ORIE Nutrition Research in Northern Nigeria

Gender barriers to nutrition services: Lessons from the WINNN programme

Key messages

- Nutrition-specific interventions are more effective in improving nutritional outcomes if they take context-specific gender roles and relations into account.
- Understanding relations among women and men in households and communities can unlock effective strategies for service uptake and behaviour change.
- Messages targeted directly at fathers can help to reduce resistance to the use of nutrition services.
- Finding ways to reach adolescent mothers is especially important, given the low level of autonomy of young mothers in relation to their husbands and older women in northern Nigeria.
- The potential of nutrition-specific interventions to improve nutritional outcomes among mothers and children is greater if they are combined with nutrition-sensitive interventions that also act on gender levers.

Northern Nigeria has a high prevalence of child malnutrition, with around 10% of children (aged 6–59 months) acutely malnourished, one-third underweight, and over 50% stunted.[1] This brief summarises learning from Working to Improve Nutrition in Northern Nigeria (WINNN) programme[2] which supported the implementation of three nutrition-specific interventions for mothers and children in five states in northern Nigeria.[3]

15 years
average age girls get married

1/3
husbands makes child health care decisions alone

17 years
average age of first pregnancy

Gender roles and relations can have a powerful effect on development processes and outcomes. WINNN successfully influenced some of the gender-related barriers in northern Nigeria in order to increase service use and behaviour change.[4]

Context

Studies by the Operations Research and Impact Evaluation (ORIE) project and others have shown that conservative social norms and practices underpinning gender roles and power relations in households and communities in northern Nigeria act as a constraint on the use of health and nutrition services and behaviour change among mothers.

Women marry at an early age (at 15 years, on average), often to older men (an average age gap of 13.5 years), and bear children early (at 17 years, on average). Their mobility is often limited upon marriage, as are their opportunities to earn an income. Many mothers have limited decision-making power relative to their husbands and older women in the home over use of household income and child health care and feeding. Formal education is low across the population, especially among women. Many husbands refuse to allow their wives to use services at health facilities, or withhold the cash needed to travel to facilities. Many older women are resistant to the adoption of recommended improved infant and young child feeding (IYCF) practices that are contrary to the way they fed their own children. These factors hinder mothers' abilities to care for their children, to access health and nutrition services, and to adopt recommended IYCF practices, and have been shown to underpin poor child nutritional outcomes in Nigeria.[5]

What worked well?

WINNN evolved the following strategies on the basis of ongoing efforts to understand and respond to gender roles and relations, and decision-making responsibilities, among men and women of different ages in households and communities in northern Nigeria.

WINNN created teams of male and female community volunteers (CVs) attached to health facilities, and developed gender-specific roles for them. Male CVs have taken the lead in reducing resistance to change among men by sensitising them about the benefits of using Community management of Acute Malnutrition (CMAM) services to treat severely malnourished children and adopting recommended IYCF practices as a way to prevent malnutrition. Female CVs have educated women on recommended breastfeeding and complementary feeding practices in community settings, in Support Groups, and at health facilities.

