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## **Primary Health Care (PHC)**

# **Knowledge, Attitudes, and Practices (KAP) Baseline Survey Report**

**Changara, Chifunde, And Moatize Districts  
Tete Province, Mozambique**

Grant number 656-0217-G-00-5009-00  
Project number - 656-0217

**American Refugee Committee**

**May 1995**

## Acknowledgments

The American Refugee Committee would like to gratefully acknowledge the contributions of everyone involved in the design and implementation of the Primary Health Care Baseline KAP Survey. Each person's contributions were invaluable in making the survey a success both in the results of the survey and in the learning experience that it provided.

We would like to give our special thanks to:

- Dr. Fumane, Provincial Director of Health for Tete Province, Senhor Sabado, Director of Community Health and Education for Tete Province and Dona Luisa, Coordinator for Maternal and Child Health for Tete Province; for their constant support, collaboration and feedback on the survey instrument.
- All Secretaries, Presidents, Community leaders and community members of the sites where ARC is working for their support and collaboration for survey implementation.
- Dr. Ann Aschengrau, Professor of Epidemiology, Boston University School of Public Health for her assistance and advice in survey development.
- ARC administrative staff for their patience and cooperation in writing, typing, translating, and back-translating of the survey and for their logistical support for the teams in the field.
- The Supervisors and Enumerators for their excellent participation in the training's and field implementation of the survey despite the heat and distances involved:

Julie Archer  
David Sande  
Amelia Denja  
Isabel Jeque  
Ana Paula Patinho  
Elias Passageiro  
Lucinda Mtengamande

Judith Lane  
Texious Masaomphambe  
Joaquima Wanchi  
Gomez Merque  
Pedro Rodriguez  
Ricardo Tendekai  
Emilio Domingos Caçicaça

Melissa McLemore  
Reis Campiao  
Ana Paula Solinho  
Domingas Jimo  
Rassida Salgado  
Antonio Roia

- USAID, PRM, SV and UNHCR for offering us the chance to implement and evaluate our programs in Moçambique.

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## Glossary of Terms

Activista	Unpaid health volunteer from the community who provides health education and promotion of good health behaviors; but no curative care.
AC	Activista Coordinator; an ARC paid employee who trains and supervises Activistas
AIDS	Acquired Immune Deficiency Syndrome
ARC	American Refugee Committee
AS	Activista Supervisor: supervises the ACs
Bairro	Portuguese term for Neighborhood
CVM	Mozambique Red Cross
DK/NR	Don't Know / No Response
GRM	Government of the Republic of Mozambique
HEC	Health Education Coordinator: oversees primarily the Activista program
HELP team	Hygiene Education and Latrine Promotion team: consists of 1 Sanitation Coordinator, 2 Sanitation Assistants, 3 Latrine Slab Producers, and 1 Guard
HH	Household
HPM	Health Program Manager: oversees all health program activities
KAP	Knowledge, attitudes, and practices
MOH	Ministry of Health
PHC	Primary health care
PRM	US State Dept. Bureau of Population, Refugees, and Migration
STD	Sexually Transmitted Disease
SV	Stichting Vluchteling (a Dutch donor NGO)
TBA	Traditional birth attendant
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development

## Executive Summary

American Refugee Committee (ARC) began its activities in Tete Province in 1993 at the request of the Government of Mozambique. ARC program activities have included: provision of water; construction of health facilities, schools and staff houses; road rehabilitation; and hygiene education and latrine promotion in 12 sites within Changara, Chifunde, and Moatize Districts. In order to address additional health needs of the communities and to work towards a more sustainable program, ARC is proposing to implement a community health volunteer (Activista) program in the target areas where the ARC hygiene education and latrine promotion (HELP) teams are already working.

Prior to expanding activities into maternal and child health and other primary health care (PHC) topics, a survey was needed to determine the current knowledge and practices of the community to assist in the implementation plan and development of materials.

In May 1995, ARC conducted a baseline household survey to assess the adult target population's knowledge, attitudes, and practices (KAP) with regards to primary health care (PHC). The PHC baseline KAP survey focused primarily on maternal and child health issues, including: prenatal care; breast feeding; weaning; nutrition; family planning; sexually transmitted diseases (STDs); AIDS; immunizations; malaria; and care of wounds. In addition, questions were included to gather general information about the respondents, the situation in which they live, their participation in health talks, and their knowledge of the local traditional birth attendants (TBAs).

For the survey, 423 households were randomly selected and an adult member from each household was interviewed: 213 men 15-90 years old and 210 women of reproductive age (15-49 years old) who were married or had been pregnant.

## Results

Knowledge and use of safe health practices is slightly higher than fifty percent for many of the PHC topics, including prenatal care, AIDS transmission, family planning, wound care, and immunizations. Lower levels of health knowledge and safe health practices existed for malaria, weaning, nutrition, and condom usage.

Most respondents knew why a woman should receive prenatal care, and over half knew that a pregnant woman should go for prenatal care within the first 3 months of pregnancy. Many of the respondents were also aware that a pregnant woman should change her diet to an improved or increased (more food) diet. The majority of respondents knew how AIDS is transmitted and prevented. Family planning methods were known by slightly over half of the respondents. Most knew the basics of wound care and slightly over half of the respondents knew both when a child should begin to receive immunizations and that measles is preventable through an injection.

Most surprising was the lack of knowledge of malaria transmission and the misconceptions that malaria is transmitted through the wind or poor hygiene, and therefore having a latrine was seen as the only preventive measure needed, or worse, prevention was not seen as a possibility.

Breast-feeding, weaning, and nutrition knowledge was also low. Only 23 percent of the respondents knew that a baby should begin to receive other food or liquid in addition to breast milk at 4-6 months; and only 20% reported giving or planning to give additional foods at 4-6 months. Less than half of the respondents thought it was important to give their newborn colostrum; some saying that colostrum is dirty and should not be given to the newborn. Over half of the respondents, however, continued or will continue to breast-feed for two or more years.

One-quarter of the men admitted to having worn a condom; and only a slightly larger percent said they would wear one if asked to.

### **Implications**

With not a very high level of PHC knowledge and safe health practices, and many misconceptions, the health of the community is at risk. To reduce the morbidity and mortality within the community, health knowledge and behaviors need to be improved. A community-based health education program would be a practical approach to increasing the level of PHC knowledge within the communities. And by increasing the communities' level of health knowledge, their health practices should simultaneously improve, assuming that necessary resources are available and the community is willing to participate in improving their own health.

## Introduction

### Overview of ARC's Mozambique Program

American Refugee Committee (ARC), at the request of the United Nation's High Commissioner for Refugees (UNHCR) and the Government of the Republic of Mozambique (GRM), began its program in Tete Province, Mozambique soon after the signing of the peace accord in October 1993. ARC's goal has been to improve the health of approximately 140,000 residents, returnees, and displaced persons in three districts of Tete Province: Moatize; Changara; and Chifunde. ARC will achieve this goal through assisting the Mozambican government with the reconstruction and rehabilitation of infrastructure, and through the increased knowledge and improved practices which lead to good health among the targeted population.

ARC's Mozambique program began with water point rehabilitation and communal ventilated improved pit (VIP) latrine construction in Moatize district. Later, construction of health facilities, schools and staff houses, road rehabilitation, and further water points began in Changara District. This was followed by a hygiene education and latrine promotion (HELP) project in Moatize district in April 1994. As a result of the project's success, the hygiene education and latrine promotion project was expanded to Changara District in August 1994, and to Chifunde District in March 1995. School and health facility construction was also expanded to Chifunde District at the beginning of 1995.

The HELP project concentrates mainly on disease transmission of diarrhea and prevention through improved hygiene. As part of their prevention education, the HELP teams work with the community to promote communal and individual latrine construction and utilization. The HELP teams were primarily trained and instructed to provide focused health education on disease transmission, importance of latrines, importance of hand-washing, oral rehydration, and latrine maintenance. Each household with a latrine is to receive at least those five messages. The HELP teams have also received some training in and provide health education on general hygiene (personal, household, food, and water) and malaria.

The HELP program revolves around a team of health educators, most of whom originate from the area where the program is located, and are employed, trained and supervised by ARC. These health educators coordinate, mobilize, and educate the community and community leaders to take responsibility for their health through improved health practices. The health educators are responsible for conducting community health education sessions, household visits in their neighborhoods (bairros), and health education talks at the schools and health facilities. The messages, which are as short and simple as possible, are presented using a variety of non-formal adult education techniques, including discussions, puppets, visual aids, drama, and songs.

The HELP teams also provide interested families with concrete dome slabs for their latrine. The family digs a latrine pit, provides sand, water and gravel for the slab, and constructs the superstructure of the latrine once the slab is in place. ARC provides the cement, tools, and the skilled labor to construct the slabs, and provides guidance on siting, use and maintenance of the latrine. The HELP teams are currently operating full-time in 12 sites.

Although the HELP teams are providing health education, their scope is limited mainly to hygiene. In order to provide additional health education on other primary health care topics, and not overburden the HELP teams, it is necessary to add another program component. This program component will be based upon the functioning Mozambican Red Cross (CVM) Activista (community health volunteer) program. ARC has begun collaboration with CVM to enhance the Activista program's success and to increase the possibility of its sustainability. Plans include handing over the ARC-initiated Activista program to CVM for additional training and continued supervision at the end of the project.

The proposed Activista program consists of approximately 10 community health volunteers in each of twelve sites where ARC has established HELP teams. The Activistas (community volunteers working with ARC) will be selected by the community. Each Bairro will select two Activistas for whom they have respect and confidence. They will be asked to select Activistas that will continue teaching after ARC has left. Activistas will provide health education through home visits and group talks for about four hours a week. The Activista Coordinators (ACs), paid staff whom ARC and Mozambican Red Cross (CVM) have trained, will supervise and train the Activistas. The ACs will attend monthly training seminars with the Health Education Coordinator (HEC) to enhance teaching methodologies as well as to enhance their knowledge on a variety of primary health care topics. The ACs will then use what they have learned to train the Activistas each month. The ACs and Activistas will collaborate with the HELP teams to mobilize the community and to educate them in safe health practices.

Health messages will be developed based on the results of the baseline survey and on guidelines in *Facts For Life*<sup>1</sup>. Training will be based on non-formal adult education. All health topics will be taught using methods appropriate for non-readers and for development of learning and teaching skills. Activista training sessions will be conducted in Chinyungwe and Chichewa. Community leaders, TBAs, and traditional healers will be encouraged to participate in all training sessions in hopes that they will aid the community in taking ownership of its own health.

Proposed Primary Health Care topics for which the Activistas will be trained to provide health education will be based on the results of the survey. Main topics will most likely include: AIDS/STDs, water treatment, hygiene (personal, household, water, and food), diarrhea transmission and prevention, oral rehydration, family planning, nutrition, malaria, safe motherhood, child health and respiratory illness. Activistas will also receive training in prevention of accidents, alcoholism, and smoking.

Prior to commencing program activities, separate surveys have been developed and administered to assess specific needs for health posts, schools, road rehabilitation, water points, latrines, and hygiene education. In a similar fashion, before expanding activities into maternal and child health and other primary health care (PHC) topics, a survey is needed to determine the current knowledge and practices of the target communities. The information will provide a foundation in which to begin planning the Activista portion of ARC's health program. In addition, the information will provide a basis for comparison for a final evaluation of the Health Education program.

## Objectives of the Survey

The specific objectives of the Primary Health Care (PHC) Baseline KAP Survey are:

1. To identify the needs in health education and health practices on selected PHC topics within the target communities in order to assist in the development and implementation of the Community Health Promotion Volunteer Program (Activista Program).
2. To collect baseline information to serve as a basis on which to evaluate ARC's Activista program with respect to the program goals and objectives specified in the program log frame (see Appendix 1).

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<sup>1</sup> *Facts for Life*, UNICEF/WHO/UNESCO, New York

## Methodology

### Survey Instrument

The Primary Health Care (PHC) Baseline KAP Survey was based on numerous other PHC surveys to which ARC had access. Major influences in developing the survey instrument came from surveys implemented by ARC in other countries, the rapid survey questionnaire located in the PHC MAP module<sup>2</sup>, and a questionnaire found in a draft of the 'Rapid Knowledge, Practice, and Coverage Survey Training of Survey Trainers (TOST) Guide'<sup>3</sup>. The development of the survey instrument was also aided by the experience and information gleaned from the three water and sanitation baseline surveys conducted by ARC in the past year in Mozambique.

The topics of interest for the survey were selected by a working group consisting of the health program management staff and the Activista Supervisor. The PHC baseline KAP survey focused primarily on maternal and child health issues, including: prenatal care; breast feeding and weaning; nutrition; family planning; sexually transmitted diseases (STDs); AIDS; immunizations; malaria; and care of wounds. In addition, questions were included to gather general information about the respondents, their participation in health talks, and their knowledge of the local traditional birth attendants (TBAs).

