SAVING LIVES
CHANGING LIVES

Social and Behaviour Change Communication Pre- & Post-test Comparative Analysis: Sexual and Reproductive Health Topic Module

Gender Transformative and Nutrition-sensitive Project 2019-2021(2023) in Chemba District, Sofala Province, Mozambique

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WFP
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Country	Mozambique
Project Title	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
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Cooperating Partners	Government of Mozambique Pathfinder International
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Front cover photo caption: Female beneficiaries of the GTNS project participating in a radio listening group on Family Planning. Credit: Julia Vettersand (2022)

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Executive Summary

Social and Behaviour Change Communication (SBCC) is an evidence-based strategy to improve health and nutrition by increasing and improving knowledge, attitudes and practices. SBCC is guided by an ecological approach which intends to address both individual level change and change at broader environmental and structural levels. The Gender Transformative and Nutrition-sensitive (GTNS) project implements SBCC activities, in parallel to resilience and post-harvest loss interventions, with the aim of contributing to girl's and women's empowerment and stunting reduction among children in Chemba district, Sofala province, Mozambique. The SBCC strategy uses three approaches to achieve this aim: community mobilization, interpersonal counselling and media. Activities under the three approaches are categorized into three main themes within the project: Nutrition, Gender, and Sexual and Reproductive Health.

This report focuses on the interpersonal counselling approach of the Sexual and Reproductive Health (SRH) topic module. These sessions targeted all 1,500 project households, specifically the couples and adolescent girls and boys.

When implementing SBCC activities particularly aimed at reducing or preventing stunting, it is essential to engage in robust monitoring as behavioural change is a slow process and may not significantly impact project outcomes when looking solely at end line indicators. Nevertheless, this does not mean project efforts are not making progress at the individual level. Closely tracking knowledge, attitudes and practices linked to reducing and preventing stunting can guide project implementers in better understanding willingness to change and actual change related to desired outcomes. To measure the project's influence on beneficiaries, the project conducted pre- and post-test surveys on a sample of 120 beneficiaries immediately before and after each interpersonal counselling topic module focusing questions on knowledge, intention, self-efficacy (confidence) and self-reported behaviour. Using a comparative analysis, this report presents the findings regarding the Sexual and Reproductive topic module.

The Sexual and Reproductive Health pre- and post-test questionnaire consisted of fourteen questions in two categories:

- Obstetric fistula
- Family planning

The obstetric fistula domain featured four subthemes:

- causes
- symptoms
- treatment
- prevention

The family planning domain featured four subthemes:

- recalling key messages
- birth spacing
- consulting a medical professional
- shared responsibility/decision-making

Project beneficiaries in Chemba District have had prior exposure to SRH services as well as media campaigns and messaging emphasizing reproductive health and family planning. Several organizations have such programs in Mozambique such as Pathfinder International, International Planned Parenthood Federation (IPPF), United Nations Fund for Population Activities (UNFPA), Population Services International (PSI) and other international non-governmental organizations. Pre-test results reflect these efforts whereby there exists some amount of prior knowledge, favourable attitudes and good practices around family planning and receiving routine counselling at health facilities. However, findings demonstrate that there are still some gaps in knowledge as well as hesitancy to practice some key facets of sexual and reproductive health and family planning. Nevertheless, there was some positive influence across several of the thirteen outcome indicators when comparing pre- and post-test results for sexual and reproductive health, particularly understanding that family planning avoids unplanned pregnancy and the importance of shared responsibility in family planning.

I. Background

The Gender Transformative and Nutrition-sensitive (GTNS) pilot 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 the World Food Programme (WFP) under the leadership of the Government of Mozambique, and in close coordination with Government and cooperating partners. The project receives multi-year funding from the Austrian Development Agency (ADA). The catchment area is limited to Mulima-sede locality of the Mulima Administrative Post of Chemba District. The population of Chemba is approximately 87,925 people (17,730 households), and the project aims to reach 7,500 people (1,500 households) using the criteria of at least 500 pregnant and lactating women (PLW), 500 adolescent girls, 750 children under 2 (CU2), and women living with obstetric fistula; an additional 20,000 people will be reached indirectly through Social and Behaviour Change Communication (SBCC) media activities.

The GTNS project directly supports the priorities of the Government of Mozambique and is fully aligned to WFP's Country Strategic Plan 2017-2021[1]. The aims of the project are to improve gender equity and women and adolescent girls' empowerment; increase dietary diversity; and reduce stunting among girls and boys under 5 in the context of a changing

[1] Mozambique Country Strategic Plan (2017-2021) | World Food Programme. (n.d.). Www.wfp.org. Retrieved March 22, 2022, from https://www.wfp.org/operations/mz01-mozambique-country-strategic-plan-2017-2021.

climate. The project design is innovative and integrates multiple nutrition-specific and -sensitive interventions to address the determinants of malnutrition, with a focus on women's empowerment. It combines:

i) construction of gender- and nutrition-sensitive household and community assets (fuel efficient cooking stoves, water catchment systems, household gardens and afforestation);
ii) trainings on post-harvest loss for smallholder women and men farmers (food conservation, transformation and storage) and linkages to improved products (hermetic storage); and
iii) multi-level SBCC activities implemented at individual, household, and community level[2]

II. Social and Behaviour Change Communication

SBCC is a crucial evidence-based strategy to improve health and nutrition by increasing and improving knowledge, attitudes and practices. The GTNS project's SBCC component is being implemented by WFP Mozambique's SBCC partners[3] through three approaches: interpersonal counselling, media (radio), and community mobilisation (see Figure 1). Combining dynamic approaches to engage men for gender equality and behaviour change with nutrition-sensitive programming is expected to facilitate sustainable results at the household level, which can be cascaded to the wider community for replication.

*due to the COVID-19 pandemic theater performances have been adapted to a media modality

Figure 1: The three approaches of the GTNS Project SBCC strategy

The GTNS project categorizes SBCC into three main themes: Nutrition, Gender, and Sexual and Reproductive Health (SRH). The SRH theme consists of SRH Sessions and target all 1,500 project households, focusing on participants of CU2 and their partners.

[2] In parallel to its SBCC activities, the GTNS project is also generating demand for acute malnutrition treatment, including community-level mid-upper arm circumference (MUAC) screening of PLW and children under 5 (CU5) and referrals of malnourished cases by volunteer community health workers. If screening indicates malnourishment, PLW and CU5 are referred to their local health facility for further treatment. This activity is not included in the pre- & post-test questionnaire and results can be found in the SBCC routine monitoring.

[3] District Services of Health, Women and Social Action (SDSMAS), Pathfinder International, and PCI Media.

Topic modules consist of six sessions, facilitated by community health worker pairs, and trained and supervised by field partners.[4]

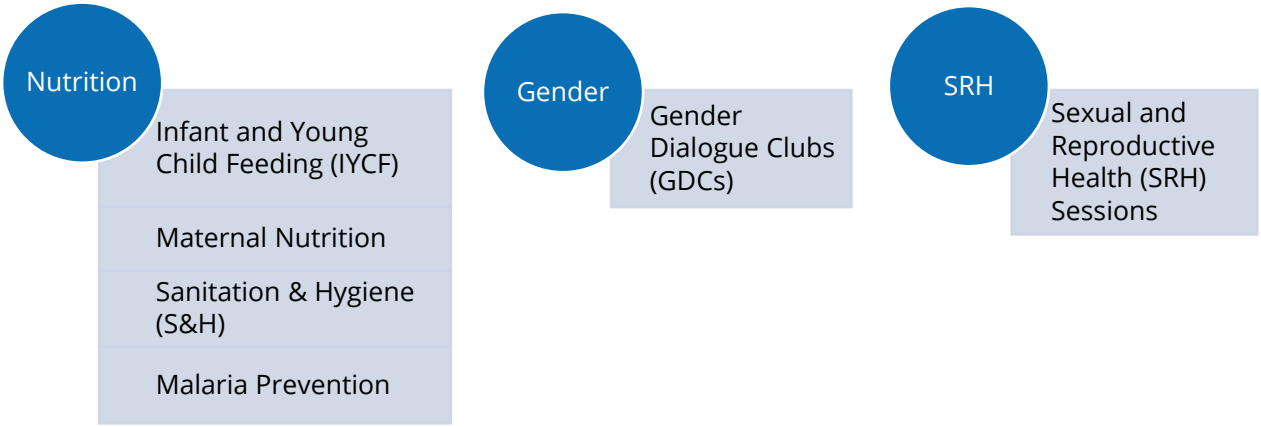


Figure 2: SBCC themes and topics of the GTNS Project

To evaluate the efficacy of SBCC activities, the GTNS project conducted pre- and post-testing to compare and analyse beneficiary knowledge, intention, confidence and self-reported behaviour. The pre- and post-test exercise focused on interpersonal counselling sessions, including cooking demonstrations but excluding food processing demonstrations.

III. Aim and Objective of Pre- and Post-testing

When implementing SBCC activities, particularly those aimed at reducing or preventing stunting, it is essential to engage in robust monitoring, as behavioural change is a slow process and may not significantly impact project outcomes when looking solely at end line indicators. Unlike baseline and endline evaluations that elucidate whether or not the programme worked, regular monitoring focuses on systematic tracking of activities to assess the effectiveness of implementation efforts. This analysis also serves as evidence for project impact.

The main aim of pre- and post-testing was to understand the influence of interpersonal counselling sessions on project beneficiary knowledge, attitudes and behavioural practices in each topic module. The objective was to use a comparative analysis to determine which concepts and messages within each theme are influencing a positive change among project beneficiaries.

IV. Methodology

Each topic within the SRH module was carefully reviewed to identify key areas where the project seeks to positively change knowledge, attitudes and practices among adult beneficiaries. This was used to develop outcome indicators to measure behavioural

[4] Gender Dialogue Clubs consist of complex and sensitive concepts and will therefore be mainly facilitated by implementing partner field staff with some community health worker support.

change over the course of each topic module. The body of research from similar contexts and documentation from the project site shows that men are generally the main decision-makers in the household, and often influence the behaviour of other household members, therefore it was imperative to separately consider assessing men and women when developing the indicators and questionnaires for each topic module. Therefore, the indicators may target three groups: men and women participants together, women participants only and men participants only.

Social and behaviour change can be negatively influenced by external factors. To account for these externalities, at the individual level, behaviour change can be measured not only through behavioural outcomes but also through the desire or plan to change. This can be evaluated through psychosocial domains: knowledge, intention, self-efficacy (confidence), attitude, subjective norms and perceived behavioural control (see Table 1).

Table 1: Psychosocial domains for measuring behavioural change[5]

Domains	**Descriptions** (Adopted from NCI, 2005)	**Domains**	**Descriptions** (Adopted from NCI, 2005)
Knowledge	Facts, information, and skills necessary to perform a behaviour	**Attitude**	Perceived evaluation and / or enthusiasm toward the behaviour
Intention	Perceived likelihood of performing a behaviour	**Subjective norm**	Perception about whether key people approve or disapprove of the behaviour
Self-efficacy	Confidence in one's ability to take action and successfully carry out the behaviour	**Perceived behavioural control**	Belief that one has, and can successfully exercise, control over performing the behaviour

For the GTNS context, the appropriate psychosocial indicators for this pre-/post-testing exercise were knowledge, intention and confidence. Within the pre-post questionnaires, the psychosocial indicators mentioned below were combined with questions on self-reported behaviour to give a more holistic picture of the potential behaviour change impact pathway, as well as to shed light on behavioural outcomes.

For each indicator, objectives based on SMART criteria[6] were developed to measure against the comparative analysis of the pre- and post-tests. The SMART objectives were agreed through discussion with the programme team based on context, expertise and secondary data sources. A matrix was created to consolidate this information per topic, to guide the M&E team in producing short questionnaires on WFP's corporate data collection tool (Open Data Kit – ODK) (see Annex 1 for Sexual and Reproductive Health topic matrix).

[5] WFP. (2019, January). *Social and Behaviour Change Communication (SBCC) Guidance Manual for WFP Nutrition*. Chapter 8: Monitoring Phase [partially adapted]. Originally titled "Table 15. SBCC-related psychosocial indicators".
[6] Specific, Measurable, Achievable, Relevant, and Timebound

The questionnaire was used both during the pre-test and post-test to assess the change in results after a beneficiary completed the module (See Annex 2).[7] The SRH pre- and post-test focused on two main areas and subthemes for desired behaviour change:

- Obstetric fistula
    - cause
    - symptoms
    - Treatment
    - prevent
- Family planning
    - recalling key messages
    - birth spacing
    - consulting a medical professional
    - shared responsibility/decision-making

In total, there were thirteen indicators covering these areas that translate into fourteen questions on the questionnaire.

