

SAVING
LIVES
CHANGING
LIVES



Knowledge, Attitudes and Practices (KAP) Study

On maternal nutrition, infant and young child feeding, sanitation and hygiene, and sexual and reproductive health, including obstetric fistula, in Chemba District, Sofala

*Gender Transformative and Nutrition-sensitive (GTNS)
Stunting Prevention Project in Mozambique 2019-2021*



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ACRONYMS

ADA	Austrian Development Agency
ANC	Antenatal Care
APEs	Agentes Polivalentes Elementares
CEDAW	The Convention on the Elimination of all Forms of Discrimination Against Women
CHW	Community Health Worker
CU2	Children under two years of age
DD	Dietary Diversity
DO	Direct Observation
DPS	Provincial Health Directorates
EBF	Exclusive Breastfeeding
FEWS Net	Famine Early Warning System Network
FFA	Food Assistance for Assets
FGD	Focus Group Discussion
GTNS	Gender Transformative and Nutrition Sensitive
GDC	Gender Dialogue Club
HF	Health Facility
HSB	Health-Seeking Behaviour
IFPRI	International Food Policy Research Institute
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
KII	Key Informant Interviews
MAD	Minimal Acceptable Diet
MoH	Ministry of Health (MISAU)
MN	Maternal Nutrition
MODA	Mobile Operational Data Acquisition
OF	Obstetric Fistula
PHL	Post-Harvest Loss
PLW	Pregnant and Lactating Women
PQG	Programa Quinquenal do Governo
PW	Pregnant Women
SBCC	Social and Behaviour Change Communications
SDGs	Sustainable Development Goals
SDSMAS	District Services of Health, Women and Social Action
SEM	Socio-Ecological Model
SETSAN	Technical Secretariat for Food Security and Nutrition
S&H	Sanitation & Hygiene
SRH	Sexual and Reproductive Health
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
WFP	World Food Programme



*Photo Caption: A community member
Photo Credit: Nilda Lima*

I. EXECUTIVE SUMMARY

The KAP (Knowledge, Attitudes and Practices) Study is one of three key studies within the Gender Transformative and Nutrition-sensitive (GTNS) project, following the recent baseline study and gender analysis. Together, these studies will inform the GTNS implementation and the SBCC field strategy. Applying a mixed methods quantitative and qualitative approach, the KAP study sought to complement information concerning components of the project that were not covered by the baseline study.

The objective the of the KAP Study was to explore key aspects related to nutrition to better understand the community's knowledge, perception and practices around maternal nutrition, infant and young child feeding, sanitation & hygiene, and sexual and reproductive health, including Obstetric Fistula.

Key Findings & Recommendations

1. First 1,000 days of life

The first 1,000 days of life are a window opportunity to ensure a child's health and nutrition. KAP Study participants were unable to specify which kind of adequate care and diet are required for proper child growth and development.

1.1 Strengthen partnerships with key health facilities near project sites to leverage their support for successful project implementation.

1.2 Develop and broadcast semi-regular radio programmes targeting caregivers on the importance of the first 1,000 days of life using key SBCC messages for this critical time period.

2. Health of Pregnant and Lactating Women (PLW) and Children Under Two Years of Age (CU2)

The KAP Study data showed that malaria and diarrhoea are considered the diseases that most affect children. Preventing these diseases is crucial and their impact on nutritional status should not be underestimated. The beliefs concerning treatment of these diseases pose barriers to accessing proper care, where a non-trivial amount of people mentioned the need to seek out traditional healers.

Findings also showed women are not resting as much as they should during pregnancy. Physical effort and a high household burden have negative effects on pregnancy and a woman's health during this period. While the majority of men indicated their intention to support their wives during pregnancy, many wives indicated needing support from their husbands during pregnancy and lactation. This includes, but is not limited to, support with domestic tasks, lifting heavy items, and accompanying them to antenatal care (ANC) and children consultations.

2.1 Engage traditional healers in SBCC messaging to leverage their community influence in improving children and PLW health and nutritional outcomes.

2.2 Improve sensitisation of key health facility staff near project sites on the link between gender and nutrition to ensure greater engagement of men in women's care.

3. Maternal Nutrition and Care of PLW & baby (0 – 6 months)

The overwhelming majority of KAP Study participants are not knowledgeable about maternal nutrition during pregnancy, with only a small number of KAP participants able to identify the four food groups for an essential diet for PLW. While, the KAP Study showed that PLW reported eating between 2-3 meals per day, micronutrients were missing. This indicates poor attitudes and practices around nutrition and diet during pregnancy among the target population. The situation is more serious in remote areas, where people have less access to information.

Findings showed that a poor diet was not only related to food scarcity, but also to a lack of information on how to better use local resources for a more nutritious and balanced diet for PLW. It should be highlighted in the communities that an investment in nutrition is an investment in future income.

Breastfeeding is widely practiced; however, exclusive breastfeeding remains low among lactating women. Despite the fact that they are knowledgeable about the importance of exclusive breastfeeding, they believe that breast milk alone is not enough. The main barrier to the adoption of exclusive breastfeeding is not knowledge, but attitudes – the community's preconceived ideas towards this issue.

3.1 Support mobile brigades to prioritise dissemination of information in remote communities on proper diet and care for PLW and provide basic health services to women facing barriers in consuming a nutritious and balanced diet.

3.2 Sensitise community members through existing SBCC activities and an additional livestock-rearing component to use locally available food sources to improve maternal nutrition.

3.3 The SBCC strategy should change from an awareness raising campaign to a behaviour change campaign, focusing on perceptions of the benefits, risks and seriousness of the issues around exclusive breastfeeding.

4. Infant and Young Child Feeding (IYCF)

Due to food scarcity, data showed that feeding infants and young children appropriately is a serious problem. The typical daily diet for a child under two is very poor, missing the recommended dietary diversity and not constituting a minimum acceptable diet. For most caregivers, it is difficult to feed their child a variety of foods each day. The KAP Study participants reported that they do not manage to feed their young children more than 2-3 food groups per day. It is evident that the recommended frequency of feeding children is very low. Moreover, knowledge on food consistency and quantity of food for children at each meal is very limited, leading caregivers to adopt an intuitive practice, without following any recommendations. The daily diet for a young child becomes more worrying as parents and caregivers do not have information on fortified products and, consequently, on how to choose these in the local market. Likewise, the practice of adding oil, butter, or other fats to children's diets is lacking.

4.1 Refocus the cooking demonstration strategy to be more community-focused and include messages related to food quantity and consistency and adding fats to improve IYCF diet.

5. Sanitation and Hygiene (S&H)

Safe drinking-water is the most challenging issue in all communities where the project is being implemented. The KAP Study shows that main sources of drinking water are public water pumps, ponds, streams and rivers. The KAP participants are able to distinguish safe water from unsafe water by looking at its turbidity (how cloudy it appears). Although it is recognised that muddy water is unsafe to drink and should be treated, and a majority of KAP respondents indicated they intended to or might treat their water before drinking it, it is extremely difficult for them to boil water because they do not have the resources nor the time to do so. As a result, the water they consume is unsafe. The same water is used for bathing, cleaning and doing the laundry.

5.1 Create synergies and alignment wherever possible through multi-sectoral approaches to increase the number of local water pumps.

6. Sexual and Reproductive Health (SRH)

Findings from the KAP Study revealed young people's - adolescent girls and boys - dreams: they want to finish school, make money, get a job and have a profession. Some professions mentioned were teacher, nurse, policewoman, director of a health facility and a businessperson. "Dream" was used because they are uncertain if they will succeed in achieving it as they face many obstacles. Early marriage and/or early pregnancy is not compatible with finishing school. The KAP Study highlighted that while polygynous marriages remain widely practiced and strongly valued culturally in Chemba District, young people do not intend to maintain this tradition and are much inclined toward monogamous marriage. The rationale stated by adolescents is that polygynous marriage creates instability in the family and increases household expenses. The adolescents are not only questioning both their parents' attitudes and behaviours, but also existing social norms, and ending the status quo to promote deviant behaviour instead. Adolescents emphasized that polygynous marriages have posed an obstacle for caring of PLW and children as men are not able to support all their wives and children properly.

Given their great potential to act as a positive deviant, engaging adolescents in existing community sessions on SRH and gender is crucial to bring together different perspectives and encourage productive intergenerational discussion.

Health facilities provide family planning services at community level through mobile brigades and health campaigns. For this reason, the KAP Study findings show people in the community are knowledgeable about contraceptive methods and have access to them. According to interviews, a couple should decide together on contraceptive use; however, it is understood that actually men have the final say on contraceptive use. Although a considerable number of women indicated they would continue to use contraceptives if their husbands did not agree to do family planning. It should be noted that men refuse to use condoms because they say that it diminishes sexual pleasure.

6.1 Liaise with district government education authorities and encourage supporting adolescent girls finishing school by providing technical and financial support.

6.2 Expand the target audience of the SBCC interpersonal community sessions to include adolescents from the project household in addition to the caregivers of CU2 and their partners.

6.3 Design a visually artistic complementary activity to ensure that adolescents can transform what they have learned from the community sessions into a piece of artwork that can be displayed in the community.

6.4 Design a context-specific gender action plan to further strengthen the link between gender and nutrition throughout all activities.

7. Obstetric Fistula (OF)

Fear, taboo, shame, lack of knowledge, misinformation and cultural values are the key words that come up when discussing OF. Women living with OF confine themselves to social isolation because participating in daily life was reported to bring embarrassment due to the symptoms and taboos of this disease. With that being said, women living with OF do not feel comfortable talking about their symptoms or this issue overall. Furthermore, OF is strongly associated with witchcraft, external causes, and “bad spirits”, leading to people living with OF to seek solutions by traditional healers.

There is opportunity to strengthen local government partnerships with health authorities in relation to OF. Findings revealed that treatment is only available outside of Chemba District at provincial level hospitals, where many project beneficiaries cannot travel to without support.

7.1 Develop an awareness campaign around Obstetric Fistula and its related messages utilizing the media component.

7.2 Support local and provincial health authorities in Obstetric Fistula campaigns by aligning project-supported mobile brigades and radio messages with the Mozambique national plan.



*Photo Caption: A mother with her young child from the FGDS
Photo Credit: Nilda Lima*

II. BACKGROUND

Nutritional Context

Chronic malnutrition (stunting) in Mozambique has remained relatively unchanged for the past 15 years. The Demographic and Health Survey carried out in 2011 revealed a 43% prevalence rate of chronic malnutrition in children under 5 years of age and that 6% of children under 5 are classified as acutely malnourished (National Statistics Institute (INE); Ministry of Health (MISAU), 2012). The percentage of children suffering from chronic malnutrition is higher among children living in rural areas (46%) than those living in urban areas (35%). Moreover, Sofala is among the provinces with the highest rates of acute malnutrition in Mozambique (7%), where a mere 13.7% of children aged 6–23 months receive a minimum acceptable diet (National Statistics Institute (INE); Ministry of Health (MISAU), 2012).

In addition, a study from 2015 investigating the association between child mortality rates and gender inequality found that gender inequality harms children during antenatal, perinatal, postnatal periods and during further development stages (Brinda, Rajkumar, & Enemark, 2015). The study also highlighted that a “lack of autonomy hinders women equitably accessing health, education and preventive as well as curative health services to prevent transmission of disease to their children”. Furthermore, the International Food Policy Research Institute (IFPRI) published a study that found half of the global reduction in hunger between 1970 and 1995 is likely attributed to improvements in women’s societal status (Smith, Ramakrishnan, Ndiaye, Haddad, & Martorell, 2003). Progress in women’s education access (which explained 45% of increase in food security) was nearly as significant as increased food availability (26%) and health advances (19%) together. It is believed that placing women at the centre of decision-making in food systems, dietary practices, and their own personal nutrition can improve overall health of the wider household because international evidence clearly demonstrates that empowering women is central to tackling malnutrition (European Commission, ISS FANSSA & Nutrition Advisory Service, 2019).

Sociocultural and traditional norms often result in women consuming smaller amounts of food or foods with less nutritional diversity, prioritizing the more nutritious food items for the men. Effectively understanding sociocultural structures and gender dynamics has served to strengthen results from interventions for improved nutrition practices or enforcing nutrition programmes with education on rights and advocacy skills (Root, 2019).

While Mozambique is a signatory to the Universal Declaration of Human Rights, The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), The Maputo Protocol and the 1995 Beijing Platform for Action, and ahead of the relatively stagnant nutrition outcomes in the country, Mozambique still needs to improve gender equality. In 2009, following some years of lobbying and debate, the Law on Domestic Violence Against Women (Law Nr. 29/2009) was approved (Romao, et al., 2012) and on 22 October 2019, the Government of Mozambique unanimously approved the Law for the Prevention and Fight Against Early Marriage (Law Nr. 19/2019) (Government of Mozambique, 2019). From the last data in 2013 from the DHS 2011 study, 14.3% of girls between 20 and 24 years of age in Mozambique had been married before the age of fifteen and at least 48.2% of girls in this age group had been married before the age of eighteen (UNICEF, 2015). The provinces of Nampula, Zambezia and Niassa present the highest rates of early marriage in the country, with the Province of Sofala coming sixth according to the most recent data. There is a strong correlation between early pregnancy and early marriage since the majority of teenage mothers marry very early. Furthermore, literacy rates in Mozambique stand at 71% for the population aged 15–24 years and women are significantly less literate than their male counterparts, highlighting disparities between girls’ and boys’ participation in school (UNESCO Institute for Statistics, 2020).

Project Context

The Gender Transformative and Nutrition-sensitive (GTNS) project titled “*Reaching the furthest behind first: Gender Transformative and Nutrition-sensitive programming to increase food and nutrition security for women, adolescent girls, and children in Chemba district, Sofala province*” is implemented by WFP with multi-year funding from the Austrian Development Agency (ADA) and implemented under the leadership of the Government of Mozambique and in close coordination with three implementing partners.¹ The catchment area is limited to Mulima-sede locality of the Mulima Administrative post of Chemba District. The aim of this project is to improve gender equity and women and adolescent girls’ empowerment, dietary diversity and reduce stunting among girls and boys under the age of five in the context of a changing climate.

This project is implemented through three main activities: (i) *Food Assistance for Assets (FFA)* (ii) *Post-Harvest Loss (PHL)* and (iii) *Social and Behaviour Change Communications (SBCC)*. The SBCC component addresses gender inequality with a focus on early marriage, sexual and reproductive, and health seeking behaviors. For the GTNS Project, these topics are categorized into three themes: Nutrition (infant and young child feeding, maternal nutrition, malaria prevention and sanitation & hygiene), Gender, and Sexual and Reproductive Health.

The project is projected to have the following impact: *Women and adolescent girls’ empowerment enables improved nutritional diversity and reduced stunting among girls and boys under the age of five in the context of a changing climate.* The two main outcomes of the project are (i) improved availability, diversity, and consumption of nutritious food by women, adolescent girls, and children under-two through gender- and nutrition-sensitive household and community assets creation and post-harvest loss trainings in Chemba district that contribute to climate risk management, and (ii) increased women’s and adolescent girl’s empowerment related to early marriage, sexual and reproductive health, and health seeking behaviours for basic childhood illnesses through intensive Social and Behaviour Change Communication targeted towards men, women, boys and girls.

This project supports the Government’s 5 Year Programme (Programa Quinquenal do Governo, (PQG)) Priority 2: Developing human and social capital, and aligns with the United Nations Development Assistance Framework’s (UNDAF) core programming principles, which are human rights, gender equality and women’s empowerment, resilience, accountability, and to leave no one behind. Due to its integrated and multisectoral, and innovative approach, this project has the potential to be considered a scalable reference of a nutrition-sensitive program that contributes simultaneously to the achievement of Sustainable Development Goals (SDGs) that target food and nutrition security, women empowerment, sustainable agriculture and climate change (e.g. SDGs 2, 3, 5, 12,13, and 17).

There is a significant, yet untapped, potential to contribute to a reduction in malnutrition and achievement of the Sustainable Development Goals (SDGs) through nutrition-sensitive programming. Nutrition-sensitive programming takes place in sectors and fields complementary to nutrition, such as agriculture, education, WASH and social protection and reflects the global shift towards multi-sectoral nutrition policies and programmes to end all forms of malnutrition. While there is a strong emphasis on targeting women through the various project activities, the aspect of gender transformation is further explored by engaging men through the gender dialogue clubs, thus the programme has the potential to go further in addressing sociocultural and intersectional challenges relating to equality and empowerment of women and girls.

¹ At the time of writing, the three non-government implementing partners are Pathfinder International, PCI Media and European Commission for Training and Agriculture (CEFA).

The GTNS Project has been placing a strong emphasis on building a shared understanding among male and female project beneficiaries on the added value of equal access to resources, opportunities and overall decision-making. Through this approach, and the understanding of the inherent correlation of gender equality and maternal and child nutrition, it is expected that the project will impact positively on women and girls' sexual and reproductive health (SRH), nutrition and social environment. Strengthening the voice and choice of women and girls requires challenging gender inequalities and other power inequalities that intersect with gender relations. Age is a critical factor that shapes how women and girls experience gender inequalities. Applying a life-cycle approach factors in how the intersection of age with gender shapes the expansion of choice and strengthening of voice of women and girls, and with it, nutritional outcomes.

Changing nutrition-related behaviours, which are steeped in traditional practices and social norms, requires a strategic and methodological intervention. Guided by the Socio-Ecological Model (SEM), SBCC programming plays a crucial role in addressing potential barriers to changing behaviours with a view to improving nutrition outcomes.

Under the GTNS Project, SBCC is being implemented with the aim of increasing and improving knowledge, attitudes, and practices related to:

- Gender equality and women's empowerment;
- Early marriage, sexual and reproductive health and family planning;
- Maternal nutrition, infant and young child feeding; malaria prevention and sanitation and hygiene; and
- Health seeking behaviours for basic childhood illnesses.

The SBCC component is applying a combination of three approaches, namely interpersonal communication, community mobilisation, and radio programming.

Overview of Chemba District

Chemba is a district in northern Sofala Province. It is in the central semi-arid zone with sandy-clay soils and moderate fertility. There are three geographical administrative posts: Chemba, Mulima and Chiramba. Within the Mulima administrative post, there are two localities: Goe and Mulima-*sede*. The district has 17,730 households and a total population of 87,925 (41,077 men and 46,848 women). The agricultural production is insufficient and affected by the semi-arid climate and low precipitation. All the participating communities rely on agriculture as their main livelihood. Generally, communities tend to grow maize, sorghum, millet and cow peas for sustenance, and although a few communities grow cotton and sesame seeds as cash crops, they reported limited production and low prices indicating this to be a limited income source (WFP Mozambique, 2020). All communities stated that their entire production was lost to Tropical Cyclone Idai in 2019 as a result of heavy winds and, in many locations, subsequent floods (WFP Mozambique, 2020). The few families that had managed to preserve food and seeds from the previous harvest had already consumed everything when the Gender Analysis study was conducted during the first week of November 2019, underlining the importance of the timing of the project interventions.

Chemba is prone to floods, drought, and man-wildlife conflicts. With a large segment of its population relying on their own production during at least four to five months of the year and with limited sources of incomes (agricultural labour and sale of natural products such as coal), families must rely on

consuming wild foods. During project designing, the FEWS NET Country Outlook for December 2018 to May 2019 had found that many areas in Sofala, including Chemba, were to experience crisis levels (IPC 3) of food insecurity, but the projected level is stressed (IPC 2) for October 2020 – March 2021 (FEWS Net, 2020). Another indicator of this poor situation is the status of the agricultural campaign. On average, 28.5% of crops are lost after harvesting (WFP; ICRAF, 2020).²

Similar to the national landscape, nutrition outcomes in Chemba are very poor. Stunting is prevalent in children under two years of age (CU2) and under five years of age (CU5), 33% and 38% respectively (WFP; ICRAF, 2020).³ Additionally, no child 6 – 23 months of age is reaching a minimum acceptable diet (MAD) and the prevalence of childhood illness is 71% in Chemba, with fever and malaria being the most common (WFP; ICRAF, 2020).⁴

Chemba has weak infrastructure with poor road networks and an inadequate health system that cannot provide appropriate coverage to meet needs. There are 12 health units with a catchment population per unit of 6,083 people, one hospital bed available per 1,140 people and one technical professional for 1,057 people. Long distances to health facilities, lack of infrastructure and inadequate drug supply are common problems.

