Assessment of Infant and Young Child Feeding Practices and Household feeding practices among Refugees from DRC in Lunda Norte, Angola

Report from Focus Group Discussions

(Cacanda Reception Center - August 2017)

Key Findings

- Overall, there were not major changes in the feeding practices before leaving DRC and after arriving in Angola; the major difference was seen in the number of meals and variety of complementary foods provided to the infants and children.
- Mothers seem aware of the importance of breastfeeding, and early initiation of breastfeeding is the common practice among refugees.
- Although breastfeeding is well perceived and common, the practices do not comply with the recommendation of exclusive breastfeeding during the first 6 months after birth. Water, tea, sugar, and maize porridge are the usually the first foods to be introduced in infants' diet, normally at the age of 2-4 months.
- The limited financial resources of the families in the center hamper the provision of adequate and diverse complementary foods for young children.
- Mothers face difficulties in preparing the food for children due to the precarious conditions in which families are currently living, and the limited access to cooking utensils/tools.
- Short spacing of pregnancies is one of the main reasons for early termination of breastfeeding.
- Wet-nursing is not common or well perceived in DRC. However there are a few cases in the center where another woman is breastfeeding an orphan infant.
- Since leaving their village in DRC, families have reduced the number meals from 3-4 to 1 per day. Children under 5 years old currently eat 1-2 daily meals.

Purpose

This focus group discussion (FGD) aimed to provide initial insights on the breastfeeding and complementary feeding practices among mothers and caregivers of infants and young children refugees from Democratic Republic of the Congo (DRC) in Lunda Norte, with the objective to guide future nutrition interventions and communications with this population.

The main topics assessed were breastfeeding and complementary feeding practices, and any factors disrupting these practices after leaving DRC. In addition, the FGD also included questions on household food security. The groups discussed general practices, in order to reach a consensus (as much as possible) about the situation in the community.

Methods

A series of FGD were conducted with the refugee community in Cacanda Reception Center (CRC). In order to obtain a wider range of information, three groups were initially organized, as follows:

i. mothers/caregivers of infants younger than 6 months;
ii. mothers/caregivers of infants and young children aged 6 to 23 months;
iii. midwives, traditional birth attendants (TBAs), grandmothers and other key informants.

To ensure the representation of different ethnic groups in the discussion, it was discussed that one of the groups should predominantly include *Baluba* mothers/caregivers and another should predominantly include *Tchokwe* mothers/caregivers. As the number of the former was small, it was decided by the FGD team that a fourth group, comprised of:

iv. *Tchokwe* mothers/caregivers of infants and young children under the age of 2 years.

The area selected for the discussion was the registration centre inside the CRC as registration activities were not taking place at that time. The four groups sat in different areas of the registration centre.

Characteristics of the participants:

All participants are female refugees living in CRC, identified and called for the discussion by UNICEF community health workers. The recruiters were asked to identify women with infants and children younger than 2 years old, and formal and traditional midwives. Women should not be from the same family, although it was advisable that they knew each other in order to be comfortable in sharing information. In addition, the recruiters looked for groups of women coming from different ethnic backgrounds.

	Number of Participants	**Age group**
i. Mothers/caregivers of infants younger than 6 months	11	Youth and Adults (13-59y)
ii. Mothers/caregivers of infants and young children aged 6 to 23 months	11	Adults (18-59y)
iii. Midwives, TBAs, grandmothers, and other key informants	6	Adults (18-59y)
iv. Tchokwe mothers/caregivers of infants and young children under the age of 2 years	7	Youth and Adults (13-59y)

Results

A. Birth of the youngest child

Of the mothers participating in the discussion, all children with less than 6 months of age were born in Angola, and 9 out of the 11 (82%) deliveries occurred at the hospital and 2 (18%) did not have timely access to the health services. The two '*extra-hospitalar'* (out of hospital) deliveries were attended by a TBA. It should be noted that the impossibility of access is due to lack of transportation during the process of childbirth.

Conversely, all children older than 6 months were born in DRC. Out of the 11 mothers in the discussion, 9 delivered in the local hospital, and 2 (18%) delivered at home. Both births were attended by a midwife/nurse: in one case it was the husband of the woman in labour, who is a nurse; in the other, a family friend.

In the *Tchokwe* households the practice was similar: all births took place in the maternity/hospital, attended by midwives.

The key-informants group reported that in DRC most births take place in the maternity/hospital. As an example of the recent changes occurring, the episode of one mother who gave birth while fleeing from DRC to Angola was described: the baby was born in the woods and without any specialized assistance.

B. Infants' feeding practices

Across all groups, breastfeeding of infants was mentioned as the common practice, both in DRC and in Angola. When asked about when breastfeeding starts, the mothers of *group ii.* indicated that breastfeeding started right after birth, and the colostrum was given to the infants.