The interviews were conducted in the local language of Xisena which required field staff to be confident with the questionnaire to easily translate between Portuguese and Xisena. WFP trained the implementing partner, Pathfinder International, to conduct the data collection.

For the SRH topic, the target sample for both the pre- and post-test was 120 project beneficiaries (60 women and 60 men) across Mulima locality in Chemba District, Sofala. The sample size was calculated based on the feasibility to collect these results, taking into consideration the elements of limited resources and timing. The results are to provide indications as to how the response of the SBCC-indicators may be impacted by targeted community members before and after SBCC topic module sessions. The results inform the project's overall SBCC programming and field implementation. The methodology does not serve to inform other SBCC interventions and is specific for the GTNS project in Chemba.

The survey was conducted through individual interviews with men and women separately, using convenience sampling[8] during community visits. Data was collected immediately before the first of six SRH sessions for the pre-test (in January 2022) and after the sixth session for the post-test (in February 2022). The target sample is not necessarily the same individuals across pre- and post-testing as the methodology does not require tracking the same community members. Due to a technical error with the data collection webform (MoDa), questions regarding obstetric fistula were collected

[7] In the questionnaire, men and women were also asked a question that is related to the parallel cooking demonstration activity that occurs once in each topic module (question 3.1 in Annex 2). This data is analysed and reported separate from this comparative analysis report (see forthcoming GTNS Tableau dashboard).

[8] Convenience sampling method is selecting respondents who are easily accessible (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5606225/). For SRH pre- and post-test data collection, enumerators surveyed eligible, accessible beneficiaries who had consented to being interviewed.

from a sample of 120 non-beneficiary residents of Chemba district, in order to compare results with the 120 beneficiary respondents on the post-test. Given that in both cases the pre-test was administered to people who had not yet attended the learning sessions for the topic module, we believe that the data will accurately reflect the general level of understanding of SRH topics across the region.

For the SRH pre-test, 120 project beneficiaries (60 men and 60 women) were surveyed across 42 communities. For the post-test, 120 project beneficiaries (55 men and 65 women) were surveyed across 20 communities. Across the pre- and post-testing, 39 out of 49 communities[9] were included in the data collection.

While not a complete representation of the population, this analysis will provide insight into programme implementation within the service area.

V. Results

The pre- and post-test questionnaire consisted of fourteen questions (all targeted at participants across gender) corresponding to and measuring thirteen indicators. Overall, five indicators were reached based on the SMART objectives developed for the Sexual and Reproductive Health topic (see Table 2). Eight indicators were not reached.

When looking at the average results for interviewed households, only three of the thirteen indicators met their SMART objectives during the pre-test (1.5, 1.9 and 1.10). The SMART objectives for the remaining ten indicators (1.1-1.4, 1.6-1.8, 1.11-1.13) were not met during the pre-test. In fact, several were far from their goal. As for the post-test, an additional two indicators were met (1.8, 1.13), resulting in five of the thirteen indicators being met (1.5, 1.8-1.10, 1.13). However, when disaggregated by gender, an additional three indicators (1.1, 1.3 and 1.7) were met by women only. As such, during the post-test, eight of the indicators were met by women alone and five were met by men alone.

Most notably, the SMART objectives for indicators 1.2, 1.4, 1.6., and 1.7 were not met in either the pre or post-test, by varying margins. There were two exceptions here: when disaggregated by gender indicators 1.6 and 1.7 were met by solely by women, and only in the post-test. This will be explored in greater detail in the discussion section. The percentage points for each indicator are listed below.

Table 2: Pre- and Post-test Results (in percentages)

#	Indicator Detail	SMART Objective	Pre-test Result (%)			Post-test Result (%)		
			Men	Women	Avg	Men	Women	Avg

[9] Andrassone, Arnelo, Bangwe, Bhaumbha, Bucha, Candima, Cassume, Castela, Deve, Dzunga 1, Dzunga 2, Fernando, Francalino, Fumbe 1, Fumbe 2, Macendua, Mandue, Mapata, Mateus, Melo 1, Melo 2, Muandinhoza, Mulima-sede, Nhacagulagua 1, Nhacagulagua 2, Nhacavunvu, Nhalunga, Nhamaliwa, Nhamazonde, Nhambhandha, Nhamingale, Nhancaca, Nhangue, Nhapwete, Nharugue, Nhasulu, Nhatsete, Nhakuiyoyo, Niquice, Ofece, Shonsua, Thenda, Tomucene 1, Tomucene 2, Tsera, Xavier, Zenguerere, Zomdane 1, Zomdane 2

1.1	Increased percentage of SRH messages recalled by men and women.	After complete SBCC topic area is conducted [6 weeks], *75% of men and women* partaking in the SBCC sessions, will be able to recall at least 3 key SRH messages	55	50	53	38 (-17)	77 (+27)	59 (+6)
1.2	Increased percentage of men and women know sexual and reproductive health and family planning should be taught to all people regardless of marital status, gender or age.	After complete SBCC topic area is conducted [6 weeks], *66% of men and women* partaking in the SBCC sessions, know sexual and reproductive health and family planning should be taught to all people regardless of marital status, gender or age.	20	8	14	16 (-4)	5 (-3)	10 (-4)
1.3	Increased percentage of men and women know both parents are responsible for family planning in the household.	After complete SBCC topic area is conducted [6 weeks], *75% of men and women* partaking in the SBCC sessions, know that both parents are responsible for family planning in the household.	52	42	47	67 (+25)	78 (+36)	73 (+26)
1.4	Increased percentage of men and women intend to share decision-making around family planning.	After complete SBCC topic area is conducted [6 weeks], *66% of men and women* partaking in the SBCC sessions, intend to discuss and agree together with your partner on family planning.	60	58	59	64 (+4)	63 (+5)	63 (+4)
1.5	Increased percentage of	After complete SBCC topic area is	43	32	38	64 (+21)	63 (+31)	63 (+25)

	men and women report sharing decision making around family planning with their partners.	conducted [6 weeks], *33% of men and women* partaking in the SBCC sessions, report discussing and agreeing around family planning with their partners, such as which contraceptives to use, when and how many children to have.						
1.6	Increased percentage of men and women can recall different types of contraceptive methods.	After complete SBCC topic area is conducted [6 weeks], *75% of participants* in the SBCC sessions, can recall at least 3 methods of contraception	70	72	71	76 (+6)	74 (+2)	75 (+4)
1.7	Increased percentage of men and women intend to go to the health facility with their partner to discuss family planning.	After complete SBCC topic area is conducted [6 weeks], *50% of men and women* partaking in the SBCC sessions, intend to go to the health facility with their partner to discuss family planning with a medical professional.	65	57	61	62 (-3)	68 (+11)	65 (+4)
1.8	Increased percentage of men and women reported going to the health facility with their partner to discuss family planning.	After complete SBCC topic area is conducted [6 weeks], *50% of men and women* partaking in the SBCC sessions, reported going to the health facility to discuss family	38	18	28	55 (+17)	58 (+40)	57 (+29)

		planning with a medical professional.						
1.9	Increased percentage of men and women know the minimum time that is needed for a woman to wait before getting pregnant again after giving birth that is safe.	After complete SBCC topic area is conducted [6 weeks], *75% of men and women* partaking in the SBCC sessions, know the minimum time needed for a woman to wait before getting pregnant again after giving birth that is safe is at least two years.	67	67	67	69 (+2)	65 (-2)	67
1.10	Increased percentage of men and women intend to wait at least two years after giving birth to become pregnant again.	After complete SBCC topic area is conducted [6 weeks], *50% of men and women* partaking in the SBCC sessions, intend to wait at least two years after giving birth before getting pregnant again in the next pregnancy	83	68	75.5	65 (-18)	58 (-10)	62 (-13.5)
1.11	Increased percentage of respondents know the key causes of obstetric fistula.	After complete SBCC topic area is conducted [6 weeks], *75% of participants* in the SBCC sessions, will be able to recall at least 3 key causes of obstetric fistula (OF).	61	55	59	66 (+5)	62 (+7)	64 (+5)
1.12	Increased percentage of respondents know the key symptoms of obstetric fistula.	After complete SBCC topic area is conducted [6 weeks], *75% of participants* in the SBCC sessions, will	49	52	52	47 (-2)	38 (-14)	43 (-9)

		be able to recall at least 3 symptoms of obstetric fistula (OF).						
1.13a	Increased percentage of respondents know that obstetric fistula is **curable** and preventable.	After complete SBCC topic area is conducted [6 weeks], *50% of participants* in the SBCC sessions know that obstetric fistula is *both preventable and* ***treatable***.	53	49	51	69 (+16)	68 (+19)	68 (+17)
1.13b	Increased percentage of respondents know that obstetric fistula is curable and **preventable**.	After complete SBCC topic area is conducted [6 weeks], *50% of participants* in the SBCC sessions know that obstetric fistula is *both* ***preventable*** *and treatable.*	73	77	75	71 (-2)	69 (-8)	70 (+5)

Note: Values in the parentheses indicate the percentage point change, comparing values from the pre- and post-test results

The results will be presented in two categories:

1. Obstetric fistula
    a. causes
    b. symptoms
    c. treatment
    d. prevention
2. Family planning
    a. recalling key messages
    b. birth spacing
    c. consulting a medical professional
    d. shared responsibility/decision-making

Obstetric Fistula

i. Causes

Findings indicate that participants demonstrated an increase of knowledge around key causes of obstetric fistula as discussed in the SRH sessions. While neither the pre- or post-test results reached the SMART objective of 75% of participants, 59% of participants could recall at least three key causes of obstetric fistula in the pre-test (see Figure X). By the post-test, 64% of participants surveyed were able to recall at least three key causes of

obstetric fistula, an average increase of 5 percentage points. More specifically, the percentage of men increased from 61% to 66% and women increased from 55% to 62% (see Figure 1).

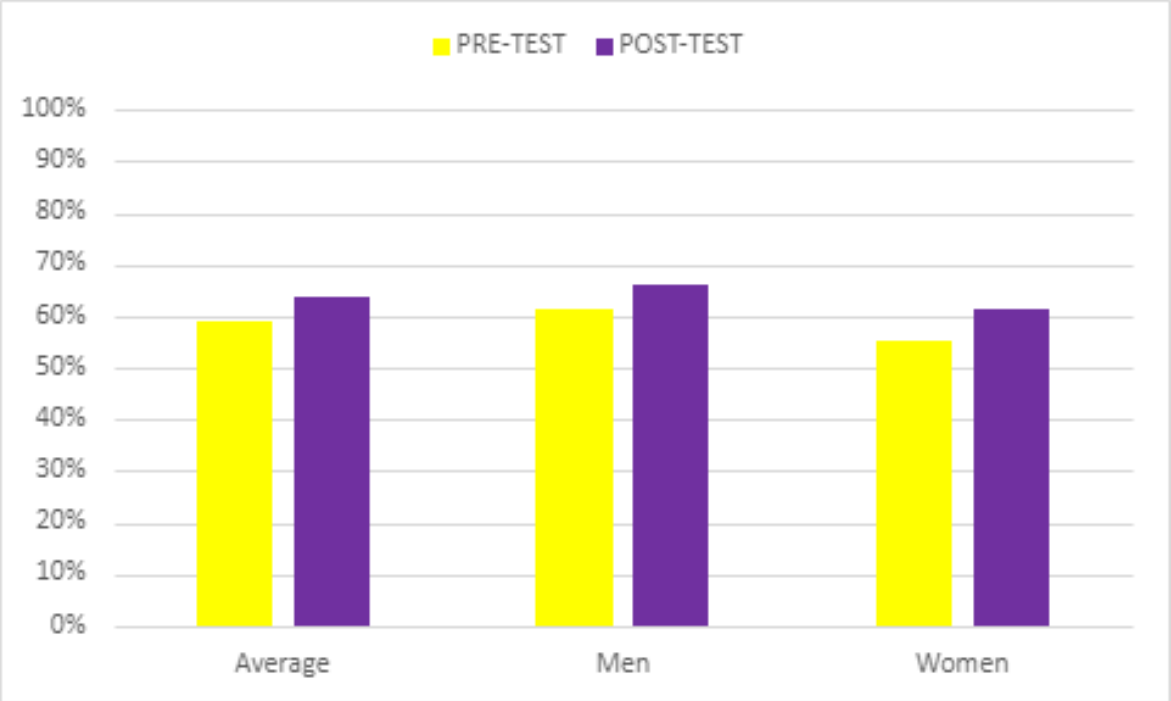


Figure 1: Percentage of participants who knew at least three key causes of obstetric fistula

The top three causes recalled in the pre-test were: prolonged, complicated labour, lack of medical care during and after labour, and early age/teenage pregnancy. In the post-test, results showed that there was an overall increase in knowledge about key causes of obstetric fistula. The top three causes recalled in the post-test were prolonged, complicated labour, early age/teenage pregnancy, and wrongly positioned foetus during labour.

