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Trials of Improved Practices in Karamoja

Investigating Behaviours of Nutrition and Hygiene

Final Report

Prepared by Christine Fernandes
August 2013



Resiliency through Wealth, Agriculture, and Nutrition in Karamoja (RWANU)
AID-FFP-A-12-00011

Table of Contents

List of Abbreviations.....	2
Definition.....	3
Executive Summary.....	4
Introduction.....	5
Background.....	6
Objectives.....	7
Methodology.....	8
Findings.....	10
Assessment Visit.....	10
Dietary Diversity.....	11
Hand Washing.....	11
Designated Defecation.....	12
Contrasts Between Districts.....	13
Counselling Visit.....	14
Dietary Diversity.....	14
Hand Washing.....	17
Designated Defecation.....	19
Contrasts Between Districts.....	21
Follow up Visit.....	21
Dietary Diversity.....	22
Hand Washing.....	24
Designated Defecation.....	26
Contrasts Between Districts.....	28
Conclusions and Recommendations.....	29
References.....	33
Annexes.....	34

List of Abbreviations

BCC	Behaviour Change Communication
CLTS	Community Led Total Sanitation
DGLVs	Dark green leafy vegetables
FAO	Food and Agriculture Organization of the United Nations (maybe)
FGD	Focus Group Discussions
GOU	Government of Uganda
IYCF	Infant and Young Child Feeding
RWANU	Resiliency through Wealth, Agriculture and Nutrition in Karamoja
SBC-SAP	Social Behaviour Change Strategic Action Plan
SDA	Small, doable action
TIPs	Trials of Improved Practices
UNICEF	United Nations Children's Fund
VHT	Volunteer Health Team
WHO	World Health Organization

Definitions

posho	Also called 'ugali', a common staple made of maize or sorghum flour cooked with water to a porridge or dough-like consistency.
manyatta	semi-permanent homesteads that are usually part of a cluster that forms a neighbourhood or village
kraal	an enclosure for cattle or other livestock, located within an African settlement or village surrounded by a palisade, mud wall, or other fencing, roughly circular in form.
tippy-tap	The Tippy Tap is a simple device for hand washing with running water. A container of 5 litres with a small hole near the cap is filled with water and tipped with a stick and rope tied through a hole in the cap. As only the soap is touched with the hands, the device is very hygienic. A gravel bed is used to soak away the water and prevent mosquitoes. ¹



¹ Definition and image from http://akvopedia.org/wiki/File:TippyTap_icon.png.

Executive Summary

Trials of Improved Practices (TIPs) was commissioned by the Resiliency through Wealth, Agriculture and Nutrition in Karamoja (RWANU) programme. It is a formative research method designed to test the feasibility and acceptability of practices at the household level that a programme plans to promote. The outcomes obtained through TIPs will inform the RWANU programme's behaviour change activities and will be used to update the Social and Behaviour Change Strategic Action Plan (SBC-SAP). The behaviours that were investigated were: dietary diversity of children 6-24 months, hand washing, and designated defecation. Each behaviour was simplified into smaller, doable actions that were suggested to the participants.

The TIPs research took place in the four southern districts of Karamoja: Moroto, Napak, Nakapiririt, and Amudat. There were three phases of the TIPs process:

Phase 1 – Household assessment visits were conducted in each home to identify current practices as well as identify potential motivators and barriers related to the promoted behaviours.

Phase 2 – Counselling visits were conducted in each home to raise a mother's awareness to the new behaviours, record her reactions, build on her current practices and motivations, and negotiate on trying new practices that were easy for the participant to do.

Phase 3 – Follow up visits were carried out to record the results and any modifications of the tried recommended practices.

The TIPs study revealed that caregivers were willing to increase the diversity of a child's diet if the foods were affordable. It was also easy and time saving for the mothers to incorporate additional foods in a child's daily porridge. Hand washing practices were motivated by practical demonstrations, and the practice of latrine usage and digging and burying was more acceptable than designating a space for defecation for the entire family. Participants also requested community support for promoted behaviours related to designated defecation.

The recommendations for the SBC-SAP were examples of key messages and images for IEC materials, community sensitizations and involvement in decision-making for programme activities, mobilising men and village leaders, integrating topics of the three behaviours into current group and individual counselling sessions, integrating the successful recipes in the trials into a recipe booklet, scaling up practical demonstrations, and promoting behaviours through radio, community announcements, and performances.

Introduction

Trials of improved practices (TIPs) is a formative research technique used in behaviour change programming to pre-test a practice (or practices) that a programme aims to promote. It is designed to explore the feasibility and acceptability of the practices, in order to refine and modify recommended behaviours to make them more acceptable and doable for the target audience. TIPs allows for an in-depth understanding of a household's current practices, preferences, and capabilities; it tests participants' reactions to the new recommendations, determines the relative ease or difficulty of communicating various practices, and helps a programme to learn more about the motivations and constraints of the advocated behaviours. Participants' experiences and opinions are then used to design a programme.

The TIPs process involves a series of household visits (3 visits total in the case of the TIPs research conducted in Karamoja) to selected homes to test new behaviours to improve health practices. The reason it is helpful is to provide individual counselling with caregivers to adopt key optimal behaviours. The basic process is: an initial home visit to interview the caregiver and gather background information on the current practice(s), a second visit with the caregiver to present and counsel on several options for improving the current practice(s), to record her reactions to the options, and to negotiate with her to choose one or more options that she is willing to try during the following week, and a third follow-up visit to see how the caregiver has progressed and address any challenges found.²

In the TIPs research process for RWANU, special emphasis was placed on counselling and negotiating during home visits. The goal was to establish a rapport with caregivers, building trust between mothers and field staff in order to obtain honest answers from all participants. Counselling skills such as listening and learning, building confidence, 'reflecting', and 'accepting' mothers' responses were emphasised. Communicating through negotiations was equally as important during the home visits. The TIPs planning guide *Designing by Dialogue* (1998) defines negotiation in TIPs research as 'a process of dialogue between a counsellor and mother during which the mother agrees to try one or more specific practices for a specified period of time. The new, negotiated practice may not achieve optimum or ideal nutrition, but it will be a nutritional improvement (compared with usual or customary practices).'

This report details the process and results of the assessment, counselling, and follow up visits as well as the analysis and final outcomes of the research. The report also addresses how the findings of the research determine and modify the programme recommendations for behaviour change communication (BCC) activities in the field.

² Based on the process for *Designing by Dialogue, A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*, Kate Dickin and Marcia Griffiths, The Manoff Group, Ellen Piwoz, SARA/AED, Washington, D.C., 1998

Background

Concern Worldwide (Concern), ACDI/VOCA and WeltHungerHilfe (WHH) have designed the Resiliency through Wealth, Agriculture and Nutrition in Karamoja (RWANU) programme to respond to Food for Peace's (FFP) overall strategic objective for the Title II programme in Uganda: *reduce food insecurity among chronically food insecure households*. RWANU proposed to implement in 16 sub-counties in Napak, Moroto, Amudat and Nakapiripirit Districts of South Karamoja, an area selected because of the high levels of malnutrition, the existing social and economic interrelationships, the relative security of the area, and the potential for sustainable results. The programme has a five-year duration, and began in late August/early September 2012, with full implementation beginning in January 2013. In total the RWANU program is expected to reach a total of 200,399 beneficiaries.³

The Karamoja region of Uganda suffers from low agricultural productivity, limited availability of production inputs and extension services, declining livestock population and weak linkages to markets. It also struggles with inadequate infant and young child feeding practices, poor hygiene practices and lack of access to health services. Improved security in the region, coupled with commitments by the government of Uganda and donors to invest in economic and social development, is opening a window of opportunity to address the root causes of food insecurity.

For decades, the Karamoja region has been characterized by violent conflict, high levels of poverty and food insecurity. It is vulnerable to severe natural disasters with frequent droughts and resulting loss of crops and livestock and historically, has been isolated. The economic growth experienced in the rest of Uganda has had little impact in Karamoja. An estimated 82 percent of the population in Karamoja lives in poverty. As a result, the area has been dependent on food aid and donor assistance for decades with numerous emergency aid programs. Insecurity and violent conflict related to livestock raiding and the proliferation of small arms in the area have made it difficult to implement long-term development strategies. The situation, however, is changing. Disarmament programs have reduced the incidence of raiding and improved security. The GOU also is committed to investing in the development of infrastructure and human capital in the region. This now makes it possible to address the root causes of poverty and food insecurity while reducing household dependency on donor aid.⁴

The TIPs research was conducted in the four districts of Karamoja in the towns and villages below. Three of the areas were located in the green belt areas of southern Nakapiripirit District and Iriiri subcounty (Napak).

