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Effective ECD Programs that can be scaled up

Parallel Session C-2

**Getting the Child ready for
School: Working with Families
and Communities**

**Ensuring Effective Caring Practices
within the Family and Community**

by Isatou JALLOW

**Working Document
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FINAL DRAFT

ENSURING EFFECTIVE CARING PRACTICES WITHIN THE FAMILY AND
COMMUNITY



NaNA files (GAM) Sibling Care

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BACKGROUND

The theme of this paper, “ensuring effective caring practices within the family and the community”, gives rise to several questions such as - are the concepts of “care” and “caring practices” well understood; how do we define caring practices in the African context; where does the responsibility lie for ensuring effective caring practices within families and communities?

In the most basic sense, when we talk about caring for someone, one immediately thinks of concern, a feeling of responsibility and possibly affection for an individual whether it be an adult or a child. These feelings may be translated into actions that can loosely be referred to as caring practices. Therefore every human being, under normal circumstances, has been or can be a recipient of some sort of care at one time or the other in his or her life.

How important is care in the African context? This question is partly answered in an *African Regional Nutrition Strategy (1993-2003)* that was adopted by the then OAU Council of Ministers at their 58th ordinary session in 1993. “Inadequate care” was cited as an important factor in the *poor nutritional status of women and children in Africa*. It was further noted that “inadequate care” was due to the disappearance of the traditional African extended family system for childcare especially in the urban areas.

This paper will attempt to answer the question of how to ensure effective caring practices within families and communities in the African region. It will be done by examining the current status of caring practices, factors influencing caring practices as well as challenges and opportunities. Issues considered crucial for the effectiveness of caring practices, will be raised as a “way forward” to ensuring effective caring practices within families and communities.

Defining Care

A formal definition of care was provided during the International Conference on Nutrition in 1992. Care means the “provision in the household and the community of time, attention and support to meet the physical, mental and social needs of the growing child and other household members” (FAO/WHO, 1992).

Another definition of care is the “provision in the household and community of resources in the form of time, attention, love and skills to meet the physical, mental and social needs of nutritionally vulnerable groups (Longhurst, 1995).

Care has also been defined as the “behaviours and practices of caregivers (mothers, siblings, fathers and child-care providers) to provide the food, health, care, stimulation, and emotional support necessary for children’s healthy growth and development (Engle and Lotska, 1999). The definition further elaborates that “these practices translate food security and health care resources into a child’s well-being”. Furthermore it was noted that it was not only the practices which are critical to children’s growth and development but also the way these practices are performed with affection and responsiveness to the child.

The three definitions are similar but with slightly different variations. The growing child seems to be the primary recipient of care but other household members and those classified as “nutritionally vulnerable” are also targeted for care.

Care can be divided into three categories – nutritional, psychosocial and physical care. Some of these practices are within the home environment but preventive and curative care including ante-natal care, are outside of the family environment (FAO/WHO 1992).

Box 1 Examples of caring practices in all categories

- breastfeeding,
- providing emotional security and reducing the child’s stress,
- providing shelter, clothing, feeding, bathing, supervision of child’s toilet;
- preventing and attending to illness;
- nurturing and showing affection, interaction and stimulation;
- playing and socialising;
- protecting from exposure to pathogens;
- providing a relatively safe environment for exploration.

Source: FAO/WHO ICN 1992

Caring practices such as those mentioned in box 1. can be classified further; those that directly affect the child, those that directly affect the mother and those that affect both mother and child. However as is stated in the Global Strategy on Infant and Young Child Feeding, “*Mothers and babies form an inseparable biological and social unit; the health and nutrition of one group cannot be divorced from the health and nutrition of the other*”. Therefore most if not all of the caring practices will benefit both mother and child. Van Esterik (1995) puts it more succinctly – “care is twice blessed”.

If there is one caring practice that cuts across all the categories mentioned above, it is breastfeeding, which has been described as the foundation of care (Armstrong, 1995). A combination of breast milk the product and breastfeeding the process provides nutritional, psychosocial as well as physical care. Breastfeeding also benefits the health of the lactating mother (Dermer, 1998).

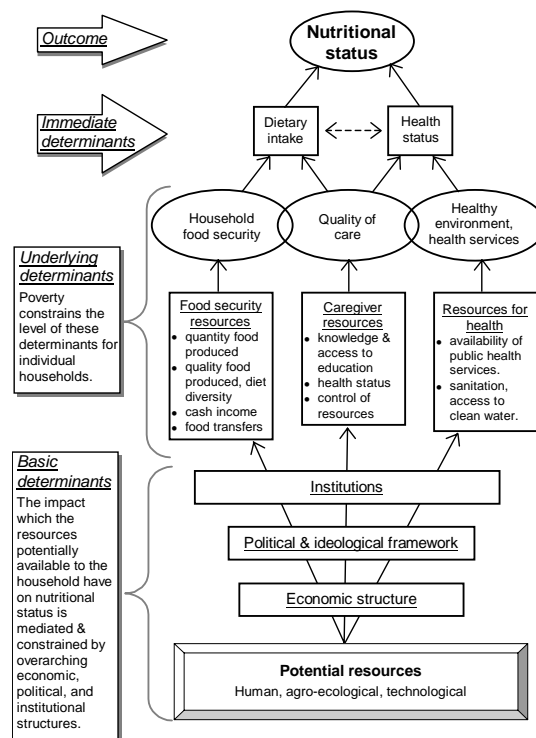
Nutrition Security, Care and Early Childhood Development

Care has for a long time been a silent component of Nutrition security. Today Nutrition security is defined as “Food security coupled with a sanitary environment, adequate health services and knowledgeable care to foster good nutritional status through the life cycle and across generations” (Benson 2004). We now know that neither Nutrition security nor Health security for the child can be attained in the absence of adequate care.

This is best illustrated by the UNICEF conceptual framework (Figure 1) on the determinants of nutritional status from the immediate to the basic level. It is clear that a child’s nutritional status is influenced first and foremost by dietary intake and by the absence or presence of disease. However, underlying factors at the household level

include access to adequate and appropriate food -food security, adequacy of maternal and child caring practices, adequacy of the mechanisms for preventing and controlling diseases (adequate health services including clean water and proper sanitation) as well as mother's or caregiver's knowledge, access to education, health status and control of resources (Benson, 2004). The framework goes further to identify basic causes, which include the economic, social, and political situation of a country.

Figure 1. UNICEF conceptual framework of the determinants of nutritional status (adapted by Benson, 2004)



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Child Development

“Stimulating a child is like motivating a worker – the output is greater”.

Child development is multi-dimensional and inter-dependent. The social, emotional, cognitive and motor performance of the child is linked not only to its pattern of behaviour but to its health and nutritional status. The early year's i.e. the first three years of a child's life, are a critical foundation for healthy psychosocial development which includes intelligence, personality and social behaviour.

It is also known that the development of the brain at less than one year of age is rapid and extensive and is vulnerable to environmental influences such as nutrition, health, care and stimulation. Therefore early intervention in nutrition, health and care are crucial. Likewise early stimulation such as singing and talking to the child makes the child more responsive.

Thus the Early Childhood Development (ECD) strategy reflects an integrated approach that promotes a holistic vision of the child and a coordination of activities in the five priority areas – health, water, hygiene and sanitation, nutrition, early stimulation/education and protection. The approach further recognises the indivisibility of the Rights of the Child (UNICEF, 2000).