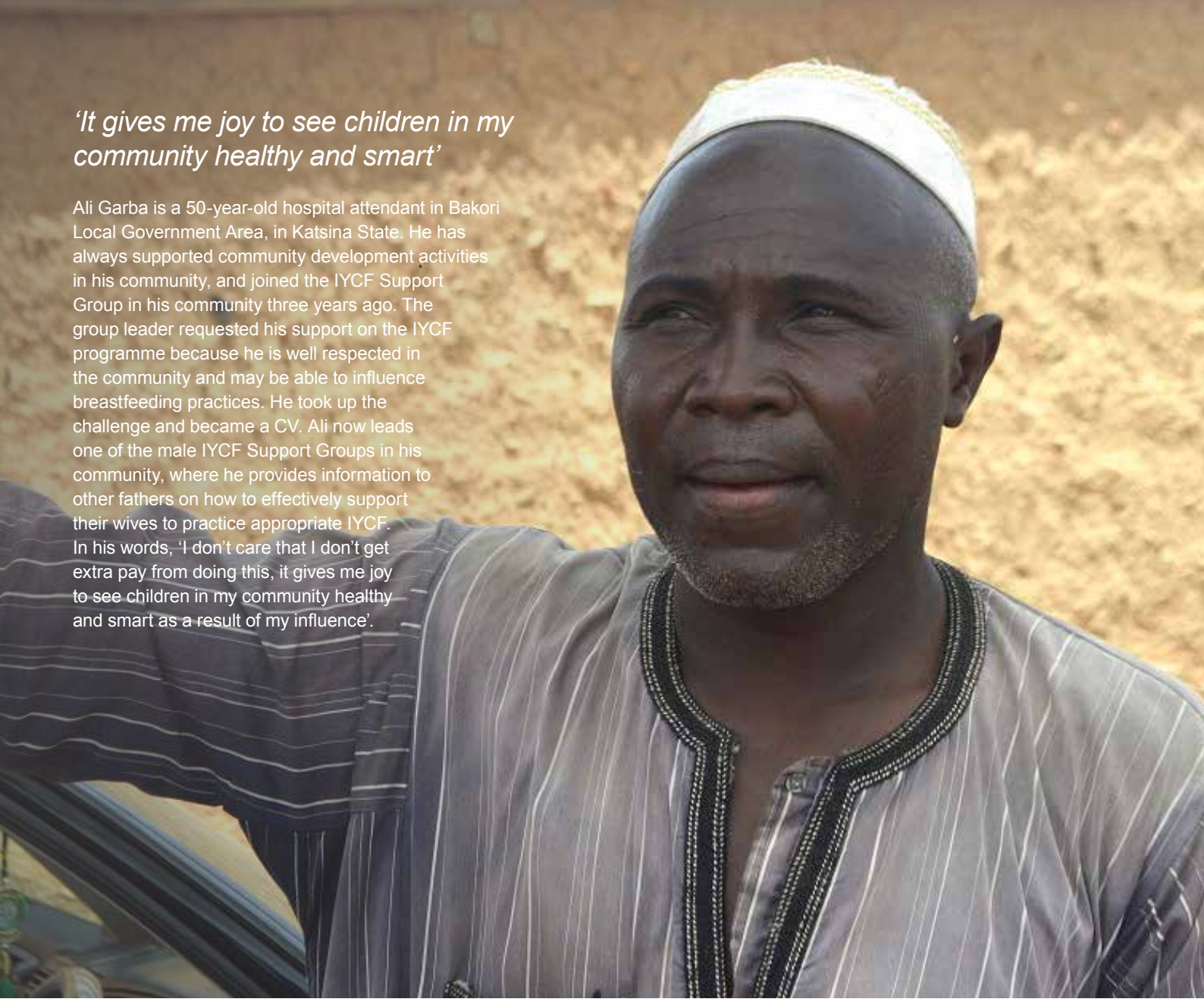
WINNN engaged male community and religious leaders to play important roles in the delivery of WINNN's nutrition interventions. Their roles included recruitment of CVs, overseeing Maternal and Child Health Weeks (MNCHWs) and CMAM implementation, and hosting IYCF counselling meetings. The involvement of these leaders from early on fostered their own understanding of, and belief in, the importance of nutrition services, and their willingness to encourage community acceptance. They have played a crucial role in sensitising men, counselling resistant husbands, and mobilising women to attend services.

WINNN developed strategies for male change agents in communities to communicate important messages about child nutrition directly to fathers. These included 'community dialogues' and informal conversations organised by male community leaders, Ward Development Committee members and CVs in male spaces (e.g. mosques and markets), social mobilisation strategies to encourage fathers to allow their children to be taken to MNCHWs, and IYCF Support Groups for fathers to help them understand the benefits of healthy child feeding practices. The core message underpinning these interventions was that the Qur'an teaches that men are responsible for the health of their family, along with the importance of good nutrition for their children's future prospects. Evidence shows that these strategies helped to change attitudes among fathers and enabled some to act as advocates of change in their homes and communities.

WINNN evolved its approach to IYCF counselling in Support Groups to take account of the dynamics among women of different ages and to target adolescent mothers directly. Support Groups were intended as a safe space in which mothers could learn practical skills and share ways to overcome difficulties. CVs running these groups also saw them as an opportunity to sensitise older women, as they frequently make decisions on child feeding, but over time it became apparent that the presence of older women inhibited the participation of younger women. WINNN responded by establishing separate Support Groups for adolescents.

What more needs to be done?

