HOW ASTUTE USES INNOVATIVE BEHAVIOUR CHANGE APPROACHES TO IMPROVE COMMUNITY NUTRITION PRACTICES IN TANZANIA

OVERVIEW

Social and Behaviour Change (SBC) programmes are most successful when they marry a thorough understanding of local context with a knowledge of state-of-the-art programmes that have improved nutrition outside of Tanzania. However, often, Tanzanian development professionals have not been exposed to the many successful nutrition programmes that are being implemented elsewhere. This brief outlines ASTUTE's efforts to bring together a solid understanding of both the local context and global experience in reducing stunting.

ASTUTE Programme Background

The ASTUTE programme has used a number of strategies to mobilise Tanzanian communities for behaviour change around stunting reduction, including:

Close collaboration with the Government of Tanzania (GoT) at all levels, such as support for the government's National Multi-sectoral Nutrition Action Plan (NMNAP). ASTUTE worked with the GoT to co-train 6000 community health workers (CHWs) and 1200 health facility workers (HFWs) on evidence-based SBC as part of the project.

Active engagement of government staff from agriculture, education, community development, and other sectors to improve the nutrition of women and children.

Capacity building in behaviour change of civil society organisation (CSO) staff, including how to make support groups both more personal and action-oriented.

Reminders to community members during home visits and support groups about ASTUTE's radio messages they are hearing each week.

Follow-up with families to see if they are able to practise recommended behaviours and to address challenges families face practicing those behaviours.

Positive deviance/Hearth—a government-implemented, assets-based strategy that helps communities identify the uncommon but beneficial practices that enable some families to keep their children well-nourished and to spread such practices to other community members.

KEY APPROACHES USED AND LESSONS LEARNED

Our recommendations—based on ASTUTE programme experience—appear below.

Use evidence to select a few behaviour change strategies that reduce stunting:

Prior to identifying how to best reduce stunting, ASTUTE staff 1) reviewed the government's nutrition-specific and nutrition-sensitive programmes and policies that were already in place, 2) identified especially poor practices among target populations, 3) conducted research to understand why individuals fail to practise behaviours known to reduce stunting, 4) apply health behaviour theory, and 5) thoroughly review the global literature about which programme interventions are most likely to reduce stunting.

We consulted the 2015-16 Tanzania Demographic and Health Survey (TDHS), conducted our own baseline survey and qualitative research (including Trials of Improved Practices), and reviewed health behaviour theories and the global programme literature on nutrition and stunting.

As examples of using the evidence base, per the 2011 TDHS (the most recent data at the time ASTUTE was designed), about one in three Tanzanian children 6-23 months of age consumed meat, fish, or poultry and only one in ten ate eggs in the previous 24 hours. Hence, we prioritised consumption of animal source foods during radio spots, home visits, and support groups. The scientific literature backs up the importance of animal source foods: starting at six months, children who eat meat, fish, and eggs; green, leafy vegetables; and orange-fleshed foods are less likely to be stunted. [1]

1 Arimond M, Ruel MT. Dietary diversity is associated with child nutritional status: evidence from 11 demographic and health surveys. Journal of Nutrition. 2004;134:2579–85. Dewey KG, Adu-Afarwah S. Systematic review of the efficacy and effectiveness of complementary feeding interventions in developing countries. Maternal and Child Nutrition. 2010;4:24–85. Dror DK, Allen LH. The importance of milk and other animal-source foods for children in low-income countries. Food and Nutrition Bulletin. 2011;32:227–43.

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Health behaviour theory and research point to certain interventions that are particularly effective. For example, home visits are especially good at addressing the individual challenges mothers and fathers face as they try new practices such as hand washing. Support groups and radio are effective in increasing knowledge and improving social norms. We also found that certain programme strategies have a demonstrable impact on nutrition-related behaviours. For example, based on a comprehensive review of the literature,[2] 18 of 23 studies showed that community-based counselling and group education had a positive impact on breastfeeding practices. 10 of 13 studies showed associations between support groups and complementary feeding behaviours. In 28 of 32 studies, home visits had a positive impact on breastfeeding practices and in 6 of 13 studies, home visits were associated with improvements in complementary feeding.

To bring about behaviour change, establish and maintain one-on-one contact with caregivers: The government and implementing partners In Tanzania rarely use home visits to bring about behaviour change. Rather, most of their interventions are group-based, such as community-based support groups. ASTUTE believes it is very difficult to improve the way parents care for their children without understanding *why* parents are unable to try such practices as early childhood stimulation, hand washing, or feeding the child more frequently. Home visits allow CHWs to tailor messages to parents' individual needs. Group-based interventions do not.

