



## The Baby Friendly Community Initiative – A Pilot Study in Koibatek, Baringo County, Kenya

### Executive summary

Interventions promoting optimal infant and young child nutrition could prevent a fifth of under-five deaths in countries with high mortality. Effective strategies to improve infant and young child feeding practices are needed. This study was designed to pilot implementation of the Baby Friendly Community Initiative (BFICI), a global initiative recommended by the World Health Organization (WHO) to promote optimal infant and young child feeding practices. The study set out to determine feasibility and effectiveness of the BFICI, with regards to exclusive breastfeeding in the first six months after delivery, within a rural Kenyan setting.

The study, employing a cluster-randomized trial design, was conducted in Koibatek, Baringo County between 2014 and 2016. A total of 823 pregnant women and their respective children were recruited into the study. The mother-child pairs were followed up until the child was about six months. The intervention involved regular counselling and support of mothers by trained Community Health Volunteers (CHVs) and health professionals on Maternal, Infant and Young Child Nutrition (MIYCN) as well as provision of support to mothers through Community Mother Support Groups (CMSGs) and Mother To Mother Support Groups (M2MSGs). Regular quantitative assessment of Knowledge, Attitudes and Practices (KAP) on MIYCN was done. A qualitative exploration of the effects of the intervention was also conducted. An assessment of KAP on MIYCN was done. The analysis involved assessing the effectiveness of the intervention – exclusive breastfeeding for the first six months after delivery.

The study indicates potential effectiveness of the the BFICI in promoting optimal infant feeding as well as maternal and child health outcomes in a rural setting. With regards to the primary objective, significantly higher exclusive breastfeeding rates were documented in the intervention compared to the control group. For children aged less than two months, 95% were on exclusive breastfeeding compared to 86% in the control group ( $p < 0.05$ ). While 88% of children in the intervention group were reported to be exclusively breastfed for six months, 44% were reported as doing so in the control group ( $p < 0.05$ ). Narratives indicated that the counselling of women by CHVs and the support received from the support groups (CMSGs and M2MSGs) enhanced their skills and competencies in breastfeeding and infant feeding which led to better practices of the same.

In conclusion, projects with the objective of enhancing maternal and child health can leverage on the community health strategy framework. CHVs are the pillars of the community health strategy and can influence change when they are easily accessible to community members and have their goodwill. Support groups (CMSGs and M2MSGs) are an innovative and sustainable way of leveraging peer support for mothers. This pilot study recommends implementing the BFICI model within other settings in Kenya and conducting further research on what works for scale-up nationally.

