction of foods before 6 months.

VCHPs in Chenicha said that children are not getting enough food and would have difficulty getting the right types of food because families had limited income, whereas VCHPs in Misha and Mareka said that children are getting enough food and that there is adequate food available to feed children. VCHPs would benefit from understanding how much food children need. Since they believe that families can feed themselves with what they already have, VCHPs could also help focus on practical strategies for optimal feeding.
Working more with VCHPs could also provide an entry point for working with men and community leaders to provide more support for child feeding. A possibility might be to recruit specific volunteers to focus on nutrition and food-related work. These could be model mothers with experience, men who provide support in food production, and respected individuals who interact well with families and community leaders.

4.5 What is the HEP currently doing to support child feeding in communities, and what could be done to further support frontline workers and the community to optimize child feeding?

This study found the HEP system to be well established, with trained HEWs implementing many of the 16 key HEP packages. HEW supervisors and HEWs said that the overall health situation is improving in communities and that morbidity and mortality have decreased. They feel that significant gains have been made in family planning and immunization coverage, latrine coverage, and overall hygiene, and that increased exclusive breastfeeding and timely complementary feeding has contributed to improvements in child health.

The HEP has provided the main human resource base, with the HEWs and VCHPs as the focal point for all the health and nutrition initiatives in the community. However, each new initiative places more demand on HEWs and VCHPs’ time and establishes potentially competing priorities. While IYCF is part of the maternal and child care package of the HEP, additional training and activities have been introduced, such as the Therapeutic Supplemental Food program and the new strategy for Community Based Nutrition (CBN). Nutrition activities in Misha and Chenicha sites focus more on a therapeutic approach with screening of children for malnutrition and distribution of plumpynut, whereas in Mareka the CBN approach has recently been introduced on top of existing activities in therapeutic feeding. The convergence of these programs and how this translates into priorities and activities at the community level, especially in promoting key feeding practices, is unclear and may need some guidance. While HEW supervisors interviewed in Mareka have been trained in ENA and CBN, only one in Misha has had training in ENA and the rest have only been trained in therapeutic feeding, with one supervisor in Chenicha having no training in nutrition. Additional support and training may be needed to reorient efforts towards a preventative approach; otherwise nutrition programming will remain focused on a therapeutic approach and will be less effective for children under two.

HEP supervisors strongly suggest more training to HEWs’ skills and improve their capacity to solve problems with mothers. One remarked that HEWs need to work within existing culture and beliefs, and that families need to learn to work with what they have.

“Even if we have food, we don’t know how to give it to children in a balanced way.” – HEW supervisor in Misha

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4 The Community Based Nutrition strategy seeks to “build community capacity for assessment, analysis, and action specific to preventing child malnutrition” (The Triple A approach promoted by UNICEF).
All supervisors said that more promotion of specific practices is needed in addition to counseling, and that HEWs need more help in communicating effectively. One HEW supervisor commented that trainings are held in the woreda, but that afterwards there is no follow-up. It would be helpful to look at how promotion activities could be incorporated, including activity planning, monitoring and follow-up, as well as how promotion of specific practices could be integrated into other ongoing HEP activities. Supervisors also noted that VCHPs and model families could be used more effectively, and one encouraged training of and involvement of community leaders because, “they have respect and will be heard.”

The HEP does provide support for key workers with HEW supervisors working closely with HEWs and VCHPs in their area, providing guidance and support. HEWs and supervisors talked of annual plans and monthly activity plans and how this is a tool used to guide their work and for follow-up. HEW supervisors have been trained in IFHP supervision guidelines and checklists, and one HEW mentioned that supervision has improved from a critical approach to a more supportive and problem-solving approach. When asked about the frequency of supervision visits, HEW supervisors initially talked of the ideal situation where they visit health posts on almost a daily basis, meeting with each HEW once a week or at least twice a month. However, when supervisors were asked to talk about recent supervision visits and HEWs were interviewed, the reality is that the frequency of meeting depends very much on distance. In Kebeles close to the woreda health office or health center, HEWs meet with their supervisors weekly or even more frequently, but for those HEWs posted further from these centers, meetings are once a month, and in a few cases, only once every 3 months. Long distances, limited access to F-MOH motorcycles, and a lack of budget for transport allowances were highlighted as the main barriers to meeting more frequently.
5. Summary and Implications for Programming

The SNNP formative research on infant and young child feeding identified the beliefs and current feeding practices for breastfeeding and complementary feeding of children, along with key facilitating factors to improve young child feeding. The study also assessed the roles of different groups, including family and community members, health extension workers, and voluntary community health promoters in supporting IYCF in their communities.

5.1 IYCF practices and related beliefs and attitudes

This study indicates that breastfeeding is widely practiced in the research communities and is expected of all mothers and valued in the community for its contribution towards child growth and healthy development. Unlike the findings in related studies, mothers in the study areas seem to know the expected breastfeeding requirements such as: on-demand feeding, frequency of breastfeeding, and the need to feed from both breasts. Yet exclusive breastfeeding is not widely practiced in the study communities. Mothers commonly introduce water, fenugreek, or linseed water as early as 2 months. Mothers also use bottle feeding and consider this a good practice for feeding the child thin gruel, because the bottles are believed to keep the food covered and clean.

This study demonstrates that mothers and other family and community members are concerned that feeding a sick child extra food will cause further illness, diarrhea, and vomiting, or that it would stimulate the child’s appetite and develop a habit for eating more food than the family can afford.