The survey questionnaire comprised approximately 45 questions and took about 30 minutes to administer. A separate questionnaire for women was developed to include an additional 6-15 questions on prenatal care, delivery, breast-feeding, and weaning. Refer to Appendix 2 for the English versions of the men's and women's PHC baseline KAP survey questionnaires.

Once the survey questionnaire was drafted and translated into Portuguese, copies were sent to the Ministry of Health to ensure that the survey met their needs and to receive their feedback. Back-translations were carried out by translators not involved in the initial writing of the survey to check the accuracy of the translation. Once the revisions were in from the Ministry of Health and health program staff, the Portuguese version was translated into Chinyungwe and Chichewa, and back-translated again into English. Further revisions were made after the back-translations and the pilot test.

The instrument was pilot tested in the sites of Matambo for the Chinyungwe version and in Mussacama for the Chichewa version. A total of 40 respondents were interviewed, representing 20 women and 20 men. The initial results from the pilot showed that the instrument as a whole was sound; however, several questions had to be revised or deleted due to unclear wording and/or meaning. An important result of the survey is that it demonstrated areas in which special attention was needed for the enumerators' training seminar for the main survey administration.

### Sample Selection

Thirty randomly selected clusters of at least seven men and seven women each were sampled for a total of 423 respondents: 210 women and 213 men. Clusters were randomly assigned to the sites which comprise the target areas of the HELP teams in the three districts of Moatize, Changara and Chifunde. Then the clusters were further assigned to the bairros within the catchment area of each site. Population numbers reported for each site by HELP team members were used in the selection of the bairros. Out of the 12 sites comprising ARC's target area, only one site, Vila Mualadzi, was not selected through the randomization process for inclusion in the survey.

<sup>2</sup> See Appendix C in the Primary Health Care Management Advancement Program (PHC MAP), Module 2 User's Guide, Aga Khan Foundation, 1993.

<sup>3</sup> Unpublished document, March 17, 1993

The target population consisted of women of reproductive age and adult men. This was further specified by: 1) men 15 years or older, and 2) women of reproductive age, defined as 15-49 years old, who were either married (currently or previously) or who were single but had a previous pregnancy. The pregnancy could have resulted in a live birth, a still birth, a miscarriage, or an abortion. The target population was selected to include potentially sexually active individuals who could provide current information on family planning, AIDS/STDs, and motherhood knowledge and practices, from both the male and female perspective.

### **Selection of Households**

Permission was obtained and all sites were notified of the date that the survey was to be conducted in their bairro. Due to time constraints and the physical barriers in the survey area (heat, long distances between households, mountains, and land mines) it was essential that the communities be aware of the date of the survey to encourage community members to be present on that day.

Upon arrival at each site, the survey team would first locate the ARC project personnel and arrange for one representative to accompany them to meet the village President or Secretary of the Bairro. Permission was again obtained each time to conduct the survey in that particular area. The village leader would select one woman and one man to act as guides for the male and female survey teams. The guides would assist the survey team in determining the geographic center and the borders of the bairro. A directional diagram labeled 1-16 was placed at the geographic center of the bairro. Each guide was asked to **blindly** select one card from a group of cards numbered 1-16. The number chosen by the women's guide represented the direction in which the women's team would begin and the number selected by the men's guide represented the direction in which the men's team would begin.

Once the direction was selected, the teams would walk in that direction counting households on their right until they reached the edge of the bairro. Households were counted up to and including 50 meters from the directional walking path. At the edge of the bairro, the guide would blindly select another card from the numbered cards (numbered up to and including the number of households counted). The random number selected represented the number of the first household to be interviewed.

### **Selection of the Respondent**

Upon arriving at the household, the team would introduce themselves to an adult member of the household. Each team was provided with a standard introduction sheet which was to be read word for word. Each sheet was provided in Chinyungwe, Chichewa, and Portuguese.

The survey team would assess how many members of the household were eligible to be interviewed using the criteria specified. If more than one member qualified to be interviewed, the respondent was randomly selected using the numbered cards. Each qualified member would blindly select a numbered card; the person with the highest number would be interviewed. Where the selected member was not present, two call-backs were attempted before the respondent was replaced with another randomly selected person.

All interviews were conducted in private away from other family members and the village guide.

## Selection of the Next Household

Selection of the next household was done by choosing the household with its front door closest to the front door of the household just selected. If it was unclear which household was closer, the enumerators were instructed to pace out the distance. If the next closest households were equidistant from the household just interviewed, the household on the right was always selected. Since the selection of households by the men's and women's teams was conducted independently, a man and a woman from the same household could both be interviewed if they both met the selection criteria.

In order to know which households had more than one gender interviewed or selected, chalk marks were drawn on each house selected. One of 5 symbols was used: **H** for male selected, **H** with a circle for male interviewed, **M** for woman selected, **M** with a circle for woman interviewed, and **X** for household refusing to participate in the survey. Chalk marks were also useful in identifying the households where call-backs were needed.

## Rate of Response

Survey team supervisors recorded all selections on a "Supervisor's Checklist." This assisted the team in monitoring the number of houses selected and houses where call-backs and replacements were necessary.

A total of 455 respondents were selected to be interviewed; of these 423 were interviewed. Out of those not interviewed, 9 refused to be interviewed and 23 had not returned home by the second call back. An additional 153 households were not able to be included (representing 2 of the 3 districts) because no one from the household was present, nor would anyone be returning during the interview day either because the family had moved away, they were too ill, or they were absent for the day.

At 15 of the households both a woman and man were independently selected and interviewed from the same household; at one of the households a member of the opposite sex was selected but not interviewed.

## Selection and Training of Survey Personnel

Three teams of six, four enumerators and two supervisors, were selected to conduct the survey. Within each team, two gender teams consisting of two enumerators and one supervisor each, were formed. Same-gender teams were formed so that the women's teams could interview women and the men's team could interview men. Due to the sensitive nature of some of the questions, same-sex teams were used to try to make the respondent feel more at ease. One team of six was selected for each of the three districts.

Supervisors were responsible for monitoring the selection of respondents and administration of the survey instrument. Enumerator partners were used in order to monitor that no questions were skipped and that responses were marked correctly. Supervisors would also check each questionnaire before signing it to ensure completeness.

Survey supervisors consisted of the three health program management staff, two health program Field Supervisors, and one Sanitation Coordinator. All but one of the Supervisors had been involved in conducting prior surveys.

A full-day training session was conducted for the survey supervisors. The session consisted of a general overview of the survey, its design, how it was to be administered, and supervisors' roles and responsibilities during the survey. All supervisors also participated in the training of enumerators to reinforce their skills and information and to assist with the training, where necessary.

Selection of enumerators was made from ARC field staff consisting of Activista and Sanitation Coordinators and Sanitation Assistants. Enumerators were chosen on the basis of their literacy skills in Chichewa or Chinyungwe, their prior survey experience, and their ability to work in a team setting. Two former ARC employees were also invited to participate in the training seminar due to a shortage of female enumerators with sufficient language skills.

Two separate training seminars were conducted: one for enumerators participating in the survey pilot test and a more extensive training seminar for those participating in the full survey administration. Trainees were assessed during the practice sessions to determine their ability to administer the survey in a consistent and effective manner. Only those participants in the training seminar who performed best were selected to become enumerators.

Training for the administration of the pilot survey took place over three days. The training seminar included: the basic introduction to the purpose and design of the survey, an overview of the pilot survey details such as arriving at the bairro, selecting respondents and conducting the interviews, review of the questionnaire in Portuguese and Chinyungwe or Chichewa, role plays, and practice administering the survey. Trainees also gained additional practice by administering the survey at home with friends and family members.

Training for the administration of the baseline survey consisted of five intensive days of reviewing the survey questionnaire, selection of respondents, problem solving, role plays, and practice in implementing the survey. Day five was a practice run of the survey in a bairro just outside of Tete City which offered respondents that spoke both Chinyungwe and Chichewa.

## Data Entry

Completed survey questionnaire forms were brought to the ARC Tete office where forms were sorted and entered into the computer. Data was entered and analyzed using EPI INFO 5. Data entry was checked by looking for inconsistent or incorrect entries. Where questions were skipped, or too many responses recorded, the responses were left blank and not included in the final analysis.

## Quality Control during Coding and Data Entry

All possible efforts were made to ensure consistency of coding. One such effort was the extensive training of enumerators using role plays and group coding of responses, followed by discussion. Also, during the survey, enumerators interviewed in pairs to ensure that all of the questions were asked, all skip patterns followed, and all responses were marked correctly. After the interview was completed, the enumerators and supervisor would briefly review and discuss the interview; any skipped questions or responses not marked would be rectified at that time. After the cluster was finished and before leaving the site the supervisor would re-check all survey forms for completeness.

Each survey had a six-digit identification number. The numbers assigned represented the respondent's gender, district, site, bairro, cluster, and respondent number. The detailed ID number aided in initial organization of the survey forms, and in the data entry and analysis.

Data was entered by the 3 lead health staff in Tete with assistance from survey supervisors and office support staff who would read out the data. A random check of the data was made to identify problems in data entry, and corrections were made, where necessary. The data entry 'check' feature in EPI INFO was also utilized to eliminate gross errors by only allowing entry of specified numbers and skipping questions, where appropriate.

*Refugees/Displaced Persons*

Approximately three-quarters of the respondents reported having been refugees or displaced persons because of the Renamo/Frelimo conflict. The percentage of refugees and displaced persons varied by district from 51% in Changara District, to 79% in Chifunde District, to 98% in Moatize District. By project site, the percentage of refugees/displaced persons out of those interviewed ranged from 21 to 100 percent; by bairro the range was 0-100% that were refugees/displaced persons. An insignificant difference between men and women was found: 75% men vs. 77% women reported having been refugees/displaced persons.

*Household wage-earner*

Nineteen percent of the households (HHs) interviewed (n=82) had someone in their HH who had a job for which he/she earns money. The percentage of HHs with a wage-earner varied by district, with Moatize having the fewest at 12.7%, and Chifunde having the most at 30%. By project site the percentage of HHs with a wage-earner varied from 7% to 39%. See Table 2.

**Table 2: Employers of Wage-Earners<sup>5</sup>**

For whom wage-earner works	n	%
Self-employed	30	37.0%
Ministry/Political party	17	21.0%
ARC	12	14.8%
CVM	3	3.7%
Other NGO	14	17.3%
Private business	4	4.9%
Don't Know/No Response (DK/NR)	1	1.2%
<b>Total of 3 Districts</b>	<b>81</b>	<b>100.0%</b>

*Literacy*

33.9% (n=143) of those surveyed reported that they could read. However, after verification by reading a passage in Portuguese, Chichewa, Chinyungwe or Chinyanja, only 30.8% (n=130) were considered literate<sup>6</sup>: 107 men and 23 women. Languages in which respondents could read include: Chichewa (25%); Chinyungwe (11%); Portuguese (47%); Chinyanja (5%); other (12%). The language respondents preferred to read was Portuguese (60%), followed by Chichewa (34%), and Chinyungwe (6%). The preferred language varied by district (refer to Table 3, below). Out of those who could read, 56% were classified as able to read with ease; 44% had reading difficulty.

5 DK/NR= Don't Know/ No Response, or a response was provided that did not answer the question asked and was later recoded as DK/NR.  
6 However, 5 of these were not verified due to literacy in other languages not tested

## Summary of Results

### Respondents' Characteristics

Four hundred and twenty-three respondents were interviewed from 11 of ARC's 12 project sites, as detailed below in Table 1:

**Table 1: Number of Respondents Interviewed, by District and Project Site**

District	Project Site	Number of Respondents
Changara District		
	Chioco	14
	M'saua	42
	Marara	28
	Mazoe Ponte	56
	Muchamba	14
	<b>Subtotal</b>	<b>154</b>
Chifunde District		
	Bulimo	14
	Chifunde	28
	Namiramba	28
	Nsadzu	28
	Thequesse	14
	<b>Subtotal</b>	<b>112</b>
Moatize District		
	Kaphiridzanje	157
	<b>Subtotal</b>	<b>157</b>
<b>Total of 3 Districts</b>		<b>423</b>

For distribution of clusters by district, project site and bairro, see Appendix 3.

### *Gender and Age*

Out of the Respondents interviewed, 210 were women and 213 were men. The 303 respondents, for whom their age was known, ranged in age from 15 to 90 years old, with an average age of 33 years and a median of 30 years. No age was known for 120 respondents (28%). The average age of the women was 28.9 years (range: 15 - 49 years), and the average age of the men was 36 years (range: 15 - 90 years).