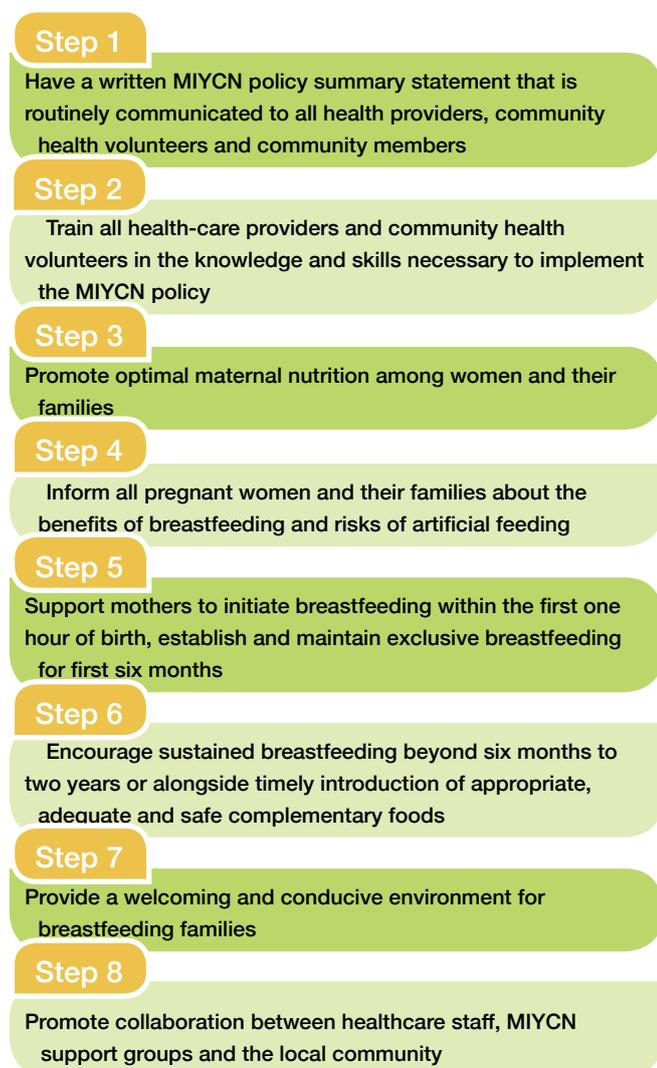
## Introduction

A pilot BFCI project was implemented in Koibatek sub-County in Baringo County, Kenya between August 2014 and December 2016. The aim was to determine the feasibility of implementing the BFCI in Kenya and its effectiveness in improving breastfeeding and other Maternal, Infant and Young Child Nutrition (MIYCN) and health outcomes.

The objectives of the intervention were aligned with child health priorities in Kenya as outlined in the Global Health Initiative (GHI) Strategy and the Child Survival and Development (CSD) Strategy. We also aligned the project objectives with the strategic health objectives of the Kenya USAID Mission for promoting maternal, newborn and child health as outlined in the Mission's health framework, 2010 – 2015 strategy.

Findings from the study would inform effective scale-up of the BFCI in Kenya, which in turn is anticipated to improve child health and survival indicators in the country.

**Figure 1: Implementation plan for the eight-step Baby Friendly Community Initiative**



## Why implement the Baby Friendly Community Initiative?

Kenya adopted the Baby Friendly Hospital Initiative (BFHI) in 2002. Although the initiative has proven effective in promoting optimal breastfeeding practices, the strategy only reaches women who deliver in health facilities. The 2014 Kenya Demographic and Health Survey estimated that 39% of women, especially the poor, deliver at home and are therefore not reached with the BFHI. The BFCI applies the principles of BFHI but extends the follow-up and care of the mother and child to the community. The BFCI, therefore, transfers benefits to the community level where over a third of women deliver, in order to provide women with a comprehensive support system to improve breastfeeding practices and other MIYCN practices. Little is known, however, about the feasibility and effectiveness of the BFCI in Kenya. Evidence on its feasibility and effectiveness was therefore needed to inform decisions on scaling up including budgetary allocation for implementation.

## Objectives

Beyond determining the feasibility and effectiveness of implementing the BFCI with regards to child nutritional and health status, we also set out to determine:

- i Effectiveness of the BFCI on knowledge, attitudes and practices (KAP) around MIYCN;
- ii Effectiveness of the BFCI on nutritional and health status among the children;
- iii Enabling factors and barriers associated with the implementation of the BFCI as well as how to address them

## Methods

This was a cluster randomized trial that utilised existing Community Units (CUs) as clusters. CUs are geographically defined units, mostly equal to a village or a sub-location, with a population size of approximately 5,000 people. They are defined by the Government of Kenya's Community Health Strategy which involves CHVs in the provision of health care services to people at the community level. Of the 13 existing CUs found in Koibatek sub-County, six were randomized into intervention and seven into control. A formative qualitative study was conducted in August 2014, followed by the prospective, cluster-randomized trial between April 2015 and December 2016. Midline and endline qualitative evaluations of the intervention were also conducted.

**Table 1: Community Units in Intervention and Control Groups**

Intervention	Control
Esageri	Torongo
Kiptuno	Arama
Simotwet	Shauri
Solian	Poror
Toniok	Makutano
Tugumoi	Timboroa
	AIC

## Structure of the intervention

The intervention was implemented across 20 months between April 2015 and December 2016. Women were recruited as early as possible during pregnancy. Those randomized into the intervention were followed up by CHVs who were equipped with knowledge on the BFCI and also provided with tools such as aids for home-based counselling. Home-based counselling focused on a number of issues including optimal MIYCN practices, Antenatal Care (ANC) attendance, delivery by skilled health care providers at health facilities and postnatal care (PNC). Mother-child pairs were followed up for six months in order to document their involvement with the intervention and its resultant impacts on health, nutrition and other MIYCN indicators on the mother and child pair.

