



Key barriers to adequate Infant and Young Child Feeding (IYCF) practices in poor urban settings of Bangladesh

Empirical findings
By Asfia Azim

CONCERN
worldwide



Extreme poor families cope with high costs of living in cities by compromising on living conditions in squatter settlements and on pavements. Concern Worldwide/Dhaka, Bangladesh/ December 2011

1. Introduction

Concern Worldwide is a non-governmental, international, humanitarian organisation dedicated to the reduction of suffering and working towards the ultimate elimination of extreme poverty in the world's poorest countries. Since 1972, Concern has been working in Bangladesh for more than four decades in urban and rural areas, addressing hunger, maternal and child health, primary education, inequality, and disaster risk reduction to alleviate extreme poverty in the country. Currently, Concern implements four contextual programmes in Bangladesh - Urban, Char, Haor and Coastal, to tackle the existing pockets of extreme poverty in the country.

In the urban context, Concern has been implementing the Integrated Urban Programme since 2012 where one of the main sectors is nutrition. With the support of Irish Aid, this programme is being implemented in extremely poor areas of Dhaka and Chittagong City Corporations that have the greatest number of squatters and pavement inhabitants in the country. Within these cities, the programme targets the extreme urban poor, living in squatter settlements and on pavements, according to Concern's Urban Programme Strategy 2011-2015.

Like other programmatic areas, the urban context has its unique characteristics and complexities. The urban extreme poverty and malnutrition scenario is completely different than that of the rural areas, and so are the immediate and underlining causes of malnutrition. The objective of this document is to capture the empirical findings of poor practices of Infant and Young Child Feeding (IYCF) among poor urban dwellers. UNICEF's conceptual framework has been used to capture underlining causes of key barriers towards practicing proper IYCF.

UNICEF's Conceptual Framework for Malnutrition¹ (Figure 1) shows that the causes of malnutrition are multi-sectoral, and embrace food, health and caring practices. The causes of malnutrition are also classified as immediate, underlying, and basic causes; with factors at one level influencing those of other levels. The framework serves as a guide to assess and analyze the causes of malnutrition, and helps to identify the most appropriate mixture of actions. For this paper, the following framework will be used to identify the underlying causes behind low performance of IYCF practices in urban areas of Bangladesh which are prone to extreme poverty.