### *Household Size*

The respondent's household<sup>4</sup> size ranged from one to twenty-five, with an average of 5.9 and a median of 5. On average, a household had at least one woman of reproductive age, one adult male (15 or more years old), and one child under two years of age.

<sup>4</sup> Household consists of one or more people who regularly live and eat together. Laborers are considered to be part of the household.

Table 3: Most Preferred Language to Read, by District:

District	Portuguese	Chichewa
Changara	80.4%	
Chifunde		75.0%
Moatize	55.3%	34.0%

## Questionnaire Topics

### Maternal Care (Prenatal Care and Delivery)

#### 1. Knowledge Questions on Prenatal Care

##### 1a. Prenatal Consultations

More than half of the respondents, 64%, could provide valid reasons why a pregnant woman should seek prenatal care. Three-quarters of the male respondents (161/213) interviewed (some gave multiple responses) knew why a woman should consult a traditional birth attendant (TBA) or other health staff before the baby is born; 24% did not know why. A little more than half (53% or 112/210) of the women interviewed knew why a woman should receive prenatal consultations (some gave multiple responses). See Table 4 for the reasons given for seeking prenatal care.

Table 4: Reasons for Seeking Prenatal Care, by gender

	Men		Women		Total	
	n	%	n	%	n	%
No need for consult	0	0.00	2	0.94	2	0.47
To check progress/complications	109	50.50	78	36.60	187	43.60
Vaccination	13	6.00	9	4.20	22	5.10
Advice/health education	42	19.40	25	11.70	67	15.60
It's good to	0	0.00	1	0.50	1	0.20
Don't Know/No Response	52	24.10	98	46.00	150	35.00
<b>TOTAL</b>	<b>216</b>	<b>100.00</b>	<b>213</b>	<b>99.94</b>	<b>429</b>	<b>99.97</b>

Just over one-half (56%) of the respondents, or 62% of the men and 50% of the women, knew that a woman should go for prenatal consultation within the first three months after knowing that she's pregnant. Only four percent (n=15) of those interviewed responded that a woman need not go until the end of her pregnancy (7-9 months) or at the beginning of labor or delivery. About one-quarter of the respondents did not know or did not respond.

##### 1b. Diet of a Pregnant Women

The majority of respondents, 75%, stated that a pregnant woman should change her daily diet. The men and women responded significantly differently, with the men being slightly more aware of the need for a change: 80% men responded that a pregnant woman's diet should change, whereas 69% of the women did. See Table 5.

Table 5: Diet Change For a Pregnant Woman

	Men	Women
Diet should change	80	69
<i>Of above, how changed:</i>		
Diet should improve*	57	53
More food eaten	21	1
Less food eaten	0	0

\* An improved diet is defined as one with more vegetables, milk, protein, and iron.

2. Health Behavior Questions on Pregnancy, Prenatal Consultations, Delivery, Breast-feeding and Weaning (women respondents only)

*Sample Interviewed*

Only the women respondents were asked a series of questions concerning behaviors related to prenatal consultations, delivery, breast-feeding and weaning practices. All questions address the woman's current pregnancy or her most recent pregnancy occurring within the past 2 years.

Overall, 57.6% (n=121) of the women interviewed had been pregnant within the past two years, 9.5% (n=20) of whom were pregnant at the time of the interview. A total of 106 women (50.5%) had a pregnancy outcome (including abortion, miscarriage, still birth and live birth) in the past two years: four were both pregnant at the time of interviewing and another time during the past two years; 101 were not pregnant at the time of interviewing.

2a. Prenatal Consultations

Slightly less than half of the women who were pregnant during the past two years received prenatal care. Refer to Tables 6 and 7.

Table 6: Percentage of Woman Receiving Prenatal Care

	#	Received/ing prenatal care	No prenatal care*	DK/NR
Pregnant within last 2 years (but not currently)**	102	49%	40%	11%
Pregnant at time of interview	19	47%		

- From the results of the Chinyungwe survey where a skip had been omitted it became evident that the majority of women being interviewed in Chinyungwe did not understand the question about who they principally visited for prenatal consultations. 21 out of 25 Chinyungwe respondents originally responded that they had not visited anyone for prenatal consultations, yet on further questioning it was clear that they had visited someone for prenatal visits. For this reason, all of the Chinyungwe responses were included for the questions detailing prenatal visits.
- The question on birth outcomes was not well understood by some respondents. Observations and additional questioning was used at times to ascertain the results presented.

Table 7: Whom Women Principally Visited For Prenatal Consultations

Whom Visited	n	%
Someone	59	49%
<i>health center/hospital staff</i>	42	35%
<i>traditional birth attendant (TBA) (7 untrained; 4 trained; 1 not known)</i>	12	10%
<i>neighbor (3) / relative (1) / traditional healer (1)</i>	5	4%
No One	51	42%
Don't Know/No Response	11	9%
<b>Total</b>	<b>121</b>	<b>100%</b>

*Women With Pregnancy Outcome in Past Two Years, But Not Currently Pregnant*  
 There were 101 women pregnant in the past two years, but not pregnant at the time of the interview, and one woman who was pregnant at the time of the interview.

Fifteen out of 102 women (15%) reported having a prenatal care or vaccination card, but only 14 cards were available at the time of the interview. Prenatal Care information was gathered directly from the card where available, otherwise information on the Prenatal Care visits and tetanus toxoid vaccine (TTV) were obtained orally.

Pregnancy consultations were recorded on 8 respondents' cards. One to six visits were recorded on the cards, with the average number of visits being 3.1. An average of 3.8 pregnancy consultations (ranging from 0 to 7 visits) were reported orally by 62 respondents (86%), and ten of the respondents did not answer or did not know.

An average of 2.2 tetanus toxoid vaccinations (TTV) per woman was recorded on 13 respondents' cards (93%) (with a range of 1-5 TTV). TTV was orally reported as being received by 46 women (74%) with an average of 2.5 TTV received; and not received by 26%.

Risk factors were recorded on only five of the respondents' cards. Two of those were considered 'at risk': both had given birth to six or more children and were more than 35 years old; the other 3 women had none of the listed risk factors marked on their cards. Out of the 2 at-risk mothers, 1 had 2 visits to an untrained TBA for prenatal consultations and had a home delivery assisted by an untrained TBA resulting in a live birth. The other mother had 4 prenatal consultations by an unknown entity and had a home delivery assisted by a trained TBA resulting in a live birth.

Out of the women currently pregnant (n=20), information on their current pregnancy was obtained from 19 (95%) of the women; from the other woman information on her most recent birth was obtained instead.

Eight of the nine women having prenatal consultations reported having a prenatal or vaccination card, but relevant information was only obtained from seven. Of those seven, all had gone for one consultation, and six had received at least one tetanus toxoid vaccination. The overall number of injections received ranged from zero to five, with an average of 1.7 injections.

Concerning the woman without a card, she did not know how many consultations she had, and she had not received any tetanus vaccinations.

2b. *Pregnancy Outcomes*

Out of the 106 women with a pregnancy outcome in the past two years, the majority, 81%, reported their pregnancy resulted in a live birth. See Table 8.

Table 8: Pregnancy Outcomes<sup>7</sup>

Pregnancy outcomes	n	(%)
live birth	86	81.1%
still birth	6	5.7%
abortion/miscarriage	7	6.6%
twins where 1 died/1 lived	1	0.9%
dk/nr	6	5.7%
<b>Total</b>	<b>106</b>	<b>100.0%</b>

Out of the 99 women who delivered a baby in the past two years, 67% (n=66) delivered at home and 33% at the health center or hospital. Details of who assisted at delivery are presented in Table 9.

Table 9: Who Assisted at Delivery

Pregnancy Assistance	(%)
Health Center Staff	32%
Trained TBA	13%
Untrained TBA	12%
TBA training unknown	5%
Relatives/friends	31%
Not assisted	6%
<b>Total</b>	<b>99%</b>

2c. *Breast-feeding*

Eighty-nine percent (n=80) of the women who had responded that they had a live birth in the past two years or said they did not know or did not respond were breast-feeding at the time of the interview; 11% were not. When asked when will/did you stop breast-feeding your child, a little over half of the respondents said at two or more years as shown in Table 10.

Seventy percent (n=63) of the respondents reported giving their newborn the colostrum; 28% (n=25) did not; 1 did not know or did not answer. Out of the 25 who did not give their newborn colostrum, 10 (40%) said "because it was dirty", 3 said "the milk delayed in coming", and 8 did not know or did not respond. Other responses for why colostrum was not given to their newborn included: "the baby may get sick"; "I was ill"; "it is left over from the previous baby", and "breasts were aching".

<sup>7</sup> The question on birth outcomes was not well understood by some respondents. Observations and additional questioning was used at times to ascertain the results presented.

Table 10: Age at Which Breast-Feeding Will/Did Stop

Age	%	(n)
two or more years	51.1%	46
12-23 months	11.1%	10
child decides	4.4%	4
don't know/no response	25.6%	23
other	7.8%	7
<i>when pregnant again</i>		3
<i>child died</i>		1
<i>restart relations with man</i>		1
<i>before 6 months</i>		1
<i>7-11 months</i>		1
<b>Total</b>	<b>100.0%</b>	<b>90</b>

2d. *Weaning*

Only eight percent of the respondents reported giving or planned to give other food or liquid in addition to breast milk at four months, and 19% will or did provide additional food or liquid at the age of 4-6 months. See Table 11.

Table 11: Age At Which Other Food Or Liquid Was/Will Be Given In Addition To Breast milk

Age	n	%
before 4 months	30	33.7%
at 4 months	7	7.9%
5-6 months	10	11.2%
>6 months	12	13.5%
DK/NR	30	33.7%
<b>Total</b>	<b>89</b>	<b>100.0%</b>

3. Knowledge Questions on Breast-Feeding and Weaning (all respondents)

3a. *Colostrum*

Forty-six percent (n=195) of all of the people interviewed (54% of the men and 38% of the women) responded that it is not important to give a newborn colostrum; 38% (n=161) said it is important (30% men and 46% women), and 16% did not respond or did not know. Reasons given for the importance of colostrum are detailed below.

Table 12: Why Colostrum is Important

	Men	Women
Importance of Colostrum	%	(%)
Colostrum not important	54%	38%
DK/NR	16%	15%
Colostrum important	30%	46%
Important because:		
<i>Protects against illness</i>	44%	20%
<i>Stimulates breastmilk</i>	30%	21%
<i>Nothing else available</i>	11%	16%
<i>Contains vitamins/important food</i>	2%	1%
<i>Other responses</i>	7%	12%
<i>No reason given</i>	6%	30%

### 3b. Weaning Foods

Knowledge about when a baby should begin to receive other food or liquid in addition to breast milk was poor. 41% (men 51%; women 31%) responded that a baby should begin to receive other food or liquid before four months of age, 25% (men 16%; women 34%) did not know or did not answer. Only nine percent responded as Mozambican Ministry of Health recommends: at 4 months, another 14% said at 5 or 6 months, and the remaining 11% responded after 6 months of age.

The majority of the respondents said that either energy foods (50%) or body-building foods (46%) should be added to the porridge when the baby first begins to receive it. Men and women responded in a similar fashion, although 7% more of the men mentioned body-building foods, and about four percent more of the women gave no response or did not know (total DK/NR = 11%). Foods rich in vitamin A were only mentioned by three percent of the respondents, most of whom were men. Three percent also said vegetables should be added, and another six percent, mostly women, mentioned that salt should be added to the porridge.

## Family Nutrition

### Varied Diet

When asked if they thought it is important to eat a variety of foods, most of the interviewees responded that it is (77%: 83% men; 62% women), 5% responded that it is not, and 23% did not know or did not respond<sup>8</sup>.

Upon asking what foods should be eaten at least three times a week to enhance one's overall health, grains were most often mentioned (82%), followed by body-building foods (13%), and vegetables/fruit (11%). Nine respondents (2%) were able to mention 3 food groupings and 58 respondents (13%) could mention 2. Eleven percent did not know or did not respond.