### Capacity building, sensitization and orientation of key stakeholders

The sub-County health management team (SCHMT) members and community health extension workers (CHEWs) were also trained on principles of the BFCI for CUs. They were in addition trained in the provision of supervision and on-the-job training for CHVs and health care workers in the intervention CUs working in lower level health facilities - dispensaries (level 2) and health centres (level 3) - who had been trained on the the BFCI package at the start of implementation. This was followed up by regular mentoring and supportive supervision by the SCHMT and the CHEWs.

### Counselling, information, education and communication materials

Counselling materials were developed and distributed to each community health volunteer. The content of the counselling materials covered key messages addressing the first 1,000 days from pregnancy to the second year of the child's life. A counselling checklist with the mothers' contacts and key messages for each of the eight steps of the BFCI was also developed and given to the CHVs for use during home visits.

Information, education and communication (IEC) materials consisting of brochures on maternal nutrition, pregnancy, exclusive breastfeeding and expressing breast milk were distributed in both intervention and control facilities. The MIYCN policy summary statement was distributed to all health facilities in the 13 CUs.

### Community mother support groups

CMSGs were established with the support and the facilitation of the CHVs and extension workers. This was a new structure that was established within the community health strategy. Each CMSG had a committee consisting of 9-11 members selected from the community with the help of local leaders and committee members from participating health facilities. Core members of the support group included a community health extension worker, nutritionist, community health committee (CHC) representative, CHVs, a local administrator (Chief or Assistant Chief) and lead mother. Workers at the health facility, CHC members, volunteers and extension workers as well as the nutritionist supported the identification of appropriate members. Other members included religious leaders, opinion leaders, birth companions and other representatives in the community, for



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instance, young mothers below the age of 18. The group met every two months. The role of the CMSG committee was to:

- Oversee, plan and execute community meetings on the BFCI;
- Mobilise all the community members to participate in the BFCI activities;
- Support the CHEWs and nutritionist in monitoring and documenting monthly the BFCI activities at the community level;
- Monitor and document the MIYCN activities in the community on a monthly basis.

While the plan was to have one CMSG established in each unit, some units like Solian established three support group committees, each with a supervisory area because they had established four Mother-to-Mother Support Groups (see below) which were very far apart. CMSG members organized baby friendly meetings in the community where all members of the community were involved, including pregnant and breastfeeding mothers recruited in the study as the primary targets, their family members (mostly spouses and other influencers like mother in laws and grandmothers), traditional birth attendants, herbalists, political leaders like Member of the County Assembly (MCAs) and ward representatives. Through these meetings, the CUs were able to request for other resources from the county, such as additional beehives for their income-generating activities (IGAs).

## Mother-to-mother support groups

Mother-to-Mother Support Groups (M2MSGs) were established in all the six CUs in the intervention group. Members of these support groups met every month for peer support. A total of 13 such support groups were established. They consisted of pregnant and breastfeeding mothers who came together to learn about and discuss issues regarding pregnancy, infant and young child nutrition and other health related issues. Pregnant and lactating mothers in the intervention group were recruited by CHVs and the lead mothers during home visits, ANC visits and other community gatherings. Each support group had 9-15 members. When the membership exceeded 15, a new mother support group was established. So Solian had four support groups, Kiptuno had three, Esageri and Tugumoi had two each, while Toniok and Simotwet had one each. In some CUs, M2MSGs also incorporated husbands, traditional herbalists and even grandmothers. Each mother support group had a leader known as the lead mother who worked with the community health volunteer in facilitating group activities and acted as a link between the mother-to-mother support group, the CMSG and the health facility. The lead mother supported the CHVs in collecting the BFCI data as well as identification and referral of mothers to the support group.

## Income generating activities for community units

Entrepreneurial projects such as horticultural farming, livestock and bee-keeping were started as income generating activities (IGAs) by the CUs. All the CUs received seed grants to establish

IGAs of their choice. These projects were based on economically viable activities to help address concerns about income and livelihood. Every member of the community unit including CHC members and the CHVs participated in these activities while carrying out their regular project activities under the supervision of CHEWs. To ensure viability and sustainability of the income generating activities, the CUs were linked with Hand in Hand East Africa (HiH-EA), a non-governmental organisation (NGO). The mission of HiH-EA is to reduce poverty through enterprise development and job creation. The NGO assisted the CUs to formally register as self-help groups (SHGs) and community-based organisations (CBOs), trained them on business proposal development, financial management and assisted them in establishing the IGAs. The NGO also connected the CUs to potential markets to sell their produce. For instance, some units were connected to African Bee Keepers Ltd. who provided them with additional training on harvesting techniques and honey processing.