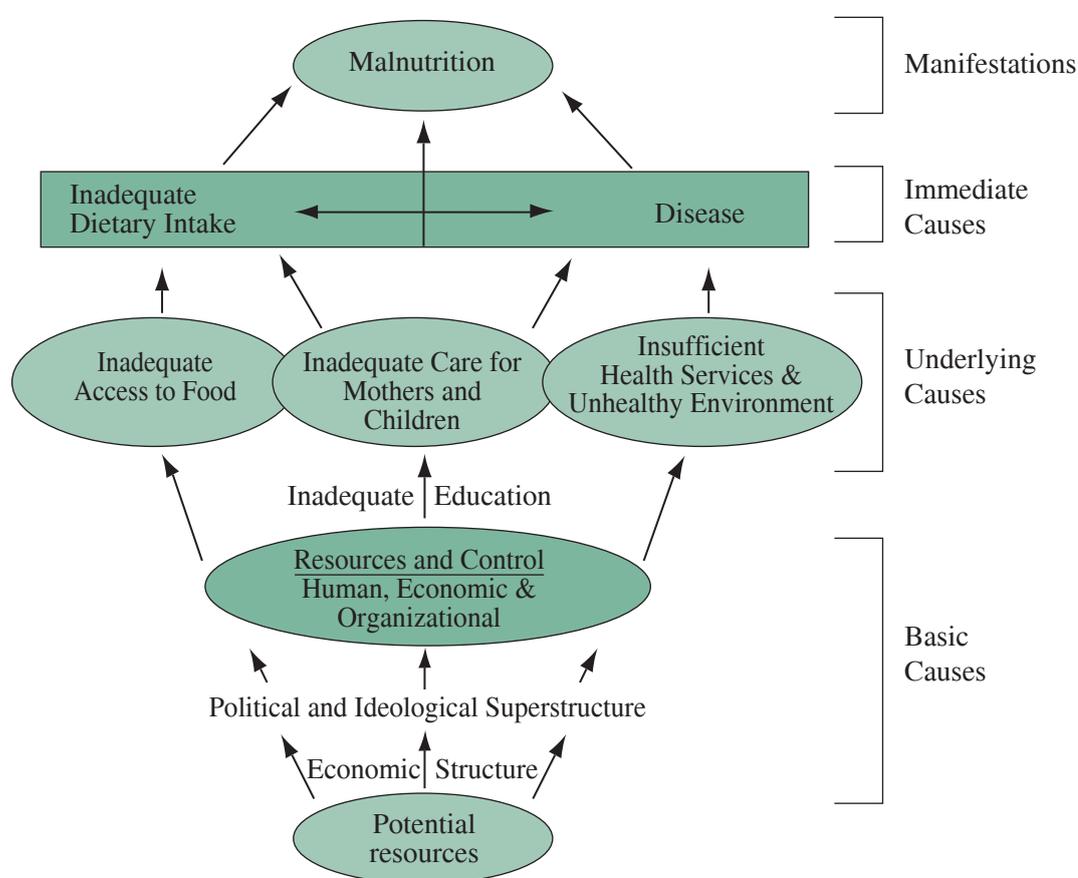


Figure: 1: UNICEF's Conceptual Framework for Malnutrition

2. Methodology

The purpose of this paper is to summarise findings and learning around the key barriers to adequate IYCF practices faced by the extremely poor people living in urban areas of Bangladesh. Most of the information was collected in different phases of Concern Worldwide, Bangladesh's Integrated Urban Nutrition Project. Concern has been implementing the Urban Integrated Programme in Bangladesh since 2012. One of the components of this programme is ensuring child nutrition.

For this report, secondary information was reviewed such as the reports from various surveys, studies, progress updates, and evaluations, along with literature reviews. In addition, primary data was collected in the form of a situation analysis and a transect walk. The table below lists the reports used in this paper .

Name of Document	Year
1. Urban Programme Contextual Analysis	2012 and 2016
2. Baseline Study To Understand The Perception Of Target Community And Health care Service Providers About The Available Healthcare Facilities And The Service Delivery Process	2012
3. Baseline Knowledge, Practice and Coverage (KPC) Survey of the integrated urban nutrition	2012
4. Dietary Diversity Survey among Squatters and Pavement women and children	2015
5. Annual Country Programme Progress Report Bangladesh	2015
6. Urban Integrated Programme Bangladesh, 2012- 2015 Irish Aid Programme Evaluation	2016

2.1 Secondary Data Analysis

The following documents have been reviewed to gather information for this analysis: Concern's Urban Contextual Analysis, Urban Integrated Programme progress reports, Baseline and End line surveys and studies (malnutrition situation), process documentations, output and outcome monitoring data, abstract papers, and evaluation reports produced by Concern and other organisations, Bangladesh Demographic Health Survey 2011 and 2014, Bangladesh Urban Health Survey 2013, etc. A comprehensive list of the secondary data cited can be found in the references section.

2.2 Primary Data Analysis

Primary data has been collected from all over Dhaka and Chittagong cities. To learn about IYCF behaviours and practices, primary data from the community level was collected from people living in slums, squatters, and pavements. A variety of qualitative data collection methods were applied during this process, such as Focus Group Discussions (FGD), Key Informant Interviews (KII), In-depth interviews (IDI), Transect walk, and Observational study. A total of 21 FGD, 3 KIIs, 7 IDIs, 5 Transect walks and 4 Observational studies have been conducted.