The cause of obstetric fistula that had the largest percent change in recall from the pre-test to post-test (a decreased by 29 percentage points) was "lack of medical care during and after labour". See Annex 2, question 3.1 for a full list of key causes.

ii. Symptoms

Findings indicate that participants demonstrated a decrease of knowledge around key symptoms of obstetric fistula as discussed in the SRH sessions. While neither the pre- or post-test results reached the SMART objective of 75% of participants, 52% of participants could recall at least three key symptoms of obstetric fistula in the pre-test (see Figure 2). By the post-test, 43% of participants surveyed were able to recall at least three key symptoms of obstetric fistula, an average decrease of 9 percentage points. More specifically, the recall among men decreased from 49% to 47% and among women decreased from 52% to 38% (see Figure 2).

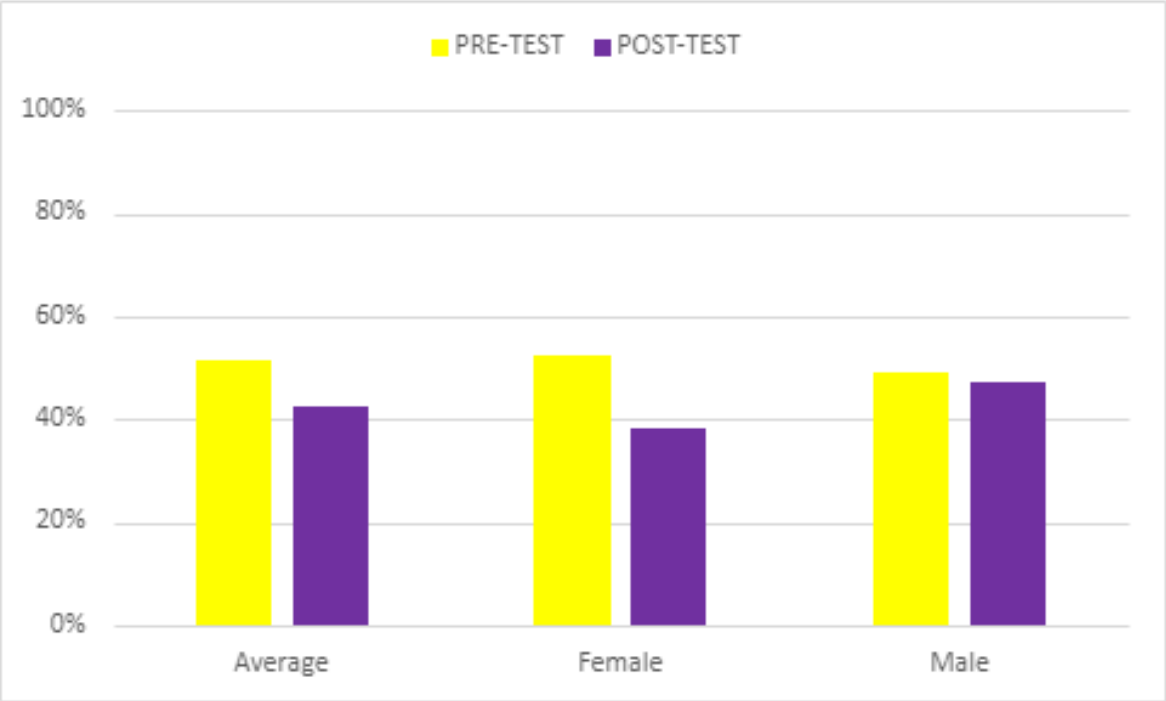


Figure 2: Percentage of participants who knew at least three key symptoms of obstetric fistula

The top three symptoms recalled in the pre-test were: foul odour/smell coming from vaginal area, constant, uncontrollable leakage of urine and/or faeces from the vagina/birth canal and a hole between the vagina and rectum.

In the post-test, results showed that there was an overall increase in knowledge about key symptoms of obstetric fistula. The top three symptoms recalled in the post-test were the same as those in the pre-test: foul odour/smell coming from vaginal area, constant, uncontrollable leakage of urine and/or faeces from the vagina/birth canal and a hole between the vagina and rectum.

The symptom of obstetric fistula that had the largest percent change in recall from the pre-test to post-test (a decrease of 13 percentage points) was "foul odour/smell coming from vaginal area". See Annex 2, question 3.2 for a full list of key symptoms.

iii. Treatment

Findings indicate that the SMART objectives developed to measure knowledge of treatment for obstetric fistula were met in the pre- and post-test. The goal was for 50% of respondents to know that OF can be cured. The data showed that on average, 51% of respondents (49% of women and 53% of men) knew this in the pre-test. Note that women alone did not meet the SMART objective. In the post-test, the average percentage increased to 68%, an increase of 17 percentage points. When disaggregated by gender we see that for men there was an increase of 16% from pre to post-test, and for women there was an increase of 19% (see Figure 3).

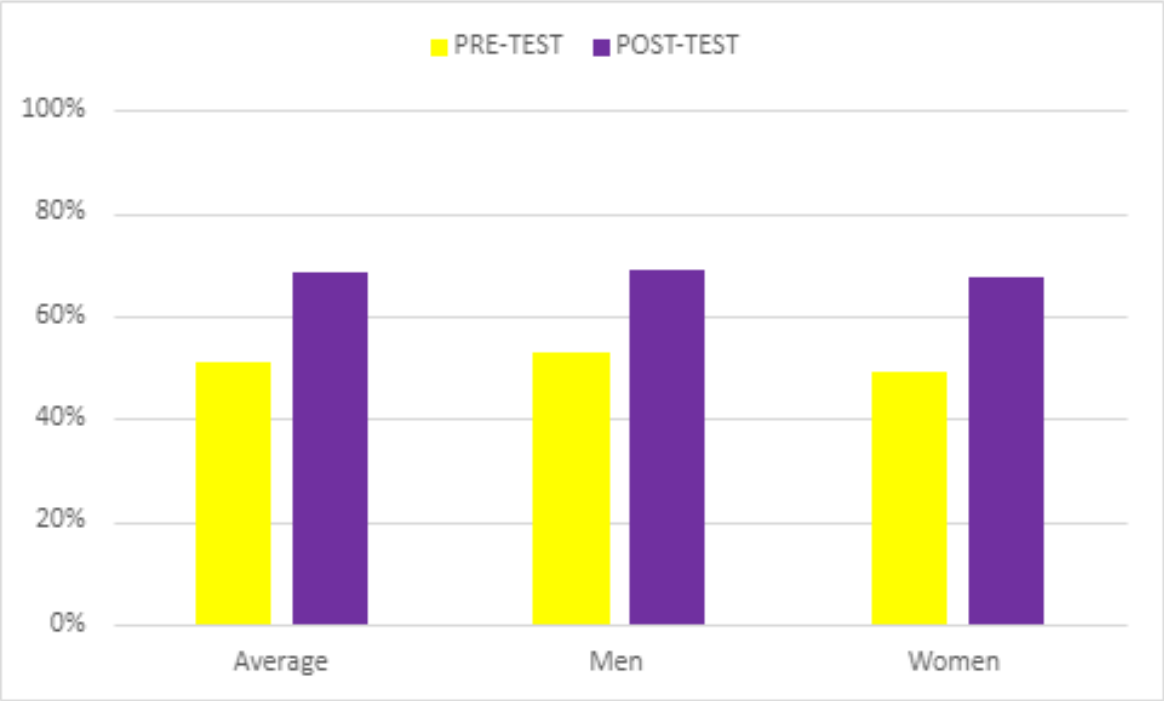


Figure 3: Percentage of participants who knew that obstetric fistula (OF) is treatable

iv. prevention

When assessing knowledge about prevention of obstetric fistula, findings indicate that the SMART objectives developed were exceeded in the pre- and post-test. The goal was for 50% of respondents to know that OF is a preventable condition. The data showed that on average, 75% of respondents (77% of women and 73% of men) knew this in the pre-test. (see Figure 4). In the post-test, the average percentage decreased to 70% of respondents (69% of women and 71% of men), still well above the target.

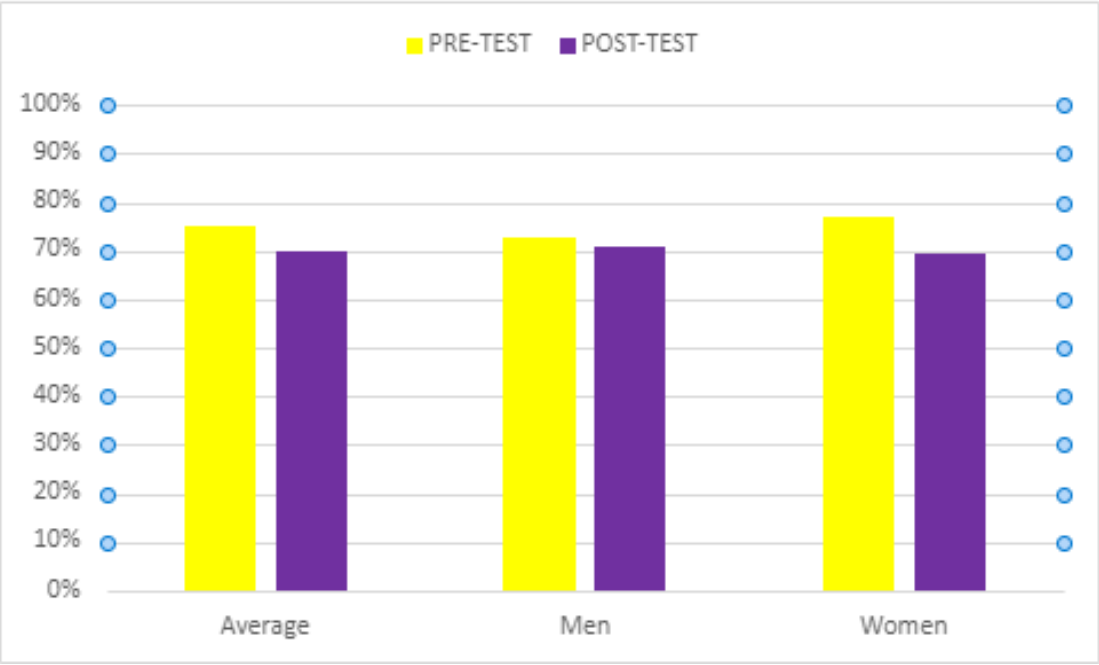


Figure 4: Percentage of participants who knew that obstetric fistula (OF) is preventable

Family Planning

i. Recalling key messages

Findings indicate that participants demonstrated a decrease of knowledge around both SRH-related messages and family planning messages discussed in the learning sessions. With regards to general SRH, the pre-test results did not reach the SMART objective of 75% of participants, with 53% of participants recalling at least three key sexual and reproductive health-related messages (see Figure 5). By the post-test, there was a surprising decline in the percentage of participants surveyed who were able to recall at least three key SRH messages, with an average decrease of 6 percentage points (see Figure 5). However, women on their own *did* meet the SMART objective during the post-test (77%), experiencing a 27% increase from pre to post-test. Meanwhile, men on their own experienced a 17% decrease from pre to post-test.