## Support supervision and mentorship

The SCHMT, assisted by the CHEWs provided support supervision to the CUs on a regular basis, usually at the end of each quarter. As part of the supervision, they reviewed work done by the CHVs during the household visits, IGAs and the reports being collected and filed at the health facilities. In addition, they provided on-the-job training on further elements of the BFCI to healthcare workers at health facilities in the intervention group. They also used this time to address any questions or issues at hand.

**Table 2: Structure of the intervention**

Activity	Intervention	Control
Distribution of MIYCN educational materials	✓	✓
Supportive Supervision	✓	✓
CHV motivation package (seed money and training for income generating activities)	✓	✓
Information, communication and educational materials	✓	✓
Counselling tools including aids	✓	✗
Orientation of the health workers, CHVs and extension workers on the BFCI	✓	✗
Community mother support and M2MSGs formed for mothers of infants and young children in the communities	✓	✗

## Evaluation of the intervention

Prospective household level evaluation with participating mothers as well as cross-sectional qualitative community-level evaluation at baseline (formative), mid-line and at end-line was conducted. The evaluation involved interviewing intervention participants, their families, community leaders, CHVs and extension workers as well as healthcare workers in the link facilities and the SCHMT

members. The evaluation aimed to determine their knowledge and perceptions about the project, achievements, implementation challenges, and suggestions on possible measures to improve the intervention. At the end-line, we sought to understand their opinions and perceptions regarding the impact including achievements and successes of the project.

## Findings

A total of 823 pregnant women were recruited into the BFCI trial. The intervention group had 351 (42.6%) women while the control group had 472 (57.4%) women.

### Maternal and child health services

As shown in Table 3, 64% of women attended the minimum recommended four ANC visits (79% in the intervention group and 54% in the control group;  $p < 0.05$ ). Likewise, 94% of women delivered in a health facility assisted by a skilled attendant (97% in the intervention group and 92% in the control group;  $p < 0.05$ ).

With regards to immunization, 85%, (94% in the intervention and 76% in the control group;  $p < 0.05$ ) had the vaccination card. Based on card and recall, 65% of children had obtained all the vaccine doses required by the age of six months, including OPV0 (75% in the intervention compared to 56% in the control group;  $p < 0.05$ ).

### Breastfeeding, early feeding practices and complementary feeding

#### Breastfeeding

Our findings show that the intervention led to significant improvements in breastfeeding practices among the participants. Overall, 85% of children were initiated on breastfeeding within the first hour (90% in the intervention group compared to 81% in the control group;  $p < 0.05$ ). 90% of children aged 0-2 months were exclusively breastfed (95% in the intervention group compared to 86% in the control group;  $p < 0.05$ ). While 88% of children in the intervention group were reported to be exclusively breastfed for six months, 44% were reported as so in the control group ( $p < 0.05$ ). This is summarized in Table 3..

Narratives from participants and their families indicated that the intervention was important in influencing higher rates of exclusive breastfeeding in the intervention group. Community members narrated that before the intervention, infants as young as two weeks old would be fed on light solids and liquids but this changed after the intervention.

#### Breastfeeding mother, Simotwet CU

“There are many changes because, say like feeding the baby, we used to know that you could give birth to a baby and start feeding him/her even after 2 weeks, the people of old used to teach us like that. But we have been told that when you give birth to a child, you should breastfeed him/her for 6 months and then after that, you now start feeding him/her after she/he has reached 6 months.”

The community reported a decrease in harmful traditions like the practice of giving herbal concoctions to women who have just given birth and their newborns because of their perceived medicinal value. The changes in breastfeeding and early feeding practices were attributed to the nutritional counselling given to pregnant and breastfeeding women, as women were said to practice the knowledge gained.

#### Herbalist, Esageri CU

“Since the guidance and counselling started, we have seen that there are very many new changes in the community. We were giving our babies herbs which are harmful to their stomachs but it has now stopped. We have also been taught on the importance of toilets and treating water which has really assisted us. Now many toilets have been built and we are treating our drinking water.”