Only when children are old enough to grab food by themselves, mothers give them snacks such as bread, biscuits and cakes. as these are convenient and are easily available in slums and pavements squatter settlements. Concern Worldwide/Dhaka, Bangladesh/November 2011

3. Findings

3.1 Inadequate access to safe and nutritious food

One major cause of food insecurity in urban areas is low purchasing power. Poor urban households are predominantly dependent on cash for food purchases. Income is a critical issue for extreme poor families for ensuring access to safe, healthy and nutritious food. Concern's Urban Contextual Analysis 2016 stated that *'the income of the extreme poor people in urban areas is < 5000 taka'*. Therefore, many families are unable to meet daily nutritional and household needs. The Baseline Study 2012 supported the statement, *'Most respondents are hugely constrained with budget (daily budget for protein and vegetable for the whole family is often between taka 20- taka 30). This makes it very difficult for them to secure a meal with minimum required nutrition'*. The cost of rent, electricity, fuel, water and sanitation in urban areas are much higher than in rural areas (Concern's Urban Contextual Analysis 2016, Dhaka Tribune, 2014³). The Contextual analysis report showed that the *'monthly cost for extreme poor is 7000-8000 BDT'*. To cope with the high costs of living in urban areas, extreme poor people are forced to compromise with both the quality and quantity of food which affect their dietary diversity adversely.

*"My employer's child eats cookies and chips the whole day. Since he is healthy, so I buy those for my children too. I am glad I can buy these items at a cheaper price." -
Mother living at a slum in Dhaka*

Women and girls, in particular, often face additional challenges such as, fewer income earning opportunities and complex intra-household dynamics where the needs of women and children are not prioritized. Results from a dietary diversity survey⁴ conducted by Concern among slum and squatter dwellers showed that women's dietary diversity scored a meagre 5.2 on average (out of 10), which was the borderline figure. Although the average dietary diversity is at satisfactory level, observational findings revealed that serving portions were tiny for women and children in reality. During a survey, a woman residing in a squatter in Chittagong reported that she consumed fish regularly. However, an observational study discovered that she only ate a small portion of fish curry with big pieces of potato and along with big helpings of gravy.

For children aged under two years, the minimum dietary diversity was found to be 3.94 (out of 7). Children eat a diverse diet if they had at least four food groups out of seven in the last 24 hours. Families living in slums and squatters cook a maximum of three items, which uses firewood costing around BDT 30-40. Due to limited to no kitchen spaces, the majority of women prefer to cook only once a day, which limits their dietary diversity scores and the meal frequency. This is supported by the findings from the FGDs undertaken as part of the contextual analysis where it is stated 'Food diversity is a major constraint for the urban poor, with their diet consisting mainly of vegetable/fish, dal and rice. As fuel costs are high, they cannot afford to cook more than two items other than rice. They avoid cooking meat as meat requires more fuel. People usually cook once and eat three times a day'. The evaluation report of the Urban Integrated Programme (UIP) has similar findings. The evaluator commented, 'During FGDs, women specifically mentioned that it is difficult to buy animal source foods (milk, eggs) and no respondent mentioned meat (but several mentioned the consumption of fish, which is the same food group for children)'.

For working mothers, challenges are bigger. Due to extended working hours and the heavy workload, they have to adopt negative coping mechanisms. It was found that working mothers bought low-cost, processed, ready-made food for their children which is unsafe and contain less micronutrient. Consuming mainly nutrient-poor foods, reducing the meal frequency, limiting food diversity, and eating convenient readymade snacks of poor nutritional value was found to be the major causes of child malnutrition in urban poor settlements. This was confirmed by transect walks and observational studies. Snacks such as chocolate, cookies, biscuits, cakes, candy, salty chips, etc. that are of poor nutritional value are highly popular among young children and their mothers.

In slums and squatters, it was found that expired food items were available at affordable prices, which the poor households widely purchase for consumption. FGD findings revealed that parents were unaware of the existence of expiry dates and what they mean and that they perceived these processed food items to be healthy for consumption by their children. Further discussions revealed that attractive television advertisements had influenced their purchasing decisions as they were convinced that these food items were indeed nutritious for their children.

