

# Sierra Leone: Getting beyond nutrition as “a women’s issue”

## Key messages

- Promoting good child nutrition must go beyond dissemination of infant and young child feeding practices to engage with key influences on mothers’ behaviour.
- ‘Exclusive’ breastfeeding is rarely exclusive, with traditional remedies frequently given to infants.
- Decision-making around food distribution, household finances and when to stop breastfeeding is deeply gendered, influencing the ability of women to act on knowledge about appropriate feeding practices.
- These social conditions that sustain malnutrition are exacerbated during ‘lean seasons’, when there are greater labour demands, compromised sanitation, and limited coping mechanisms.

Malnutrition is one of the greatest threats to human development in the twenty-first century. Its impacts are both immediate – each year, 3.5 million children under the age of five die as a result of infant and maternal undernutrition – and long-lasting: undernourished children tend to perform worse at school and are less productive in the labour market (Martins et al., 2011).

We know that community-level interventions are one important part of trying to prevent cases of malnutrition from emerging in the first place (Shrimpton et al., 2001). One popular policy approach at this level is to promote good infant and young child feeding (IYCF) practices. This is typically done through the dissemination of key messages through various channels, including government-run health clinics (when, for example, expecting women attend antenatal check-ups) and community-based peer groups such as Mother-to-Mother Support Groups.

Implicit in these approaches is the idea that information should target women – and mothers specifically. Recent research conducted by the Secure Livelihoods Research Consortium (SLRC), however, suggests this may be a flawed approach. While knowledge transfer may seem straightforward, in reality is far from easy. The actions and behaviours of mothers are mediated by others in the household and community – and they cannot be changed by targeting behaviour change programmes at mothers alone.

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Abdul with his newborn son in Freetown, Sierra Leone

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Two recent SLRC studies in Kambia district, Sierra Leone – a country where more than half of all under-five deaths are attributable to malnutrition (WHO, 2011) – show how healthy child development is not simply a product of knowing the right information, but that it is also strongly connected to questions of power, social relationships and informal institutions, which influence how information gets used. Malnutrition is a deeply gendered issue. As such, those interested in preventing it should be concerned with the position of women vis-à-vis others. This briefing paper demonstrates how childcare is influenced by a range of household actors, and sets out what efforts to prevent malnutrition can do to engage with this reality.

### Why power and relationships matter for nutrition: three key findings from our research

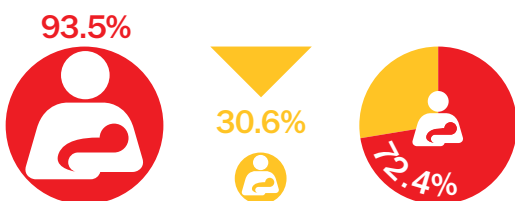
#### 1 Exclusive breastfeeding is rarely exclusive

In line with international best practices, Sierra Leone’s Ministry of Health and Sanitation focuses on promoting breastfeeding as a key approach to reducing stunting and malnutrition. But while government data suggest that rates of exclusive breastfeeding in Kambia are 93.3%, far higher than the national average of 32% (GoSL and UNICEF, 2013), a semi-quantitative study conducted by SLRC found the rate to be more like 30% – a huge divergence from official statistics (Binns et al., 2014).

What might explain this? According to Binns et al., in 72.4% of cases where a mother reported exclusive breastfeeding, the child had received additional herbal medicines on a regular basis. This suggests that many do not perceive exclusive breastfeeding and the consumption of herbs or warm water to be mutually exclusive. If these nuances are not reflected in data collection methods, then inflated rates of exclusive breastfeeding are likely to be reported (see Figure 1).

#### Figure 1: Getting good feeding data means asking the right questions

On the face of it, strong progress against this is already being made. In the northern district of Kambia, for example, official data\*\* suggest an exclusive breastfeeding rate of over 90%. But new research by SLRC suggests a different story.



Source: SLRC, 2014 (original data from Binns et al., 2014 and GoSL / UNICEF, 2013)

In addition, SLRC research suggests there is no relationship between the prevalence of such practices and the level of formal health services in a community. One of our research sites, for example, was a large town with relatively



Social forces within the household and community influence the ability of women to act on knowledge about appropriate feeding practices.