- Moroto
 - Nadunget
 - Natari
 - Arengkenye
- Napak
 - Lotome

³ Concern Worldwide Uganda TOR for the TIPs consultancy June 2013.

⁴ RWANU Revised Technical Narrative ACIDI/VOCA 2013.

- Namendela (green belt area)
- Alekilek (green belt area)
- Nakapiripirit
 - Kanagakinoi
 - Komojoj (green belt area)
 - Ariamoi
- Amudat
 - Chepuise
 - Namodoi
 - Cheptapoyo



Image 1.1 Map of the Seven Districts of Karamoja.

The communities living in the three districts of Moroto, Napak, and Nakapiripirit are Karamajong-speaking and mostly agro-pastoralists. Their livelihoods are primarily herding livestock and crop cultivation, although poverty is increasing due to droughts and poor harvests in the dry season as well as many other factors. The Pokot in Amudat are Pokot-speaking pastoralists with some cultivation activities. They have less access to food varieties and clean water, travelling further distances to markets and walking between 15-60 minutes to water points.⁵

Objectives

The objective of the TIPs study was to investigate three different behaviours that the RWANU project will be promoting. These behaviours are dietary diversity of a child 6-24 months, hand washing, and designated defecation. TIPs aimed to determine the feasibility and acceptability of the recommended practices, identify the motivations and

⁵ DHO-ACF and UNICEF Nutrition Surveillance Report Karamoja Region, Uganda, Round 8, May 2012.

constraints, as well as record any modifications of the new practices. The specific recommendations explored for each behaviour were:

Dietary diversity – Caregivers give foods that are high in vitamin A, iron, and protein.

Hand washing – Caregivers wash hands at the 5 critical times:

1. Before preparing food
2. Before eating
3. Before feeding a child
4. After defecating
5. After cleaning a baby's bottom

Designated defecation – Caregivers create a designated space (a fenced area at least 50 metres away from water points) for entire family, and identify a place to defecate just outside of the manyatta at night times if insecurity is a concern.

The final outcomes will help to determine programme recommendations for behaviour change communication activities that will be integrated into the design and implementation of the current Social Behaviour Change and Strategy Action Plan (SBC-SAP).

Methodology

Data Collection and Tools

Three data collection tools were drafted for the three phases of TIPs: the household assessment tool (questionnaire), the counselling recording tool, and the follow up visit tool (see Annexes 1, 2, 3). The recording forms were based on the FAO's *Trials of Improved Practices Reference Notes And Tools*, (2011) and tailored for the Karamoja context. Each drafted tool was submitted to the Senior Nutritionist and Regional Nutrition Advisor for comments and suggestions. The revised documents were distributed and discussed at length with all enumerators during the trainings, and additional amendments were made prior to the field visits. Translations of the first assessment tool were prepared in Karamajong as well as Pokot for the district of Amudat. Group work was then assigned to the enumerators to review the translated versions and discuss any problems with language.

Training of Field Staff

Three rounds of training were carried out with the 24 enumerators, facilitated by the consultant. Each training corresponded with each phase of TIPs. The first round of trainings was carried out over a 3-day period, focusing on the background and general process of the TIPs research, complementary feeding and WASH technical information, and guidance on the assessment tool. The second set of trainings took place over 2 days and focused on counselling and negotiating skills and a step-by-step process of how to counsel individual households. The recording tool and counselling guide were also reviewed in detail. The last 1-day training session prepared enumerators for the final interview. The recording tool was reviewed and a guide for follow up questions was

distributed for additional support. Each pair reviewed their households' counselling information and prepared specific follow-up topics to discuss with each caregiver. (For complete details of the trainings and curriculum please refer to the *TIPs Activity Report* submitted to the RWANU team.)

Pilot Study

Following the first series of trainings, the field staff and supervisors pilot tested the questionnaire in Lokilala, Moroto. Each field staff team of 2 (male/female) randomly chose a household with caregivers who had a child 6-24 months. The Amudat team tested the assessment tool with a Pokot speaking woman in Moroto Town. The assessments took over 2 hours per household. At the debriefing session, there was consensus to eliminate more questions that were thought to be irrelevant.

Identification and Selection of Participants

All four districts were informed of the TIPs research conducted in the field through notifications letters. The village VHT and/or the LC1 were contacted prior to the visits in order to mobilise the participating communities. Caregivers were then selected at random by either the VHT or village members with the requirement that the caregiver have a child aged 6-24 months. Each participant was informed of the TIPs research purpose and process. Household visits were explained in detail and all field staff confirmed the willingness of each caregiver to take part in the interviews without remuneration of any kind. A total of 119 households were involved in the assessment visit, 107 in the counselling visit, and 94 in the final follow up visit.

Data Analysis

The field staff were assigned to the four districts of Amudat, Moroto, Nakapiripirit, and Napak. Each team aimed to interview 4 households per day, although due to time constraints some were only able to interview 2-3 per day. During the field visits, nightly debrief meetings were held by the supervisors to check the data collected as well as to provide feedback on the challenges and successes of the interviews. In addition, a 1-day debriefing session was held for each phase of the TIPs fieldwork.

Raw data from the interviews was tallied and arranged into simple tabulation form for simple frequency analysis. Each district was tabulated separately then added together for a full picture of all four districts. As the responses documented for all three interviews were mostly qualitative rather than quantitative, analysis focused on the major trends of participants' answers and reactions. For each TIPs phase the main trends were tallied, summarized in report form, and sent to the Senior Nutritionist and Regional Nutrition Advisor for comments. Analysis was also carried out through a consultative process with the enumerators. Debrief meetings included general identifications of trends of the outcomes, observations, successes, and challenges. These were cross-checked by the supervisor as well as a small team of selected enumerators who assisted in the tallying.

Limitations of the Study

Although the TIPs research technique is an effective way to gauge future adoption of promoted behaviours, it is not without limitations. The TIPs methodology heavily relies

upon counselling and negotiating, but only through a one-time session (the second house visit). As regular counselling visits are assumed to be more effective than one, the lack of tried practices during the 2-week gap between the counselling visit and the follow up visit should not be equated with absolute rejection of the recommendations. Rather, more time is necessary to ensure the successes and failures of certain practices, and even some households requested more time to get used to practicing certain behaviours on a daily basis.

With regards to the dietary diversity assessments, field staff had difficulties identifying nutrition gaps in a child's diet, as the enumerators were not nutritionists and had very little formal training. In order to compensate for this all field supervisors checked every team's nutrition analyses for accuracy.

Findings

Assessment Visit

The TIPs research included assessments of households in order to gain an in-depth understanding of the current practices and circumstances for individual caregivers or families. This was particularly important for the second household visits for the purposes of counselling, negotiating, and offering tailored recommendations based on the families' current practices along with specific motivators and barriers of each caregiver. Although the TIPs research did not utilise all of the information produced in the assessments, the general findings are summarised below for an overall picture of the four districts, as well as key trends of practices related to the three promoted behaviours.

A total of 119 households were interviewed in all four districts. Out of all the families interviewed 54% were male-headed households, with 44% headed by females, and an average family size of 4-8 people. Over half of the respondents reported that they are receiving food aid through OTC, SFP, or MCHN with CSB as the main product of distribution. 82% of respondents reported that their main source of income was earned through casual labour. Almost all caregivers were interested in the growth of their child/children, and reported to help their child grow by mostly giving foods, breastfeeding, and practicing good hygiene such as bathing their children or cleaning their compounds. Most households ate 2 meals a day but prepared meals only once or twice per day. 43% of caregivers reported that their child eats 2 meals a day, and 40% responded that their child eats 3 times a day. However, the majority of caregivers (71%) prepared children's meals only 1-2 times in a day. Through observations, the overall hygienic conditions of the family kitchen areas were dirty with over half of the households keeping both dirty and clean dishes on the floor. Only 22 households were reported to store leftover food in covered containers.

Dietary Diversity

The usual foods consumed by households are sorghum and maize (in the forms of porridge and bread), vegetables (mainly leafy greens and tomatoes), oils/fats, beans or pulses, cow's milk, and dregs made from the local sorghum brew. Other common foods were sunflower seeds, roots/tubers, silver fish, meat (cow, goat, offal) and seasonal fruits. The child's diet reflected mainly sorghum and maize porridge or bread, breast milk, leafy green vegetables, and animal milk. There was some knowledge by caregivers to give their children a variety of foods, however most diets of children were lacking in yellow-coloured vegetables high in vitamin A, all types of fruits, and most forms of protein.

