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Engaging Fathers to Improve Children's Dietary Diversity in Rural and Semi-Urban Communities

LESSONS FROM KADUNA STATE

After 6 months of age, children need additional—or complementary—foods while continuing breastfeeding to meet their nutritional requirements. The World Health Organization (WHO) recommends feeding children over 6 months of age a variety of food groups, each of which provides a unique set of nutrients to ensure that physical growth, cognition, and immunity are protected (WHO, 2013). Complementary feeding practices for children over 6 months are influenced by a variety of factors, including the knowledge and beliefs of mothers, fathers, and other family members of what and how to feed children over 6 months, access and availability of affordable nutritious foods, and family's and community's support for recommended practices. In Nigeria, only 31% of children aged 6 to 23 months achieved minimum dietary diversity in 2021 (NBS & UNICEF, 2022). While mothers are often the focus for programs and interventions seeking to improve nutrition outcomes, Alive & Thrive (A&T), the government of Nigeria, and other stakeholders identified fathers' engagement as a priority to improve children's dietary diversity, particularly in rural and semi-urban areas of northern Nigeria.

Background

From 2019-2020, A&T and the Kaduna State Primary Health Care Board worked with a local civil society organization, I Care Women and Youth Initiative (ICARE), to engage fathers of children 6 to 23 months old through a package of community-based interventions to improve children's dietary diversity. This pilot aimed to motivate fathers to provide money for or otherwise procure nutritious foods for their children and to support their wives with child feeding. The key interventions were selected based on formative research, which identified enablers and barriers for children's dietary diversity in Kaduna state (shown in Table 1). This brief presents results from the pilot evaluation, which was conducted by RTI International in 6 of 12 wards in the Igabi local government area (LGA) of Kaduna State. The brief also summarizes the approaches used and offers key learnings for future program designers and implementers seeking to engage fathers through community-based approaches.

Key Learnings

To promote shifts in complementary feeding outcomes, the programme strengthened the capacity of multiple delivery channels and platforms linked with the primary health care and local government structures and monitoring systems. The following section describes some of the platforms and channels engaged in the programme.

CHEWs and Primary Health Care Teams

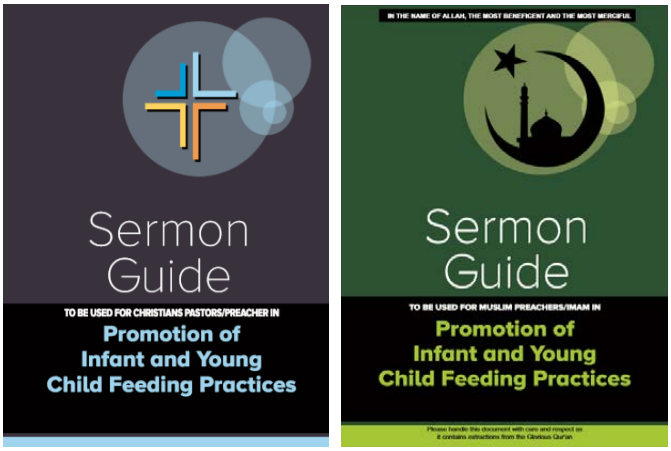
- A&T worked with primary health care teams to develop new job aids, such as pamphlets for fathers and mothers, counselling tools for CHEWs and community leaders, and posters on children's dietary diversity.
- A&T trained 60 CHEWs and provided them with A&T feeding bowls that indicate the appropriate quantity of food to be given to children 6 to 23 months old, to be used during home visits. CHEWs conducted weekly age-specific home visits and reached mothers and fathers through routine health activities such as growth monitoring and monthly immunization meetings.
- CHEWs worked with primary health care facilities to develop (and continuously update) a register of new fathers and mothers of children 6–23 months in communities within their catchment areas and health structures.

TABLE 1: ENABLERS AND BARRIERS FOR CHILDREN'S DIETARY DIVERSITY IN KADUNA STATE IDENTIFIED THROUGH FORMATIVE RESEARCH.