As a starting point, ASTUTE staff looked to successful home visit strategies used in other countries. ASTUTE's home visits differ markedly from information sharing alone, which some parents may interpret as scolding. ASTUTE's approach—known as negotiating for behaviour change (or negotiation for short)—helps CHWs establish trust with parents. During negotiation, CHWs find out what parents are already doing (or not) to keep children well-nourished; the CHWs identify "small, do-able actions" parents can try; help them pick one action they can attempt this week; resolve barriers to behaviour change parents may experience; and set a time for a follow-up visit. For example, a father may believe that his infant cannot hear and thus there is no reason to speak to the child. He may say that he does not have time to play peek-a-boo or does not have ideas about how to stimulate the child. While discussing these challenges with the father, the CHW formulates options the father can try (imitating the infant's sounds to see if the baby reacts; playing peek-a-boo; or consulting other fathers to get ideas about how they stimulate their children). The CHW then asks the father to commit to one of the proposed actions and thereafter helping him try the new behaviour.

Home visits are not without challenges. ASTUTE has found that CHWs cannot possibly visit all 'thousand day' households (those with pregnant mothers and children less than two years of age). To address this issue, the project prioritised homes with infants three to nine months of age. This period is when mothers prematurely stop breastfeeding exclusively or offer their infants a diet made up of primarily of *ugali*. An additional challenge is that negotiation is complicated and it takes time for CHWs to master it. In addition to initial training, ASTUTE provides on-the-job mentoring during monthly supervisory meetings when CHWs have half a day each month to practise negotiation in the classroom and in the field.

To improve parents' nutrition-related behaviours, use action-oriented support groups: Similar to home visits, well-intentioned volunteers sometimes scold parents who attend support groups for not caring for their children's health properly. This is due, in part, to volunteers' lack of skills needed to bring about behaviour change. Not surprisingly, when volunteers see that parents' practices remain unchanged, they become demoralised in their work.

Unlike most support groups, ASTUTE trains CSO volunteers how to:

1. Personalise the support group topic that day to reflect the issues parents themselves want to talk about;
2. Discuss together and then brainstorm solutions to challenges parents face;
3. Have parents teach back what they understand each solution to be (otherwise, it is not clear that group members fully understand the solutions under consideration);
4. Collectively commit parents to each try one of several behaviours; and
5. Have parents tell others what they have learned and how, specifically, they have committed to improving their children's nutrition.

Subsequent support groups are used to:

Follow-up with parents to see whether they have been able to adopt the practice they committed to during the last meeting;

Congratulating all parents for trying new practices (regardless of whether or not they succeeded);

Resolving any barriers to behaviour change;

Sharing successes parents have had in changing their practices; and

Repeating the process with a new, small, do-able action.

2 Helen Keller International. Homestead food production: empowering women and feeding families. New York, New York, Author. No date.

Select a few priority behaviours for programmes to focus on; divide complex behaviours into small, doable actions: In its first year, ASTUTE and the GoT selected six cost-effective behaviours that, when practised, reduce stunting. Limiting the behavioural focus ensures government and CSO buy in to the behaviours and increases their ability to manage SBC interventions.

We often expect parents to adopt complex behaviours overnight. For example, we anticipate that a single support group will convince parents to wash their hands with soap and water at all five critical moments. In the Lake zone, CHWs and CSO volunteers have found greater success when they break complex behaviours into small, do-able actions. For example, during one support group, CSO volunteers might ask mothers to place a bar of soap and water next to the sink. In a subsequent meeting, volunteers may ask mothers to wash hands with soap and water before preparing food. In yet another meeting, volunteers might ask mothers to wash hands before feeding the child, and so on. We have found this approach to be more effective than expecting mothers to adopt all hand hygiene behaviours at once.

TOOLS AVAILABLE

The DFID ASTUTE Stunting Reduction Toolkit includes a number of tools that will improve behaviour change around stunting in Tanzania. These are labeled under the **Behaviour Change** section of the toolkit:

- Home visit dialogue guides for CHWs to help them effectively share evidence-based messages on exclusive breastfeeding, complementary feeding, WASH and women's workload based upon recent research.
- Small doable actions that CHWs and volunteers can recommend to families during home visits.
- Steps to negotiating behaviour change with households and individuals, as well as how to design an evidence-based SBC intervention to reduce stunting.
- Checklists and manuals for implementing and evaluating Positive Deviance/Hearth programming.
- Guidance on how to create compelling radio or TV messaging on nutrition and stunting.