Cultural Beliefs, Motivations, and Constraints

Foods that were considered good for children were mainly plain porridge, beans, animal milk, Irish potatoes, green vegetables and soup broth (not the meat). These foods were believed to be nutritious and help a child to grow healthy, strong, and fat. The two main foods considered bad for children were dregs from alcohol as it was believed to cause diarrhoea, and leafy greens. Although leafy green vegetables were sometimes believed to be good for children, they were also perceived to be difficult for a child to swallow and were thought to cause an upset stomach. Offal was also not given, as it was perceived to cause soft stools in children, making it easier for them to defecate inside the house. Brain is perceived to make the child go insane when eaten. One mother simply explained, "If offal is eaten, it will kill."

Some trends in **motivation** included:

- Availability of food
- The desire to keep a child healthy with foods
- Availability of livestock for animal-source foods

Some **constraints** included:

- Cultural beliefs or perceptions of certain foods
- Access to market too far
- High cost of living/lack of funds

Hand Washing

60% of respondents had knowledge of washing their hands as a way to prevent illness. Many caregivers (46%) reported that they wash their hands more than five times a day or several times a day without remembering the exact number, while 57% of mothers said that they wash their hands with soap or ash. However, there was very little observation of hand washing in general, with 32% of mothers showing field staff the location of soap, and only 31 houses having a designated hand washing space. Over half (53%) of all households interviewed had containers for water specifically for hand washing, although some households were observed using the water for washing other items. Between 34% and 80% of caregivers knew some of the critical times to wash their hands, with the majority reporting that they wash mostly before eating, cooking, and after defecating. Although 66% of caregivers said that availability of water would

make it possible to wash their hands on a daily basis, almost all households reported to have enough water to wash hands every day.

Cultural Beliefs, Motivations, and Constraints

95% of mothers responded positively to washing hands, and there was a common trend among respondents that hand washing keeps the family clean, rids germs, and prevents diseases or illnesses. Although there were very few observations of hand washing and the use of soap or ash, it was clear that there was knowledge of the benefits to keeping hands clean. There were no responses that indicated family members, neighbours, or community elders did not approve of hand washing. Only two mothers showed a negative attitude toward using soap or ash with one mother stating, “I don’t feel anything about washing my hands because it’s expensive to buy soap and I’m too lazy to collect ash.” There were more motivations than constraints, however, with the common themes being the prevention of illnesses for the family, and just to simply feel cleaner.

Some trends in **motivation** included:

- Availability of water and ash
- Knowledge of some of the critical times of hand washing
- Awareness of prevention of diseases through hand washing
- When is it time to eat, respondents *want* to wash their hands

Some **constraints** included:

- Preference to buy food over soap
- Not motivated to use soap or ash every time hands are washed with water
- Some families share same dirty water in a basin

Designated Defecation

As expected, the majority of households practiced open defecation, with 94% of family members defecating outside of the compound in the fields or near water sources such as rivers. Some mothers (13) said that family members defecated in the corral, or *kraal*, and that defecating in the fields is a good source of manure for their crops. In the night, 45% of respondents reported defecating inside the compound (especially the children) due to security reasons or matters of convenience (nearby) if they had an upset stomach or diarrhoea. The small doors to the manyattas or compounds are usually blocked at night. This makes it very difficult and inconvenient for family members to go outside until morning. Although 35 caregivers reported to use a latrine and 74% felt positively toward using one, many mothers said they did not use existing latrines because they were either too far away from the household or very dirty. Out of the 28 latrines observed by field staff 20 were reported to be dirty.

Cultural Beliefs, Motivations, and Constraints

There were no mothers who reported to have a designated space for defecation in either the day or night. General attitudes toward identifying and utilizing a designated space for defecation were indifferent, with 21% of caregivers not able to have anything good to say about it and 35% said that the practice could at least keep faeces in one place. Some mothers responded negatively with 28% concerned about the smell and

25% worried about being embarrassed of other people seeing them defecate within the designated space. 28 respondents said that culturally, family members should not defecate in the same area, and neither should men and women. It was generally perceived by caregivers (68%) that open defecation is much more hygienic than designated defecation and that if all family members defecate within the same area, they will be able to catch diseases and illness very easily.

One mother stated: “I cannot imagine having the same place for designated defecation. Maybe a latrine, but not defecating in the same place. I do not see that happening.”

Another caregiver said, “There is no good thing about defecating in only one particular place.”

Some trends in **motivation** included:

- Some households already practiced digging and burying, whether outside or inside the compound.
- If there is no latrine, a designated space could be seen as an alternative.
- 56% of mothers reported that they keep their compound tidy to keep the family from becoming ill.

Some **constraints** included:

- Family members cannot defecate in same place
- No privacy
- Bad smell
- Perceived to be unhygienic
- General negative attitude

Contrasts Between (and within) Districts

In the town of Lotome, located in the district of Napak, more caregivers reported more accessibility to and usage of latrines compared to the rest of the district. They also washed their hands more often with soap or ash, and it was observed that households in Lotome had slightly better hygiene levels with cleaner kitchen areas, dishes/utensils, and compounds.

Caregivers in Lotome Trading Center Town in Napak, as well as in the whole district of Moroto, reported having latrines within their villages. However, in Moroto, caregivers admitted (when probed) that they do not usually use the existing latrines due to the distance from their house, the flies, and the smell. Through observation, field staff found faeces both inside and outside of the compounds and pathways. Children were also observed defecating near the manyattas, and latrines were found to be very dirty.

In the district of Amudat, the consumption of maize, rather than sorghum, was much higher compared to the other districts. 100% of caregivers said that they eat maize on a daily basis, and 67% of their children ate maize bread the day before. Although families regularly consumed animal milk, only 2 mothers reported to occasionally eat other animal products such as silver fish. A common trend showed that most households in

Amudat did not eat meat unless an animal has died. Apart from animal milk, there was little protein reported in the families' diets.

The practice of hand washing was also slightly different than the other districts. Although the knowledge of the importance of hand washing exists, and 67% of households assessed had soap available, washing hands before milking an animal was more common than washing after defecating. There were also no reported latrines near the households in Amudat District.

Counselling Visit

The second household visit was centred on providing caregivers one or two recommendations to try to improve practices on dietary diversity, hand washing, and/or designated defecation. Prior to the counselling visit the enumerator pairs analysed each household's assessment form and prioritised 1 or 2 behaviours to suggest to the mothers, as well as which demonstrations to conduct during the visit.

Caregivers were counselled on the benefits of the new behaviours using motivations identified in the first assessment (i.e. a mother would like to keep her child healthy), and given praise for any current optimal behaviours that were already being practiced. The visits also recorded the participants' reactions to the proposed behaviour changes as well as the motivations that had the most influence on agreeing to the new practice. The field staff negotiated with mothers who resisted certain recommendations by suggesting smaller steps or modifications toward the desired optimal behaviour. These are sometimes referred to as small doable actions (SDA). A total of 107 participants were counselled.

Dietary Diversity

Recommended Practices

A total of 90 recommendations were suggested to 63 caregivers on dietary diversity. Based on the assessment findings, specific recommended practices were:

- Offer the child more vitamin A rich foods such as dark leafy greens and yellow-coloured fruits and vegetables.
- Offer the child more protein or animal-source foods.
- Enrich or fortify the child's porridge with additional foods such as greens, yellow fruits, oils/fats, milk, eggs, sugar, or silver fish.

10 demonstrations were carried out in 10 different households, which included making a new porridge recipe together with the mother, or cutting a yellow fruit/vegetable (also with a hand washing demonstration) and feeding it to the child. Demonstrations on dietary diversity were conducted with the caregiver on a one-to-one basis, with many spectators such as the neighbours or other family members watching nearby. There were fewer demonstrations conducted on dietary diversity than the other two behaviours because many families did not have any foods (yellow fruits for example) available. Home visits were also conducted after families had already eaten their morning meals,

and field staff felt it was not appropriate to ask mothers to cook another meal as a trial when food in the home was already limited.

Enriching the child’s porridge was a recommendation that most mothers were willing to try. Fortifying porridge was positively received by many (38) mothers because it was easier for the mothers to incorporate a variety of foods in one meal rather than preparing various meals or snacks several times a day – even cutting a piece of fruit. Giving leafy greens and yellow fruits or vegetables was also a recommendation readily received as many of proposed foods are grown wild, available, accessible or easily affordable.