ENABLERS	BARRIERS
• Existing community awareness and education of mothers, fathers, and grandmothers on minimum dietary diversity to meet the child's nutritional requirements • Fathers motivated to ensure provision of specific food varieties for children 6–23 months of age to achieve optimal brain development and protection from illness • Health care providers aware of the need to feed children from 6–23 months at least four specific food varieties to meet nutritional needs • Community opinion leaders supportive of fathers' provision of key food groups (e.g., fish, eggs, vegetables)	• Lack of knowledge of mothers, family members, and health care providers on the need for at least four specific food varieties to meet the child's nutritional requirements • Mothers unable to access the specified varieties of foods needed to meet the nutritional requirements of children due to affordability and lack of family support • Beliefs of mothers and family members that some foods are meant only for adults or parents • Lack of awareness of the critical needs of young children for specific foods; social norms and misperceptions about some foods

FIGURE 1. PAMPHLET ON CHILDREN'S DIETARY DIVERSITY

FIGURE 2. COVER PAGES OF SERMON GUIDES FOR RELIGIOUS LEADERS



Religious and Traditional Leaders

- A&T trained religious leaders (14 imams and four pastors) on appropriate child feeding practices and key messages to share with their congregants during religious services.
- A&T also worked with leaders to adapt sermon guides with key messages on children's dietary diversity, which were used during daily and weekly religious gatherings attended by fathers. Mothers and other family members were also present at some gatherings. Sermon guides featured quotes from religious texts about good nutrition and health practices. The guides also encouraged fathers to take responsibility for their family and provide a variety of foods for their children to be healthy.
- A&T trained leaders of 13 community-based organizations (CBOs) on the use of pamphlets and counselling cards with the same messages. CBOs included Okada Riders Association (motorbike taxis), local tea and bread café association, meat sellers association, and tailoring groups. CHEWs participated in monthly CBO meetings to share key messages on child feeding and answered questions on challenges faced by households and families to provide nutritious diets.
- Regular feedback meetings were held with key stakeholders—including leaders, local government health officials, and CHEWs—to share lessons learned, challenges, and success stories, and to conduct refresher trainings. These meetings resulted in adjustments to implementation, for example, shortening the timing of mobile phone communications to end at 6:30 p.m. rather than 8 p.m.

Mobile Phones

- Weekly key messages were delivered in English, Hausa, and Pidgin on dietary diversity through SMS and voice prompts to mobile phone numbers of fathers enrolled in the program. Contact numbers of fathers were obtained at the time of enrollment along with network availability and preferences on how to reach them.

Mass Media Broadcasts

- Key messages were aired on major radio and TV stations to reinforce messages on SMS; thus, most fathers and mothers continued to learn more about dietary diversity.

Key Learnings

The pilot interventions to engage fathers led to increased paternal support for complementary feeding practices.

- The pilot evaluation found that at endline mothers and fathers agreed that fathers provided money for complementary foods or purchased specific food for their children (Flax et al., 2022). The number of fathers providing money for complementary foods increased by 11% from baseline to endline (from 79% to 90%, p<0.001) (Flax et al., 2022). However, the number of fathers who reported purchasing specific foods, giving advice on child feeding, and feeding children directly did not improve (see figure 3z). Fathers' ability to purchase specific foods may have been limited by affordability and availability of given foods.

FIGURE 3. COMPLEMENTARY FEEDING SUPPORT OFFERED BY CHILD'S FATHER, ACCORDING TO FATHERS

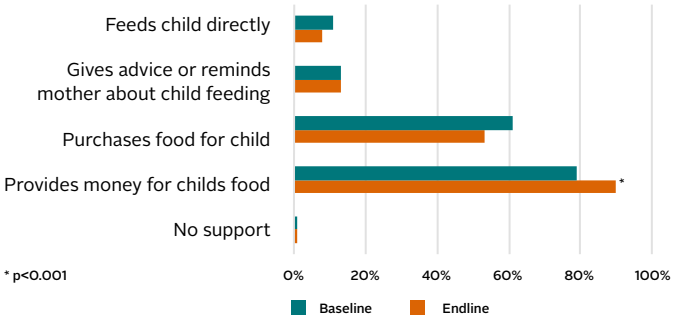
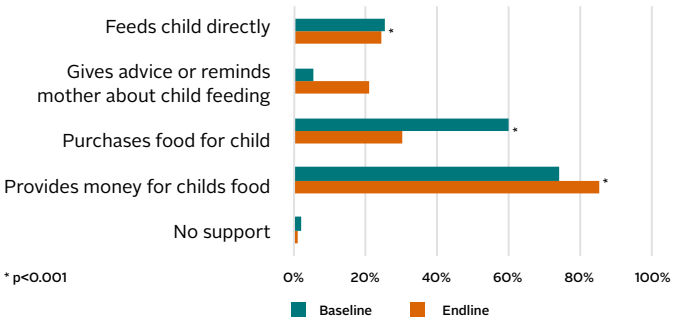