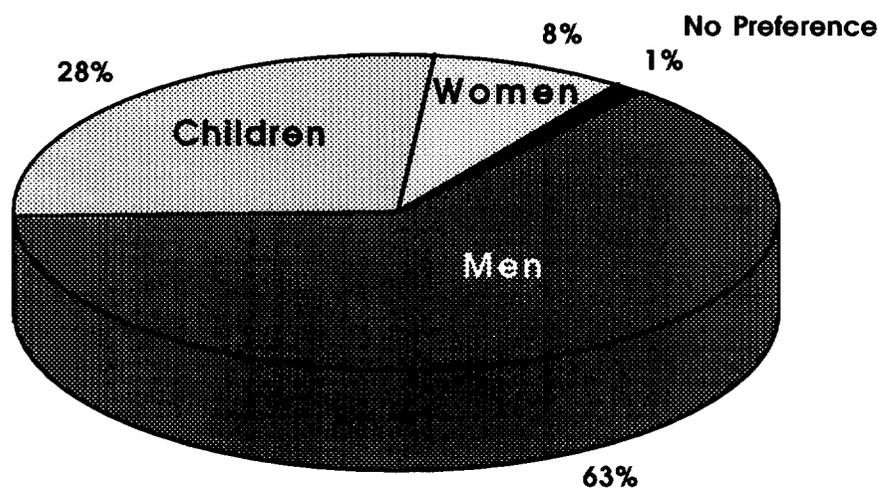
The three food groups taught are Body Building foods (Proteins), Protection foods (vitamins and minerals) and Energy Foods (carbohydrates).

<sup>8</sup> Note: This question, according to the supervisors, was felt to be poorly understood by many and should be removed from any future surveys.

### Food Distribution within HH

When asked how food is distributed within the household when there is only a limited quantity of meat men hold the top position in receiving the meat first.. See Figure 1. Second in line to receive meat are women according to 45% of the respondents, or children according to 32%, and men by 21%.

**Figure 1: Distribution of Meat in Family**



Children from 3-5 years usually share a bowl with the women (57%), or men (23%), or with same gender (5%), but only 12% responded that the young children eat by themselves.

### Food Production within HH

Ninety percent of the households (HHs) interviewed produce food, i.e. raise animals, grow crops or vegetables, or catch fish. Out of those HHs which produce food, 66% of them do not sell any of the food produced, and the remaining 34% sell some of the food produced.

By district, the percentage of HHs producing food was similar. However, the percentage selling some of their produced food varied by district: Chifunde (52%); Changara (18%); and Moatize (38%).

### Family Planning

#### Knowledge of Family Planning Methods

At least one method of family planning was known by 62 percent of the respondents. Use of modern methods (37%) and avoiding sex (28%) were the two most common responses to the question "What can a man and woman do to avoid or postpone becoming pregnant?" Nine percent mentioned traditional medicine as a means of family planning, five percent said there's nothing one can do, a few mentioned exclusive breast-feeding, control of menstrual cycle or (sleeping with) an impotent man, and 23% did not know or did not respond. Ten respondents (2.4%) mentioned more than one method, all of whom mentioned both modern methods and traditional medicine as a means of family planning. A greater percentage of

men mentioned traditional medicine and avoiding sex, whereas a greater percentage of women said either there is nothing one can do or they did not know or did not respond.

### Use of Family Planning Methods

Forty-five percent of the respondents reported ever practicing a method of family planning. Fifty-eight percent (n=124) of the men responded positively that they and their spouse/partner have used a method to avoid or postpone pregnancy; whereas only 32% (n=68) of the women reported having practiced family planning. About five percent of the men and nine percent of the women did not know or did not answer.

**Table 13: Family Practice Utilization**

	Men	Women
Family Planning Practice (ever)	%	(%)
Practiced (at some time)	58%	32%
Method used:		
<i>Abstinence</i>	52%	31%
<i>Oral contraceptives</i>	11%	43%
<i>Condoms</i>	19%	4%
<i>Traditional methods</i>	13%	3%
<i>Other or DK/NR</i>	5%	19%
Never practices	37%	59%
Reason given:		
<i>Not sexually active</i>	13%	15%
<i>Desire for more children</i>	8%	18%
<i>No methods available</i>	14%	10%
<i>Lack of knowledge about methods</i>	4%	8%
<i>Fear of side effects</i>	9%	5%
<i>Other</i>	17%	12%
<i>No reason given</i>	35%	32%
DK/NR	5%	9%

### Spacing of Children

Fifty-seven percent of respondents (68% of men; 46% of women) knew that two or more years should elapse between the birth of one child and the beginning of the next pregnancy. Whereas 14% (22% of men; and 6% of women) said less than 2 years should elapse, and 29% (10% of men; 48% of women) did not know or did not respond.

### STDS/AIDS

The great majority of respondents (96%; n=406) had heard of a disease called AIDS. A significant difference existed between men and women, with 99% of the men and 93% of the women having heard of AIDS.

### Transmission

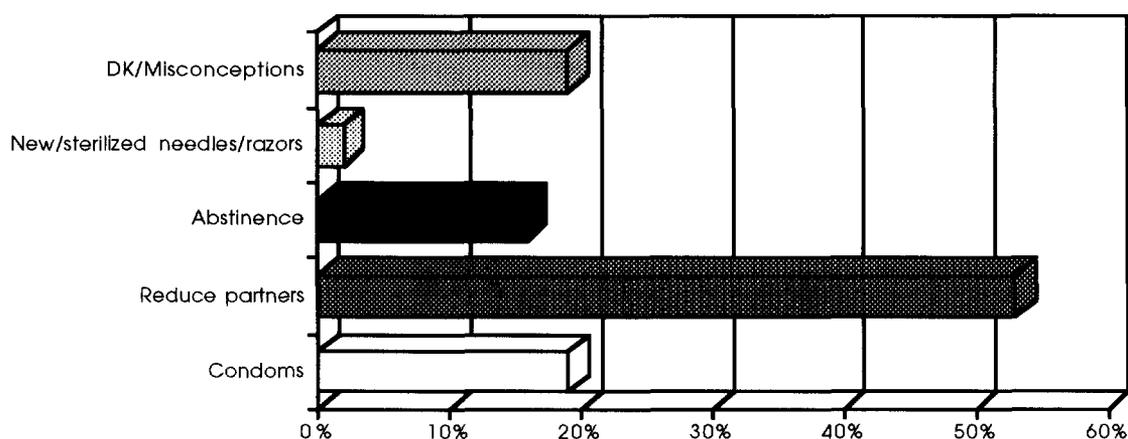
The majority, 81%, of the respondents who had heard of AIDS also knew how it is spread: 85% of the men and 76% of the women. Out of the modes of transmission described, most (74%) said AIDS is transmitted through sexual transmission, either simply 'through sex' (mentioned by 53% of the respondents), or through bargirls (0.2%), by having multiple sex partners (26%: 31% men; 21% women), and through ejaculation (0.2%). Only 3% of the responses given specified AIDS is transmitted through unprotected sex. Eight percent said that AIDS is transmitted by sharing or using unsterilized needles or razor blades and 0.7% mentioned transmission through blood or blood transfusions. Only 16% (11% of men and 22% of women) said they did not know or gave no response and 3% held various misconceptions, including that AIDS is spread through social contact, sharing food/clothing/utensils with an infected person, or through latrines.

However, when directly asked if AIDS can be transmitted by shaking hands with or hugging an infected individual, the proportion of respondents with misconceptions increased to 22% (22% men; 23% women) from 3%, and those not responding or not knowing was about the same, at 17% (11% men; 24% women). Sixty-one percent correctly responded that AIDS is not transmitted by shaking hands with or hugging an infected person.

### Prevention

Eighty-one percent (n=330) of the respondents knew they could reduce their risk of infection by the AIDS virus. Nineteen percent (n=76)(23% of the women; 10% of the men) did not know or had misconceptions about how they could reduce their risk of infection. Methods given by respondents included:

**Figure 2: How Can AIDS Be Prevented?**



When asked whether AIDS could be prevented by receiving an injection a higher percentage of men knew that it could not (78%) than women (60%). Of those who that it could, similar percentages were noted for men and women, 15% and 17%, respectively. Seven percent of the men and 23% of the women said they did not know or they did not respond.

## STD Prevalence

Only about four percent (n=16) of the respondents reported having an STD in the past two years: 6% of the men and 2% of the women. Out of those with an STD, treatment was most often sought from health center or hospital staff (69%); others sought treatment from a traditional healer, or treated themselves.

## Condoms

During the interview, three condoms were shown to the respondent: two different styles of condoms in their packages and one condom out of its package. The majority of respondents (77%) knew they were looking at a condom or at least knew the item's use. 60% (78% men; 41% women) stated that it was a condom, using any one of a number of terms discussed during the training seminar as valid responses, and 17% (11% men; 23% women) stated its use but not its name. The remaining 23% (12% men; 35% women) did not know what it was or did not respond.

Twenty-five percent of the men questioned said that they had worn a condom before; whereas only 11% of the women questioned said that their husband or partner had ever worn a condom.

Only 34% of the men said they would wear a condom if their wife or partner were to ask them; whereas 65% said they would not. Similarly, only 32.5% of the women responded that they could ask their husband or partner to wear a condom; 67.5% did not feel they could request this.

## Immunizations

Over half of the respondents were aware that a child should receive his/her first vaccination at birth or within the first two months after birth, with fifty-six percent (n=234) of those stating (56% of the men and 54.5% of the women) at birth. Seven percent said that the first vaccination should be at six weeks, three percent said 3-7 months, 2.4% said at 1-5 years, 1.2% said at 1-2 months, and 30% did not voice an opinion.

Fifty-eight percent of the respondents (n=246) knew that measles was preventable through an injection, with 63.8% of the men and 52.6% of the women being aware. Whereas, 33.4% (28.2% of the men and 38.8% of the women) did not think measles was preventable through an injection, and 8.3% did not have an opinion.

## *Malaria*

### Transmission

Lack of knowledge about malaria transmission was abundant. Only 14% of the respondents (23% of men and 4% of women) were aware that malaria is transmitted by mosquitoes. Ten percent attributed malaria transmission to lack of hygiene (including lack of latrines, personal hygiene and HH hygiene), 8% attributed it to the wind or cold, 4% said it just happens, and 4% said it's through social or more intimate contact with someone who has malaria. Fifty-three percent said they did not know or they did not respond.

## Prevention

The lack of knowledge about how malaria is transmitted is similarly demonstrated through the manner in which the respondents reported they were protecting themselves against malaria. Only 14 respondents (3%) reported that they take proper preventive measures against malaria: 13 said they eliminate standing water and one said he uses a mosquito net. Another 190 respondents (45%) gave partially correct responses by saying that they either cut the grass or keep the yard tidy (25%), or they take medicine or go to the hospital (20%). Half of the respondents (n=212) said that they either do nothing to protect themselves (n=153; 36.2%), or they mentioned irrelevant practices related to latrines, hygiene, etc. (n=59; 13.9%). It also appears that the misconceptions about the role that latrines and hygiene play in the prevention of malaria are most common in Changara and Kaphiridzanje where ARC has been promoting latrines and hygiene for a longer period of time.

## Signs and Symptoms

Forty-eight percent of the respondents reported that someone in their household had malaria in the past two months. Out of those HHs where someone had malaria, most respondents (97%) were able to correctly identify signs or symptoms which led them to believe that someone had malaria (that is those signs which are often present when someone contracts malaria). Only four respondents appeared to mention irrelevant signs, and 3 said they did not know or they did not respond.

## Wounds

When asked, "What should you do at home to care for an open cut?", men and women responded similarly, with 77% responding that one should wash it: 4% specifically mentioned soap and water; and 4% mentioned the addition of salt. Seven percent of the respondents said the wound should be covered with a bandage or cloth, 2% said it should be covered with leaves, and 24% mentioned that medicine should be applied. Only 5% said nothing should be done at home, and another 8% did not know or did not respond. A few surprising/disturbing responses included applying battery powder (n=1), chloroquine tablets (n=1), or mud/dung (n=2) on an open wound<sup>9</sup>.

<sup>9</sup> Note: A few individuals in Chifunde District responded with things like "avoid sex", "don't sleep with a woman", etc. as if they interpreted "open cut" as a sore on the penis; these were recoded as dk/nr.

Table 14: Treatment of Wounds

Treatment of Wounds	(%)
Wash	77%
Of those:	
<i>Soap and water</i>	4 %
<i>Salt water</i>	4 %
Cover with bandage/cloth	7 %
Cover with leaves	2 %
Apply medicine	24%
Do nothing	9 %
Other	1 %
DK/NR	8 %

### Health Talks

The men who were interviewed reported participating in a health talk within the past two months more often than the women: 36% of the men reported attending, but only 19% of the women did.

ARC health team was reported to present 77% (n=89) of the health talks, whereas health center/hospital staff presented 8% of the talks, the secretario 6.0%, and CVM, World Vision, and political parties were all mentioned by less than five percent of those interviewed.

Ninety-four percent of those attending health talks reported remembering what messages were presented. The most common topics mentioned included: latrines (n=72); hygiene (n= 49) (or more specifically: HH hygiene (n=19), personal hygiene (n=5), general hygiene (n=25)); water (n=10); food/nutrition (n=4); AIDS/STDS (n=5); family planning (n=3); and diarrhea (n=3).

### TBA<sub>s</sub>

Over half of the respondents, 63% (men 62%; women 64%) knew where the closest TBA was located, and almost half, 49%, knew her name.