Polygamy has been prohibited by the Family Law (2004), yet polygamy is a common practice in Chemba district, with most men reported to have three to four wives (WFP Mozambique, 2020). Men claimed to have more than one wife both due to cultural norms and because this increased their capacity for agricultural production as they were able to cultivate more land and thus produce more. However, during focus group discussions most communities stated that the effects of climate change in recent years have to some extent been resulting in changed dynamics with younger men opting for only one wife to limit the stresses resulting from crops failing; however, this cannot be generalised across the whole district.

² International Centre for Research in Agroforestry (ICRAF) conducted the data analysis and and ELIM Serviços, Lda (ELIM) conducted the data collection.

³ These figures are averages over the study intervention and control groups.

⁴ An average over the study intervention and control groups.

III. PURPOSE & AIM

The purpose of the Knowledge, Attitudes, and Practices (KAP) Study is to collect information in order to ensure a context and culturally appropriate project. The KAP Study accessed the environment in which programme activities are being implemented, focusing on the topics of the programme concerning **Knowledge** - *what people know and their understanding*; **Attitude** - *how they feel, their preconceived ideas towards this subject*; and **Practice** - *how they behave, how they demonstrate their knowledge and attitude through their actions* (Kaliyaperumal 2004). The KAP Study findings, therefore, will allow the project to move forward in a more effective way and ensure that activities, messages, approaches, and field guidance are more strategic.

The KAP Study aimed to provide information for the enhancement of the SBCC approach, such as:

- (i) Provide information on knowledge, attitude and practices of those in charge of children under two (CU2) in terms of maternal nutrition and child health and nutrition related issues, focusing on the first 1,000 days of life (the period between conception and a child's 2nd birthday considered a unique window of opportunity to support child development and long-term health);
- (ii) Identify knowledge gaps, cultural beliefs or behavioural patterns and practices that create barriers to Infant and Young Child Feeding, maternal nutrition, sexual and reproductive health, good practices hygiene and health seeking behaviours for basic childhood illnesses; and
- (iii) Obtain a good understanding of knowledge, attitude, and practices concerning sexual and reproductive health and gender dynamics related to early marriage and education for adolescent girls, focusing on young people (10 – 19 years of age).

IV. METHODOLOGY

The KAP Study is one of three key studies within the GTNS project, following the recent baseline study and gender analysis. Together, these studies will inform the strategy and project implementation. The KAP study explored key aspects related to nutrition to better understand the community's knowledge, perception and practices about maternal nutrition (MN), infant and young child feeding (IYCF) as well as complementing information concerning components of the project that were not covered by the baseline study, namely sexual and reproductive health (SRH), including obstetric fistula (OF), and sanitation and hygiene (S&H). The KAP Study also addressed specific gender-related issues identified in the gender analysis report in order to obtain a more comprehensive picture of gender dynamics related to early marriage and education for adolescent girls.

The KAP Study applied a mixed methods approach consisting of qualitative data collection through focus group discussions (FGDs), key informant interviews (KII), and Direct Observations (DO); and quantitative data collection through concisely formed questionnaires. The study was conducted over a period of two weeks (3 days of training, 1 day of pre-testing data collection tools, and 9 days of actual data collection) in Mulima locality, Chemba district, the geographical area where the GTNS Project is being implemented. The KAP Study Team recognizes the potential differences between knowledge, attitudes and practices between communities in more remote locations versus communities closer to resources, such as a health facility. In order to capture these differences, participating communities were selected in both remote areas and more central areas of Mulima locality. The Study Team decided to engage one community per day of data collection. The nine participating communities were chosen by random selection within two strata criteria:

- Peripheral communities (defined as more than 5 km from Mulima central health facility)
- Central communities (defined as less than 5 km from Mulima central health facility)

There are 49 communities (locally referred to as *povoados*) in the project area. According to the Mulima health facility staff, the nine communities located in Mulima-*sede saphanda*⁵ are within 5 kilometers of the Mulima health facility. The remaining 40 communities in Bangwe, Bucha, Cassume, Dzunga, Melo, Nhamaliwe and Xavier *saphandas* are more than 5 kilometers from the Mulima health facility. To ensure fair representation in the data, it was planned to consider the proportion of central and peripheral communities of the 49 project communities to calculate how many of the sample communities to be randomly selected for the KAP should be centrally located. It was determined that 18% of the 49 project communities are centrally located, resulting in a selection of 2 communities randomly selected from the list of centrally located communities for data collection (see Table 1). Moreover, 82% of the project communities are classified as peripherally located, resulting in a selection of 7 communities randomly selected for data collection (see Table 1).

⁵ There is no direct translation of "*saphanda*" or "*sede*". Mulima locality is segmented into two kingdoms, which is further divided into 8 *saphandas*. There are 49 *povoados* (village communities) within Mulima locality located within in the 8 *saphandas*. *Sede* loosely translates to the central area of an administratively recognized territory (an area smaller than a town but larger than a village) where Government services are located for that jurisdiction. In the case of *Mulima-sede*, it is both the name of a *saphanda* and a *povoado*. The Mulima Administrative Post and Mulima health facility are headquartered in *Mulima-sede povoado*, which is located in *Mulima-sede saphanda*.

Table 1: Community Information

Communities		Total reached in project	KAP Study sample
		49	9
Central	9	18%	2
Peripheral	40	82%	7

Using excel, each of the 49 communities was assigned a random number in two separate lists, central and peripheral communities (RAND function). Researchers then randomly selected 2 central communities and 7 peripheral communities (INDEX Rank). Each community had an equal chance of being selected in each list, respectively. This is a total target sample of 9 communities (see Figure 1 and Table 2).

However, when arriving at the community of Tsera, the FGD research team was unable to engage community members and, instead, FGDs were quickly organized in Mulima-sede. It is important to note here that Tsera community is classified as a “pergroup” community and Mulima-sede is classified as a “central” community. Different to what we planned in the methodology through random selection, we have a slightly higher representation of centrally located communities than the proportion found in the project catchment area. The quantitative research team was able to conduct household interviews at all the randomly selected communities, including Tsera community.

Table 2: List of Randomly Selected Communities for Data Collection

Saphanda	Central Communities	Saphanda	Peripheral Communities
Mulima-sede	Francalino	Bangwe	Zenguerere
	Niquisse	Bucha	Bucha
	Mulima-sede*		
		Cassume	Nhakuiyoyo
			Tsera*
		Melo	Melo 1
		Nhamaliwe	Candima
		Xavier	Tomucene 1

*As noted above, FGDs were unable to be conducted in Tsera community and the qualitative research team organized FGDs in its replacement community of Mulima-sede.

Note: some of the community names are spelled differently between the map and table due to translation differences by different parties.

Table 3: KAP Topics in Detail

Topics	Subtopics
<i>First 1,000 days of life and care of children</i>	<ul style="list-style-type: none"> • Importance of the first 1,000 days and Care of Children
<i>Maternal Nutrition and care of pregnant and lactating women and babies</i>	<ul style="list-style-type: none"> • Energy and protein and quality of diet intake during pregnancy and lactation • Rest and physical work during pregnancy • Breastfeeding practices: Early initiation of breastfeeding and Exclusive breastfeeding.
<i>Infant and Young Child Feeding</i>	<ul style="list-style-type: none"> • Continued breastfeeding and timely introduction of complementary foods • Dietary diversity • Fortified foods • Food preservation • Frequency of feeding children • The quantity of feeding children at each meal • Food consistency and variety • Adding fats or oils to children’s foods • Responsive/active feeding • Feeding during and after illness
<i>Sanitation & Hygiene</i>	<ul style="list-style-type: none"> • Critical handwashing times • Safe drinking-water • Sanitation and Open defecation
<i>Sexual and Reproductive Health and education for adolescent girls</i>	<ul style="list-style-type: none"> • Sourcing SRH Information • School attendance during menstruation • Early marriage and education • Pregnancy • Contraceptive methods • Safety of abortions • Obstetric Fistula <ul style="list-style-type: none"> • Recognition of symptoms • Health seeking behaviour • Taboo and stigma

Data Collection

1. Qualitative sample and instruments

(i) Focus Group Discussions (FGDs)

Detailed FGD guides and questions were developed in close coordination with the quantitative team (see Annex 1). The discussions were held in the local language, Sena, and translated into Portuguese by a local translator. Illustrations related to the topics were used to stimulate discussion and engage the participants. The FGDs were facilitated by the main researcher and the notes of the focus group discussion were taken by the main researcher and the research assistant. The FGDs consisted of 8 - 12 participants each. Only one member of each household was selected in order to avoid mutual influence in the responses, except for the group comprised of caretakers of CU2 where both parents were invited to participate. It was not preferable to have project beneficiaries participate in the Study, but during discussions it was realized that some participants were beneficiaries. The qualitative research team took into consideration this fact and reworded questions to avoid socially desirable responses. FGDs took place in the village communities in which participants reside to make them feel more comfortable. A total of 37 groups, with a total of 353 participants, were formed separately in accordance with age, sex and characteristics to allow the participants to speak freely. The FGDs were conducted with the following people (see Table 4):

Table 4: Qualitative Sample

Topics	FGDs profile	Average number of participants group per sex		Number of FGDs	Average number of participants per group	Total number of research participants
		M	F			
<i>Infant and Young Child Feeding (IYCF)</i> <i>1,000 days of life and Care of Children</i> <i>Maternal Nutrition and Care of PLW</i>	Pregnant and lactating women (PLW)	1	9	10	10	100
<i>1,000 days of life and Care of Children Infant and Young Child Feeding</i>	Caretakers of CU2	6	7	6	13	78
<i>SRH and education for adolescent girls</i>	Young people (adolescent boys and adolescent girls)	3	6	8	9	72
<i>Obstetric Fistula Sanitation & Hygiene</i>	Community influencers	7	3	10	10	100
	Total			34	10.5	350

(ii) Key Informant Interviews (KII)

In addition to FGDs, a KII guide was carefully developed in the field based on broader lines of inquiry to further explore the Obstetric Fistula topic. The semi-structure of the KIIs allowed for relative flexibility in gathering data based on sensitive issues (see Annex 2). The individual interviews consisted of three women living with obstetric fistula and their family members. These 3 respondents were invited to talk to the qualitative team in order to provide more detailed information concerning obstetric fistula and share their experiences. The interviews took place at their homes separately in order to create a safe space to allow them to talk about this sensitive topic. Explicit consent to interview each person was collected and data from these interviews containing sensitive health information is kept under the strictest confidence. The KIIs provided information about symptoms, stigma, challenges faced and health-seeking behaviour (HSB).

(iii) Direct Observation (DO)⁶

The observational technique was used to collect information specifically on the sanitation and hygiene topic in order to obtain a good understanding of local context and to complement information from the FGDs (see Annex 3). In this context, a camera was used to capture relevant aspects.

2. Quantitative sample and instruments for household questionnaire

The quantitative team consisted of four locally based enumerators and one nutrition-sensitive research supervisor. Data collection involved a total of 258 respondents: 125 men, 133 women.⁷ The male and female household members were interviewed separately to avoid influencing each other's results and ensure independent responses. In the original methodology, 144 respondents (72 men and 72 women) were projected to be included in the quantitative sample based on the available time for data collection, enumerator capacity and length of the survey. Each enumerator was expected to conduct two interviews each session, totalling 16 interviews per day; however, in the field, the tool was tested and found to take less time to interview household members after complex ideas local terms were established. With this adjustment, each enumerator could conduct approximately 7 interviews per community, totalling 28 interviews per day. Each interview was originally scheduled for 1 hour and 30 minutes, while in reality, it took under an hour per person.⁸ Households were chosen by project field staff based on the following criteria:

- Households with caretakers of children under two years of age (plus their partner)
- Households with a pregnant and/or lactating woman (plus her partner)

⁶According to this method, the data is collected via an observational method or subjects in a natural environment. In this method, the behaviour or outcome of situation is not interfered in any way by the researcher. The advantage of direct observation is that it offers contextual data on people, situations, interactions and the surroundings. Retrieved from: <https://www.questionpro.com/blog/field-research/>

⁷The original methodology indicated one man and one woman from each household would be interviewed. During the data collection of the first community of Zenguerere, without prompting, the community leader positioned interviewees from his community in the nearby community of Bangwe for fear of WFP cars being unable to reach the wide-reaching and remote location of Zenguerere. Enumerators found it challenging to ensure both men and women were interviewed from the same household as they were not all in the same location and, when needed, interviewed otherwise planned community members who fit the study criteria. This is why there is an odd number of men and women. A better communication system was put in place for the remainder of data collection.

⁸It is important to note this is the total interview time, but some interviews were not conducted over one sitting. Many of the survey respondents are small holder farmers and needed to stop interviews part way through to attend to their fields to prepare for the rainy season.

The quantitative questionnaire was developed in close coordination with the qualitative team to ensure alignment of topics. Most of the questions were directed at both men and women and a select few within the Maternal Nutrition topic were directed only at men or only at women (see Table 5).

Table 5: Topics of the Quantitative Tool by Gender

Maternal Nutrition
<ul style="list-style-type: none"> • For men and women, 2 questions on diet during pregnancy and lactation • For men only, 1 question on men encouraging their wives on eating balanced meals
<ul style="list-style-type: none"> • For men and women, 1 question on rest and work during pregnancy • For men only, 1 question on intention to support wives with domestic work encouraging PLW/supporting women / husband support
<ul style="list-style-type: none"> • For men and women, 2 questions on colostrum and exclusive breastfeeding practices • For women only, 1 question on colostrum
Infant and Young Child Feeding (IYCF)
<ul style="list-style-type: none"> • For men and women, 2 questions on diet diversity, specifically on a child’s balanced diet and fortified foods
<ul style="list-style-type: none"> • For men and women, 1 question on responsive and active feeding
<ul style="list-style-type: none"> • For men and women, 1 question on child’s diet when sick, feeding during and after illness
<ul style="list-style-type: none"> • For men and women, 2 questions on the importance of the first 1000 days
Sanitation & Hygiene (S&H)
<ul style="list-style-type: none"> • For men and women, 5 questions on handwashing, sanitation, safe drinking water, associating harmful sanitation practices with disease and health seeking behaviour
Sexual and Reproductive Health (SRH) & Obstetric Fistula (OF)
<ul style="list-style-type: none"> • For men and women, 2 questions on perceptions on girls going to school and early marriage related to school • For men and women, 1 question on where community members are getting information on SRH
<ul style="list-style-type: none"> • For men and women, 3 questions on early marriage, specifically decision-making, intention of parents⁹ on the ideal age, early pregnancy, and the link between early marriage and malnutrition
<ul style="list-style-type: none"> • For men and women, 5 questions on family planning and abortion, specifically knowledge and decision making on contraceptives, perceptions of safety with contraceptives and abortions, and birth spacing • For women only, 1 question on disagreement with husband on contraceptive use
<ul style="list-style-type: none"> • For men and women, 3 questions on Obstetric Fistula, specifically on trusted information sources, treatment and stigma

The household interviews were conducted in the local language (Sena) but the questionnaire on the data collection platform, ODK collect, was in Portuguese. This required the enumerators to be intimately familiar with the questionnaire and be comfortable translating between Portuguese and Sena (see section on training below for details on how this was addressed).

⁹Mother and a father.

Interviews were conducted using a smartphone application called ODK Collect. This data collection application is linked to WFP's data collection platform called Mobile Operational Data Acquisition (MODA) where data is compiled for analysis.

The quantitative sample is not a representative sample and, therefore, broad generalizations cannot be made from the findings. The following findings are restricted to the area in question.

Training

Training of enumerators took place over 3 days, where 2.5 days occurred in a classroom setting, and 0.5 days in a selected community for pre-testing. The training schedule included the basics of a KAP Study overall, interviewing methodology by enumerators, review of questionnaires, translation (orally) to local language from Portuguese, and pre-testing of questionnaires in the field as elaborated below.

Pre-testing

The pre-testing involved reviewing the qualitative and quantitative instruments with a view to ensuring the questions are clear, understandable, relevant to the intended topics, effective in providing useful information and, very importantly, avoid questions that seem redundant or unnecessary. Pre-testing was conducted immediately prior to data collection in Chemba-*sede* area. Pre-testing also allowed enumerators and qualitative researchers to verify the correct local words and phrases of some of the complex ideas to which the Study Team wanted to gain insights. After pre-testing, the quantitative field research team sent the updated tool to WFP country office to support in revising the smartphone survey to be ready for data collection, such as adding local words and removing unclear language. Data collection tools were developed in English and translated into Portuguese for quantitative and qualitative researchers to use in the field.

Informed consent

The participation of all research subjects in the KAP Study was voluntary and orally informed. Participants were informed before an interview or discussion took place about the purpose and given the opportunity to refuse upon understanding the purpose. No exercise of undue inducement or any other form of constraint or coercion to participate in the study was permitted or accepted.

A photo camera was used to capture key images during the data collection. All photos published have permission from participants and were taken in accordance with WFP guidelines and cooperate procedures.

Limitations

The KAP Study team tried to avoid having project beneficiaries participate in the Study in order to avoid 'socially desirable responses' rather than report what they actually think or believe, resulting in respondent bias. However, during data collection it was realized that some participants were beneficiaries. Taking into consideration that there is a tendency for respondents provide answers to what they perceive to be the "correct" answers to interviewers, the qualitative research team reworded questions to obtain more reliable responses.



*Photo Caption: The official welcome sign upon entering Mulima Administrative Post in Mulima, Chemba district, Sofala Province.
Photo Credit: Nilda Lima*

V. FINDINGS

The first 1,000 days of life¹⁰ and care of children



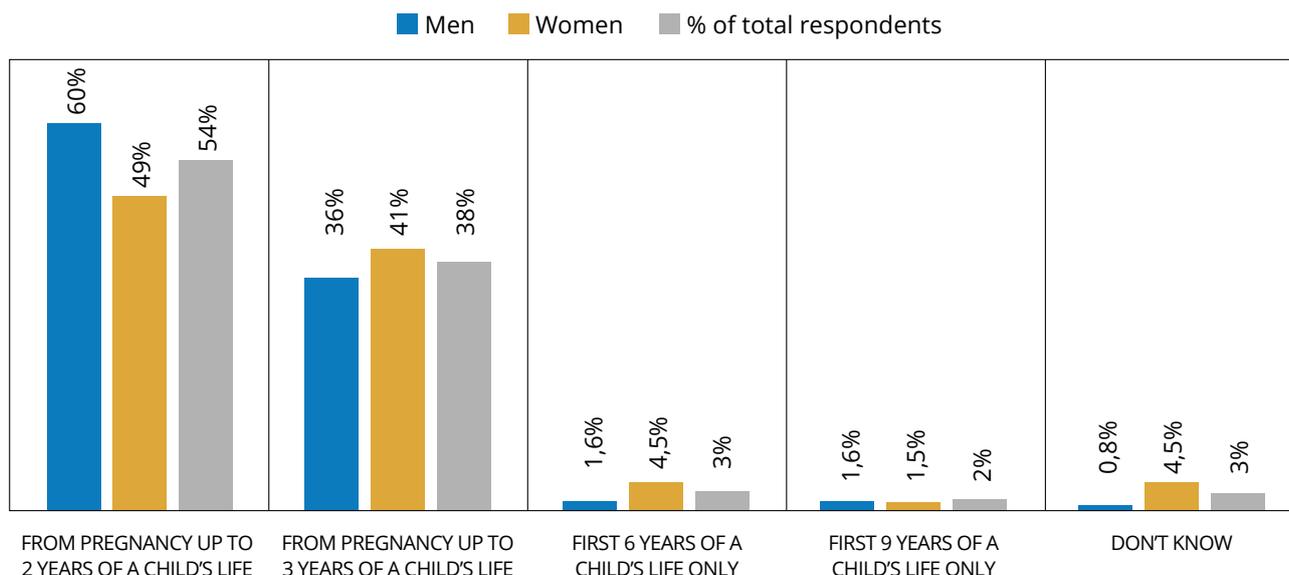
Photo Caption: A mother with her 1-month old newborn baby in Mulima locality

Photo Credit: Nilda Lima

The results and findings presented in this section of the report include both the qualitative and quantitative data both assessed in the KAP Study. The data collection tools were developed in coordination and aligned in order to complement each other. After data analysis, certain sections showed contradictory results depending on if the topic had been assessed as quantitative or qualitative. These differences will be addressed throughout the report.