It was also observed that affordable seasonal fruits are widely available in slums and squatters. However, not surprisingly most children seem to prefer sugary or salty snacks and are often unwilling to consume fruits or vegetables making feeding difficult and as a result, parents are reluctant to buy those. Replacing low quality, less nutritious and unsafe snacks



Extreme poor families cope with high costs of living in cities by compromising on living conditions in squatter settlements. Concern Worldwide/Dhaka, Bangladesh/ December 2011

with nutritious food is therefore a challenge for extreme poor people living in urban areas. Parents were not aware about the nutritional value of seasonal fruits. Their perception is that imported costly fruits contain more nutrients. The baseline qualitative survey report supports this statement- 'Most respondents believe that nutrition costs a lot. They perceive that costlier foods (meat, big fish, egg, milk, butter, foreign fruits etc.) offer more nutrition. Since they are aware of their low purchasing power, they seem to accept the idea that their children and they would be under-nourished'.

3.2 Inadequate care for mothers and children

Exclusive and continued breastfeeding

To supplement family income and cope with price hikes, it was found that more members from extreme poor households were joining the labour force, including pregnant and lactating women despite their physiological conditions. This has huge impacts on lower IYCF performance in urban extreme poor households. Since extreme poor women tend to work in the informal sector, therefore the majority of them work extended hours. In the informal sector, maternity leave and nursing breaks are rare, if at all available. Exclusive breastfeeding is not possible for these women as they work outside home for more than 10 hours⁵ on average.

Overall, there is limited support available to the urban poor like day care facilities for children. But not only for working mothers, even women who stay home report that exclusive breastfeeding for more than two months becomes difficult as they are burdened with household chores and have little to no help from the family. The Bangladesh



A participant of Concern's Integrated Urban Nutrition Project feeding her child at home in a squatter settlement in Dhaka. Concern Worldwide/Dhaka, Bangladesh/October 2011

Demographic Health Survey 2014 supports this statement. 'Women in urban poor settlements practice exclusive breastfeeding for only 2.7 months⁶ on average. Men and other family members are not sensitized on the importance of exclusive breastfeeding for the first six months and the recommended IYCF practices, and thus do not support women during pregnancy and lactation period. Several informal discussions revealed that knowledge of women around importance of exclusive breastfeeding is very high (around 85%); however, practicing comes with a number of challenges.

Although nutritionists suggest women away from their babies for extensive hours express breast milk which is then fed to the baby by a secondary carer while mother and baby are separated, this is not easy. In the hot, humid and unhygienic environment of slums, squatters and pavement settlements, mothers are not convinced that breast milk can be kept safe for long hours when they are away. Additionally, feeding expressed breast milk to children by a secondary carer such as older siblings and mothers in law is not a common practice in Bangladesh.

Introduction of solid, semi-solid or soft foods

As mentioned earlier, women working in the informal sector do not get formal maternity leave so they have to leave their children at home for long hours. Very few workplaces allow children to accompany their mothers. During a FGD, women reported that they introduce complementary foods as a part of habituating their child before returning to work after delivery. Women usually feed rice powder, semolina, powdered milk, and sugar water to children when 3-4 months old or even younger.

On the contrary, women who stay home are reluctant to introduce appropriate complementary feeding practices at the age of 6 months and instead, continue to breastfeed. Only when children are old enough to grab food by themselves, mothers give them snacks such as bread, biscuits, cakes, etc. as these are convenient and are easily available. Cooking nutritious meals is perceived to be expensive and not affordable for households that are resource constrained.

Children of different age groups require different type and quantities of food and frequency of feeding. However, it is difficult for slum, squatter and pavement dwellers to follow the recommendation as a significant number of children are left alone or stay with their siblings at home without an adult caregiver's support. During an individual informal discussion with a widow, she reported that she cooks meals for her children very early in the morning before she leaves for work at 7am. She preferred to cook mashed potato or lentils instead of more nutritious dishes like fish or egg curry as they take longer time to go rancid. She said that her children stayed home alone and only ate when they were hungry, with little attention given to the special needs of the youngest.

Another obstacle was discovered through informal discussions with women in the slums. The women said that they did not feel like cooking during summer time because of the hot and humid weather. Slums are usually extremely crowded. In summer when the temperature goes up tremendously, women are reluctant to cook as they feel lethargic, overworked and tired.