## Discussion

The questions were asked of both men and women to ascertain if there are any major differences between the women's and men's knowledge. Overall, there was not a large difference in knowledge; usually within ten percent of each other, with the men typically scoring higher than the women. The two exceptions were the importance of colostrum and the age a child should commence weaning foods. A surprising difference came from a practice question on the use of family planning methods, where 58% of the men reported using a method, and only 32% of women did. In this case, asking only men or only women would have provided a skewed picture of the community's practices. Similarly, condom usage when asking men was reported as quite a bit higher than it was when asking women. It is difficult to know if the differences are true reflections of reality, or if it has more to do with the type of questions and how different genders respond. For example, perhaps the men may report higher use of condoms and family planning methods because they feel it's the 'macho' thing to do; whereas, women may feel shy about answering this sort of question, and therefore under report usage.

## Prenatal Consultations

The women's knowledge about why a pregnant woman should seek prenatal care corresponded well with the number of women receiving prenatal care. It was surprising that men were more aware than the women of why a pregnant woman should receive prenatal care. Men were also better informed about when a pregnant woman should go for prenatal care. One possible explanation for this is that men often have more access to community meetings and therefore more access to Health Education.

The majority of the women receiving prenatal care, 77%, responded that they had received tetanus toxoid vaccinations, with an average of more than two TTV received. Risk factors were available only for five of the women, not enough information to be representative of the population. At least both of the women considered at risk had received prenatal care and one of the births was assisted by a trained health worker.

## Diet of a Pregnant Woman

Most of the respondents knew that a pregnant woman should change her diet, and half of those respondents also knew that she should eat a better diet. However, household distribution of meat demonstrated that there is still limited understanding of the importance of good nutrition for women.

## Deliveries

Overall, 46% of the deliveries were assisted by a trained health worker: 13% by a trained TBA and 32% by health facility staff. Although 33% of the deliveries occurred at a health facility, only 32% of the mothers reported being assisted by health facility personnel. Perhaps one woman was assisted by a trained TBA at the health facility. The percentage of births assisted by trained health personnel could rise by 12-17% by training those TBAs reported as untrained or training not known. The training of traditional birthing attendants is essential to decreasing the Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) for Mozambique.

## Understanding The Importance of Colostrum

The number of women giving colostrum to their newborns (71%) differed greatly from the number of women who actually understood why it is important to give colostrum (46%). Only 12% of the women could actually verbalize why. Often women responded that they gave it because there was nothing else to give. The woman, in a future delivery may chose tea, water or another nursing mother if they are available which would jeopardize the health of the child. Other common misconceptions were that colostrum was dirty or the baby might get sick.

Not providing colostrum to the child is a particularly difficult custom to change because there is active social pressure by husbands, TBAs, family, and neighbors not to give colostrum. Teaching on colostrum will have to be wide spread and will have to include men and traditional health providers in order to positively effect change.

## Weaning foods

When asking mothers when they started giving, or plan to give, their infants other food or liquid in addition to the breast milk, very few (19%) followed the Mozambique Ministry of Health (MOH) or the WHO/UNICEF guidelines of adding other foods at 4 months and 4-6 months, respectively. Thirty-four percent reported adding other foods too early: before four months. And the remainder didn't know or said they began to give additional foods after six months.

## Family Nutrition

Few respondents mentioned eating foods from the three basic food groups, 13% mentioned eating foods from more than one food group, and most of the respondents just mentioned that energy foods should be eaten to enhance one's overall health. Grains, the communities' staple diet, are what were mentioned most, maybe because that is what everyone eats everyday. Other things which are not as readily available nor affordable, such as meat, milk, and vegetables, were not mentioned. Field experience shows that men and women believe that because the man works outside the home and is physically bigger, he needs more meat. It is hoped that if knowledge about the importance of eating protective and body-building foods is increased, even though they are not available nor affordable, the population should be able to correctly respond to the question. And perhaps with increased nutritional knowledge, more demand would exist and more products would be made available in the protective and body-building food categories.

Those who sell the food they produce, 34% of the respondents, have a better chance of eating a more varied diet since they can purchase those items which they do not produce. However the desire for a varied diet will have to be nourished through consistent health education.

## Distribution Of Food Within The Family

The question concerning food distribution confirmed earlier suspicions, that if there's special food, like meat, available for a meal, the women and children, those who need it most, will not usually receive any unless there's enough to first satisfy the men. Young children, 3-5 years old, may be given a chance to eat their fill when they eat by themselves, although this practice isn't very common.

## Family Planning

The two methods cited and used the most often were methods from health centers or stores (modern methods) and abstinence. The modern method reported as being used the most was oral contraceptives. A few other interesting responses, all given by men, which demonstrate some lack of understanding about family planning include: 'marry 2nd wife', 'sleep with someone else', 'work far away', 'spend nights drinking'. Most of these 'methods' would only prevent their wife from getting pregnant, but not necessarily prevent another woman from getting pregnant.

About one-half of the respondents knew that at least two years should elapse between the birth of one child and the start of the next pregnancy. If the respondents also put this knowledge into practice, then the mother's risk will be greatly reduced. The practice of spacing births has a strong base in the teachings provided by the traditional health providers. The amulet tied around the mother's waist is placed by the Curandeiro (Traditional healer) and only removed when the child is seen to be strong and healthy.

## AIDS/STDs

The great majority have heard of AIDS, but knowledge of how it is transmitted or prevented was low. Still, the overall knowledge is higher than for many other topics, so some education is certainly reaching the people. Most of the respondents knew AIDS was transmitted through sex, but few mentioned the other methods of transmission. Also, very few respondents made a distinction between unprotected and protected sex. Most respondents cited reduction of risk through reducing the number of sexual partners or remaining faithful to their partner/spouse. Almost 20% mentioned using condoms as a means to reduce one's risk of contracting AIDS. But 30% thought that AIDS was preventable through injection.

Unfortunately, misconceptions of AIDS spreading through social contact exist, and therefore it makes care for someone with AIDS more difficult, and it places the AIDS victim in a socially isolated situation since others are afraid to go too close.

It appears that some knowledge about AIDS is present in the communities perhaps partially attributable to previous health education received in the refugee camps or promotion by the Mozambican Ministry of Health by radio and posters. However, not enough information has been passed on especially to wives and children. This is also, most likely a result of men's increased access to community meetings and health education. Also, many social customs prohibit women from taking an active role in decisions about sex. Women fear that if they ask their husbands to use a condom, then the husband would suspect the woman of being dirty and therefore a prostitute.

Either few had, or few admitted, or few realized that they had an STD in the past two years (4%). If this is an accurate figure the rate of morbidity from STDs is much lower than expected. However, the number appears to be artificially low, perhaps because of the sensitive nature of the topic and because of lack of knowledge of symptoms. This is especially true for women who only have sex with their husbands. They believe that they have little reason to suspect that they have an STD and therefore, they might identify the STD symptoms as something else. This belief does not take into account the accepted practice of multiple partners for Mozambican men.

## Condoms

With AIDS such a big problem, and multiple partners often accepted, condoms are an important strategy for prevention of AIDS. But still, although three-quarters of the respondents knew what a condom was, not many use them: about one-quarter of the men and one-tenth of the women. And unfortunately, only about one-third of the women could ask their partner/husband to use a condom, and only one-third of the men would use one even if the woman did ask.

## Immunization

Often times a survey question on immunizations asks at what age a child should receive her/his measles vaccination. On this survey, however, the interest was on whether the communities even knew measles could be prevented through a vaccine and at what age a child needs to receive his/her first vaccination. It was felt that if a parent knows when a child needs his/her first vaccination, and the parent takes the child for vaccination, then the timing of subsequent visits will be explained each time they go for vaccines. Sixty-three percent knew the approximate start day for vaccines, and 58% knew that measles is preventable through vaccination.

## Malaria

Although malaria is a common cause of morbidity and mortality, very few people understand how malaria is transmitted or prevented. Almost half of the households surveyed had someone in their HH who had an illness that they identified as malaria within the past two months. And most respondents knew at least one of the major symptoms of malaria: fever, muscle aches, and headaches. But only fourteen percent of the respondents realized that malaria is spread by mosquitoes. Another ten percent attributed malaria transmission to lack of personal or HH hygiene, including not having a latrine. The number of respondents who held the misconception that malaria is transmitted through lack of hygiene was of particular concern because more of these responses came from places where ARC HELP teams have been in place the longest teaching about the importance of good hygiene. The reason that this is of special concern is that if communities see latrines as the sole preventive measure and they become ill with malaria, they may possibly negate the benefits of the latrine.

## TBAs

TBAs are not as well known by the community as expected. Only about half of the respondents knew the TBA's name, and 63% knew where she lived. This may be explained by the fact that many community members, including TBAs are only recently returning to their homes of origin. Community structures continue to be in flux and are currently being rebuilt.

## Recommendations

Health education on the primary health care topics included in the survey, as well as others, should be provided in the communities. Emphasis should be placed on the topics where knowledge and good health practices were low. Health education messages should take into account the correct responses and misconceptions provided during the survey. Health education messages need to be kept short and simple. Literacy was found to be low, so message transmission should not rely on written materials and should be transmitted in the local languages of the communities using interesting and varied forms of non-formal adult educational methodologies (e.g. puppets, songs, dramas, posters). Individual as well as group health education sessions should be conducted in order to reach as many community members as possible. Since the men appeared to have better access to health education messages, the Activistas should attempt to increase the access to health education for women through health meetings directed at women's groups and through household visits. Discussions with the community members should be conducted regularly to better understand the health concerns and constraints, and to arrive at solutions to their health problems together.

Improved knowledge of health, and easily replicated activities and teaching aids that use widely available local materials should be emphasized. This way, when people move they will have their health knowledge which they can take with them and put into practice wherever they go.

The Activista program as proposed in the Introduction of this report should be implemented. Curriculum development should take into account the survey results.

ARC should conduct follow-up surveys at six-months and at the end of the program to monitor and evaluate program activities. Additional means of gathering information for assessing, monitoring, and evaluating program activities should also be implemented, e.g. focus groups, observations, etc.

### Safe motherhood

- Raise awareness of community members about the importance of having all deliveries assisted by a trained health worker
- Teach warning signals for high risk pregnancies in order that women can make informed decisions about where to deliver their babies
- Additional TBAs should be trained so that the number of available trained health workers in the communities is increased.
- Communities should select the TBAs to be trained in order to ensure that the TBA is respected and will be utilized by the community.
- Health education should focus on the importance of prenatal visits and deliveries assisted by trained health workers
- Tetanus toxoid vaccinations (TTV) should be encouraged, at least two vaccinations should be received by each woman of reproductive age.
- Activistas should work side by side with Ministry officials and NGOs in all vaccination campaigns.
- Locations of health facilities providing prenatal consultations, TTV, and referrals for deliveries of at-risk mothers should be listed out and provided to all communities and ARC field staff.
- Lists of trained TBAs need to be updated regularly. Demonstrations and group discussions on nutrition should be a regular part of the Activista program.

### Weaning and breast-feeding/Family Nutrition

- Further weaning and breast-feeding education is needed with an emphasis on the timing and preparation of weaning foods
- Because many diets are based almost solely on maize teaching will have to have a strong component of the three basic food groups and the importance of planting other fruits and vegetables in addition to maize.
- Health education should be especially strong before planting begins and directly before the harvest to encourage the community to put health as the priority especially in terms of how family income is utilized.
- Health education will need to focus on the need for children to have their own bowls and to eat several small meals during the day as opposed to three large meals.
- More information on colostrum is also needed. Men, women and traditional health providers should be included in the education.

### Family Planning

- Education about family planning methods is needed.
- ARC should try to increase knowledge about which methods are available in each site and give honest and direct answers in order to help lessen fears of side effects.
- ARC should also assist in making methods more available, whenever possible.

ARC will attempt to build on traditional beliefs and encourage more efficacious methods in addition to the amulet around the mother's waist and a longer waiting period. We hope to collaborate with the Traditional Birth Attendants and the Curanderos on this topic as well as others.

### AIDS/STDs and Condoms

- More information about AIDS and STDs needs to be transmitted.
- Both sexes need additional education on the benefits of condoms.
- Women need to be empowered so they can more easily request that a condom be used.
- Men need to be further educated as to why they should use a condom, and why a woman may request that one be used.
- ARC should collaborate with the Ministry of Education, Ministry of Health and other interested NGOs to develop a School AIDS Education Program.

### Malaria

- Both the HELP teams and Activistas should focus on correcting the misconception that latrines prevent malaria by focusing on 2 simple and concise messages:
  - 1) Mosquitoes carry malaria and when bitten you can become infected.
  - 2) To reduce mosquitoes the community must eliminate standing and stagnant water sources.
- Additional preventive measures should be taught including appropriate dress, and utilization of mosquito nets when possible.