“Community members narrated that before the intervention, infants as young as two weeks old would be fed on light solids and liquids but this changed after the intervention.”

## Complementary feeding

Complementary feeding practices were also better in the intervention compared to the control group. About 45% of children aged 6-8 months were fed on a minimum acceptable diet (55% in the intervention group compared to 36% in the control group;  $p < 0.05$ ). While there was no variation in terms of meal frequency, with 99% in both groups attaining the minimum meal frequency, there was variation with regards to dietary diversity. About 60% of children in the intervention group attained the minimum dietary diversity, compared to 37% in the control group ( $p < 0.05$ ) as shown in Table 2.

### Sub County Health Management Team member

“The training the CHVs were given when the project came into being, enhanced their knowledge on various issues like complementary feeding, growth monitoring, the use of counselling cards among other key information. Now as they go round they have their tools of trade which, help them to teach the community.”

### Breastfeeding mother, Kiptuno CU

“They (CHVs) tell us how to take care of the children, how to feed the babies. They even told us that up to six months you just give the child breast milk. Then when it reaches six months, you start giving mashed food. It should be a really balanced diet. They have really helped us. They have also told us to be attending (the) clinic. Like me, they found me when I was two months (pregnant) but I went to the clinic four times - even more than four times. They taught us how to use nets (mosquito nets), family planning, so many things.”

## Nutritional status

The nutrition status among the children was generally better in the intervention arm when compared to the control. Those in the intervention arm had significantly lower levels of underweight compared to children in the control arm. However, there was no statistically significant difference with regards to wasting and stunting. Only 2% of children were underweight in the intervention arm compared to 10% in the control group ( $p < 0.05$ ). A smaller proportion of children (8%) in the intervention arm were wasted compared to those in the control arm (12%), while stunting levels tended to be higher in the intervention group at 31% compared to 25% in the control arm. However, the differences were not statistically significant in both cases ( $p > 0.05$ ).

When stratified by age categories, children in the intervention group younger than 6 months and those aged 6 months or more, had statistically significant lower levels of underweight when compared to the control group. There was no statistically significant difference with regards to stunting in both age categories. For wasting, there was no statistically significant difference by intervention status for children under six months. However, for children aged six months and above, more children in the control group were wasted (12%) compared to the intervention group (4%) ( $p < 0.05$ ). Wasting remained constant in the control group in the two age categories at 12%, however, in the intervention group it fell from 11% during the first six months to 4% from six months onwards.



“About 60% of children in the intervention group attained the minimum dietary diversity, compared to 37% in the control group...”

**Table 3: Key indicators for maternal and child health and nutrition**

Indicator	Intervention (%)	Control (%)	Total (%)	p-value
<b>Maternal and Child Health Services</b>				
<b>Antenatal and delivery care</b>				
Focused ANC	78.5	53.5	64.4	<0.001
Delivery at health facility	96.5	91.7	93.8	0.074
Skilled delivery	96.5	91.7	93.8	0.023
Low birthweight (<2.5kg)	2.3	3.5	3.0	0.450 (NS)
<b>Immunization</b>				
Immunization - card/book seen	94.3	75.6	84.5	<0.001
Full Vaccination with all vaccine doses required by six months including OPV0	74.6	55.6	64.7	<0.001
BCG	98.9	99.4	99.2	0.573 (NS)
Full OPV (OPV 0-3)	80.5	71.5	75.8	0.010
Full OPV (OPV 1-3)	75.6	80.9	78.1	0.125 (NS)
Full pentavalent (Pentavalent 1-3)	82.6	83.3	83.0	0.818 (NS)
Full Rotavirus (Rotavirus 1 & 2)	73.4	66.0	69.5	0.051§
Full Pneumococcal (Pneumococcal 1-3)	83.7	74.7	79.0	0.007
<b>Breastfeeding &amp; complementary feeding</b>				
Immediate initiation of breastfeeding	89.5	80.8	84.6	0.007
Exclusive breastfeeding for children below two months	95.0	86.0	90.1	0.001
Proportion reported to be exclusively breastfed for 6 months	87.8	43.8	63.0	<0.001
Attained minimum dietary diversity	59.9	37.2	48.2	<0.001
Attained minimum meal frequency	99.0	99.1	99.0	1.000
Attained minimum acceptable diet	55.4	35.8	45.2	0.004
<b>Nutrition status for all ages</b>				
Underweight	2.3	10.1	6.8	<0.001
Stunting	31.0	25.3	27.7	0.100 (NS)
Wasting	8.3	12.4	10.7	0.097 (NS)
<b>Nutritional status by age category</b>				
Underweight among children <6 months	3.0	8.4	6.3	0.026
Underweight among children 6+ months	1.4	13.3	7.4	<0.001
Stunting among children <6 months	30.8	24.1	26.7	0.134 (NS)
Stunting among children 6+ months	31.2	27.5	29.3	0.514 (NS)
Wasting among children <6 months	11.0	12.4	11.8	0.668 (NS)
Wasting among children 6+ months	3.9	12.4	8.8	0.022