Overall, a slight majority (54%) of survey respondents (60% of men and 49% of women) know that the first 1,000 days - from pregnancy up to the first 2 years when the conditions are created for a child to grow into a healthy, intelligent and productive adult- are the most important period of a child's life (see Figure 2). On the other hand, there was no consensus among adolescents and adults in FGDs. Some of the FGD participants indicated that the first 1,000 days of life starts when the baby is born while others thought it started from 6 months onwards. In addition, they struggled to specify which kind of care and diet are most adequate for child growth and development.

¹⁰ The 1,000 days between a woman's pregnancy and her child's second birthday offer a brief but critical window of opportunity to shape a child's development. It is "a time of both tremendous potential and enormous vulnerability" (Thousand Days; Think Babies).



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents was calculated out of the total 258 respondents

Figure 2: Men & women who know the time period of the first 1000 days of life

Regarding the health of children, FGD participants cited that malaria, pneumonia, diarrhoea, and tuberculosis are diseases affecting children in communities, with diarrhoea and malaria being considered the most worrying given that they kill children in large numbers. Convulsion, fever, malaria, diarrhoea and lack of appetite are considered by caregivers the most alarming signs, leading them to seek treatment urgently. For problems related to malaria with convulsion and diarrhoea, participants seek treatment at health facilities and at traditional healers. It is believed that these illnesses are the result of supernatural phenomena requiring prayer or other spiritual interventions that counter the presumed negative influence of powerful forces. During the FGDs with traditional healers, they confirmed that these diseases are mostly treated by them.



Photo Caption: Parents of CU2 from the FGDs
 Photo Credit: Nilda Lima

“ We get so scared when our children have diarrhoea or malaria because we know when it happens, we can lose them. We believe they can be treated at the hospital and also by the traditional healer because there are a couple of things that in the hospital they do not understand. For instance, for convulsion cases, we take children to the traditional healer because they know specific herbs for treatment; for diarrhoea it is the same. But sometimes when we see that children are not getting any better, we take them to the hospital.” (Caregivers of CU5, community of Bucha) .

Conversely, according to the quantitative data, the overwhelming majority, 98% of respondents, prefer to have their child, who is suffering from diarrhoea, treated at a health facility or hospital; only one woman indicated preference for a traditional healer. Researchers also asked respondents around availability of options for treatment of child diarrhoea in addition to preference. Still only 2% of respondents answered traditional healers as an option. Of the survey respondents, 87% indicated they can take their child to the hospital or a health

facility (although some indicated that the nearest health facility is outside of Mulima) and 10% of respondents indicated *Agentes Polivalentes Elementares* (APEs)¹¹ through mobile brigades. This poses a significant contradiction between the quantitative and qualitative data collection methods. It might be explained by the fact that some of the study participants were also project beneficiaries and felt obligated to provide socially desirable responses, resulting in respondent bias; however, it is impossible to verify as beneficiary status was not captured in the interview. The differences in outcomes show a good example of how qualitative and quantitative data can be complementary of each other, as the nature of their interviewing techniques allows for different information to be captured. In this case, qualitative data collection allowed questions to be further probed to understand more in-depth details on the type of health care sought by community members.

Maternal Nutrition and Care of PLW and babies

Undernutrition during pregnancy and lactation is a critical determinant of maternal, neonatal, and child health outcomes. It is also associated with an increased risk of maternal mortality (Lamstein, et al. 2014).

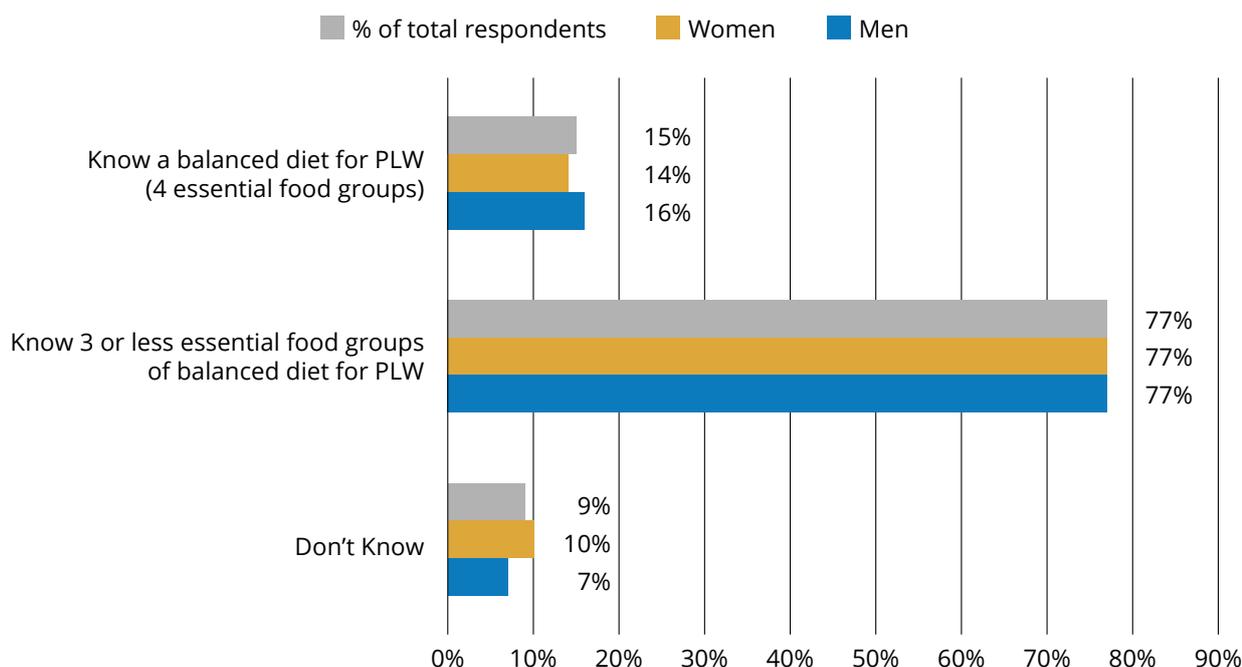


Photo Caption: Lactating women from FGDs
Photo Credit: Nilda Lima

¹¹ Local term for a community health worker recruited and trained by the Mozambique Ministry of Health (MISAU) to improve community health.

Energy and protein and quality of diet intake during pregnancy and lactation

At least 85% of survey respondents feel that diet and care for mothers ensures the baby's health. Likewise, most of the FGD participants reported that they knew that PLW should eat regularly because they associate the diet with a healthy pregnancy. However, when asked to describe a balanced diet for PLW, only a small number of survey respondents could identify the 4 food groups for an essential diet (15% of survey respondents) (see Figure 3). Furthermore, FGD participants believe *all* food is good for them, without distinguishing an adequate diet for PLW.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents was calculated out of the total 258 respondents

Figure 3: Percentage of respondents who know a balanced diet for pregnant and/or lactating women

In reality, PLW are not getting enough nutrients during pregnancy and do not follow a diet specific for this phase. They consume inadequate energy, protein and iron-rich foods. When asked to inform their daily diet, FGD participants said they mostly eat what is produced in their *machamba*.¹² The study reveals the study participants both do not have enough nutritious food available year-round and are not knowledgeable about maternal nutrition during pregnancy and clearly indicates that proper attitudes and practices toward nutrition and diet during pregnancy are still lacking among the target population. FGD participants reported eating between 2-3 meals per day (see Table 6).

¹² Small plot of land claimed by small holder farmers usually near their house where they plant and cultivate crops. There is no deed to the land as it is not legally owned.

Table 6: Typical Meal of a Pregnant and/or Lactating Woman¹³

Breakfast	Lunch	Dinner	Snacks	Harvested ¹⁴ from the machamba
<p>Sweet potato, cassava, and tea</p>	<p><i>Xima</i>¹⁵ and curry made of okra or leaves (pumpkin leaves, cabbage leaves, cowpea, and sweet potato). Curry is prepared with peanuts when it is peanut season. When peanuts are not available, the curry is prepared with water and salt.</p>  <p>Photo Caption: <i>Xima</i> Photo Credit: Nilda Lima</p>	<p><i>Xima</i> and curry made of leaves or okra</p>  <p>Photo Caption: <i>Okra curry</i> Photo Credit: Ernesto Almeida</p>  <p>Photo Caption: <i>leaves curry</i> Photo Credit: Ernesto Almeida</p>	<p>Banana, sweet potato, and bread (when available)</p>	<p>Animal and plant-based protein: cow peas, peanuts, and sesame seeds</p> <p>Cereals and tubers: maize, sweet potato, cassava, millet, sorghum, sugar cane</p> <p>Fruits and vegetables: banana, papaya, lettuce, okra, tomato, cabbage onion, garlic, pumpkin, cucumber, dark green leafy vegetables (e.g. cassava leaves)</p> <p>Fats: purchased from the local market</p>

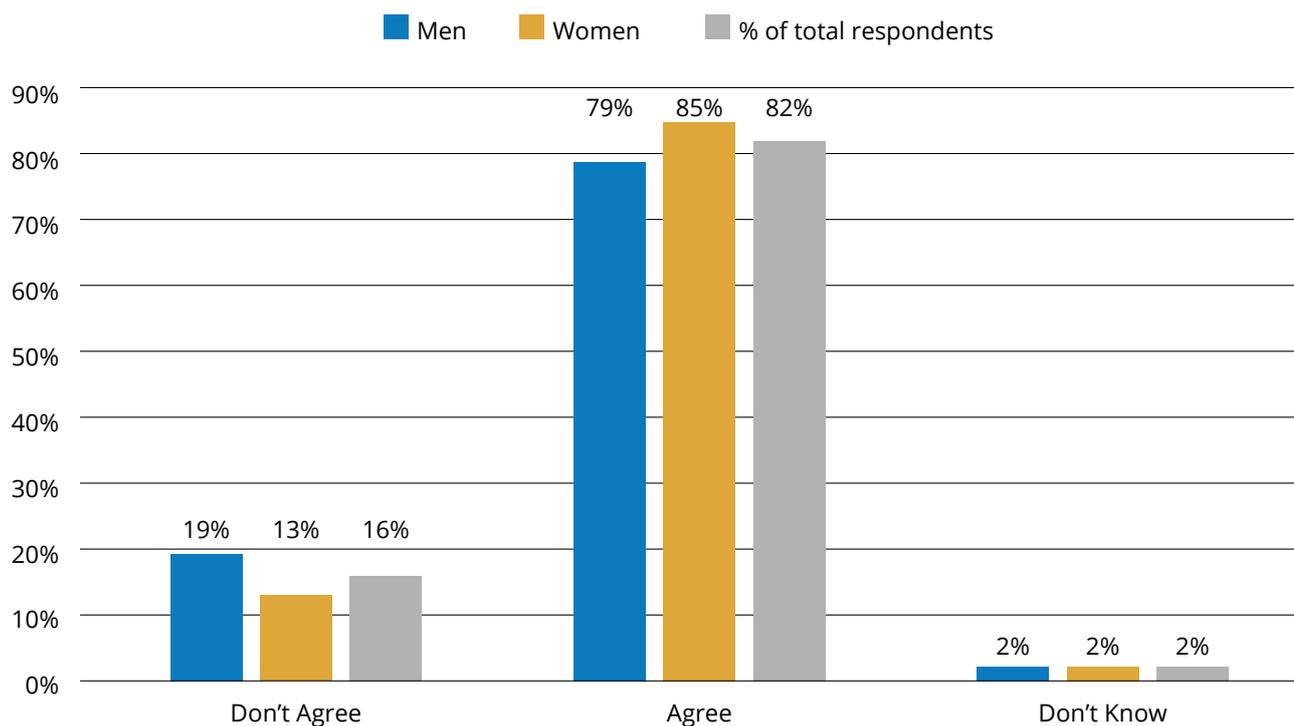
Although 84% of survey respondents know that a PLW should eat animal and plant-based protein, they do not eat this frequently. While there are some households who raise livestock, it is used as a source of income and not for consumption; and only some households produce plant-based protein. Diversity in *machamba* production is a big issue in the communities, leading to poor nutritional status. The main reason is not only the unavailability of food sources and financial restrictions when it comes to obtaining food, but also a lack of knowledge concerning a more comprehensive and balanced diet for PLW and how to better use local resources. It is important to note that the frequency of nutritious foods intake was inadequate during pregnancy.

Approximately 82% of survey respondents (75% of men and 85% of women) agree that eggs are safe for PLW and the majority of FGD participants mentioned that they do eat eggs when they have the opportunity. However, some people from both FGDs and survey responses (16% of survey respondents) still believe eating eggs might be harmful for their health (see Figure 4).

¹³ While assumed by the Study Team that rice is commonly eaten in the project district, the findings showed that this only occurred at rare occasions.

¹⁴ There are two seasons over the course of 11 months: December – September. The first season begins with planting in December – February and ends with harvesting in March – July. The main crops are corn, millet, sorghum, peanuts, cowpeas and sesame. The second season planting begins concurrently with the first season harvest. Second season planting is from March – June and harvesting is from July to September. Corn is included in a second cycle in the second season, and sweet potato, beans, tomatoes, onions and garlic are also grown.

¹⁵ *Xima* is a filling thick porridge made from corn meal/millet/sorghum with a gelatinous consistency. It is a common meal as corn is a staple crop in the community, and thus widely available after a good harvest.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 4: Percentage of men and women who agree that eggs are safe to eat for pregnant and/or lactating women

In relation to men's support, when it comes to PLW diet, 89% of men intend to support their wives in having diverse and balanced meals when they are pregnant and lactating (see Figure 5). In practice, men in FGDs explained that they will prioritize their pregnant and lactating wives when there is only a small amount of food in the house over themselves.

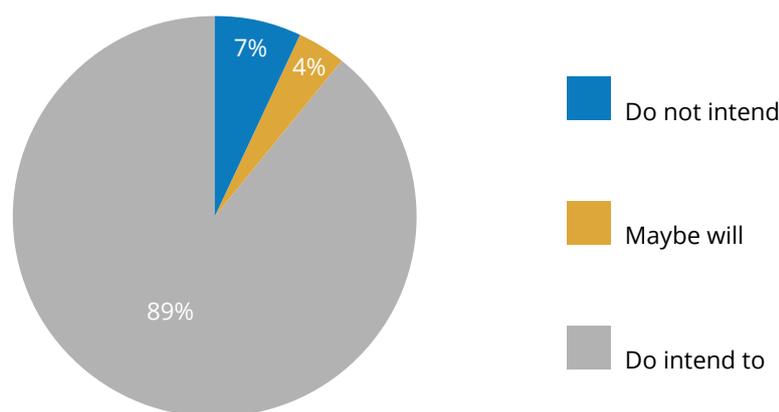


Figure 5: Percentage of men who intend to support their wives in eating a diverse and balanced meal when pregnant and/or lactating

Antenatal care (ANC)



Photo Caption: FGD comprised of influential people from the community
Photos Credit: Nilda Lima

FGD participants stated that they visited Antenatal Care (ANC) regularly during pregnancy because they believe it is an effective way to monitor the fetus and the health of the mother, thus aligning with the baseline result of 72%¹⁶ indicated attending at least four ANC visits. Despite the fact that they considered the long distance between home and health facility to be a challenge, many respondents discussed creating their own way to ensure attendance because they are able to associate care during pregnancy with the baby's health.

“ We came together because we know that is important for our health. As we have to walk for a long time the health unit, we joined a group of pregnant women in the community to go to the consultation together as way to encourage ourselves.”
(PW, community of Francalino [Bizua]).

However, women highlighted that their husbands do not accompany them, and they regard this as an obstacle to complying with the health center recommendations concerning care needed during pregnancy as their husbands do not hear directly from the health professionals what kind of support they are supposed to offer at home. As a result, women perceive that their husbands are less likely to accept their request for help, particularly when it comes to physical work.

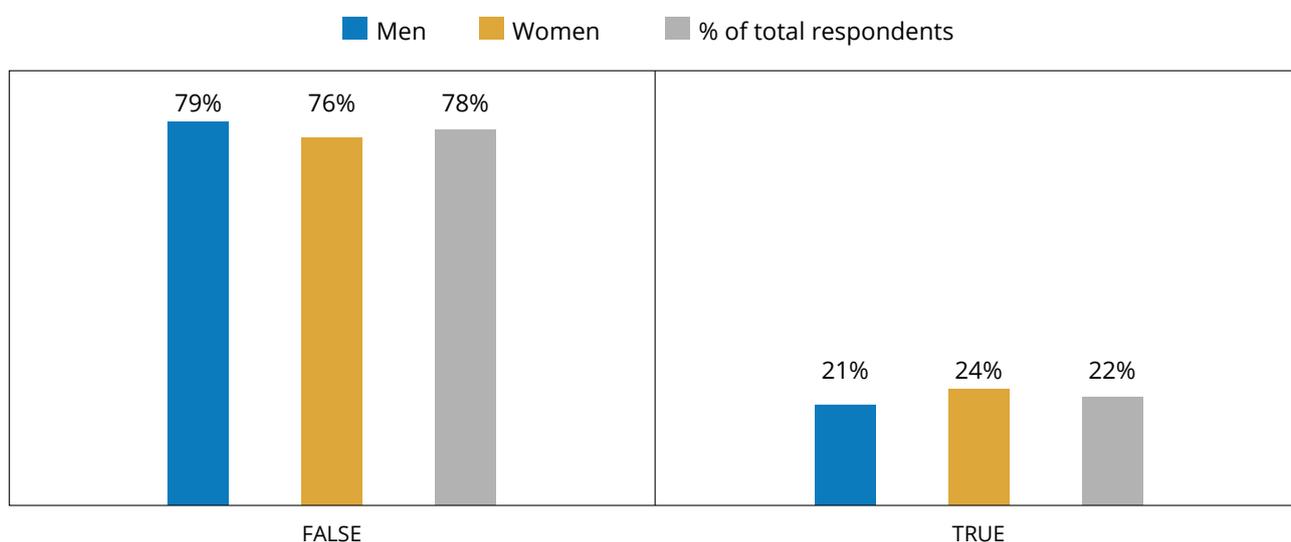
¹⁶ This is an average of intervention (73%) and control villages (71%) reported in the GTNS project baseline report (2020) commissioned by WFP Mozambique.

“The husbands should be at the consultation to be advised of what to do and how to support us. If he gets advice directly from the health center, he is more likely to support us. But if we are the ones to talk to them, we will not be heard.” (PLW, community of Bangwe).

“The husband is also the owner of the bellies – these bellies do not belong to us only. Our husbands should be at the consultation with us to encourage us, support us.” (PLW, community of Bangwe).

Rest and physical work during pregnancy

Although considered a crucial aspect of a healthy pregnancy, 78% of respondents (79% of men and 76% of women) do not believe pregnant women should be doing less physical work during pregnancy or lactation (see Figure 6). However, 76% of men intend to support their wives with domestic work, working in the fields and collecting water while pregnant and lactating.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 6: Percentage of men & women who think pregnant women should do less physical work while pregnant and/or lactating

Most PLW do not have time to rest and end up doing a lot of physical work, especially fetching water and firewood. A few men in FGDs stated that they help their wives with heavy work while pregnant, but only after the seventh month of pregnancy. Others said that they help their pregnant wives any time, provided they are sick. In general, men and women believe that pregnancy in an advanced stage is more of a concern. Nevertheless, it is not common for men to help their pregnant wife with physical work, but it may happen:

“I do help my wife because I know she should not lift heavy loads. So last time when she was pregnant, I helped her with fetching water, so she did not need to fetch all water by herself.” (Husband, Community of Zenguerere).