Image 1.2 Demonstration of fortified porridge (uncooked)

Although 18 participants agreed to try giving their children animal-source foods, and the recommendation was acceptable, some mothers said that these foods were expensive (as well as fruits not in season) and would not be as feasible to give their children on a daily basis. Field staff and caregivers arrived at a mutual agreement for mothers to buy and give their children animal-source foods a few times a week. One mother disagreed to give her child more animal-source foods, saying that they were simply too expensive. However, she was willing to give other recommended foods such as greens and any yellow fruits or vegetables that were in season (i.e., less expensive).

Give foods rich in Vit A		Give more protein or animal-source foods		Enrich/fortify child’s porridge	
33 recommendations offered		19 recommendations offered		38 recommendations offered	
Agree	Disagree	Agree	Disagree	Agree	Disagree
33	0	18	1	38	0

Reactions

Most of the participants reacted positively toward the proposed behaviours of dietary diversity so long as the foods recommended were available and accessible. Giving a child a variety of foods was seen as something ‘good’ to do. Even when some mothers did not immediately agree to give their child foods that they thought were expensive

such as animal-source foods, most were willing to at least try after receiving counselling from field staff. Many mothers were not aware of the nutritional values of certain foods and were very surprised to learn the health benefits. Prior to the counselling, during the first household assessment, some caregivers viewed greens as a food that was harmful to the child, especially if it was mixed with other foods or the pieces were not cut small enough. It was believed to cause stomach upset. However, after the counselling session, participants were excited and appreciative of the newfound knowledge of greens, yellow fruits and vegetables, and animal-source foods. Generally speaking, in the behaviour change process, most mothers were in the stage of becoming aware of the benefits of providing a diverse diet for their child, as many caregivers had a lack of knowledge, cultural beliefs, or personal perceptions that did not support dietary diversity.

Mothers were also interested in giving their children something new to try. For example, in the district of Amudat, there was positive reception to feeding a child with fortified porridge in place of tea and maize. In other districts, the suggestion of adding silver fish to a child's porridge was not the most popular as some mothers said that they could not imagine mixing fish with sugar in porridge. Field staff then modified this recommendation to either replace the sugar with a bit of salt, or give the child silver fish as a separate meal. Overall, caregivers thought that adding additional foods to porridge such as greens was strange and amusing, but they still agreed and were willing to try the new recipes during the trial period.

Motivation

Health benefits such as keeping a child nourished and helping a child to grow strong and healthy was the main motivation for caregivers' willingness to improve the diversity of a child's diet. This was followed by food availability and accessibility. Despite the negative perception of green vegetables (believed to give the child an upset stomach), when field staff recommended foods that households were already consuming and explained the health benefits of these foods, mothers agreed that they were able to feed a child yellow fruits and dark green leafy vegetables, and even add them to porridge. Mothers also accepted to give yellow fruits, especially wild fruits if they are in season.

One mother responded: *"Ok, I think I will be giving my child pumpkins, gourds, and mangos because these are produced by our households unlike yellow sweet potatoes."*

The few cooking demonstrations that took place helped to motivate the mother as well as put her at ease once the child tasted the porridge and was able to eat it. For the mothers that said they could not afford certain foods, field staff negotiated to buy less of one food item, such as sugar, in order to buy an expensive fruit or vegetable for a child. This was readily accepted, as well as saving a few eggs for a child rather than selling all of the household eggs at the market.

Hand Washing

Recommended Practices

A total of 151 recommendations were suggested to 74 caregivers regarding hand washing. Based on the assessment findings, specific recommended practices were:

- Wash hands at some or all of the 5 critical times
- Create a designated area for hand washing
- Use soap or ash
- Create and utilise a tippy-tap

For those mothers who already reported to wash their hands at the 5 critical times (and could list all of them) during the first assessment visit, TIPs field staff made the decision to counsel on other practices such as identifying a designated hand washing space inside the compound, or to build a tippy-tap.

62 hand washing demonstrations were carried out which included how to wash hands with soap or ash, building a tippy-tap, and identifying and creating a hand washing space inside the compound. 'How to' hand washing demonstrations as well as identifying a space for washing hands were mostly done together on a one-to-one basis with the caregiver, with some husbands and family members as spectators. Some of the onlookers even participated. Tippy-tap demonstrations were at times conducted with only the caregiver and her family, or in some villages, demonstrations were conducted with women and neighbours from several manyattas. Every time there was tippy-tap demonstration or a caregiver was supported to find a hand washing area, a demonstration of how to wash hands was also carried out. Sometimes field staff did not conduct demonstrations when they observed that the participant was growing impatient or bored.



Image 1.3 A caregiver tries using a tippy-tap during a hand washing demonstration.

Participants easily accepted all of the four suggestions, deeming all practices feasible. There was only some concern over the cost of soap. However, mothers were made aware during the assessment visit that ash can be used as an inexpensive alternative.

As ash is readily available and free, participants readily agreed to try the hand washing practices. Two caregivers did not agree to create a space for hand washing within the compound. One mother disagreed because she found it much more convenient to take a basin wherever she goes and use it to wash her and her family's hands.

Wash hands at some or all of 5 critical times		Create a designated area for HW		Use soap or ash		Create your own Tippy-Tap	
57 recommendations offered		30 recommendations offered		40 recommendations offered		27 recommendations offered	
Agree	Disagree	Agree	Disagree	Agree	Disagree	Agree	Disagree
57	0	28	2	40	0	27	0

Reactions

Participants were positive and appreciative of the new hand washing practices suggested by the field staff. Many mothers were happy and surprised that ash could be used instead of soap. They were also grateful for the knowledge of washing hands at the 5 critical times. The demonstrations of hand washing, creating a tippy-tap and the practical help of identifying a designated space for the household attracted great interest not only from the mothers being counselled, but also from neighbours, friends, and husbands. These demonstrations brought excitement to the villages and the mothers commented that they were thankful to learn and acquire new skills.

Motivation

Most mothers interviewed in the first assessment were already aware of the benefits of hand washing. Using participants' own responses of "washing hands eliminates germs and prevents illnesses" and "washing hands helps to keep you clean", field staff encouraged caregivers to try out the new hand washing practices and praised them for any current ones. As a result, mothers accepted the advice and were easily motivated to try out new hand washing practices in order to keep their family healthy.

In addition, caregivers felt that the recommendations were easy and feasible, and that using soap or ash would not be very difficult, as ash is inexpensive and always available. Mothers commented that identifying a hand washing space within the manyatta or homestead would actually act as a good reminder to wash their hands at the critical times, and building a tippy-tap was not only exciting to have in their home, but easy to build using locally available materials. Tippy-taps were also seen to be very convenient for busy mothers who do not have a lot of time. Mothers' enthusiasm and motivation was evident in these statements:

"I will make sure all family members follow the 5 critical times of washing hands because its really very important in avoiding diseases."

Response to washing at the 5 critical times: *"I would love to see my child healthy and free from diseases or diarrhoea."*

“By the time you come for the next visit, you will see a specific place for hand washing and you will see a tippy-tap.”

Designated Defecation

Recommended Practices

As there was strong resistance to and little motivation for creating and using a designated space for defecation, field staff focussed their counselling and negotiating skills on achieving small behaviours at a time such as digging and burying in the day time (as well as children’s faeces) and trying to defecate in another area at night that is just outside of the compound, yet still secure. If there was a latrine and no one wanted to use it due to bad smells or flies, family members were asked to take faeces to the latrine with a shovel, rather than digging and burying. The counselling also stressed the motivation identified in the assessment visit to keep the compound clean in order to avoid diseases. A total of 90 recommendations were suggested to 69 caregivers regarding designated defecation. Based on the assessment findings, specific recommended practices were:

- Create a fenced, designated area for defecation for the family or compound
- Dig and bury outside the manyatta or compound, even at night
- Use the existing latrine or take children’s faeces to the latrine with a shovel

About 34 demonstrations were carried out which included helping a mother to identify a designated space for the family, going outside of the manyatta with the mother to identify a space to dig and bury (sometimes burying children’s faeces if found), or using a shovel to take faeces found near or in the manyatta to the latrine.

The suggestion of digging and burying outside of the manyatta or homestead was mostly received positively. Other times it was met with resistance, especially at night due to insecurity, or the worry that it would look strange to others if they were in the field defecating and digging at night. Some mothers said that others could associate this act with witchcraft. Field staff negotiated with the mothers and asked them if they could identify any other place *just outside* of the homestead to defecate at night, or to *at least* dig and bury in the day. After counselling and negotiating, 44 out of 48 caregivers were willing to try digging and burying during the day, night, or both. Those who disagreed thought that carrying a hoe or shovel would be too heavy and troublesome. One caregiver thought she would try to use a stick instead but still did not completely agree to dig and bury her faeces.