A child's capacity for mental and social development depends on biological systems shaped by early experience and attachment. Studies show that children, who have secure attachments early in life, function better in society and perform better at school. The importance of care-giver – child interactions for the survival and healthy development of young children, is well documented in a review by the World Health Organisation (WHO, 2004).

Box 2 Different categories of development

Development is usually categorised as:

- *Cognitive (or mental) development* including memory, problem-solving, and numerical understanding
- *Language development*, the ability to communicate with others, to comprehend speech and express thoughts (receptive and expressive language).
- *Social-emotional development*, including an understanding of the relationship of self to other, ability to regulate oneself and one's emotions, development of social skills.
- *Temperament*, a biologically-based tendency such as the ease or difficulty with which a child approaches routine and novel situations
- *Fine and gross motor development*, including child's ability to sit, walk, run, and handle small objects

Source: WHO, 1999

Care-giving

Women have multiple roles of reproducing, nurturing, caring and producing and are recognised as the single most important group of caregivers globally. In Africa this care usually extends beyond the immediate family to include other members of the extended family and even the community. But who cares for the caregiver - how can we ensure “care for the caregiver” and how does this translate into increased “caring capacity of the carer”?

Van Esterik (1995) in her paper on “Care, care giving and caregivers” and Winkvist (1995) on the “Health and nutritional status of the caregiver and the effect on care giving capacity”, discuss these issues. Baker et al. (1996) also make a case for improving women's nutrition for a positive impact on child survival and reproductive health. A lifecycle approach is therefore justifiably proposed for addressing women's health and nutrition and thereby the health and nutrition of their children and other family members (World Bank, 1994).

Box 3. Examples of maternal caring practices

- Family planning services
- Ante-natal care
- Skilled attendance at birth
- Post-natal care
- Maternity protection laws
- Education
- Reducing maternal workload
- Reducing maternal stress
- Showing care and affection for women

Other categories of care-givers that should be considered in the African setting are grandmothers and older siblings. These provide substantial care for infants and young children especially in the absence of the mother.

The role of men as care-givers however may be underestimated since the perceived traditional care-givers are women. Fathers may provide care to mothers and their children in several ways. These include ensuring they consume nutritious foods; ensuring that pregnant spouses attend antenatal clinic; encouraging and supporting mothers to practice exclusive breastfeeding; ensuring that children get the necessary immunisations; ensuring that their children, especially the girl-children, are educated. *Studies however need to be done to identify and document father's (men's) contribution to care-giving.*

Indicators of care for women and children

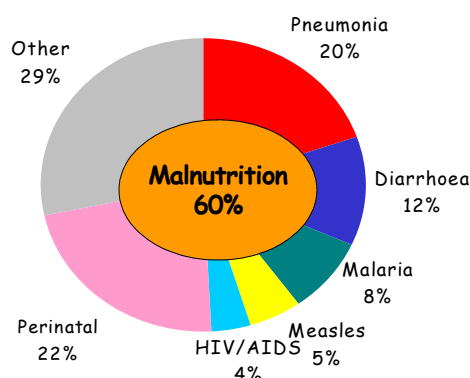
In assessing care, it is important to note that care includes not only measurable inputs and outputs but also processes. Care also contributes to a desired impact e.g. child's nutritional status as well as a reduction in child mortality.

In sub-Saharan Africa, adequate caring practices may contribute to the reduction of child mortality rates. Measles for example is a leading cause of death among children. An important caring practice therefore is the utilisation of preventive health services to immunise children against measles. The use of insecticide treated nets likewise is a caring practice that can reduce malaria among both women and children.

It is further estimated that malnutrition contributes to about 60% of child deaths in developing countries (figure 2). Child malnutrition has been identified as the combined outcome of food insecurity, inadequate care as well as inadequate health care or services. A child's nutritional status can therefore also inform us on the status of Early Childhood Development including the adequacy of care.

Figure 2. Causes of child mortality in sub-Saharan Africa

Adapted from WHO World Health Report, 2002



How do we measure the adequacy of care? Table 2 shows a list of indicators that may be used to assess the adequacy or inadequacy of care for both women and their children.

Table 1. A selection of Indicators to assess the level of care for women and children

Child Mortality Rates	Maternal Mortality Rates
Nutritional status – underweight, stunting, wasting	Body Mass Index (BMI)
Low birth weight	Skilled attendance at birth
Micro-nutrient status –Iron, Vitamin A, Iodine	Weight gain monitoring during pregnancy
Immunisation coverage; measles, TB, tetanus toxoid	Ante-natal care
Exclusive breastfeeding rates	Availability/use of Family Planning services
Complementary feeding practices	Iron/folate supplementation
Growth monitoring	Duration of maternity leave – formal sector
Use of Insecticide Treated Nets	Support for women in non-formal sector
Vitamin A Supplementation	Provision of clean water and adequate sanitation
Use of iodised salt	Provision of day care centres

This paper will only provide data on some of the indicators. This is because a major constraint in sub-Saharan Africa is the lack of adequate nationally representative and timely data. Much data in this paper will therefore be drawn from UN Agencies' estimates.

WOMEN AND CHILDREN - AN OVERVIEW OF THEIR SITUATION

Universal Declaration on Human Rights 1948, Article 25: "Motherhood and childhood are entitled to special assistance and care".

Using some of the indicators in the table above, what is the status of care for women and their children?

Mortality Rates

Maternal Mortality Rates are difficult to measure in the African region due to weak health information and vital registration systems (AbouZahr & Wardlaw, 2001). Whatever the limitations, estimated figures of 940 maternal deaths per 100,000 live births in sub-Saharan Africa with a range from 150 to 2000, emphasises the urgency of the situation (UNICEF, 2004).

Adequate and effective maternal care is crucial in the reduction of maternal mortality of which the major causes are haemorrhage, eclampsia, unsafe abortion, infection and obstructed labour. Some of these causes are influenced by nutritional factors for example a malnourished woman is more susceptible to infection while nutritionally stunted women are more at risk of obstructed labour. A maternal death may also be considered a double tragedy since most maternal deaths result in the death of their infants (Greenwood, 1987).

Four million neonatal deaths, 4 million stillborns and 0.5 million maternal deaths are estimated to occur globally in the course of one year! These figures were recently highlighted in a publication titled “*4 million neonatal deaths: When? Where? Why?*”(Lawn et al. 2005). The publication further highlighted the proportion of neonatal deaths as 38% of all under five deaths with Sub-Saharan Africa having the highest rates of neonatal deaths. Furthermore, fourteen out of eighteen countries with Neonatal Mortality Rates (NMR) of >45 per 1000 were from Sub-Saharan Africa. Countries in conflict situations such as Sierra Leone and Liberia registered the highest rates.

The major causes of neonatal mortality are due to prematurity and severe infections which include pneumonia, sepsis, diarrhoea, tetanus and complications of asphyxia. In very high mortality settings of NMR>45, almost 50% of deaths are due to severe infection, diarrhoea and tetanus. Most of these deaths are preventable with adequate care. A specific example of inappropriate feeding practices contributing to neonatal deaths was a study done in The Gambia where an association was found between prelacteal feeding (fluids) and neonatal mortality (Leach et al. 1999). Maternal health and health care are important determinants of neonatal survival.

Regarding children under five years of age, almost eleven million die each year mostly from preventable causes. Out of the forty two countries that account for 90% of these deaths, twenty three are from Sub-Saharan Africa and account for 41% of the deaths. Risks factors that are identified, include an unhygienic environment, unsafe and inadequate water, poor sanitation with under- nutrition as an underlying factor (Black et al. 2003).