Breastfeeding practices



*Photo Caption: A mother from a FGD breastfeeding her CU2.
Photo Credit: Nilda Lima*

a. Early initiation of breastfeeding

i) Colostrum¹⁷

Most survey respondents, 81% (74% of men and 88% of women), were aware of the importance of giving a newborn baby colostrum, also known as “the first milk”. Almost all of the FGD participants reported usually giving the first milk to their babies. Mothers ensure to breastfeed from the day the babies are born, with 93% of the mothers interviewed stating that they give or plan to give their newborn babies colostrum after giving birth (see Figure 7).

¹⁷ Colostrum (the first milk when mothers start breastfeeding) is “loaded with nutrients and immunity-boosting compounds to fuel and support your baby in their first few days of life”. Retrieved from: <https://www.verywellfamily.com/colostrum-the-first-breast-milk-431990>.

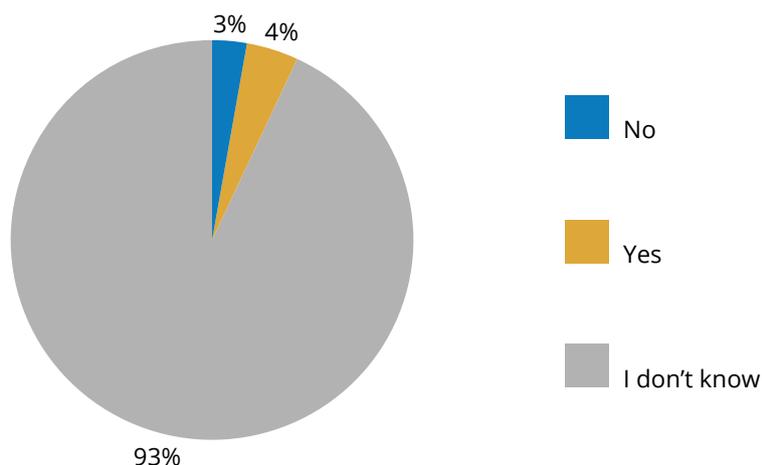


Figure 7: Percentage of women who did or will give their babies colostrum in the first 3-5 days after giving birth

Additionally, breastfeeding is widely practiced in communities. Without exception, all female FGD participants said that they breastfeed their children since they are born until they are at least two years of age, however some indicated the frequency was not often during the day. Mothers highlighted lack of time as a barrier to frequent breastfeeding, given the fact that they must go to the *machambas* every morning. In order to deal with this, mothers usually take their babies with them and interrupt their work every time the babies cry to be breastfed. Ensuring affection and skin-to-skin contact during breastfeeding is challenging at times. With regards to young children, mothers from the FGD mentioned that they often have to combine breastfeeding with another domestic task due to a lack of time in the day.

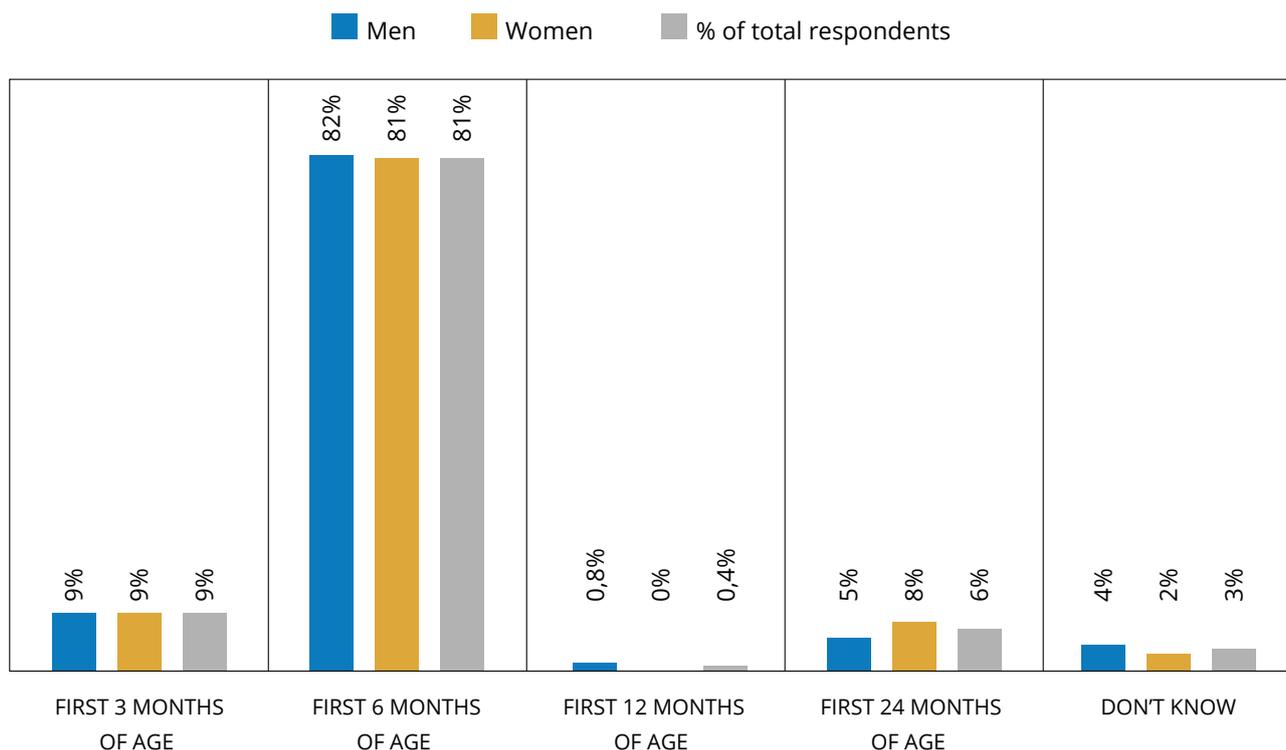
Conversely, the survey shows that there is an overwhelming majority of respondents that set aside time specifically to feed their young children and babies, approximately 87% (77% of men and 97% women).

This discrepancy may be due to the nature of the closed questions. When the qualitative team asked the same question, the FGD participants answered that they set aside time for breastfeeding but when further probed it was found to be not consistent. They described that sometimes they do not actually manage to give the babies and young children exclusive attention when they are breastfeeding and that is why it is sometimes combined with domestic tasks, in particular with food preparation.

b. Exclusive breastfeeding¹⁸

The FGD participants say that the health facility (HF) staff has placed great emphasis on avoiding giving liquids and food to the baby until six months of age and ensuring only breast milk. This reflects the acknowledgment of 81% of survey respondents who indicated knowing the correct period to exclusively breastfeed their babies for the first 6 months after giving birth (see Figure 8).

¹⁸According to the WHO, exclusively breastfeeding means giving only breast milk to the infant in the first six months of life, without mixing it with water, other liquids, tea, herbal preparations or food, with the exception of vitamins, mineral supplements or medicines (Frequency and Demographics of Exclusive Breastfeeding in Turkish Women in Ankara).



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 8: Men & women who know to exclusively breastfeed for the first 6 months after baby's birth

However, very few caregivers comply with this recommendation. The reason is that they believe that breast milk does not satisfy babies and they cry because they are hungry. Without exception, FGD respondents stated that after three months they start giving the baby porridge, water and sometimes tea.¹⁹ They can also give the baby traditional medicine when the baby is sick.

“ I was told to give only breast milk to my baby until six months of age. But after three months, he started crying a lot. So I initiated adding porridge and I see that he gets calmer after eating. I am not the only one. Most lactating women in my community give their baby under six months porridge, water and tea. Additionally, sometimes when our babies are sick, we need to take them to the traditional healer, so then we give them the herbal medicine prescribed for treatment.” (Mother, community of Nhakuiyoyo).

¹⁹ Tea in this context refers to traditional herbal medicine.

Infant and Young Child Feeding



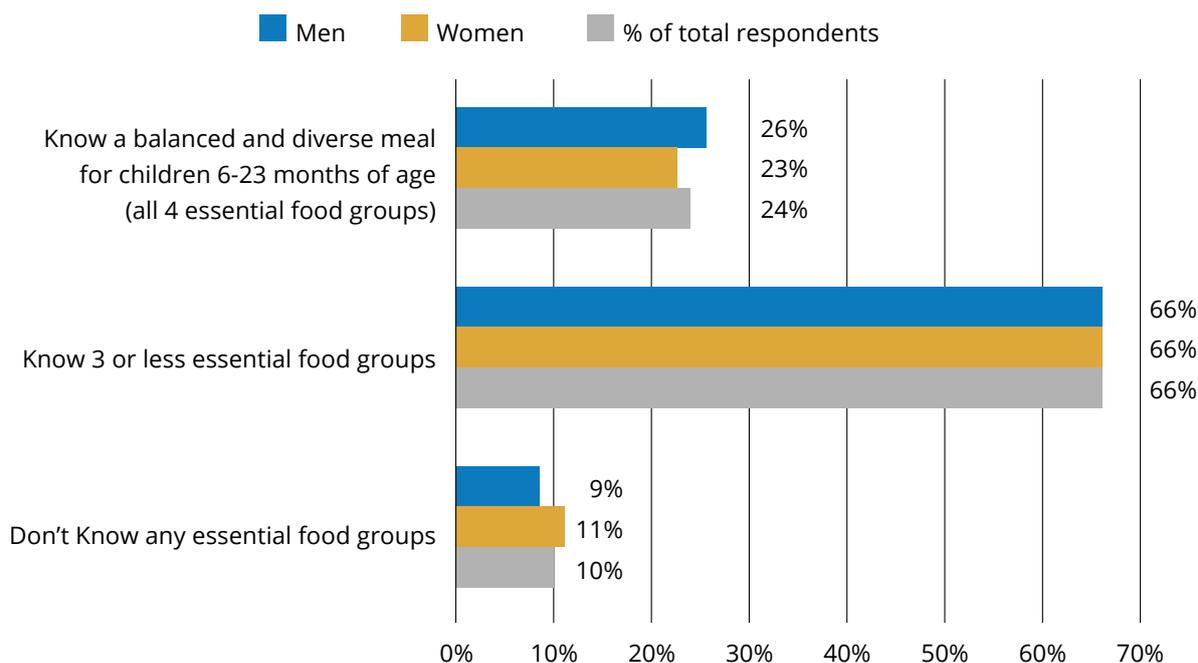
Caption: Two young children eating a snack in their community
Photo Credit: Nilda Lima

Timely introduction of complementary foods and continued breastfeeding

The FGD participants are knowledgeable about the timely introduction of complementary foods. However, as mentioned above, part of the caregivers said that they started introducing complementary foods at 3 months of age; others start at 6 months with small amounts of food and increase gradually as the child gets older. Regarding *continued breastfeeding*, all FGD participants added that they know that it is important to breastfeed children until at least 24 months. They mentioned that there is no difficulty in ensuring continued breastfeeding.

Dietary Diversity (DD)

While only 15% of survey respondents could identify the 4 essential food groups (proteins, tubers, fruits and vegetables, and fats) for a balanced and diverse diet for PLW, approximately 24% of the survey respondents indicated that they knew a balanced and diverse meal for a child between 6-23 months of age (see Figure 9). At least 77% of survey respondents know that proteins, animal- and plant-based, are an essential food group for a balanced and diverse meal for these children.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 9: Percentage of men & women who know the 4 essential food groups that comprise a balanced and diverse meal for children 6-23 months of age

Contrary to the information survey respondents indicated they know on a child’s diet, caregivers from the FGD reported that they do not manage to feed their young children more than 2-3 food groups per day in reality. Furthermore, they stated that they do not manage to feed children enough times during the day. As a result, children do not receive the recommended dietary diversity,²⁰ nor a minimum acceptable diet (MAD),²¹ something which indicates household food insecurity.²² See Table 7 below that describes a typical child’s daily diet.

²⁰ Recommended dietary diversity refers to the number of food groups consumed over a given period, indicating variety.

²¹ MAD is a composite of dietary diversity and meal frequency and was reported by the GTNS Baseline as not reached (WFP; ICRAF, 2020).

²² Similarly found in the baseline report commissioned by the Project.

Table 7: Typical Daily Diet for a Child under Two²³

Ages	Breakfast	Lunch	Dinner	Snacks
6–8 months of age	Maize porridge with sugar		Maize porridge with sugar	Banana, and sweet potato (when available)
9–23 months of age	<i>Xima</i> (millet, sorghum, maize) and curry made of leaves, okra curry, cowpeas	<i>Xima</i> (millet, sorghum, maize) and curry made of leaves, okra curry, and cowpeas	<i>Xima</i> (millet, sorghum, maize) and curry made of leaves, okra carry, and cowpeas	

It is important to note that feeding children animal source foods is a big issue for many households as some of them do not raise animals; others have very limited production (essentially only chickens and goats), hampering an adequate diet for children and for the household at large.

“ It has been hard for us to feed all these children. There are so many, and food is very little because what we produce is not enough for the whole year. There is a certain time of the year that our children can eat only once a day.” (Parents of CU2, community of Bucha).

Fortified foods²⁴

All FGD participants stated that they are unable to identify fortified foods, so they cannot distinguish fortified and non-fortified foods in the market, and they cannot make an informed choice when it comes to buying micronutrient supplements or fortified products. Consequently, the consumption of fortified products by children is something caregivers know little about. They indicate that they have never been told about the existence of these products by any communication channels in the communities. However, only 30% of survey respondents indicated they do not know what fortified foods are. Moreover, 64% of survey respondents (66% of men and 62% of women), indicated they purchase fortified foods in the market for their children and only a mere 3% indicated they do not. This misalignment between FGD participants and survey respondents may be attributed to the misunderstanding of what fortified foods are when asked in the survey and the closed nature of a questionnaire does not allow enumerators to verify with follow up questions.²⁵

²³ According to the guiding principles for appropriate complementary feeding on increasing the number of times that the child is fed are: 2–3 meals per day for infants 6–8 months of age and 3–4 meals per day for infants 9–23 months of age, with 1–2 additional snacks as required (World Health Organization (WHO), 2011).

²⁴ Food fortification is usually regarded as the deliberate addition of one or more micronutrients to particular foods, so as to increase the intake of these micronutrient (s) in order to correct or prevent a demonstrated deficiency and provide a health benefit. (WHO Library. Guidelines on food fortification with micronutrients/edited by Lindsay Allen . . . [et al.].

²⁵ However, it was noted by the quantitative field research team that it is difficult for the surveyed families to know whether the food they consume is fortified or not. Local sellers repackage food to adjust to the purchasing power of families. For example, the oil sold in the local market is repackaged into smaller containers, such as mineral water or soda bottles. This is because families are not able to purchase a 1-liter bottle of oil at one time. Thus, many of those families do not have access to or contact with the original packaging where they could see the food fortification logo.

Food preservation



*Caption: (left) Bowl of sun-dried miniature apples; (right) Bowl of sun-dried thobve leaves.
Photo credit: Nilda Lima*

The FGD participants are knowledgeable about the importance of preserving food. They have preserved food as a way to deal with food scarcity. They stated that they preserve garlic, *maçanica* (miniature apple), leaves of *thobve*, sweet potato, cowpeas, cucumber seeds, okra and tomato. Tomato can be stored for up to two months. It is worth noting that tomato preservation is not widely practiced because in certain remote communities, people believe that children may get leprosy when they uncover a bowl containing dried tomatoes.

“ Here we have preserved a lot of food products, as much as we can, to cope with a lack of food. But we do not dry tomato because we have been told that children may get leprosy when they uncover a bowl containing dried tomatoes. This is something that has been made clear by old people and we heard that it does happen in our community. ” (FGD participants, community of Melo 1).

They indicated that they do not preserve other products because they do not know the techniques necessary for doing so and keep repeating what is commonly practiced in the communities.

Frequency of feeding children

The FGD participants do not know how often children from 6 to 12 months are to be fed. They mentioned that after starting to feed children solid foods, they gradually increase frequency of meals intuitively. When asked about the recommended frequency of children of different age groups, they answered “many times”, without being able to specify how many times a day. The lack of information may have an effect on meal frequency. In practice, many of them indicated that they feed their babies two times a day; and children from 6-23 months, 2-3 times a day. They believe that young children should be fed 3 times a day and should have snacks.



*Photo Caption: Community member grinding millet for a family meal
Photo credit: Nilda Lima*

The quantity of food for children at each meal

The FGD participants are aware of the need to increase the quantity of food consumed by young children (6 – 23 months) at each meal as they get older, but they are unaware of the food proportion that should be given to children. Children are fed intuitively by each caregiver. Consequently, it is unclear whether children receive the recommended amount of daily food.

Food consistency and variety

The FGD participants are knowledgeable about increasing food consistency. But they add that they do not know the exact consistency that a child should have according to age group. In practice, mothers prepare the food with a certain consistency and modify it depending on the child’s reaction to the food. Generally, they hold the belief that children cannot digest food with a certain consistency, and they can choke on thick porridge.

“ I prepare porridge and give it to my child and check on their reaction. I try to make her/his meal thick, but not very much because my children cannot cope with this.”
(Lactating Woman, Community of Francalino).

With regards to variety, they struggle with ensuring varied food given the fact that food products are very limited. As mentioned above, children eat the same meals, such as porridge and *xima*, every day because the mothers mention that they do not know other recipes (for instance, soup recipes and variations of nutritional porridges) and they keep repeating what they learn from older people in the community. It is important to highlight that this scenario is slightly different for those who live near health centers because these people had the opportunity to attend some cooking demonstration sessions arranged by the health professionals, and so could learn new recipes.

Adding fats or oils to children’s foods

Overall, there is very little knowledge on the importance of adding oil, butter, or other fats to children’s diets so as to increase energy density. In practice, the caregivers from the FGD indicated that they added peanuts to their family meals because it is an ingredient in the traditional cuisine, not because they know the importance of this product to children’s food. Besides that, they use oil, but they say that both these products are not available throughout the year. They also do not know about the fat sources, specifically the ones found naturally in foods like nuts, seeds, plants, fish, which is an additional obstacle to implement the recommended healthy behaviors for the benefit of children.

Responsive/active feeding²⁶

An overwhelming majority of survey respondents, 87%, set aside time specifically to feed their young children and babies (77% of men and 97% of women).

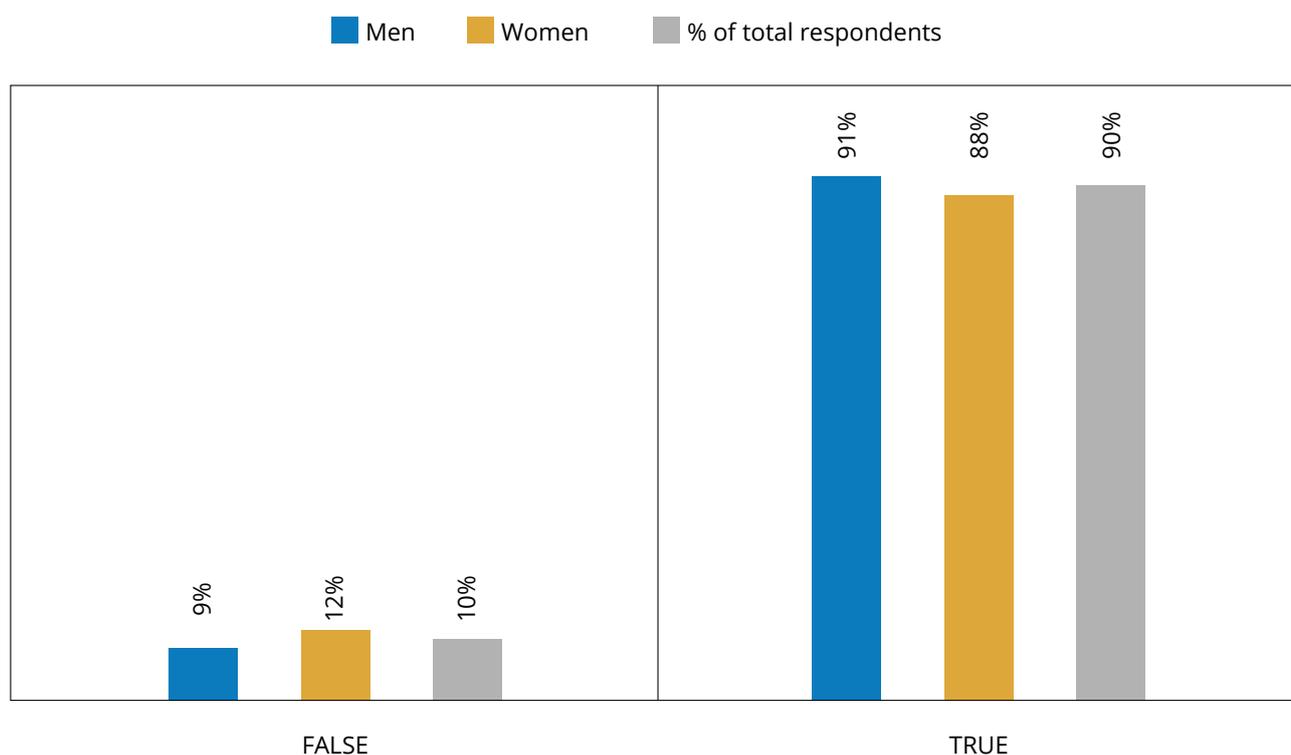
When asked about the significance of responsive/active feeding, the FGD participants did emphasize the importance of being affectionate when feeding children. Furthermore, the mothers from FGD indicated that sometimes not all family members eat together because they are busy with domestic tasks, and young children (older than 12 months) eat by themselves without being carefully observed by their caregivers.

