Can UNICEF’s C-IYCF Counselling Package be successful at scale? Results from a Large-Scale Evaluation in Nigeria

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The author declares no conflict of interest.
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The **Community Infant and Young Child Feeding Counselling** package offered one approach to rolling out those interventions.
In 2014, we embarked on a rigorous evaluation of the package implemented at scale in Kaduna State, Nigeria.
We used mixed methods.

- Key informant interviews
- Costing exercise
- Maternal surveys
- Health worker assessments
- Community volunteer assessments
- Community leader surveys
Implementation followed a Program Impact Pathway

Contextual and Environmental Factors
- Policies and protocols
- Governance and management
- Resources
- Sociocultural norms and social support

Decreased morbidity and mortality
Improved growth
Improved nutritional status

Mothers/ caregivers have access to adequate resources (food, money, time)
Community members have the education to understand MIYCN messages
Households have access to sanitation services

Improved MIYCN practices
Families understand and support optimal MIYCN practices
Mothers and caregivers have knowledge, skills, and self-efficacy
Mothers/ caregivers seek health care
Households have access to health care services
Community members have the education to understand MIYCN messages

10. Conduct monthly review meetings
9. Monitor program activities
8. Promote C-IYCF program activities and health facility services
7. Conduct C-IYCF home visits
6. Conduct C-IYCF support group meetings

5. Mobilize community leaders and members
4. Train community volunteers
3. Nominate and screen community volunteers
2. Sensitize community leaders
1. Train health authorities and health facility staff

Program planning with federal, state, and LGA leaders

Note: MIYCN stands for maternal, infant, and young child nutrition. In this context, this includes hygiene and healthcare seeking behaviors (recognition of danger signs).
We trained 16 health authorities, 65 health workers, and 238 community volunteers.
We conducted **40 community dialogues** and **80 community sensitizations** in Kajuru LGA, reaching an estimated **4,800 people**.
Pregnant women learned the importance of **eating more during pregnancy** than before pregnancy.

- During the first month of C-IYCF support group meetings, **2,923** people attended.
- Approximately **261** new participants joined support group meetings each month.
- In total, C-IYCF support groups reached **7,358** unique participants and made **64,132** contacts over the 18 months of implementation.
- Community volunteers also conducted **8,308** home visits.
- By endline, more than **70 percent** of pregnant women and mothers had seen the C-IYCF counselling cards in use.
As a result, there were impressive improvements in knowledge, attitudes, and practices related to breastfeeding initiation.

Statistically significant difference in differences

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>ATTITUDES</th>
<th>PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows to start breastfeeding immediately after birth</td>
<td>Agrees/strongly agrees that breastfeeding immediately after birth is important for their health</td>
<td>Breastfed children under two immediately after birth</td>
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</tbody>
</table>

* Significant at p<0.05 **Significant at p<0.01
And also related to **exclusive breastfeeding**.

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
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</thead>
<tbody>
<tr>
<td>Knows children should be exclusively breastfed for 6 months</td>
<td>Knows that breastfed children under 6 months old do not need additional water if the weather is hot</td>
<td>Agree/ strongly agree that breastfeeding exclusively for 6 months is important for the health of mothers and/or children</td>
<td>Very confident to be able to exclusively breastfeed for 6 months</td>
<td>Exclusive breastfeeding among children 0-5 months old</td>
</tr>
</tbody>
</table>

![Significance Levels](image)

- **Significant at p<0.05**
- **Significant at p<0.01**
Knowledge and practices related to the introduction of solid, semi-solid, or soft foods were harder to change.

<table>
<thead>
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<tbody>
<tr>
<td>Kajuru</td>
<td>Kauru</td>
<td>Kajuru</td>
<td>Kauru</td>
</tr>
<tr>
<td>1.8</td>
<td>44.0%</td>
<td>2.9</td>
<td>3.3*</td>
</tr>
<tr>
<td>42.2%</td>
<td>37.1%</td>
<td>80.4%</td>
<td>81.4%</td>
</tr>
<tr>
<td>-1.8</td>
<td>35.3%</td>
<td>2.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>43.1**</td>
<td>45.3%</td>
<td>35.6**</td>
<td>37.1%</td>
</tr>
<tr>
<td>3.7</td>
<td>40.1%</td>
<td>3.7</td>
<td>27.7%</td>
</tr>
<tr>
<td>36.4%</td>
<td>37.6%</td>
<td>36.4%</td>
<td>37.6%</td>
</tr>
</tbody>
</table>

- Knows a baby should first be given complementary foods at 6 months
- Agrees/strongly agrees that introducing complementary foods to a baby when 6 months old is important for the health of mothers and/or children
- Very confident to introduce her baby to nutritious and safe complementary foods when 6 months old
- Baby reportedly started being fed complementary food when 6 months old

* Significant at p<0.05 ** Significant at p<0.01
And dietary diversity declined, but not quite as much in Kajuru as in Kauru, suggesting a protective effect of the program.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Minimum dietary diversity</td>
<td>24.3%</td>
<td>7.5%</td>
<td>42.9%</td>
<td>0.7%</td>
<td>49.2%</td>
<td>36.2%</td>
</tr>
<tr>
<td>Minimum meal frequency</td>
<td>21.4%</td>
<td>4.2%</td>
<td>43.6%</td>
<td>15.9%</td>
<td>3.8%</td>
<td>10.5%</td>
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<tr>
<td>Minimum acceptable diet</td>
<td></td>
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* Significant at p<0.05  ** Significant at p<0.01
Conclusions and recommendations were finalized with stakeholders.
Preliminary conclusions include...

• The C-IYCF program was implemented according to plans thanks to bottom-up engagement and top-down support.

• The program was implemented in such a way that the likelihood of the program being sustained and scaled up to other locations is high.

• The program improved knowledge, attitudes, and several key IYCF practices.

• Dietary practices did not improve as hoped, suggesting important barriers to change such as sociocultural norms, inflation, fuel prices, and availability of diverse foods.

• Findings indicate a need for continued implementation with additional interventions to address barriers.
Thank you for listening!
And thank you to everyone involved!

The study team included Rafael Perez-Escamilla, Chris Isokpunwu, Peggy Koniz-Booher, France Begin, Susan Adeyemi, Christine Kaligirwa, Florence Oni, and Babajide Adebisi. Christiane Rudert played an important role in launching this evaluation. Stanley Chitekwe, Arjan De Wagt, Simeón Nanama, and Bamidele Omotola, also of UNICEF, have been extremely supportive. Monica Biradavolu, consultant to SPRING, with assistance from Yeri Son of JSI, played a lead role in the collection and analysis of endline key informant interviews. We are thankful for the input and feedback provided by USAID Bureau of Global Health representatives, Mike Manske, Anne Penniston, Kellie Stewart, Jeniece Alvey, and Laura Itzkowitz. This work would not have been possible without additional funding from UNICEF and the work of the Kaduna State Ministry of Health (SMOH), the Kajuru local government area (LGA)—particularly Anjo Adams, the Nutrition Focal Person for Kajuru—as well as the health workers and Community Volunteers of Kajuru. Finally, we wish to thank the community leaders and members of both Kajuru LGA and Kauru LGA who have taken the time to answer our questions on numerous occasions.