Nutritional status

“Low height-for-age reflects the cumulative effects of numerous insults experienced by children during infancy and early childhood. It begins at birth and continues through the initial three and a half years of life, after which it is irreversible” (Lutter 2003)

Malnutrition while on the decline in most parts of the world, is on the increase in sub-Saharan Africa in terms of both numbers and prevalence (UN/SCN 2004). According to the WHO classification (table 1), both stunting and underweight are high in Africa.

Table 2: Classification for assessing severity of malnutrition by prevalence ranges (%) among children < 5 years of age

Indicator	Interpretation	Severity of malnutrition by prevalence rates %			
		Low	Medium	High	Very High
Stunting Low height for age	Chronic malnutrition: Process of failure to reach linear potential growth as a result of sub optimal health and /or nutritional conditions. Levels of stunting associated with the socio-economic conditions of a population	<20	20-29	30-39	≥ 40
Underweight Low weight for age	Combination of chronic and acute malnutrition	<10	10-19	20-29	≥ 30
Wasting/ thinness Low weight for height	Acute malnutrition: Recent and severe process of weight loss, often influenced by short-term hunger and or severe disease	<5	5-9	10-14	≥ 15

Source: WHO Technical Report Series no. 854 1995

**Table 3. Estimated prevalence and number of stunted children
1990-2005**

Prevalence of underweight %				Number underweight children (millions)		
Africa Sub-region	1995	2000	2005	1995	2000	2005
Western	33.8	32.9	32.0	11.8	12.7	13.9
Central	40.0	37.8	35.8	6.3	6.8	7.4
Eastern	44.4	44.4	44.4	17.3	19.4	21.6
Northern	24.4	21.7	19.1	5.1	4.6	4.2
Southern	25.0	24.6	24.3	1.4	1.5	1.4
Africa	36.1	35.2	34.5	41.9	45.1	48.5

Source; 5th Report on the World Nutrition Situation, ACC/SCN 2004

**Table 4. Estimated prevalence and number of underweight children
1990-2005**

Prevalence of underweight %				Number underweight children (millions)		
Africa Sub-region	1995	2000	2005	1995	2000	2005
Western	27.5	27.1	26.8	9.6	10.5	11.7
Central	26.9	26.1	25.3	4.2	4.7	5.3
Eastern	27.9	29.2	30.6	10.9	12.8	14.8
Northern	10.9	9.7	8.6	2.3	2.1	1.9
Southern	13.9	13.7	13.6	0.8	0.8	0.8
Africa	23.9	24.2	24.5	27.8	30.9	34.5

Source; 5th Report on the World Nutrition Situation, ACC/SCN

**Table 5. Estimated prevalence and number of wasted children
1995-2005**

Africa Sub-region	Prevalence of wasting (%)			Number wasted (millions)		
	1995	2000	2005	1995	2000	2005
Western	10.5	10.3	10.2	3.7	4.0	4.4
Central	7.0	9.1	11.9	1.1	1.6	2.5
Eastern	6.6	7.6	8.7	2.6	3.3	4.2
Northern	4.7	6.2	8.0	1.0	1.3	1.7
Southern	3.7	4.9	6.6	0.2	0.3	0.4
Africa	7.7	8.3	9.5	8.5	8.5	13.3

Source; 5th Report on the World Nutrition Situation, ACC/SCN

Table 6 below shows the situation in individual countries regarding all three indicators of malnutrition. Thirty countries out of the 46 sub-Saharan Africa register high to very high rates of underweight (low weight for age) and 28 with high to very high rates of stunting (low height for age). Less countries i.e. 17, register high to very high rates of wasting (low weight for height). There are also differences within countries with child malnutrition lower in the urban areas than in the rural areas. The current situation is dismal and needs to be reversed.

Can effective caring practices within the family contribute to a reduction in malnutrition rates? This can partly be answered by looking at an analysis of why child malnutrition is lower in urban than in rural areas. The study found that urban children had better nourished mothers with better health care seeking behaviour. These mothers were also more likely to receive prenatal and birthing care. Furthermore infant feeding practices and child care were more likely to be better in the urban areas (Smith et al. 2004).

Data on provision of clean water and adequate sanitation (UNICEF, 2004) show urban areas at an advantage.

Table 6. Nutrition indicators for Children 0 – 5 years in Sub-Saharan Africa *1995-2003 except where otherwise indicated

Countries	Under - 5 Mortality Rate 2003	% infants low birth weight <2,500 grams 1998-2003*	Underweight For Age < -2SD % Severity	Stunting For Age < -2SD % Severity	Wasting For Height < -2SD % Severity
Sub-Saharan Africa	175	14	29 High	38 High	9 Medium
Angola	260	12	31 Very High	45 Very High	6 Medium
Benin	154	16	23 High	31 High	8 Medium
Botswana	112	10	13 Low	23 Medium	5 Medium
Burkina Faso	207	19	34 Very High	37 High	13 High
Burundi	190	16	45 Very High	57 Very High	8 Medium
Cameron	166	11	21 High	35 High	5 Medium
Cape Verde	35	13	14x Medium	16x Low	6x Medium
Central African Republic	180	14	24 High	39 High	9 Medium
Chad	200	17x	28 High	29 Medium	11 High
Comoros	73	25	25 High	42 Very High	12 High
Congo	108	-	14 Medium	19 Low	4 Low
Congo, Dem. Republic	205	12	31 Very High	38 High	13 High
Cote d'Ivoire	192	17	21 High	25 Medium	8 Medium
Equatorial Guinea	146	13	19 Medium	39 High	7 Medium
Eritrea	147	21x	40 Very High	38 High	13 High
Ethiopia	204	15	47 Very High	52 Very High	11 High
Gabon	91	14	12 Medium	21 Medium	3 Low
Gambia	123	17	17 Medium	19 Low	9 Medium
Ghana	95	11	25 High	26 Medium	10 High
Guinea	160	12	23 High	26 Medium	9 Medium
Guinea Bissau	204	22	25 High	30 High	10 High
Kenya	123	11	20 High	31 High	6 Medium
Lesotho	84	14	18 Medium	46 Very High	5 Medium
Liberia	235	-	26 High	39 High	6 Medium
Madagascar	126	14	33 Very High	49 Very High	14 High
Malawi	178	16	22 High	45 Very High	5 Medium
Mali	220	23	33 High	38 High	11 High
Mauritania	183	-	32 High	35 High	13 High
Mauritius	18	13	15 Medium	10 Low	14 High
Mozambique	158	14	24 High	41 Very High	4 Medium
Namibia	65	14	24 High	24 Medium	9 Medium
Niger	262	17	40 Very High	40 Very High	14 High
Nigeria	198	14	29 High	38 High	9 Medium
Rwanda	203	9	27 High	41 Very High	6 Medium
Sao Tome and Principe	118	-	13 Medium	29 Medium	4 Low
Senegal	137	18	23 Medium	25 Medium	8 Medium
Seychelles	15	-	6x Low	5x Low	2x Low
Sierra Leone	284	-	27 High	34 High	10 High
Somalia	225	-	26 High	23 Medium	17 High
South Africa	66	15	12 Medium	25 Medium	3 Low
Swaziland	153	9	10 Medium	30 High	1 Low
Tanzania	165	13	29 High	44 Very High	5 Medium
Togo	140	15	25 High	22 Medium	12 High
Uganda	140	12	23 High	39 High	4 Medium
Zambia	182	12	28 High	47 High	5 Medium
Zimbabwe	126	11	13 Medium	27 Medium	6 Medium