“ Sometimes I have time to just sit on the ground and feed my children. But there are days that I cannot give them exclusive attention and the small children eat with the old ones. I have tried to devote more time to my little one who is 9 months, but even so many times I have to feed/breastfeed while doing something else in the house.”
(Mother, community of Candima).

²⁶ According to the concept of responsively feeding, breastfeeding is not just for passing on nutrition but also serves the interchange of love, comfort and reassurance between baby and mother (UNICEF UK, 2016).

Feeding during and after illness

The study shows that approximately 90% of the survey correspondents know that children who are sick should be eating more frequently and differently than a healthy child, such as eating at least 5 times per day, drinking more liquids and eating foods that are more nutritious (see Figure 10). Additionally, caregivers from FGD reported feeding breast milk and preparing easy-to-digest foods to their children when they suffer from diarrhoea.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 10: Percentage of men and women who think children should eat differently when sick

Sanitation and Hygiene

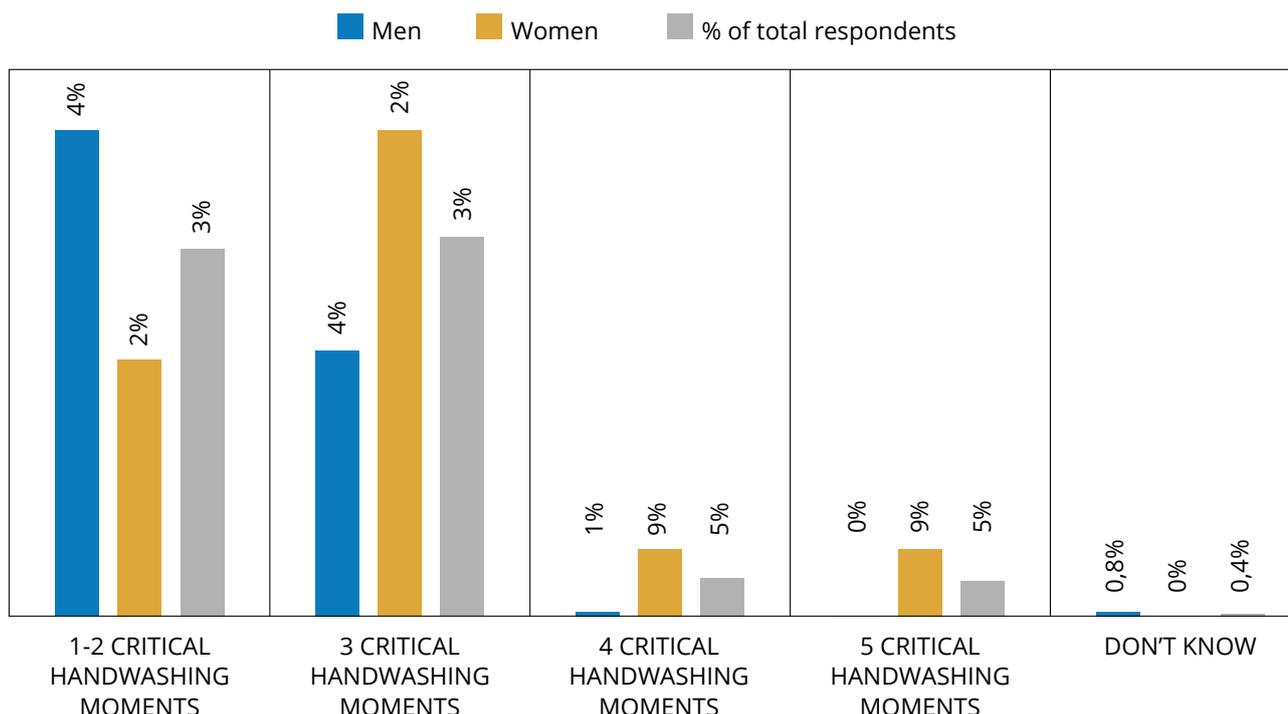
Critical handwashing moments



Photo Caption: People collecting water at a public water pump

Photo Credit: Nilda Lima

There are 5 critical handwashing moments: before preparing food and cooking; before eating; before breastfeeding; after using the bathroom; and after cleaning the baby's bottom/changing the diaper. Most FGD participants know at least two critical moments of handwashing. This information is well aligned with the quantitative data, according to which half of the survey respondents (35% of men and 64% of women) recalled at least three hygiene messages while 48% recalled at least one or two, 64% of men and 34% of women (see Figure 11). Only women (9%) were able to recall all 5 critical handwashing moments.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 11: Percentage of men and women recalling critical handwashing moments

The three most commonly indicated critical moments of the five critical moments surveyed were washing hands after using the bathroom, before preparing food and before eating/feeding. Some survey respondents further indicated that it is crucial to wash hands after returning from the *machamba*. The remaining two critical moments for washing hands are washing after handling children’s feces and before breastfeeding, and, while mentioned by some respondents, recall on these two messages was limited (see Figure 12).

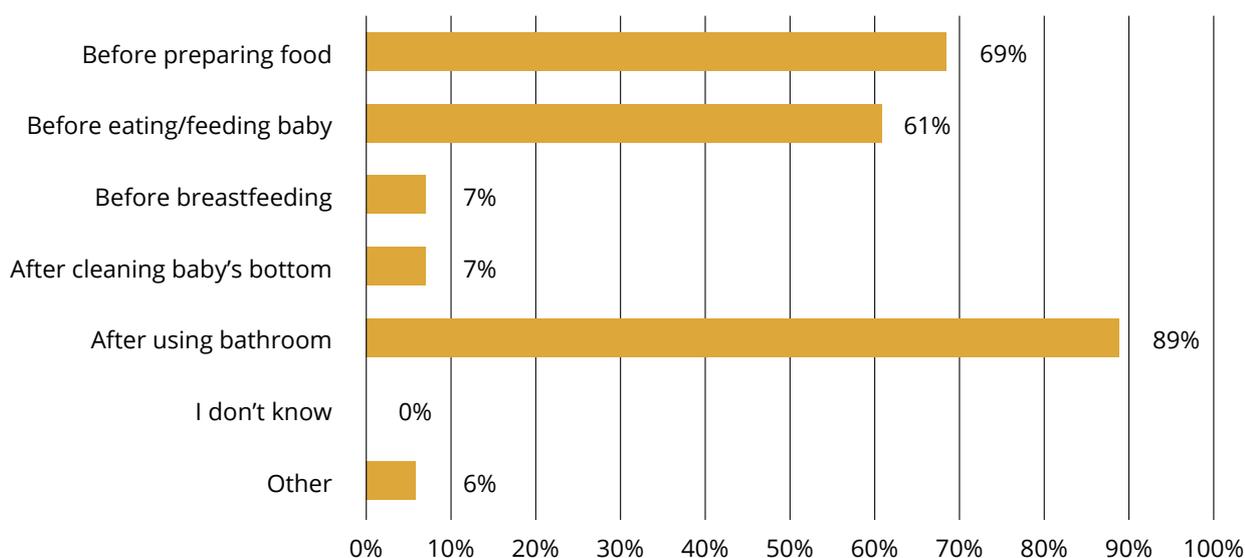


Figure 12: Frequency of each critical handwashing moment mentioned by men and women

Although they indicated that not complying with the critical moments of handwashing can cause diseases, existing hygiene practices are very poor as there is a lack of water for many people in Mulima. There are handwashing stations, but these are not used as often as necessary given the lack of water. Additionally, it was observed that soap for handwashing is lacking. As a result, people in the communities most likely do not wash their hands using soap at critical times.

That said, 98% of the survey respondents feel that washing their hands and cleaning around the house prevents illnesses such as diarrhoea, fever and malaria.

“ Here we wash our hands specially after using latrine. We know that children can get sick if they do not wash their hands. But the truth is that sometimes we do not have water. We hardly have water for the needs we have in the house.” (Community leader, community of Niquice).

Safe drinking-water²⁷

The FGD participants indicated that their main sources of drinking water are public water pumps, ponds, streams and rivers and that these sources are quite distant from their homes. In general, the participants said that in their communities they spend more than 3 hours (one way) to fetch water. A few people indicated they are within a 30-minute walking distance from their homes to water pumps, but sometimes they prefer to use a water source further away to avoid long queuing times. Others prefer to fetch water from the ponds formed by water from the river because it is closer to their homes, although they know water is not clean.

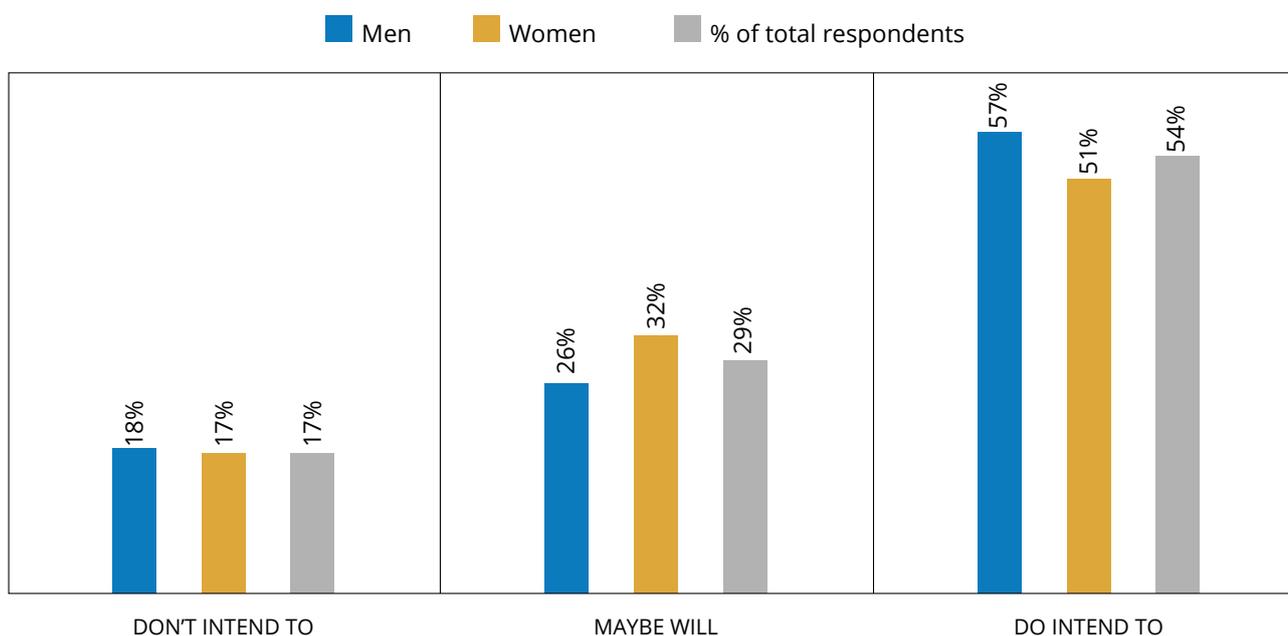


Photo Caption: Cloudy ground water source found in some communities in Mulima locality

Photo credit: Nilda Lima

²⁷ In Mozambique, only 53% of the population drink water from improved supply sources (UNICEF, 2014).

According to the quantitative data, a slight majority of survey respondents (54%) intend to treat their water before drinking it and an additional 29% indicated they might treat it (see Figure 13). The FGD participants find themselves able to distinguish safe water from unsafe water by turbidity (how cloudy it appears). On this note, the line of thinking is that water that is not muddy is ready to drink. It was indicated that the water from fountains is safe to drink because it looks clean, but water from rivers and ponds is turbid and therefore they are of the opinion that this water should be treated. Although they do believe that muddy water is unsafe to drink, most of the time water is not treated because the chemical water treatment product (*certeza*²⁸) is not available, particularly in the most remote communities. The same water is therefore used for bathing, cleaning and doing the laundry. The lack of knowledge combined with the lack of enabling conditions for accessing safe drinking water is a notable obstacle to realize the intention to treat water.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 13: Percentage of men and women who intend to treat water before drinking it

The FGD participants emphasized that water treatment requiring boiling water is a huge problem. Most participants know that boiling water is a treatment method, but they find themselves unable to comply with this recommendation because they find it time consuming and costly as they would have to fetch firewood and obtain big pots in order to boil water. Clearly, lack of resources is noted as the main barrier to having access to safe drinking water.

“Boiling water is not easy for us. It demands a lot of resources, which we do not have. We can do it one day and then another, but then we will fail. It is something that we cannot sustain.” (Traditional healer, Community of Melo 1).

²⁸ Certeza is handed out through local health facilities when in stock.

Regarding water storage, they know that water should be stored in clean containers and that these should be covered with a lid. However, the containers observed were being kept on the ground/floor and were not in a particularly good hygienic condition.

Sanitation & open defecation²⁹



Photo Caption: One of the communities where the FGD was conducted
Photo credit: Nilda Lima

Solid waste is a critical issue in communities. At the household and community levels, the collection of solid waste is not organized in a standardized way. FGD participants communicated that solid waste is unhealthy, especially when children are playing near it, but in most cases, there are no waste bins and some people throw waste around their homes and public spaces. Many people in the communities do not have access to an improved sanitation facility;³⁰ others have gained access to latrines. They do believe this facility is helpful for their health and, the families with latrines use them daily. On the other hand, in the communities where people do not have latrines, they are still practicing open defecation, leading to an unhealthy environment as the rain drags the fecal waste close to their homes. They are aware of the association between bad hygiene practices and diseases, particularly diarrhoea and cholera.

“ Here children get diarrhoea very often. Many people in the communities do open defecation because there is no choice. Some people are near the river and it is possible that the fecal waste goes to the river from where we usually get water. That is our life.” (Community leader, community of Candima).

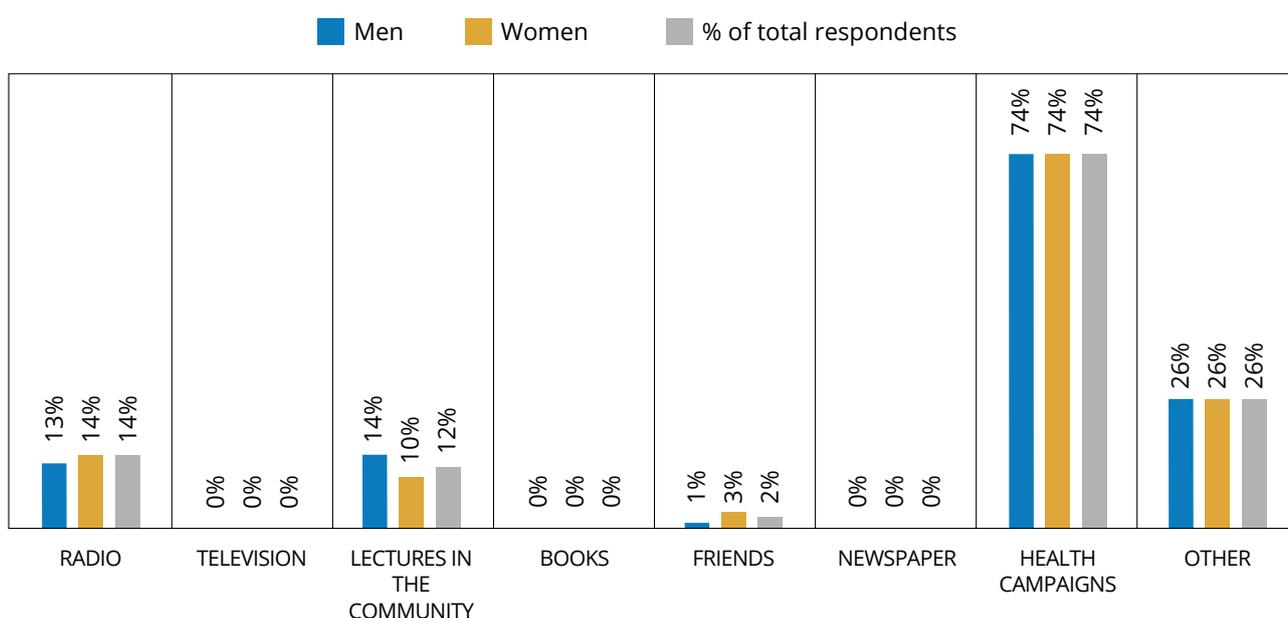
²⁹ Open defecation is defined by WHO “when human feces are disposed of in the fields, forests, bushes, open bodies of water, beaches, and other open spaces” (WHO; UNICEF, 2013). Additionally, in Mozambique, 39% of the population still practises open defecation (UNICEF, 2014).

³⁰ According to WHO, an improved sanitation facility is one that hygienically separates human excreta from human contact. (Retrieved from: http://www.who.int/water_sanitation_health/en/index.html)

Sexual and Reproductive Health

Sourcing SRH Information

Health services are pointed out as the main sources for receiving information about SRH by study participants. Of the survey respondents, 71% (62% of men and 80% of women) indicate that they receive information about SRH from health campaigns and 14% of respondents self-reported getting information from hospitals (see Figure 14). Radio was mentioned as an information channel by 18% of survey respondents, with some respondents indicating both hospitals and the radio as their sources. Additionally, respondents stated that mobile brigades provide contraceptive methods, information on family planning and SRH services.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 14: Percentage of where men and women are getting information on sexual and reproductive health, by source type

School attendance during menstruation

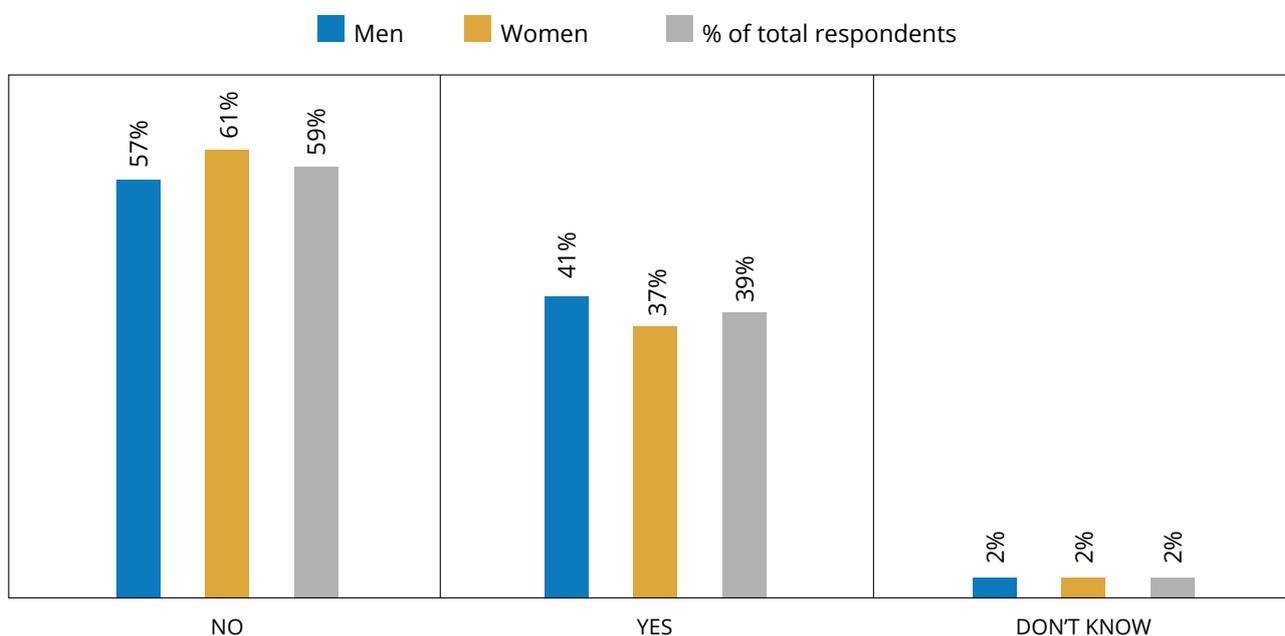
With respect to the question whether girls should attend school while menstruating, 57% of the survey respondents (54% of men and 60% of women) indicated that girls should attend school as usual, whereas 19% (20% of men and 18% of women) thought differently and indicated girls should not. Some respondents (24%) were unsure (26% of men and 22% of women). The main reason was that they think menstruation is dirty and that girls should be isolated during this period. Another reason presented by girls from the FGD was that there are no facilities at school, and it is embarrassing for them.