### **Immunizations**

- Further information on immunizations is needed to encourage community participation in regular immunizations and campaigns.
- Activistas should be knowledgeable about the times and locations that vaccinations are offered.
- Activistas should work side by side with Ministry and NGO officials during vaccination campaigns.

### **Health Talks**

- Health education needs to be spread by a variety of media.
- Smaller focused health discussions, aimed especially at women, and household visits should be attempted to try and reach more of the population.

APPENDIX 1  
ARC Mozambique Program Log Frame

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ARC Moçambique Program Logframe  
1 January 1995- 30 September 1996

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Prepared for: ARC Staff

Prepared by: Charles, Judith, Melissa, Mark, Gwen, Magombo, Julie

Date: January 8, 1996

Project: ARC-MOZ

**Project Logical Framework ARC\_MOZ**

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Goal:</p> <p>1 To improve the health of approximately 140,000 residents, returnees, and displaced persons, in the target areas of Moatize, Changara, Chifunde, and Mutarara districts of Tete Province, Mozambique</p>	<p>1.1 Decreased morbidity and mortality among the target population (beyond the scope of this project to measure)</p>	<p>1.1 CDC cites significant decreases of morbidity and mortality from similar interventions</p> <p>The primary health care approach is the key to obtaining 'Health For All' (Declaration of Alma Ata, 1978)</p>	<p>(Goal to Supergoal):</p> <p>1 Interventions sustained</p>
<p>Purpose:</p> <p>1 To improve primary health care knowledge and practices among the target population</p>	<p>1.1 (End of Project Status)</p> <p>80% of HH living within 750 m radius of ARC water point get their drinking water from that protected source</p> <p>20 % increase in PHC knowledge among adult target population</p> <p>70% of HH in target areas have and use family latrines</p> <p>50% of births in target areas are attended by a trained health worker</p> <p>ARC trainees show a 25-50 % increase in knowledge for each training</p> <p>33% of adults in target area report practicing appropriate health behaviors</p>	<p>1.1 1.2.4.6: Surveys</p> <p>3: ARC records; Visual inspection</p> <p>5: ARC records of pre/post-tests</p> <p>7.8: ARC records &amp; available population data</p>	<p>(Purpose to Goal):</p> <p>1 Environmental stability</p>

## Project Logical Framework ARC\_MOZ

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
	<p style="text-align: center;">% (CFE to add) of target population served by ARC-built health posts</p> <p style="text-align: center;">% (CFE to add) of school-aged children in target areas are served by ARC-built primary schools</p>		
<p>Outputs:</p> <p>1 Provision of clean drinking water</p> <p>Provision of sanitary facilities</p> <p>Provision of health centers/posts and equipment</p> <p>Provision of road access to project sites</p> <p>Provision of health education</p> <p>Provision of schools</p>	<p>1.1 107 protected water points constructed or rehabilitated</p> <p>Water point committees established and trained for each water point</p> <p>65 VIP latrines constructed</p> <p>8,750 family latrines constructed</p> <p>6 health centers/posts constructed or rehabilitated and equipped</p> <p>Open and maintain 230 km of access roads</p> <p>320 village-level health workers trained</p> <p>9,375 HHs visited at least once by ARC trained village-level health worker</p> <p>150,000 health education messages delivered</p> <p>5 school-based AIDS clubs established</p>	<p>1.1 1,3,4,5,6,11: visual inspection</p> <p>2,7,8,9,10: ARC reports</p>	<p>(Output to Purpose):</p> <p>1 Target population conducive to change</p> <p>Facilities utilized by target population</p> <p>Facilities maintained by GRM and target population</p> <p>Facilities staffed and supplied by appropriate Ministries</p> <p>Population remains stable</p>

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**Project Logical Framework ARC\_MOZ**

Narrative Summary (NS)	Verifiable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Activities:</p> <p>1.1 Recruit, hire, train, and supervise staff</p> <p>Secure material and equipment</p> <p>Revise administration and operation systems</p> <p>Maintain donor support</p> <p>Maintain collaboration with appropriate Ministries, NGOs, and communities</p> <p>On-going monitoring, evaluation, and revision of activities</p> <p>Implementation of program (and project activities)</p>	<p>15 classrooms constructed and furnished</p> <p>Inputs:</p> <p>Personnel (1 CD, 1 HPM, 1 HEC, 1 WPC, 0/CM, 1 AM, and project personnel)</p> <p>Material and equipment</p> <p>Transport</p> <p>Information</p> <p>Facilities</p>	<p>1.1 Budget:</p>	<p>(Activity to Output):</p> <p>1 Continued donor support</p> <p>Materials available and affordable</p> <p>Qualified staff available</p> <p>Appropriate Ministries, NGOs, and communities will cooperate and support ARC's program</p>

APPENDIX 2: PHC BASELINE KAP SURVEY  
WOMEN'S AND MEN'S QUESTIONNAIRES

AMERICAN REFUGEE COMMITTEE  
BASELINE PRIMARY HEALTH CARE KAP SURVEY  
CHIFUNDE, CHANGARA, and MOATIZE DISTRICTS  
MAY 1995

WOMEN

100 IDENTIFICATION

- 101 ID N°: \_\_\_\_\_
- 102 Village: \_\_\_\_\_
- 103 Bairro: \_\_\_\_\_
- 104 Interviewer: \_\_\_\_\_
- 105 Date: \_\_\_\_/\_\_\_\_/1995
- 106 Supervisor: \_\_\_\_\_

200 RESPONDENT'S CHARACTERISTICS

- 201 a. How many people usually live and eat here in this household (including children and workers)? \_\_\_\_\_ (total)
- b. How many women of reproductive age (15-49 years old) live here? \_\_\_\_\_
- c. How many men 15 years old or more live here? \_\_\_\_\_
- d. How many children less than two years old live here? \_\_\_\_\_
- 202 How old are you? \_\_\_\_\_ years  
IF AGE NOT KNOWN, ASK: "What year were you born?" \_\_\_\_\_
99.  DK/NR<sup>1</sup>
- 203 Did you move to another place within Mozambique or to another country because of the Frelimo/Renamo conflict?
0.  no
1.  yes
- 204 Does anyone in this household currently have a job for which he/she earns money?
0.  no (GO TO 206)
1.  yes

- 
- 205 For whom does this person or do these people work?  
(MULTIPLE RESPONSES ACCEPTED)
1.  ARC
  2.  CVM
  3.  other NGO
  4.  Ministry/ political party
  5.  self-employed
  8.  other: \_\_\_\_\_
  9.  DK/NR
- 206 Do you know how to read?
0.  no (GO TO 301)
  1.  yes
- 207 Which languages can you read?  
(MULTIPLE RESPONSES ACCEPTED)
1.  Chichewa
  2.  Chinyungwe
  3.  Portuguese
  4.  Chinyanja
  8.  other: \_\_\_\_\_
- 208 Which language do you read best, Chichewa, Chinyungwe, or Portuguese?
1.  Chichewa
  2.  Chinyungwe
  3.  Portuguese
- 209 [GIVE TO THE RESPONDENT THE PASSAGE IN THE LANGUAGE SELECTED IN 208,  
AND ASK:] "Would you please read this passage to me?"
1.  reads with ease
  2.  reads with difficulty
  9.  could not read/ refused to read

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**300 MATERNAL CARE (PRENATAL CARE AND DELIVERY)**

- 301 Why do you think a pregnant woman should consult a traditional birth attendant (TBA) or other health staff before the baby is born?  
(MULTIPLE RESPONSES ACCEPTED)
0.  no need to consult a TBA or health staff (GO TO 303)
  1.  to check for complications/ to check on progress of pregnancy
  2.  for an injection/vaccination/to prevent tetanus
  3.  for health education/advice
  8.  other: \_\_\_\_\_
  9.  DK/NR
- 302 How soon after a woman knows she is pregnant should she go for a pregnancy consultation?
1.  immediately/ within the first few months/ within 1-3 months
  2.  in the middle of her pregnancy/ within 4-6 months
  3.  at the end of her pregnancy/ within 7-9 months
  4.  at the beginning of labour or delivery
  9.  DK/NR
- 303 Should a pregnant woman change what she eats daily?
0.  no (GO TO 305)
  1.  yes
  9.  DK/NR (GO TO 305)

- 
- 304 How should a pregnant woman change what she eats?  
(MULTIPLE RESPONSES ACCEPTED)
1.  eat better food (more vegetables, milk, protein, iron)
  2.  eat more food
  3.  eat less food
  8.  other: \_\_\_\_\_
  9.  DK/NR
- 305 Are you pregnant now?
0.  no
  1.  yes (GO TO 318)
  9.  DK/NR
- 306 Have you been pregnant within the past 2 years?
0.  no (GO TO 407)
  1.  yes
  9.  DK/NR (GO TO 407)
- 307 During your last pregnancy whom did you principally visit for your pregnancy consultation?
0.  no one (GO TO 315)
  1.  health center or hospital staff
  2.  traditional birth attendant [ASK: "Has TBA been trained?"]
    - a.  untrained
    - b.  trained
    - c.  don't know if trained
  8.  other:
  9.  DK/NR
- 308 Do you have a vaccination card and/or a prenatal care "ficha" for this last pregnancy?
0.  no (GO TO 313)
  1.  yes
- 309 May I see your card, please? (IF THE CARD IS FROM ANOTHER COUNTRY AND YOU CANNOT READ IT, MARK YES SHE HAS A CARD. THEN WRITE IN THE COUNTRY THAT IT IS FROM. GO TO 313)
0.  no, card lost or not available, or she refused to show the card (GO TO 313)
  1.  yes, given the card

(DO NOT ASK THESE QUESTIONS: TAKE THE INFORMATION OFF OF THE MATERNAL HEALTH CARD)

310 How often did she go for pregnancy consultations?  
\_\_\_\_\_ times

311 How many tetanus vaccinations did she receive?  
\_\_\_\_\_ times

312 Tick all of the risk factors which are marked on the Maternal Health Card.  
(MULTIPLE RESPONSES ACCEPTED)

1.  she had already given birth to 6 or more children
2.  she was less than 16 years old or more than 35 years
3.  she had a previous difficult birth, or cesarean birth
4.  she had a previous miscarriage, abortion, or still birth
5.  her height is less than 150 cm
8.  NONE APPLY

==>> GO TO 315

313 How often did you go for pregnancy consultations?  
1.  \_\_\_\_\_ times  
9.  DK/NR

314 Have you ever received any tetanus vaccinations?  
0.  no  
1.  yes: How many? \_\_\_\_\_  
9.  DK/NR

315 What was the outcome of your most recent pregnancy?  
1.  live birth  
2.  still birth  
3.  abortion / miscarriage (GO TO 407)  
8.  other: \_\_\_\_\_  
9.  DK/NR

316 Where did you last give birth?  
1.  home  
2.  health center / hospital  
8.  other: \_\_\_\_\_  
9.  DK/NR

317 Who was the main person assisting with the delivery?  
1.  health center or hospital staff  
2.  traditional birth attendant (TBA) [ASK: "Has TBA been trained?"]  
a.  untrained  
b.  trained  
c.  don't know if trained  
3.  friend/relative/neighbor  
8.  other: \_\_\_\_\_  
9.  DK/NR

==>>GO TO 400

318 During your current pregnancy whom do you principally visit for your pregnancy consultations?

- 0.  no one (GO TO 325)
- 1.  health center or hospital staff
- 2.  traditional birth attendant [ASK: "Has TBA been trained?"]
  - a.  untrained
  - b.  trained
  - c.  don't know if trained
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

319 Do you have a vaccination card and/or a prenatal care "ficha" for this last pregnancy?

- 0.  no (GO TO 323)
- 1.  yes

320 May I see your card, please? (IF THE CARD IS FROM ANOTHER COUNTRY AND YOU CANNOT READ IT, MARK YES SHE HAS A CARD. THEN WRITE IN THE COUNTRY THAT IT IS FROM AND GO TO 323)

- 0.  no, card lost or not available, or she refused to show the card (GO TO 323)
- 1.  yes, given the card

(DO NOT ASK THESE QUESTIONS: TAKE THE INFORMATION OFF OF THE MATERNAL HEALTH CARD)

321 How often has she gone for pregnancy consultations?

\_\_\_\_\_ times

322 How many tetanus vaccinations did she receive?

\_\_\_\_\_ times

==>> GO TO 325

323 How often have you gone for pregnancy consultations?

- 1.  \_\_\_\_\_ times
- 9.  DK/NR

324 Have you ever received any tetanus vaccinations?

- 0.  no
- 1.  yes: How many? \_\_\_\_\_
- 9.  DK/NR

325 Have you been pregnant any other time in the past 2 years?

- 0.  no (GO TO 407)
- 1.  yes
- 9.  DK/NR (GO TO 407)