Source: State of the World's Children 2005, UNICEF 2004

*most recent data during this period

- data not available

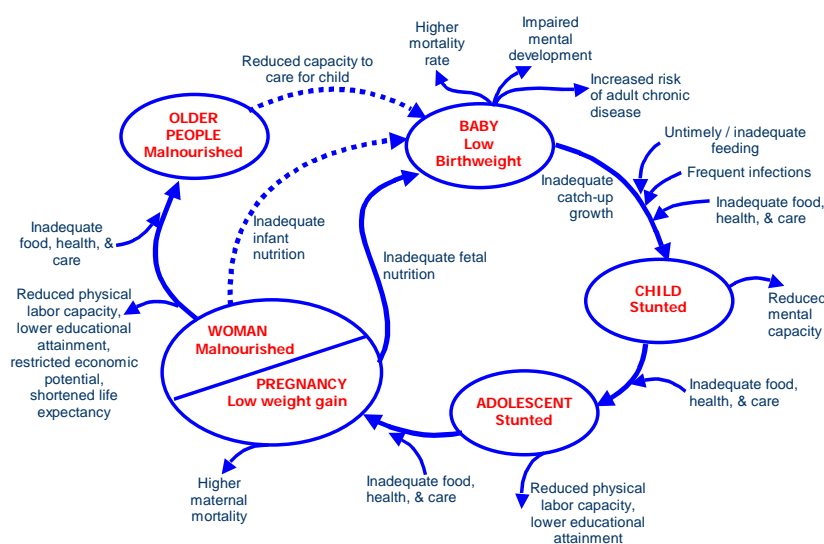
x indicates data that refer to years or periods other than those specified in the column heading, differ from the standard definition, or refer to only part of a country

Low Birth Weight

Low birth weight (<2,500 grams) data for developing countries often indicate intrauterine growth retardation (IUGR) or foetal malnutrition, rather than prematurity as in developed countries. While there is inadequate data on the prevalence of low birth weight in sub-Saharan Africa, it is estimated that almost 15% of all babies born in this region are of low birth weight (AbouZahr et al 2003).

A major cause of low birth weight in developing countries including the African region is poor maternal nutritional status. Therefore birth weight has been used as a proxy indicator of maternal nutritional status where poor dietary intake combined with infections and a heavy workload during pregnancy, result in inadequate gestational weight gain. The prevention of low birth weight involves several caring actions along the lifecycle as illustrated in the malnutrition cycle below (figure 3).

Figure 3. The Malnutrition Cycle



Source: UN ACC/SCN 2004

Micro-nutrient malnutrition

Micro-nutrient malnutrition and interventions to combat it (diet diversification, fortification, supplementation), may be used to indicate the level of maternal and child care. Micro-nutrient malnutrition such as Vitamin A Deficiency, Iodine Deficiency Disorders and Iron Deficiency Anaemia may reflect inadequate care at different levels. At the national level, this could be in the form of inadequate or no policies on food fortification including salt iodisation, vitamin A supplementation, iron supplementation or diet diversification. Even where policies do exist, service delivery may be poor and thus not reach the most vulnerable in the society. Likewise, policies may exist as well as effective service delivery but demand for and utilisation of these

services may be poor due to lack of awareness and or resources of the target population.

Iodine Deficiency Disorders (IDD)

Out of the 46 States in sub-Saharan Africa, it is estimated that Iodine Deficiency Disorders are a public health problem in 44. It is further estimated that 20% of the African population are affected by goitre and a further 48% are at risk (ACC/SCN 2000). The most recent information from the WHO global database on iodine deficiency reveal that the situation is still far from ideal in all the regions in Africa (table 7).

Table 7. Insufficient iodine intake by UN region, 2003

Insufficient Iodine intake (UI <100 µg/l)				
Region/subregion	General population		School age children (6-12 years)	
	%	Total no. millions	%	Total no Millions
Africa	43.0	324.2	42.7	59.7
West	41.4	96.2	41.1	18.6
Central	32.7	26.3	32.4	5.1
Eastern	45.2	98.2	45.1	19.4
Northern	50.6	88.2	50.7	14.1
Southern	31.2	15.4	31.6	2.5

WHO Global Database on Iodine Deficiency – WHO (2004)

Ensuring the universal iodisation of salt in these populations is a preventive health caring practice and remains the primary responsibility of governments with the support of development partners. However, many populations in sub-Saharan Africa are still consuming non iodised salt with its consequences on reproductive health as well as on mental and health development of children. The proportion of households consuming iodised salt in sub-Saharan Africa is estimated at 67% (UNICEF, 2004). Only three countries, Nigeria, Uganda and Zimbabwe have more than 90% of their households consuming iodised salt. Tremendous efforts are however currently being made to increase availability and consumption of iodised salt in the region as demonstrated by a recent conference to accelerate Universal Salt Iodisation in Western and Central Africa (Aguayo et al. 2005).

Vitamin A Deficiency (VAD)

An analysis based on national data from 8 States in sub-Saharan Africa indicates that in the absence of appropriate and sustained policies and programmes to control Vitamin A Deficiency, an estimated 42.4% of children aged 0-59 months (43.2 million children), would be at risk of VAD (Aguayo V in Technical Update Report, ECOWAS Nutrition Forum 2002). The most recent national data on VAD among children in Benin, Gambia and Liberia show prevalence rates of 53%, 64% and 70% respectively. It is estimated that 71% of children aged 6 to 59 months in sub-Saharan Africa, received at least one high dose of Vitamin A capsule in 2000 (UNICEF, 2004).

Iron Deficiency Anaemia (IDA)

Anaemia in pregnancy is a major contributing factor to the high maternal mortality in the African region. While data may not be available for all the countries, anaemia in pregnancy is estimated as ranging from 47% in East Africa to 56% in West Africa (UN/SCN, 2000). Data from 8 out of the 16 States in West Africa (Shrimpton R in Technical Update Report, ECOWAS Nutrition Forum, 2002) show a prevalence range from 42% to 86%.

For sub-Saharan Africa, it is estimated that bioavailability of dietary iron is the most important determinant of anaemia in every age group except pregnant women. In pregnant women, malaria is a more important determinant of anaemia in primigravidae with iron deficiency more important for multigravidae (ACC/SCN, 2000).

Information on coverage of pregnant women by national iron/folate supplementation programmes, is not readily available. There are indications however of less than effective programmes based on the continued high rates of anaemia in pregnancy in many countries. A recent study found that iron supplementation of pregnant women improved birth weights significantly (Cogswell et al. 2003).

While all the focus has been on maternal anaemia, the most vulnerable period for anaemia is during infancy and childhood (Yip and Ramakrishnan, 2002). It is estimated that Africa has among the highest anaemia prevalence rates in preschool children (ACC/SCN, 2000). This is illustrated by data from a national survey conducted in the Gambia where 88% of children aged one year and 71% of five year olds were anaemic (NaNA and MRC, 2000). National policies on reducing anaemia in children however, are rare in the region.

Infant feeding practices

“Infant and young child nutrition will improve only if improvements in complementary feeding are combined with improvements in breastfeeding, environmental sanitation and health care” (Lutter, 2003).