Early marriage and education



Photo Caption: (left) Adolescent boy with peers in Mulima and (right) Adolescent girl with her peers on Mulima
Photo Credit: Nilda Lima

Of the 258 survey respondents, 39% (41% of men and 37% of women) reported that a girl who is married and/or has children before 18 years of age is less likely to finish school than a girl who postpones marriage and/or pregnancy until after 18 years of age; while 59% did not think so (see Figure 15). Findings from FGDs were not aligned with the quantitative data and all participants mentioned that early marriage/early pregnancy is not compatible with finishing school.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 15: Percentage of men and women who think that a girl who is married and/or has children before 18 years of age is less likely to finish school than a girl who waits until after 18 years of age

“ I am 19 years old. I am not prepared to be a mother because I do not want to stop my school. My dream is to finish my studies and go to university to get a university certificate. But I’m married and my husband wants to be a father. I have talked to him many times, but he asked me to stop trying to convince him to wait until I finished my studies. He made it clear that he would not accept my refusal. So since last year I have done nothing to avoid pregnancy. I do not know what to do.” (Adolescent girl, 19 years old, GTNS project activist).³¹

They say that it is widely known that girls immediately leave school upon becoming pregnant. Most caregivers indicated that even though they would like their daughters to finish school, they support their decision of being at home to take care of their children.

While practices around child marriage appear to indicate that it is normalized in some areas, survey responses suggested that it is negatively perceived. Of the survey respondents, 87% (95% of men and 79% of women) know that the minimum legal age to marry is 18 years, and 88% (93% of men and 83% women) do not intend to allow their children to marry before they are 18 years of age.³²

On the other hand, marriage still seems to be a social obligation. Adolescent girls in the FGDs emphasized that they do not intend to marry before finishing secondary school. The main reason is that they want to make money, to get a job and have a profession. Some professions mentioned were teacher, nurse, policewoman, director of a health center and a businessperson. However, they say that is a dream and they are uncertain if they will succeed in achieving it as they face many obstacles. The majority of the obstacles are related to social pressure, either at household or community level, for girls to get married as soon as they turn 18 years old.

“ We are not seen as good girls. We do not [want to] get married soon after we are 18 years old. They [community members] call us bad names and do not treat us well. I speak on my own behalf. I do want to finish my school and get my certificate, but I do not know if I can resist this pressure.” (Adolescent girl, 18 years old, community of Bucha).

Likewise, adolescent boys cited that they do not want to marry very soon because they also want to finish school and get a job. They mentioned that they also feel the pressure to marry early (by the community) as well as to become fathers though this is not a priority for them.

Polygynous³³ versus monogamous marriage

Most young people (boys and adolescent girls)³⁴ from the FGDs stated that despite the fact that polygynous marriages remain a cultural value widely practiced in Chembra district, they do not intend to maintain this tradition and are more inclined towards monogamous marriage. The main reason presented by both adolescent girls and boys is that polygynous marriage creates instability in the family and increases the household’s expenses.

³¹ Identifying details will not be disclosed to keep the privacy of the interviewee.

³² However, it was noted in the quantitative field research team’s notes that while many women surveyed knew the minimum legal age to marry is 18 years old, they did not know their own age.

³³ Polygynous marriages are defined as a man having multiple wives concurrently whereas polyamorous marriages are defined as a woman having multiple husbands concurrently. Polygamy is a gender-neutral term that refers to the practice of having multiple marriage partners at the same time.

³⁴ Young people cover the age range 10-24 years. <https://www.who.int/southeastasia/health-topics/adolescent-health>.

- “ My father has three wives. What our family produces is not enough for all of us to eat because he has so many children with other wives. When we have some money left my father does not know what to do with the money because there are so many priorities among the families. Other than that, there is a lot of conflict among wives, and families cannot be happy. When I get married, I just want one wife. That is for sure.” (Boy, 17 years old, community of Candima).
- “ My father has four wives. I do not like that. I have so many brothers and sisters and my father does not have time to look after all of us. Additionally, there is conflict among wives and my father, sometimes between my mother and her rivals. I am not married. But when I get married, I want a monogamous marriage. Polygamous marriage is not worth it.” (Adolescent girl, 17 years old, community of Tomucene 1).

In this regard, it is highlighted that the young people are questioning not only their parents' attitudes and behaviors, but also existing social norms, which clearly indicate the need to not reproduce the status quo. Adolescent boys and girls drew attention to the fact that they do not share the same marriage ideas with their parents, but they are expected to perpetuate traditional behaviors. Countering their traditions would be considered insulting, leading to latent social punishment among young people.

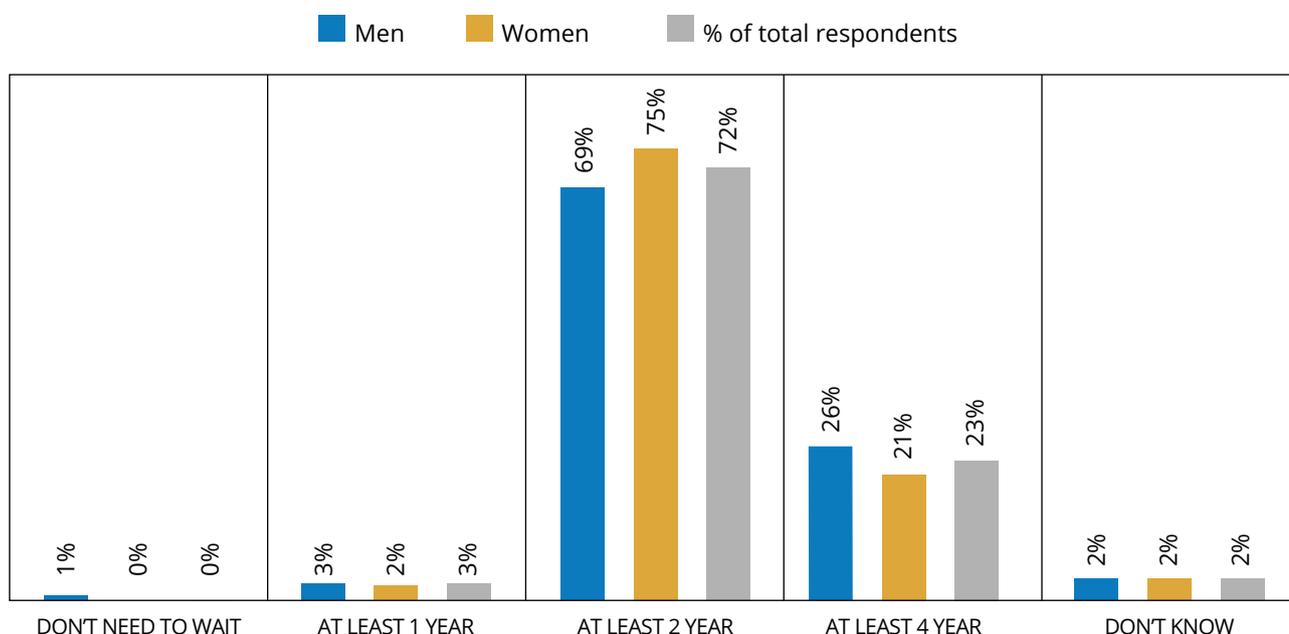
- “ Once I told my father that I will never have several wives like him. He got so furious. He said: I do want rebels here. Since then I do not tell him what I think. When my times comes, I will know what to do.” (Boy, 16 years old, community of Nhakuiyoyo).
- “ My mother does not support me. She wants me to get married whatever happens. I want to get married too when I am older, but I do not want to get involved with a man who has many wives because even my child will suffer because he will not take care of us properly. I told my mother I do not accept this. My mother got angry at me and said that I have to obey, but I do not want to. So I prefer not to talk to her about it.” (Adolescent girl, 17 years old, community of Nhakuiyoyo).

Pregnancy



*Caption: Pregnant women participating in one of the FGDs
Photo Credit: Nilda Lima*

Regarding the minimum time needed for a woman to wait to become pregnant again after giving birth, 72% of the survey respondents (69% of men and 75% of women) knew that women should wait at least two years between births in order to be safe (see Figure 16). Of the respondents, 23% (26% of men and 21% of women) indicated that they think the minimum period between births should be four years. Even though the majority are well-informed, some women stated from the FGDs that they got pregnant earlier because their husbands do not accept family planning or do not want to wait so long.

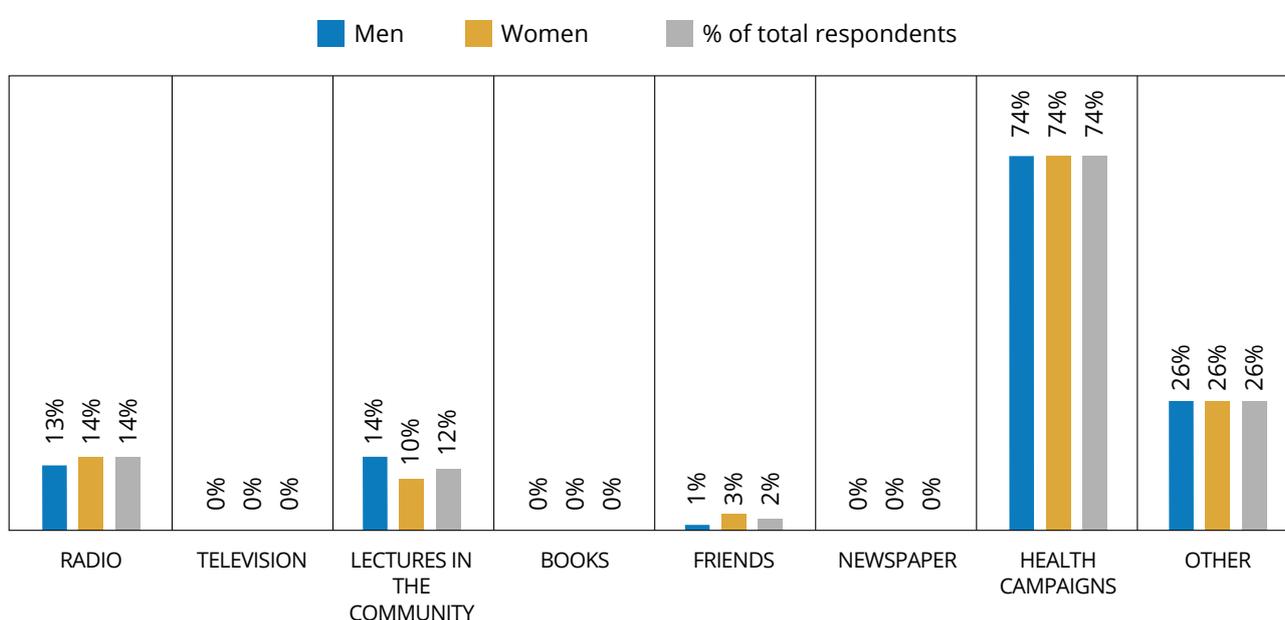


Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 16: Percentage of men and women who know the correct birth spacing period in order to be considered safe

Contraceptive methods

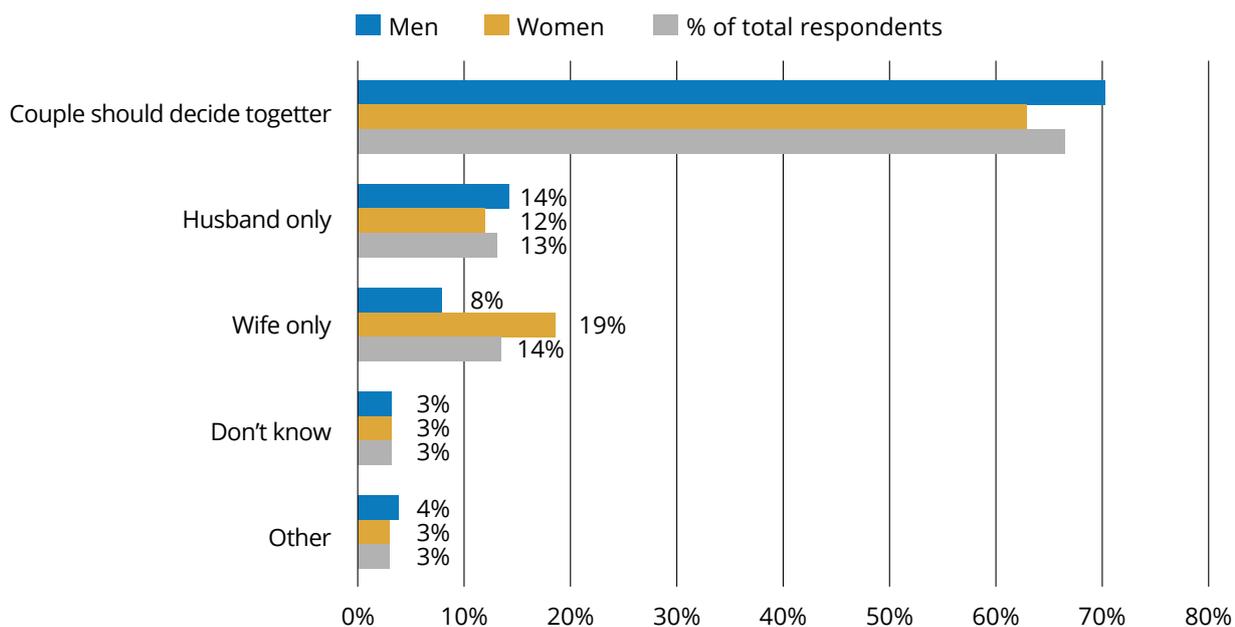
Approximately 97% of the survey respondents (98% of men and 96% of women) have heard about contraceptives. A majority receive information on contraceptive methods through health campaigns and hospitals (see Figure 17). Additionally, 14% of respondents indicated they get information from the radio while 12% of respondents receive information on contraceptives from lectures conducted in the community. *All* respondents who indicated radio also indicated at least also hearing from health campaigns. With respect to safety of contraceptives, 78% of the survey respondents (78% of men and 78% of women) are fully confident that contraceptives are safe to use, while 12% are somewhat confident and 10% are not confident. During the FGDs, participants stated that some women are not confident when it comes to implant safety and some of them have returned to the health facility to have it removed.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 17: Percentage of where men and women get information on contraceptives, by source type

Regarding the choice of contraceptive method, 67% of the survey respondents (70% of men and 63% of women) think that a couple should jointly decide what type of contraceptive will be used (see Figure 18). During the FGDs, men mentioned that whatever their wives decide is acceptable, but it was understood that men widely have the final say. However, men refuse to use condoms because they say that it diminishes sexual pleasure.



Note: men and women percentages were calculated within their own groups (125 men, 133 women) and the % of total respondents is out of the total 258 respondents

Figure 18: Who has final say on what type of contraceptive to use (disaggregated by gender and in percentages)

Interestingly, 42% of women interviewed in the survey further indicated that they would continue to use contraceptives if their husband did not agree to do family planning (see Figure 19).

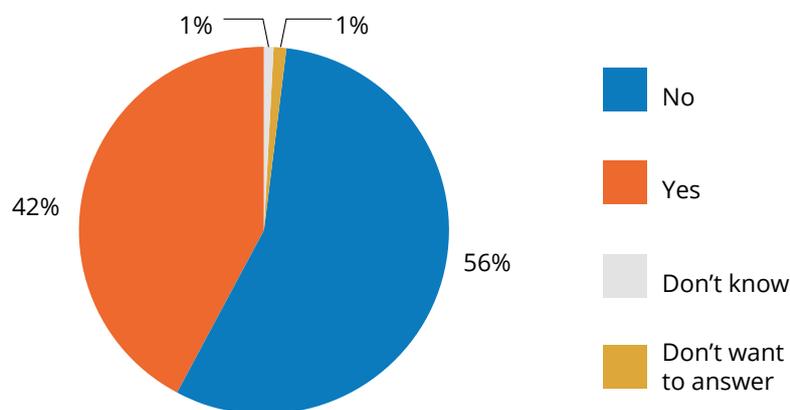


Figure 19: Percentage of women who will continue to use family planning methods despite their husband not agreeing

Safety of abortions

Many FGD participants state that abortion is not a common practice in their communities.³⁵ However, they are confident that abortions can be done safely at the health facility. Of the survey respondents, 79% (82% of men and 76% of women) indicated that abortions are safe when performed at the health facility, whereas 14% do not agree that abortions performed at health facilities are safe. The latter figure of 14% may explain why some people expressed their preference to go to a traditional healer for an abortion because they believe that the healers know the correct herbs to be used for an abortion.

Obstetric Fistula³⁶

This topic was explored through the survey and qualitative methods (FGDs and KII). While the FGDs were conducted with influential people in the communities, the KII were conducted with three women living with OF and their family members.

Taboos around the subject

According to the survey, 80% of the respondents (206 of 258 respondents, equally across men and women) have heard about OF (or in the local language, *tixvuzi / ndenda za chizazi*), mainly from health campaigns, radio and people in their community, such as family, friends, older members and neighbors. Conversely, most FGD participants have never heard about this. Curiously, when the qualitative team asked about their knowledge of OF, they answered positively, but after probing further it was noticed that people confused OF and urinary incontinence.³⁷ Obstetric fistula is not actually known in communities, which compels the Study Team to question the survey data mentioned above.

When FGDs participants finally understood the question of OF, they said that they knew some people in the communities living with it, but they could not add additional information, because OF is a sensitive issue and people do not want to talk about it freely. This was confirmed during the KII, in which all women living with OF and their family members stated that they just talk about it among themselves, not only because the subject is surrounded by taboo but also because women living with this problem feel ashamed due to other people's reactions.

“ Since having this problem my life changed. My husband left me. Before I suffered from this all was good between us. I avoid being with my friends and neighbours because I do not feel comfortable being with them or confident when I go out. I keep myself most of the time indoors and just go out when it is absolutely necessary. ”
(Community member, 20 years old).³⁸

³⁵ This view was confirmed in the quantitative field research team notes such that when women were asked about abortion a notable number of women were surprised by this question, potentially aligning with FGD participants who do not think abortion as a common practice.

³⁶ Obstetric fistula is “[a]hole between the birth canal and bladder and/or rectum... caused by prolonged, obstructed labour without access to timely, high-quality medical treatment” Retrieved from: UNFPA <https://www.unfpa.org/obstetric-fistula>

³⁷ Urinary incontinence is loss of bladder control.

³⁸ Identifying details will not be disclosed to keep the privacy of the interviewee.

Preconceived ideas towards this subject

FGD participants and survey respondents believe that there is treatment for OF, either at health facilities or by the traditional healer. A majority of survey respondents (54%) who had previously indicated knowing what OF is, know there is a treatment (111 out of 206 survey respondents). From these respondents, 94% indicated treatment was available at the health facility and only 7% indicated from a traditional healer. However, because OF is strongly associated with witchcraft and external causes, all the FGD participants desperately sought a solution with traditional healers within and beyond their province. They believe they need to be cured not only of this disease but also to get rid of the “bad spirits” that were sent to them.