Participants also agreed to use a nearby latrine and to throw children’s faeces down the pit. However, only 18 caregivers said they were willing to try to create a designated space for defecation for their families. One caregiver disagreed outright with the designated area recommendation. In fact, some participants who at first said that they did not want to use the existing latrines because they were either too far or too dirty changed their minds, and were more willing to walk the far distance to use and take children’s faeces to the latrine rather than to defecate in a designated area just outside their compound.

Create a fenced area for family or children		Dig and Burry Outside Compound		Use existing latrine or take faeces to latrine	
19 recommendations offered		48 recommendations offered		4 recommendations offered	
Agree	Disagree	Agree	Disagree	Agree	Disagree
18	1	44	4	4	0

Reactions

Creating a designated space for defecation was mostly met with laughter. Most caregivers found creating a designated space for defecation unacceptable for a number of reasons. First and foremost it was seen as strange, embarrassing, and unhygienic. Many mothers were worried about the potential smells, flies and were worried that children may play near or on top of the area. Most caregivers had concerns over cultural beliefs saying that it would be inappropriate and unacceptable to mix faeces and defecate in the same area as their in-laws. Other mothers felt uncomfortable to create a designated space for other family members, saying that it was not in their power to make decisions for others. Furthermore, husbands or community elders were believed to make these types of decisions and determine reasons for land use. Participants also said that if they had enough land to use as a designated area they would prefer to use it for vegetable gardens instead.

On the other hand, caregivers had much more positive reactions to digging and burying, although there was still preference for open defecation. Some mothers who disagreed to dig and burry questioned the necessity of the act so long as they defecated far away. They believed burying would be meaningless. Others thought that the children's faeces were not as harmful as adult's and it was not a problem to let them defecate out in the open. There were other caregivers however who were very happy to dig and burry all faeces for hygiene purposes.

Motivation

After counselling and negotiating with field staff, many mothers were motivated to dig and burry faeces outside of the homestead. Participants cited health and hygiene reasons as the main motivation behind the willingness to try the new practice: to avoid bad smells, avoid flies that may carry diseases, avoid illnesses through contact with faeces, and to have a clean compound.

After the field staff supported the proposed behaviour change with demonstrations many caregivers, and even husbands and other family members, were more motivated to try the new practices. A couple of husbands helped to dig trenches, and mothers said it would be easy to carry a hoe into the field when they defecate. Others felt very encouraged by the field staff when praised for burying their children's faeces or taking it to the latrine. After the demonstrations caregivers commented:

"It is better to practice digging and burying since constructing a latrine is expensive. Instead of carrying the hoe daily, I will get a specific place in the bush where me and my husband will hide the hoe to be used for burying."

“I will always dig and burry the poo poo after defecation and I will educate my family members about digging and burying.”

“I will make sure I collect all the children’s poo-poo littered around the home and throw it into the pit latrine.”

Contrasts Between Districts

There were recipe differences worth noting between the districts. In the district of Amudat, the recipe for fortified porridge was slightly different to the other districts. As the Pokot tribe rarely eat silver fish or meat, this was excluded from the suggested recipe. As it is common for the child to be given milky, sugary tea and maize bread, field staff tried to dissuade the giving of tea and incorporate the other ingredients for a new porridge: maize, milk, oil, sugar, and chopped greens (sometimes eggs).

In the other districts, a common porridge recipe suggestion was: sorghum or maize, oil/fats, sugar, eggs, greens, and/or silver fish. This combination was not a prescribed recipe for field staff. However, enumerators suggested these food items because they were earlier identified in the household assessments as available, accessible, and commonly eaten in the home. Mothers in the district of Moroto were especially willing to give children silver fish. Only in the district of Nakapiriprit did mothers say that silver fish might not be feasible as it was expensive in the markets.

Follow Up Visit

Two weeks after the counselling visit, field staff returned to the households to investigate the outcomes of the agreed recommendations. The caregivers were asked to report on whether or not they tried the new practices, if it was easy or difficult, their thoughts about the new practices, and if they were willing to continue the practices on their own. A total of 119 mothers were originally assessed on the three key behaviours, 107 households were counselled, and 94 caregivers were interviewed on the outcomes. The number of participants decreased due the absence of the caregivers in their homes. Although the field staff did their best to find the mothers (interviewing in health clinics, driving to the gardens, waiting as long as possible for a mother to return), some caregivers were either out of town, experienced a recent death in the family, fell ill in the hospital, had a child in the hospital, experienced marriage problems, etc. *Therefore, the analysis of the outcomes only includes the final number (94) of mothers interviewed for all three phases of TIPs.*

Field staff verified the mothers’ reports of successful practices. This was confirmed by inspecting where the caregiver said to dig and burry, checking for evidence of regular use of the hand washing spaces or tippy-taps. Staff also asked mothers if they could see what yellow fruits and vegetables they had been feeding the child, or asked what the child ate in the morning. Verifying the practice of adding new foods to the child’s diet or fortifying porridge was the most difficult to confirm as interviews usually took place after the morning meal.

Some communities were mobilised by government workers before arrival of the field staff. This was positive in that this ensured caregivers to be home the morning of visitation. However, at times the mobilisation meant that participants deliberately set up tippy-taps that same day, or swept and cleared faeces from the compounds, not reflecting true practices. In the areas that were not mobilised beforehand and where households did not expect the field staff that day, some homes had unused or broken tippy-taps, open faeces within and near the compounds, etc. This made it easier for the enumerators to observe what was actually practiced rather than relying solely on the caregiver's report.

In some areas, neighbours had copied new practices that were recommended to the participants. They had built their own tippy-taps and started to dig and burry their own (or children's faeces). This gave the caregivers confidence and motivation to continue the new practices.

Dietary Diversity

Results

For the behaviour of dietary diversity a total number of 52 households were interviewed on the outcomes of the tried practices. Some households agreed to try more than one nutrition recommendation and therefore a total number of 76 recommended trials were investigated. Out of 52 households, 30 caregivers tried giving their children foods rich in vitamin A such as dark green leafy vegetables (DGLVs) and yellow fruits and vegetables, 17 participants tried to add more animal source foods to the child's diet, and 26 caregivers tried to fortify or enrich the child's porridge with either vitamin A-rich foods, animal-source foods, (or both) as well as oils/fats or sugar.

Dietary Diversity – 52 HH interviewed								
Give foods rich in Vit A			Give more protein or animal-source foods			Enrich/fortify child's porridge		
31 recommendations followed up			17 recommendations followed up			28 recommendations followed up		
Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue
30	1	28	17	0	16	26	2	28

With regards to enriching a child's porridge the TIPS research revealed that there were some variations in the types of foods offered and prepared for children throughout the four districts. Some combinations were:

- Posho made from both maize and sorghum with a side mixture of greens, ground peanuts, oil, and milk. – Moroto District
- Thick maize porridge, milk, eggs, sugar, oil/fats, (and sometimes greens). One mother said her child enjoyed it very much. – Amudat District
- Sorghum porridge with DGLVs and cooking oil. – Nakapiripirit District

- Thick sorghum porridge with sugar, greens, and sunflower seed paste. – Napak District
- One mother modified the practice by adding honey to her child’s porridge and making it thicker. – Napak District



Image 1.4 Family recipe in Moroto: Greens, ground peanuts, oil, and milk with maize and sorghum posho.

One caregiver in Napak explained how she modified the porridge on her own in order to suit her schedule, budget, and still satisfy her child:

“Sometimes I mix simsim, groundnuts, sunflower, green beans and millet together then take it to the machine for grinding and use it to make porridge for my baby. This is because the foods are available and grown around the home. This is also easy and cheap because it’s ground at once. The baby really enjoys it.”

It is also worth mentioning that caregivers in Amudat, who usually gave maize bread and sugary, milky tea to their children every day changed their feeding behaviours and happily made fortified porridge for their children.

Constraints

Even though the majority of mothers tried out the dietary practices, some could only afford to give the recommended foods a few times a week rather than every day due to high costs of yellow fruits and animal source foods, especially in Moroto and Amudat. In Nakapiripirit caregivers said that wild fruits and berries were more feasible because they were less expensive. The 3 caregivers who did not try the recommendations did not carry out the practices because they could not afford to buy the foods. However, mothers said that when they get more access to funds they would try to buy these foods for their children. Those who were not willing to continue the practice refused due to lack of money.

There was an exception in the Napak District (along the green belt areas), where caregivers found it easy to feed their children DGLVs and mangoes, oranges, papaya,

pumpkin, and passion fruits. Although animal-source foods were also reported to be expensive in Napak, many mothers said that they were still able to afford silver fish and eggs. However, seasons greatly affect how caregivers in Napak feed their children. Mothers said that when foods are plentiful during the rainy season (at the time of this TIPs research), children might get too used to the lifestyle and good eating habits, and will therefore be greatly affected during the dry season when there are fewer foods available. As a result, mothers said it was not good to give too many foods to their children in the rainy season in order to ‘prepare’ them for the lean, dry season.