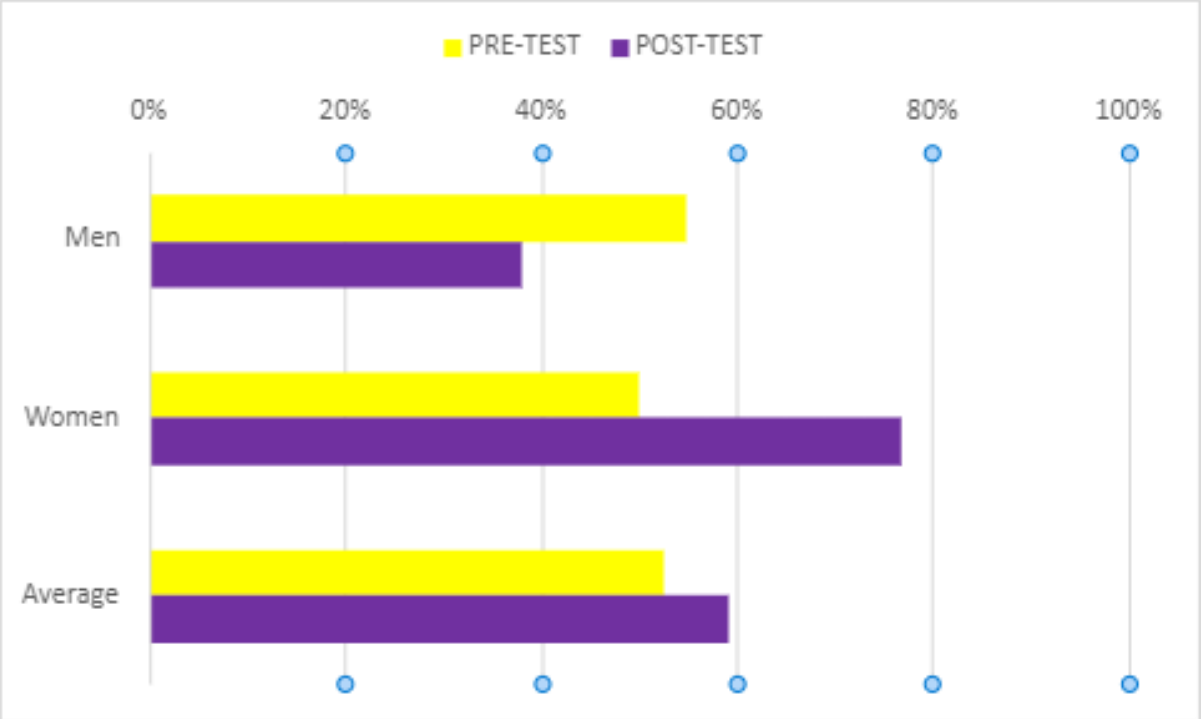


Figure 5: Percentage of participants who could recall at least 3 key SRH messages

With regards to key messages specific to family planning, the pre-test results failed to reach the SMART objective of 75% of participants, with 71% of participants recalling at least three family planning methods (see Figure 6). By the post-test, there was an increase in the percentage of participants surveyed who were able to recall at least three family planning methods, with an average increase of 4 percentage points. (see Figure 6). However, women on their own did not meet the SMART objective during the post-test (74%).

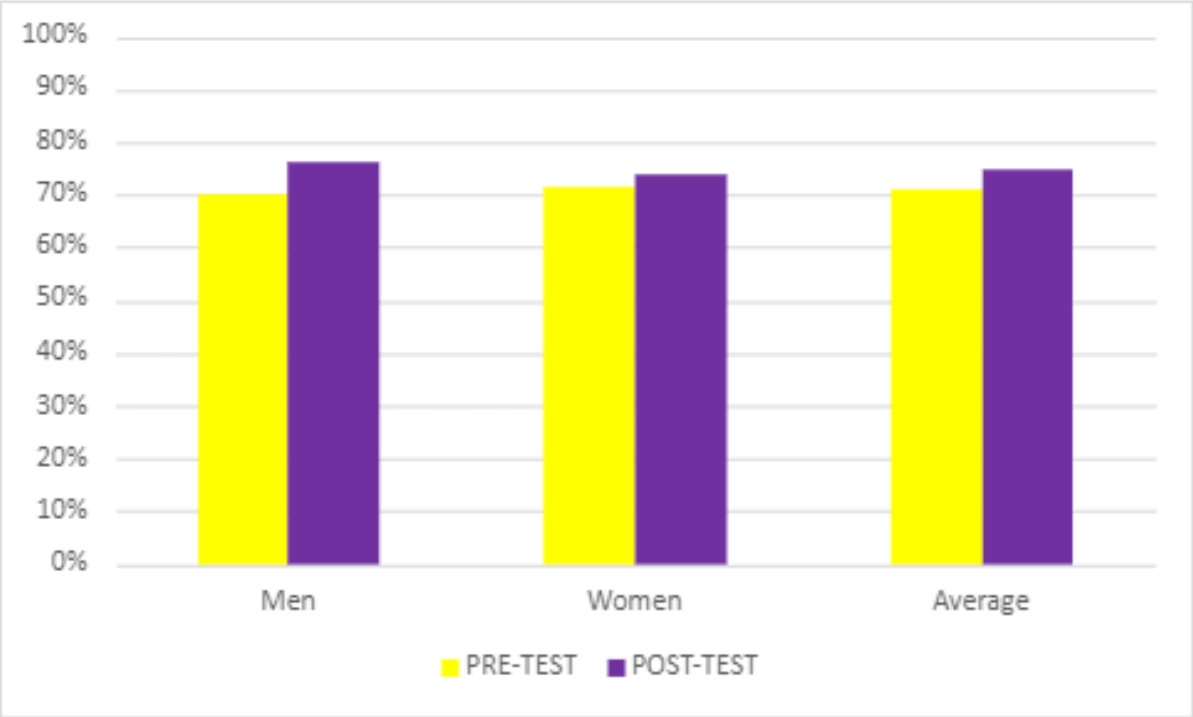


Figure 6: Percentage of participants who could recall at least 3 family planning methods

ii. Birth Spacing

One key component of family planning is birth spacing. Research reflects that short intervals between birth and pregnancy can contribute to risky pregnancy and poor infant and child nutrition outcomes. An analysis of Demographic and Health Survey (DHS) data from 52 non-industrial nations revealed that children conceived less than 24 months (2 years) after the birth of the previous child had one to two times greater risk of mortality within their first year of life than children conceived 36 to 47 months (3 to 4 years) apart. The DHS analysis also showed that decreasing birth intervals increased the likelihood of stunting or chronic undernutrition. Children conceived after an interval of only 12 to 17 months (1 to 1.5 years) are 25% more likely to be stunted and 25% more likely to be underweight than those conceived after an interval of over 24 months[10].

In the pre-test results, participants surpassed the SMART objective of 50% of participants knowing that births should occur in two-year intervals, with 67% of both female and male participants knowing this fact. Even with a minor decline in percentage points, this achievement remained in the post-test, with 65% of women and 69% of men demonstrating knowledge of appropriate birth spacing intervals (see Figure 7).

10 Maternal Infant and Young Child Nutrition and Family Planning (MIYCN-FP) Integration Toolkit. (n.d.). Retrieved March 22, 2022, from: https://toolkits.knowledgesuccess.org/sites/default/files/toolkit_custom_pdfs/Maternal%20Infant%20and%20Young%20Child%20Nutrition%20and%20Family%20Planning%20%28MIYCN-FP%29%20Integration%20Toolkit.pdf

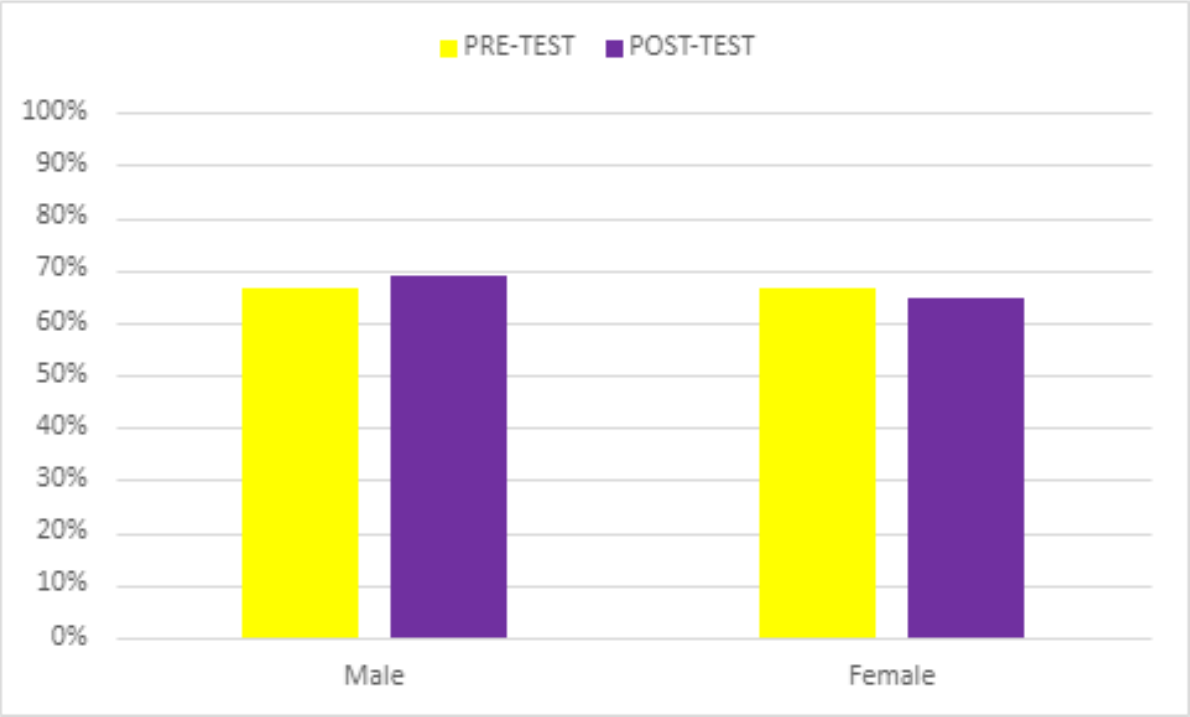


Figure 7: Percentage of participants who know that 2 years is the appropriate amount of time between births

While the above data is promising, it is worth noting that high recall does not necessarily equate to behaviour change. With regards to intention to engage in birth spacing, the data yielded different results than that measuring knowledge. In both the pre- and post-test we see that the SMART objective of 50% of men and women intending to space pregnancies by at least two years was met, with 83% intention among men and 68% intention among women in the pre-test. However, there was a decline in the post-test data, by 18% for men and 10% for women. Notably, the number of respondents who answered “Maybe” increased between pre and post-test, by 16% for men and 12% for women. Refer to Figure 8 below for details.

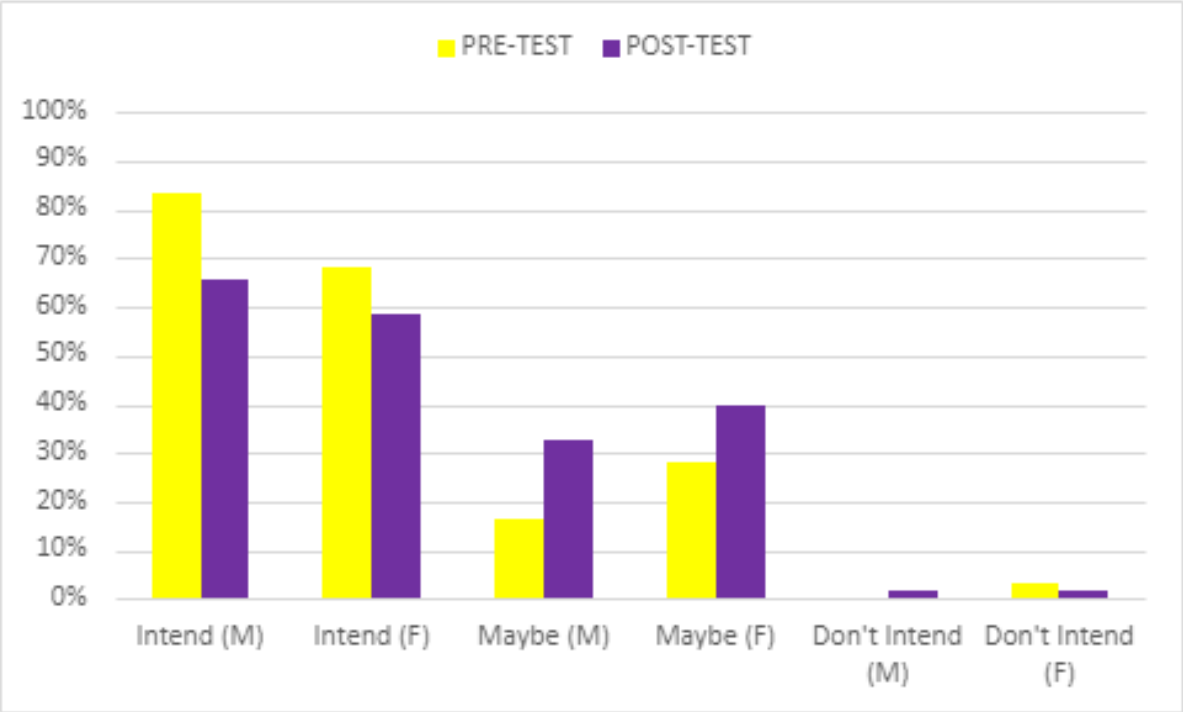


Figure 8: Levels of intention regarding appropriate birth spacing. F=Female and M=Male.

iii. Consulting a medical professional

Findings indicate that the SMART objectives framed around intention and behaviour with regards to discussing family planning with a medical professional were not met in the pre- or post-test. The goal was for 66% of respondents to intend to enact said practice. However, the data showed that on average, 61% of respondents carried this intention. 57% of women and 65% of men had this intention in the pre-test. In the post-test, the average percentage increased to 65%, just one point short of the indicator. However, when disaggregated by gender we see that women slightly surpassed the indicator with 68% intention, while men did not meet the indicator, with 62% intention. For men there was a decrease by 3% from pre to post-test. See Figure 9 below for details.