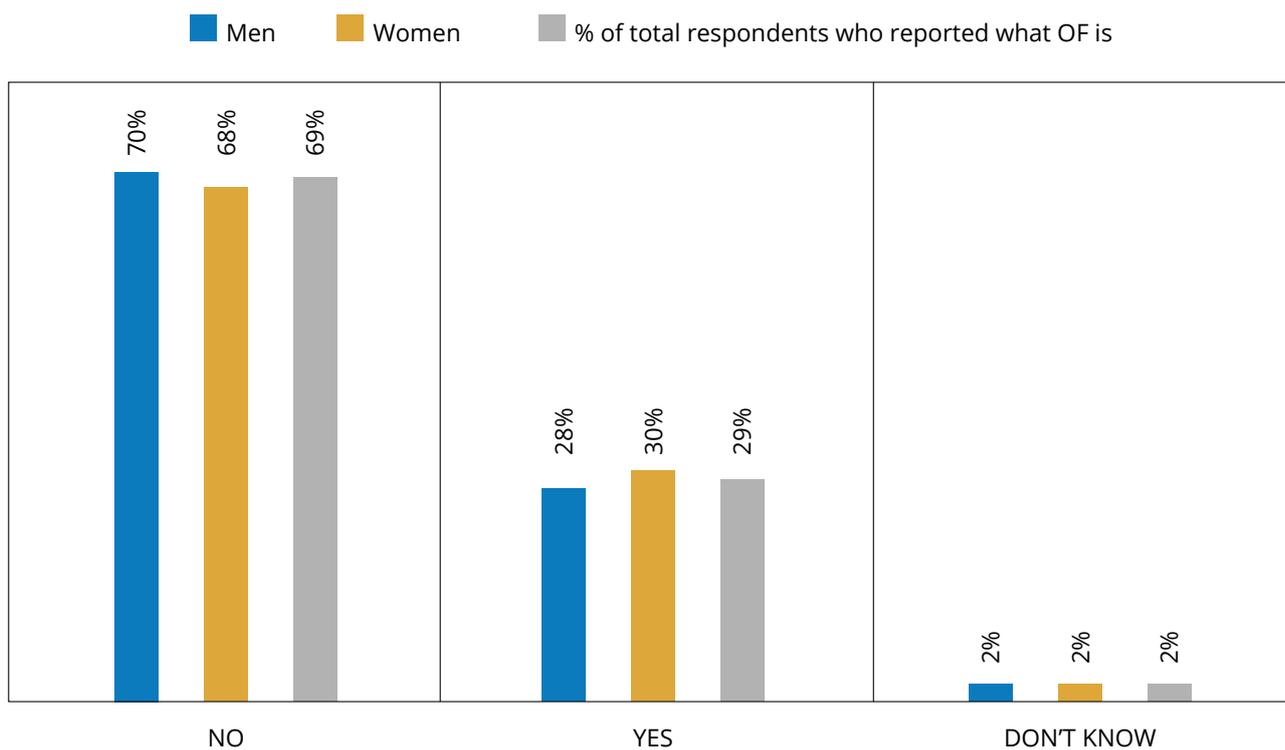
“ I am sure my daughter has been bewitched. They [spirits] put a spell on her. I have sold livestock I had, including part of our crop harvest to be able to pay the traditional medicine services. I did all I could to see my daughter healed, but it was not enough, and she is still sick. Now I have nothing to sell and no money. She cannot go to school... I do not know what to do.” (Mother of a 19-year-old adolescent living with OF).

Fear, taboo, shame, lack of knowledge, misinformation and cultural values all encourage negative attitudes towards OF and impose a social isolation that affects women living with OF and creates instability in the family.

Health Seeking Behaviors at health facility

Despite the fact that they have devoted the time, resources and efforts necessary to seek treatment through traditional medicine, when asked whether they would accept hospital treatment, they answered positively. Yet, given the taboo and sense of embarrassment, they stated not to share this information with anybody in the community to avoid social exposure. This is aligned with survey respondents of which the majority (69% of survey respondents who indicated to know what OF is) stated that people living with OF are not comfortable talking about symptoms (see Figure 20).

“ If I am informed that I have an operation appointment at the hospital, I would go, but I would leave very early in the morning, discreetly so no one would ask me where I am going.” (Woman living with OF, unknown age).



Note: men and women percentages were calculated within their own groups (100 men, 106 women) and the % of total respondents refers to the 206 survey respondents who reported knowing Obstetric Fistula

Figure 20: Percentage of men and women who think women living with Obstetric Fistula are comfortable talking about symptoms



VII. CONCLUSION & RECOMMENDATIONS

The aim of the KAP Study was to explore key aspects related to nutrition to better understand the community's knowledge, perception and practices about MN, IYCF as well as complementing information concerning components of the project that were not covered by the baseline study, namely SRH, including OF, and S&H, to strategically inform programme implementation. The findings clearly reveal crucial areas for change in the project and, most importantly, key insights into community members' perceptions, knowledge and practices and reasons why given beliefs have been perpetuated even when running counter to knowledge. Unquestionably, the KAP Study helps to better understand people's behaviours and local dynamics and, therefore, the results of the KAP Study can promote a valuable force for change.

Although the quantitative data collection is not representative, in combination with the qualitative data it is possible to draw valid conclusions since it is interpreted within the context of the population studied and the communities where the GTNS Project is being implemented. Interpreting the data, the KAP Team sought to address methodological limitations that may have affected the results.

It should be noted that the KAP Study captured certain differences between communities situated in rural areas from those in peripheral areas. Regarding knowledge, the communities surrounding the Mulima central area, although displaying rural characteristics, are more knowledgeable and more exposed to public services; while remote communities seem to have more ingrained traditional practices. This, therefore, suggests that more attention should be given to the people living in peripheral communities.

On the other hand, the gender dynamic remains the same across communities. Irrespective of where they are located, men remain reluctant to ensure more support for their wives when it comes to domestic work, accompanying them to the ANC visits and providing the support needed during pregnancy. It appears to be an established and accepted behaviour. That said, it is worth noticing that there are men (noting it is very few) who do not fully follow this pattern, a potential entry point that may be seized when encouraging a positive environment.

Another relevant characteristic of communities is that young people - adolescent girls and boys - tend to be critical of certain traditional practices adhered to by their parents or people in the community, particularly polygynous marriage. Most of them indicated that polygynous marriages are harmful to family well-being, and this is the reason they would rather enter into monogamous marriage. In addition, young people emphasized the need of achieving their dreams. They indicated the completion of studies and having a profession as a priority, followed by marriage, which, again, reveals a potential for change, as it differs substantially from the context from which they come.

The KAP Study results highlighted seven target areas to which recommendations are directed. The following recommendations are presented taking into consideration that the programme is running and some actions are already in place.

1. First 1,000 days of life

1.1 Strengthen partnerships with key health facilities near project sites to leverage their support for successful project implementation.

Health facilities are key stakeholders of the project as well as a key source of information for communities, both in Mulima and in the surrounding areas, and are crucial in engaging community members and project beneficiaries in health services and messaging. Greater sensitisation of project aims and support to health facility staff can strengthen the bridge between communities and health facilities. This can include involving health facility staff in key GTNS trainings and meetings.

1.2 Develop and broadcast semi-regular radio programmes targeting caregivers on the importance of the first 1,000 days of life using key SBCC messages for this critical time period.

Although most parents and caregivers in the KAP Study were aware of the importance of the first 1,000 days of life, they are not knowledgeable about the consequences on a child's physical and mental development from not providing adequate care and nutrition during this critical period. It is especially important to also communicate to the communities the correct interval of this critical period, from pregnancy through the first two years of age.

A field strategy should highlight the benefits of ensuring proper care and nutrition, taking into consideration that this period of a child's life is crucial to prevent stunting and critical for a child to grow and develop healthily. Applying an SBCC lens, a radio programme should be created based on the first session of the standard package SBCC manuals to sensitise parents, community health workers (CHWs) and health professionals on the importance of the first 1,000 days of life.³⁹ Findings have shown that many KAP Study participants receive information through radio and this modality would allow for a wider range of community members to benefit from SBCC messages that are already being communicated to beneficiaries through interpersonal counselling sessions.

2. Health of PLW and CU2

2.1 Engage traditional healers in SBCC messaging to leverage their community influence in improving children and PLW health and nutrition outcomes.

All KAP Study data, similar to baseline findings, showed that malaria and diarrhoea are considered the diseases that most affect children, and global data shows that malaria and diarrhoea are deadly for young children (UNICEF, n.d.). Preventing these diseases is crucial and their impact on nutritional status should not be underestimated. The beliefs concerning treatment of these diseases pose barriers to accessing proper care, where a non-trivial amount of people mentioned the need to seek out traditional healers. Health outcomes of young children and PLW would be improved if traditional healers were specifically targeted and engaged in SBCC messaging around the first 1,000 days and care of children in groups for interpersonal counselling in addition to primary beneficiary households.

³⁹ The first session of each SBCC topic in the standard SBCC package focuses on the first 1000 days of life and the importance good nutrition and care for child development. The 4 SBCC topics in the standard package are IYCF, Maternal Nutrition, Malaria Prevention and Sanitation & Hygiene.

2.2 Improve sensitisation of key health facility staff near project sites on the link between gender and nutrition to ensure greater engagement of men in women's care.

Findings showed women are not resting as much as they should during pregnancy and many mothers indicated that it is vital that their husbands support them during pregnancy and lactation. This includes, but is not limited to, support with domestic tasks, lifting heavy items, and accompanying them to ANC and children consultations. Physical effort and a high household burden have negative effects on the pregnancy and a woman's health during this period. The project field strategy needs to put a greater emphasis on the importance of PLW doing less physically demanding activities during pregnancy and lactation and include its links to short-term and long-term health of the baby. This can be facilitated by *strengthening the partnership with key health facilities near project sites; it is vital for care of young children and PLW*. Moreover, according to the survey respondents, health professionals are the main information source and seen as the most trusted people in the community. Health facility staff should be empowered to deliver all messages from the gender package to community members.

3. Maternal Nutrition and Care of PLW & baby (0 – 6 months)

i. PLW's diet

3.1 Support mobile brigades to prioritise dissemination of information in remote communities on proper diet and care for PLW and provide basic health services to women facing barriers in consuming a nutritious and balanced diet.

The overwhelming majority of KAP Study participants are not knowledgeable about maternal nutrition during pregnancy, with only a small number of KAP participants able identify the four food groups for an essential diet for PLW. While, the KAP Study showed that PLW reported eating between 2-3 meals per day, micronutrients were missing. This indicates poor attitudes and practices around nutrition and diet during pregnancy among the target population. The situation is more serious in remote areas, where people have less access to information.

The GTNS Project team should guide the mobile brigade staff on specific areas to prioritise. The package should include a) information about the linkage between nutritious foods (including egg consumption) and a healthy pregnancy, focusing on the availability of local products; and b) screening and treatment of acute malnutrition for PLW by mobile brigades throughout the project period at community level to quickly capture women at risk of, or suffering from, malnutrition and provide the proper healthcare needed.

3.2 Sensitise community members through existing SBCC activities and an additional livestock-rearing component to use locally available food sources to improve maternal nutrition.

Results showed that a poor diet was not only related to food scarcity, but also to a lack of information on how to better use local resources for a more nutritious and balanced diet for PLW. Despite the majority of KAP participants knowing that protein is an important element of PLW diet, PLW are not eating such foods. It is known that in Mulima people use livestock as a source of income rather than a source of food. It should be highlighted that an investment in nutrition is an investment in future income. This can be immediately implemented by including more protein-rich recipes into cooking demonstrations. For more long-term sustainability,

strengthening climate resilient agriculture and reducing post-harvest loss to ensure small holder farmer income year-round could complement the ability to consume parts of household livestock without fear of losing future income. Additionally, interpersonal counselling on maternal nutrition should include promoting egg consumption from chicken raising.

ii. Exclusive breastfeeding

3.3 The SBCC strategy should change from an awareness raising campaign to a behaviour change campaign, focusing on perceptions of the benefits, risks and seriousness of the issues around exclusive breastfeeding.

It should be noted that breastfeeding is widely practiced by all mothers from the FGDs. However, exclusive breastfeeding remains low among lactating women. Despite the fact that they are knowledgeable about the importance of exclusive breastfeeding, they believe that breast milk alone is not enough.

The main barrier to the adoption of exclusive breastfeeding is not knowledge, but attitudes – the community's preconceived ideas towards this issue. In this context, a behaviour change campaign should take into account the following aspects:

- Supporting the caregivers in overcoming barriers - such as fear of letting the baby go hungry - to change behaviour by creating an enabling environment.
- Address traditional practices that conflict with the desired behaviour by involving trusted messengers (at household level) and influential people in the community [such as religious and community leaders and APEs].
- Identify in the community potential *positive deviants*⁴⁰ and actively involve them in the campaign.
- Do not focus on the 1,500 beneficiary household families only. Aim at targeting a larger audience to allow for an enabling environment.

The aforementioned aspects can be written into and broadcasted on existing radio talk shows or used as criteria for selecting success story interviewees. Utilizing radio will also broaden the target audience to beyond the primary project beneficiaries.

4. Infant and Young Child Feeding

4.1 Refocus the cooking demonstration strategy to be more community-focused and include messages related to food quantity and consistency and adding fats to improve IYCF diet.

Due to food scarcity, data showed that feeding infants and young children appropriately is a serious problem. The typical daily diet for a child under two is very poor, missing the recommended dietary diversity and not containing a minimum acceptable diet. For most caregivers, it is difficult to feed their child a variety of types of foods each day. The KAP Study participants reported that they do not manage to feed their young children more than 2-3 food groups per day. It is evident

⁴⁰ The first session of each SBCC topic in the standard SBCC package focuses on the first 1000 days of life and the importance good nutrition and care for child development. The 4 SBCC topics in the standard package are IYCF, Maternal Nutrition, Malaria Prevention and Sanitation & Hygiene.

that the recommended frequency of feeding children is very low. Moreover, knowledge on food consistency and quantity of food for children at each meal is very limited, leading caregivers to adopt an intuitive practice, without following any recommendations. The daily diet for a young child becomes more worrying as parents and caregivers do not have information on fortified products and, consequently, on how to choose these in the local market. Likewise, the practice of adding oil, butter, or other fats to children's diets is lacking.

On the other hand, there is a positive aspect regarding food preservation. Caregivers have managed to preserve a variety of food through local methods to feed their children to cope with food scarcity, although they do not have much knowledge on new techniques. Additionally, they resist consuming certain products such as sun-dried tomatoes and sun-dried *thobve* leaves due to community taboos around these foods. Consumption of eggs was explored in another project assessment (WFP Mozambique, 2020) as well as in this Study; however, practices around young children consuming eggs should be further explored.

A field strategy should reinforce:

a) Refocus the existing cooking demonstration sessions by:

- Using fortified products in order to raise awareness around them to the audience. Due to market repackaging of foods, fortified foods are difficult to identify and capacitate community-based *bancas*⁴¹ and market sellers to be able to assist caregivers are looking for fortified foods for their young children. It would be beneficial to engage food sellers (at all levels) to create an enabling environment around fortified foods. Communication materials might include fortified logo stickers to place on repackaged foods.
- Demonstrating the recommended consistency and quantity of food for children at each meal, in accordance with the age group.
- Adding locally available fats (such as peanuts and sesame) to children's diets and emphasize the importance of fats in children's diets.
- Adding different types of micronutrient-rich foods (such as animal products, fruits and vegetables) to encourage their consumption.

b) Refocus the existing food preservation sessions by:

- Teaching project beneficiaries techniques about new products that can be preserved, including meat and eggs.
- Addressing the barriers to the consumption of certain products by promoting the exchange of information and feelings by people who have consumed these products and have positive stories to share with those afraid of consuming them (either by radio or interpersonal counselling sessions).

⁴¹ *Bancas* are small locally-owned and operated kiosks located in remote villages that re-sell food products from the larger district markets.

5. Sanitation and Hygiene

5.1 Create synergies and alignment wherever possible through multi-sectoral approaches to increase the number of local water pumps.

Safe drinking-water is the most challenging issue in all communities where the project is being implemented. The KAP Study shows that main sources of drinking water are public water pumps, ponds, streams and rivers. The KAP participants are able to distinguish safe water from unsafe water by looking at its turbidity (how cloudy it appears). Although it is recognised that muddy water is unsafe to drink, and therefore should be treated, and a majority of KAP respondents indicated they intended to or might treat their water before drinking it, it is extremely difficult for them to boil water because they do not have the resources nor the time to do so. As a result, the water they consume is unsafe. The same water is used for bathing, cleaning and doing the laundry. Moreover, open defecation leads to an unhealthy environment as the rain brings fecal waste close to their homes.

Create synergies and alignment wherever possible through multi-sectoral approaches to increase access to clean, safe drinking water. Taking into consideration that community sessions on Sanitation & Hygiene (covering the main aspects raised in the KAP study), the KAP Study team recommends identifying partnerships that can provide public water pumps or support in implementing projects at the water sources, such as a handwashing campaign at local water pumps. If not, it would be very difficult for the programme beneficiaries to comply with the recommended hygiene practices as the correct infrastructure is not in place.

6. Sexual and Reproductive Health

i. Early Marriage and Education

6.1 Liaise with district government education authorities and encourage supporting adolescent girls finishing school by providing technical and financial support.

Findings from the KAP Study revealed young people's - adolescent girls and boys - dreams: they want to finish school, make money, get a job and have a profession. Some professions mentioned were teacher, nurse, policewoman, director of a health facility and a businessperson. "Dream" was used because they are uncertain if they will succeed in achieving it as they face many obstacles. Although a majority of respondents think that early marriage or early pregnancy do not affect the ability of girls to finish school, all FGD participants, without exception, made clear that early marriage/early pregnancy is not compatible with finishing school. That is why they do not intend to marry before finishing secondary school, and a majority of caregivers indicated they do not intend to allow their children to get married before 18 years of age. Adolescents girls, in particular, feel scared because they know that if they become pregnant, they will immediately need to leave school and parents generally do not encourage continuing after leaving. The GTNS Project team should create synergies to more clearly link education and nutrition using the multisectoral approach employed by the project.

ii. Polygynous versus monogamous marriage

6.2 Expand the target audience of the SBCC interpersonal community sessions to include adolescents in the project household in addition to the caregivers of CU2 and their partners.

The KAP Study highlighted that while polygynous marriages remain widely practiced and strongly valued culturally in Chemba district, young people do not intend to maintain this tradition and are more inclined toward monogamous marriage. The rationale stated by adolescents is that polygynous marriage creates instability in the family and increases household expenses. The adolescents are not only questioning both their parents' attitudes and behaviors, but also existing social norms, and ending the status quo to promote deviant behavior instead. Adolescents emphasized that polygynous marriages have posed an obstacle for caring of PLW and children as men are not able to support all their wives and children properly. This may require re-orienting the geographical target to include older adolescents given the fact that there is no secondary school in Mulima and these children are attending school (and living) in Chemba-*sede* or other larger towns outside of Mulima AP. Older adolescents are at a crucial age at the most risk for early marriage and/or early pregnancy.

6.3 Design a visually artistic complementary activity to ensure that adolescents can transform what they have learned from the community sessions into a piece of artwork that can be displayed in the community.

Engaging adolescents in existing community sessions on SRH and gender is crucial to bring together different perspectives and encourage productive intergenerational discussion. A complementary visual artistic activity is a photo exhibition. Artistic activities are quite attractive for adolescents in the sense that it helps them express themselves more openly and creatively in a public space and engages them on a more personal level. Given their great potential to act as a positive deviant, the GTNS Project needs to use this opportunity to address tipping points⁴² for change at the individual and community level.

iii. Family planning

6.4 Design a context-specific gender action plan to further strengthen the link between gender and nutrition throughout all activities.