326 What was the outcome of the last pregnancy?

- 1.  live birth
- 2.  still birth
- 3.  abortion / miscarriage (GO TO 407)
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

327 Where did you last give birth?

- 1.  home
- 2.  health center / hospital
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

328 Who was the main person assisting with the delivery?

- 1.  health center or hospital staff
- 2.  traditional birth attendant (TBA) [ASK: "Has TBA been trained?"]
  - a.  untrained
  - b.  trained
  - c.  don't know if trained
- 3.  friend/relative/neighbor
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

400 BREAST-FEEDING AND WEANING

**ONLY IF THE WOMAN RESPONDED THAT SHE HAD A LIVE BIRTH IN QUESTION 317 OR 326 (option 1), SHOULD YOU ASK THE FOLLOWING QUESTIONS:**

Otherwise ==>> GO TO 407

401 Are you currently breast-feeding a child who is under age two?

- 0.  no, not breast-feeding (GO TO 403)
- 1.  yes, breast-feeding
- 9.  DK/NR (GO TO 407)

402 When will you stop breast-feeding him/her?

- 1.  before 6 months (before baby can sit without help)
- 2.  from 7-11 months (baby can sit without help and crawl)
- 3.  from 12-23 months (child can walk on its own)
- 4.  2 years or more (child can dress on his/her own and speak more than a few words)
- 5.  when I become pregnant again
- 6.  when my next child is born
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

==>> GO TO 404

- 
- 403 When did you stop breast-feeding him/her?
- 0.  never started breast-feeding him/her (GO TO 407)
  - 1.  before 6 months (before baby can sit without help)
  - 2.  from 7-11 months (baby can sit without help and crawl)
  - 3.  from 12-23 months (child can walk on its own)
  - 4.  2 years or more (child can dress on his/her own and speak more than a few words)
  - 5.  when I become pregnant again
  - 6.  when my next child is born
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 404 At what age will you/did you begin giving your baby other food or liquid in addition to breast milk?
- 1.  before 4 months of age
  - 2.  at 4 months
  - 3.  at 5 or 6 months
  - 4.  after 6 months of age
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 405 Did you give your newborn the colostrum (the thick yellowish breast milk produced in the first few days after birth)?
- 0.  no
  - 1.  yes (GO TO 407)
  - 9.  DK/NR (GO TO 407)
- 406 What was the main reason that you didn't give your newborn the colostrum?
- 1.  it is dirty
  - 2.  it is left over from previous baby
  - 3.  the baby could not suck
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 407 Is it important to give your newborn colostrum (the thick yellowish breast milk produced in the first few days after birth)?
- 0.  no (GO TO 409)
  - 1.  yes
  - 9.  DK/NR (GO TO 409)
- 408 Why is it important to give your newborn colostrum?  
(MULTIPLE RESPONSES ACCEPTED)
- 1.  to protect the baby against common infections
  - 2.  to stimulate the production of breast milk early on
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 409 At what age should a baby begin to receive other food or liquid in addition to breast milk?
- 1.  before 4 months of age
  - 2.  at 4 months
  - 3.  at 5 or 6 months
  - 4.  after 6 months of age
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR

---

410 When the baby first begins to receive porridge in addition to breast milk, what foods should be added to the porridge?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  sugar, oil, or fat
  - 2.  beans/nuts/fish/meat/chicken/eggs/milk
  - 3.  dark green leafy vegetables
  - 4.  orange/yellow vegetables or fruit (for example: pumpkin; mango)
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 

500 NUTRITION

501 Some people say that even if it's available and affordable, it's not important to eat a variety of foods. What do you think?

- 0.  it's NOT important to eat a variety of foods
- 1.  it IS important to eat a variety of foods
- 9.  DK/NR

502 When there is only a small amount of meat, only enough for about two people,

a. who receives the meat first?

- 1.  man
- 2.  woman
- 3.  children
- 4.  the whole family eats together (GO TO 504)
- 9.  DK/NR (GO TO 503)

b. who receives it second?

- 1.  man
- 2.  woman
- 3.  children
- 9.  DK/NR

503 With whom do the children from 3 to 5 years old usually share a bowl?

- 0.  no one; they eat by themselves
- 1.  men
- 2.  women
- 3.  older children
- 4.  no children that age
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

504 What foods should be eaten at least 3 times a week to enhance one's overall health?

(MULTIPLE RESPONSES ACCEPTED)

- 0.  maize/nsima/rice/millet/sorghum/potatoes/cassava
- 1.  vegetables/fruit
- 2.  beans/nuts/meat/fish/chicken/eggs/milk
- 3.  oils/butter/sugar
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

505 Does this household produce food? For example do you raise animals, grow crops or vegetables, or fish?

- 0.  no (GO TO 601)
- 1.  yes

506 Do you sell none, some, or all of the food that this household produces?

- 0.  none
- 1.  some
- 2.  all
- 9.  DK/NR

---

600 FAMILY PLANNING

601 What can a man and a woman do to avoid or postpone becoming pregnant?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  nothing
- 1.  use methods from health center/store (e.g., condoms, injectables, pills, IUD)
- 2.  use traditional medicine (e.g., amulets, special liquid)
- 3.  avoid sex
- 4.  exclusive breast-feeding
- 5.  withdrawal
- 8.  other: -----
- 9.  DK/NR

602 Have you and your husband or partner ever used any method to avoid or postpone getting pregnant?

- 0.  no (GO TO 604)
- 1.  yes
- 9.  DK/NR (GO TO 605)

603 What do you/did you and your husband or partner do primarily to avoid or postpone getting pregnant?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  use injectables
- 2.  take pills/tablets
- 3.  use condoms
- 4.  use an IUD
- 5.  drink or bathe with special liquid
- 6.  tie amulets around waist
- 7.  avoid sex
- 8.  exclusive breast-feeding
- 9.  withdrawal
- 88.  other: -----
- 99.  DK/NR

==>>GO TO 605

- 
- 604 What is the major reason that you and your husband or partner have not used any method to avoid or postpone getting pregnant?
- 0.  I want to get pregnant/ I want more children
  - 1.  religious reasons
  - 2.  husband/partner objects
  - 3.  fear of side effects
  - 4.  not available
  - 5.  too expensive
  - 6.  don't know of any method
  - 7.  no longer have sexual relations
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR

- 605 How much time should elapse between the birth of one child and the beginning of the next pregnancy?
- 1.  2 or more years
  - 2.  less than 2 years
  - 3.  does not matter
  - 9.  DK/NR

---

700 STDS/AIDS

- 701 Have you ever heard of a disease called AIDS?
- 0.  no (GO TO 706)
  - 1.  yes
  - 9.  DK/NR (GO TO 706)

- 702 How is AIDS transmitted?  
(MULTIPLE RESPONSES ACCEPTED)
- 0.  through sex
  - 1.  through sex without condoms
  - 2.  by having multiple sex partners
  - 3.  through bar girls
  - 4.  by sharing or using unsterilized needles or razor blades
  - 5.  from infected mother to unborn child
  - 6.  through blood transfusions from infected person
  - 7.  by sharing food, utensils, or clothes of an infected person
  - 8.  through social contact: shaking hands, hugging, kissing or being near an infected person
  - 9.  through using latrines
  - 88.  other: \_\_\_\_\_
  - 99.  DK/NR

- 703 What can one do to reduce one's risk of infection by the AIDS virus?  
(MULTIPLE RESPONSES ACCEPTED)
- 0.  nothing
  - 1.  use condoms
  - 2.  reduce number of sexual partners/remain faithful to partner(s)
  - 3.  traditional medicine
  - 4.  abstain from (avoid) sex
  - 5.  ensure needles or razors are sterilized or new
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR

---

704 Can AIDS be transmitted by shaking hands with or hugging an infected person?

- 0.  no
- 1.  yes
- 9.  DK/NR

705 Is AIDS preventable through an injection?

- 0.  no
- 1.  yes
- 9.  DK/NR

706 Have you had an STD in the past two years?

- 0.  no (GO TO 708)
- 1.  yes
- 9.  DK/NR (GO TO 708)

707 Whom did you see for treatment?

(MULTIPLE RESPONSES ACCEPTED)

- 0.  no-one/ no treatment
- 1.  no-one/ self-treatment
- 2.  health center/ hospital staff
- 3.  traditional healer
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

708 What is this? (SHOW CONDOM)

- 0.  does not know that it is a condom/ NR (GO TO 801)
- 1.  states that it is a condom
- 2.  does not know the name, but knows its use

709 Has your husband or partner ever worn a condom with you?

- 0.  no
- 1.  yes (GO TO 801)
- 9.  DK/NR

710 Could you ask your husband or partner to wear a condom?

- 0.  no
- 1.  yes
- 9.  DK/NR

---

800 IMMUNIZATIONS

801 At what age should a child receive his/her first vaccination?

- 1.  at birth
- 2.  at 6 weeks
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

802 Is measles preventable through an injection?

- 0.  no
- 1.  yes
- 9.  DK/NR

---

---

900 OTHER DISEASES / INJURIES

MALARIA

901 How is malaria transmitted?

- 1.  by mosquitoes
- 2.  from the wind
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

902 What are you currently doing to protect yourself against malaria?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  nothing
- 1.  take medicine/ go to the hospital
- 2.  cutting grass/ keep yard tidy
- 3.  eliminating standing water
- 4.  burning green leaves
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

903 Has anyone in this household had malaria in the past 2 months?

- 0.  no (GO TO 905)
- 1.  yes
- 9.  DK/NR (GO TO 905)

904 Which signs or symptoms did this person have which allowed you to know that he/she had malaria?  
(MULTIPLE RESPONSES ACCEPTED)

- 1.  fever/night sweats/chills
- 2.  headaches
- 3.  muscle aches
- 4.  diarrhea
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

---

WOUNDS

905 What should you do at HOME to care for an open cut?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  nothing
- 1.  wash it with water
- 2.  wash it with soap and water
- 3.  cover it with bandage/cloth
- 4.  cover it with mud/dung
- 5.  cover it with leaves
- 6.  apply medicine
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

---

1000 OTHER

1001 Have you participated in any health talks in the past two months?

0.  no (GO TO 1004)  
1.  yes  
9.  DK/NR (GO TO 1004)

1002 Who presented the health talk(s)?  
(MULTIPLE RESPONSES ACCEPTED)

1.  health center/hospital staff  
2.  CVM Activista  
3.  ARC health team  
8.  other: \_\_\_\_\_  
9.  DK/NR

1003 What messages were presented?

1.  remembers: (SPECIFY) \_\_\_\_\_  
9.  does not remember or no response

1004 In which bairro is the nearest TBA found?

1.  Name or number of Bairro \_\_\_\_\_  
2.  DK/NR (GO TO END)

1005 What is the name of that TBA?

1.  Name \_\_\_\_\_  
2.  DK/NR

---

---

END

THIS CONCLUDES THE INTERVIEW. PLEASE THANK THE RESPONDENT FOR HER TIME AND COOPERATION, AND AGAIN EXPLAIN THAT HER RESPONSES ARE VERY USEFUL TO US FOR THE PLANNING AND DEVELOPMENT OF HEALTH EDUCATION MESSAGES.

APPENDIX 2B: PHC BASELINE KAP SURVEY  
WOMEN'S AND MEN'S QUESTIONNAIRES

AMERICAN REFUGEE COMMITTEE  
BASELINE PRIMARY HEALTH CARE KAP SURVEY  
CHIFUNDE, CHANGARA, and MOATIZE DISTRICTS  
MAY 1995

MEN

100 IDENTIFICATION

101 ID N°: \_\_\_\_\_

102 Village: \_\_\_\_\_

103 Bairro: \_\_\_\_\_

104 Interviewer: \_\_\_\_\_

105 Date: \_\_\_\_/\_\_\_\_/1995

106 Supervisor: \_\_\_\_\_

200 RESPONDENT'S CHARACTERISTICS

201 a. How many people usually live and eat here in this household (including children and workers)? \_\_\_\_\_ (total)

b. How many women of reproductive age (15-49 years old) live here? \_\_\_\_\_

c. How many men 15 years old or more live here? \_\_\_\_\_

d. How many children less than two years old live here? \_\_\_\_\_

202 How old are you? \_\_\_\_\_ years

IF AGE NOT KNOWN, ASK: "What year were you born?" \_\_\_\_\_

99.  DK/NR<sup>2</sup>

203 Did you move to another place within Mozambique or to another country because of the Frelimo/Renamo conflict?

0.  no

1.  yes

204 Does anyone in this household currently have a job for which he/she earns money?

0.  no (GO TO 206)

1.  yes

---

205 For whom does this person or do these people work?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  ARC
- 2.  CVM
- 3.  other NGO
- 4.  Ministry/ political party
- 5.  self-employed
- 8.  other: -----
- 9.  DK/NR

206 Do you know how to read?

- 0.  no (GO TO 301)
- 1.  yes

207 Which languages can you read?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  Chichewa
- 2.  Chinyungwe
- 3.  Portuguese
- 4.  Chinyanja
- 8.  other: -----

208 Which language do you read best, Chichewa, Chinyungwe, or Portuguese?

- 1.  Chichewa
- 2.  Chinyungwe
- 3.  Portuguese

209 [GIVE TO THE RESPONDENT THE PASSAGE IN THE LANGUAGE SELECTED IN 208,  
AND ASK:] "Would you please read this passage to me?"