Breastfeeding is the norm in sub-Saharan Africa, but according to the WHO global data bank on infant feeding, most of these infants are not exclusively breastfed. The most recent estimates from available data suggest that only 28% of infants less than six months of age are exclusively breastfed (UN/SCN2004) which is below the world average of 39%. There are however positive developments in individual countries where exclusive breastfeeding rates have increased significantly over the past decade. Exclusive breastfeeding as a caring practice benefits not only the infant but also the mother in for example reducing postpartum haemorrhage and delaying pregnancies.

Complementary feeding practices still remain a challenge for most of the developing world including the African region (Lutter 2003). These concerns include the early or late introduction of foods; the frequency of feeding, the poor quality of the foods with low energy density and low nutrient value, the high microbiological content of the foods due to poor environmental sanitation and unhygienic practices of the caregiver. Furthermore the poor nutritional value of complementary foods in terms of low dietary iron combined with low bioavailability may be a major contributing factor to high anaemia prevalence rates among weaning age children. Therefore the most

critical period at which iron deficiency anaemia develops is during the weaning period i.e. between the age of 6 to 18 months (Yip and Ramakrishnan 2002).

Traditional household food technologies such as germination and fermentation can improve the quality and safety of complementary foods (Mensah and Tomkins, 2003; eds. Alnwick et al. 1988).

Immunisation/antenatal care

Immunisation services are offered by all the African States with utilisation of these services varying from country to country as indicated by coverage rates in table 6. Measles being among the top killer diseases has a coverage ranging from as low as 30% to almost 100%. Fifteen governments are financing a hundred percent of the routine immunisation programme with fourteen not providing any financing at all.



NaNA files (GAM)

Ante-natal care

It is estimated that globally, twenty seven countries account for 90% of the global burden of maternal and neonatal tetanus. Out of these twenty seven, sixteen are from sub-Saharan Africa. Some of the challenges identified include poor access to or use of general health services, including child immunisation; low access to and use of ante-natal care services including maternal immunisation, low literacy levels and income. It has been estimated that almost 60% of women in sub-Saharan Africa attend at least two ante-natal clinics, yet only 42% receive the recommended two tetanus toxoid immunisations. Furthermore, the poorest quintile in SSA registered the lowest antenatal care and skilled attendance at birth (Neonatal Survival Series, 2005).

Table 8. Caring practices – Infant and young child feeding practices and Immunisation

Countries	% Exclusively breastfed <6 months 1995-2003	% Breastfed with complementary foods 6-9months 1995-2003	% Still breastfeeding 20 – 23 months 1995-2002	% immunised 2003 1 year old children				% routine EPI vaccines financed by government 2003	
				TB hepB3	DPT3	Polio3	Measles		
Sub-Saharan Africa	28	64	51						
Angola	12	77	37	62	46	45	62	-	10
Benin	38	66	62	99	88	88	83	81	0
Botswana	34	57	11	99	97	97	90	78	100
Burkina Faso	6	49	87	83	84	83	76	-	100
Burundi	62	46	85	84	74	69	75	-	100
Cameron	12	72	29	82	73	72	61	-	100
Cape Verde	57k	64	13	78	78	79	68	54	80
Central Africa Rep.	17	77	53	70	40	40	35	-	0
Chad	10	68	51	72	47	48	61	-	75
Comoros	21	34	45	75	75	75	63	27	0
Congo	4k	94	13	60	50	50	50	-	0
Congo, Dem. Rep.	24	79	52	68	49	55	54	-	0
Cote d'Ivoire	10	54	42	66	54	54	56	48	0
Equatorial Guinea	24	-	-	73	33	39	51	-	0
Eritrea	52	43	62	91	83	83	84	83	0
Ethiopia	55	43	77	76	56	57	52	-	18
Gabon	6	62	9	89	38	31	55	-	100
Gambia	26	37	54	99	90	90	90	90	63
Ghana	31	70	57	92	80	80	80	80	28
Guinea	11	28	73	78	45	43	52	-	20
Guinea Bissau	37	36	67	84	77	75	61	-	0
Kenya	13	84	57	87	73	67	72	73	36
Lesotho	15	51	58	83	79	78	70	-	10
Liberia	35	70	45	43	38	39	53	-	0
Madagascar	41	82	43	72	55	58	55	55	12
Malawi	44	93	77	91	84	85	77	84	0
Mali	25	32	69	73	57	57	33	-	100
Mauritania	20	78	57	98	83	82	81	-	100
Mauritius	16x,k	29x	-	87	88	88	84	88	100
Mozambique	30	80	65	78	60	55	58	60	21
Namibia	19	57	37	83	77	78	68	-	100
Niger	1	56	61	47	23	25	48	-	100
Nigeria	17	64	34	54	26	25	40	-	100
Rwanda	84	79	71	99	88	85	69	88	50
Sao Tome and Principe	56	53	42	99	92	93	85	-	-
Senegal	24k	64	49	77	77	73	60	-	100
Seychelles	-	-	-	99	99	99	99	99	100
Sierra Leone	4	51	53	87	70	60	73	-	20
Somalia	9	13	8	65	40	40	40	-	0
South Africa	7	67	30	97	94	94	83	94	100
Swaziland	24	60	25	97	95	95	94	95	100
Tanzania	32	64	48	91	95	97	97	95	30
Togo	18	65	65	84	64	63	58	-	0
Uganda	63	75	50	96	81	82	82	63	7
Zambia	40	87	58	94	80	80	84	-	5

Zimbabwe	33	90	35	92	80	80	80	80	0
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Source: UNICEF State of the World's Children 2005

- Data not available

x indicates data

k refers to exclusive breastfeeding less than 4 months

Table 9. Maternal indicators

Countries	Maternal Mortality Rate per 100,000 2000 *adjusted	Antenatal Care coverage % 1995-2003	Skilled attendant at delivery % 1995-2003*	Contraceptive prevalence (%) 1995-2003*	% pregnant women immunised against tetanus 2003
Sub-Saharan Africa	940	73	41	22	53
Angola	1700	66	45	6	72
Benin	850	81	66	19	56
Botswana	100	97	94	48	-
Burkina Faso	1000	73	31	14	50
Burundi	1000	78	25	16	46
Cameron	730	75	60	26	65
Cape Verde	150	99	89	53	-
Central Africa Republic	1100	62	44	28	63
Chad	1100	42	16	8	43
Comoros	480	74	62	26	46
Congo	510	-	-	-	59
Congo, Dem. Rep.	990	68	61	31	48
Cote d'Ivoire	690	88	63	15	80
Equatorial Guinea	880	86	65	-	53
Eritrea	630	70	28	8	55
Ethiopia	850	27	6	8	24
Gabon	420	94	86	33	54
Gambia	540	91	55	18	-
Ghana	540	92	44	25	70
Guinea	740	71	35	6	74
Guinea Bissau	1100	62	35	8	66
Kenya	1000	88	41	38	66
Lesotho	550	85	60	30	-
Liberia	760	85	51	10	56
Madagascar	550	71	46	19	55
Malawi	1800	94	61	31	70
Mali	1200	57	41	8	32
Mauritania	1000	64	57	8	41
Mauritius	24	-	99	26	-
Mozambique	1000	78	46	17	57
Namibia	300	91	78	44	85
Niger	1600	41	16	14	36
Nigeria	800	58	35	13	51
Rwanda	1400	92	31	13	76
Sao Tome and Principe	-	91	79	29	-
Senegal	690	79	58	11	75
Seychelles	-	-	-	-	-
Sierra Leone	2000	68	42	4	62
Somalia	1100	32	34	1x	-
South Africa	230	94	84	56	52
Swaziland	370	87	70	28	-
Tanzania	1500	49	36	25	83

Togo	570	73	49	26	47
Uganda	880	92	39	23	48
Zambia	750	93	43	34	60
Zimbabwe	1100	93	73	54	60

Source: State of the World's children 2005

*reported data received by UNICEF, UNFPA and WHO and adjusted for misclassification and underreporting, also estimates made for countries with no data

Family planning

According to data from UNICEF (2004), Sub-Saharan Africa has the highest total fertility rate at 5.4. High fertility rates may influence the quantity and quality of childcare and can have implications for maternal health, child survival health and development. However maternal care in terms of family planning services may be deficient in most countries as judged by the low prevalence of use of contraceptives estimated at only 22% for sub-Saharan Africa (UNICEF, 2004). Likewise, the low utilisation of contraceptives may be due to ignorance, lack of resources or to women's low status.