Male resistance to the use of health and nutrition services and the adoption of recommended IYCF practices is still a challenge. The endline evaluation found that 8% of mothers who had not attended the last



'It gives me joy to see children in my community healthy and smart'

Ali Garba is a 50-year-old hospital attendant in Bakori Local Government Area, in Katsina State. He has always supported community development activities in his community, and joined the IYCF Support Group in his community three years ago. The group leader requested his support on the IYCF programme because he is well respected in the community and may be able to influence breastfeeding practices. He took up the challenge and became a CV. Ali now leads one of the male IYCF Support Groups in his community, where he provides information to other fathers on how to effectively support their wives to practice appropriate IYCF. In his words, 'I don't care that I don't get extra pay from doing this, it gives me joy to see children in my community healthy and smart as a result of my influence'.

MNCHW did not go because they lacked their husband's permission and found some cases in which men who knew about MNCHWs did not tell their wives because they were not supportive of their attendance. More work is needed to understand how male resistance to the use of health services may be overcome. Improvements in the quality of services may help. Some men reported not allowing their wives to use services due to a poor experience on prior visits, particularly stock-outs of health commodities at MNCHWs and CMAM days. Some were also resistant to their wives being attended by a male health care provider. This points to a wider problem in the Nigerian health system: the shortage of female health workers, particularly in primary health care.

Additional effort is needed to reach poorer mothers, mothers with no formal education, and mothers living further way from health facilities. Endline evaluation data pointed to lower use of services and adoption of recommended IYCF practices among these mothers. The cost of transportation to facilities during MNCHWs, and the direct and opportunity costs of repeat visits to CMAM facilities, can deter poorer households from using services. Inability to afford appropriate foods for pregnant and breastfeeding women and weaning children can deter poorer households from following recommended feeding practices. WINNN has made some inroads in relation to this problem, by setting up mobile MNCHW teams and encouraging Emirs to provide free bus services on CMAM days.

Adolescent mothers were also less likely to use some services and to adopt recommended IYCF practices. Qualitative research found that the mobility of adolescent girls was particularly limited upon marriage, and that adolescent mothers had particularly low autonomy around child care, feeding and health-seeking

behaviours relative to their husbands and mothers-in-law.

Further exploration is needed to find ways of convincing older women to support younger mothers to adopt recommended IYCF practices. This may include the development of separate spaces for educating older women on the benefits of recommended practices. The Care Group model being piloted by WINNN, in which neighbourhood 'mother leaders' work with all household members together, may help to increase understanding across women of different ages. It may also increase exposure to counselling among women who did not have their husbands' permission to attend Support Group meetings.

The potential of nutrition-specific interventions to improve maternal and child nutrition is greater when they are combined with nutrition-sensitive interventions that also act on gender levers. Given the sensitivity of addressing girl child marriage and teenage pregnancy in northern Nigeria, strategies to increase the economic resources under female control via livelihoods interventions and/or social protection may be the most appropriate short-term approach: they could help to increase women's decision-making power in relation to resource allocation, and reduce household poverty. The global evidence base for the impact of cash transfers on women's decision-making and use of health services is mixed. However, a recent review suggests that design and implementation features can be used to enhance gender outcomes.[7]

References

[1]National Nutrition and Health Survey (NNHS) 2015. [2]WINNN is a six-year programme (2011–2017) funded by the UK Department for International Development. The Operational Research and Impact Evaluation (ORIE) project is a separate component of the programme, undertaking independent research around, and evaluation of, WINNN. The project is conducted by a consortium led by Oxford Policy Management. This brief draws on evidence collected between 2013 and 2016. [3]The interventions were: micronutrient supplementation (mainly through bi-annual Maternal, Newborn and Child Health Weeks (MNCHWs) campaigns), community management of acute malnutrition (CMAM) and infant and young child feeding (IYCF) counselling. [4]The evidence used in the brief comes from ORIE studies covering four states in northern Nigeria: Jigawa, Kebbi, Katsina and Zamfara. These states are majority Muslim, and most of the data relate to Muslim households. [5]Ajieroh, V. (2009) 'A Quantitative Analysis of Determinants of Child and Maternal Malnutrition in Nigeria', Nigeria Strategy Support Program (NSSP) Background Paper No. NSSP10; Ibrahim, A., Tripathi, S., and Kumar, A. (2015) 'The Effect of Women's Empowerment on Child Health Status: Study on two Developing Nations', International Journal of Scientific and Research Publications, Volume 5, Issue 4, April 2015; Omilola, B. (2010) 'Patterns and trends of child and maternal nutrition inequalities in Nigeria', IFPRI Discussion Paper 00968. [6]Hagen-Zanker, J. et al. (2017) 'The impact of cash transfers on women and girls. A summary of the evidence', ODI Briefing March 2017.

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