3.3 Insufficient health services and an unhealthy environment

Insufficient health services:

Urban Primary Health Care delivery structures are NGO-operated, with linkages to donor-supported government projects such as the Urban Primary Health Care Service Delivery Project (UPHCSDP) and the Smiling Sun Franchising Program (SSFP) led by Pathfinder International which is supported by USAID. The government does not have formal health care service delivery structures for urban areas. Both UPHCSDP and SSFP consist of NGO-run static and satellite clinics that provide communities with primary health care services using an Essential Service Delivery package. Although the existing primary health care services have reduced the gaps in urban primary health care coverage by serving the urban poor in a focused manner, they do not particularly include nutrition as a vital component. The UIP evaluation reported, *'These donor-funded programmes (UPHCSDP and SSFP) historically did not include a large number of nutrition services'*. Therefore, nutritional services were not integrated into the existing urban health service delivery structure.

Moreover, these primary health care facilities have limited options to provide services free of charge. The UIP finding shows *'Access to free health services is guaranteed if the household has a 'red' card or a 'poorest of the poor' ('POP' card). While not every household who participated in the group discussions mentioned they had such a card, there seems to be general access. The official lists of people who qualify for the cards, however, seem outdated'*. The survey findings from Concern's 5 year Integrated Urban Nutrition Project⁷ show that utilization of primary health care services is extremely low among pavement and squatter dwellers. Service providers' unfriendly attitude, highly rigid rules and regulations, the

*"We have no fear of mosquitoes because even mosquitoes do not want to enter where we stay."
- Man living on the pavement*



A squatter settlement in Dhaka. Concern Worldwide/Dhaka, Bangladesh/December 2011

long waiting hours, and for the urban poor unsuitable opening hours were found to be the major reasons behind the low utilization rate.

During FGDs, the majority of pavement dwellers stated that they felt uncomfortable to visit static clinics. Because of their poor attires and appearances, staff and other patients at primary health care facilities had shown discriminatory attitude towards them. The baseline perception study 2012⁷ has similar findings, 'Most respondents feel that doctors and attendants at the static clinics are busy all the time and cannot give enough time to each of the patients. When asked for an explanation or further suggestions, the doctors and attendants are often irritated and reply in a harsh/cold tone that discourages further interaction'. For children's curative care, slum and squatter dwellers relied more on pharmacies instead of formal primary health care service centres as they did not want to wait for a long time to get their medicine. This kind of behaviour increases the medical costs of households, and the use of drugs might jeopardize children's health and nutritional status.

Unhealthy environment

*"I prefer pharmacy because they are open till midnight. The clinic beside my place closes by afternoon. Also, their consultation time is not feasible for people like me who work outside till late evening."
- Pregnant woman from a squatter settlement*

The nature of the unhealthy environment in slums, squatters, and pavements are more or less similar: they are over-crowded, with no drainage and waste disposal option, open sewerage, improper and unhygienic toilets, unavailability of safe water, pollution, hot and humid weather, etc. The monsoon makes the situation even worse.

It was found that children aged below two years barely wear any footwear and hardly maintain personal hygiene. Proper hand washing is a critical issue for these groups and are often not practiced as recommended due to the scarcity of safe and affordable water and a lack of soap.

Findings from informal IDIs, FGDs and observational studies have been given below to illustrate the reasons for practicing unhealthy IYCF behaviours that negatively impact children's health:

Behavior	Reasons stated by respondents
Caregiver washes hands with water only	<ol style="list-style-type: none"> 1. Soap is not available during feeding time for pavement dwellers. 2. Caregiver washes hands in bowls or buckets before feeding since there is a lack of running water at home. 3. Using soap when washing hands needs more water. 4. The physical environment of squatters and slum does not permit its residents to wash hands with soap frequently. 5. Water point is located far away, and the caregiver is reluctant to go the distance and wash hands with soap. 6. Caregiver is unaware of the benefits of washing hands properly.
Caregiver does not wash children's hands	<ol style="list-style-type: none"> 1. Caregiver thinks that there is no need to wash the child's hands since s/he will not be eating on his/her own. 2. A child is usually fed after s/he is bathed, so there is no need to wash hands again after his/her bath. 3. Hands look clean so there is no need to wash hands and waste expensive water. 4. Caregiver is unaware of the benefits of washing child's hands.
Wearing sandals/ open-toed footwear	<ol style="list-style-type: none"> 1. Children do not want to wear sandals or open-toed footwear 2. Footwear for children are costly and/or not commonly available. 3. Children tear or damage their footwear in a short period of time. 4. Open-toed footwear such as flip-flops do not protect children's feet when walking in wet, muddy alleys.
Using mosquito nets	<ol style="list-style-type: none"> 1. Children do not want to stay under mosquito nets. 2. Mosquito nets are uncomfortable in the hot, humid weather. 3. Pavement dwellers often cannot afford mosquito nets.
Indoor air pollution	<ol style="list-style-type: none"> 1. There is no separate space for cooking.. 2. Food is cooked inside a tiny room. 3. People are unaware of the consequences of indoor air pollution

These issues mentioned above govern the low performance of IYCF practices in urban extreme poor households of Dhaka and Chittagong cities.

4. Conclusion

Urbanization is continually rising in Bangladesh. Compared to the malnutrition situation in rural areas, the urban situation is more complex, especially when it comes to service delivery system and nutritional governance. Bangladesh has agreed to the Sustainable Development Goal of ending all forms of malnutrition by 2030. This goal is contingent on achieving the World Health Assembly's global target and 4th health sector programme target on stunting and wasting among children.

There is a need to create a more supportive environment to assist carers of children with the practice of adequate IYCF behaviours. Behaviour change activities are required starting from raising awareness and to address existing wrong beliefs.

Without addressing these sorts of underlying causes of child malnutrition, Bangladesh will not be able to achieve the targets. An integrated urban development programme which ensures service provision, access to water, sanitation and hygiene, availability of safe food, livelihood security, as well as, policy implementation is needed.

References

1. UNICEF Conceptual framework. Causes of Malnutrition:
http://www.tulane.edu/~panda2/Analysis2/nutrdta/causes_of_malnutrition.htm, [Downloaded: 06.03.2016]
2. Chodhuary S, Furlong Met. al. Contextual Analysis, Urban Programme (Updated), Concern Worldwide, Unpublished document, April 2016
3. Dhaka Tribune. Slum dwellers pay more but get much less. February 10, 2014.
<http://www.dhakatribune.com/bangladesh/2014/feb/10/slum-dwellers-pay-more-get-much-less> [Downloaded: 19.03.2016]
4. Azim A., Rahman Z., Dietary Diversity Survey among Squatters and Pavement women and children, 2015. Concern Worldwide, Unpublished document, January 2016
5. Begum A & Majumder P, The Gender Imbalances in the Export Oriented Garment Industry in Bangladesh, Policy Research Report on Gender and Development Working Paper Series No. 12, June 2000. The World Bank:
<http://siteresources.worldbank.org/INTGENDER/Resources/trademajumder.pdf> [Downloaded: 12.05.2016]
6. Bangladesh Demographic Health Survey 2014, National Institute of Population research and Training, MOH&FW, Bangladesh, March 2016
7. A Report of Findings From A Baseline Study To Understand The Perception Of Target Community And Healthcare Service Providers About The Available Healthcare Facilities And The Service Delivery Process, Quantum Consumer Solutions Ltd, January 2012, Unpublished Document.
8. 2012 - 2015 Irish Aid Programme Evaluation, Urban Integrated Programme Bangladesh 2016

CONCERN
worldwide

Country Office
House 15 SW (D), Road 7, Gulshan 1, Dhaka 1212, Bangladesh
Tel: +880 2 985 4387, Fax: +880 2 5881 7517
Email: bangladesh.info@concern.net

Head Office
52-55 Lower Camden Street, Dublin 2, Republic of Ireland
Tel: +353 1 417 7700, Fax: +353 1 475 7362
Email: info@concern.net