Maternity laws- formal and non-formal sector

Mothers require adequate time to practice exclusive breastfeeding. Governments that have adequate Maternity leave for their female workforce are providing care not only for the mother but for her infant as well. Many African States have the 12 weeks leave originally stipulated as a minimum in the ILO Convention 103. The updated convention 183 that now stipulates 14 weeks as a minimum leave has yet to be ratified by most African countries.

What about the majority of women in the region who are in the informal sector, for example agriculture? *What traditional or local practices prevail in such communities to care for a mother and her baby? What role can governments play in encouraging communities to support new mothers through the reduction of their workload for example?*

CHALLENGES TO EFFECTIVE CARING PRACTICES AND EARLY CHILDHOOD DEVELOPMENT - Economic/Political/ Social factors

Poverty, Conflict and Disease

“There are currently mothers and their children living under poverty, conflicts and infected or affected by HIV and AIDS all at the same time. These are the vulnerable among the vulnerable”.

The economic, political and social situation of a country has far reaching implications for maternal and child well being. Poverty as defined by the percentage of a population living on less than US\$1 per day is widespread in Sub-Saharan Africa with an estimated 300 million people living under the poverty line.

Poverty impacts not only the purchasing power of people but also their access to and utilisation of services such as health and education. Poverty also influences the quality of services offered with governments being less capable of allocating adequate resources to essential basic services.

Furthermore, poverty limits access of women to resources needed to improve their own nutrition as well as the nutrition of their family. These include among others access to land, agricultural inputs and micro credit services (Kurz and Johnson-Welch, 2000).

According to the Food and Agriculture Organisation (FAO,2003), one third of African countries or two hundred million Africans are estimated to be food insecure, an increase of 20% since 1990 (table 10). Sub-Saharan Africa is home to thirty three percent of the food insecure with more than fifty percent living in countries in conflict situations. Food insecurity may have negative implications for caring practices at the household level.

Table 10. Prevalence of under-nourishment in Sub-Saharan Africa

Region/Sub-region	Total population		Number of people undernourished		Proportion undernourished in total population	
	1990-92	1999-2001	1990-92	1999-2002	1990-92	1999-2002
	millions		millions		%	
Sub-Saharan Africa	474.5	603.0	165.5	198.4	35	33
Western	174.7	222.6	36.2	32.7	21	15
Central	62.8	81.7	22.0	47.6	35	58
Eastern	166.1	209.5	73.2	81.3	44	39
Northern	120.7	142.8	5.7	6.1	5	4
Southern	71.0	89.2	34.2	36.8	48	41

Poverty is further compounded by conflicts in some of these countries. For example in 2003, two million, two hundred and thirty people were estimated to be affected by conflicts in West Africa alone (SCN RNIS 2003). Even States not directly involved in conflict situations may still be affected through the influx of refugees, returnees or both.

Conflicts have resulted in peoples' livelihoods among others, being destroyed especially if they depend on agriculture, as is the case for most of sub-Saharan Africa. A study of conflicts in sub-Saharan Africa, found reduced food production in all countries with conflicts (Messer et al, 1998). Caring practices and access to social services including clean water and adequate sanitation are also affected by conflict situations.

Sub-Saharan Africa is estimated to have the largest proportion of HIV infected persons with women having higher prevalence rates than men. The implications of HIV/AIDS on food and Nutrition security can be devastating as experienced by many communities in sub-Saharan Africa. An extensive review confirms the negative impact of HIV/AIDS on rural livelihoods which include both agriculture and non farm livelihoods (Gillespie and Kadiyala, 2005). Likewise food and nutrition insecurity have implications for the spread of HIV.

Women and children living with HIV/AIDS whether infected or affected need special care and attention. Communities and families need resources to care adequately for this target group. Information is a crucial resource that can be used to reduce the spread of HIV/AIDS as well as improve caring practices for people living with HIV

and AIDS. *How do such communities and families currently cope with local resources to ensure care for women and their children in these situations?*

How can governments support communities and families in providing effective care to mothers and their children living with HIV/AIDS as well as those living in conflict situations?

Longhurst (1995) in his paper on “Nutrition and care during emergencies” discusses the importance of care for children living under emergency situations. The paper emphasises that care is even of greater importance in emergencies than under normal circumstances.

Water and sanitation

A healthy environment includes access to clean and adequate water as well as proper sanitation. Provision and use of these services are therefore part of care. In sub-Saharan Africa, it is estimated that only 57% and 36% of the population are using improved drinking water sources and adequate sanitation facilities respectively. The disparity between the rural and urban population regarding access is evident and in some cases, the proportion of the urban population with access to both clean water and adequate sanitation, nearly doubles that of the rural population. Estimates show that 82% of the urban population and 44% of the rural population have access to improved drinking water while 55% urban and 26% rural are using adequate sanitation facilities (UNICEF, 2004).

How can adequate care be provided when access to adequate sanitation facilities is as low as 4% for a rural population in Africa? The Millennium Development Report concludes that the proportion of African people enjoying access to adequate sanitation has stayed essentially the same during the last ten years. Progress has however been noted in individual countries regarding both safe water supply and adequate sanitation.

OPPORTUNITIES FOR EFFECTIVE CARING PRACTICES AND EARLY CHILDHOOD DEVELOPMENT

“There are numerous traditional caring practices which remain to be explored and exploited in the promotion of effective caring practices”.

In identifying opportunities for effective caring practices in the African region, one can start by identifying local resources within communities. In this case, local resources would include positive traditional/local beliefs, knowledge and practices. Examples are, the African extended family system where a child may have several carers; practices such as breastfeeding for 24 months and breastfeeding on demand; knowledge on fermentation or germination of local cereals (in the preparation of complementary foods); practice of encouraging children to sing and dance from an early age.

Poverty and low literacy levels of mothers may influence caring practices negatively. However, a study in Accra found that good care practices in terms of child feeding and use of preventive health services could mitigate the negative effects of poverty

and low maternal schooling and cause a reduction in childhood malnutrition (Ruel et al. 1999). The study therefore suggested targeting specific education messages to mothers with little or no schooling and to do so as early as during pregnancy. Most rural communities have traditional media which can be used to disseminate relevant messages to such women as well as the use of traditional birth attendants in the Primary Health Care setting.

Ignorance and the lack of information is always a challenge in any situation but who is ignorant and needs information? It is usually wrongfully assumed that the beneficiaries – communities and families are the ones that are ignorant. But service providers, decision and policy makers can also be ignorant due to lack of information regarding the beneficiaries' beliefs and practices, and this can influence their service delivery and their policies.