NS=Not Significant at 5% level of significance; §=Borderline significance

## Experiences with community mother support groups

More than 200 women in the intervention units were recruited into 13 CMSGs. The women participated in activities around the preparation of nutritious foods for their babies and other family members through cooking demonstrations, practical lessons on feeding children beyond six months, the importance of exclusive breastfeeding for the first six months, proper hygiene, ante-natal and post-natal care visits. They were also trained on income generation, among other activities.

### Breastfeeding mother, Kiptuno CU

“We have learned, we even have a merry-go-round, we have learned how to feed children, (about) balanced diet, exclusive breastfeeding... starting clinic early, they even tell us that our husbands should take us to the clinic.”

The inclusion of major MIYCN influencers in the community like herbalists, traditional birth attendants, spouses, community leaders in the CMSGs contributed to their success. Champion mothers who promote exclusive breastfeeding also ensured that mothers could relate to experiences of women just like themselves who had successfully practised exclusive breastfeeding, among other MIYCN practices.

### Community Health Extension Worker

“Mothers have come to know that, like breastfeeding a child exclusively for six months without adding any other food is good and it’s important and it has helped them and we have proved that it is true, because as of now, we have champion mothers who have come out and said they have done exclusive breastfeeding as one of the objectives we have been doing in The BFCI and in my opinion I see it is a project which is helping.”

A few challenges were encountered with the CMSGs, mostly arising from the lack of tangible incentives for participating women and their families.

## Experience with income generating activities

Throughout the 13 CUs, more than 30 IGAs were initiated and established by the CHVs and the community health committees, translating to an average of two IGAs per unit. The IGAs ranged from table banking which is a form of pooling money together and lending back to group members at a favourable interest rate, to agri-business activities such as farming of maize, beans, peas, millet, vegetables, grass (hay), and oats. Other activities that the groups engaged in were rearing of rabbits and chicken, bee-keeping and honey processing, soap making and yoghurt preparation. Our evaluation findings show that some CUs had doubled the seed money advanced to them within a year of setting up the IGAs.

### Sub County Health Management Team member

“I can say actually they have been able to benefit because some of them have been able to double the money they have been given. Like Solian as we talk now, they are going to almost 150,000/-, from the initial (amount) that they had been given of around 80,000/- because now the project has given them around 100,000 to date.”

The greatest contribution of the IGAs has been the economic empowerment of the CHVs and other group members as they gained access to low-interest loans through table banking. Involvement in IGA activities has also enhanced teamwork among the CHVs, extension workers and committees.



“Champion mothers who promote exclusive breastfeeding also ensured that mothers could relate to experiences of women just like themselves who had successfully practised exclusive breastfeeding...”

### Sub County Health Management Team member

“Some of the CHCs also are members of these IGAs, they have been incorporated into the IGAs, and even some of our CHEWs are members of the IGAs. So actually the reason why we did that is to ensure that the entire workforce work(s) in togetherness ... that is why we have been having them, when they have IGA meetings, you find our CHEW is there, the CHC is there and the CHVs.”

Benefits accruing from the IGAs included members being awarded a small stipend during the monthly reporting meetings, lower prices for farm produce and elimination of the need to travel to the central market to buy foodstuffs. Other benefits

extended to the CMSG meetings, where participants were provided with snacks and refreshments bought from the income raised by the CUs.