Health facilities provide family planning services at community level through mobile brigades and health campaigns. For this reason, the KAP Study findings show people in the community are knowledgeable about contraceptive methods and have access to them. According to interviews, a couple should decide together on contraceptive use; however, it is understood that actually men have the final say on contraceptive use. Although a considerable number of women indicated they would continue to use contraceptives if their husbands did not agree to do family planning. Another important aspect is that women have the final say on the choice of contraceptive method, except in regard to condoms. Men refuse to use condoms because they say that it diminishes sexual pleasure.

Given the fact that family planning will be addressed in both the gender dialogue club and SRH sessions of the GTNS Project, no further specific activity is recommended. Nevertheless, it is recommended to develop a more coordinated approach to linking gender and nutrition within all the project activities beyond of the GDCs. A gender action plan will ensure alignment with gender dialogue club component with any following supplementary gender activities.

⁴² A tipping point refers to the dynamics of social change, where trends rapidly evolve into permanent changes. It can be driven by a naturally occurring event or a strong determinant for change. Tipping points describe how momentum builds up to a point where change gains strength and becomes unstoppable. [C-Change (Communication for Change). C-Modules: A Learning Package for Social and Behavior Change Communication. Washington, DC: C-Change/FHI 360; 2012].

7. Obstetric Fistula

7.1 Develop an awareness campaign around Obstetric Fistula and its related messages utilizing the media component.

It is known that OF is caused by early pregnancy, malnutrition and lack of access to emergency surgery related to labor issues. (UNFPA; EngenderHealth, 2003) Women living with OF are vulnerable and socially isolated without community support. In some cases, they are abandoned by their husbands and cannot provide proper care for their children and themselves.

Fear, taboo, shame, lack of knowledge, misinformation and cultural values are the key words that come up when discussing OF. Women living with OF confine themselves to social isolation because participating in daily life was reported as embarrassing due to the symptoms and taboos of this disease. With that being said, women living with OF do not feel comfortable talking about their symptoms or this issue overall. Due to the taboo around this subject, the GTNS Project team should raise awareness of OF. Furthermore, OF is strongly associated with witchcraft, external causes, and “bad spirits”, leading to people living with OF to seek solutions by traditional healers. *When developing and disseminating messages on OF - focusing on causes, symptoms and availability of treatment - for more rigorous impact, it is crucial to engage health professionals to better assist and refer patients for treatment at hospitals.* The GTNS Project radio partner is best positioned to disseminate messages on OF to the wider community. Spots, scripts and success stories should feature clear information on symptoms, causes and treatment as well as ways to address the stigma around living with OF.

7.2 Support local and provincial health authorities in Obstetric Fistula campaigns by aligning project-supported mobile brigades and radio messages with the Mozambique national plan.

Creating demand for treatment of OF through radio messaging cannot begin without first liaising with health authorities as treatment is only available outside of Chemba district at provincial hospitals. There are national OF campaigns in the country that the GTNS Project team should align any and all SBCC messages, particularly around free treatment support through health authorities. The GTNS Project can leverage CHWs to also disseminate messages or mobilize communities when the national campaign is occurring.

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ANNEXES

Annex 1: Qualitative Data Collection Tool: Focus Groups Discussions

Topics	Knowledge	Attitudes	Practices	Facilitating factors	Barriers
Maternal Nutrition					
ANC and PLW's diet	Do you know how many times a pregnant woman should go to the health facility for prenatal consultations?	Do you trust that consultations help in the health of pregnancy for the result of a healthier baby?	How many consultations did you have during pregnancy? Does the husband accompany her during consultations?	What motivates you to carry out consultations?	Have you faced barriers to meeting consultations?
	Do you know the type of diet a pregnant or lactating woman should have?	What do you think healthy eating would be for pregnant and lactating women?	What did you use to eat / usually eat during pregnancy / lactation?	What are the factors that facilitate an appropriate diet during pregnancy?	What barriers have you encountered to a healthy diet?
Energy and protein and quality of diet intake during pregnancy and lactation	Do you know the foods that are essential in the diet of pregnant or lactating women?	Is there any type of food that you think MGL should not eat? Why?	What do you eat daily during pregnancy / breastfeeding?	What can you do to ensure that you have a rich and healthy diet?	What are the barriers to accessing a healthy diet?
		What do you consider a good diet for pregnant or lactating women?			
Rest and work during pregnancy	Do you know about fortified foods?	What do you think about the choice of fortified foods in the diet of pregnant or lactating women?	Do you usually buy fortified foods? Why?	Do you think it is important to have access to fortified foods?	What are the difficulties in gaining access to fortified foods?
	Do you know what fortified means?		What kind of physical activities do you usually do?	What could help to have a pregnancy with more rest and less physical work?	What are the main difficulties you encounter to having more rest during pregnancy and to do lighter jobs?
	Do you know what kind of physical effort a pregnant woman should avoid in order to have a healthy pregnancy?	Do you think that pregnant or lactating women can do physical effort: To what extent? (examples: housework, carrying water, fetching firewood)	Does the husband support you to have more rest and less physical work? In what way?		
	Do you know if rest is important during pregnancy? Why?				

Breastfeeding practices: the first milk and exclusive breastfeeding	Do you know how long after birth the baby should be breastfed?	What is your opinion about breast milk for baby's health?	How do you breastfeed / did you breastfeed your baby under 6 months old?	Do you face / Have you faced difficulties to ensure breastfeeding within 1 hour of the baby's birth?
	Do you know how important it is to breastfeed your baby with the first breast milk immediately after delivery?	Do you believe that the first breast milk is essential for the child's health?		
	Do you know what exclusive breastfeeding means and its importance for the health of babies under 6 months of age?	Do you think the baby needs additional food? (examples: water, tea, juice, porridge)	Have you ever added breastfeeding with other food or liquids?	Do you face / have you faced any difficulties to ensure your baby under 6 months is exclusive breastfeeding?
Infant And Young Child Feeding				
Continued breastfeeding	Do you know how many months young children should continue to be breastfed? Why?	Do you think that not breastfeeding a young child until at least 2 years of age would cause a problem for her health?	Until what age have you been breastfeeding your young child?	Have you faced any difficulties in continuing to breastfeed your young child?
	Do you know when the mother should start complementary feeding? Why?	Do you think that ensuring complementary feeding for children after 6 months of age is important for their health? Why?	How did you feed young child after 6 months of age?	Have you encountered barriers to ensure complementary feeding?
Timely introduction of complementary foods			What helps you ensure a complementary feeding for young children	

<p>Dietary diversity: Feeding children animal source foods</p> <ul style="list-style-type: none"> - Feeding children animal source foods - Feeding children fruits and vegetables - Feeding children a minimum number of food groups (dietary diversity) 	<p>Do you know what foods are essential for the health and growth of young children? Why?</p> <p>Do you know the importance of mixing different food groups? (examples: a dish with green leaves, pumpkin and fish). Why?</p>	<p>What do you think would be the ideal everyday dish for young children? What should it contain on the plate?</p> <p>Is there any kind of food that you think young children should not eat?</p>	<p>What does your young child usually eat? (breakfast, lunch, dinner and snacks)</p> <p>How often do young children eat fruits, vegetables, and animal proteins?</p>	<p>What would motivate you to carry out a varied diet for the young child?</p> <p>Have you had support from your spouse to offer young children food?</p>	<p>What are the main difficulties in ensuring young children eat different food groups?</p>
<p>Micronutrient supplementation or fortification</p>	<p>Do you know which fortified foods are recommended for children? Do you know what fortified means?</p>	<p>Do you trust fortified foods?</p>	<p>Do you usually buy fortified foods? Why?</p>	<p>Do you think it is important to have access to fortified foods?</p>	<p>What are the difficulties in gaining access to fortified foods?</p>
<p>Increased meal frequency and/or density</p> <ul style="list-style-type: none"> - Enhancing the consistency of children's foods - Adding fats or oils to children's foods - Increasing the quantity fed to children at each meal 	<p>Do you know if the consistency of the food is important for a child's food?</p> <p>Do you know the recommended frequency for feeding young children: 6 - 8 months? 9 - 12 months? 12 to 24 months?</p>	<p>Do you think that the consistency of the food interferes with the health of young children? In what way?</p> <p>And does frequency and quantity count for the health of young children?</p>	<p>Describe how you have prepared food for young children in terms of consistency, frequency and quantity?</p>	<p>What would motivate you to want to ensure your young children have a proper consistency, frequency and quantity of food?</p>	<p>What barriers do you find to offer your young children have a proper consistency, frequency and quantity of food?</p>
<p>Do you know the ideal amount of food for each young child's meal: 6 - 8 months? 9 - 12 months? 12 to 24 months?</p>	<p>Do you know if fatty foods like peanuts, coconut, and oil are good or bad for children?</p>	<p>What kind of food do you think young children cannot stop eating?</p> <p>Do you think you offer the right amount of food for your young child? How do you know?</p>	<p>Do you usually offer fatty foods to young children? What types?</p> <p>How much food do you usually offer your young child at each meal?</p>	<p>What would motivate you to want to ensure your young children eat the right fatty foods?</p> <p>What support would you need to ensure your young children have a good amount of food at each meal?</p>	<p>What are the main barriers to ensuring your young children have access to fatty foods?</p> <p>What are the main barriers to ensuring your young children have a good amount of food at each meal?</p>

Responsive/active feeding	Do you know if it is important for caregivers to dedicate sufficient and exclusive time to feed / breastfeed their young children? If so, why?	Do you think that the moment of feeding one's young children is also beneficial for the mother's affectionate relationship with her?	Do you have enough time for your young children when breastfeeding / feeding or is it something you have to hurry to do because of other chores?	What kind of support would you need to be able to ensure enough time for your child's breastfeeding / feeding?	What are the main barriers to dedicating enough time in the act of breastfeeding / feeding the young child?
Feeding during and after illness	Do you know what kind of care to provide to your young child when ill and after recovery?	How should young children be treated when ill? Where do you think young children could be better treated, in the health facility or with a traditional healer?	What have you been doing to care for young children, when ill and in the recovery phase?	Have you had enough support from your family / husband when facing health problems with your child?	What have been the main barriers to taking care of your young children when they are ill and even during the recovery phase?
Sanitation & Hygiene					
Handwashing	Do you know what are the essential moments for hand washing? (before breastfeeding / before feeding the child / before preparing food / before / after using the bathroom / after changing the baby's diaper)	Do you think there is a connection between not washing your hands at critical moments and the presence of diseases, especially in children?	In your daily life, when do you usually wash your hands and your child's hands?	What factors could facilitate hand washing, at least in essential moments?	What are the difficulties you encounter in ensuring hand washing in essential moments?
	Do you know the consequences of not washing your hands, at least during essential moments?	What diseases do you think can be caused by not washing your hands?			
Safe drinking-water	Do you know what potable water means? Do you know the consequences of drinking non-potable water?	Do you think that non-potable water can affect the health of the family, especially the child?	Where do you get the water you drink? Do you treat the water you drink? In what way?	What would facilitate family water treatment before drinking?	What are the difficulties you encounter in ensuring safe water for the whole family?
	Do you know what to do to ensure safe water at home?	Do you think there is a problem with taking the water that is collected from wells or public places?	How do you store the water you use to prepare food?		

Sexual and Reproductive health						
Information source	Do you know what Sexual and Reproductive Health (SRH) means?	In your opinion, do you think SRH issues are important?	Where have you heard about SRH (health center, radio, community meetings)?	Would you like to know more about Sexual and Reproductive Health? Why?	Are there difficulties in obtaining information about Sexual and Reproductive Health?	
School attendance versus menstruation	Do you know if there is reason for girls to miss school during menstruation?	Do you think girls should go to school during menstruation?	Do girls regularly go to school during menstruation?	What makes girls miss school?	What are the difficulties for girls to be in school during menstruation?	
Avoiding births/ Use of contraceptive	Do you know what family planning means?	Do you know how to differentiate which contraceptive method that is better for your health?	What contraceptive method have you used?	What kind of support would you need to comply with family planning?	Is there a barrier to family planning?	
	Do you know contraceptive methods? Which?	What do you think you should do if your husband does not agree with the type of contraceptive you are using?	Does your husband influence the choice of method? In what way?	In case of abortion, do husbands usually help?	Are there any difficulties with accessing / using contraceptives?	
Early marriage versus education	Do you know where to find support in case of abortion (spontaneous or provoked)?	What do you think you should do if your husband does not agree with family planning?	Does your husband usually support his wife in case of abortion? In what way?	What could be a good reason for women to wait for the right time to get pregnant again?	What difficulties are encountered in the case of abortion?	
	Do you know how long a woman should wait to get pregnant again?	Do you think the woman should meet the recommended waiting time to get pregnant again?	Here in the community, how long does do people wait from one pregnancy to the next?	Is there a factor in the community that can inhibit early marriages?	Are there any barriers to being able to wait long enough to get pregnant again?	
Pregnancy	Do you know if there are any laws against early marriages? At what age can the girl legally marry?	What do you think of early marriage / early pregnancy? Why do you think this happens?	Are there cases of early marriage in the community here?	Is there a factor in the community that can inhibit early marriages?	What are the main barriers to reducing early marriages?	
	Do you know at what age a girl can safely become pregnant?	What do you think is most important for a teenager's life: finishing school or getting married?	What changes in girls' lives when they get married / get pregnant early?	What kind of support would be needed? From who? What would motivate the girl to finish school?	What are the main barriers for girls to finish school?	
	Do you know if it is healthy for a girl to have children very young, before the age of 18?	Would you allow your daughter to marry when they are still an adolescent?	What happens to girls who have early marriages in terms of access to school? Are there many cases of early pregnancy here in the community?	What could prevent early pregnancy?	What are the barriers to reducing early pregnancy?	

Annex 2: Qualitative Data Collection Tool: Key Informant Interviews

Topics	Knowledge	Attitudes	Practices	Facilitating factors	Barriers
Fístula obstétrica					
Symptoms and treatment	Have you heard of obstetric fistula (Chivuze in local language)? Do you recognize the symptoms of obstetric fistula? Do you know where to get support for the treatment of Obstetric Fistula?	How do you feel about this problem?	What is the reaction of people in the community to this problem? Where do people living with Obstetric Fistula seek treatment? What kind of treatment are you looking for?	What kind of support would be necessary for people living with Obstetric Fistula to feel safe to seek treatment?	What are the main barriers that women with Obstetric Fistula face at the family and community level?
Taboo and stigma		How do you feel within your family and community living with this problem? Do you feel supported and understood by the people around you?	Are you facing some kind of embarrassing situation because of this problem?	Has your husband and family supported this issue? In what way?	What are the main barriers that women with Obstetric Fistula face?



Annex 3: Qualitative Data Collection Tool: Direct Observation

Sanitation and Hygiene	
Name of the Observer:	Observation
Date:	
Time:	
Place/Community:	
Handwashing	
TIP TAP available in communities?	
Do people wash or don't wash their hands with soap?	
Safe drinking-water	
What are the conditions of water sources in the community?	
How do people keep water to drink at home?	
What are the conditions of drinking water?	
Sanitation and open defecation	
What are the hygiene conditions around the house?	
What are the hygiene conditions in the community?	

Annex 4: Quantitative Data Collection Tool: Household Interviews

Topic/Questions	Knowledge	Attitudes	Practices
Maternal Nutrition			
Diet during Pregnancy and Lactation	Can you please mention what a balanced diet for a pregnant and lactating woman is?	On a scale of 1 to 3 – with 1 being 'Do not agree' 2 being 'Agree', and 3 being 'I don't know', to what extent do you agree that eggs are safe for pregnant and lactating women to eat? You can only choose one option. [men] On a scale of 1 to 3 – with 1 being 'do not intend to' 2 'maybe will do so' and 3 being 'intend to' – to what extent do you intend to support your wife/wives to eat diverse and balanced meals when she is/they are pregnant and lactating? You can only choose one option.	
	Rest and work during pregnancy	True or False – pregnant women should do less physical work while pregnant and lactating? [men] On a scale of 1 to 3 – with 1 being 'do not intend to' 2 'maybe will do so' and 3 being 'intend to' – to what extent do you intend to support your wife/wives with domestic work and collecting water while pregnant and lactating? You can only choose one option.	
Breastfeeding practices	The first milk (thick yellowish liquid) women produce the first 3-5 days after giving birth is essential for babies to drink. Yes or no? How long after a baby is born should he/she only consume breast milk with no water or other liquids [medicament/treatment traditional]?		[women] Did you feed your baby the first milk (thick yellowish milk) for the first 3-5 days after giving birth? / Do you plan on giving your baby the first milk (thick yellowish milk) for the first 3-5 days after giving birth? Yes or no?
Infant and Young Child Feeding			
Dietary diversity:	Can you recall essential foods for a balanced and diverse meal for a child between 6-24 months of age?		
	Do you purchase fortified foods for your children in the market? Yes or no? If no, why?		
Responsive/active feeding			Do you set aside time specifically to feed your young children and babies? Yes or no? If no, why?

Feeding during and after illness	Sick children need to eat differently than healthy children, such as eating at least 5 times per day, drinking more liquids and eating foods that are more nutritious. - True or False?	
The first 1000 days	Which is the most important period of a child's life to ensure whether they will be a well-grown, healthy, intelligent and productive adult? You can only choose one option.	On a scale of 1 to 3 - with 1 being 'Do not agree' 2 being 'Agree', and 3 being 'I don't know', to what extent do you agree that diet and care for mothers ensures the baby's health?
Sanitation & Hygiene		
Handwashing, sanitation, safe drinking water, associating disease with harmful sanitation practices, health seeking behaviour	Can you please mention at least 3 critical moments when you should wash your hands with soap?	<p>On a scale of 1 to 3 - with 1 being 'Do not agree' 2 being 'Agree', and 3 being 'I don't know', to what extent do you agree that washing your hands and cleaning around your house prevents illness, such as diarrhoea, fever and malaria?</p> <p>On a scale of 1 to 3 - with 1 being 'do not intend to', 2 'maybe will do so' and 3 being 'intend to' - to what extent do you intend to treat your water before you drink it, such as boiling, adding bleach or adding chlorine?</p> <p>If your baby/child has diarrhoea, very liquid stools more than three times in a day, where would you want to take them for treatment?</p> <p>If your baby/child has diarrhoea, very liquid stools more than three times in a day, where is the main place you can take them for treatment?</p>
Sexual and Reproductive Health		
General	Where do you get information about SRH?	
Early marriage and Education	<p>Pregnancy under 18 years of age is more dangerous for the mother and baby's health than pregnancy after 18 years of age. True or false?</p> <p>What is the minimum age women and men are legally allowed to be married? You can only choose one option.</p>	<p>On a scale of 1 to 3 - with 1 being 'do not intend to', 2 'maybe will do so' and 3 being 'intend to' - to what extent do you intend to allow your children to marry before they are 18 years of age?</p> <p>Girls experiencing their monthly menstruating cycle have the right to attend school as usual. Yes or no? If no, why?</p> <p>A girl who is married and/or has children before 18 years of age is less likely to finish school than a girl who waits until after 18 years of age. Yes or no?</p>
Education		

Family planning and abortion	Have you heard about contraceptive methods? Yes or no? If yes, where did you learn about them?	On a scale of 1 to 3 – with 1 being ‘not confident’ 2 being ‘somewhat confident’, and 3 being ‘fully confident’, to what extent do you feel confident that contraceptives are safe for the body to use?	Who has the final say on the type of contraceptive to use?
	What is the minimum time that is needed for a woman to wait before getting pregnant again after giving birth that is safe?	On a scale of 1 to 3 – with 1 being ‘Do not agree’ 2 being ‘Agree’, and 3 being ‘I don’t know’, to what extent do you agree that abortions at the health facility are safe for the body?	
	Have you heard about fistula obstetric? Yes or no? If yes, where did you learn about them?	[women] If your husband does not agree with your decision to do family planning, such as using contraceptives, you will continue to use them without telling him. Yes or no?	
Obstetric Fistula:	There is a treatment for obstetric fistula. Yes or no? If yes, where should a woman living with OF go for treatment?	Do you think people living with obstetric fistula feel comfortable talking about their symptoms with others? Yes or no?	