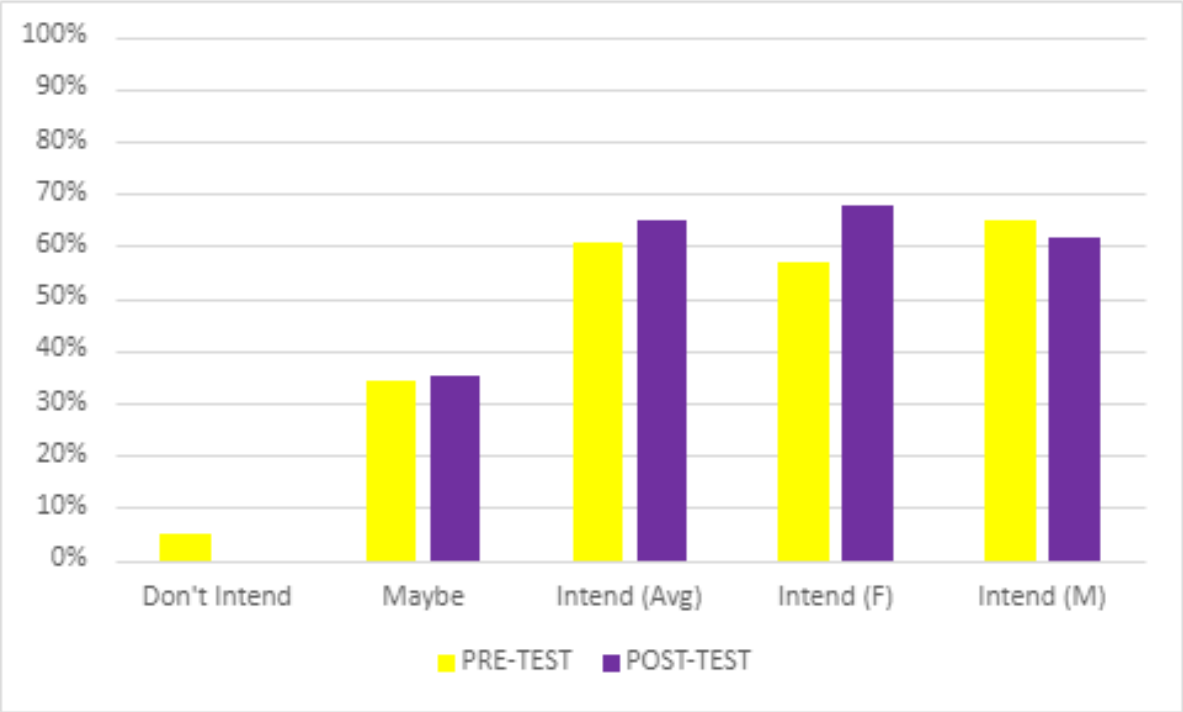


Figure 9: Levels of intention regarding consultation of a medical professional. F=Female and M=Male.

In terms of reported behaviour, both female and male respondents displayed an increase in the practice of going to a health facility with their partner and consulting with a medical professional to discuss family planning methods. However, the indicator for this SMART goal was unmet in both pre- and post-test data. In the pre-test, only 28% of respondents reported said behaviours, and in the post-test, this increased to 57%. For women, the increase between pre- and post-test was the most substantial, rising by 40 percentage points from 18% to 58%. For men, there was an increase of 17 percentage points, from 38% to 55%. See Figure 10 below for details.

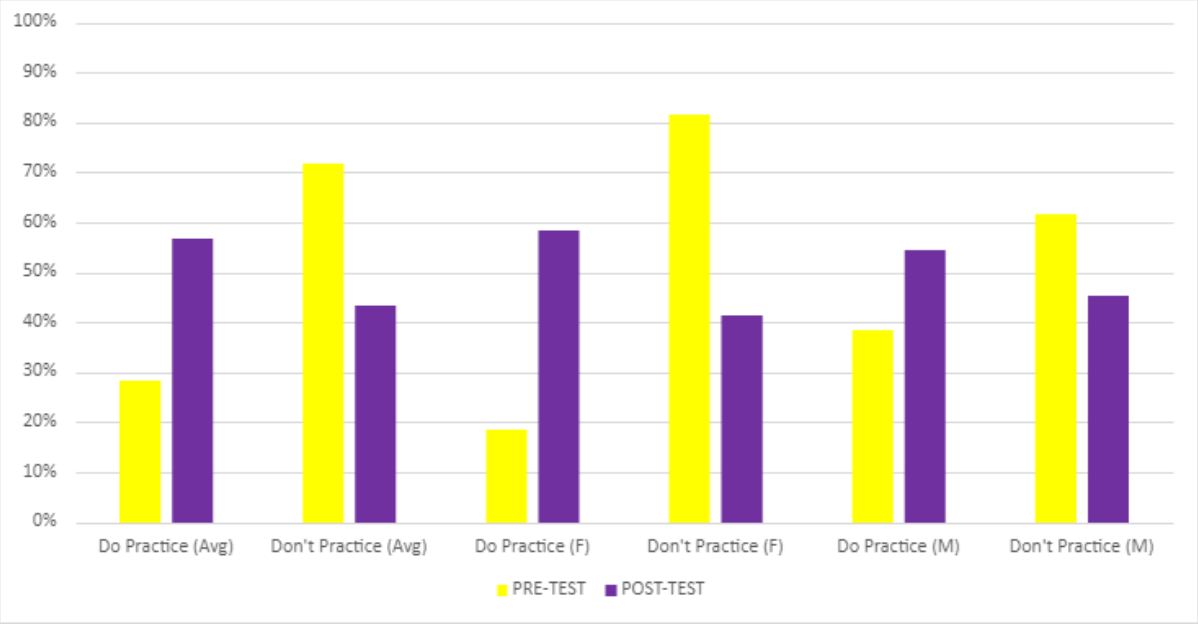
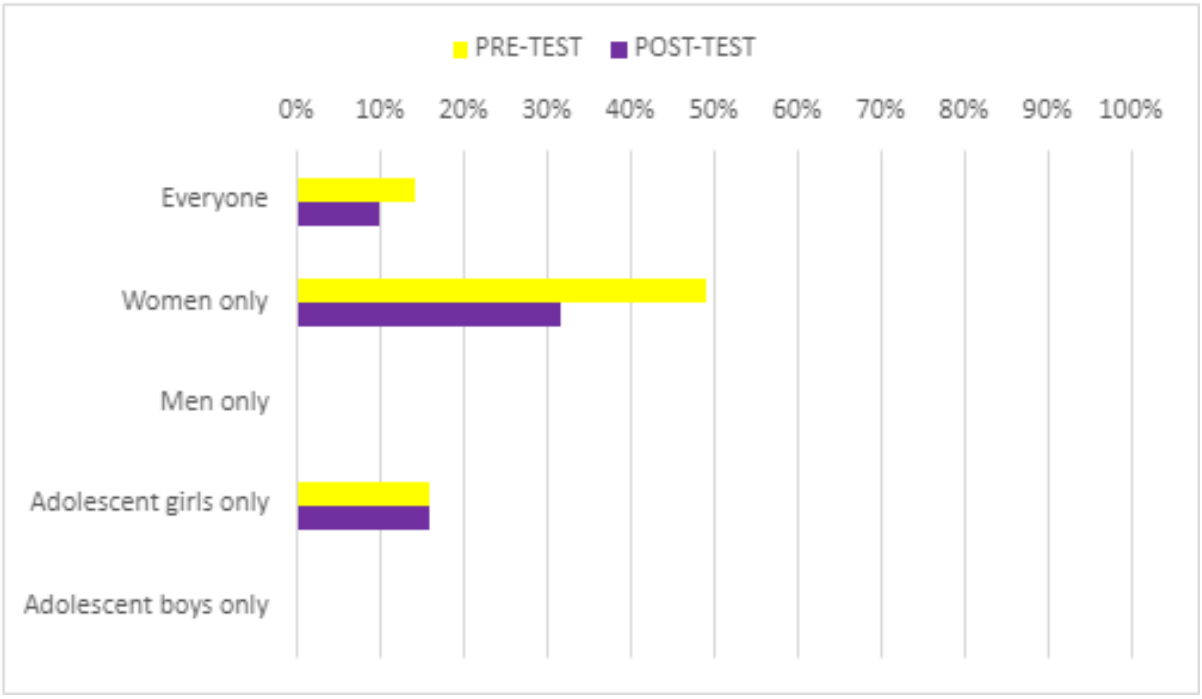


Figure 10: Behaviours regarding consultation of a medical professional. F=Female and M=Male.

iv. Shared responsibility/decision-making

Another core aspect of sexual and reproductive health is the sharing responsibility and equal decision-making power among partners. According to the WHO, sexual health is critically influenced by gender norms, roles, expectations and power dynamics[11]. As such, it was important to consider beliefs, behaviours and intentions with regards to responsibility for family planning.

When asked who should learn about sexual and reproductive health, pre- and post-test results showed that participants still have a somewhat rigid understanding of where responsibility lies, with many believing that sexual and reproductive health is mainly a concern for girls and women. In the pre-test we see that only 14% of respondents believed that everyone should learn about sexual and reproductive health. Meanwhile the majority (49%) believed that women alone should learn about SRH, followed by 16% who believed that girls alone should learn about SRH. In the post test what we see is a reduction in the percentage of respondents who believe that everyone should learn about SRH, down to 10%. Though fewer respondents believe that women alone should learn about SRH (down to 32%), there was no change in the percentage of respondents who think girls alone should learn about SRH (see Figure 11). Most notable is that not one respondent believed that men alone or boys alone should learn about sexual and reproductive health, indicating that many in the community place the burden of knowledge about SRH on feminized people. In both the pre- and post-test, the goal of 66% of respondents agreeing that everyone should learn about SRH was not met.



11 WHO | World Health Organization. Conceptual Elements of Sexual Health. Retrieved 15 Mar 2022, from: https://www.who.int/reproductivehealth/topics/sexual_health/conceptual_elements/en/

Figure 11: Beliefs regarding who is responsible for learning about family planning (FP)

When measuring beliefs about who is responsible for family planning in the household, the pre-test data reflected that beneficiaries were far from the goal of 75% believing that the couple together is responsible for family planning. On average, 45% of respondents believed that the wife alone is responsible for family planning, and 8% believed that the husband alone is responsible for family planning. Meanwhile, only 47% believed that the couple together are responsible. In the post-test data, the results changed significantly, yet still did not meet the goal of 75%. On average, 23% of respondents believe that the wife is responsible for family planning, and 4% believe that the husband alone is responsible for family planning. Meanwhile, 73% believe that the couple together are responsible. While the goal was not met, it was only by two percentage points. Furthermore, the 26% increase from pre- to post-test indicates a willingness to change ideas over time. Additionally, when the post-test data was disaggregated by gender, it was found that female respondents in fact surpassed the SMART goal of 75%, with 78% of them believing that the couple together is responsible for family planning in the household. Figure 12 below details these beliefs, disaggregating by gender.