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sophisticated healthcare infrastructure and a total of 18 community health workers. Yet, we found that key IYCF messages were not being taken up by many community members. In contrast, in another of our research sites – a small town with a much lower level of health infrastructure – we found that exclusive breastfeeding was practised more widely.

The contrasting social relationships between health providers in these sites appear to be a vital part of the story behind variations in IYCF compliance. Where relationships between health staff and the community were better and more communicative – as in the second site – better uptake of IYCF messages was apparent. This highlights the importance of interpersonal and communication skills of health workers, which are often overlooked in training programmes that focus instead on technical knowledge. While this is clearly important, it is not sufficient in achieving behaviour change within communities.

#### 2 Household decision-making is sharply gendered

A young mother may know how to keep healthy during pregnancy, about the importance of exclusive breastfeeding, and how long to wait before weaning her child. But our research suggests that often she may not be in a position to act on that knowledge. In each research site, social forces work to limit the autonomy and decision-making capacity of young women and make it difficult for them to translate IYCF knowledge into practice. Understanding these social forces and what governs acceptable behaviour – the ‘rules of the game’ – is integral to understanding the factors that drive and sustain malnutrition. We focus on three aspects.

## Feeding and food distribution

Young women are at the bottom of the hierarchy when it comes to who gets what at mealtimes. In all households in our research sites, it was a woman's husband and her parents-in-law who received the first, largest and best meal portions. Food distribution is determined in line with strong cultural ideas about family identities. For example, when asked why the food in her household goes first to her husband and mother-in-law, one focus group participant answered: '[Because] he married me and he is the father of my children. The mother-in-law takes care of me as well'.

This has consequences for the nutritional status of children in a number of ways. It is possible that girls, in particular, will not receive enough nutrients for optimal development, potentially influencing early brain development and having consequences for educational prospects and beyond. Furthermore, during pregnancy – when good nutrition is vital – limited food intake can affect an expecting mother's own nutritional status, as well as that of her unborn child.

## Decision-making around when to stop breastfeeding

Gendered constraints are also observable in relation to decisions around when to stop breastfeeding. In each research site, community members reported a belief in *banfa* – that is, the notion that if a woman has sexual intercourse while breastfeeding, her child will suffer from diarrhoea, possibly leading to death. Some have suggested that *banfa* may have the unintended benefit of promoting birth spacing, and thus have a positive effect on child wellbeing.

But we found that many couples continue to have intercourse despite a belief in *banfa*. Other considerations appear to outweigh traditional beliefs and thus negate the potential advantages of birth spacing. For example, some women in polygamous marriages feel the need to engage in sexual intercourse with their husbands while breastfeeding in order to avoid falling out of his favour. Some women in monogamous relationships resumed sexual intercourse with their husbands while breastfeeding to deter them from taking 'girlfriends'. In other cases, poor mothers struggling to meet basic subsistence needs at times reportedly participate in transactional sex just to put food on the table or get to the local health clinic (our research found examples of both).

More generally, the research found that the decision to stop breastfeeding is largely made by the father of the child. Many men appeared to want breastfeeding to continue for their children for as long as possible, because they thought this was best for the child. Others felt that a woman voicing the suggestion to stop was evidence of them sleeping with – or wanting to sleep with – other men, and so would insist on the continuation of breastfeeding. In any case, our findings support those of other studies illustrating the powerful role played by husbands in regulating breastfeeding practices (e.g. Turay, 2014).

## Figure 2: Improving exclusive breastfeeding rates means paying attention to the social status and decision-making power of young women

### Gender really matters

In order to reach that target of 60% exclusive breastfeeding, special attention will have to be paid to the social status and decision-making power of young women.



Source: SLRC, 2014

## Control over the household economy

In line with other dimensions of social and economic life, there is a strong patriarchal influence over household decisions and control of income. About half of the female respondents earned an income, typically through small-scale farming, fishing or petty trading. In most cases, however, these women were required to hand their earnings over to their husband. As one interviewee explained, 'You can see it but you can't touch it'.

As such, women's financial contributions do not appear to necessarily buy them much decision-making power vis-à-vis food allocation, household expenditure, or duration of breastfeeding. These domains remain largely dominated by males and household elders (particularly mothers-in-law) who ensure that younger women are less able to enforce their own ideas and preferences – with consequences for a woman's capacity to care for herself and her children.

