

7. Understanding infant feeding practices: Qualitative research methodologies used in the weaning project

By Marcia Griffiths

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Marcia Griffiths describes her experience in a number of different countries in developing a qualitative approach to understanding infant weaning practices and designing effective programmes to improve them. The countries included Indonesia, Cameroon, Swaziland, Ecuador, Ghana, and Zaire. The formal RAP guidelines owe a great deal to her experiences in this programme, and particularly to her introduction of the use of focus groups for this purpose. - Eds.

A CRITICAL FEATURE of successful public health programmes is that managers know the programme's clientele and tailor policies and activities to meet needs in an acceptable manner. Less successful programmes are often explained with such phrases as "we never anticipated that people's reactions would be..." Social science researchers can enhance programme success by offering managers a more succinct view of their clientele. However, managers seldom have large budgets for research. This means that effective research which is planned must be completed quickly, below cost, have immediate relevancy for programming, and yield new, useful insights on the clients' perspective. The methodology used in The Weaning Project, to explore and better understand young child feeding practices, met these criteria. It was:

1. Consumer-based, and as open-ended and free of researcher bias as possible;
2. Relevant for programming purposes, particularly the design of communications and training activities;
3. Adaptable to different situations (the same basic protocol was used in six countries);
4. Replicable or manageable by professionals with limited research experience; and
5. Relatively quick and affordable in many development projects. The methodology used in The Weaning Project is the product of nine years of project experience with consumer research, most of it related to the exploration of infant and young child feeding practices.

Historical perspective

In the mid-1970s, in Nicaragua and the Philippines [1] for the design of a weaning food and oral rehydration education program, local researchers were trained to apply basic survey techniques

and some open-ended questions with consumers, not too different from the KAP surveys traditionally, and still, done by health educators. Fieldwork took about two months. Evaluations of the resulting educational programs showed their weaknesses were due primarily to the fact that the initial research had been too "researcher-determined" and missed many subtleties needed for message design.

In the late 1970s, research was designed for a nutrition education project in Indonesia [2, 3] in a modified ethnographic style, with open-ended, detailed studies (interviews and observations) in carefully selected communities in the program area. In addition to the ethnography, an innovative step was added: participatory research borrowed from marketing. Mothers were asked to try out potential recommendations to get their reactions to preliminary messages and to solicit their contributions to revising the proposed suggestions for changes in standard practices. This worked well. The resulting educational program was associated with improvements in practices, increased intake of calories and protein, and improved nutritional status among children under 24 months. However, this methodology required nine months of fieldwork and from design through analysis, it took almost a year and a half. The process was guided by a full-time expatriate nutritional anthropologist. Not all programs have that luxury.

Following on this success, the challenge was raised to reduce research time and to incorporate more techniques that would help better understand lifestyle context: aspirations, desires, fears, attitudes toward child rearing, etc. For work in the early 1980s a component of focused group discussions was added, but the step of the trial of practices and much of the other contextual information gathering, typical of ethnographic research, was eliminated. This work was more like a rapid assessment. In the Dominican Republic, the process took about two months [4]; in Ecuador, about three months, from planning through analysis [5]; in India [6], about six months before the special step of the trial of recommended practices was added. Again, almost full-time guidance from a nutritional anthropologist was provided. While the resulting programs in the Dominican Republic and Ecuador were relatively successful, there was a feeling among project personnel that the education would have been better if the research plan had allowed for more exploration of the reasons for mothers' practices and particularly their willingness to change.

Based on these experiences and other work in nutritional anthropology [7], The Weaning Project developed a protocol for exploring young child feeding practices and refined it in six countries.

The complete protocol was first implemented in Indonesia and Cameroon and included a large amount of foreign technical assistance [10]. Later, in Swaziland, Ecuador and Zaire, the most salient pieces of the multi-step protocol were chosen, modified, and implemented primarily by host-country researchers, with periodic technical assistance [11]. After these experiences, there was an opportunity to utilize the protocol in Ghana. Again, based on experience, the protocol was reduced further and this time implemented with only brief orientation from expatriate consultants.

Methodology

Many of the decisions made in designing the methodology and writing the protocol were to allow researchers to go beyond the usual researcher-determined questions about feeding practices and to explore with mothers, in their terms, how they make decisions. To do this, techniques from market research, anthropology, and nutrition assessment were combined to help researchers understand, not only the importance of the different determinants of infant feeding practices, but also the lifestyle context in which infant feeding decisions are made.

The assessment methodology has several characteristics:

1. It is basically qualitative, with some quantitative analyses.
2. It has several steps, each of which builds on the preceding one, so there is limited duplication effort.
3. It is in-depth, to explore the reasons behind everyday practices, beliefs and perceptions.
4. It is rapid, although this depends on what "rapid" means. In the first countries where it was implemented in pilot regions, the process took a year. Now, the time has been reduced to six months for a national assessment.
5. Its implementation requires minimum technical assistance, although it does require a principal investigator with knowledge of qualitative research.

The protocol is divided into four parts, corresponding to the research phases. Each phase has several steps. Not all of the steps need to be done in every situation.

Generalized protocol

STAGE ONE: PROBLEM IDENTIFICATION

GOALS

1. Find critical problems impeding proper feeding and care of children;
2. Identify resources to solve problems. (Resources include physical and financial resources as well as outlooks and attitudes.)

METHODS

1. *Literature review.* A compilation of relevant information from all previous research. Most of this research is quantitative in nature; therefore, the review serves as a springboard for the design of the qualitative study and as a check on the results ultimately obtained from the qualitative process.

2. *Focused group discussions*. These are extremely open-ended and explore maternal roles, sense of control and confidence, ideas about child rearing, aspirations for children, general feeding practices, and images associated with certain practices.