- 1.  reads with ease
- 2.  reads with difficulty
- 9.  could not read/ refused to read

---

300 **MATERNAL CARE (PRENATAL CARE AND DELIVERY)**

301 Why do you think a pregnant woman should consult a traditional birth attendant (TBA) or other health staff before the baby is born?

(MULTIPLE RESPONSES ACCEPTED)

- 0.  no need to consult a TBA or health staff (GO TO 303)
- 1.  to check for complications/ to check on progress of pregnancy
- 2.  for an injection/vaccination/to prevent tetanus
- 3.  for health education/advice
- 8.  other: -----
- 9.  DK/NR

302 How soon after a woman knows she is pregnant should she go for a pregnancy consultation?

- 1.  immediately/ within the first few months/ within 1-3 months
- 2.  in the middle of her pregnancy/ within 4-6 months
- 3.  at the end of her pregnancy/ within 7-9 months
- 4.  at the beginning of labour or delivery
- 9.  DK/NR

303 Should a pregnant woman change what she eats daily?

- 0.  no (GO TO 407)
- 1.  yes
- 9.  DK/NR (GO TO 407)

---

304 How should a pregnant woman change what she eats?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  eat better food (more vegetables, milk, protein, iron)
- 2.  eat more food
- 3.  eat less food
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

400 BREAST-FEEDING AND WEANING

407 Is it important to give your newborn colostrum (the thick yellowish breast milk produced in the first few days after birth)?

- 0.  no (GO TO 409)
- 1.  yes
- 9.  DK/NR (GO TO 409)

408 Why is it important to give your newborn colostrum?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  to protect the baby against common infections
- 2.  to stimulate the production of breast milk early on
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

409 At what age should a baby begin to receive other food or liquid in addition to breast milk?

- 1.  before 4 months of age
- 2.  at 4 months
- 3.  at 5 or 6 months
- 4.  after 6 months of age
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

410 When the baby first begins to receive porridge in addition to breast milk what foods should be added to the porridge?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  sugar, oil, or fat
- 2.  beans/nuts/fish/meat/chicken/eggs/milk
- 3.  dark green leafy vegetables
- 4.  orange/yellow vegetables or fruit (for example: pumpkin; mango)
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

500 NUTRITION

501 Some people say that even if it's available and affordable, it's not important to eat a variety of foods. What do you think?

- 0.  it's NOT important to eat a variety of foods
- 1.  it IS important to eat a variety of foods
- 9.  DK/NR

502 When there is only a small amount of meat, only enough for about two people,  
a. who receives the meat first?

- 1.  man
- 2.  woman
- 3.  children
- 4.  the whole family eats together (GO TO 504)
- 9.  DK/NR (GO TO 503)

b. who receives it second?

- 1.  man
- 2.  woman
- 3.  children
- 9.  DK/NR

503 With whom do the children from 3 to 5 years old usually share a bowl?

- 0.  no one; they eat by themselves
- 1.  men
- 2.  women
- 3.  older children
- 4.  no children that age
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

504 What foods should be eaten at least 3 times a week to enhance one's overall health?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  maize/nsima/rice/millet/sorghum/potatoes/cassava
- 1.  vegetables/fruit
- 2.  beans/nuts/meat/fish/chicken/eggs/milk
- 3.  oils/butter/sugar
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

505 Does this household produce food? For example do you raise animals, grow crops or  
vegetables, or fish?

- 0.  no (GO TO 601)
- 1.  yes

506 Do you sell none, some, or all of the food that this household produces?

- 0.  none
- 1.  some
- 2.  all
- 9.  DK/NR

---

## 600 FAMILY PLANNING

601 What can a man and a woman do to avoid or postpone becoming pregnant?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  nothing
- 1.  use methods from health center/store (e.g.. condoms, injectables, pills, IUD)
- 2.  use traditional medicine (e.g.. amulets, special liquid)
- 3.  avoid sex
- 4.  exclusive breast-feeding
- 5.  withdrawal
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

602 Have you and your wife or partner ever used any method to avoid or postpone getting pregnant?

- 0.  no (GO TO 604)
- 1.  yes
- 9.  DK/NR (GO TO 605)

603 What do you/did you and your wife or partner do primarily to avoid or postpone getting pregnant?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  use injectables
- 2.  take pills/tablets
- 3.  use condoms
- 4.  use an IUD
- 5.  drink or bathe with special liquid
- 6.  tie amulets around waist
- 7.  avoid sex
- 8.  exclusive breast-feeding
- 9.  withdrawal
- 88.  other: \_\_\_\_\_
- 99.  DK/NR

==>>GO TO 605

604 What is the major reason that you and your wife or partner have not used any method to avoid or postpone getting pregnant?

- 0.  I want to get pregnant/ I want more children
- 1.  religious reasons
- 2.  husband/partner objects
- 3.  fear of side effects
- 4.  not available
- 5.  too expensive
- 6.  don't know of any method
- 7.  no longer have sexual relations
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

605 How much time should elapse between the birth of one child and the beginning of the next pregnancy?

- 1.  2 or more years
- 2.  less than 2 years
- 3.  does not matter
- 9.  DK/NR

---

700 STDS/AIDS

701 Have you ever heard of a disease called AIDS?

- 0.  no (GO TO 706)
- 1.  yes
- 9.  DK/NR (GO TO 706)

- 
- 702 How is AIDS transmitted?  
(MULTIPLE RESPONSES ACCEPTED)
- 0.  through sex
  - 1.  through sex without condoms
  - 2.  by having multiple sex partners
  - 3.  through bar girls
  - 4.  by sharing or using unsterilized needles or razor blades
  - 5.  from infected mother to unborn child
  - 6.  through blood transfusions from infected person
  - 7.  by sharing food, utensils, or clothes of an infected person
  - 8.  through social contact: shaking hands, hugging, kissing or being near an infected person
  - 9.  through using latrines
  - 88.  other: \_\_\_\_\_
  - 99.  DK/NR
- 703 What can one do to reduce one's risk of infection by the AIDS virus?  
(MULTIPLE RESPONSES ACCEPTED)
- 0.  nothing
  - 1.  use condoms
  - 2.  reduce number of sexual partners/remain faithful to partner(s)
  - 3.  traditional medicine
  - 4.  abstain from (avoid) sex
  - 5.  ensure needles or razors are sterilized or new
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 704 Can AIDS be transmitted by shaking hands with or hugging an infected person?
- 0.  no
  - 1.  yes
  - 9.  DK/NR
- 705 Is AIDS preventable through an injection?
- 0.  no
  - 1.  yes
  - 9.  DK/NR
- 706 Have you had an STD in the past two years?
- 0.  no (GO TO 708)
  - 1.  yes
  - 9.  DK/NR (GO TO 708)
- 707 Whom did you see for treatment?  
(MULTIPLE RESPONSES ACCEPTED)
- 0.  no-one/ no treatment
  - 1.  no-one/ self-treatment
  - 2.  health center/ hospital staff
  - 3.  traditional healer
  - 8.  other: \_\_\_\_\_
  - 9.  DK/NR
- 708 What is this? (SHOW CONDOM)
- 0.  does not know that it is a condom/ NR (GO TO 801)
  - 1.  states that it is a condom
  - 2.  does not know the name, but knows its use

- 
- 709 Have you ever worn a condom?  
0.  no  
1.  yes (GO TO 801)  
9.  DK/NR

- 710 If you wife or partner asked you to wear a condom, would you?  
0.  no  
1.  yes  
9.  DK/NR

---

**800 IMMUNIZATIONS**

- 801 At what age should a child receive his/her first vaccination?  
1.  at birth  
2.  at 6 weeks  
8.  other: \_\_\_\_\_  
9.  DK/NR

- 802 Is measles preventable through an injection?  
0.  no  
1.  yes  
9.  DK/NR

---

**900 OTHER DISEASES / INJURIES**

**MALARIA**

- 901 How is malaria transmitted?  
1.  by mosquitoes  
2.  from the wind  
8.  other: \_\_\_\_\_  
9.  DK/NR

- 902 What are you currently doing to protect yourself against malaria?  
(MULTIPLE RESPONSES ACCEPTED)  
0.  nothing  
1.  take medicine/ go to the hospital  
2.  cutting grass/ keep yard tidy  
3.  eliminating standing water  
4.  burning green leaves  
8.  other: \_\_\_\_\_  
9.  DK/NR

- 903 Has anyone in this household had malaria in the past 2 months?  
0.  no (GO TO 905)  
1.  yes  
9.  DK/NR (GO TO 905)

- 904 Which signs or symptoms did this person have which allowed you to know that he/she had malaria?  
(MULTIPLE RESPONSES ACCEPTED)  
1.  fever/night sweats/chills  
2.  headaches  
3.  muscle aches  
4.  diarrhea  
8.  other: \_\_\_\_\_  
9.  DK/NR

**WOUNDS**

---

905 What should you do at HOME to care for an open cut?  
(MULTIPLE RESPONSES ACCEPTED)

- 0.  nothing
- 1.  wash it with water
- 2.  wash it with soap and water
- 3.  cover it with bandage/cloth
- 4.  cover it with mud/dung
- 5.  cover it with leaves
- 6.  apply medicine
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

---

**1000 OTHER**

1001 Have you participated in any health talks in the past two months?

- 0.  no (GO TO 1004)
- 1.  yes
- 9.  DK/NR (GO TO 1004)

1002 Who presented the health talk(s)?

(MULTIPLE RESPONSES ACCEPTED)

- 1.  health center/hospital staff
- 2.  CVM Activista
- 3.  ARC health team
- 8.  other: \_\_\_\_\_
- 9.  DK/NR

1003 What messages were presented?

- 1.  remembers: (SPECIFY) \_\_\_\_\_
- 9.  does not remember or no response

1004 In which bairro is the nearest TBA found?

- 1.  Name or number of Bairro \_\_\_\_\_
- 2.  DK/NR (GO TO END)

1005 What is the name of that TBA?

- 1.  Name \_\_\_\_\_
- 2.  DK/NR

---

END

THIS CONCLUDES THE INTERVIEW. PLEASE THANK THE RESPONDENT FOR HIS TIME AND COOPERATION, AND AGAIN EXPLAIN THAT HIS RESPONSES ARE VERY USEFUL TO US FOR THE PLANNING AND DEVELOPMENT OF HEALTH EDUCATION MESSAGES.

**SHORT PASSAGE TO TEST LITERACY IN QUESTION 209  
PHC BASELINE KAP SURVEY**

Passagem Curta: PORTUGUES

Tape sempre os recipientes da água com um prato ou com uma bandeja.

---

Passagem Curta: NYUNGWE

Mbagwanakhirani bzombo bzwa madzi na mbale ayai na phande.

---

Passagem Curta: CHICHEWA

Vundikirani zidebe ndi mitsuko yamadzi ndi mbale kapena lichero.

## APPENDIX 3

Distribution of Clusters by District, Project site, and Bairro

District	Project Site	Bairro	Clusters
<i>Changara</i>	Chioco	Nhamavibvi	1
	Marara	Bairro 1	1
		Bairro 4	1
	Mazoe Ponte	Bairro 1	1
		Bairro 2	2
		Bairro 3	1
	M'saua	Bairro 1	1
		Bairro 3	1
		Bairro 5	1
Muchamba	Bairro 3	1	
<i>Moatize</i>	Kaphiridzanje	Sede	2
		Nthudzi	1
		Kadzongue	3
		Benga	1
		Samoa I	1
		Nhambulu I	2
		Nhambulu II	1
<i>Chifunde</i>	Thequesse	Adamu (Bairro 3)	1
	Namiramba	Cabango (Bairro 3)	1
		Caputo Sede (Bairro 5)	1
	Bulimo	Bairro 3	1
	Chifunde Sede	Sede (Bairro 1)	1
		Kagogu (Bairro 3)	1
	Nsadzu	Bairro 2	1
Palinji (Bairro 9)		1	
<b>Total Clusters</b>			<b>30</b>