## 3 Rainy seasons create 'perfect storms'

The inadequacy of the care that women and children receive becomes particularly pronounced during 'lean seasons'. In Sierra Leone the rainy season, typically stretching from June to September, is considered the most difficult period, although our research found that this can differ between communities – with some communities experiencing lean seasons immediately before their harvest times as well.

Lean seasons are characterised by three key dynamics that combine to create a 'perfect storm' of conditions that (re)produce malnutrition.

### Limited coping strategies

Most households in the research sites use subsistence farming to meet food needs, and it is during lean seasons that households' food supplies begin to dwindle. Most families have few coping strategies available during this time. The strategy most commonly referred to is taking loans from market traders – known as 'trust'. Households typically obtain bushels of rice from a creditor, which they then repay after the harvest. The interest rate is high, sometimes 100%. While this method gets

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a family through tough times, it also creates longer cycles of debt, thus prolonging food insecurity.

This has two particular consequences for nutrition. First, the reduced access to food during this time is potentially damaging to the health of pregnant women, their unborn children, as well as the nutritional status of children. Second, household spending is constrained even more than usual, meaning that things like healthcare or complementary foods are more likely to be foregone.

### Greater labour demands

The heightened demand for agricultural labour during the rainy season places additional pressures on households, particularly women. During this season, women are expected to cultivate land alongside men (although in some places, women do this all year round), while still undertaking their substantial everyday household responsibilities.

Pregnant and lactating women are not exempt from farming, although husbands may permit a brief period of rest immediately following childbirth. Participating in agricultural labour can keep women away from the home and limit their ability to breastfeed children, with consequences for a child’s development, particularly during early infancy.

### Poor hygiene and sanitation levels

Long-drop latrines are often absent from rural communities, meaning that people may have little option but to openly defecate in bushes or rivers. This creates a particular problem in the rainy season when excess soil saturation leads to high levels of surface runoff, increasing human exposure to contaminated water sources. This, in turn, heightens the risk of diarrhoea and other forms of infection, and makes people more susceptible to malnutrition.

## What we can do: Four key recommendations

**Recognise that the ways in which communities access food vary from community to community, and tailor interventions accordingly.** This includes understanding: how communities access food; local beliefs surrounding food (and levels of adherence to those beliefs); how power is allocated within households, and so on. These features are central to how malnutrition unfolds in a community. Interventions that can adapt to these dynamics will prove more successful than those that overlook them.

### From Mother Support Groups to Family Support Groups.

Evidence suggests that the participation of men and elders – and not just women – in behaviour change interventions and community groups can have positive effects on child health. As our research shows, nutrition is not simply a ‘women’s issue’. Addressing malnutrition therefore means also engaging the actors we know to be powerful when it comes to decision-making within the household. More often than not, this is not young mothers. Transforming Mother Support Groups into Family Support Groups and encouraging participation from fathers and mothers-in-law, amongst others, is an important step in recognising that malnutrition is a community-wide responsibility.

### Ensure that awareness raising about exclusive breastfeeding includes specific reference to risks of warm water and bitter medicine.

Despite long-standing campaigns to promote exclusive breastfeeding in the first six months, we found that the vast majority of households continue to feed infants warm water and bitter medicine – and do not perceive this to compromise ‘exclusive’ breastfeeding. Messaging needs to tackle this directly and assessments of rates of exclusive breastfeeding should ensure mothers are specifically asked whether they feed children water or bitter medicine so as to obtain an accurate picture of progress.

### Provide support to agricultural communities to help them cope during lean seasons – and pay attention to when lean seasons actually occur in different communities.

Times are toughest in Sierra Leone’s lean seasons, when food access is more limited, environmental hygiene is worse, and labour demand spikes. Government and development partners should consider a range of possible measures to support rural households during this time, including: low-interest or interest-free credit to improve food access; expansion of water, sanitation and hygiene services; and agricultural mechanisation to reduce labour demand during harvest. Sub-national variations in crop production should be taken into account when planning these, as ‘the most difficult time of year’ varies from place to place and does not always map onto the rainy season alone.

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