In Amudat, the distance to the market is too far for mothers to travel in order to feed their children the recommended foods every day. In addition, some mothers said that their husbands control the finances and have ownership of foods, meaning that they will not always allow certain foods to be given to children such as meat, or anything else that is expensive.

Observations and Changes Noted

Despite the constraints of the behaviour of dietary diversity, many mothers were able to offer a small variety of foods to their children, and found it convenient to add them in porridge. Caregivers reported a difference in their child’s health, energy and strength and noted that their children cry less because they are satisfied after consuming the new, thick porridge. One mother happily reported: *“My baby liked the porridge and has gained weight.”* In addition, it is interesting to note that participants have changed their mindsets about giving greens to children. Rather than viewing greens as harmful or causing stomach aches, most say greens are *now good* for their children, especially after becoming aware of the benefits during the counselling visits.

Hand Washing

Results

For the behaviour of hand washing a total number of 65 caregivers were interviewed on the tried practices and a total number of 107 recommendations were followed up. Out of 65 households, 41 caregivers tried washing their hands at some or all of the 5 critical times, 12 tried to designate a hand washing space in their compound, 25 participants tried to construct tippy-taps, and 23 caregivers tried to use soap or ash.

Hand Washing – 65 HH interviewed											
Wash Hands at 5 Critical Times			Create a Hand Washing Space			Build a Tippy-Tap			Use Soap or Ash		
43 recommendations followed up			15 recommendations followed up			26 recommendations followed up			23 recommendations followed up		
Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue
41	2	41	12	3	14	25	1	24	23	0	22

The outcomes of the hand washing trials and feedback from the mothers reveal that many participants were able to sustain the practices for two weeks. 41 out of 43

mothers reported to wash their hands at 5 the critical times, although some mothers admitted to forgetting a few times, simply because it is new behaviour. All mothers used ash instead of soap and some were happy to promote ash to their neighbours and family. Caregivers found hand washing at the 5 critical times to be easy because it made them feel clean and believed it promoted hygiene within their family, reducing illnesses and diseases:

“I wash my hands with my family members: after defecating, after cleaning a baby’s bottom, before cooking, before feeding the baby and before eating ... and I feel okay about it.”

“I will always keep on washing my hands based on the five critical times and it has helped reduce the spread of diseases.”

12 out of 15 caregivers identified hand washing spaces within their compounds. However, some areas were not regularly used, and the tippy-taps that were constructed with the field staff during the counselling visits were sometimes damaged and dirty, with dirty water inside the jerry can or no water at all. Many caregivers attempted to build their own tippy-taps during the two weeks. While some were successful, others did not construct them correctly. Thus field staff supported each household to rebuild their tippy-taps and encouraged whole families to use them on a regular basis.

Constraints

Although almost all participants showed readiness to try the new hand washing practices during the counselling visits, the mothers who did not try or sustain the new behaviours for the two weeks reported reasons such as: too ill, too busy, or their child was ill. Some mothers simply showed lack of interest and did not wish to open up about the constraints to the new hand washing practices, especially in Moroto.



Image 1.5 Broken and unused tippy-tap.



Image 1.6 Dry soap in the afternoon.

Three caregivers did not try to establish a hand washing space within their compounds and one caregiver did not try to make a tippy-tap because they still preferred a basin and jerry can for washing their own hands (or children's hands). Two mothers did not try to wash their hands at all 5 critical times because of negative attitudes and/or pressure from their peers. Community members sometimes perceived having clean hands as being lazy. Hard workers are thought to have dirty hands and no time to wash them. In Amudat, regular hand washing was sometimes seen as an act of pride. Some neighbours viewed mothers to be bragging or arrogant in the attempt to keep so clean. One participant in Napak explained her situation:

“My husband is complaining (and co-wife) that I have changed my lifestyle like washing hands all the time, changing my diet like working class so what is the meaning. I may divorce my husband so that I get a town man.”

Although 25 out of 26 caregivers tried using a tippy-tap, many households did not continue to use them saying that the children always wanted to play with the tippy-taps, either stepping on the stick to pour all of the water out or tearing it down. As a result many mothers took away some of the parts or stopped using the tippy-tap altogether. Dirty water was also found in many of the tippy-taps. As the TIPs research was conducted during the rainy season, some households used water in nearby ponds, puddles, etc. to fill the jerry can. In Amudat, as there were no boreholes nearby and the distance to clean water sources was far, households also used the dirty rainwater. Nevertheless, almost all participants reported that they would like to continue to try the hand washing practices, even if they did not try the first time.

Designated Defecation

Results

For the behaviours of designated defecation a total number of 60 caregivers were interviewed on the tried practices and a total number of 60 recommendations were followed up. Out of 60 households, 13 caregivers tried to designate a space for defecation, 28 tried to dig and bury their faeces outside of the compound, and 4 participants used the existing latrine or took their faeces to the latrine with a shovel the next morning (if there were insecurity issues).

Designated Defecation – 60 HH interviewed								
Create a Specific Area			Dig and Bury Outside			Use Existing Latrine or Take Faeces to Latrine		
17 recommendations followed up			39 recommendations followed up			4 recommendations followed up		
Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue	Tried	Not Tried	Willing to Continue
13	4	11	28	11	35	4	0	4

Most of the spaces created for designated defecation were for the children only. Caregivers usually preferred to try to dig and bury their own faeces outside of the homestead or use the existing latrine, even if it was far. Although participants tried digging and burying for two weeks, most caregivers did not carry out the practice on a

daily basis. Some mothers said that digging a long trench was more convenient, although in Nakapiririt the rains destroyed the trenches that were dug in advance.

Other caregivers reported digging and burying to be easy, and helpful to eliminate flies and bad smells around the manyatta. They also felt that their compounds were very clean; hence children did not fall sick as often with diarrhoea for example. One mother responded,

“I am glad I burry this poo poo. My children do not develop stomachaches these days. They are actually fine now.”

Constraints

For the practice of designating a space for defecation for the children, some mothers reported difficulties in controlling the children’s behaviours saying that the children refused to defecate in a specific area. Mothers complained that chickens and ducks would unearth the children’s faeces that had been buried, and they also found that rains and floods would continue to destroy the designated areas. When field staff returned to places that were previously identified and dug during the counselling visits, the designated areas were turned into gardens, with households preferring to use the newly cleared space for food rather than defecation. One mother who did not try the practice said that defecating in a designated area was just too strange.



Image 1.7 An unused space for designated defecation. Image 1.8 A cleared space for defecation, copied by a neighbour.

Digging and burying was the most recommended practice because many mothers accepted the suggestion more than creating a designated space. However, only 28 out of 39 caregivers tried the new behaviour and 11 did not try at all. Several participants found digging and burying and carrying a hoe or shovel each time to be too cumbersome. This was especially the case for participants in Amudat who work in gardens that are far from the homestead. They felt that it was too difficult to carry the shovel with them every time, especially when looking after animals, attributing the constraint to their mobile lifestyles. In other districts, mothers said that it was too much work to dig and burry not only for herself but also for her many children (one by one).

When participants were asked what they were willing to try to make the practice easier or to motivate them to continue, many mothers thought that digging a long trench lasting for two weeks or so was easier than digging a hole each and every time they defecate. However, some mothers said that digging trenches were tiring. One mother admitted she did not try to dig and bury because she feared to practice something that others were not doing. Despite the constraints, 35 out of 39 participants were willing to try digging and burying again.

Observations and Changes Noted

Although 39 caregivers agreed to dig and bury during the counselling sessions many participants did not seem to internally accept the practice. Caregivers were aware of the health benefits of digging and burying and that it is a good hygiene practice, but the new behaviour did not prove to be critical enough to actualise on a regular basis. Some mothers reported to field staff that they carried out the practice but when the areas were observed, there was no evidence of this. Even though some participants were open and honest, many caregivers did not want to give a direct answer as to why they did not try digging and burying, even after much probing. Therefore, it was very difficult for field staff to get to the heart of the constraint and discover exactly what was not acceptable or feasible.

Some neighbours were positively influenced by the designated defecation recommendations and began digging and burying or using the nearby latrine. This increased mothers' confidence and motivated their desire to become role models to promote the new behaviours, especially in Napak and Amudat. On the other hand some neighbours thought that digging and burying was a time wasting and bothersome practice. Other neighbours did not trust or have confidence in those caregivers wishing to pass on messages or advice. Some showed jealousy, as they believed that mothers were benefiting from participating in the research, and in turn gave no support or approval in the new practices. One mother in Nakapiripirit commented,

“ We fear what is not approved by everyone. It inconveniences, especially for the little time we have tried.”