These mothers were also aware of the need to not introduce other foods until the infant is 6 months old. However, they acknowledged that infants were not being exclusively breastfed; they usually received breastmilk and something else:

- at the age of 2-4 months (this varied between groups), mothers start complementing the feeding of the infant with plain water, or tea, or water/tea with sugar;
- at the age of 3-4 months (also varied between groups), mothers were introducing porridge, usually of cassava or maize (*fufu*), or commercial cereals for infants.

When asked if practices are different in the current situation, in Angola, the mothers in *group i.* mentioned that as they [mothers] now have poorer feeding practices, they feel that they produce less milk, so they need to initiate other foods earlier than they would normally do in DRC. *Group ii.* mentioned one case of a mother who was not being able to breastfeed; but she already returned to DRC.

The group of the key-informants (*group iv.*) mentioned an increase in the number and amount of food being given to the children, when mothers moved to Angola, resulting from an increase on mother's time availability for children's care and to access other foods in Dundo, although limited in terms of affordability of these foods.

When asked about the challenges that caregivers who use commercial infant formulas face in the current setting, the mothers in *group i.* listed the price of clean water and infant cereals (given the financial constraints), and the lack of bottles. As a result, mothers are using spoons or their hands to feed the infants. It was also mentioned that sometimes non-clean water is used to prepare the commercial infant formula and the infants have episodes of diarrhoea afterwards.

C. Distribution of Commercial Infant formula

In all groups, mothers and key-informants, expressed that until that day no distribution of free commercial infant formula took place in CRC. The few mothers/caregivers who are giving infant formula to their infants buy it from the market[1].[2]

D. Complementary feeding practices

According to the key-informants, in their community in DRC, mothers would start mixed feeding (breastmilk and others) at the age of 2 months, giving commercial infant formula to their infants. At the age of 3 months other foods, such as red tea, are introduced to the infants. Water seems to be often given to infants from birth. The mothers in *groups i.* and *iv.* mentioned the introduction of *Cerelac* and *fufu* (porridge made with cassava flour), around the age of 4 months. In the discussion with *group ii.* some mothers said that they also give biscuits and *bolinhos* (a fried sweet made with cassava flour) as complementary food to their infants.

Since arriving in Angola, some of the mothers had to change these practices as they no longer can afford to buy *Cerelac*, or face challenges preparing the food. Nonetheless, the mothers in *groups ii.* and *iv.* said that their practices did not change since they moved to Angola. Complementing the information provided by the mothers, the key-informants' group (*iii.*) referred to almost no changes in the feeding practices of infants and young children, and maybe even an increase in the frequency of feeding and portion size of the meals. According to the informants, the mothers now have more time to care for the children and better access to food, so their observation is that infants are developing better, compared with the situation in DRC.

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[1] A small portion of powdered milk (one dose), sold in CRC, costs 100 kwanzas (approx. US$ 0.60).
[2] After conducting the FGD, there was a once-time distribution of powdered milk by JRS (purchased from pharmacies in Dundo) to mothers of new-borns in Lóvua settlement.

When enquired about the main difficulties caregivers face to feed young children (older than 6 months), the participants in *group iii.* referred to financial limitation and lack of adequate space to prepare food in the house. Likewise, mothers from *group i.* mentioned not having enough food to feed their children, also referring to the high prices of food to diversify children's diet. And mothers in *group ii.* expressed their concerns regarding food preparation: no adequate space and conditions to prepare food, not enough pans, mugs, cups, etc. These mothers also associated the use of fire-wood to prepare the children's food with the increase in diarrhoea among infants, because it produces more smoke, compared to the charcoal that was used in DRC. For now, firewood is relatively easy to find, and refugees have been collecting, using and selling this commodity regularly. Nonetheless, the use of this natural resource is not sustainable or safe, thus an alternative to be introduced in the Lóvua settlement is being thought.

E. Termination of Breastfeeding

The answer to '*when do mothers stop breastfeeding'* uncovered the issue of low birth spacing among women, as new pregnancies were mentioned in most groups as a reason to stop breastfeeding. Mothers in *groups ii.* and *iv.* said that mothers would usually stop breastfeeding only when the child is old (2-3 years old) or when they become pregnant. The information provided by *group iii.* was that mothers would consider stopping with breastfeeding when the child is 1 year old, however most mothers would stop around the 18 months or when they realize that they are pregnant again. In this regards the key-informants explained that the small interval between births is one of the conducers for the early introduction of commercial infant formulas, especially among younger mothers.

In contrast, participants in *group i.*, whose children are still infants, explained that the practice in DRC is to stop breastfeeding when the baby reaches 6 months. These mothers also mentioned that this was altered after moving to Angola as they noticed changes on the amount of breast milk produced.