FIGURE 4. COMPLEMENTARY FEEDING SUPPORT OFFERED BY CHILD'S FATHER, ACCORDING TO MOTHERS



- While fathers' support for complementary feeding improved in some respects, no significant change in children's minimum dietary diversity was observed from baseline to endline. However, the percentage of children consuming fish and eggs was significantly higher at endline than at baseline (Flax et al., 2022). To improve children's dietary diversity, improvements must be made in children's consumption of missing food groups such as fruits and vegetables.
- For the detailed evaluation findings, consult the published article "Complementary Feeding Social and Behavior Change Communication for Fathers and Mothers Improves Children's Consumption of Fish and Eggs and Minimum Meal Frequency in Kaduna State, Nigeria" (Flax et al., 2022).

A multi-component approach to engage fathers for improved complementary feeding reinforced key messages and addressed multiple behavioral determinants.

- Key messages were delivered through multiple channels including religious and traditional leaders, community group meetings, mobile phones, mass media broadcasts, and home visits. The interventions and approaches aim to address multiple behavioral determinants such as individual mothers' and fathers' knowledge and attitudes on complementary feeding practices, family support for nutrition, and normative beliefs upheld by religious and traditional leaders.
- There were also opportunities for linkages between intervention approaches. For example, SMS and voice memos were sent to fathers the day before religious services, when the key messages would again be reinforced.
- A multi-component approach to reinforce key messages was important as not all interventions reached fathers consistently. Unavailability of reliable mobile networks was a barrier to communicating with fathers via SMS and voice prompts. Fathers indicated preference for voice prompts more than SMS messaging. Many fathers reported not opening their text messages and a few fathers did not have functional mobile numbers. Some fathers said they did not trust messages from unknown numbers.

- Working with religious and traditional leaders to engage fathers was viewed positively by both fathers and leaders themselves. Religious leaders who used the dietary diversity sermon guides said the use of verses in the Holy Books was spiritually appealing to large numbers of fathers, encouraging them to provide financial resources to procure locally available nutritious foods.

Key factors for success included regular monitoring of intervention activities and integration of pilot activities into existing platforms and approaches.

- A&T conducted regular monitoring of activities with the support of ICARE. Each month, ICARE gathered information on the number of mothers and fathers reached in home visits, number of fathers reached in CBO meetings, number of people reached in sermons, and number of fathers reached by SMS. Data sources included mobile phone call registers, community registers, and religious leaders' registers. Monitoring data provided insight into gaps in intervention coverage, including during the COVID-19 pandemic, when no sermons or CBO meetings were held. When community activities were paused due to the pandemic, the WhatsApp platform was used to share messages, clips, and audio files instead of in-person events.
- Other program-based monitoring activities included exit interviews with mothers after home visits and group meetings with CHEWs on how they felt about messages and adoption of recommended practices. Fathers were also interviewed after sermons on how they felt about procuring nutritious foods for their families and adoption of feeding practices. Some community leaders and fathers of children aged 6–23 months stated that the pilot activities have improved the lives of their children, reducing the cases of illness among their children, and that their children now look healthier and "started walking and crawling on time." Another community leader participating in the pilot expressed joy about the marked improvement in the physical growth of his child.
- The community-based interventions in this pilot were delivered with the support of LGA leaders and through existing platforms and approaches, which fostered increased government response and integration into the primary health care system. Activities that involved CHEWs were incorporated into their routine health activities conducted each week and month, such as growth monitoring and immunization sessions. A&T also conducted supportive supervision visits to participating religious leaders, CBOs, and CHEWs to ensure data and program intervention quality.

FIGURE 5. POSTER DISPLAYED AT COMMUNITY MEETINGS, IN HEALTH FACILITIES, AND IN PLACES OF WORSHIP.

References

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