As a result, participants stressed the need for the involvement of community leaders to influence designated defecation behaviours, especially for adults. They also requested for more community mobilization with the men, as caregivers felt they didn't have the power to decide defecation practices for the whole community.

Contrasts Between Districts

It is worth noting that many counselled mothers in Moroto District did not wish to follow through with the agreed upon recommendations. Although many participants reported to try the new practices and were willing to continue, caregivers in the Moroto district demonstrated low motivation and negative attitudes toward changing new behaviours. Caregivers gave the field staff reasons such as 'too busy' rather than giving open and honest responses for the lack of trying certain practices. If caregivers in Moroto reported in the counselling visit that silver fish were inexpensive, they reported the opposite in

the follow-up interview saying that silver fish was not affordable to give to a child on a daily basis. Even if they had cattle, mothers said that milk was too expensive. As for hand washing and digging and burying faeces, some mothers simply did not try.

Conclusions and Recommendations

In conclusion, the outcomes of the TIPs research demonstrate that the RWANU programme should promote the three nutrition and hygiene behaviours of dietary diversity, hand washing, and designated defecation using specific, small doable actions identified in the research process. For dietary diversity, TIPs results show that fortifying porridge with a variety of additional foods was easy and time saving for caregivers, and creating a more diverse diet for a child depended on the affordability and accessibility of food items. With regards to hand washing, participants washed their hands at the five critical times in order to eliminate germs and illnesses in the home. Hand washing demonstrations, including tippy-taps, had a positive effect on the motivation of mothers as well as neighbours. For designated defecation, most mothers were willing to dig and bury, however there are many constraints such as lack of effort or interest, and a common request for community support, especially from decision makers such as husbands who have the final say on financial matters in the home, and elders or leaders who have the power to approve and disapprove of social norms.

The TIPs process also revealed positive responses to and appreciation of the repetitive house visits and counselling sessions, providing the caregivers with moral support and increasing motivation to carry out the new practices. This highlights the need for counselling and negotiating skills to be emphasized in future trainings for behaviour change activities.



Image 1.9 Counselling session with a caregiver.

Finally, due to the large-scale negative response of the designated defecation practices and the contrasting high number of participants willing to continue the recommended practices, follow up is necessary to confirm the intended continuation of practices. Verification of the designated defecation results through Focus Groups Discussions (FGDs) may also be necessary to confirm participants' responses as well as other community members' experiences and opinions. Most recommendations were feasible

and acceptable, but there is need for community support in order for behaviours to be sustainable.

Drawing from the key issues emerging from the trials, the final conclusions directly impacted the development of the recommendations for the Social and Behaviour Change Strategy Action Plan. The recommended behaviour change communication activities and messages below were based on the main motivations and barriers found in the outcomes of the home visits. They were discussed at length with the RWANU team and presented to stakeholders before updating the SBC-SAP document. The recommendations are:

1. Conduct Large-scale Community Sensitisation and Mobilization

- Sensitize community leaders (male and female) on the three optimal behaviours and involve them in the decision making process for each village.
- Have community leaders support the mobilization of men with regards to the three behaviours
- Identify and include strong male leaders who are not intimidated to talk about certain topics with other men (i.e., any topics that are viewed as ‘women’s topics’).
- Have positive deviant husbands to give testimonials to other men at men’s groups
- Reach/include the next generation of leaders (in preparation for shift of power)
- Include story telling: Amusing stories can be created based on a real-life situation during TIPs research. When the husband returned to the homestead after his third wife had been counselled on digging and burying, he saw that the compound was clean, no faeces in the manyatta, she was very clean as well as the children from hand washing. As a result he decided to make her the 1st wife instead. (Stories obviously need to consider cultural sensitivity.)

2. IEC Materials and Key Messages

The materials and should build on current practices and motivations identified in the TIPs research. The key messages are not final and do not indicate exactly how they will be worded. Rather, these are examples that demonstrate how to incorporate current practices, motivations, and address barriers in messaging for greater impact.

Example 1: “It is great that you are feeding you child porridge and continuing to breastfeed him. Create different porridge recipes to help him grow strong and healthy” ... or ... “to satisfy your child so that he cries less”.

Image: bowl of porridge + local greens + eggs + oils/fats = photo of a healthy baby

Example 2: “Help keep your family healthy by keeping your house clean. Dig and bury your family’s faeces OUTSIDE of the manyatta to avoid flies, bad smells, and diseases.”

Image: Pictures of two different homesteads side by side – one clean vs. one dirty with faeces and flies. OR...

Image: Two different images of mothers side by side, one mother with a shovel, just finished burying her faeces in a trench, with a happy face vs. a mother walking away leaving faeces open with flies and smells, perhaps an ill child nearby.

Recipe Booklet:

- Integrate recipes created by the TIPs participants into the recipe book for the Mother Care Groups (the recipes should be images only).
- Have alternatives so as to spread out the food supply. For example, mothers can be encouraged to fortify porridge with a different food item on different days. This should only be shown through images with messages of the benefits of each food item.
- Include foods alone as a snack or as a reminder, such as photos of a mango, a papaya, or local wild fruits.

3. Counselling Sessions - Group and Individual

- Integrate topics of the three promoted behaviours into the Care Group Model curriculum and reach out to secondary audience during counselling sessions with entire households.
- Ensure Lead Mothers, Health Educators, Health Promoters are well trained in counselling and negotiating skills.
- Integrate counselling and negotiating sessions at health facility level or during health campaigns.

4. Give Practical Support Through Demonstrations

- Train one resident per village to construct tippy-taps so that he/she can support all households.
- Designate hand washing points at all sensitization meetings.
- Give hand washing demonstrations during health campaigns.
- Conduct cooking demonstrations during Care Group meetings.
- Incorporate CLTS activities in group counselling sessions such as ‘flagging’ (or shaming) open faeces with stones, pouring ash on faeces for quick-drying,

demonstrating the 'faeces on a plate' exercise, shake hands with chalk (showing spread of germs), for example.

5. Other Recommendations (mainly brainstormed with the RWANU team)

- Include the three promoted behaviours to be advertised on the planned radio advertisements. Have village elders verbally approve of the specific behaviours with a few seconds 'spot' each.
- Have 'community radio' sessions by attaching loud speakers on poles with a VHT announcing and promoting key messages via a microphone.
- Hire youth groups to mobilise communities through MDD (Music, Dance, Drama) related to dietary diversity, hand washing, and designated defecation.

References

1. *Designing by Dialogue, A Program Planners' Guide to Consultative Research for Improving Young Child Feeding*, Kate Dickin and Marcia Griffiths, The Manoff Group, Ellen Piwoz, SARA/AED, Washington, D.C., 1998
2. *DHO-ACF and UNICEF Nutrition Surveillance Report Karamoja Region, Uganda, Round 8, May 2012.*
3. RWANU Proposal (including): RWANU Technical Narrative ACDI/VOCA and all annexes.
4. Social Behaviour Change Documents (including): SBC-SAP report, Barrier Analysis report, frameworks, annexes, and PowerPoint presentations, Stakeholder Meeting presentation, SBC-SAP Action Plan notes.
5. TOR for Trials for Improved Practices Consultancy, Concern Worldwide, 2013
6. *Trials of Improved Practices Reference Notes And Tools, A Manual for TIPs trainers and Implementers*, FAO, 2011.
7. [http://akvopedia.org/wiki/File:TippyTap icon.png](http://akvopedia.org/wiki/File:TippyTap_icon.png)

Annexes

Annex 1

Name of Beneficiary(ies):.....

Date and Time of Initial Assessment:.....

Checklist for Initial Assessment Home Visit

Please Note:

- (1) Whole families (mother, father, grandmother, children, etc.) should be present during discussions if possible.
- (2) Assessment visits should ideally be made during COOKING TIMES.
- (3) TIPs counselors should be in teams of 2 (1 interviewer, 1 documenter).
- (4) Please carefully review the questions. Familiarize yourself with them before the home visit. Make sure the questions are clear to you.
- (5) Don't forget to ask (probe) "Which, what, when, how, where, by whom, etc." for more in-depth answers.

Scripted Introduction for TIPs Counselors:

Hello, my name is _____ and we work for the RWANU project with Concern Worldwide in partnership with ACIDI/VOCA and Welt Hunger Hilfe. The project is working with communities to help babies be healthy and grow well. We are interviewing families of young children to learn more about certain health practices in the home. We are doing this in order to learn how to improve our health programs.