Likewise, communities and families – do they have information on what constitutes effective caring practices? The bridging of this knowledge and information gap may provide an opportunity for all parties to provide better care for women and their children.

Working with and within communities for solutions: an example from the Gambia

Exclusive breastfeeding was rare in The Gambia in the late eighties. Numerous attempts to improve the situation led to the adoption of the global UNICEF/WHO Baby Friendly Hospital Initiative in 1992 where maternity units in Health facilities were encouraged to implement 10 steps to successful breastfeeding (Ebrahim J, 1993). However, in The Gambia, most deliveries took place at home often with the support of traditional birth attendants. Even mothers who delivered in health facilities only stayed there for 24 hours or less with a normal delivery. Therefore the idea of a Baby Friendly Community Initiative (BFCI) was conceived to complement the hospital initiative.

The implementation of the Community initiative started with a preparatory phase that included quantitative and qualitative studies to identify not only current infant feeding practices but also traditional and local beliefs and practices. The results from the study illustrate how traditional and local knowledge may be used to improve infant feeding practices (Semega-Janneh et al 2000).

The concept of mother to mother support groups was used to organise community representatives, both men and women into “Village Support Groups on Infant Feeding”. These were selected by their communities and trained to implement and monitor the initiative.

The training took into consideration traditional and local knowledge of the participants, identified from the study, and used it where appropriate to strengthen modern knowledge. An example is their knowledge that newborn animals survive, grow and develop on only their mother's milk for a period of time. Likewise infants can survive, grow and develop on only their mother's milk (exclusive breastfeeding) for 6 months.

Evaluation showed that the Support groups disseminated information through house to house visits, at ceremonies and village meetings and even through religious

sermons. The 10 steps which were developed for the community initiative were made into catchy songs and danced to at every occasion. Thus information on infant and maternal nutrition, environmental sanitation and personal hygiene was disseminated to the entire community.

One of the conditions for communities to be designated “Baby Friendly” was the creation of an enabling environment for mothers to practice exclusive breastfeeding. Local knowledge of the traditional 40 days rest for new mothers was combined with modern knowledge of government instituted 12 weeks maternity leave, to come up with a superior alternative in one community. This was in the form of a local maternity leave of 3 months before delivery and six months after delivery. This served not only to support mothers practice exclusive breastfeeding but to reduce maternal workload as well. Furthermore, the same community ensured that support in the form of labour was provided in the farms of these mothers.

The qualitative study also found that local communities had a traditional practice of constructing shelters called “maakas” at the fields to enable lactating women farmers take their infants with them to work. Communities were accordingly informed of the modern version of the crèche at workplaces. This resulted in the construction of a combined version of the “maakas” and the crèche at the fields and now referred to as Baby Friendly Rest Houses.



NaNA files (GAM) **Baby Friendly Rest Houses**

Several lessons were learnt from the implementation of this initiative. One is the importance of identifying traditional and local knowledge, beliefs and practices when working with communities. Likewise, in order for men to provide effective caregiving, they need to be provided with information and educated as much as women. The successful participation of men in the BFCI showed that they are interested in the health and nutrition of their wives and children, but are usually not targeted by intervention projects or programmes and then blamed for not providing adequate support for the women.

ENSURING EFFECTIVE CARING PRACTICES WITHIN FAMILIES AND THE COMMUNITY – WHO IS RESPONSIBLE?

Box 4. 10 key elements of successful ECD programmes (UNICEF, 2000)

1. incorporates the principles of the Convention on the Rights of the Child
2. builds on the Convention on the Elimination of All Forms of Discrimination against Women
3. use the existing strengths of communities, families and social structures
4. have a broad framework encompassing multidimensional programmes in health, nutrition and the child's psychosocial and cognitive development
5. are developed with and for families
6. are developed with and for communities
7. provide equal access for all children
8. are flexible and reflect diversity
9. meet the highest quality standards
10. are cost effective and sustainable

The situational analysis of women and children in Africa indicate that while there may be progress in individual countries, much remains to be done. This information is however not new, is well recognised and often acknowledged by policy makers among others. “What needs to be done”, is on the other hand less widely understood and appreciated despite tremendous recent efforts by recognised institutions and agencies. This information is yet to be packaged in a way that will be easily understood and appreciated by those outside of the inner circle of professionals, researchers etc. such as families, communities as well as decision makers at all levels.

It is especially important for communities and families no matter what their situation is, to realise the importance of their strength and local resources for improving the situation of their mothers and children. Elements of successful Early Childhood Development Programmes (box 4) for example, include the use of existing strengths of communities, families and social structures as well as developing the programmes with and for families and communities.

The WHO has also identified twelve actions (box 5) for families and communities to implement in order to promote child survival, growth and development (WHO, 2005).

Box 5. Actions for child survival, growth and development

1. Immunisation
2. Breastfeeding
3. Complementary feeding
4. Micronutrients
5. Hygiene
6. Treated bed nets
7. Foods and fluids during illness
8. Home treatment
9. Care seeking
10. Adherence
11. Stimulation
12. Antenatal care

WHO, 2005

The Bellagio Study Group likewise in their Child Survival Series (Jones et al. 2003) identified both preventive and treatment interventions that could if implemented universally, reduce child mortality rates substantially (table 11).

Table 11

Interventions	Proportion of all deaths
Preventive treatment	
Breastfeeding	13%
Insecticide treated nets	7%
Complementary feeding	6%
Zinc	5%
Clean delivery	4%
Hib vaccine	4%
Water/sanitation/hygiene	35
Antenatal steroids	3%
Newborn temperature management	2%
Vitamin A	2%
Tetanus toxoid	2%
Nevirapine and replacement feeding	2%
Antibiotics for premature rupture of membranes	1%
Measles vaccine	1%
Antimalarial intermittent preventive treatment in pregnancy	<1%
Treatment Intervention	
Oral rehydration therapy (ORT)	15%
Antibiotics for sepsis	6%
Antibiotics for pneumonia	6%
Anti-malarials	5%
Zinc	4%
Newborn resuscitation	4%
Antibiotics for dysentery	3%
Vitamin A	<1%

Both sets of interventions are similar and all can be classified as caring practices with a number of them being nutritional interventions as well. Many of these interventions are currently being implemented in various degrees in all the African countries. The challenge is to achieve universal coverage with as many of these interventions as possible to achieve any significant impact. What does it take to do this? Recognising and acknowledging the situation; knowing what needs to be done; recognising duty bearers, roles and responsibilities; being committed; identifying existing resources and establishing priorities; making the best out of available resources are just some of the considerations to achieving this.

Article 14 of the African Charter on the Rights and Welfare of the Child is very explicit in what needs to be done to ensure that children enjoy the best attainable state of physical, mental and spiritual health (box6).

Box 6. African Charter on the Rights and Welfare of the Child

Article 14: Health and Health Services

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health
2. State parties to the present charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
 - (a) to reduce infant and child mortality
 - (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care
 - (c) to ensure the provision of adequate nutrition and safe drinking water
 - (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology
 - (e) ensure appropriate health care for expectant and nursing mothers
 - (f) to develop preventive health care and family life education and provision of service
 - (g) to integrate basic health service programmes in national development plans
 - (h) to ensure that all sectors of the society, in particular parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents
 - (i) to ensure the meaningful participation of non-governmental organisations, local communities and the beneficiary population in the planning and management of a basic service programme for children
 - (j) to support through technical and financial means, the mobilisation of local community resources in the development of primary health care for children

Likewise the Convention on the Rights of the Child in its Article 18 states that, “*For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States parties shall render appropriate assistance to parents and legal guardians in the performance of their child rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of people*”.