F. Supplementation

All groups confirmed that there was no distribution of additional food for pregnant women nor micronutrient supplementation.

G. Information seeking

Mothers in *group i.* mentioned that in DRC women would normally seek information in the health center, and mothers in *group ii.* confirmed that they prefer to seek information through the nurses that they know in CRC, or through the MSF clinic when they take their children for immunization. They also mentioned that in a more informal context they seek advice from other mothers. The *tchokwe* mothers from *group iv.* said that they are not seeking information. The key-informants in *group iii.* stated that caregivers are also seeking information from the community mobilizers in CRC.

The type of information that mothers would like to receive relates to which foods to give to their children, where can they get milk for their children, the reason for their children illnesses (especially diarrhoea).

According to the different groups, the mothers (and sometimes grandmothers) are the ones making decisions when it comes to the children's feeding practices, however, the money to buy the food comes from the father.

H. Infants without mother

The participants in the FGD were aware of some cases of children who lost their mothers. Most of these children are older than 6 months, however there are a few cases of infants that are being cared by the grandmother or other relatives or friends of the family. These children were being fed with commercial infant formula, and some were also feed with another woman's breastmilk (not sufficient as the milk produced was not enough).

Nonetheless, mothers and key-informants expressed that wet-nursing was not common in DRC and that it was not well accepted in their community.

I. Family food

When in DRC, the families used to have 3 or 4 meals *per* day. Since they moved to Angola, because they no longer have a source of income and are limited in the amount of food that they receive from the organizations, they reduced it to one meal *per* day. This meal is usually eaten in the [early] afternoon. In the morning, for *mata-bicho* (breakfast), the families drink red tea.

The reduction in the number of family meals is also affecting the children younger than 5 years, as they are currently only eating 1 or 2 meals a day, depending on the existence of any leftovers from the previous day.

The most common strategies being used by the families to cope with the lack of food, in Angola, are:

- reducing the number of meals;
- finding casual labour opportunities (doing laundry, working with the organizations), collecting and selling fire-wood/charcoal, ...;
- sell or trade some of the food/non-food-items they have in order to buy complementary foods and diversify their diet;
- reduce the variety of their diet: reduce the consumption of foods other than maize meal (*fufu*);
- as a last resource, begging in the streets was also mentioned. This is not so common as refugees stated that they do not like to beg and they have had problems already in the streets while begging.

J. Final considerations from participants

The participants asked for powdered milk for the older children, and said that if conditions allowed, they would provide a more varied diet to their children (more green-leaf vegetables, more meat and fish to eat with the maize meal). The key-informants group requested the organizations to pay more attention to the living conditions of the refugees in CRC. They referred to the difficulties families face to prepare good and safe meals under the current living conditions. Also related to the living conditions, the informants highlighted the fact that these are hampering couples' sexual life and promoting sexual violence and other "inadequate behaviours".

Recommendations

As stated earlier in this report, the FGD aimed to provide information that can guide future nutrition interventions, activities and communication with the refugee community. The main recommendations from the team are:

Interventions/Activities

- A short IYCF in emergencies training should be developed and delivered to key staff from all organizations providing health and social support to the refugees in Lunda Norte, to avoid passing contradictory messages.
- A clear referring and follow-up system for mothers who cannot breastfeed and children without mother should be established, to ensure that infant formula milk is used only in cases where it is necessary, and that these cases are not left unattended.
- Develop a locally adapted manual with basic IYCF information for mothers, families and caregivers (this can be used by community health workers).
- Conduct regular women/mothers discussion sessions for information sharing, doubts clarification, identify and address taboos. This can take place during the distribution days of 'specialised nutritious foods'.
- Provide special nutritious food to women during pregnancy and breastfeeding of infants exclusively breastfed (first 6 months after birth). This will complement the already existing distribution of supplementary food for children aged 6 to 23 months.
- Target families with infants and young children for livelihood activities to allow families to diversify their diet and ensure adequate complementary foods for young children.

Communication messages could focus on:

- **Exclusive** breastfeeding during the first 6 months also means: no water, no sugar, no tea, no commercial infant formula, no *fufu*, no *Cerelac*.
- Women having difficulties breastfeeding should **seek advice** and support in MSF's/MdM's clinic.
- Use only **clean (boiled or bleached) water** to prepare and cook the family and the children's food. Always wash the hands with soap before feeding the children.
- Avoid using bottles and teats to feed infants. Use a **clean cup** instead.
- Basic food and feeding hygiene practices (refer, i.e., to WHO Five Keys for Safer Food).
- Breastfeeding can help delay a future pregnancy. **Pregnant mothers can continue breastfeeding** their infants, as long as they eat and drink properly.
- Mothers are advised to continue breastfeeding until the child is 2 years of age, at least.
- Promotion of high quality complementary foods and frequency of meals, for children 6-24 months.