This is a study that consists of three home visits during the coming month. During the first visit, we would like to ask you some questions now about feeding your child and your family's health and hygiene in general. We would then like to come back a second time and talk to you about trying out some new ideas; some things that could help your family to stay healthy. Then we would visit you a third time to discuss your experience with the new ideas.

Do you expect to be here at home during the coming month? If yes, do you have time now for the first interview? We know that you are busy and have many chores to do, so it is all right for you to continue with your chores while we talk. Our discussion might take as long as an hour. You are not at all obligated to talk with us. There is no payment for answering these questions nor is Concern dependent upon your participation in this study. It is completely voluntary. Would you be willing to talk with us now?

Before we begin the first interview, we want you to know that it is very important that you give us honest opinions and information. We are only recording your first name and only ourselves and a couple of colleagues will look at your answers. We will not share your specific information with anyone else. We would appreciate it if you would tell us how you really feel about things. Please avoid saying things just because you want to be polite. If you have any questions at the end of the interview, we will be happy to answer them as best as we can.

GENERAL INFORMATION

a) District:..... Sub-county..... Parish.....

Village:..... Manyatta:.....

b) Names of Counselors:

c) First name of Caregiver or Head of Household:.....

d) Type of Household (please tick)

(i) Household Headed Male Female Grandmother Child (ii) No. of people currently in HH:.....

(iii) No. of Children in Household..... (iv) What are the names and ages of your children?

(v) Any children 6-24 months? Clarify (vi) If currently enrolled in OTC/SFC ?.....

1. Do you watch to see how (child's name) is growing? Yes No

2. What, if anything, do you do to try to help (child's name) grow?

.....

3. What is your main source of food? (Check all that apply):

Food Aid Loans Gifts Purchase Own production Bartering/Exchange Other (*specify*).....

(If 'Own production' specify: E.g. livestock, vegetables, fruit trees, location of production, etc.)

.....

(If 'Purchase' or 'Barter' specify: which protein foods, which vegetables, which fruits, etc.)

.....

4. What is your main source of income?

Casual labor Petty trading Own business Remittance Bartering/Exchange Formal labor salaried Cash transfer

Other (*specify*).....

FAMILY MEALS AND FREQUENCY OF CONSUMPTION OF FOODS

5. How many main meals does the family *eat* every day? (Specify).....

6. How many meals are *prepared* every day? (Specify).....

7. How many snacks does the family eat every day? (Specify).....

8. What is the usual composition of your family meals (ingredients used)?

Ingredients Often Used <i>(Please Tick in the right column if ingredient is OFTEN used)</i>	Breakfast	Lunch	Dinner	Snacks <i>(Morning and Afternoon)</i>	Remarks (Which types, if they don't consume specific foods, why not?, etc.)
Sorghum					
Maize/Millet					
Wheat					
Rice					
Fruits (specify)					
Vegetables (specify)					
Milk (or milk products)					What kind?
Beans					
Gourds					
Ground nuts					
Sim Sim					
Sunflower seeds					
Blood					
Porridge					Made from what?
Meat					Which animals? Which parts (e.g. offal)?
Fish					Which type?
Eggs					
Roots/tubers					Which type (cassava, sweet potato, Irish potato)?
Sugar cane or honey					
Alcohol					
Dregs from sorghum/maize brew (adakai)					
Oil/Fat					Which type?
CSB					
Others (specify)					

FEEDING A CHILD 6-24 Months

9. Does (child's name) share family foods? Yes No

10. If yes: Does (child's name) use a separate bowl? Yes No

11. What did (child's name) eat yesterday? *(Specify and list all foods, drinks, and ingredients in the foods/drinks. Don't forget to PROBE.)*

.....

.....

.....

.....

12. How many times a day does (child's name) eat?

13. How many times a day do you prepare food for (child's name)?

.....

14. Who usually feeds (child's name)? Mother Father Grandmother Brother/Sister Himself/Herself Babysitter

15. Are there any foods that are considered good or bad for small children? Yes No

16. If yes, which ones and why? (Table below)

Foods Considered Good for Children		Foods Considered Bad for Children	
Food Item	Why Good for Children	Food Item	Why Bad for Children

FEEDING AND COOKING OBSERVATIONS

17. Observe the following: Look for common cooking utensils, measuring equipment, cooking methods used in the house. Note the most common ones, e.g. cups, cooking pots, spoons, family bowls and plates, etc. Are they clean? Are they off the floor? Do they cover food to avoid flies? Are there animals in the kitchen area? Etc?

.....
.....

18. What is cooking or being prepared (if anything)? Is there any food being stored that was prepared earlier? If so, how is it stored?

.....
.....

HAND WASHING

19. What, if anything, do you do to try keep your family from getting sick? (Probe for detailed information. Is there any mention of hand washing or designated areas of defecation, etc?)

.....
.....

20. How many times a day do you wash your hands with water?

21. The last time you washed you hands, did you use something in addition to water? Yes No

22. If yes, what did you use Soap Ash Other

23. Why do you wash your hands?

24. Are there certain times when you think it's especially important to wash your hands? Yes No

25. If yes, what are those times? After defecating Before cooking Before eating After cleaning my child who defecated

Before feeding my child When my hands are dirty Other (specify).....

26. Do you have enough water to wash your hands every day? Yes No Sometimes (Specify).....

27. If 'no' What can you do to have enough water?

28. How do you and your family feel about washing your hands with soap or ash every day?

.....
29. What do you think could be the benefits of washing your hands every day?

.....
30. What would make it possible for you to wash your hands with soap or ash often during the day?

.....

HAND WASHING OBSERVATIONS

31. Can you please show me where you usually wash your hands? Can I see your soap? (Observe and note: Where is the hand washing area? How is the water stored (running water or container)? If there is soap, what type is it? Does it look used? Did you observe any family members wash their hands before eating, preparing food, after defecating, etc?)

.....
.....

DESIGNATED DEFECATION

32. Where (what place) do you and your family usually defecate in the day?

Latrine Outside the manyatta Within the manyatta Near water/stream Other.....

33. Do you and your family defecate in another place when it gets dark? Yes No If 'yes', where?

34. Why do you defecate in those places?

35. What are the advantages of defecating in (answer to questions 37 and 38)?

36. What are the disadvantages of defecating in (answer to question 37 and 38)?.....

37. Is there a latrine for this household? Yes No

38. How do you feel about using a latrine?

39. What would be the good things about defecating only in a particular place in your yard and nowhere else?

.....

40. What would be the bad things about defecating only in a particular place in your yard and nowhere else?

.....

DESIGNATED DEFECATION OBSERVATIONS

41. If there is a latrine, does it look used? Is it clean? If there is a designated space for defecation, observe the area. What is the size? What is there now? How far is it from the house?

.....
.....

Scripted Conclusion for TIPs Counselors:

We don't have any more questions right now. Do you have anything else you would like to tell us? (Answer any questions you can, but do not make any promises.)

Thank you very much for taking the time to talk with us. We'll come back in about a week (tell the exact day if you know it) and talk with you about trying out some new practices that will help your family stay healthy.

Annex 2

Recording Tool for Counselling Visit

TIPs Counsellors..... Date.....

District..... Village..... House/Manyatta.....

Name of Caregiver.....

Complete shortly after <i>Counselling Visit</i>	
Health Practices which need improvements in relation to: dietary diversity hand washing designated defecation. (Prioritize no more than 2 behaviours.)	
Recommendations and Choices Offered (Don't forget <i>how</i> you motivated the caregiver and demonstrations you did.)	
Reactions of the family members and what made caregiver to agree or disagree on the recommendations.	
Recommendations Agreed Upon	1. 2.

Annex 3

Recording Tool for Follow-up Visit

TIPs Counsellors..... Date.....

District..... Village..... House/Manyatta.....

Name of Caregiver

Complete shortly after <i>Follow-up Visit</i>	
Recommendation 1 <input type="checkbox"/> Tried <input type="checkbox"/> Not Tried	Details...
Recommendation 2 <input type="checkbox"/> Tried <input type="checkbox"/> Not Tried	Details...
Results: Ex: Describe the outcome. To what extent did the mother carry out the recommendations? What did she think? Use her words if possible.	
Any Constraints: Ex: Did she only carry out recommendation for a few days? Why? Was food expensive? Did dig and bury become too cumbersome?	
Willingness to continue improved practices	<input type="checkbox"/> Yes Reasons...
	<input type="checkbox"/> No Reasons...
Dietary or Hygiene Changes Noted These are your observations.	