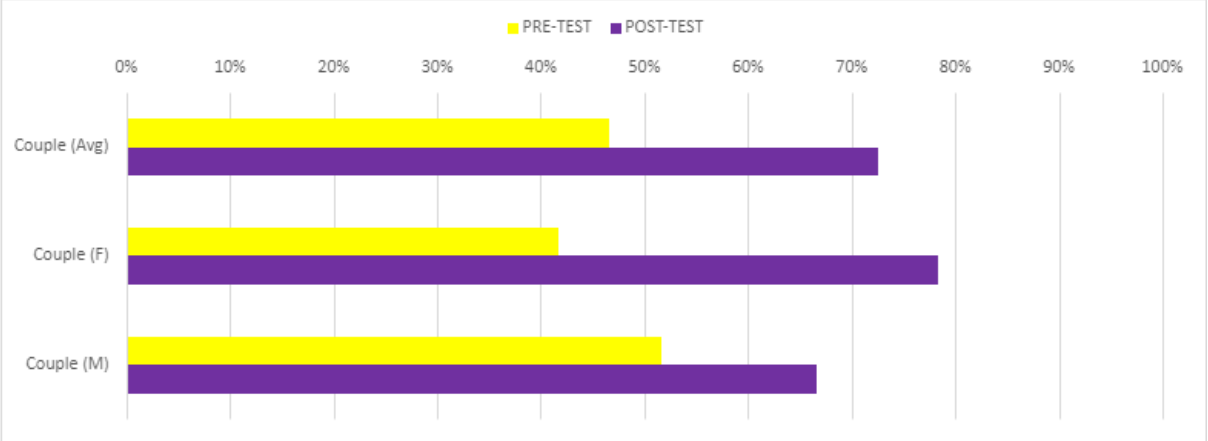


Figure 12: Percentage of participants who believe both members of a couple are responsible for FP

Regarding discussions between partners about family planning, including contraceptive use, how many children to have and the spacing of births, we sought to measure both intention and practice. In terms of intention, the goal was set at 66%; this was not met in the pre- or post-test data. In the pre-test we found that 59% of respondents held this intention. In the post-test there was an increase by 14%, just 3 percentage points away from the SMART goal. See Figure 13 below for details.

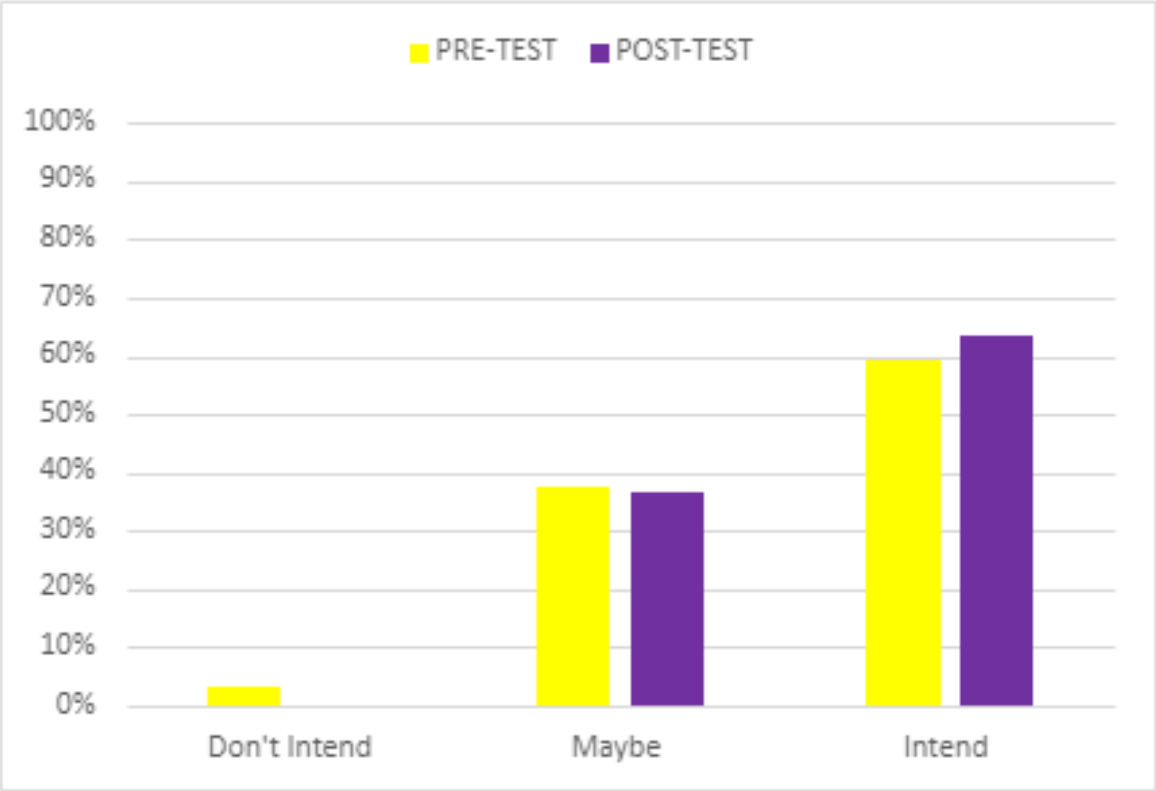


Figure 13: Percentage of participants who intend to discuss FP with partner

With regards to actual practices, the data was a bit more promising. With a SMART goal of 33% of respondents including their partners when making decisions around family planning, the pre-test results showed that 38% of respondents already engaged in this behaviour (see Figure 14). However, when disaggregated by sex we see that though males alone met this goal (43%), females alone did not (32%). This could support the common knowledge that men in these communities tend to be the key decision makers in the household, which could easily extend to decisions around family planning. Even so, there was a remarkable positive shift reflected in the post-test results, with 63% of respondents attesting that they include their partners in discussions around family planning (see Figure 14). For males it was 64%, a twenty-one percent increase, and for females it was 63%, a thirty-one percent increase (see Figure 15).

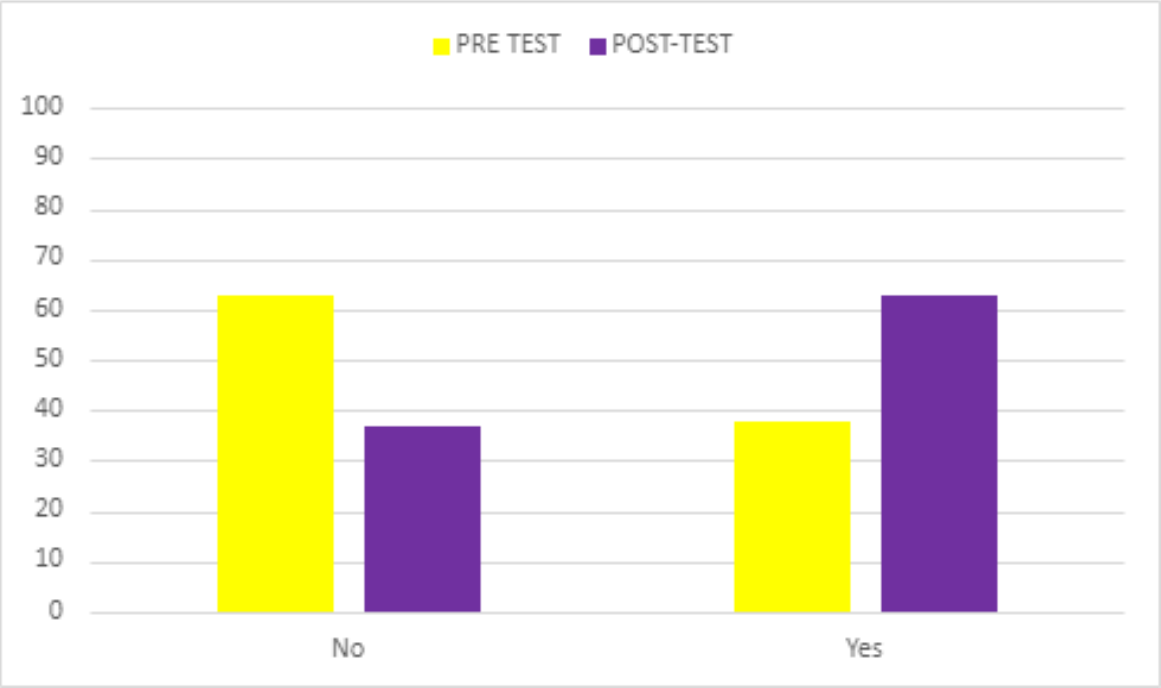


Figure 14: Percentage of participants who include partner in decisions around FP

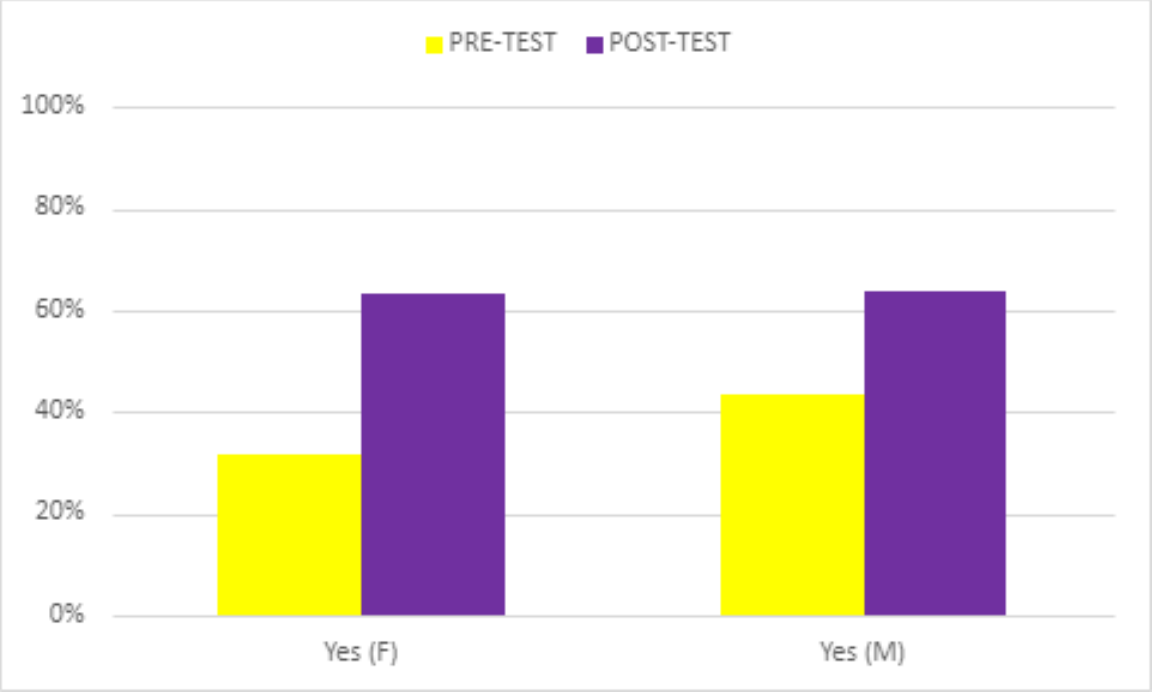


Figure 15: Percentage of participants who include partner in decisions around FP, by sex. F=Female, M=Male

Cooking Demonstrations

Lastly, the findings from the cooking demonstration question indicate that both female and male participants demonstrated an increased attempt at cooking the recipes shared in the SRH module. While the pre-test results did not reach the SMART objective of 50% of participants attempting the recipes, there was an increase in attempts between pre and post, by 37 percentage points (see Figure 16). In the post-test the SMART objective was met, with 62% of participants having attempted the recipe from the cooking demonstration. When disaggregated by gender, the percentage increased from 25% to 60% for women and from 25% to 64% for men.

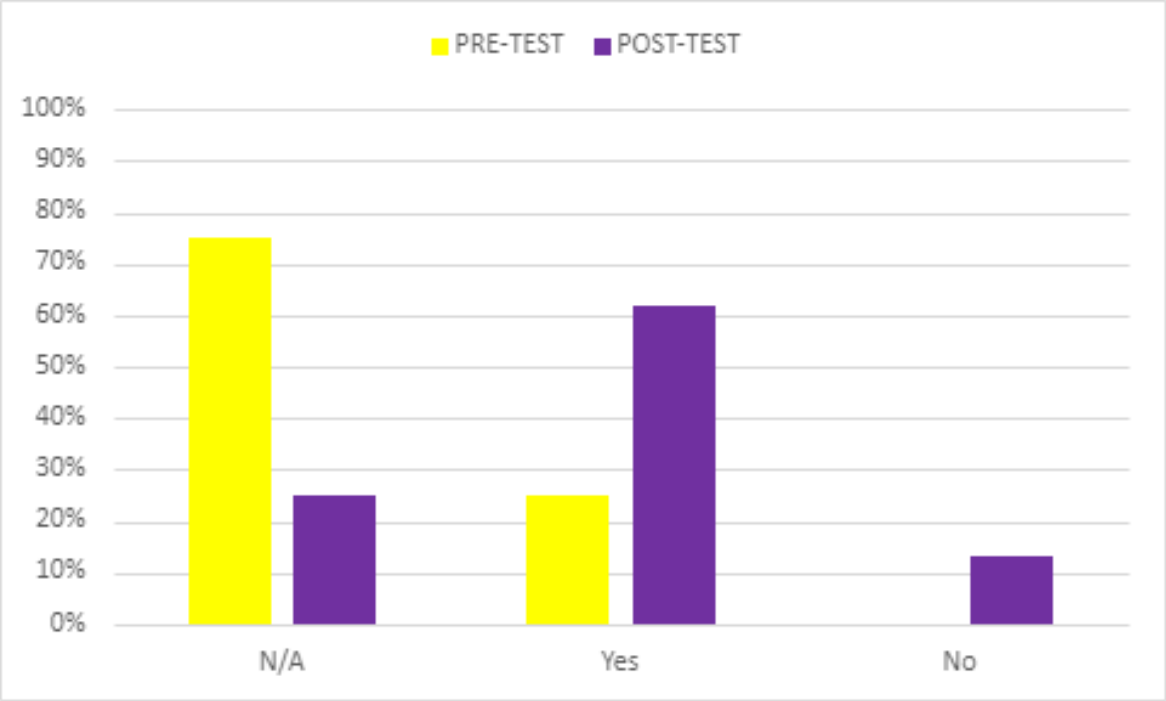


Figure 16: Percentage of participants attempting recipe from cooking demonstration

VI. Discussion

The findings from this topic module were very unlike those of the five previous modules covered through the project. In all the previous analyses and reports, we found that the majority of indicators and SMART goals were met in either the pre- or post-test. However, this was not the case for the sexual and reproductive health module. In this case, many indicators and SMART goals were not met, reflecting not only gaps in knowledge but also limited intention and practices toward the reproductive health aspects that were the focus of this topic module.