In regards to complementary foods, the study indicates that the age for introduction of additional foods ranges from 2 months to 8 months, with a majority of mothers reporting that they had started giving foods at 6 months or earlier. Certain foods such as kale, enichila, banana, egg, pumpkin, carrot, and green vegetables are considered unsuitable and “too strong” for young children to digest before 1 year of age. Meat, in particular, is considered by mothers as too hard to digest. Most mothers recommend meat for children above 1 or 2 years old. Mothers also expressed that they need to have a good income to buy or feed their children such foods.

Regardless of this, study participants believe that children in their communities are doing well due to immunization services, improved access to health services, and improved child feeding practices.

Implications. Almost universal acceptance that breastfeeding should begin early and continue through at least 2 years of age and widespread belief in the benefits of breastfeeding simplify promotion of recommended IYCF practices through 6 months of age. Program activities and materials on breastfeeding should build on its positive “brand” and address mothers’ concerns about illness.

Bottle feeding may need to be addressed. Mothers tend to use bottles for the sanitary storage of gruel, but may be introducing contaminants through unclean bottles and the water used to prepare the thin foods.
Efforts to promote extra feeds when a child is sick or recuperating may meet resistance. As noted, mothers and other family members may need to be convinced that the extra food does not contribute to the illness.

Similarly, program activities will need to help mothers put aside traditional wisdom about the many foods that are considered “too strong” for a young child to digest. This is particularly important, given the reluctance to feed meats and other animal source food at the very ages that young children require protein to prevent stunting. Program planners will want to identify interventions and messages that will resonate with mothers and enable them to adopt improved practices even in the face of entrenched traditions or misconceptions.

IYCF programs would do well to build on HEP’s credibility and community members’ perceptions that their children are becoming stronger and healthier as the HEWs and VCHPs promote recommended practices.

5.2 Community and family influences on mothers’ feeding practices

The role of family members in influencing IYCF practices was also explored. Mothers are seen as the primary caregivers for children in the home, sometimes assisted by an elder daughter, mother, or mother-in-law. Husbands appear to influence child feeding practices indirectly, primarily in their role as provider and as the one who controls family finances. Family members’ and community elders’ advice on feeding is often followed, even though traditional practices sometimes run counter to the MOH recommended IYCF practices.

Implications. The study’s findings confirm that any intervention aimed at changing traditional practices related to child feeding must engage the family and community members who influence individual mothers’ choices. These influential can play a supportive role if they are brought on board with new ideas, and just as importantly to keep in mind, can interfere with promotion of recommended practices when they offer incorrect information or outmoded beliefs.

As this study shows, the ways a community’s young children are nourished are the product of generations of tradition, and many traditional feeding practices are linked to deeply-held cultural and even spiritual beliefs.

5.3 HEW and VCHP capacities

This study looked at perceptions of staff and volunteer capacity from their own point of view and from the point of view of the families they serve. Capacity includes both knowledge of recommended IYCF practices and the skills needed to teach, train or counsel.

The study confirmed that the HEP system is well established, with trained HEWs implementing many of the 16 key HEP packages. As a result, the HEW supervisors and HEWs believe that the overall health situation is improving in communities, and that morbidity and mortality have decreased. On the
other hand, the potential burden of new initiatives on HEWs and VCHPs in terms of competing priorities and demands on their time was indicated as a challenge.

According to study participants, HEWs and VCHPs are well-known and active in the study communities. All of the HEWs have completed the 1-year HEW basic training program. They reported that they visit 40 or 50 households a week and also supervise 10 to 20 VCHPs.

Regarding BCC materials used in promoting IYCF, two previous USAID-funded projects, Essential Services for Health in Ethiopia (ESHE) and LINKAGES, have distributed these materials to area communities as well as the guidelines for the community-based nutrition approach. Additional materials the HEWs receive through the Woreda Health Office include: the family health card and two types of posters, one with pictures of a well-nourished child and a child with malnutrition, and another with the feeding guidelines. Some of the HEWs say they are using the counseling cards. The HEWs say they find the family health card very useful in working with mothers and the posters are popular for working with community groups.

The study also revealed that HEWs feel they have a need to learn more about child feeding in order to effectively counsel mothers on IYCF. Several pointed out that they need more detailed information about additional foods, types of foods, and best approaches for preparing food for young children, with follow-up mechanism.

Besides the HEWs, the role of the VCHPs was also identified. The VCHPs work more in sanitation and hygiene and family planning than in IYCF. Though not formally trained in nutrition, many of these VCHPs spoke of providing basic advice on child feeding to families during home visits, especially about breastfeeding. Most said they learned about child feeding by reading the family health card, which they believe is the most important resource for their job. Similar to the HEWs, the VCHPs suggested the need for training in giving consistent messages and feeding recommendations to avoid IYCF misconceptions and to promote optimum IYCF practices in the community.

**Implications.** Clearly, refresher training is needed for HEWs, to increase their understanding of IYCF practices as a way to prevent malnutrition and to build their counseling capabilities.

VCHPs need formal training to ensure they can carry out their IYCF-related activities. While their focus is currently on other health areas, most VCHPs in this study expressed interest in learning more about child feeding and nutrition.

Program planners should gain an understanding of why VCHPs have not been trained in IYCF. Presumably, this training should have been conducted by the HEWs. Do HEWs have the time and the skill to prepare VCHPs to carry out their IYCF responsibilities? This should be considered as the HEW training is designed.

The enthusiasm that supervisors, HEWs, and VCHPs have all expressed for learning more about IYCF bodes well for the training activities.