3. *Ethnography*. This is a community and household exploration of food availability, women's time availability, cultural norms about child feeding, ceremonies, people who influence feeding decisions, the details of food preparation, serving and consumption, childhood morbidity, etc. It usually includes child anthropometry and dietary recall.

COMMENTS

After the Indonesia and Cameroon experiences, stage one was modified:

1. Unless there are persons skilled in focused group discussions with in the country, the discussions are eliminated because it has proved too difficult to train people to get quality information using this technique.

2. The ethnography has been collapsed to in-depth household interviews and observations and some key informant inter views. The extensive questioning on food grown and purchased, on relationships between family members and on ceremonies, was dropped. Although more limited, the work is structured judiciously the households are selected carefully. They include a range of different age children, usually under two years old, and favour children who are growing well or who are undernourished.

Depending on the scope of the work, this initial phase can take up to three months, including planning and training investigators.

STAGE TWO: ANALYSIS

GOALS

1. Determine nutritional benefit or harm from current practices;
2. Identify modifications in practices and rationales for them.

METHODS

1. *Case histories*.

2. *Dietary analyses and group feeding histories*.

3. *Tabulations and content analysis of the different topics*, including dietary analysis by geographic area, the age and/or nutritional status of the child, by the amount of time the mother spends with the child, etc.; and

4. *Matrices to compare ideal and real practices* and list major resistances or motivations that may influence a change in the practice.

COMMENTS

This process is done at research headquarters and takes about a month. Most research methodologies end at this point. It is noteworthy that in The Weaning Project, this was not the case.

STAGE THREE: INTERVENTION OR CONCEPT TESTING

GOALS

1. Determine what mothers are willing to try and why;
2. Confirm what mothers can do over a brief time period;
3. Retest the successful concepts with even more mothers.

METHODS

1. *Participatory research* where the researcher returns to the homes of mothers who participated in the in-depth interviewing and provides information to these mothers about their children and discusses with them their willingness to try new practices. Then, with some mothers, the researcher actually asks them to do it - for example, to try to give their children one more meal, or a snack between meals, or to make a different weaning food. The researcher returns to the home to see if the mother has been able to follow the recommendation and if so, exactly what she has done. This step has proved easy to do and analyze once the recommendations have been decided upon. This step is indispensable.

2. *Focused group discussions*: The most successful ideas and practices to emerge from the trials are taken to other communities where focused group discussions are held to get the "top-of-the mind" responses to the new ideas from people who have not participated in the earlier work and to get reactions from health workers and clinic nurses - those responsible for disseminating the new information.

COMMENTS

This phase takes four to six weeks from planning through analysis.

STAGE FOUR: SYNTHESIS

GOALS

1. Review all of the information;
2. Synthesize information from the problem identification and concept testing phases;
3. Write a brief for programme designers.

COMMENTS

This report serves as the basic reference for those making strategy decisions and developing the creative work. It is the link so often missing between researchers and programmers. The style in which it is written is abbreviated to assist programmers to find the facts quickly and to understand recommendations about what to do.

The report contains the following sections:

1. The environment or lifestyle of the population;
2. A summary of current infant feeding practices;
3. A list of the most promising practice improvements, the major resistances to change and the possible motivations to stimulate change;
4. A review of potential media - their reach and the frequency with which they are heard or used.

The total time for this type of assessment is about six months.

Sample results

In The Weaning Project new information was abundant. Results common to almost all of the projects include:

1. *The importance of maternal self-confidence in child feeding* [12]. A mother's level of self-esteem and confidence seems to determine the amount to which she is swayed by her child's response to foods. It appears that in general mothers with well nourished children have more self-confidence they introduce foods when they feel it is right rather than when the child takes them. If they stop breast-feeding early, it is more likely to be because they want to than because of their child's reaction; they are more likely to persist in feeding their child when the child refuses; and they are more willing to try new foods and practices.
2. *The significant role of fathers*. Fathers seem to be playing, or seem willing to have a larger role related to child feeding. This was unexpected. Fathers are often the ones to convince when it comes to the purchase of "special," calorie-dense foods for young children.
3. *Using store owners and food vendors*. These community members hold great potential for disseminating some of the program messages, especially those related to foods. These people are often the most stable and abundant "medium" in the community and, in many instances, are knowledgeable about food-related topics.
4. *Establishing priorities among the different factors in child feeding by the age of the child*. That is, concepts of nutrient density, feeding frequency, and food quantity are difficult for mothers to accept all at once. For them, each component is appropriate for different aged children. The message then must be tailored by the mother's perceptions. For example, for infants four to six months, it is important and acceptable to focus on the consistency of food (decreasing its water content); from seven to 11 months - on feeding frequency and food variety; from 12 to 24 months - on feeding frequency and food quantity.

5. *The early onset of the weaning process.* While this varies by country, in several places there was no period of exclusive breast-feeding. There is an increasingly popular tendency to introduce foods early to "accustom the child to food." A priority of The Weaning Project has been to address this problem, in part by enhancing women's confidence in their ability to breast-feed their infants.

6. *The worst characteristics of daily feeding pattern occur during and following illness.* If mothers already allow children to determine their own feeding patterns, they will do so even more during illness. If mothers give only a small amount of food regularly, they will further reduce the quantity for an ill child. However, mothers generally continue breast-feeding and do not withhold food because they think they should, but because the child "just won't eat."

The six months that researchers spent to gain these types of insights into weaning problems and solutions was cost effective. The resulting programmes have been successful in achieving improvements in practices and those improvements have improved dietary intake and young children's nutritional status [13, 14].

Endnote

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