This brings us to the question of who is responsible for ensuring effective caring practices within families and communities. This can best be answered by identifying first and foremost the various duty bearers or stakeholders. What are their roles and responsibilities? What are the actions required by the various stakeholders to ensure effective caring practices within families and communities and how do these actions complement each other?

In this paper, both stakeholders and actions are viewed from three levels – macro, meso and micro levels.

Macro actions are those that are undertaken at the government level and include the formulation, approval and adoption of national policies that promote, support and protect effective caring practices within families and the community. These include for example national laws on infant and young child feeding, reproductive health policies; maternity protection laws; food fortification laws, early childhood development policies; health policies; nutrition policies; water and sanitation policies. Macro actions also include budgetary allocations to support the implementation of such policies. What policies exist at the national levels that contribute to early childhood development? What are the budgetary allocations for programmes on or contributing to early childhood development?

The meso level includes actions at the service delivery level such as immunisation, iron supplementation, ante-natal care, training, nutrition and health education or information. However, are we using the health system effectively and efficiently to deliver health and nutrition services? An assessment by the Helen Keller International (HKI) of 3 African countries showed that the quality of services provided by national health systems left significant room for improved delivery of essential nutrition services.

Improving quality and coverage of services is linked to a number of factors however. These include adequate financial resources, adequately trained and motivated staff as well as enlightened beneficiaries with the necessary capacity to make a demand for such services. Developing the capacity of all key players including communities and families is crucial therefore in achieving this.

The African traditional support system starts with the community where tradition calls for a whole community or village to care for a child. At the household level with an extended family, a child has several “mothers” to care for him or her. The micro level therefore, includes actions at community, household and family levels. Actions at the community, household and family levels may include health care seeking behaviour; communal gardens, community efforts to improve environmental sanitation; efforts at the household to reduce the workload of pregnant and lactating women; husbands making an effort to ensure that their pregnant and lactating spouses get a nutritious diet; community efforts to provide an enabling environment for mothers to breastfeed their infants; parents taking their children to be immunised.

A specific example is the promotion of a caring practice like exclusive breastfeeding. What is the role of government? Article 24 of the Convention on the Rights of the Child states that State parties shall take appropriate measures ***“To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition and the advantages of breastfeeding”***. Is there a breastfeeding policy including a “6 months exclusive breastfeeding” policy? Are there appropriate maternity protection laws? Has the government endorsed global instruments that protect, promote and support breastfeeding e.g. the international Code of Marketing of Breastmilk Substitutes and the Global Strategy on Infant and Young Child Feeding? Has the government adopted the BFHI strategy? How much government funds are allocated to infant and young child feeding programmes? Do service providers have adequate and appropriate training on optimal infant feeding practices?

Regarding the level of service providers, do they disseminate relevant and appropriate information to communities, families and mothers? Are fathers also given information on optimal infant feeding practices? Do service providers have any knowledge on local infant feeding beliefs and practices? Are communities and households encouraged and supported to provide an enabling environment for optimal breastfeeding?

The actions at one level impact the actions at another level. Therefore if a caring practice such as universal exclusive breastfeeding is to be achieved, the ideal situation is that policies, information, training, community-household/family support must all

be present. Actions at one level should complement and impact actions at another level as illustrated in the figure below.

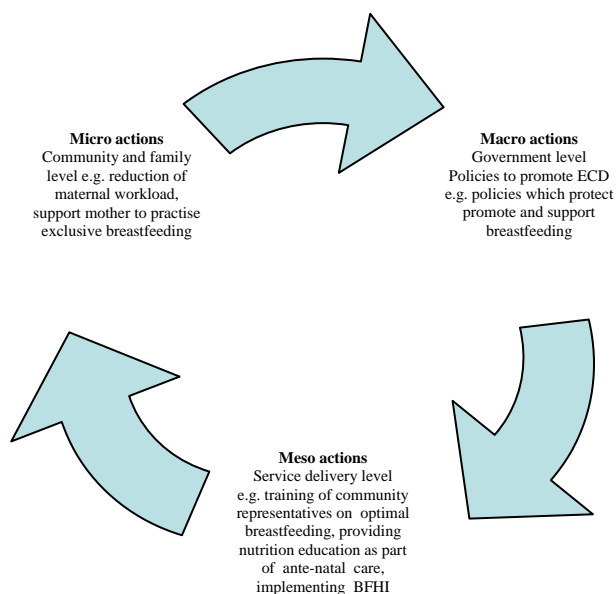


Figure 1. Stakeholder /Action interactions

Inadequacies at one level may affect actions at another level. An example of this is the mother working in the formal sector and is encouraged to practice exclusive breastfeeding. She may be willing but may not have adequate maternity leave, a crèche at the work place or breastfeeding breaks to enable her do so without any stress. For women in traditional rural communities and working in the informal sector, a barrier may be the lack of support at the community and household level due to local perceptions on infant feeding. These local perceptions may persist due to inadequate or ineffective information from service providers which in turn may be due to the inadequacies of their training, policies as well as resources allocated to the relevant activities.

Box 7. Examples of traditional practices that improve maternal and child care

- **Forty days rest for new mothers**
- **Sexual abstinence during the breastfeeding period – family planning**
- **Special nutritious foods for new mothers**
- **Bathing and massaging infants with shea nut butter¹ believed to have soothing properties.**
- **Singing to the infant, handclapping and dancing**
- **Wet nursing of orphans**
- **²Stimulating, encouraging and supporting a child to take its first steps.**

¹The massage is believed to strengthen the infant as well as promote restful sleep

² When a child reaches the age of walking, it is usual for the caregiver to patiently support and encourage the child to take small steps at a time. In The Gambia, this is done by holding both the child’s hands, walking slowly with the child and at the same time talking to the child in a coaxing voice. “Teteh” a Gambian word, which can loosely be translated as “support and guidance”, is repeated over and over again in a soothing voice by the caregiver at the same time as the child is being supported to take these steps.

WHAT IS THE WAY FORWARD?

“Ensuring effective caring practices in communities and within families is possible because “caring” is what families and communities in Africa have always done. They just need to be supported to do it better. Everyone must play their role”.

The responsibility for ensuring effective caring practices within families and the community lies with several stakeholders. These include national and local governments, relevant sectors such as health, education, agriculture etc, as well as communities and families themselves.

For the way forward, specific questions in addition to those raised elsewhere in the paper need to be answered and these include:

What local knowledge, skills and resources do families and communities have regarding Early Childhood Development, Care for mothers and their children?

How can local knowledge, skills and resources be used positively to enhance caring practices?

What additional knowledge, skills and resources do communities and families need to improve current caring practices?

What are the specific roles of the various stakeholders for achieving universal coverage of the identified interventions or caring practices above?

What are the resources needed at community and family level to ensure universal coverage of the interventions?

What is the situation of care for the adolescent girl?

Do communities and families recognise the vulnerability of the adolescent girl?

Educating the girl child – is it recognised as a caring practices by communities and families?

Care and support for women during pregnancy and lactation – How can men be encouraged and supported to play an active role?

What child caring activities can men take an active role in?

How can men’s or fathers’ contribution to care-giving be identified, quantified and used as a basis for promoting their involvement in care-giving?

What is the role of the traditional media in promoting effective caring practises?

How are international rights instruments understood at the local level – within communities and families?

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