Unlike the Infant & Young Child Feeding, Gender, Malaria Prevention, Sanitation and Hygiene, and Maternal Nutrition topic modules, the majority of pre and post-test results for the Sexual and Reproductive Health module did not exceed SMART objectives. Only three of the indicators reached their SMART objectives in the pre-test: sharing decision-

making around family planning (1.5), knowing that births should occur at least two years apart (1.9) and intending to space births by at least two years (1.10). Two additional indicators reached the SMART objective in the post-test: going to a health facility with their partner to discuss family planning (1.8) and knowing that obstetric fistula is curable and preventable (1.13).

When disaggregated by gender, an additional three indicators were reached by women only: recalling key SRH messages (1.1), knowing that all parents in a household are responsible for family planning (1.3) and intending to go to a health facility with a partner to discuss family planning (1.7). As demonstrated in the data, none of the thirteen indicators resulted in 100% reach of their respective SMART objective in the pre- or post-test.

There could be several reasons as to why the data resulted in this manner. For one, the topic of sexual and reproductive health remains very culturally taboo in the communities where the learning sessions and pre/post-tests took place. The desire to evade being associated with taboo subjects can be a strong influence on one's ability to engage with the material in a profound or lasting way. Enumerators, otherwise referred to as community health volunteers (CHVs), reported that some respondents were afraid to answer some of the questions posed to them. Given the strong knowledge retention capacity demonstrated in all former modules, it is unlikely that respondents were lacking in the ability to understand what was taught in the learning modules. There are several external factors which influence communal and individual willingness to adhere to or change a behavioural pattern. This includes habit, fear and negative prior experience[12]. Additionally, community health workers faced challenges navigating familial relationships within the learning sessions where relatives were often in attendance. They had to relay the information in a sensitive manner to avoid embarrassing attendees. Furthermore, some CHV still had difficulties fully understanding the messages of the learning modules, some of which were heavily focused on early marriage, and not enough on other issues related to sexual and reproductive health or obstetric fistula.

While the findings of this topic module were not as expected, they help implementers to make changes to better meet the needs of the community and more successfully implement the intervention. The failure to reach most of the SMART objectives indicated that in the future such a project could need a change of methodology, at least for the SRH topic module. For the GTNS project, it was decided for the SRH module to have a strong a focus on family planning, to the exclusion of other key sexual and reproductive health components. Of the fourteen questions on the questionnaire, ten were about family planning and four about obstetric fistula. If the SRH module was implemented again there are additional SRH focus areas which could be included such as: HIV/STI prevention and treatment; consent and prevention of sexual assault; gender diversity; sexual orientation;

12 Barriers and Facilitators to Behavior Change – SBCC and Gender. (2015, November 2). https://sbccimplementationkits.org/gender/barriers-facilitators-behavior-change/#:~:text=Barriers%20to%20change%20prevent%20or%20make%20it%20difficult

post-partum and post-abortion care; prevention, diagnosis and treatment of cervical and prostate cancers; prevention of gender-based violence and care of survivors.

The maternal, infant and young child feeding nutrition (MIYCN) and family planning (FP) integration toolkit states that "integrating SBCC activities for MIYCN and FP benefits the health of mothers and their children by reinforcing the mutual benefits of nutrition and family planning practices" (Maternal Infant and Young Child Nutrition and Family Planning (MIYCN-FP) Integration Toolkit). As such, family planning addresses a core, cross-cutting aspect of promotion of proper nutrition for pregnant and lactating women and children under 2 years old. However, family planning alone will not fully address the needs of this, or any, community. When developing learning resources, it is important to address the full spectrum of sexual and reproductive needs of a community, and the unique needs for vulnerable individuals including adolescents and pregnant people[13]. Some primary SRH components include contraception and condom use, HIV/STI prevention and treatment, gender-based violence education & prevention and sexual self-efficacy. Common psychosocial intervention components included: assertiveness training, communication skills, and problem-solving[14]. Inclusion of HIV messaging is of particular importance given the critical negative impact it has been found to have on food security for women and girls[15]. It is also important to note that LGBTQI people and other sexual and gender diverse people have been excluded from this study, thus the results can not accurately define the experiences of such persons who exist in the community.

VII. Conclusion

Project beneficiaries in Chemba District have received education and possess some prior knowledge of sexual and reproductive health and pre-test results reflect this effort whereby there exists a small amount of knowledge, favourable attitudes and good practices around family planning. Nevertheless, findings have shown some positive influence across a few of the indicators when comparing pre- and post-test results for family planning promotion and obstetric fistula prevention, particularly understanding the importance of birth spacing and discussing family planning with the partner. The pre

13 LaRose E, Osman N, Santos Dias K, Poonawala A, Gonzalez W, Felix Z, Falla A. Nourishing Heroínas in Mozambique: understanding, designing with, and tailoring nutrition interventions to adolescent girls. Global Alliance for Improved Nutrition (GAIN). Working Paper #19. Geneva, Switzerland, 2021. DOI: https://doi.org/10.36072/wp.19

14: Developing sexual health programmes: A framework for action. (n.d.). http://apps.who.int/iris/bitstream/handle/10665/70501/WHO_RHR_HRP_10.22_eng.pdf

15 Mambulu, Faith N., "Agricultural Interventions as a Means to Improving Food Security: Experiences of HIV/AIDS-Affected Households in Northern Malawi" (2014). Electronic Thesis and Dissertation Repository. 2375. https://ir.lib.uwo.ca/etd/2375

and post test results also demonstrate a need for continued messaging and counselling on the importance of imparting sexual and reproductive health knowledge on everyone, not just women and girls or people of reproductive age.

Some recommendations on how to improve the content of this topic module includes emphasizing the importance of intention and behaviour change, as well as a more comprehensive focus on key conceptual elements of sexual and reproductive health as identified by UNFPA and the WHO. When designing SBCC interventions, there several evidence-based methods that can be utilized to improve the efficacy of a project. Some methods that are relevant to this project and population are: theory of planned behavior, extended parallel processing, diffusions of innovations, theory of gender and power and feminist political ecology[16]. These are theories that can be considered for when designing future SRH related interventions to ensure higher knowledge and intention to behaviour change.

The Theory of Planned Behavior (TPB) is used to design interventions that target health-enhancing individual behavior that may be socially unacceptable, such as condom use, check-ups, STI/HIV testing, family planning and other behaviours that require individual or partnered decision making but have varying levels of social acceptability[17]. In applying a gender lens to the Theory of Planned Behavior it is important to consider if and how prohibitive and enabling factors support or limit individual behaviour change, and how this can differ for girls, boys, men, women and those across the gender spectrum. Extended Parallel Processing is useful in SBCC interventions when a health issue poses a risk (real or perceived) to personal health. For gender-sensitive programming, it is important to identify how women and gender minorities perceive a particular risk and how, if at all, this differs for men and boys[18]. The Diffusion of Innovations model is helpful in interventions where the time to make an impact on a community is limited. Diffusion of Innovations approach is most effective when applied to issues that can be influenced by prominent members of society or spread through traditional methods of communication. For programs that integrate gender, identify and collaborate with any positive deviants and female leaders in the community[19]. The Theory of Gender and Power examines the ways in which social structures are built on gender inequality and gender-based power imbalances. It can help us understand why women and girls face great risk of sexual and reproductive related health issues including HIV infection and

16 Barriers and Facilitators to Behavior Change – SBCC and Gender. (2015, November 2). https://sbccimplementationkits.org/gender/barriers-facilitators-behavior-change/#:~:text=Barriers%20to%20change%20prevent%20or%20make%20it%20difficult

17 Theory of Planned Behavior: An HC3 Research Primer (n.d.). https://www.healthcommcapacity.org/wp-content/uploads/2014/03/theory_of_planned_behavior.pdf

18 The Extended Parallel Processing Model: An HC3 Research Primer (n.d.). https://www.healthcommcapacity.org/wp-content/uploads/2014/09/Extended-Parallel-Processing-Model.pdf

19 Diffusion of Innovations: An HC3 Research Primer (n.d.). https://www.healthcommcapacity.org/wp-content/uploads/2014/03/diffusion_of_innovations_kim.pdf

obstetric fistula[20]. Related to the Theory of Gender and Power, we can consider using the Feminist Political Ecology theory for interventions that aim to address structural barriers or facilitators at lower rungs of the socio-political strata to inform health outcomes. Feminist political ecology analyses the influence of gender in a regional landscape and explores gender as a factor in socio-political relations[21]. As stated by the WHO's Department of Reproductive Health and Research, "while it is difficult to measure the success of behaviour change programmes, there is evidence that integrated multisectoral approaches are effective"[22].

20 Wingood, G. M., & DiClemente, R. J. (2000). Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women. Health Education & Behavior, 27(5), 539–565. https://doi.org/10.1177/109019810002700502

21 *Feminist Political Ecology - Understanding Agriculture and Food Security in the Context of HIV/*. (n.d.). 1library.net. Retrieved March 23, 2022, from https://1library.net/article/feminist-political-ecology-understanding-agriculture-food-security-context.yro415oy

22 Action framework Action framework Developing sexual health programmes A framework for action. (n.d.). http://apps.who.int/iris/bitstream/handle/10665/70501/WHO_RHR_HRP_10.22_eng.pdf

Acronyms

ADA	Austrian Development Agency
CHW	Community Health Worker(s)
CU2	Children Under 2 (years)
CU5	Children Under 5 (years)
GTNS	Gender Transformative and Nutrition-sensitive (project)
GDC	Gender Dialogue Club(s)
HIV	Human Immunodeficiency Virus
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practices (Study)
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MIYCN	Maternal, Infant and Young Child Feeding Nutrition (MIYCN)
MN	Maternal Nutrition
ODK	Open Data Kit
PLW	Pregnant and Lactating Women
SBCC	Social and Behaviour Change Communication
SDSMAS	District Services of Health, Women & Social Action
SMART	Specific, Measurable, Achievable, Relevant and Timebound
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
S&H	Sanitation & Hygiene
TPB	Theory of Planned Behavior
WHO	World Health Organization
WFP	United Nations World Food Programme

Annex 1: Sexual and Reproductive Health Indicators and SMART Objectives

#	Indicator detail	SMART Objective	Respondent	Behavioural domain	Psychosocial indicators	Reference (template question)
3. Sexual Reproductive Health (SRH)						
1.1	Increased percentage of SRH messages recalled by men and women	After complete SBCC topic area is conducted [6 weeks], 75% of men and women partaking in the SBCC sessions, will be able to recall at least 3 key SRH messages	WOMAN/MAN	SRH (GENERAL)	KNOWLEDGE	2.1
1.2	Increased percentage of men and women know sexual and reproductive health and family planning should be taught to all people regardless of marital status, gender or age	After complete SBCC topic area is conducted [6 weeks], 66% of men and women partaking in the SBCC sessions, know sexual and reproductive health and family planning should be taught to all people regardless of marital status, gender or age.	WOMAN/MAN	INCLUSIVITY	KNOWLEDGE	2.2
1.3	Increased percentage of men and women know both parents (man and woman) are responsible for family planning in the household	After complete SBCC topic area is conducted [6 weeks], 75% of men and women partaking in the SBCC sessions, know that both parents are responsible for family planning in the household	WOMAN/MAN	SHARED RESPONSIBILITY	KNOWLEDGE	2.3
1.4	Increased percentage of men and women intend to share decision-making around family planning	After complete SBCC topic area is conducted [6 weeks], 66% of men and women partaking in the SBCC sessions, intend to discuss and agree together with your partner on family planning	WOMAN/MAN	SHARED DECISION-MAKING	INTENTION	2.4