However, the IGAs also experienced some challenges at the initial stages of establishment. Some community unit members felt that the seed money should have been divided among the members while others felt that the money was not enough to establish any significant project and were, therefore, reluctant to start anything. This situation led to protracted discussions on what kind of IGAs to implement, with some members pulling out of the activities. Other challenges that affected the rollout and implementation of the IGAs included a change in weather patterns that threatened failure of crops, as well as undependable land leases to carry out IGAs that involved farming.

## Achievements, challenges and lessons learned

### Achievements

- i Support to the community health strategy (CHS) in Koibatek sub-County through:
  - Training of healthcare workers, CHVs and the SCHMT on the BFCI. This has enhanced the capacity of the health care system in promoting maternal and child health in the sub-County.
  - The project has strengthened the health care referral system by equipping CHVs with the right tools.
- ii Enhanced the capacity of CHVs to collect and file good quality data that can be used for planning purposes in the sub-County.
- iii Contributed to the development of the BFCI tools and materials including improved CHV counselling cards; information, communication and educational material; monitoring and supervision tools; and the National Guidelines for Implementation of the BFCI program in Kenya that was launched in 2016.
- iv The model that incorporates IGAs to incentivize CUs and CHVs was a successful public-private partnership. The CHVs were trained on IGAs by the NGO - Hand in Hand East Africa. Establishment of the IGAs was supported by seed grants from the project funds while the Baringo County Government donated beehives and goats to two of the CUs in the project.
- v The project became a model for other implementers such as the Ministry of Health, UNICEF & World Vision as well as the County Governments of Kericho, Kisumu, Garissa and Nandi.
- vi The community mother support group was a unique model that involved other community members including spouses, opinion and administrative leaders and health professionals in providing support to the mothers. In some of the groups, mothers initiated IGAs which was an unanticipated outcome.

### Challenges encountered

- i CUs and CHVs who were used to receiving stipends found it difficult to accept and get involved in the group income generating activities. Some CHVs dropped out of CUs which reduced the number of CHVs involved in the project.

However, this challenge occurred in only two of the units; one in the intervention and the other in the control arm. Generally, most of the CHVs remained involved and the projects were said to be successful.

- ii There were some challenges in the supportive supervision offered by the health extension workers and the SCHMT. Some health extension workers left their units for various reasons including further studies and reallocation of duties. New extension workers joining the project had to undergo orientation on activities which required time and resources.
- iii Only 13 out of the targeted 26 CMSGs were formed. The biggest hindrance to setting up and sustaining the activities of these support groups was a lack of tangible incentives. However, in cases where the CMSGs were established and running, participants - especially mothers in the group - came together to establish their own income generating activities, strengthening the peer support they offered to each other.
- iv There were some challenges in the commitment of some of the health care providers who were to carry out counselling in health facilities as set out in the eight-point the BFCI implementation plan.

### Lessons Learned

- i Working with and leveraging on the community health strategy, combined with the involvement of the SCHMT to offer supportive supervision is vital for the success of such initiatives.
- ii Initiating IGAs for CUs instead of providing monthly stipends for CHVs is a viable and potentially sustainable approach to incentivizing them. However, not all IGAs were successful and there is a need to further investigate ways of further strengthening them to ensure feasibility as a potentially sustainable, lower cost model for ensuring availability of CHVs.
- iii The CMSGs called for participation of a wide range of community members and influencers to support pregnant and breastfeeding women. These groups also provided mothers with an opportunity to initiate IGAs similar to those in the community units, which is likely to have enhanced the sustainability of these groups.

## Conclusions and recommendations

The study demonstrates the potential feasibility and effectiveness of the BFCI in promoting optimal infant feeding practices and health outcomes. Projects with the objective of enhancing maternal and child health can leverage on the community health strategy framework. CHVs who are the principal pillar of the community health strategy, cover a lot of ground and have the goodwill of their communities to influence change. They are also accessible to the community for consultation and can communicate in a language that's easy to understand. CUs can be transformed into economically viable groups through income generating activities. This will not only earn them an income, it will act as a common bond and facilitate regular meetings where they can challenge and encourage each other in their work. CMSGs are an innovative way of leveraging peer support for mothers, and these can be transformed into income generating groups for the mothers to ensure long-term sustainability. This pilot study recommends implementing the BFCI model in other settings in Kenya and calls for further research on how to translate the strategy to scale.



## Programs and institutions

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