1.5	Increased percentage of men and women report sharing decision making around family planning with their partners	After complete SBCC topic area is conducted [6 weeks], 33% of men and women partaking in the SBCC sessions, report discussing and agreeing around family planning with their partners, such as which contraceptives to use, when and how many children to have	WOMAN/MAN	SHARED DECISION-MAKING	SELF-REPORTED BEHAVIOUR	2.5
1.6	Increased percentage of men and women can recall different types of contraceptive methods	After complete SBCC topic area is conducted [6 weeks], 75% of caregivers partaking in the SBCC sessions, can recall at least 3 methods of contraception	WOMAN/MAN	FAMILY PLANNING METHODS	KNOWLEDGE	2.6
1.7	Increased percentage of men and women intend to go to the health facility with their partner to discuss family planning	After complete SBCC topic area is conducted [6 weeks], 50% of men and women partaking in the SBCC sessions, intend to go to the health facility with their partner to discuss family planning with a medical professional	WOMAN/MAN	HEALTH FACILITY	INTENTION	2.7
1.8	Increased percentage of men and women reported going to the health facility with their partner to discuss family planning	After complete SBCC topic area is conducted [6 weeks], 50% of men and women partaking in the SBCC sessions, reported going to the health facility to discuss family planning with a medical professional	WOMAN/MAN	HEALTH FACILITY	SELF-REPORTED BEHAVIOUR	2.8
1.9	Increased percentage of men and women know the minimum time that is needed for a woman to wait before getting pregnant again after giving birth that is safe	After complete SBCC topic area is conducted [6 weeks], 75% of men and women partaking in the SBCC sessions, know the minimum time needed for a woman to wait before getting pregnant again after giving birth that is safe is at least two years	WOMAN/MAN	BIRTH SPACING	KNOWLEDGE	2.9

1.10	Increased percentage of men and women intend to wait at least two years after giving birth to become pregnant again	After complete SBCC topic area is conducted [6 weeks], 50% of men and women partaking in the SBCC sessions, intend to wait at least two years after giving birth before getting pregnant again in the next pregnancy	WOMAN/MAN	BIRTH SPACING	INTENTION	2.10
1.11	Increased percentage of respondents know the key causes of obstetric fistula.	After complete SBCC topic area is conducted [6 weeks], 75% of participants partaking in the SBCC sessions, will be able to recall at least 3 key causes of obstetric fistula (OF).	WOMAN/MAN	SRH (GENERAL)	KNOWLEDGE	3.1
1.12	Increased percentage of respondents know the key symptoms of obstetric fistula.	After complete SBCC topic area is conducted [6 weeks], 75% of participants partaking in the SBCC sessions, will be able to recall at least 3 symptoms of obstetric fistula (OF).	WOMAN/MAN	SRH (GENERAL)	KNOWLEDGE	3.2
1.13	Increased percentage of respondents know that obstetric fistula is curable and preventable.	After complete SBCC topic area is conducted [6 weeks], 50% of people partaking in the SBCC sessions know that obstetric fistula is both preventable and treatable.	WOMAN/MAN	SRH (GENERAL)	KNOWLEDGE	3.3 and 3.4

Annex 2: Sexual and Reproductive Health Questionnaire

WFP	**SBCC Monitoring Questionnaire – Sexual and Reproductive Health** **To be filled in by: Beneficiaries - Interviewed by Pathfinder Staff** **Version 2 – December 2021**	**Moçambique** **GTNS Project** Pathfinder INTERNATIONAL Sexual and reproductive health without fear or boundary

Introduction

Read introduction to beneficiary

Hello, My name is _____. I work for the local organization Pathfinder, supporting the Ministry of Health and WFP. You have been selected by chance within the GTNS (Khaliro Adidi) project beneficiaries at this site for this interview. You will gain no material benefit from agreeing to conduct this interview. You will not receive any extra assistance than you would otherwise have received. The survey is voluntary and you can choose not to take part.

The purpose of this interview is to obtain information about the health behaviours of community members. It helps us understand whether we are implementing our program properly and whether we are addressing the needs of the population we serve. The information that you give will be confidential. The information will be used to prepare reports, but all information will be confidentially and no names will be shared.

This interview will only take about 20 minutes.

Please provide the most accurate answer that you can to best inform and improve the program.

If you agree, we will now start the questions.

If respondent says 'Yes' – start the data collection. If respondent says 'No' – thank you for his/her time and end the interview.

1. General information - INTERVIEWER TO FILL IN

1.1 . Name of community [drop down list]: Andrassone, Arnelo, Bangwe, Bhaumbha, Bucha, Candima, Cassume, Castela, Deve, Dzunga 1, Dzunga 2, Fernando, Francalino, Fumbe 1, Fumbe 2, Macendua, Mandue, Mapata, Mateus, Melo 1, Melo 2, Muandinhoza, Mulima-sede, Nhacagulagua 1, Nhacagulagua 2, Nhacavunvu, Nhalunga, Nhamaliwa, Nhamazonde, Nhambhandha, Nhamingale, Nhancaca, Nhangue, Nhapwete, Nharugue, Nhasulu, Nhatsete, Nhakuiyoyo, Niquice, Ofece, Shonsua, Thenda, Tomucene 1, Tomucene 2, Tsera, Xavier, Zenguerere, Zomdane 1, Zomdane 2

1.2. Beneficiary is a □ Man □ Woman [ALL RESPONDENTS SHOULD RESPOND TO ALL QUESTIONS]	1.3. Date __ / __ / ____ dd mm yyyy

2. Questions for men and women

2.1	Can you please recall key messages about sexual and reproductive health?	***Do not read options to beneficiary*** Mark each option that the caregiver mentions. ▪Family planning is the responsibility of the couple (man and woman) and the couple should both attend consultations together ▪Family planning helps us avoid unplanned pregnancy ▪It is important that the couple respect each other and together make all decisions, including on issues related to FP and contraception

		▪Negotiating the FP method that best fits the couple's needs depends on communication and balance in making decision ▪There is a lot of wrong information/myths about family planning, such as using a condom reduces the couple's sexual pleasure or contraceptive methods do not cause infertility in women ▪Women may become pregnant again some time after stop taking the contraceptive injection ▪Using IUD does not cause infertility in women, exception with tubal ligation ▪Short-term family planning methods are: male and female condoms, pills ▪Long-term methods: injection (DEPO), IUD, and implants ▪Permanent methods: Vasectomy and tubal ligation ▪I can go to the health facility to find free information on family planning methods ▪Women should wait at least two years between births. ▪ I have the right to have relevant information about the various methods of family planning and nobody can force me to choose a certain method ▪The are many barriers that limit access to family planning, such as fear of secondary effects, myths/wrong information, men opposition to it, women fearing men's opposition, lack of dialogue around family planning and SRH, pressure to have children, lack of diversity/stock of contraceptives in health facilities. ▪HIV-positive women should attend ANC visits and receive PTV counseling. ▪Other; please specify_____
2.2	Who should learn about sexual and reproductive health, such as family planning and contraception?	***Read options to beneficiary*** Mark each option that the beneficiary mentions. 1- women (if selected, "only married women" or "all women") 2 - men (if selected, "only married men" or "all men") 3- adolescent girls (if selected, "only married adolescent girls" or "all adolescent girls") 4- adolescent boys (if selected, "only married adolescent boys" or "all adolescent boys") 5- Other, please specify _____

2.3	According to you, who is responsible for the family planning in the household? You can only choose one option.	***Read options to beneficiary*** □ 1 - The wife □ 2 - The husband □ 3 - the couple (husband and wife)
2.4	To what extent do you intend to discuss and agree with your partner (husband/wife/wives) on family planning, such as use of contraceptives and when to and how many children to have? You can only choose one option.	***Read options to beneficiary*** □ 1 - Do not intend to □ 2 - Maybe will □ 3 - Do intend to
2.5	Did you include your partner when making decisions around family planning, such as which contraceptive to use or when and how many children to have? Yes or no?	***Read options to beneficiary*** □ 1 - Yes, I included my partner when making decisions around family planning □ 2 - No, I did not include my partner when making decisions around family planning
2.6	Can you please recall some family planning/contraceptive methods?	***<u>Do not read</u> options to beneficiary. Mark each option that the caregiver mentions.*** ▪ Mark each option that the beneficiary mentions. ▪Male condom ▪Female condom ▪Pills ▪Injection (DEPO) ▪IUD ▪Implants ▪Vasectomy ▪(Tubal) ligation ▪Other; please specify_____
2.7	To what extent do you intend to go to the health facility with your partner to discuss family planning methods with a medical professional? You can only choose one option.	***Read options to beneficiary*** □ 1 - Do not intend to □ 2 - Maybe will □ 3 - Do intend to
2.8	Did you go to the health facility with your partner to discuss family planning methods with a medical professional? Yes or no?	***Read options to beneficiary*** □ 1 - Yes, I went to the health facility with my partner to discuss family planning with a medical professional □ 2 - No, I did not go to the health facility with my partner to discuss family planning with a medical professional
2.9	What is the minimum time that is needed for a woman to wait before getting pregnant again after giving birth that is safe? You can only choose one option.	***Read options to beneficiary*** 1- do not need to wait, a woman can have become pregnant immediately after giving birth 2- a woman should wait at least 1 year before getting pregnant again 3- a woman should wait at least 2 years before getting pregnant again 4-a woman should wait at least 4 years before getting pregnant again 5- I don't know

2.10	To what extent do you intend to wait at least two years after giving birth before getting pregnant again in your next pregnancy/in your wife's next pregnancy? You can only choose one option.	***Read options to beneficiary*** □ 1 - Do not intend to □ 2 - Maybe will □ 3 - Do intend to
3. Obstetric Fistula (OF)		
3.1	Can you please recall some causes of obstetric fistula?	Do not read options to beneficiary. Mark each option that the respondent mentions. ▪ Prolonged, complicated labour ▪ Lack of medical care during and after labour ▪ Early age/teenage pregnancy ▪ Maternal malnutrition ▪ Short spacing between pregnancies ▪ Limited access to health clinics ▪ Wrongly positioned foetus during labour ▪ Constricted blood flow during labour ▪ Female genital cutting ▪ Sexual violence ▪ Other; please specify_____
3.2	Can you please recall some symptoms of obstetric fistula?	Do not read options to beneficiary. Mark each option that the respondent mentions. ▪ Foul odour/smell coming from vaginal area ▪ Chronic urinary tract infections ▪ Constant, uncontrollable leakage of urine and/or faeces from the vagina/birth canal ▪ A hole between the vagina and rectum ▪ Infertility ▪ Nerve damage or paralysis ▪ Sexual dysfunctional ▪ Painful sexual intercourse ▪ Itching, burning and irritation in the vagina and/or of the vulva

		▪ Vaginal discharge ▪ Abdominal pain ▪ Lack of a regular menstrual period ▪ Difficulty walking ▪ Other; please specify_____
3.3	Obstetric fistula is curable.	Read options to beneficiary □ 1 - True □ 2 - False
3.4	Obstetric fistula is preventable.	Read options to beneficiary □ 1 - True □ 2 - False
4. Cooking Demonstrations		
5.1	[**If applicable**], did you try to make the recipe(s) from the cooking demonstration at your home anytime over the last 6 weeks?	□ 0 - Not applicable □ 1 - Yes, I tried to make the recipe(s) at home □ 2 - No, I did not try to make the recipe(s) at home
6. Do you have anything you want to ask about what we discussed now?		
Final remarks		
Read conclusion to beneficiary This was the last question and we are done now. Thank you once again for your generous time and for sharing your thoughts with us. We greatly appreciate your help and we hope this research will help us improve the health of the member in your community. If you have any specific questions, please do not hesitate to call our free hotline, Linha Verde, at 1458.		
7. Signatures and approvals by Pathfinder staff - NOT RELEVANT FOR MODA ONLY IF PAPER VERSION WILL BE USED		
Pathfinder field staff:		Pathfinder District MCH Officer:
Signature:	Date:	Signature: Date: