

**Assessment of Social and Behavior
Change Communication (SBCC) in the
U.S. Agency for International
Development Office of Food for Peace
(USAID/FFP) Title II Multi-Year
Assistance Programs (MYAPs) in
Mozambique**

May 2012

This report is made possible by the generous support of the American people through the support of the Office of Health, Infectious Diseases, and Nutrition, Bureau for Global Health, United States Agency for International Development (USAID) and USAID/Mozambique, under terms of Cooperative Agreement No. AID-OAA-A-12-00005, through FANTA, managed by FHI 360.

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Unpublished May 2012

Recommended Citation:

FANTA. 2012. *Assessment of Social and Behavior Change Communication (SBCC) in the U.S. Agency for International Development Office of Food for Peace (USAID/FFP) Title II Multi-Year Assistance Programs (MYAPs) in Mozambique.* Washington, DC: FHI 360/FANTA.

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Acknowledgments

The Social and Behavior Change Communication (SBCC) team extends its gratitude to the following individuals that provided technical and logistical support to the authors in their field visits while in Mozambique: Maria Pinto (United States Agency for International Development [USAID]/Mozambique); Choi Lin Silva, Paulo Defelice (World Vision); Farai Muchigual and Anselmo Lisboa (Adventist Development and Relief Agency), Agy Herminio, Said Amur, Salva Baldizon, and Milly Djevi (Save the Children); and Gino Regina and Enrique Maradiaga (Africare). The team also thanks Title II multi-year assistance program organization staff with whom it met in Maputo and the many field staff that assisted with logistics and organization for the field visits and shared valuable information with the SBCC team. The SBCC team deeply appreciates all the support and assistance.

In addition, the team would like to extend its appreciation to the numerous staff from the Government of the Republic of Mozambique with whom it met, including staff from the Department of Nutrition of the Ministry of Health and provincial and district directors of health in Zambezia and Nampula provinces. The team also thanks the many individuals from USAID/Mozambique with whom it met, as well as staff from UNICEF. Appreciation is also extended to staff from FHI 360's Community Clinical HIV/AIDS Service Strengthening project for meeting with the team. The team extends many thanks to all the above for providing extremely valuable information for the assessment.

The team is also very grateful to the many community members with whom it met who so openly shared their experiences and enriched the team's knowledge and understanding of SBCC programming within their communities.

The SBCC team also wishes to thank USAID/Mozambique for providing review comments on earlier drafts of this assessment report.

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Abbreviations and Acronyms

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
ANC	antenatal care
BCC	behavior change communication
CHC	Community Health Council
CHV	community health volunteer
CLC	Conselho de Líderes Comunitários
ComCHASS	Community Clinical HIV/AIDS Service Strengthening
CSC	Conselhos de Saúde Comunitária
DANIDA	Danish International Development Agency
DAP	Development Assistance Program
DDS	Direcção Distrital de Saúde (District Directorate of Health)
DPS	Direcção Provincial de Saúde (Provincial Directorate of Health)
ENA	Essential Nutrition Actions
FANTA-2	Food and Nutrition Technical Assistance II Project (FANTA-2 Bridge)
FFP	Food for Peace
FTF	Feed the Future
FY	fiscal year
GHI	Global Health Initiative
GMP	growth monitoring and promotion
GRM	Government of the Republic of Mozambique
HIV	human immunodeficiency virus
IEC	information, education, and communication
IMNCI	Integrated Management of Neonatal and Childhood Illness
IPC	interpersonal communication
IPTT	Indicator Performance Tracking Table
IYCF	infant and young child feeding
LLIN	long-lasting insecticidal net
LQAS	Lot Quality Assurance Sampling
M&E	monitoring and evaluation
MAM	moderate acute malnutrition
MCHN	maternal and child health and nutrition
MISAU	Ministério da Saúde (Ministry of Health)
MUAC	mid-upper arm circumference
MYAP	multi-year assistance program
NGO	nongovernmental organization
ODN	Oficial Distrital de Nutrição
OPN	Oficial Provincial de Nutrição
ORS	oral rehydration salts
PAMRDCM	Plano de Acção Multisectorial para a Redução da Desnutrição Crónica em Moçambique 2011–2014

PARPA	Plano de Acção para a Redução de Pobreza Absoluta
PD	positive deviance
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PNB	Pacote Nutricional Básico (Basic Nutrition Package)
SAM	severe acute malnutrition
SANA	Segurança Alimentar Através de Nutrição e Agricultura (Food Security through Nutrition and Agriculture)
SBCC	social and behavior change communication
SC	Save the Children
SCIP	Strengthening Communities through Integrated Programming
SDSMAS	Serviços Distritais de Saúde, Mulher e Acção Social
SO	Strategic Objective
U.N.	United Nations
U.S.	United States
USAID	U.S. Agency for International Development
USG	United States Government
WHO	World Health Organization
WV	World Vision

Executive Summary

Introduction

In Mozambique, the Food for Peace (FFP) Title II Multi-Year Assistance Programs (MYAPs) implemented FY 2008–present and their predecessor projects, the Development Assistance Programs (DAPs) implemented FY 2001–2007, have worked to develop and implement activities to improve the nutritional status of children, pregnant and lactating women, and their families. These programs have never been collectively evaluated using a standardized methodology to fully document their successes, lessons learned, and promising practices, as well as gaps and challenges with regard to social and behavior change communication (SBCC) activities. Given this concern, the United States Government (USG) in Mozambique requested the Food and Nutrition Technical Assistance II Project (FANTA-2 Bridge) to analyze current MYAP SBCC strategies, activities, and materials related to preventing undernutrition in children under 5, with a specific focus on those under 2 years of age, as part of the MYAPs in Zambezia and Nampula provinces.

Objectives

The overall purpose of this assessment was to document lessons learned, best practices, and challenges of current SBCC activities. The assessment findings are intended to be used to strengthen current programming and inform new programs implemented by the U.S. Agency for International Development (USAID) and the Government of the Republic of Mozambique (GRM) Ministério da Saúde (MISAU) (Ministry of Health).

The specific objectives of the assessment were to:

- Describe the SBCC approach related to preventing undernutrition used by each of the USG partners implementing a MYAP
- Describe the SBCC materials (pamphlets/posters, etc.) used by the USG partners implementing the MYAPs
- Describe the implementation of SBCC activities by the USG partners implementing the MYAPs
- Identify specific approaches, materials, and activities (“best practices”) that are having an impact on promoting positive nutrition attitudes, practices, and behaviors among target populations
- Identify lessons learned through implementing SBCC activities as part of the MYAPs
- Identify aspects of SBCC approaches, materials, and activities needing improvement
- Recommend how SBCC approaches, materials, and activities could be improved
- Recommend how to overcome barriers related to gender that result in poor nutritional status among women and children under 2 years of age

Methods

The assessment focused on the SBCC activities of World Vision (WV) and the Adventist Development and Relief Agency (ADRA) in Zambezia Province and of Save the Children (SC) and Africare in Nampula Province. Sites were selected by the MYAP partners, in collaboration with the Nutrition Technician at the Direcção Provincial de Saúde (DPS) (Provincial Directorate of Health). Given time limitations, visits were focused in three districts in Zambezia Province and three districts in Nampula Province where SBCC activities had strong implementation and good coverage, as defined by the MYAP partners and the DPS. Visits were also made to the DPS and the Serviços Distritais de Saúde, Mulher e Acção Social (SDSMAS) (District Services of Health, Women and

Social Action). Data collection took place through a review of existing documents, key informant interviews, group discussions with community members, and direct observation of SBCC activities. The SBCC activities examined as part of the assessment included those related to infant and young child feeding (IYCF), sanitation and hygiene, agricultural production and use of nutritious foods in the household, and management of household resources to ensure presence of adequate and nutritious food.

The assessment uses the “C-Planning” process as a model to analyze MYAP activities and as a framework to organize the assessment findings and recommendations. The C-Planning process, developed by FHI 360, was adapted from several other frameworks used with success during the past two decades, including the National Cancer Institute’s Health Communication Program Cycle (1989); the Academy for Educational Development’s Tool Box for Building Health Communication Capacity (1995); and the Johns Hopkins University, Center for Communication Programs’ P-Process (2003). While commonly used SBCC planning processes may vary slightly from program to program, the steps of C-Planning are generally accepted as best practices in SBCC today.

Summary of SBCC in GRM Policies, Strategies, Plans, and Protocols

There are several GRM policies, strategies, plans, and protocols that directly or indirectly include nutrition-related SBCC. The GRM has a national policy on neonatal and infant health, a National Strategy for Health Promotion, and a separate strategy for community involvement in health that all include aspects of SBCC such as empowering communities to improve their health and training health workers and community volunteers in participatory educational methods, interpersonal communication (IPC), counseling, and community mobilization.^{1,2,3} GRM plans related to SBCC include a draft of the GRM’s strategic health sector plan for 2007–2012, a MISAU Department of Nutrition 2004 document on the strategic component of the national nutrition development plan, the multisectoral action plan for the reduction of chronic malnutrition (*Plano de Acção Multisectorial para a Redução da Desnutrição Crónica em Moçambique 2011–2014* [PAMRDCM]), which is the GRM’s key plan to reduce stunting and includes several SBCC activities under each strategic objective, and a communication and social mobilization plan for promoting, protecting, and assisting breastfeeding.^{4,5,6,7}

MISAU’s Pacote Nutricional Básico (PNB) (Basic Nutrition Package) is designed to serve as a resource for health staff for learning during training and as an ongoing resource in their work so they may know what, when, and how to educate mothers/caregivers to improve nutritional status for children, women, and families.⁸ In 2006, MISAU developed an orientation manual for staff that deliver nutrition education messages to assist them in supporting positive behaviors and changing poor behaviors related to food intake.⁹ The “Well Child and Child-at-Risk Clinic Protocols” define

¹ MISAU. 2006. *Pólítica Nacional de Saúde Neonatal e Infantil em Moçambique*. Direcção Nacional de Saúde, Departamento de Saúde da Comunidade, Secção da Saúde Infantil. pp. 38, 41.

² GRM. 2010. *Estratégia Nacional para a Promoção da Saúde*. MISAU, Direcção Nacional de Saúde Pública. pp. 20–30, 36.

³ GRM. 2004. *Estratégia de Envolvimento Comunitário*. MISAU. pp. 11, 17.

⁴ GRM. n.d. *Plano Estratégico do Sector Saúde 2007–2012, 1º Rascunho (Não Citar)*. MISAU. pp. 43, 63.

⁵ GRM. 2004. *Componente Estratégica do Plano de Desenvolvimento Nutricional em Moçambique*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição. pp. 51–52.

⁶ GRM. 2010. PAMRDCM.

⁷ GRM. 2009. *Plano de Comunicação e Mobilização Social para a Promoção, Protecção e Apoio ao Aleitamento Materno*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição.

⁸ GRM. 2007. *Manual do Participante, Orientação para Introdução do Pacote Nutricional Básico ao Nível das Unidades Sanitárias Urbanas e Rurais, 3ª Versão*. Dirigido aos Trabalhadores de Saúde, MISAU, Direcção Nacional de Promoção da Saúde e Controlo das Doenças, Departamento de Nutrição. p. i.

⁹ GRM. 2006. *Manual de orientação para a mudança de hábitos e práticas alimentares negativas, com base nas principais constatações nas regiões sul, centro e norte de Moçambique*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição.

one of the principal activities of health staff in the well child clinic as providing orientation to caregivers about IYCF.¹⁰

Summary of SBCC in USG Strategies, Plans, and Programs

The USG Feed the Future (FTF) FY 2011–2015 Multi-Year Strategy for Mozambique recognizes that progress in reducing undernutrition among children under 5 years of age in Mozambique has slowed since 2003 due in part to poor nutrition behaviors.¹¹ The USG’s Country Assistance Strategy for Mozambique 2009–2014, under its third goal to improve the health of Mozambicans, includes activities to increase community participation by establishing sustainable *Conselhos de Líderes Comunitários* (CLCs) (Community Leadership Councils) and training community-based health workers in behavior change communication (BCC).

Summary of Main Findings

A summary of assessment findings includes the following.

Understanding the Situation

Some MYAP partners conducted studies and assessments (formative investigations) to better understand determinants of behaviors and barriers to behavior change. However, others did not.

Focusing and Designing

Overall SBCC strategy. Information available from MYAP partners regarding their SBCC strategies included only descriptions of desired changes, audiences, and interventions (including channels and activities). The MYAP partners did not complete a comprehensive process of developing SBCC strategies, such as the C-Planning process described in Section 5. Therefore, there are no comprehensive documents containing a full description of the MYAP SBCC strategies.

Desired changes and key messages. Main desired changes could be gleaned from the MYAP proposals, and were numerous, covering various topics, such as IYCF, maternal nutrition, water and food hygiene, and food processing, among others. While each of the MYAP partners has an extensive list of key messages for its programs, it does not appear that the messages were developed to match the intended audience’s need and motivation with the most compelling solution, which should outweigh or at least address the barriers the audiences face.

Audiences. Target audiences for improving nutrition for the MYAPs included children under 5 years of age, with a focus on children under 2. The primary audiences for nutrition and health SBCC activities included mothers and fathers of children under 5 and, in some cases, pregnant and lactating women. Secondary audiences included communities. However, activities were not differentiated in age groups (for children) and everyone received the same messages and demonstrations.

Interventions. Each MYAP partner used a mutually reinforcing mix of interpersonal, community-based, and BCC approaches. Many activities took place through community health councils (CHCs), community health volunteers (CHVs), and mother/fathers groups through home visits; community groups, such as the farmers associations and women’s groups; community gatherings; and some partners also used mass media through radio programs. However, advocacy, a key component to a comprehensive SBCC program, was not a part of any of the partners’ programs.

¹⁰ Ibrahimo, N.A.; Fernandes N.; and Mikusova, S.M. 2011. *Ficha Técnica, Normas de Atendimento à Criança Sadia e à Criança em Risco*, República de Moçambique, Ministério de Saúde. p. 14.

¹¹ USG. 2011. *Feed the Future FY 2011–2015 Multi-Year Strategy*. p. 5.

Best intervention practices. Several MYAP intervention practices are noteworthy as promising practices, including support for development of strong, high-functioning community leadership, integration of nutrition in agriculture associations, community planning tools, formation of junior farmer groups, and use of radio for messaging.

Creating

Materials. BCC materials used in the MYAP programs were produced by the MYAP partners, either individually or in coordination with each other, adapted from materials from the DAP, developed with the Strengthening Communities through Integrated Programming (SCIP) project, or were MISAU materials. Materials included various flipcharts, posters, recipes, and manuals. MYAP awardees stated that the materials were based on MISAU protocols and materials, such as the PNB. A few materials were pretested by some MYAP awardees, but pretesting was not consistently conducted for all materials by all awardees.

Some MYAP awardees provided community volunteers with bicycles or other support materials, such as identification cards, t-shirts, caps, bags, or materials for cooking demonstrations, while others did not. Few SBCC materials were observed being used by volunteers in the communities during the assessment and those materials observed were in Portuguese. Volunteers shared the need for SBCC materials with large graphics suitable for use with mothers/fathers groups. A poster that included a written guide for engaging the audience was a good example of the interactive methods that should be taught to volunteers and field workers.

Implementing and Monitoring

Staffing structure. The staffing structure and general technical capacity of MYAP staff seemed adequate.

Training. MYAP partners used a cascade training model with regular retraining of staff and volunteers. Most training materials were taken directly or adapted from MISAU materials, including the PNB and Integrated Management of Neonatal and Childhood Illness (IMNCI) manuals. Materials for health and nutrition technicians were more detailed and technically oriented, while for volunteers materials were simplified and shortened and used more images. Materials were all in Portuguese, and were translated into local languages by the technicians during trainings as needed. Generally, field staff and volunteers received little if any training in IPC specifically or SBCC methods more generally.

Coordination with partners. MYAP partners coordinated with the DPS and Direção Distrital de Saúde (DDS) (District Directorate of Health) through a continuous exchange of information regarding project activities through regular reports and coordination meetings and joint supervisory visits. The DPS Nutrition Technician (*técnico de nutrição*) participated in training sessions, and MYAP staff and CHVs also assisted mobile brigades in the communities. Coordination with partners implementing SCIP was strong to complement and fill gaps in each program and cross-train staff on the different topics covered by each program

Coverage. Coverage among MYAP awardees differed by partner, and the way coverage was expressed also differed. For example, ADRA staff estimated coverage was on average 4 percent of the population in each project district, with between 40 percent and 60 percent of communities covered, while SC estimated that 30 percent of mothers in project communities were covered. Communities did not appear to have a vision of graduating from the MYAP activities.

Supportive supervision. Supervision plans varied by MYAP partner, ranging from one visit per month to one visit every 3 months for more senior field staff; weekly to quarterly visits for technicians; and 1–2 visits per month for community volunteers. Supervision visits were either recorded in books or recommendations provided verbally, and supervisors generally had supervision

tools or the tools were being developed. In some cases, managers were specifically trained in supervision, while in other MYAP programs they were not. The collection, reporting, and analysis of monitoring and evaluation (M&E) data were also supervised. One MYAP specifically mentioned collaborating with the SDSMAS on supervision. Generally, the number of supervisors appeared adequate. However, supportive supervision visits to volunteers were not always performed as often as planned because other priorities sometimes conflicted.

Evaluating and Replanning

MYAP partners routinely collected information on program inputs, processes, and outputs, and conducted annual surveys among beneficiaries to monitor outcomes of their program activities. All of the MYAP partners reported using monitoring information to evaluate program activities, weaknesses, gaps, and impact at the community level, and had planning meetings to address issues at the program and community levels. Many of the MYAP monitoring indicators related to whether a behavior was being practiced. However, attitudes and beliefs change before people adopt new behaviors; therefore, it is useful to monitor attitudes and beliefs in addition to the actual behaviors. For example, when beliefs and attitudes are changing but behavior is not, barriers to behavior change may not be sufficiently addressed by the SBCC program or there has not been enough time for the behavior to become a “habit.”

Recommendations

Based on the analysis of results from the SBCC assessment of the MYAPs, the following is recommended for future USAID/Washington- and USAID/Mozambique-funded programs in Mozambique, organized by the critical steps in SBCC design, implementation, and M&E.

Understanding the Situation

- Use a SBCC planning process such as C-Planning, which includes formative research or analysis of secondary formative work, to inform the SBCC strategies and activities.

Focusing and Designing

Overall SBCC Strategy

- Develop an integrated health and nutrition SBCC strategy for USG-supported programs.
- Develop a brand for interventions such as the MYAPs aimed at reducing chronic malnutrition.
- Ensure program-level SBCC strategies take into consideration SBCC components of GRM policies, strategies, plans, and protocols.
- Ensure SBCC strategies include a strong gender component and analysis and incorporation of gender issues, including facilitators and barriers to women’s and children’s improved nutrition and health.

Desired Changes and Key Messages

- Concentrate SBCC efforts on promoting evidence-based Essential Nutrition Actions (ENA), key household hygiene actions, and preventive and curative practices proven to improve nutritional status.
- Improve messages to discuss only one or two key points according to the principles of the “Seven C’s of Communication.”¹²
- Target messages and SBCC activities according to age groups and lifecycle stages.
- Link the desired behavior with results that demonstrate successful outcomes of that behavior.

¹² Piotrow, P. et al. 1997. *Health Communication: Lessons from family planning and reproductive health*. Westport: Praeger.

- Ensure desired changes and messages address gender-related barriers to improved nutrition for women of reproductive age and children under 2 years of age.
- Ensure that desired changes and messages promote shared responsibility for nutrition at the family and community levels and clarify roles and responsibilities for family and community members so that they are clear on actions and behaviors that they can take or adopt to support mothers' and children's nutrition.

Audiences

- Target children under 2 years of age, pregnant women, and women of reproductive age as the primary audiences most directly affected by malnutrition.
- Conduct audience consultations.
- Focus more activities and target specific messages to fathers, grandmothers, and mothers-in-law as key target audiences.
- Include messages for health facility workers, as they are also a key audience indirectly influencing community-level nutrition and health behaviors, to ensure nutrition and health messages are consistent between health facilities and communities.

Interventions

- Include advocacy, social and community mobilization, and BCC in SBCC strategic approaches.
- Include a mutually reinforcing mix of communication channels, including interpersonal channels, community-based channels, and mass media channels.
- Continue to support community structures, such as the *Grupos de Suporte* (community support groups) and CHCs, to mobilize community leadership and members to support behavior change and address barriers to behavior change.
- Integrate nutrition and agriculture activities as a way to involve fathers and husbands in supporting the health and nutrition of their families.
- Expand and strengthen the use of community planning tools to link nutrition and agriculture together, as well as to create participatory plans to increase coverage and for graduation from program support.
- Expand junior farmer groups and other activities that target older children that are often the caregivers of younger siblings and young women.
- Expand and strengthen the use of entertainment education, such as radio programming and theatrical groups.
- Promote the participation of women in agricultural marketing cooperatives and other income-generating activities.
- Analyze the impact of interventions on women and men and adjust interventions as necessary to support women and “do no harm” with regard to women's position in the family and community, burden of labor, and decision-making power.

Creating

Materials

- Develop materials using a guided process as outlined in C-Planning, including development of creative briefs and pretesting with target audiences.
- Research, identify, and pretest the types of job aids and support materials most effectively used by community workers to support IPC.

- Analyze materials for gender considerations and test materials with both women and men of different ages and life stages to ensure that the messages and illustrations support women and “do no harm” and convey shared roles and responsibilities for nutrition.
- Consider assigning one partner or an SBCC contractor to employ a team of SBCC experts to conduct the research needed to design BCC materials and a standard toolkit for volunteers, which they can receive after completing training.

Implementing and Monitoring

- Train staff in SBCC, particularly IPC or SBCC communication techniques.
- Future programs should consider:
 - ♦ Implementing a plan for the basic training and mentorship of management and technical/supervisory staff in SBCC and communication methods.
 - ♦ Developing curricula in SBCC and communication methods for management and technical/supervisory staff and field workers.
 - ♦ Implementing a plan for building the capacity of field workers and volunteers in SBCC and communication methods.
 - ♦ Deploying instructors adept in SBCC methods to teach SBCC and communication methods at all levels, rather than relying on the cascade approach to training.
 - ♦ Improving frequency of supervision and developing/adapting supervision checklists to ensure that key aspects of the defined SBCC strategy are supervised/monitored, including integration of project components (nutrition, agriculture, health) and gender issues.
 - ♦ Employing synchronous “best-to-many” distance learning techniques, such as those described in “Re-Inventing Health Care Training in the Developing World: The Case for Satellite Applications in Rural Environments.”¹³ In “best-to-many” techniques, participants learn directly from the best teachers available in the country. This contrasts with cascade learning, where the quality of teaching and learning success deteriorates with each successive cascade.
- USAID/Mozambique may also consider developing a tool to assist its staff to evaluate whether proposals and programs are following state-of-the-art practice in design and implementation of SBCC program components, modeled on the C-planning process discussed in this report.

Evaluating and Replanning

- Align monitoring indicators with the key behaviors being promoted.
- Investigate the barriers to using Lot Quality Assurance Sampling (LQAS) and other methods of gathering monitoring indicators at disaggregated levels.

¹³ Haridasan, K.; Rangajaran, S.; and Pirio, G. 2009. “Re-Inventing Health Care Training in the Developing World: The Case for Satellite Applications in Rural Environments.” *Online Journal of Space Communications*.

1. Introduction

In Mozambique, the Food for Peace (FFP) Title II Multi-Year Assistance Programs (MYAPs) implemented FY 2008–present and their predecessor projects, the Development Assistance Programs (DAPs) implemented FY 2001–2007, have worked to develop and implement activities to improve the nutritional status of children, pregnant and lactating women, and their families. These programs have never been collectively evaluated using a standardized methodology to fully document their successes, lessons learned, and promising practices, as well as gaps and challenges with regard to social and behavior change communication (SBCC) activities.

Given this concern, the United States Government (USG) in Mozambique requested the Food and Nutrition Technical Assistance II Project (FANTA-2 Bridge) to analyze current MYAP SBCC strategies, activities, and materials related to preventing undernutrition in children under 5, with a specific focus on those under 2 years of age, as part of the MYAPs in Zambezia and Nampula provinces. The overall purpose of this assessment was to document lessons learned, best practices, and challenges of current SBCC activities. The assessment findings are intended to be used to strengthen current programming and inform new programs implemented by the United States Agency for International Development (USAID) and the Government of the Republic of Mozambique (GRM) Ministério da Saúde (MISAU) (Ministry of Health).

The assessment uses the “C-Planning” process as a model to analyze MYAP activities and as a framework to organize the assessment findings and recommendations. The C-Planning process, developed by FHI 360, was adapted from several other frameworks used with success during the past two decades, including the National Cancer Institute’s Health Communication Program Cycle (1989); the Academy for Educational Development’s Tool Box for Building Health Communication Capacity (1995); and the Johns Hopkins University, Center for Communication Programs’ P-Process (2003). While commonly used SBCC planning processes may vary slightly from program to program, the steps of C-Planning are generally accepted as best practices in SBCC today.

This assessment report provides background information regarding the context for the SBCC assessment, the overall and specific objectives of the assessment, and the methods used for collection and analysis of information. The assessment report also summarizes characteristics of SBCC, including the SBCC process, strategy components, models, and interventions, and provides an overview of nutrition-related SBCC within key GRM and USG documents. Findings are presented regarding the SBCC approaches and interventions used by the MYAP partners based on interviews, field visits, and observations in assessment topic areas and a review of key documents. Lastly, the report provides recommendations to strengthen SBCC in current programming and to inform SBCC within new USAID nutrition programs to prevent undernutrition.

2. Background

Although the GRM has made great economic and political advances since the end of Mozambique's 16-year civil war in 1992, the country remains one of the poorest in the world, with widespread poverty and food insecurity and high levels of undernutrition among young children. Mozambique ranks 172 out of 182 countries in the United Nations (U.N.) Human Development Index; 55 percent of the overall population lives in poverty with no improvement in overall poverty since 2003; and 38 percent of the population has food consumption levels that fall below the threshold to meet minimum energy requirements.^{14,15,16} According to World Health Organization (WHO) standards of classification, the level of stunting among children under 5 years of age is very high, 44 percent.^{17,18} The prevalence of stunting and underweight increases dramatically between the ages of 6 months and 23 months.¹⁹ In addition, the high prevalence of HIV infection continues to be a serious problem in Mozambique. Nationally, the prevalence of HIV infection is 11.5 percent. However, among women the prevalence is even higher (13.1 percent), compared to men (9.2 percent).²⁰

Regarding the persistently high levels of chronic undernutrition in Mozambique, a 2009 evaluation of the GRM's poverty reduction strategy (*Plano de Acção para a Redução de Probreza Absoluta* [PARPA] II) recommended actions to accelerate the prevention and reduction of chronic undernutrition, including development of a plan of action to reduce chronic undernutrition, which was completed in 2010 (*Plano de Acção Multisectorial para a Redução da Desnutrição Crónica em Moçambique 2011–2014* [PAMRDCM]).²¹ The action plan has identified the prevalence of low height-for-age (stunting) as the target measurement to be reduced from 44 percent in 2008²² to 30 percent by 2015 and to 20 percent by 2020.²³ The plan emphasizes the following target groups: adolescent girls, women of reproductive age before and during pregnancy and during lactation, and children under 2 years of age. The plan focuses on improving access to and use of nutritious foods and improving coordination, monitoring and evaluation (M&E), advocacy, and social mobilization on activities to reduce chronic undernutrition. The action plan also incorporates interministerial coordination and is led by MISAU.

The USG in Mozambique is implementing various programs with nutrition components that support prevention of undernutrition. By far the largest programs focusing on prevention of undernutrition are the FFP Title II MYAPs active in Nampula, Zambezia, and Cabo Delgado. The Title II MYAPs dedicate a significant portion of resources to community-based nutrition programs to prevent undernutrition, including mothers groups, mobile brigades, community-level nutrition education, and

¹⁴ The U.N. Human Development Index provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and gross enrollment in education), and having a decent standard of living (measured by purchasing power parity and income). Accessed October 30, 2010. http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs MOZ.html.

¹⁵ GRM. 2010. *Poverty and Wellbeing in Mozambique: Third National Poverty Assessment*. Ministry of Planning and Development, National Directorate of Studies and Policy Analysis. p. 26.

¹⁶ Food and Agriculture Organization of the United Nations. 2009. Accessed October 28, 2010. <http://www.fao.org/economic/ess/ess-fs/en/>

¹⁷ WHO. 1995. According to WHO, prevalence of stunting \geq 40 percent is very high, 30–39 percent is high, 20–29 percent is medium, and $<$ 20 percent is low. p. 208.

¹⁸ National Statistics Institute. 2009. p. 7.

¹⁹ National Statistics Institute. 2005. *Inquérito Demográfico e de Saúde 2003, Instituto Nacional de Estatística*. MISAU. Calverton, Maryland: Measure DHS+/ORC Macro. p. 181.

²⁰ MISAU, Instituto Nacional de Saúde. 2010. *Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique, INSIDA 2009, Relatório Preliminar Sobre a Prevalência da Infecção por HIV*. p. 7.

²¹ Please note the Integrated Nutrition Investment Framework will refer to this GRM action plan by the English translation of the Portuguese document, which uses the term “malnutrition” rather than “undernutrition.” Undernutrition is the term used in FTF.

²² Multiple Indicator Cluster Surveys. 2008.

²³ GRM. 2010. PAMRDCM. p. 41.

referral of children with severe acute malnutrition (SAM) or moderate acute malnutrition (MAM) to health centers.

The Title II programs are scheduled to end in 2012. For community-based interventions and SBCC activities that require time to become established and result in positive change in practices, it is important to capture what works and what has not. In Mozambique, the MYAPs and their predecessor projects, the DAPs, have worked over the last 10 years to develop and implement activities at the community level to reinforce positive nutrition-related behaviors among pregnant and lactating women and mothers/caregivers to improve the nutritional status of children, pregnant and lactating women, and their families. These programs have never been collectively evaluated using a standardized methodology to fully document their successes, lessons learned, and promising practices, as well as gaps and challenges with regard to SBCC activities to reduce undernutrition. Given this concern, the USG in Mozambique requested this assessment to analyze current MYAP SBCC strategies, activities, and materials related to preventing undernutrition in children under 5, with a specific focus on those under 2 years of age.

3. Objectives

The overall purpose of this assessment was to document lessons learned, best practices, and challenges of current SBCC activities of the MYAP partners in Mozambique related to preventing undernutrition in children under 5 years of age and pregnant and lactating women. The assessment findings are intended to be used to strengthen current programming and inform new programs implemented by USAID and the GRM's MISAU.

The SBCC activities examined as part of the assessment included those related to infant and young child feeding (IYCF), sanitation and hygiene, agricultural production and use of nutritious foods in the household, and management of household resources to ensure presence of adequate and nutritious food. This assessment focused on the SBCC activities of World Vision (WV) and the Adventist Development and Relief Agency (ADRA) in Zambezia Province and of Save the Children (SC) and Africare in Nampula Province. See **Annex 1** for a Map of MYAP provinces and districts visited by the SBCC field team.

The specific objectives of the assessment were to:

- Describe the SBCC approach related to preventing undernutrition used by each of the USG partners implementing a MYAP
- Describe the SBCC materials (pamphlets/posters, etc.) used by the USG partners implementing the MYAPs
- Describe the implementation of SBCC activities by the USG partners implementing the MYAPs
- Identify specific approaches, materials, and activities (“best practices”) that are having an impact on promoting positive nutrition attitudes, practices, and behaviors among target populations
- Identify lessons learned through implementing SBCC activities as a part of the MYAPs
- Identify aspects of SBCC approaches, materials, and activities needing improvement
- Recommend how SBCC approaches, materials, and activities could be improved
- Recommend how to overcome barriers related to gender that result in poor nutritional status among women and children under 2 years of age.

4. Methods

4.1 SBCC Assessment Team

The SBCC assessment team was composed of FANTA-2 Bridge consultants Gregory Pirio and Carolyn D'Alessio O'Donnell. The team members worked collaboratively to prepare for the assessment and to collect and analyze the assessment data. The assessment was further supported by FANTA-2 Bridge Maternal and Child Health and Nutrition Advisor Monica Woldt, FANTA-2 Bridge Senior Nutrition and HIV Project Associate Melanie Remane, FANTA-2 Bridge Maternal and Child Health and Nutrition Specialist Tara Kovach, and FANTA-2 Bridge Nutrition Advisor Alison Tumilowicz.

4.2 Sample Population

Selection of Assessment Sites

The assessment sites were selected from the MYAP areas in Nampula and Zambezia provinces. A MYAP is also operating in Cabo Delgado province. However, given time limitations, USAID/Mozambique requested the SBCC team focus data collection in MYAP areas in Nampula and Zambezia, particularly given that these are focal provinces for USAID/Mozambique for their Global Health Initiative (GHI)-, FTF-, and United States President's Emergency Plan for AIDS Relief (PEPFAR)-funded programs, among others.

Sites were selected from among the WV and ADRA sites in Zambezia and from among the SC MYAP sites in Nampula. Africare is a partner in SC's MYAP and Africare sites were also visited. Sites were selected by the MYAP partners, in collaboration with the Nutrition Technician at the Direção Provincial de Saúde (DPS) (Provincial Directorate of Health). WV implements its MYAP in a total of 330 communities, while ADRA operates in approximately 271 communities and SC operates its nutrition activities in 2,124 communities, 77 of which are Africare communities. Sites for the field visits were selected from among these communities.

Given time limitations, visits were focused in three districts in Zambezia Province and in three districts in Nampula Province where SBCC activities had strong implementation and good coverage, as defined by the MYAP partners and the DPS. Visits were also made to the DPS and the Direção Distrital de Saúde (DDS) (District Directorate of Health).

Selection of MYAP Staff and Participants at the Community Level

The process of selecting MYAP staff to interview used purposive sampling and included staff that are managers, technical staff in nutrition or agriculture that manage, train, and/or supervise staff, and community health volunteers (CHVs) and agriculture promoters/volunteers that implement SBCC activities.

Selection of participants at the community level was based on a convenience sample of community members that agreed to participate at the time the SBCC team visited the community. Participants were mobilized prior to the visit by MYAP staff and were met in both a large group and smaller group settings. Participants included mothers/caregivers of children under 5 years of age, fathers and grandmothers, CHVs, support groups, mothers and fathers groups, agriculture promoters/volunteers, members of the agricultural groups, and community leaders.

4.3 Data Collection

Data collection took place through a review of existing documents, key informant interviews, group discussions with community members, and direct observation of SBCC activities. The schedule of the

SBCC team's field activities can be found in **Annex 2**. Assessment instruments can be found under **Annex 3** and include five interview guides:

- Interview Guide for Provincial and District Public Health Officials
- Interview Guide for Community Health Volunteers
- Interview Guide for Targeted Beneficiaries
- Interview Guide for Partner Staff
- Interview Guide for Agricultural Field Workers

Interviews of MISAU, DPS, DDS, and MYAP staff were conducted in Portuguese. Interviews with community-level groups were conducted in either Portuguese or the local language with a local translator. Lead interviewers were native Portuguese speakers or speakers fluent in Portuguese.

The assessment followed standard ethical guidelines for confidentiality. Internal Review Board exemption for the assessment was received from USAID/Mozambique based on the following criteria.

1. The assessment is not considered experimental biomedical research that involves human subjects.
2. Information collected is not specific to human subjects nor is it highly sensitive or confidential.
3. Survey data and/or literature that maybe reviewed is already publicly available.
4. The goal of the assessment is to improve the SBCC programs in Mozambique so it falls under the category of Operational or Operations Research (Ref. USAID Human Subject Research Policy, Section 5 (d) – “Operational/operations research or service delivery research includes research on service delivery systems for the purpose of understanding how they function and how to improve efficiency and effectiveness”²⁴).

Document Review

The SBCC team reviewed key country, USAID, and MYAP partner project proposals, annual results reports, M&E reports, Indicator Performance Tracking Tables (IPTTs), and other documents, including:

- USAID/Mozambique MYAP baseline, midterm, and final evaluation reports; annual reports; M&E reports; formative research results; special studies; supervision and quality improvement reports/results, SBCC materials (job aids, BCC materials, training materials, etc.)
- PAMRDCM
- Evaluation of Knowledge and Practices of Health Professionals in Relation to the Basic Nutrition Package, March 28, 2011
- *Pacote Nutricional Básico* (PNB) (Basic Nutrition Package), MISAU
- USG Integrated Nutrition Investment Framework, Sections 1–5
- USAID Program Nutrition Analysis/Mapping against GRM, Global Hunger and Food Security Initiative/FTF priorities
- USAID Mission Country Strategies and Frameworks
- USG FTF Multi-Year Strategy
- SC, Revision and Development of the Behavior Change Strategy for Nutritional Objectives, September 2009

²⁴ USAID, n.d. *USAID Human Subjects Research Guidelines, Procedures for Protection of Human Subjects in Research Supported by USAID*. p. 5.

- Pathfinder International, Strengthening Communities through Integrated Programming (SCIP) – Program Description, Nampula²⁵
- WV, SCIP – Program Description, Zambezia

The SBCC team also reviewed a series of MISAU PowerPoint presentations used as modules in the training of nutrition field workers based on MISAU’s PNB (2006).

4.4 Summary of SBCC Field Activities

The SBCC team field schedule can be found in **Annex 2**. A summary of field site visits is presented in **Table 1**.

²⁵ SCIP is a USAID/Mozambique-funded program designed to integrate programming beyond sector-specific activities in Zambezia and Nampula provinces. The program focuses on maternal and child health, malaria, nutrition, and reproductive health/family planning; HIV prevention, care, and treatment; strengthening of MISAU institutions; orphans and vulnerable children; water, sanitation, and hygiene; and, in addition in Zambezia, micro-enterprise development. In Nampula, the focus starts at the health facility level and flows down to the community, whereas in Zambezia, the emphasis is in the community and developing its links to the health facility. MYAP and SCIP programs collaborate and coordinate their implementation in Zambezia and Nampula provinces.

Table 1. Summary of Field Site Visits

Community Name	District	Province	MYAP Partner
Chinde	Namacurra	Zambezia	WV
3 de Fevereiro	Lugela	Zambezia	ADRA
Nassabão	Lugela	Zambezia	ADRA
Nanzua	Gurue	Zambezia	WV
Moripa	Gurue	Zambezia	WV
Cresci	Gurue	Zambezia	WV
Murrimo	Gurue	Zambezia	WV
Napala	Monapo	Nampula	Africare
Sanhote	Monapo	Nampula	Africare
Namassica	Nacala Porto	Nampula	SC
Murrupelele	Nacala Porto	Nampula	SC
Pedreira	Mussoril	Nampula	SC
Ampivene	Mussoril	Nampula	SC

Community Meetings

In each community visited, there was a community meeting organized for the SBCC team. Community meetings included the participation of community leaders, MYAP technical field staff, health and leadership committees, agriculture association members, health and nutrition volunteers, and program beneficiaries. Interviews were conducted in a group with a convenience sample of people who chose to attend the community meetings. Interviews lasted 2–3 hours, and the discussion and scope of questions were based on the interview guides but evolved over the course of the conversation based on community responses. The SBCC team conducted additional small group interviews with technical field staff and community volunteers after each community-wide meeting.

Information was sought and obtained on a variety of topics, including community mobilization and leadership, agriculture practices, food security and food shortage, nutrition and health knowledge and practices, program structure, training and materials, program participation and activities, program benefits and impact, and community and individual challenges in health, nutrition, and agriculture.

Rapid Assessment Interviews with Beneficiaries

Following the larger community meeting, the SBCC team conducted individual interviews with mothers that participated in the program as beneficiaries. All mothers interviewed participated in monthly group meetings with program volunteers and/or had individual household visits from volunteers. Mothers interviewed consisted of a convenience sample of those that attended the community meeting and volunteered to speak with the SBCC team members. Depending on availability of beneficiaries, three to five mothers were interviewed in each community. The purpose of these interviews was to assess the knowledge and behavior change in beneficiaries of the program. Interviews were conducted in the local language with the assistance of a translator. The interview questionnaire addressed areas of nutrition

(breastfeeding, complementary feeding, and diet diversity), sanitation and hygiene, malaria prevention, agriculture practices, and household food security, as well as opinions of the program and perceptions regarding program impact.

Interviews with MYAP Partner Staff

Prior to initiating field work, WV, SC, and Africare provincial senior staff and specialists briefed the SBCC team on their programs. Due to a cancellation of flights, plans for a similar briefing with ADRA staff prior to field visits had to be cancelled, but ADRA was able to brief the team at the conclusion of the meetings with ADRA-served communities. Throughout the period of fieldwork, the SBCC team had numerous opportunities to interact and ask questions of program district-level personnel and field workers. At the end of the field work in Nampula Province, SC and Africare organized an out-briefing for provincial-level management and program personnel, at which the team was able to explain its preliminary findings and receive additional feedback.

DPS and DDS Interviews

The SBCC team conducted interviews with staff of the DPS in Quelimane and Nampula, the provincial capitals of Zambezia and Nampula provinces, respectively. In both cases, the team spoke with the director. In Zambezia Province, team members also met with two DDS directors in Lugela and Gurue districts. The purpose of these meetings was to inform the directors of the intended visits in the province/district, answer questions or concerns about the assessment, and understand the director's vision and plan for nutrition and SBCC activities in the province/district. A formal letter describing the SBCC team's activities was given to each director.

Visit to Gurue Community Radio Station

The SBCC team visited the Gurue Community Radio Station in Zambezia Province and met with the station administrator to learn about the health programming that was being aired, the financial situation of the station, and the producers of the health radio programs.

5. Characteristics of SBCC²⁶

5.1 The Socio-Ecological Model

Over the years, there has been a shift in thinking about human behavior. For example, 20 years ago, health communication practitioners largely believed that behavior change would result directly from giving correct information about prevention. While providing correct information is an important part of behavior change, information alone has proved to be insufficient. Four key facts about human behavior are now widely acknowledged:

1. People make meaning of information based on the context in which they live.
2. Culture and networks influence people's behavior.
3. People cannot always control the issues that determine their behavior.
4. People are not always rational in deciding what is best for their health and well-being.

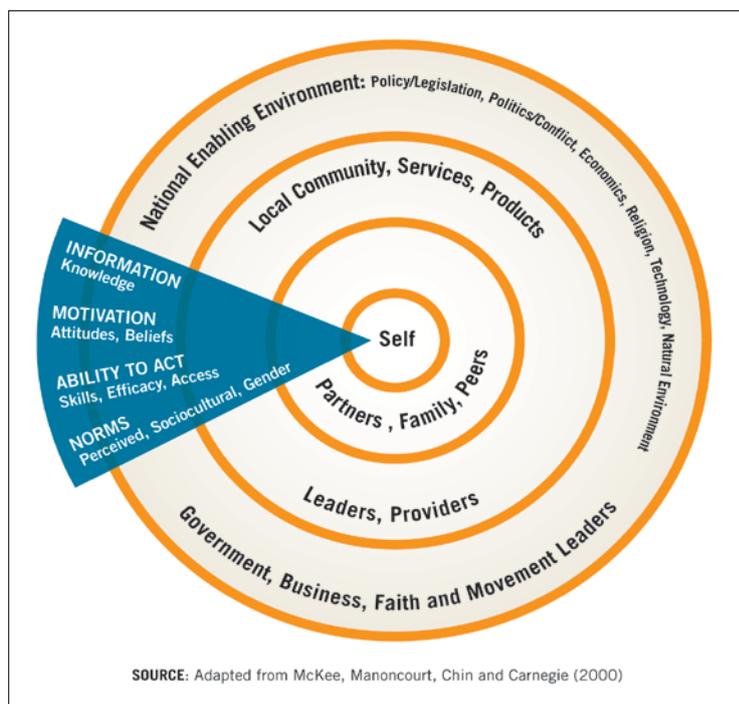
Theories and models are instrumental for program planners to identify and make explicit the assumptions behind interventions and strategies; they help clarify the reasons why programs succeed or fail.²⁷ A model is often used to describe an application of theory to a particular case. While several models exist, the Socio-Ecological Model, illustrated in **Figure 1**, demonstrates the evolution of thinking from approaches focused on the individual alone to those considering social conditions. This comprehensive model examines several levels of influence to find the “tipping point” for change and examines individual knowledge and motivation, as well as social/gender norms, skills, and enabling environment. It was developed based on existing theories, models, and approaches from several disciplines, including political science, sociology, psychology, and communication. The Socio-Ecological Model views individual behavior as a product of multiple overlapping individual, social, and environmental influences, and combines individual change with the aim to influence the social context in which the individual operates.

In this model, levels of analysis are represented by the rings, which show domains of influence as well as the people representing them at each level. The “self” ring represents those most affected by the issue. The next two rings represent those that have direct contact with those most affected and influence their attitudes, beliefs, and actions. They may shape community and gender norms and/or access to and demand for community resources and existing services. The outermost ring includes those that indirectly influence those most affected by the issue and represent the enabling environment. Components of this ring may facilitate or hinder change and include government policies and regulations, political forces, prevailing economic conditions, the private sector, religion, technology, and the natural environment.

²⁶ The content of this section is adapted from: C-Change. 2011. *C-Modules: A Learning Package for Social and Behavior Change Communication*. Washington, DC: FHI 360/C-Change.

²⁷ McKee, N. et al. 2000. *Involving People Evolving Behavior*. Penang: Southbound.

Figure 1. The Socio-Ecological Model



Each level is influenced by four main cross-cutting factors that SBCC interventions may be able to modify to generate change. These factors may act in isolation or in combination and are discussed below.

Information. People need information that is timely, accessible, and relevant. With such information, some individuals, groups, or communities may be empowered to act. For most people, however, information is not enough to ignite change.

Motivation. Motivation, represented by attitudes and beliefs about the issues, is needed. Motivation can be affected by SBCC through effective counseling, peer education, or radio programs, for example. If done well, such communication can foster individual attitudinal and behavioral change, as well as social norm change. However, even motivation may not be enough.

Ability to Act. In particular circumstances, especially those that may pose a threat or that involve strong gender or social norms against the behavior, people need the ability to act. Skills needed for the ability to act include problem solving, decision making, negotiation, critical and creative thinking, and interpersonal communication (IPC), for example. Efficacy, the confidence of individuals and groups in their own skills to affect change, access to services and transportation, and the ability to buy a diversity of foods, for example, are important elements in the ability to act.

Norms. Finally, norms, as expressed in perceived, socio-cultural, and gender norms, have considerable influence. Norms reflect the values of the group and specify those actions that are expected of the individual by its surrounding society. Perceived norms are those that an individual believes others are holding and therefore are expected of him or herself. Socio-cultural norms are those that the community as a whole is following because of social status or cultural conventions. Gender norms shape the society's view on what is expected of males and females.

5.2 SBCC Process

SBCC is an interactive, researched, and planned process aimed at changing social conditions and individual behaviors. This assessment uses the “C-Planning” process as a model to analyze MYAP

activities and as a framework to organize the assessment findings and recommendations. **Figure 2** illustrates the C-Planning steps of a systematic SBCC program design. While commonly used SBCC planning processes may vary slightly from program to program, the steps of C-Planning are generally accepted as best practices in SBCC today.

Figure 2. The C-Planning Process



Understanding the situation should be the first step in any communication effort. This requires looking at the effects and the direct and indirect causes of the problem; defining people affected and influencing; and examining their context, including determining the desired changes per audience and barriers to that change. In this step, formative research is conducted to understand the local context and to analyze secondary quantitative and/or qualitative data.

In the next step, “Focusing & Designing,” appropriate communication objectives are created, directly addressing key social and behavioral barriers to ensure efforts are relevant to selected audiences. The strategic approach and positioning for a comprehensive campaign is decided, as is an appropriate and mutually reinforcing channel mix.

In the third step, “Creating,” the emphasis is on developing communication materials and shaping the required activities. Creative briefs outlining the key messages, including the promise of the message (i.e., the most compelling benefit that the target audience will receive from their perspective by taking the desired action) and the “call to action” (i.e., what the audience should do or where they need to go for products or services), are developed. These messages take into account information gathered in each of the previous steps and address identified barriers. Also at this stage audience research and concept testing/pretesting is undertaken to ensure that the materials in development are appropriate and relevant to their intended audiences and evoke the required responses.

In the fourth step, programs move to implementation and address issues related to planning budgets, capacity, and quality control.

Finally, for outcome and sustainability, in the “Evaluating & Replanning” step, it is important to learn from the experiences of the program and to ensure that they guide the next round of work. However, research, monitoring, and evaluation does not happen only at the end of the process. It is relevant throughout, in gathering baseline information, in setting measurable communication objectives, and in monitoring implementation plans.

5.3 Components of a SBCC Strategy

A SBCC strategy, developed in the second step C-Planning, is a tool that enables communication practitioners to bridge between the analysis of the situation and the creation of materials and activities. It provides direction and ensures that different materials and activities all ultimately work well together and support each other toward a clear vision of change. **Table 2** outlines the components of a communication strategy.

Table 2. Components of a Communication Strategy

Component	Description
Problem statement	This should summarize the problem based on your audience and context analysis.
Changes the problem calls for	<ul style="list-style-type: none"> • What changes (in policy, services, products, social norms, or individual behaviors) would lessen the problem? • Consider how these changes might come about through communication. • A Change Statement captures the direction you've decided makes most sense to respond effectively to the current problem as you understand it.
Final audience segmentation	<ul style="list-style-type: none"> • Which audiences (people most affected, directly influencing, or indirectly influencing become your primary, secondary, and tertiary audiences) would need to be addressed for these changes to occur? • Which audience segments are a priority and why?
Desired changes	<ul style="list-style-type: none"> • What do you want your audiences to change: attitude, behavior, value, perception, skills, social norms, policies, or something else?
Barriers	<ul style="list-style-type: none"> • What gets in the way of the changes you described above? From your analysis, name the main reasons why the audiences currently do not do this.
Communication objectives	Establish smart communication objectives for each audience segment. Address the key barriers just named. For example: By the end of the project there will be an increase in the proportion of _____ (audience segment)... 1. <u>who know</u> ; 2. <u>who feel confident</u> that; 3. <u>who start</u> a dialogue about; 4. <u>who do</u> or <u>take steps to do</u> ; 5. <u>who learn skills</u> to. . .
Strategic approach	<ul style="list-style-type: none"> • How do we bring all our communication objectives together into one approach to work toward change? • How will your materials and activities link together and support each other with reinforcing messages?
Positioning	<ul style="list-style-type: none"> • How do you want people to remember your program or campaign? Work on presenting your approach in such a way that it stands out from other comparable or competing issues. • What is the distinctive logo or image that you want people to associate with your program?
Key content	<ul style="list-style-type: none"> • What are the key content points to be communicated through each channel for each audience segment? Note: These are not messages; those will be developed later.
Channels, activities, and materials	Select channels, activities and materials for each audience based on how to effectively reach a majority of them. Consider the way channels reinforce each other to create an "environment of change." For example, a program might use IPC at a community level, which then links to billboards and radio programs.
Draft implementation plan	Develop a brief plan that provides detail on each activity and material with a corresponding timeline and M&E plan.

5.4 Strategic Approaches and Channels

Strategic Approaches

The strategic approach is one of the most important elements in a communication strategy because it drives the program—it tells you *how* the communication objectives will be achieved. While objectives are specific (they spell out what needs to be achieved), approaches are descriptive. **Figure 3** shows the three key SBCC strategies, all of which are mutually reinforcing:

- Advocacy to raise resources and political and social leadership commitment for development action and goals
- Social and community mobilization for wider participation, coalition building, and ownership
- BCC for changes in knowledge, attitudes, and practices of specific participants/audiences in programs

Figure 3. Three Key SBCC Strategies



Channels

Communication channels can be categorized into three basic types: interpersonal channels, community-based channels, and mass media channels (**Table 3**). The greatest impact will be achieved by strategically combining communication channels with each other. Within each category, multiple activities can be employed. Ideally, the different channels send mutually reinforcing messages.

Table 3. Channel Types

Channel Type	Examples of Materials, Products, and Activities
Interpersonal	<ul style="list-style-type: none"> • One-to-one communication, such as provider-to-client, peer-to-peer, and partner-to-partner exchanges and counseling • Training and skills-building activities in small groups • Visits with leaders and politicians • Peer education • Home visits/household outreach
Community-Based	<ul style="list-style-type: none"> • Community meetings • Parent-teacher meetings • Church bulletin boards, posters, drama groups, cultural events, etc. • Community dialogues • Community theatre shows
Mass Media	<ul style="list-style-type: none"> • Radio and TV spots • Celebrity testimonies • Serial dramas • Game shows • Newspaper articles • Posters, brochures, etc.

6. Summary of Nutrition-Related SBCC in Mozambique

6.1 SBCC in GRM Policies, Strategies, Plans, and Protocols

There are several GRM policies, strategies, plans, and protocols that directly or indirectly include nutrition-related SBCC.

National Policies and Strategies

The GRM national policy on neonatal and infant health includes an objective to empower communities to improve health and priority actions related to the use of local methods of communication and BCC materials to disseminate information. The policy also mentions the importance of education to improve practices in child nutrition and health.²⁸ The GRM's food and nutrition security strategy does not mention SBCC per se, but does mention education to promote healthy food habits and lifestyles, and the corresponding action plan does mention use of campaigns to promote consumption of a balanced diet and nutrient-rich foods and to promote breastfeeding.^{29,30}

The GRM has a National Strategy for Health Promotion with the overall objective to involve communities in actions to promote and protect their own health and adopt healthy lifestyles.³¹ The specific objectives of the strategy include creating changes in perceptions and actions at the individual and community levels to obtain societal physical and mental well-being, including that of children, youth, women, men, the elderly, and other vulnerable population groups; increasing the perception of health risks in relation to the surrounding environment; providing communities with knowledge so that they have the capacity to promote individual and collective health; encouraging adequate health-seeking behavior in health facilities; and encouraging follow-through with advice/prescriptions received from health professionals. The three components of the strategy include **health education** from the professional level to the community level; **health communication** (including mass communication campaigns; use of radio, television, and mobile phone technologies; health fairs and health debates; IPC via health professionals and various individuals at the community level; development and distribution of communication materials [pamphlets, posters, etc.]; and training of professionals in this area); and **community involvement** (including training of health professionals and various individuals and groups at the community level to support mobilization and promotion and monitoring of community-level health activities). Nutrition is one of 17 action areas outlined in the strategy and includes promoting exclusive breastfeeding during the first 6 months of life, good child feeding practices after cessation of breastfeeding, good feeding practices for children under 5 years, good food consumption practices during pregnancy, and appropriate diet for people living with HIV (PLHIV).

The GRM also has a separate strategy for community involvement in health that includes activities to train health staff in participatory methods, IPC, and counseling and to train community health workers and volunteers to conduct educational sessions at health facilities and in communities and to mobilize communities and conduct home visits.³² The strategy also describes the role of the Conselho de Líderes Comunitários (CLC) (Community Leadership Councils) to mobilize communities and support community workers and volunteers.

²⁸ MISAU. 2006. *Pólitica Nacional de Saúde Neonatal e Infantil em Moçambique*. Direcção Nacional de Saúde, Departamento de Saúde da Comunidade, Secção da Saúde Infantil. pp. 38, 41.

²⁹ GRM. 1998. *Food and Nutrition Security Strategy*. National Executive Secretariat of Food Security and Nutrition. p. 17.

³⁰ GRM. 2007. *Estratégia e Plano de Acção de Segurança Alimentar e Nutricional 2008-2015*. Secretariado Técnico de Segurança Alimentar e Nutricional. pp. 44–45.

³¹ GRM. 2010. *Estratégia Nacional para a Promoção da Saúde*. MISAU, Direcção Nacional de Saúde Pública. pp. 20–30, 36.

³² GRM. 2004. *Estratégia de Envolvimento Comunitário*. MISAU. pp. 11, 17.

National Plans

Regarding GRM plans, a draft of the GRM's strategic health sector plan for 2007–2012 includes general language about using education for behavior change and the need to develop a communication strategy for the health sector and mobilize communities to adopt healthy practices.³³ The MISAU Department of Nutrition has a 2004 document on the strategic component of the national nutrition development plan that recommends improving the capacity of health staff and community members to promote positive nutrition practices and educate on nutrition, but does not include other specific recommendations related to SBCC.³⁴ The document states that, although the Department of Nutrition developed various posters, pamphlets, and flipcharts on such topics as breastfeeding, vitamin A, iodized salt, and processing of bitter cassava, there do not appear to be studies on the impact of these materials on knowledge and practice among the target populations, and at the time the document was produced, very little nutrition education appeared to be taking place at health facilities.³⁵

The PAMRDCM, which is the GRM's key plan to reduce stunting, includes several SBCC activities under each strategic objective to plan and manage advocacy and social mobilization activities for the multisectoral plan.³⁶ For example:

- For **adolescent nutrition**, counseling for adolescents, mass educational campaigns to raise community awareness on adolescent nutrition, mobilization of community leaders and hands-on practice (e.g., school gardens)
- For **pregnant women**, active searching for pregnant women by CHVs to refer pregnant women to health services and counseling
- For **children under 2**, distribution of BCC materials, counseling and assistance by CHVs, formation of mothers groups, and food preparation demonstrations
- For **families**, education on food production, nutrition education and demonstrations of food storage and processing through agricultural extension, and hygiene education through theater groups and community mobilization
- For **national advocacy, coordination, and management**, creation of national, provincial, and district groups

Box 1 lists seven “good existing practices” (*boas práticas existentes*) described in the PAMRDCM. For each “good practice,” the plan includes a description of the target group, objectives, methods, impact, lessons learned, source of information, and how the good practice would contribute to the multisectoral action plan. The MISAU Department of Nutrition's strategic plan for 2012, which is based on the multisectoral action plan, does include SBCC activities, namely, formation of breastfeeding support groups; reproduction and distribution of pamphlets and counseling cards on infant feeding for support groups, community volunteers, and health facility staff; dissemination of radio and TV spots on breastfeeding; distribution of wall calendars with breastfeeding messages; implementation of activities for World Breastfeeding Week; support for the Baby-Friendly Hospital Initiative in each province; updating of the PNB (see below for more information); and supervision of provincial-level nutrition activities, which may include SBCC activities.³⁷

³³ GRM. n.d. *Plano Estratégico do Sector Saúde 2007–2012, 1º Rascunho (Não Citar)*. MISAU. pp. 43, 63.

³⁴ GRM. 2004. *Componente Estratégica do Plano de Desenvolvimento Nutricional em Moçambique*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição. pp. 51–52.

³⁵ *Ibid.* p. 27.

³⁶ GRM. 2010. PAMRDCM. pp. 46–63.

³⁷ MISAU. 2011. *PES Nutrição, 2012*. Departamento de Nutrição. pp. 1–2.

Box 1. Good Existing Practices in the PAMRDCM

1. Nutrition education through community-level care groups and mother leaders
2. Use of community theater to promote good nutrition, hygiene, and sanitation practices, and to prevent malaria and HIV
3. Implementation of nutrition rehabilitation program
4. Implementation of school feeding program
5. Prevention of adolescent pregnancy and infection with HIV
6. Integration of promotion of food security, nutrition, agricultural commercialization, and water and sanitation
7. Community mobilization for construction of latrines and boreholes to change hygiene and sanitation practices

Source: GRM. 2010. PAMRDCM. pp. 109–115.

MISAU developed a communication and social mobilization plan for promoting, protecting, and assisting breastfeeding based in part on results of a 2009 qualitative study of barriers to exclusive breastfeeding in Mozambique.³⁸ The study found that where mothers know the recommendation to exclusively breastfeed for the first 6 months, they often do not practice it, due to lack of support from influential family and community members that do not understand the importance of exclusive breastfeeding. Community members and even maternal and child health nurses shared that they know very little about how to support mothers with breastfeeding problems. Mothers-in-law and husbands said that they would be willing to provide support if they had the necessary information.

The MISAU communication and social mobilization plan for breastfeeding has general objectives around improving maternal and infant health and reducing mother-to-child transmission of HIV; behavioral objectives on initiating breastfeeding within 1 hour of birth, exclusive breastfeeding until 6 months of age, and continuation of breastfeeding until 2 years of age or older; and social mobilization objectives around informing mothers, mothers-in-law, and other family and community members about the benefits of these behavioral objectives. The plan includes the following four main strategies and corresponding examples of activities:

- **Promotion through social communication.** Train journalists and communicators, disseminate press releases, produce and disseminate radio and television spots
- **Community mobilization.** Produce and disseminate posters, pamphlets, and calendars with messages; celebrate World Breastfeeding Week; promote theater followed by debate; form and train support groups; train CHVs and traditional birth attendants
- **Strengthening of health staff capacity.** Develop training materials and job aids and train staff in breastfeeding and counseling, create/reactivate Baby-Friendly Hospital Initiative, and educate and monitor code for marketing breast milk substitutes
- **Promotion of advocacy.** Create partnerships with local leaders, discussion groups to sensitize men to support wives, and advocacy meetings with women's groups; promote breastfeeding through the education sector and promote breastfeeding rights in the workplace.

The plan is led by MISAU's Department of Nutrition. **Box 2** provides a summary of key breastfeeding messages included in the plan.

³⁸ GRM. 2009. *Plano de Comunicação e Mobilização Social para a Promoção, Protecção e Apoio ao Aleitamento Materno*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição.

Box 2. Key Messages in Breastfeeding Communication and Social Mobilization Plan

- Initiate breastfeeding in the first hour after birth to accelerate production of milk. The infant knows how to suck and feeds immediately after birth.
- Colostrum, the yellow milk that is produced in the first days, protects the infant against illnesses like diarrhea and pneumonia.
- Give the infant only breast milk in the first 6 months of life. During this period, breast milk has all that the child needs, including water.
- Always breastfeed the infant when he/she wants to, during the day and especially at night. The more the infant breastfeeds, the more milk is produced.
- Continue to breastfeed when the infant is sick or has diarrhea.
- A pregnant or ill mother can continue to breastfeed.
- Introduce complementary foods after 6 months of life and continue to breastfeed until 2 years of age or older.
- The mother needs assistance from the whole society (family, community, health and work staff, if applicable), to initiate and continue breastfeeding.
- HIV-positive mothers should go to the health center to receive orientation on how to best feed their infant.
- If an HIV-positive mother decides to breastfeed for the child's first 6 months of life, she should not give the infant other foods or liquids in addition to breast milk.

Source: GRM. 2009. *Plano de Comunicação e Mobilização Social para a Promoção, Protecção e Apoio ao Aleitamento Materno*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição. pp. 8–9.

National Protocols

The MISAU's PNB is designed to serve as a resource for health staff for learning during training and as an ongoing resource in their work so that they may know what, when, and how to educate mothers/caregivers to improve nutritional status for children, women, and families.³⁹ The PNB also recommends health staff mobilize and sensitize family members, including fathers, grandmothers, and aunts, and influential community members through various means of social communication. The PNB acknowledges the importance of nutrition education at the community level and of SBCC implemented centrally and in communities. However, the focus of the PNB is on implementation of activities at the health facility level. The main points of contact to integrate nutrition into health services include pre-, peri-, and postnatal consultations; well child and child-at-risk clinics; pediatric triage; nutrition rehabilitation for children with acute malnutrition; mobile brigades; and monthly health days. Key actions and action areas outlined in the PNB are identified in **Box 3**. The PNB has extensive lists of key messages, strategies, and actions for each key action/area.^{40,41}

³⁹ GRM. 2007. *Manual do Participante, Orientação para Introdução do Pacote Nutricional Básico ao Nível das Unidades Sanitárias Urbanas e Rurais, 3a Versão*. Dirigido aos Trabalhadores de Saúde, MISAU, Direcção Nacional de Promoção da Saúde e Controlo das Doenças, Departamento de Nutrição. p. i.

⁴⁰ Ibid. pp. 11, 25–26, 29–33, 35, 46–47, 51–52, 55–56, 59–60, 61, 64–66, 78–79.

⁴¹ In 2010, MISAU conducted an assessment of health service provider knowledge and practice regarding the PNB. Of 122 surveyed nurses, midwives, and nutrition technicians that had been trained in the PNB, only 3 percent could name all eight components of the PNB. Although breastfeeding and balanced diet were mentioned by a majority of those interviewed as priority counseling topics, fewer than 30 percent mentioned other nutrition topics that should be priorities for counseling, such as recommended food intake for pregnant women or sick children. Observations in the well child clinic, child-at-risk clinic, and pediatric triage showed that dialogue between health staff and mothers was almost nonexistent and there was lack of “empathy” of health staff for clients. The authors of the report recommended that the PNB document be made available to

Box 3. Key Actions/Areas Outlined in the PNB

- Exclusive breastfeeding during first 6 months
- Appropriate complementary feeding at 6 months and continued breastfeeding to 2 years
- Adequate nutrition care for sick and malnourished children
- Balanced diet for family, with focus on pregnant women
- Adequate vitamin A supplementation for children and postpartum women
- Adequate iron/folic acid supplementation for pregnant women
- Adequate iodine supplementation and regular consumption of iodized salt
- Nutrition surveillance

Source: GRM. 2007. PNB. p. 6.

In 2006, MISAU developed an orientation manual for staff that deliver nutrition education messages to assist them to support positive behaviors and to change poor behaviors related to food intake.⁴² The manual is based on results of qualitative studies in the north, central, and southern regions of Mozambique. Although the document states that the results cannot be generalized nationally or by region or province, they are seen as providing relevant information regarding some food intake practices among pregnant and lactating women, young children, and families in the areas where data were collected, including urban, peri-urban, and rural areas. The document contains strategies and recommendations to change negative practices and promote positive behaviors, taking into consideration locally available channels and means of communication and potential key interventions to promote behavior change. **Table 4** provides an example of results from the central part of Mozambique based on data collected in Zambezia Province. The document is also mentioned as a valuable resource in the PNB.

staff in the workplace given its importance; that job aids be provided apart from the manual for ease of use; that there be continued training, refresher training, and on-the-job training in the PNB, with an emphasis on skills in IPC; that indicators related to counseling be included in the M&E system to promote counseling activities; and that the PNB be updated. The MISAU Department of Nutrition does have plans to revise the PNB in the near future. MISAU. 2011. *Relatório Final, Avaliação do Conhecimento e Práticas dos Profissionais de Saúde em relação ao Pacto Nutricional Básico*. Departamento de Nutrição, Ernst & Young. pp. 19, 20, 31, 42–43.

⁴² GRM. 2006. *Manual de orientação para a mudança de hábitos e práticas alimentares negativas, com base nas principais constatações nas regiões sul, centro e norte de Moçambique*. MISAU, Direcção Nacional de Saúde, Repartição de Nutrição.

Table 4. Some Recommendations on SBCC Messages and Modes of Communication for Breastfeeding, Infant Feeding, and Complementary Feeding, and Maternal Nutrition in Zambezia Province

	Breastfeeding	Infant feeding and complementary feeding	Nutrition during pregnancy and lactation
Recommendations for health workers	<ul style="list-style-type: none"> • Congratulate mothers with good practices and encourage them to be model mothers, sharing at prenatal, postnatal, and well child clinic visits • Explain the importance of colostrum, why it is yellow; explain to older women and youth • Sensitive grandmothers, mothers-in-law, and aunts on infant feeding because they counsel young women • Sensitize men to support their wives in breastfeeding • Educate on the dangers of giving liquids other than colostrum in the first days of life • Explain to mothers how to stimulate milk production • Recommend safe sex to avoid pregnancy and infection with HIV or sexually transmitted infections 	<p>Up to 6 months:</p> <ul style="list-style-type: none"> • Breastfeed on demand, day and night, at least 8 times per day • Do not give any liquids or food other than breast milk <p>6–12 months:</p> <ul style="list-style-type: none"> • Breastfeed on demand • Introduce enriched porridge using locally available foods • Give seasonally and locally available fresh fruits between meals • At 7–9 months, gradually introduce family foods, well cooked and mashed <p>12–24 months:</p> <ul style="list-style-type: none"> • Continue breastfeeding as the child desires • Continue providing family foods and gradually increase quantities • Explain to mothers that 9 months is too late to introduce complementary foods because of high nutritional needs • Taboos only impede children from getting needed nutrients for good physical and mental development • Do not feed food from the day before because it can be contaminated • Promote porridge enriched with diverse foods • Explain to mothers that only two meals/day for a child is very little and that children need food more frequently in small quantities 	<ul style="list-style-type: none"> • Recommend that women take a variety of food to the fields, not just cassava and sweet potato • Recommend that women eat breakfast and snacks in addition to other meals because of nutrient needs in pregnancy and lactation • Encourage consumption of meat from domesticated or wild animals to help meet nutrient needs

	Breastfeeding	Infant feeding and complementary feeding	Nutrition during pregnancy and lactation
All mothers should know that:	<ul style="list-style-type: none"> • Breast milk helps defend against infection • Colostrum is rich in nutrients and for this reason is yellow; it helps defend against infection and allergies and helps the intestines mature • Breast milk can be expressed and given by spoon or cup; use good hygiene on hands and utensils • If the breast has cracked skin, breastfeed from the breast without cracks and express the milk from the breast with cracks to avoid engorgement 	<ul style="list-style-type: none"> • Complementary food should not be based on thin porridge; porridge should be enriched with various foods • Cassava porridge is of poor nutritional value and needs to be enriched with beans, sesame, groundnut, cashew, etc. • At 9 months, infants can consume family foods, but they should be well cooked and mashed • Children should have their own plate • Food from the day before can be contaminated and cause diarrhea, vomiting, and stomach pain • Adults should help and stimulate children to eat 	<ul style="list-style-type: none"> • Pregnant and breastfeeding women are not eating only for their own needs but also for the child • Consumption of eggs by pregnant women helps the healthy development of the child • Consumption of wild animals like salamanders is very important for pregnant women and does not affect the birth
Methods to transmit information	<ul style="list-style-type: none"> • Counseling on positioning • Discussion groups with older women and family members that support breastfeeding • Theater, songs and talks, celebration of World Breastfeeding Week, highlighting advantages of breastfeeding • Use of flipcharts to illustrate key aspects • Use of “model mothers” 	<ul style="list-style-type: none"> • Communicate verbally in the local language • Use visuals, such as posters, flipcharts, counseling cards, etc. • Information packages can be transmitted via radio in the local language • Use religious leaders and model families to transmit information/messages 	<ul style="list-style-type: none"> • In remote zones, mobile brigades should provide educational information and practical demonstrations • Transmit messages via radio, song, and theater in local languages • Form community groups to serve as animators or promoters of good practices • Take advantage of the enthusiasm of the elderly and educate and train them to collaborate

The well child and child-at-risk clinic protocols define one of the principal activities of health staff in the well child clinic as providing orientation to caregivers about IYCF.⁴³ Chapter 5 and Chapter 9 of the well child clinic protocols instruct health staff to promote exclusive breastfeeding and adequate child feeding through information, education, and communication (IEC) materials; psychosocial support to strengthen caregiver confidence; practical support (for example, to demonstrate good positioning for breastfeeding); and group education. The key messages outlined in the protocols are summarized in **Box 4**.

Box 4. Key Actions/Areas Outlined in Well Child and Child-at-Risk Clinic Protocols

- Exclusive breastfeeding during first 6 months
- Appropriate complementary feeding at 6 months and continued breastfeeding to 24 months
- Adequate nutrition care for sick and malnourished children
- Appropriate hygiene practices, including handwashing, safe food conservation, and safe drinking water
- Infant feeding in the context of HIV
- Treatment of SAM with ready-to-use therapeutic food

Source: Ibrahimo. 2011.

6.2 SBCC in USG Strategies, Plans, and Programs

The USG Feed the Future FY 2011–2015 Multi-Year Strategy recognizes that progress in reducing undernutrition among children under 5 years of age in Mozambique has slowed since 2003 due in part to poor nutrition behaviors.⁴⁴ The FTF strategy includes a program area to improve nutrition among children under 5 years of age and pregnant women through SBCC.⁴⁵ Central to the FTF Multi-Year Strategy are community-based nutrition activities that are aligned with the GRM PAMRDCM and complement existing USG-funded community-based nutrition activities, particularly those in the MYAP and SCIP projects. MYAP and SCIP staff work through mothers and fathers groups, community-based health and hygiene volunteers, agricultural associations, and junior farmer clubs to strengthen links between community and facility-based nutrition and health services. The FTF strategy includes a focus on documenting and reinforcing improved nutrition behaviors, such as improved child feeding practices and dietary diversity, through district and community-based nutrition activities and linking to activities to improve hygiene and access to safe water and production of more nutritious crops.⁴⁶

The USG's Country Assistance Strategy for Mozambique 2009–2014, under its third goal to improve the health of Mozambicans, includes activities to increase community participation by establishing sustainable CLCs and training community-based health workers in BCC. The goal is to prevent common illnesses; provide care for common health issues; increase demand for health services through community mobilization; and provide education, including nutrition education.⁴⁷

⁴³ Ibrahimo, N.A.; Fernandes, N.; and Mikusova, S.M. 2011. Ficha Técnica, *Normas de Atendimento à Criança Sadia e à Criança em Risco*. GRM, MISAU. p. 14.

⁴⁴ USG. 2011. *Feed the Future Mozambique FY 2011–2015 Multi-Year Strategy*. p. 5.

⁴⁵ *Ibid.* p. 11.

⁴⁶ *Ibid.* pp. 28–29.

⁴⁷ USG. 2009. *U.S. Government Country Assistance Strategy for Mozambique 2009–2014*. p. 12.

7. Assessment Findings

7.1 Understanding the Situation

Adventist Development and Relief Agency

The name of the ADRA MYAP project was “Osanzaya Zambezia” (“Make Zambezia Happy”). ADRA developed a general program strategy, including nutrition activities, based on the findings of a needs assessment, but did not develop a detailed SBCC strategy. The needs assessment was conducted after the conclusion of the DAP to build on the DAP experiences for the MYAP proposal. The needs assessment identified health and nutrition problems and priorities for behavior change (e.g., low percentage of women exclusively breastfeeding their infants under 6 months of age), but did not include information related to determinants of behaviors, barriers to behavior change, channels of communications, or other components of a SBCC strategy.

World Vision

The name of the WV MYAP project was “Ocluvela” (“Hope”). WV defined the behavior change activities that would be implemented as part of Ocluvela in its MYAP proposal. However, there was no documentation of formative research used to inform the development of the activities. WV did not plan or implement a process to develop or refine its SBCC activities during the life of the project, but small adjustments were made in practice to address barriers perceived from experience in the field. For example, CHVs and mothers and fathers groups now explained the reasons behind the messages transmitted to beneficiaries, so that beneficiaries could weigh the benefits against the risks of adopting new behaviors. Moreover, to address resistance to the adoption of new behaviors, examples of success stories of mothers whose children’s health and nutrition improved after adopting the behaviors promoted by the MYAP were shared with the community.

Save the Children

The name of the SC MYAP project was “Segurança Alimentar Através de Nutrição e Agricultura” (SANA) (Food Security through Nutrition and Agriculture). The SANA behavior change strategy was based on the DAP. During the DAP, SC conducted a positive deviance (PD) study to identify determinants of behaviors and barriers to behavior change. At the beginning of the MYAP in mid-2009, SC hired a consultant to evaluate the methods and tools proposed under the SANA nutrition behavior change strategy, recommend how to strengthen the strategy, and work with the nutrition team to develop a work plan to incorporate new methods and tools.⁴⁸ The consultant used a variety of methods to work collaboratively with SC staff, including a workshop with senior managers of SANA and nutrition staff, using the BEHAVE Framework, developed by the Academy for Educational Development and the CORE Group.⁴⁹ As a result of the consultancy, recommendations and plans were made to improve the SANA behavior change strategy.

7.2 Focusing and Designing

7.2.1 Overall SBCC Strategy

This section describes what was documented in MYAP proposals and training and BCC materials, and what was learned by the assessment team during interviews and observations. The MYAP

⁴⁸ Michaud-Létourneau, Isabelle. 2009. *Revision and Development of the Behavior Change Strategy for Nutritional Objectives, Report of Technical Assistance to the SANA MYAP Program.*

⁴⁹ For more information on the BEHAVE Framework, see <http://www.coregroup.org/our-technical-work/working-groups/social-and-behavior-change/111>.

partners did not complete a comprehensive process of developing SBCC strategies, such as the C-Planning process described in Section 5. Therefore, there were no comprehensive documents containing a full description of the MYAP SBCC strategies that included information about audience(s), desired changes, barriers, communication objectives, strategic approaches, positioning, and channels. Information was available only for desired changes, audiences, and interventions (including channels and activities).

7.2.2 Desired Changes and Key Messages

Adventist Development and Relief Agency

The Strategic Objective (SO) of Osanzaya Zambezia related to preventing undernutrition in children under 5 years of age and pregnant and lactating women is SO2, “Improved health and nutrition of 61,875 vulnerable people in targeted areas.” The main desired changes gleaned from the ADRA MYAP proposal and training and BCC materials include:

- Exclusive breastfeeding of infants until 6 months of age
- Optimal complementary feeding
- Optimal hygiene and healthy environmental practices
- Optimal nutritional care of sick and severely malnourished children
- Consumption of balanced diet
- Optimal nutrition intake through food during pregnancy
- Optimal practices to prevent and treat malaria
- Optimal practices to prevent and treat diarrhea
- Optimal nutritional care of PLHIV and those suffering from prolonged illness
- Consumption of foods rich in vitamin A
- Children given vitamin A supplements every 6 months
- Postpartum women given vitamin A supplements
- Recognition of danger signs for sick children
- Recognition of importance of growth monitoring

During interviews, ADRA staff identified barriers to behavior change, including division of labor in the family, which affected child care giving; the roles of husband and wife in decision making, such as use of family resources; and knowledge/education levels and ability to understand and analyze complex messages. These barriers were identified by ADRA through personal field experience, the needs assessment, and experience with the DAP.

World Vision

The SO of Ocluvella related to preventing undernutrition in children under 5 years of age and pregnant and lactating women is SO2, “Human capacities protected and enhanced.” The activities under SO2 were aimed at strengthening the capabilities of communities to address nutrition and health concerns and to promote optimal IYCF practices, childcare practices, antenatal care, and family planning. The main desired changes gleaned from the WV MYAP proposal and training and BCC materials include:

- Exclusive breastfeeding of infants until 6 months of age
- Optimal complementary feeding
- Optimal hygiene and healthy environmental practices
- Optimal nutritional care of sick and severely malnourished children
- Consumption of balanced diet

- Optimal nutrition intake through food during pregnancy
- Pregnant women consume daily iron and folic acid tablets during at least 6 months of gestation, and 3 months after delivery
- Optimal practices to prevent and treat malaria
- Optimal practices to prevent and treat diarrhea
- Optimal nutritional care of PLHIV and those with prolonged illness
- Consumption of foods rich in vitamin A
- Children given vitamin A supplements every 6 months

A list of the WV key messages compiled from training materials can be found in **Annex 4**.

Save the Children

The SO of SANA related to preventing undernutrition in children under 5 years of age and pregnant and lactating women is SO3, “Increased adoption of key MCHN practices and use of MCHN services, targeting 94,520 children under the age of 2, and 31,905 pregnant and lactating mothers.” The main desired changes gleaned from the SC MYAP proposal and training and BCC materials include:

- Exclusive breastfeeding of infants until 6 months of age
- Optimal complementary feeding
- Optimal hygiene and healthy environmental practices
- Optimal nutritional care of sick and severely malnourished children
- Consumption of balanced diet
- Optimal nutrition intake through food during pregnancy
- Optimal practices to prevent malaria
- Optimal practices to prevent and treat diarrhea
- Optimal care seeking for children with respiratory tract infection
- Correct processing of bitter cassava
- Optimal nutritional care of PLHIV and those with prolonged illness
- Storage and conservation of seeds and foods
- Consumption of foods rich in vitamin A
- Drying and conservation of fruits and green leafy vegetables

A list of the SC key messages compiled from training materials can be found in **Annex 5**.

During interviews, SC staff identified barriers to behavior change, including cultural beliefs about food, education level, and lack of resources. SC staff stated that community nutrition promoters and CHVs called “*animadoras*” were trained to overcome barriers through problem solving and discussions with mothers. SC involved men and grandmothers in its activities, because they could influence the behavior of caregivers. SC also collaborated with programs that could assist families with accessing necessary resources, such as mosquito nets and point-of-use water purification products.

7.2.3 Audiences

Adventist Development and Relief Agency

The target group for improving nutrition was children under 5 years of age, with focused priority given to children under 2. The primary audience for ADRA’s nutrition and health SBCC activities

included mothers and fathers of children under 5. CHVs were instructed to recruit mothers with younger children. However, activities were not differentiated in age groups and everyone received the same messages and demonstrations. Pregnant women were also included in the mothers/fathers groups,⁵⁰ but they did not receive targeted recruitment and there were no specific activities that targeted them. Pregnant women were identified for participation in mothers/fathers groups when it became evident that they were pregnant, and at that time they were also encouraged to attend a prenatal visit at the health center. Note that ADRA tried to promote the participation of fathers in the mothers/fathers groups. However, fathers often did not participate in these groups.

The secondary audience of ADRA's nutrition and health SBCC activities included the entire community. In previous programs, including the DAP, the audience was limited to mothers. However, ADRA found that targeting only mothers was not effective, so ADRA began to include the entire community, especially fathers, grandmothers, community leaders, and other influential community members. The community was engaged through the Community Health Council (CHC) by the health and nutrition technician. The objective of working with the CHC was to promote community mobilization to take responsibility for the health of the community and to create a link between the community and health services. The participation of the CHC seemed to create ownership of the project and increases sustainability of activities. The president of the CHC was responsible for guaranteeing the maintenance of this structure and commitment as well as the continuation of activities.

World Vision

The target group for improving nutrition was children under 5 years of age, with focused attention on children under 2. The primary audience of WV's nutrition and health SBCC activities included mothers and fathers of children under 5. The secondary audience of WV's nutrition and health SBCC activities included the entire community, especially fathers, grandmothers, community leaders, and other influential community members.

Save the Children

The target group for improving nutrition was children under 5 years of age, with focused priority on children under 2 and pregnant women. The primary audience of SC's nutrition and health SBCC activities included mothers and fathers of children under 5. The secondary audience of WV's nutrition and health SBCC activities included the entire community, especially fathers, grandmothers, community leaders, and other influential community members.

7.2.4 Interventions

Adventist Development and Relief Agency

ADRA used interpersonal and community-based SBCC approaches. Implementation of activities happened predominantly through CHCs, CHVs, and mothers/fathers groups. The CHC was composed of 1 head of the council, 1 Integrated Management of Neonatal and Childhood Illness (IMNCI) volunteer, 1 mothers/fathers group (with eight members), 15 CHVs, and other members that are influential in the community. ADRA used the approach of community mobilization to catalyze and facilitate collective action through the CHC. An objective of the CHCs was to enable communities to identify, prioritize, and address their own health needs and become advocates of their own change needs. The role of the CHC focused on identifying and addressing critical child and maternal health issues in the community and promoting behavior change and the use of health services by the community. The CHVs and mothers/fathers groups used interpersonal approaches to promote key

⁵⁰ Mothers/fathers groups include both mothers and fathers together.

messages and to facilitate mothers/fathers groups. The CHCs built social capital and social support for participants.

Table 5. ADRA’s SBCC Channels

Channel	Examples
Interpersonal	CHVs, mothers/fathers groups
Community-based	CHCs

World Vision

WV used interpersonal, community-based, and mass media channels. Similar to ADRA, WV used the approach of community mobilization to catalyze and facilitate collective action through the CHCs. The health technicians trained and supervised the CHVs and worked with the CHCs to monitor the overall health and nutrition situation in the community. The CHCs received training in optimal feeding and health practices. The CHVs and mothers/father groups employed an interpersonal approach, delivering nutrition messages and providing instructions for mothers to address and prevent malnutrition among their children through home visits and community gatherings. The CHCs built social capital and social support for participants. WV also integrated nutrition and agriculture through providing health and nutrition training to farmers associations and supporting the CHCs to establish community gardens. Due to the strong link between the health activities and the agriculture association members, the health and nutrition messages seemed successful in reaching fathers and other influential people in the community, such as community and religious leaders and traditional healers.

The WV MYAP, in collaboration with SCIP and Johns Hopkins University Center for Communication Programs, also used community radio programming in both Portuguese and the local language through the series *Vozes da Vida* (Voices from Life). The radio shows reinforced messages transmitted during household visits and community gatherings. CHVs said radio shows helped them because the target beneficiaries heard the same messages that they provided on the radio, giving the CHVs credibility. CHVs noted that when they went to a home to recruit new members for a mothers group, the mothers had often already heard the messages on *Vozes da Vida*.

Table 6. WV’s SBCC Channels

Channel	Examples
Interpersonal	CHVs, mothers/fathers groups
Community-Based	CHCs, agriculture associations
Mass Media	Community radio

Save the Children

SC used interpersonal, community-based, and mass media channels. Implementation was conducted through a large cadre of *animadoras* that were supervised and supported by community volunteer nutrition promoters to reach out to the target population. The *animadoras* employed an interpersonal approach through monthly learning sessions with 2 groups of 15 mothers each. The learning sessions included cooking and hygiene practice demonstrations and were complemented with home visits to monitor adoption of nutrition and health practices. *Animadoras* also worked with *Grupos de Suporte*

(community support groups) to mobilize communities to participate in health facility mobile brigades and semi-annual health days, and assisted with *animadora* referrals of sick and malnourished children to health facilities. The *Grupos de Suporte* built social capital and social support for caregivers to improve nutrition and health practices. During health days, SANA used a PD approach by publically featuring beneficiaries of the program whose children were well nourished as a result of adopting improved nutrition and health practices. SANA also used the Nampula provincial radio station and selected community radio stations to disseminate nutrition messages. In addition, Pathfinder, as part of SCIP and in collaboration with SC, sponsored a contest for songs that deal with key health messages. The best songs in Makua were then recorded and aired on two different community radio stations. These programs appeared to be popular and volunteers indicated that the programs motivated mothers to pay attention to their messages.

The *Grupos de Suporte* appeared to be an effective way of mobilizing communities to adopt desired behavior change. These groups consisted of respected and influential members of the community who supported community volunteers in their efforts to get community members to adopt new behaviors and practices. *Grupos de Suporte* membership typically consisted of *regulos* (chiefs); *cabos* (headmen); religious leaders, such as pastors and headmen; *curandeiros* (traditional healers of the herbalist variety); *parteiras* (traditional birth attendants); and other influential community leaders. When a community volunteer encountered a challenge, such as a household that was not adopting recommended nutritional practices or a family not taking an undernourished child to the health facility, the volunteer solicited the assistance of the *Grupos de Suporte*. The *Grupos de Suporte* also helped solve such problems as transport to a health facility. According to volunteers and other community leaders, the *Grupos de Suporte* were a very effective method of obtaining widespread community adoption of changes and accelerated the pace of change and increased coverage. Members of the *Grupos de Suporte* were typically also members of other community groups, such as farmers groups and health councils. The SC project provided them with identification badges, which they proudly wore during the team’s visit.

Table 7. SC’s SBCC Channels

Channel	Examples
Interpersonal	<i>Animadoras</i> , mothers groups
Community-Based	<i>Grupos de Suporte</i>
Mass Media	Nampula provincial radio, community radios

7.2.5 Best Intervention Practices

Community Leadership

Communities that appeared to have high functioning CHCs tended to have higher levels of knowledge of key nutrition messages than communities that appeared to have less dynamic leadership. The SBCC team members noted that the participation of certain community figures in the CHCs appeared to strengthen a community’s knowledge of and response to nutrition, hygiene, and sanitation messages. The involvement of *regulos*, *cabos*, religious leaders, *curandeiros*, and *parteiras* seemed to invigorate community activity, including agricultural and nutrition planning and positive influence over resistant community members to adopt desired behavior change. SC and WV field staff described creating forums where communities could share their experiences, best practices, and lessons learned. This apparently was done on a limited basis, but it seems likely that it was helpful for communities where leadership was relatively weak so that less effective leaders could learn from their more effective counterparts.

Integration of Nutrition and Agriculture

Integration of nutrition activities with agriculture associations was observed as a method to ensure that husbands received the same key messages as their wives. Incorporating nutrition activities with these associations seemed to increase the sense of responsibility of the male farmers in the nutrition and health of their household and community.

Community Planning Tools

Most communities had planning materials that they used as a group to present the activities of their agriculture association, health committee, and volunteers. These tools were useful to plan activities and time needed to conduct such activities, as well as for accountability through the documentation of responsibilities and accomplishments. Tools observed by the SBCC team included a community map, an organizational diagram of the structure of the health committee, two plans related to agriculture, two plans linking agriculture with nutrition, and work plans for health volunteers and health committees. The community map and diagram of committee structure served to unify the group toward common goals and objectives. The agriculture association plans detailed intended production of each staple crop for the season, expected yields, sources of seed, and areas of cultivation. It allowed the community to know roughly how much food it could expect to produce for consumption and sale. Most associations also had a commercialization plan that addressed prices and expected gains from the sale of each crop.

The stock plan and seasonal calendar were particularly useful in linking agriculture and nutrition by making them part of the same plan. The stock plan gave estimates of how many sacks of cereals and legumes needed to be stored to feed a family for the entire year based on family size. The SBCC team observed that communities with this detailed planning of crop production and storage appeared to have less food insecurity, whereas communities that lacked these tools were already facing food shortages. Communities also created a seasonal calendar that presented the climate, crops, common diseases and their prevention, fruits available, and common foods consumed for each season. This plan provided a holistic look at weather, health, agriculture, and nutrition at the community level.

Many communities had work plans for their health volunteers or various health committees. These work plans generally displayed the number of days per month and activities planned per volunteer or committee. One community, Murrimo in Gurue District, also had developed a detailed chart of activities accomplished by the health committee by month. It included various statistics, including number of latrines constructed; the number of diarrhea, malnutrition, and malaria cases identified; the distribution of condoms and birth control; the number of referrals for antenatal care (ANC); birth attendance; and the number of demonstrations given. This idea had come from the community and reaffirmed its accomplishments and the importance of its work.

Community organization of activities, goal setting, and documentation of accomplishments through community planning tools seemed correlated with the community's motivation and capacity to work effectively together. Community planning exercises served a practical purpose in terms of agriculture production and time management, but also served an important function in validating the importance of the work and unifying the community as active participants rather than passive recipients.

Junior Farmer Groups

Several communities had junior farm groups. These groups had an established leadership, president, and secretary, and met weekly with an extension worker to learn conservation agriculture, health, and nutrition lessons. They cultivated a small communal farm together and were responsible for the production, sale, and consumption of the crops. The junior farmer program component not only engaged young people in community empowerment of the MYAP, but also promoted behavior change early in life, when it is theoretically easier to change practices. It also gave key health and

nutrition messages to older children that are often the caregivers of younger siblings while parents are away at work.

Radio

Radio in both Zambezia and Nampula provinces appeared to be a very effective communication channel. Entertainment education has been an integral element of many health-related SBCC campaigns in developing countries for the past few decades.⁵¹ A body of evidence shows that entertainment-education interventions can have measurable effects on behavior change with regard to topics ranging from nutrition, HIV/AIDS, and family planning to developing important life skills by demonstrating problems people face, role-modeling solutions, and providing incentives and techniques for positive outcomes.^{52,53}

7.2.6 Other Observations

Gender

The SBCC team observed gender equity in community discussions and the exercise of leadership in CHCs. *Curandeiras* (female traditional healers) and *parteiras* were particularly articulate and powerful spokespersons. Farmers groups, water and sanitation committees, and leadership councils appeared to have fairly balanced representation of both men and women. Women overwhelmingly dominated the groups of CHVs and *animadoras*, as would be expected since their issues dealt with the domestic sphere. In the few communities that did have agricultural marketing cooperatives, the team observed a lower ratio of female-to-male members in comparison to other community-based groups. This may be important to women's status in the long run, as it may negatively affect their income-generation ability.

Food Insecurity

The SBCC team found two communities that were experiencing food shortages. Residents reported reducing the amount of food that was being consumed each day. In the community, Bairro de Murrupelane in Nampula's Nacala Porto District, community leaders reported food shortages because the district's farmers did not have enough land for cultivation. They explained that 12 years ago their common fields had been given to another "owner" for cattle production. The community was unable to overcome the effects of the loss of this land on its own. In Sanhote in Nampula's Monapo District, the community reported a shortage of food due to poor harvests caused by inadequate rainfall. For certain communities to succeed, SBCC is not enough. Broader solutions may be necessary to assist such communities to move out of poverty, and the programs should have mechanisms for assisting such communities.

7.3 Creating

7.3.1 Materials

Adventist Development and Relief Agency

ADRA's BCC materials were developed by ADRA or in coordination with other MYAP partners or were developed by MISAU. ADRA reported that the content of the materials was based on MISAU

⁵¹ Noar, S. 2006. "A 10-year retrospective of research in health mass media campaigns: Where do we go from here?" *Journal of Health Communication*.

⁵² Bandura, A. 2004. "Health promotion by social cognitive means." *Health Education & Behavior*.

⁵³ Vaughan, P.W. et al. 2000. "Entertainment-education and HIV/AIDS prevention: A field experiment in Tanzania." *Journal of Health Communication*.

protocols or scientific literature. Some materials were adapted from the DAP and other program experience after internal review by the ADRA nutrition staff. ADRA reported that MISAU reviewed the materials. No pretesting was conducted on the BCC materials.

ADRA BCC materials included:

- PNB Manual (MISAU)
- IMNCI Manual (MISAU)
- Pamphlet based on the PNB (ADRA)
- Flipchart: The story of little Adelina (MISAU)
- Poster: “A Nossa Alimentação” (“Our Foods”) (MISAU)
- Flipchart: Training of farmers in health and nutrition (ADRA)
- Flipchart: Hygiene and prevention of diarrhea and cholera (MISAU)
- Recipes adapted to use local foods (ADRA)

ADRA did not provide CHVs with support materials (e.g., T-shirts, bags, hats) because they were viewed as incentives and there was concern that the support materials would change the focus and motivation behind participation in the program. CHCs were provided with one bicycle.

World Vision

The BCC materials used by WV included posters that were developed by MISAU as well as flipcharts created by the WV SCIP and MYAP, based on the PNB. WV reported that the materials from MISAU and the previous DAP were updated to reflect most current scientific literature. MYAP and SCIP also created flipcharts, with the assistance of Johns Hopkins University, with key messages derived from MISAU’s reference documents, including the PNB, Nutritional Guidance for PLHIV, Maternal and Child Health Manual, Education for Health Manual, Community Nutrition Manual, Infant Feeding Manual, and Prevention of Mother-to-Child Transmission of HIV (PMTCT) Manual. The flipcharts were reviewed by technical WV staff at central level, DPS/Zambezia, and MISAU. Materials were distributed for use only by MYAP implementers once they received approval from MISAU. One of the flipcharts created by SCIP, entitled “Life Cycle” was pretested in the community, in collaboration with the DPS/Zambezia, with the result that further revisions were made to the language and imagery to better respond to the needs of the communities. WV also provided all members of CHCs with branded T-shirts, plastic folders with notebooks, pens, pencils, pencil sharpeners and erasers, and, to health auxiliaries only, bicycles.

Save the Children

The BCC materials used by SC included posters that were developed by MISAU as well as flipcharts created by SC DAP and MYAP, based on the experiences and the PD study completed during the DAP. SC staff reported that most of the BCC materials were tested in the community during the DAP. SC also provided nutrition promoters and *animadoras* with branded T-shirts, identification cards, backpacks, and hats. SC also provided materials for demonstrations, such as pots, buckets, plates, cups, and foods produced in the community. Nutrition promoters were given bicycles.

Overall Observations

The SBCC assessment team found few BCC materials that were being used by community volunteers or field staff in their group meetings and household visits. When printed materials were available, many communities visited as part of this assessment did not have sufficient quantities. BCC materials that were found were written in Portuguese.

One of the key messages nutrition and health volunteers focused on was the four basic food groups and their functioning in the body. The one BCC material used by all of the MYAP partners is *A Nossa Alimentação* (The Food Groups), originally developed by MISAU, to demonstrate the various foods in each food group (see **Figure 4**).

Figure 4. Food Groups Poster



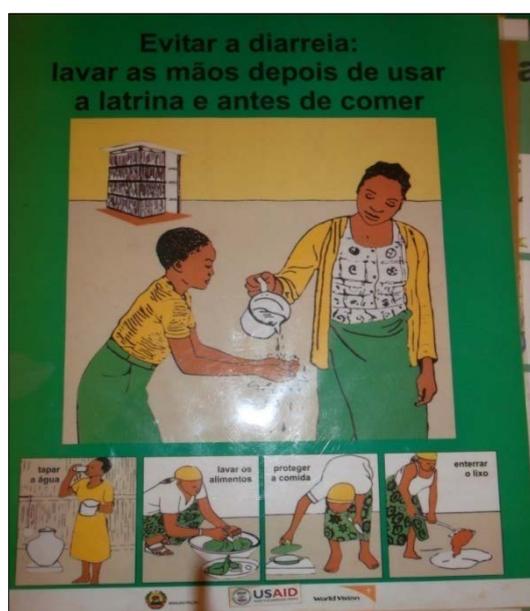
Volunteers consistently indicated the need for BCC materials, in particular large graphics that they could use in education sessions with mothers. Field staff and volunteers stated that the poster-sized materials with smaller graphics (see **Figure 5**) were not practical for use in presentations. They were cumbersome to manipulate in front of a group, as the volunteers were trying to talk, read the text, and show the graphics at the same time. Mothers were normally seated on mats on the ground, often with babies or toddlers on their laps, so it was unlikely that they would move around to look at smaller pictures.

Figure 5. Example of Poster with Small Graphics



Volunteers and field staff stated that material with larger graphics are preferable so that the graphics could be seen more easily (see **Figure 6**).

Figure 6. Example of Poster with Large Graphics



The other side of the poster in Figure 6 has a written guide for engaging the audience. Although many volunteers that are not literate in Portuguese could not use the guide, the interactive methodology of the guide is a good example of the SBCC methods that volunteers and field workers should be taught as part of their training.

A few volunteers did have brochure-size BCC materials, for instance, on breastfeeding. The informants explained that they could use these in one-to-one presentations. The volunteers seemed to value these because possessing them appeared to enhance their credibility and authority with their target audiences.

According to the volunteers, program T-shirts, IDs, and caps also helped establish their authority and credibility with members of the target group. In the Nampula Province communities served by SC,

volunteers most often and very proudly wore T-shirts and IDs. In communities where volunteers did not have access to such items, they lamented the fact that the programs did not supply them. The supply of these items to volunteers also seemed to boost their morale, and, given the importance of these non-paid program supporters to the success of the programs, provision of these items is a wise and relatively modest investment.

Volunteer informants also noted that they did not have bags to carry BCC materials. Volunteers frequently had to walk long distances, often carrying a child on their backs. The team observed volunteers in a WV community in Zambezia’s Gurue District that had been provided with inexpensive large plastic envelopes to protect and carry letter-sized BCC printed materials. These volunteers said that these plastic envelopes were not practical and asked for backpacks that would enable them to carry these materials with them and transport their children and other objects, such as demonstration pots, at the same time.

7.4 Implementing and Monitoring

7.4.1 Staffing Structure

Adventist Development and Relief Agency

ADRA employed a cadre of 12 health and nutrition technicians (2–3 per district), supervised by 3 health district supervisors that were, in turn, managed by a health and nutrition coordinator. The health and nutrition technicians trained, supported, and supervised the community and caregiver groups, CHCs, and CHVs. **Table 8** summarizes the number, capacity, role, and staffing structure of program field staff.

Table 8. The ADRA Staffing Structure

Type of personnel	Total	Role	Coverage
Health and Nutrition Coordinator	1	Planning, implementation, supervision, and monitoring of all health/nutrition activities	Coverage of all 5 districts, supervises 3 district supervisors and 12 technicians
Health District Supervisors	3	Supervise and monitor health activities of the program; monthly planning of CHC activities in collaboration with CHC members	Coverage of 1–2 districts
Health and Nutrition Technicians	12	Implement planned program activities, technical training, and supervision of CHCs and CHVs; collection and reporting of community-level data for M&E	Coverage of approximately 16 CHCs (1 CHC per community)
CHC	192	Implement all program activities, resolve conflicts with community, accompany on household visits, assist with community mobilization	1 CHC per community with 25 members
CHVs	2,880	Give health lessons on hygiene and disease prevention, construct latrines, and make household visits	10–15 families

Type of personnel	Total	Role	Coverage
Mothers/fathers groups members	1,536	Give lessons on key nutrition messages, do cooking demonstrations of enriched porridges, make household visits	Entire community

World Vision

Implementation was mainly through the members of 330 CHCs, 6,960 CHVs, and 330 mothers/fathers groups.

Table 9. WV Staffing Structure

Type of personnel	Total	Role	Coverage
Health and Nutrition Coordinator	1	Coordination of all program activities in health and nutrition with agriculture activities, at district level and with partners	8 District Coordinators
District Coordinator	8	Coordination of health and nutrition activities with local authorities, i.e., Serviços Distritais de Saúde, Mulher e Acção Social (SDSMAS) (District Services for Health, Women, and Social Action), and local partners, and supervision of nutrition and health technicians	4 technicians (2 agriculture, 2 nutrition) each
Health and Nutrition Technician	16	Implementation of program health and nutrition activities in the community, training and supervision of health auxiliaries and volunteers, and reporting of monthly monitoring data to SDSMAS	3–5 auxiliaries, 600–800 volunteers per technician
Health Auxiliaries	36	Aid technicians in training and supervision of CHVs	5–6 CHCs, 100–150 volunteers per health auxiliary
CHC	330	Community mobilization, resolution of conflicts with community, plan and schedule monthly activities for CHVs or member of mothers/fathers groups	1–2 per community, depending on size of community
CHV	6,960	Household visits and group education sessions at churches/markets on hygiene and sanitation, disease prevention (malaria and diarrhea), HIV prevention, care for PLHIV family planning, nutrition	15 households per volunteer
Mothers/fathers groups members	2,640	Cooking demonstrations, household visits, and group education sessions at churches/markets on nutrition, nutrition rehabilitation, care for young children, family planning, detection, counseling and referral of pregnant women, nutrition for pregnant and lactating women, PMTCT	15 households per member

Save the Children

Implementation was through a large cadre of 2,800 community volunteer workers called “*animadoras*” that were supervised and supported by 280 community volunteer nutrition promoters to reach the target population. Fourteen SC district nutrition supervisors were responsible for mobilizing communities to elect 280 nutrition promoters that constituted the first level of community volunteers.

Table 10. SC Staffing Structure

Type of personnel	Total	Role	Coverage
Provincial Nutrition Coordinator	2	Oversee MYAP in 7 districts	7 district officials
District Official	9	Oversee MYAP at district level, train and supervise promoters, collect monitoring information, and synthesize at district level	16–20 promoters (depending on size of district)
Community Volunteer Nutrition Promoters	280	Train and supervise <i>animadoras</i> , collect and synthesize monitoring data monthly for report to District Official	10 <i>animadoras</i>
<i>Animadoras</i>	2,800	Give monthly health/nutrition lessons and cooking demonstrations, identify and refer sick or malnourished children to health center, report monthly activities to promoter	30 mothers (2 groups of 15 mothers)

7.4.2 Training

Overall Observations

The MYAP partners used a cascade training model with regular retrainings of staff and volunteers. Most training materials were taken directly or adapted from MISAU materials, including the PNB and IMNCI manuals. Materials for health and nutrition technicians were more detailed and technically oriented, while for volunteers materials were simplified and shortened and used more images. Materials were all in Portuguese, and were translated into local languages by the technicians during trainings as needed.

Table 11. MYAP Training Structures by Implementer

Type of personnel	Trainers	Training approaches	Training materials	Number of participants	Frequency of trainings
Adventist Development and Relief Agency					
Health and Nutrition Technician	DPS Nutrition Technician	PowerPoint presentation, group discussion, manuals, demonstrations	Materials from MISAU, including PNB manuals and IMNCI manual	12 technicians	Approximately every 18–24 months depending on performance and experience of the technicians

Type of personnel	Trainers	Training approaches	Training materials	Number of participants	Frequency of trainings
CHCs (including CHVs and mothers/fathers groups)	Technician from ADRA	Lecture with questions and answers, demonstrations	Illustrative manuals, flipcharts, demonstrations	Approximately 30 (CHC members and CHVs)	2–4 times per year
World Vision					
Health Technicians and Auxiliaries	MYAP/SCIP Provincial Coordinators	PowerPoint presentation, group discussion	PowerPoint presentation	Approximately 20	1 training per year
CHCs (including CHVs and mothers/fathers groups)	Health technicians	Lecture, group discussion	PNB Manual, flipcharts, posters	Approximately 30 (CHC members and CHV)	4 times per year
Save the Children					
Community Volunteer Nutrition Promoters	District official	PowerPoint presentation, group discussion	Training manual	All promoters in district	3 times/year, 4–5 day training, each training session covers a different info packet of subjects
<i>Animadoras</i>	Promoters	Lecture, group discussion	Training manual and posters	10 <i>animadoras</i>	Monthly

From a review of training curriculum and interviews with project staff, including field staff, the SBCC team encountered little evidence of training for field staff and volunteers in IPC specifically or SBCC methods more generally. SC reported that nutrition promoters and *animadoras* were trained in how to organize mothers groups and basic counseling skills, including dialogue, respect, how to ask open-ended questions, how to show interest in what is being said, and how to avoid using words that are judgmental.

The PNB PowerPoint curriculum that was provided to the research team appeared to be largely clinical in its orientation, and had little discussion of IPC or SBCC communication techniques. The SBCC team observed volunteers lecturing groups of mothers and, as time went on, the mothers were clearly losing interest in what was being said.

7.4.3 Coordination with DPS, SDSMAS, and Partners

The MYAP partners coordinated with the DPS and DDS through a continuous exchange of information regarding project activities. For example, ADRA submitted trimester reports to DPS and DDS, including data on growth monitoring, family planning, and activities of the volunteers. ADRA also had monthly coordination meetings with staff from the *Serviços Distritais de Saúde, Mulher e Acção Social* (SDSMAS) (District Services for Health, Women, and Social Action) to plan mobile brigades and other overlapping activities. The MYAP partners conducted joint supervisory field visits with SDSMAS and DPS. The MYAP partners also regularly invited the DPS Nutrition Technician (*técnico de nutrição*) to participate in training sessions. MYAP staff and CHVs often also assisted

mobile brigades in the community. Coordination with partners implementing SCIP was strong, as efforts were made to develop activities that complemented and filled the gaps in each program, and also to cross-train staff on the different topics covered by each program.

7.4.4 Coverage

Adventist Development and Relief Agency

In its original MYAP proposal, ADRA planned to cover 11 percent of the total population of five districts. However, due to funding cuts, the expected coverage was reduced to 6–7 percent of the total population of five districts. ADRA staff estimated coverage was on average 4 percent per district: Lugela – 5 percent; Mocuba – 3 percent; Maganja – 7 percent; Pebane – 3 percent; and Ile – 1 percent. The initial plan was to cover 60 percent of communities per district. Three districts reached this target, but in the other two districts only 40 percent of communities were covered. Beneficiaries were selected on the basis of vicinity to the CHVs' or mothers/fathers group members' houses.

World Vision

At the beginning of the program, WV expected to cover 495,000 beneficiaries in its project districts: Alto Molocué, Gilé, Gurue, Mopeia, Morrumbala, Namacurra, Namarroi, and Nicoadala. Actual coverage was less than a third of the expected coverage (155,598) due to factors that included dropouts of CHVs and large distances between CHVs' homes and beneficiaries' homes that made access to beneficiaries difficult.

Save the Children

SC originally planned for each *animadora* to work with two groups of 15 mothers, estimating that 60 percent of mothers with children under 5 years of age would be covered in every community. However, SC found that the *animadoras* needed to increase the number of mothers that they were reaching to cover at least 60 percent of the mothers with children under 5 years of age. In October 2011, SC estimated coverage of mothers in SANA districts to be on average 30 percent.

Overall Observations

Generally, MYAP partners were spread fairly widely across several districts and in pockets of communities throughout those districts.

The SBCC team did not observe any graduation strategy, nor did any community offer a vision of graduating from the MYAP activities. The SBCC assessment team also did not observe systems to prioritize communities so as to better direct resources and time to those with greater need. In SC communities, volunteers noted that they received bicycles to support them in their work, and they said that this enabled them to reach more distant households. In a few communities, particularly in Gurue District, Zambezia Province, volunteers and community leaders noted the difficulty that they had in reaching community members in outlying areas. They said that this limited their ability to expand project coverage. It is suggested that partners consider providing bicycle transport to ensure greater coverage in communities that are spread out over a large area.

7.4.5 Supportive Supervision

Adventist Development and Relief Agency

According to ADRA plans, the Health and Nutrition Coordinator should visit District Health Supervisors twice a week so each District Health Supervisor is visited 2–3 times per month. However, the number of visits depends on time required for other tasks and, in practice, each District Health Supervisor was visited by the Health and Nutrition Coordinator once per month. The District Health

Supervisor met with each Health and Nutrition Technician once per week; the Health and Nutrition Technician met with a CHC at least once a week, or usually about two visits per month with each of the 16 CHCs. Recommendations were made with every supervision visit at every level and recorded in a supervision book. Copies of these recommendations remained with both the supervisor and supervisee. Recommendations were made orally at the end of the visit and ideally recorded in the book for future follow-up. Informal management training was included in job training of managers but not for lower staff. Supervision forms were available for district health supervisors and health technicians, and can be seen in **Annex 6**.

World Vision

Supervision of District Coordinators occurred every 3 months and was conducted by the Nutrition Coordinator, the Agriculture Coordinator, and/or the M&E Coordinator. Supervision occurred through field visits, using a supervision form when appropriate, or regular communication via email and phone. The District Coordinator, in turn, supervised health technicians every 3 months, also using a supervision form. Recommendations were given via conversation when a particular activity was not going according to plan. Health and nutrition technicians conducted monthly supervision visits to the health auxiliaries and CHVs and mothers/fathers groups. Recommendations were given to the entire CHC via conversation. A supervision form was also available (see **Annex 7**), but it was reportedly often not used because technicians felt that volunteers may perceive the supervision as an evaluation of their performance rather than a supportive activity. Supervision of collection, reporting, and analysis of M&E data was done by the M&E Coordinator. MYAP nutrition and health coordinators and technicians did not receive any training on supervision techniques.

Save the Children

Provincial Nutrition Coordinators supervised the District Officials on a monthly basis. SC staff reported that tools used for supervision visits included checklists and a field visit report. However, these were not made available to the assessment team. Recommendations were provided after activities were observed. Supervision visits were often completed in collaboration with SDSMAS staff. Community volunteer nutrition promoters also conducted supervision of *animadoras*.

7.5 Evaluating and Replanning

The objective of monitoring is to assess progress in the implementation of the program's work plan and progress toward the achievement of expected results. The aspects of program implementation included in monitoring are inputs, processes, outputs, and outcomes (see **Box 5** for definitions). Monitoring should inform program managers where there are performance problems so that corrections can be made to improve the implementation of activities.

Box 5. Key Monitoring and Evaluation Terms

Inputs: The set of resources (staff, financial resources, space, project beneficiaries) brought together to accomplish a project's objectives.

Processes: The set of activities (e.g., training, delivering services) by which resources are used in pursuit of the expected results.

Outputs: The products (number of trainees; of immunized children; of meetings held) that result from the combination of inputs and processes.

Outcomes: The set of beneficiary- and population-level results (such as changes in practices or knowledge) expected to change from the intervention.

Impacts: The set of beneficiary- and population-level long-term results (improved food security; improved yields; improved nutritional status) achieved by changing practices, knowledge, and attitudes.

Source: Bergeron, Gilles; Deitchler, Megan; Bilinsky, Paula; and Swindale, Anne. 2006. "Monitoring and Evaluation Framework for Title II Development-oriented Projects." http://www.fantaproject.org/downloads/pdfs/TN10_MEFramework.pdf.

The MYAP partners routinely collected information on program inputs, processes, and outputs. Program outputs were monitored through forms completed by CHVs (WV and ADRA), *animadoras* (SC), community-level supervisors, and district supervisors. An example of an output indicator collected through the forms is the number of lessons or demonstrations given by CHVs to mothers groups. The community-level forms used images in addition to text to make the forms easy to understand for low-literacy populations. **Annex 8** has an example of a form used by WV.

The MYAP partners also conducted annual surveys among beneficiaries to monitor outcomes of their program activities. The behavior outcome indicators included in the surveys were chosen to reflect the expected results of the program activities as well as FFP's reporting requirements. As part of the Annual Results Report, FFP requires MYAP partners to report on selected behavioral outcome indicators. The data were reported in the FFP Standardized Annual Performance Questionnaire and IPTTs and must be representative of program beneficiaries. For MYAPs awarded prior to 2011,⁵⁴ the following behavioral outcome indicators must be reported annually, if the program includes activities relevant to the indicator.⁵⁵

To reduce the prevalence of chronic undernutrition among young children:

- Percentage of children 0–5 months of age that are exclusively breastfed
- Percentage of children 6–23 months of age with three appropriate IYCF practices (continued breastfeeding, age-appropriate dietary diversity, age-appropriate frequency of feeding)

To enhance the nutritional status of women:

- Percentage of women that consume food rich in iron
- Percentage of women that consume food rich in vitamin A
- Percentage of women that consume food rich in calcium

⁵⁴ The FFP reporting requirements for MYAPs awarded after 2011 is different than those previously awarded. See DCHA/FFP. 2011. Information Bulletin (FFPIB) 11-03, Memorandum for all Food for Peace Officers and Cooperating Sponsors.

⁵⁵ DCHA/FFP. 2007. Information Bulletin (FFPIB) 07-02, Memorandum for all Food for Peace Officers and Cooperating Sponsors.

- Percentage of women taking iron or iron folate supplements in last 7 days

To improve health status and contribute to improved household nutrition through improved water and sanitation infrastructure and practices:

- Percentage of caregivers demonstrating proper personal hygiene behaviors
- Percentage of caregivers demonstrating proper food hygiene behaviors
- Percentage of caregivers demonstrating proper water hygiene behaviors
- Percentage of caregivers demonstrating proper environmental hygiene behaviors

The MYAP partners conducted baseline surveys between November 2008 and February 2009. Due to delayed starting of the MYAP activities in 2009 and the limited amount of time between the completion of baseline surveys and when the 2009 annual monitoring data were to be collected, the MYAP partners did not conduct monitoring surveys in 2009. Monitoring surveys among beneficiaries were conducted in 2010 and 2011. **Table 12** shows the available results of the behavior outcome indicators, including the FFP standard behavioral outcome indicators, reported by ADRA, WV, and SC for the baseline survey in 2008 and the monitoring surveys in 2010 and 2011.

Table 12. Behavior Outcome Indicators Reported by ADRA, WV, and SC in the IPTT

Indicator	ADRA			WV			SC		
	2008	2010	2011	2008	2010	2011	2008	2010	2011
FFP Standard Indicators									
Percentage of children 0–5 months that are exclusively breastfed	65.2	70.8	83.0				38.4	77.0	
Percentage of children 6–23 months with three appropriate IYCF practices				43.96	60.32		5.1	48.3	
Percentage of caregivers demonstrating proper personal hygiene behaviors (SC: Percentage of caregivers of children 0–23 months that know of at least two critical times to wash their hands)							27.4	98.3	
Percentage of caregivers demonstrating proper water hygiene behavior (WV: at least 1 proper behavior)				29.0	69.94				
Percentage of caregivers demonstrating proper food hygiene behavior				11.0	69.64				
Percentage of women who consume foods rich in vitamin A				22.76	70.70				
Additional Behavior Outcome Indicators									
Percentage of children 6–23 months with continued breastfeeding	55.0	81.2	77.6						
Percentage of children 6–23 months fed solid/semi-solid food the minimum number of times per day	65.0	85.3	73.0						
Percentage of children 6–23 months fed the minimum number of food groups per day	20.0	26.67	27.05						
Percentage of caregivers that can cite at least two known ways of preventing malaria	46.8	87.87	99.2						
Percentage of caregivers that can cite at least two known ways of preventing HIV	55.2	95.8	98.8						
Percentage of children 6–23 months that received vitamin A supplementation within the past 6 months							21.7	57.7	
Percentage of children that are exclusively breastfed until 6 months				11.0	83.91				
Percentage of children 0–59 months that had diarrhea during the previous 2 weeks and were taken to a health facility				39.0	11.11				
Percentage of children 0–59 months that had fever and/or respiratory infections during the previous 2 weeks and were taken to a health facility				58.0	13.36				
Percentage of children 6–59 months that had diarrhea during the previous 2 weeks				42.0	11.11				
Percentage of children 6–59 months given extra liquids during diarrhea episodes				30.6	88.46				
Percentage of children 0–23 months that continued breastfeeding during diarrhea episodes				40.0	73.46				

In September 2009, FANTA-2 trained MYAP partner M&E staff in the use of Lot Quality Assurance Sampling (LQAS) for annual monitoring. LQAS is a sampling and analysis method that allows the identification of geographic or supervision areas that are performing adequately based on a comparison with a benchmark or target. However, MYAP partners are not currently using LQAS. ADRA used LQAS for monitoring of the DAP, but switched to cluster sampling for the MYAP. LQAS was used largely to compare data from one district to another, but ADRA reported that cluster sampling was better for analyzing the entire program area. WV did not use LQAS because provincial management staff report that all agriculture and health technicians would need to be trained to properly implement it and that using LQAS for monthly monitoring would be too time consuming for field staff. Nevertheless, WV MYAP provincial management staff recognized the importance of using LQAS and were discussing the possibility of using LQAS for monitoring at least twice a year to measure outcomes of health and nutrition activities. SC intended to use LQAS for annual monitoring. However, SC reported that LQAS was found to be too logistically difficult and opted for cluster sampling.

All of the MYAP partners reported using monitoring information to evaluate program activities, weaknesses, gaps, and impact at the community level, and had planning meetings to address issues at the program and community levels. For example, at the provincial level, ADRA used the data to measure the success and impact of the program activities and also to report to partners and DPS. At the community level, ADRA technicians used data to help the CHC make tables and graphs that showed trends and impacts of interventions. This served to motivate the community in regard to successes or areas in need of improvement. WV provided monitoring information to the communities through a report produced by the CHCs. SC also reported using monitoring information to identify areas that should be included in refresher trainings.

7.6 Beneficiary Rapid Assessment Interviews

Rapid assessment interviews with beneficiaries were conducted in 9 of the 13 communities visited. In total, 25 beneficiaries were interviewed: 15 in Zambezia Province and 10 in Nampula Province. All interviewed individuals were participants in the MYAP, either through attendance at group meetings or receiving individual household visits by trained program volunteers. All of the interviewees were mothers, except for three grandmothers. The interview results were qualitative and were not representative of the beneficiary population. However, the responses were helpful to understand the health and nutrition practices of the women that were interviewed. **Table 13** provides a summary of knowledge and reported practices addressed in the MYAPs and assessed in interviews.

Table 13. Summary of Knowledge and Reported Practices Addressed in MYAPs and Assessed in Interviews

Topic	Yes	No	n/a*
Reported having changed behavior as a result of participation in program	25	0	0
Reported improved health of children after participation in program	25	0	0
Practiced exclusive breastfeeding until 6 months	20	0	5
Young child ate at least three meals a day plus additional snacks	11	24	0
Used enriched porridge in complementary feeding	21	0	4
Improved diet diversity**	15	10	0
Increased food and liquids during or after illness	6	11	9
Washed hands with soap or ash	21	4	0
Knowledge of when to wash hands with soap or ash	23	2	0
Knowledge of at least two or more foods rich in vitamin A	14	11	0
Used mosquito net in house	12	13	0
Reported insufficient food stock	13	12	0

* n/a: Interviewee did not have a young child, or the child had not yet been sick.

** Responses that indicated improvements in dietary diversity included: consumption of fruits and vegetables in diet, personal production of vegetables on family farm, understanding of four food groups, diversity of crops produced to eat.

Among the interviewees, all reported improved health of their children and changes in their own practices. Examples of reported behavior changes include:

- Preparation and use of enriched porridge
- Improved hygiene
- Exclusive breastfeeding
- Increased health care seeking at hospitals and health centers
- Vaccinating children
- Participation in growth monitoring

The interviewees reported increased knowledge and positive behavior change particularly in the areas of exclusive breastfeeding, use of enriched porridges, sanitation and hygiene, and handwashing. Interviewees also reported taking their children to the hospital/health center in case of illness, but that their children were experiencing less illness, particularly diarrhea. All interviewees had small family farms on which they grew the majority of, if not all, food consumed in the house. Complementary feeding knowledge and practices reported by the interviewees were poor. Most interviewees did not state the importance of frequency of feeding and diet diversity, and many reported providing only 2–3 meals a day and few or no fruits and vegetables to children. Though the four food groups were included in one of the key messages of the MYAPs, few mothers seemed to really understand the concept or how to use it in preparing the family foods. Probably the weakest nutritional area was recuperative feeding during or after illness, with only six interviewees reported increasing foods and liquids in case of child illness.

8. Lessons Learned and Challenges

8.1 Lessons Learned

An analysis of the assessment results presented above led to the identification of the following lessons learned in SBCC implementation by the MYAP partners.

1. Programs can make small adjustments based on field experience to strengthen SBCC approaches. For example, in WV areas, based on an analysis of field experience, CHVs and mothers and fathers groups now explain the reasons behind the messages transmitted to beneficiaries, so that beneficiaries can weigh the benefits against the risks of adopting new behaviors. To address resistance to the adoption of new behaviors, examples of success stories of mothers whose children's health and nutrition improved after adopting the behaviors promoted by the MYAP are now shared with the community
2. Targeting only mothers was not effective in achieving the desired behavior change, so the entire community, especially fathers, grandmothers, community leaders, and other influential community members, are engaged through the community health council and *Grupos de Suporte*. Involvement of men and grandmothers in activities is important because they can positively influence the behavior of caregivers.
3. Collaboration with programs that can assist families to access necessary resources, such as mosquito nets and point-of-use water purification products, is important to facilitate behavior change.
4. Participation of community groups as support mechanisms, such as the CHCs and *Grupos de Suporte*, seem to create ownership of the project and increase sustainability of activities. CHCs and *Grupos de Suporte* build social capital and social support for adoption of improved nutrition and health practices and are effective in obtaining widespread community adoption of changes, accelerating the pace of change, and increasing coverage. Communities that appeared to have high-functioning CHCs tended to have higher levels of knowledge of key nutrition messages than communities that appeared to have less dynamic leadership.
5. Job aids and support materials, such as T-shirts, caps, and identification badges, enhance the credibility of volunteers and boost their morale. Poster-sized materials with smaller graphics are not practical for use in presentations and are cumbersome to manipulate in front of a group, and material with larger graphics is preferable so that the graphics can be seen more easily.
6. It is important to train community volunteers in IPC skills and adult learning techniques to keep mothers engaged during individualized counseling and group education sessions.
7. Communities are motivated by graphs and tables prepared by the CHCs that show trends, impacts of interventions, successes, and areas for improvement.

8.2 Challenges

An analysis of the assessment results presented above led to the identification of the following challenges in SBCC implementation by the MYAP partners.

1. Ideally, there should be a systematic and comprehensive process to understanding the situation, so that an informed SBCC strategy can be developed. However, in the context of the MYAPs, activities must be implemented very soon after the award is made to the partner. Therefore, there is very little time before activities start to conduct formative research and systematically plan SBCC strategies.

2. Barriers to behavior change in the MYAP context are formidable and require careful, strategic design of SBCC strategies to obtain positive impact. For example, ADRA found barriers to behavior change included division of labor in the family, which affected provision of child care; the roles of husband and wife in decision making, such as use of family resources; and the knowledge/education levels and ability to understand and analyze complex messages. These barriers were identified by ADRA through personal field experience, a needs assessment, and experience with the DAP.
3. Although fathers are encouraged to participate in mothers/fathers groups, fathers often do not participate and more information is needed to understand why they do not participate (ADRA project).
4. For certain communities to succeed, such as those facing serious food shortages and lack of access to land and resources, SBCC is not enough. Broader solutions may be necessary to assist such communities to move out of poverty, and the MYAP programs should have mechanisms for assisting such communities.
5. In some areas, project coverage is limited by long distances volunteers and community leaders must travel to reach homes. It was suggested that partners consider providing bicycle transport to ensure greater coverage in communities that are spread out over a large area.
6. Volunteers perceive supervision as an evaluation of their performance and not as a supportive activity, which results in fear and anxiety and can reduce the positive impact of supervisory visits.
7. The MYAP partners were trained to use Lot Quality Assurance Sampling (LQAS) for monitoring. However, for different reasons, all of the partners faced difficulties using LQAS. It is not clear if there was not sufficient preparation or additional technical support was needed for partners to use LQAS for monitoring.

9. Recommendations

9.1 Understanding the Situation

The MYAP partners reported that their SBCC strategies and activities were based on previous experience in the DAPs. There is no documentation of formative research or analysis of secondary formative work to inform the SBCC strategies and activities adapted from the DAPs in the MYAPs. Ideally, there should be a systematic and comprehensive process to understanding the situation, so as to develop an informed SBCC strategy. Understanding the situation includes gathering information about the context in which the target groups and audiences operate, desired changes, barriers to change, and those affected and influencing behaviors. In particular, this should also integrate a gender analysis to provide program staff with a sound understanding of gender-based facilitators and barriers that exist and need to be addressed through the SBCC activities to enable the program to reach its objectives.

In the context of the MYAP, activities must be implemented very soon after the award is made to the partner. There is very little time before activities start to conduct formative research and systematically plan SBCC strategies. MYAP partners did attempt to improve their SBCC activities as a part of the implementation process. At the start of the MYAP, SC worked with a consultant to improve its original strategy for BCC activities. MYAP partners also reported modifying their activities based on monitoring information and feedback from staff. However, the efforts were more reactive to a problem that surfaced instead of proactively planning to ensure that all audiences were being reached with appropriate messages through effective communication channels.

Key Recommendation

- Use a SBCC planning process such as C-Planning, which includes formative research or analysis of secondary formative work, to inform the SBCC strategies and activities.

9.2 Focusing and Designing

9.2.1 Overall SBCC Strategy

As previously discussed, there is very little time between when a MYAP award is made and when implementation must begin. An overall SBCC strategy for USG-supported implementing partners could be developed that aligns with the GRM's PAMRDCM and the National Strategy for Health Promotion. The SBCC strategy would operationalize the vision outlined in both documents and would serve as an implementation plan to better coordinate efforts of each of the USG-supported partners. By conducting formative research and developing an overarching SBCC strategy through a consultative process with USG partners, it would ensure systematic planning of SBCC activities and materials that are linked and support one another, leading to greater effectiveness of interventions.

The GRM has included SBCC related to nutrition in a few policies and several strategies, plans, and protocols. It is very important that program designers be familiar with the SBCC aspects of these GRM documents and take them into consideration when designing nutrition programs with SBCC components. USAID/Mozambique-funded programs should work to support GRM SBCC plans, as feasible, to support achieving GRM nutrition goals.

Branding

The branding of interventions such as the MYAPs holds the potential of reinforcing and linking IPC, community-level communications, and radio interventions, and positioning the "brand" as a trusted source of information on nutrition. Branding is a critical part of an overarching SBCC strategy

designed to shift the focus of intervention and its trigger (the actual stimulus for change) from knowledge, beliefs, or cognitive antecedents (for example, about self-efficacy) to action.

USG could collaborate with MISAU to develop a brand for MISAU programs aimed at improving nutrition. USG-supported programs could then support the branded MISAU program. This would allow for a common branding of activities that cuts across all the communities served by the various implementing partners and provides continuity of perceptions of the programs as the interventions themselves undergo contractual and other changes. In this way, the development effort becomes associated with the branded concept of development rather than with the vagaries of implementing partners and USAID contractual changes. A branding exercise may lead to adoption of name, slogans, colors, and music to reinforce the common theme. (This branding exercise should not be confused with the branding requirements of USAID, which is a completely parallel and fully compatible process.)

An appeal to behavior change based on a sense of belonging to a larger group also appears to resonate with the Mozambican public. Published research indicates that a sense of citizenship in (belonging to) a group has served to compel acceptance of indoor residual spraying for malaria prevention in Mozambique. This finding suggests that an appeal to individuals on the basis of their identity as members of a larger group may constitute part of an effective SBCC strategy. For this, it may be important to stress the benefits beyond individual families to community and possibly even nation, and it is worth considering the prospect of reinforcing the idea that being “Mozambican” means adopting proactive behaviors that will ultimately benefit themselves, their neighbors, and indeed all Mozambicans.

Key Recommendations

- Develop an integrated health and nutrition SBCC strategy for USG-supported programs.
- Develop a brand for interventions such as the MYAPs aimed at reducing chronic malnutrition.
- Ensure program-level SBCC strategies take into consideration SBCC components of GRM policies, strategies, plans, and protocols.
- Ensure SBCC strategies include a strong gender component and analysis and incorporation of gender issues, including facilitators and barriers to women’s and children’s improved nutrition and health.

9.2.2 Desired Changes and Key Messages

The MYAP partners did not have documented comprehensive SBCC strategies containing information about audience(s), desired changes, barriers, communication objectives, strategic approaches, positioning, and channels. By not systematically developing a strategy and building on each phase, there was no linkage from one step in the process to the next. For example, it did not appear that communication objectives were developed to address key barriers to desired changes. Because of this, the programs may not have been as focused or as effective in creating change as they could have been.

Given that malnutrition is associated with illness, inadequate quantity and quality of food intake, poor care practices for women and children, and short birth spacing, MYAP partners should concentrate their SBCC efforts on promoting the Essential Nutrition Actions (ENA)⁵⁶; key household hygiene actions; and preventive and curative practices, like timely immunization, appropriate home health care, recognition of signs of malnutrition and illness, care-seeking behavior, and healthy timing and spacing of pregnancy (refer to **Box 6** for key behaviors).

⁵⁶ Guyon, A.B. and Quinn, V.J. 2011. *Booklet on Key Essential Nutrition Actions Messages, Essential Nutrition Actions Framework Training Guide for Health Workers, Essential Nutrition Actions Framework Training Guide for Community Volunteers Workers*. Washington, DC: Core Group.

Box 6. Key Nutrition and Health Behaviors

ENA

- Optimal breastfeeding during the first 6 months of life
- Optimal complementary feeding starting at 6 months, with continued breastfeeding to 2 years and beyond
- Optimal nutrition care of sick and severely malnourished children
- Prevention of vitamin A deficiency for women and children
- Adequate iron/folic acid intake and prevention and control of anemia for women and children
- Adequate iodine intake by all household members
- Optimal nutrition for women

Key household hygiene actions

- Treatment and safe storage of drinking water
- Handwashing with soap or ash at critical times (i.e., after defecation, after handling children's feces, before preparing food, before feeding children, before eating)
- Safe disposal of feces
- Proper storage and handling of food to prevent contamination

Other key practices

- ANC attendance (at least four visits), tetanus toxoid vaccine, iron/folic acid supplementation
- Full course of immunizations for all children before their first birthday
- Children and women sleeping under insecticide-treated bednets
- Recognizing when a sick child needs treatment outside of the home and seeking care from appropriate providers
- Recognizing pregnancy danger signs
- Healthy timing and spacing of pregnancies

Although the MYAP partners' programs included most of the key behaviors listed in **Box 6**, the desired changes that the MYAP partners targeted could be better aligned with behaviors that have been proven to improve nutritional status. For example, aspects of the ENA that were not clearly promoted by all of the MYAP partners included:

- Continued breastfeeding to 2 years and beyond
- Vitamin A supplementation for children every 6 months
- Iron and folic acid supplementation during pregnancy
- Adequate iodine intake by all household members
- Optimal nutrition for women (all women, not just pregnant women)

The lack of activities to promote adequate iodine intake is especially concerning. None of the MYAP partners were promoting the consumption of iodized salt despite that in Mozambique an estimated

68 percent of children 6–12 years of age were iodine deficient and only 58 percent of households consumed iodized salt.^{57,58}

Targeting messages according to age groups and lifecycle stages has been found to be more effective in promoting behavior change than general messages provided to a heterogeneous group.⁵⁹ When messages are targeted for the specific circumstances of the audience (e.g., promoting optimal complementary feeding practices among mothers of infants 0–12 months), the information is more relevant for what is currently happening. It is also more possible to anticipate how to overcome barriers to a behavior when information is given just ahead of when needed to adopting a new practice (e.g., promoting exclusive breastfeeding among pregnant women). MYAP BCC activities were not differentiated among age groups or lifecycles. Therefore, all audiences were receiving the same messages. It would be more effective to target the messages according to age groups and lifecycle stages. Messages should also be designed to take into consideration gender issues to ensure that they effectively address barriers to improved nutrition for women and children and are directed in a culturally appropriate fashion to secondary audiences, such as husbands and male community leaders and religious leaders. This is critical to ensuring that women get the support they need from their husbands and other men in the community.

In addition, linking the stages of child development with time frames and results will help demonstrate the success of behavior change. All messages should be tested with the target audience to determine acceptability and effectiveness. Illustrative examples include:

- Birth: Good nutrition and reduced workload during pregnancy leads to healthier babies at birth.
- Infancy: Exclusive breastfeeding until 6 months leads to less diarrhea in the baby.
- 6–12 months: Preparing enriched porridge helps the baby grow quicker and walk sooner.
- 12–24 months: Practicing good hygiene helps children avoid disease and grow stronger.

Messages should be appealing and discuss only one or two key points. The “Seven Cs of Communication”⁶⁰ can be used as a guide for message development:

- Command attention: Does the message stand out? Does the audience think so?
- Clarify the desired change: Is the message simple and direct?
- Communicate a benefit: What will the audience get in return for taking action?
- Consistency counts: Do materials and activities convey the same message and reinforce each other?
- Cater to the head and heart: Does the message appeal to the audience’s emotions while still portraying the facts?
- Create trust: Does the information come from a credible source according to your audience?
- Call to action: What concrete and realistic action do you want the audience to take?

Key Recommendations

- Concentrate SBCC efforts on promoting evidence-based ENA, key household hygiene actions, and preventive and curative practices proven to improve nutritional status.

⁵⁷ MISAU. 2004. *Estudo Nacional sobre a Deficiência em Iodo nas Crianças dos 6 aos 12 Anos de Idade*.

⁵⁸ National Statistics Institute, 2009. *Preliminary Report on the Multiple Indicator Cluster Surveys, 2008*. National Statistics Institute Directorate of Demographic, Vital and Social Statistics, Maputo, Mozambique.

⁵⁹ Ruel, Marie T. et al. 2008. “Age-based preventative targeting of food assistance and behavior change and communication for reduction of childhood undernutrition in Haiti: a cluster randomized trial.” *Lancet*, Volume 371, Issue 9612, 588–595.

⁶⁰ Piotrow, P. et al. 1997. *Health Communication: Lessons from family planning and reproductive health*. Westport: Praeger.

- Improve messages to discuss only one or two key points according to the principles of the “Seven Cs of Communication.”⁶¹
- Target messages and SBCC activities according to age groups and lifecycle stages.
- Link the desired behavior with results that demonstrate successful outcomes of that behavior.
- Ensure desired changes and messages address gender-related barriers to improved nutrition for women of reproductive age and children under 2 years.
- Ensure that desired changes and messages promote shared responsibility for nutrition at the family and community levels and clarify roles and responsibilities for family and community members so that they are clear on actions and behaviors they can take or adopt to support mothers’ and children’s nutrition.

9.2.3 Audiences

The period from conception through 2 years of age is when the most rapid physical growth occurs and is a critical time in cognitive development. The period from birth to 2 years is also critical because children in this age range have relatively high nutritional needs to support growth and development. Suboptimal feeding practices and high risk of illness and infection make children more vulnerable to growth faltering and malnutrition in the first 2 years of life than at any other time in the life cycle.⁶² These children are also most responsive to nutrition interventions.⁶³ Targeting this vulnerable age group maximizes efforts to promote linear growth and prevent the long-term physical and cognitive consequences of malnutrition. The MYAP partners reported the target groups for improving nutritional status as children under 5 years of age, with prioritization of children under 2 years of age, and pregnant and lactating women. To be more aligned with the window of opportunity from conception through 2 years of age, MYAP activities should be targeting children under 2 years of age, pregnant women, and women of reproductive age.

Table 14 shows the possible audiences of SBCC interventions aimed at improving the nutrition of infants and young children. MYAP partners were targeting most of the audiences in **Table 14** with their BCC activities.

Table 14. Audiences for Nutrition SBCC Interventions

Audience	Role
Children under 2 years	<i>Directly affected</i> as the health of the child is most affected
Pregnant women	<i>Directly affected</i> as the health of the mother and child is most affected
Women of reproductive age	<i>Directly affected</i> as the health of the mother and child is most affected
Men: fathers of children under 2 years and spouses of pregnant women	<i>Directly influencing.</i> Decision maker regarding family resources.
Grandmothers/mothers-in-law	<i>Directly influencing.</i> Affect child care and feeding decisions.

⁶¹ Piotrow, P. et al. 1997. *Health Communication: Lessons from family planning and reproductive health*. Westport: Praeger.

⁶² Shrimpton, R. et al. 2001. “Worldwide Timing of Growth Faltering: Implications for Nutritional Interventions.” *Pediatrics* 107 (5): E75.

⁶³ Ibid.

Audience	Role
Older siblings that care for younger siblings	<i>Directly influencing.</i> Affect care giving to younger siblings.
Traditional birth attendants	<i>Directly influencing.</i> Deliver the newborns and provide care to the mother and child as a direct adviser and influencer.
Traditional healers	<i>Directly influencing.</i> Active roles in promotion of healthy nutrition, hygiene, and health practices.
Nurses	<i>Directly influencing.</i> Central to supporting a mother from prenatal to postnatal; prenatal visits, growth and monitoring, and nutritional counseling.
Community health workers	<i>Directly influencing.</i> Active roles in promotion of healthy nutrition, hygiene, and health practices.
Doctors	<i>Directly influencing.</i> Central to supporting a mother from prenatal to postnatal; prenatal visits; child health facility visits.
Community and religious leaders	<i>Directly influencing.</i> Mobilize community resources and advocate for appropriate water, hygiene, emergency transport support, government, or partner support.

Although the audiences were clearly identified in interviews with MYAP partners, there was not much discussion or documentation analyzing the context of each of the audiences. For example, while one barrier identified by ADRA included men (as the decision makers regarding family resources) opposing some nutrition behaviors, it was reported that often men did not participate in mothers/fathers groups. Further audience consultations have not been done to determine the barrier of male involvement or more effective venues to reach them.

While each of the MYAP partners had an extensive list of key messages for its program, it did not appear that the messages were developed to match the intended audience’s need and motivation with the most compelling solution, which should outweigh or at least address the barriers the audiences faced. Additional audience consultations should be conducted to probe for barriers to the desired change for each audience. For example, in future projects of this kind, it would be important to know, despite recruitment efforts, why men are not involved with fathers group. It would also be helpful to determine the most effective venues to reach them with more effective formats and more compelling messages.

Key Recommendations

- Target children under 2 years of age, pregnant women, and women of reproductive age as the primary audience most directly affected by malnutrition.
- Conduct audience consultations.
- Focus more activities and target specific messages to fathers, grandmothers, and mothers-in-law as key target audiences.
- Include messages for health facility workers, as they are also a key audience directly influencing community-level nutrition and health behaviors, to ensure nutrition and health messages are consistent between health facilities and communities.

9.2.4 Interventions

A mutually reinforcing mix of interpersonal, community-based, and BCC approaches was used by each MYAP partner. For example, messages given during mothers/fathers groups were expanded on and more tailored during household visits, which were then supported and reinforced by community radio programming. However, advocacy, a key component to a comprehensive SBCC program, was not a part of any of the partners' programs. The GRM's PAMRDCM includes in its strategic objective on advocacy, coordination, and management the creation of provincial and district groups to plan and manage advocacy and social mobilization activities for the multisectoral plan. MYAP partners could be involved in such activities. Advocacy campaigns at the provincial and district level could, for example, focus on stronger coordination mechanisms for SBCC programs and material development, improved counseling services, and/or gender issues affecting women's and children's nutritional status. Details on advocacy and social mobilization activities at the provincial and district levels would depend on the specific MYAP, SBCC strategy, and discussions/coordination with MISAU and other partners. With regard to interventions in general, best practices found through the assessment include the *Grupos de Suporte*, involvement of community leadership in CHCs, integration of nutrition and agriculture activities, the use of community planning tools, junior farmer groups, and radio programming.

Key Recommendations

- Include advocacy, social and community mobilization, and BCC in SBCC strategic approaches.
- Include a mutually reinforcing mix of communication channels, including interpersonal channels, community-based channels, and mass media channels.
- Continue to support community structures, such as the *Grupos de Suporte* and CHCs, to mobilize community leadership and members to support behavior change and address barriers to behavior change.
- Integrate nutrition and agriculture activities as a way that involves fathers and husbands in supporting health and nutrition of their families.
- Expand and strengthen the use of community planning tools to link nutrition and agriculture together, as well as to create participatory plans to increase coverage and for graduation from program support.
- Expand junior farmer groups and other activities that target older children that are often the caregivers of younger siblings and young women.
- Expand and strengthen the use of entertainment education, such as radio programming and theatrical groups.
- Promote the participation of women in agricultural marketing cooperatives and other income-generating activities.
- Analyze the impact of interventions on women and men and adjust interventions as necessary to support women and “do no harm” with regard to women's position in the family and community, burden of labor, and decision-making power.

9.3 Creating

9.3.1 Materials

Materials were not developed using a systematic approach, for example, outlined in a creative brief, as described in Section 5.2. Using this process would have helped the material developers clarify the promise of the content (i.e., the most compelling benefit the target audience will receive from their perspective by taking the desired action), the support for that, the “call to action” (i.e., what the audience should do or where they need to go for products or services), and the lasting impression that

the developers would like to be conveyed. Most materials appeared to have been adapted from the DAPs, but no pretesting was reported to have been done with members of the target audience. As a result, the assessment team found that CHVs had many recommendations on how materials could be improved, including size of graphics, how they are transported, and literacy issues. In addition, while much text was included in many of the materials (making them more difficult to read and comprehend), the messages within the materials were lacking in terms of comprehensive information. Pretesting of materials should also take into consideration gender issues and how gender-related facilitators and barriers to improved nutrition for women and children are represented in materials, and how messages and illustrations are understood by women and men in the target audience to ensure they “do no harm.” It is especially important that the materials convey a sense of shared responsibility for maternal and child nutrition at the family and community levels so as not to burden mothers further with child-caring responsibilities and not to blame them for inadequate care practices, but rather to actively support them through actions and behaviors of/by other family members that reflect shared responsibility for nutrition.

Food Groups Poster

The most commonly used BCC material used by all the MYAP partners was the food groups poster (*A Nossa Alimentação*), originally developed by MISAU. The food groups poster is limited in its effect for several reasons. Aside from the category of staple foods (corn, cassava, rice), the other three food groups are all labeled as “accompaniment.” Volunteers were trained to discuss the different functions of each food group (for example, fruits and vegetables provide vitamins that help defend against illness), but these messages were not included on the poster. Furthermore, each accompaniment is presented as an equal proportion to the large staple foods, making no distinction in importance, quantity, or frequency of consumption among these three groups. Nowhere on the poster did it say how much or how often each group should be consumed. In addition, the four food groups were presented as distinct groups in separate circles, rather than in combination, for example, on a plate as is now used by the United States Department of Agriculture. Presentation of food groups together, as in the plate model, helps reinforce the combination of foods, the relevant proportions necessary, and the concept of a balanced diet. Though this manner of presentation has proved successful for United States audiences, it would need to be pretested in Mozambique.

While the assessment team observed an absence of BCC materials in the field, this may not necessarily represent a failing in the SBCC campaigns, but rather that BCC printed materials may not be practical for use in the field because of storage and transport problems, low literacy, low level of knowledge of Portuguese among volunteers, and/or poor eyesight (and the accompanying lack of availability of eyeglasses). Other forms of communication were very common, including songs created by local women to teach key message to target audiences. Typically in strongly oral cultures, as is the situation in these rural communities, songs, theater performances, and radio may be more effective communication tools than printed materials. Oral cultures are rich in the nuances of their communication opportunities. For instance, there are a variety of singing occasions that can be used for teaching, reinforcing behaviors, and furthering the adoption of specific social norms. These occasions include church gatherings, singing children to sleep, and farm labor singing. The richness of African oral culture can be used as part of an SBCC campaign, and it could be very effective to purposefully incorporate traditional oral forms of communication into SBCC methods.

Key Recommendations

- Develop materials using a guided process as outlined in C-Planning, including development of creative briefs and pretesting with target audiences.
- Research, identify, and pretest the types of job aids and support materials most effectively used by community workers to support IPC.

- Analyze materials for gender considerations and test materials with both women and men of different ages and life stages to ensure the messages and illustrations support women and “do no harm” and convey shared roles and responsibilities for nutrition.
- Consider assigning one partner or an SBCC contractor to employ a team of SBCC experts to conduct the research needed to design BCC materials and a standard tool kit for volunteers, which they can receive after completing training.

9.4 Implementing and Monitoring

The staffing structure and general technical capacity of MYAP staff seemed adequate. However, the assessment team found that supportive supervision visits to volunteers were not performed as often as planned, as other priorities were sometimes conflicting. In addition, standardized supervision forms were not often used because MYAP staff felt that volunteers may perceive the supervision as an evaluation of their performance. Few staff were specifically trained in SBCC, leading to few mentorship opportunities to assist volunteers with IPC or SBCC techniques. Training materials provided to the assessment team appeared to be largely clinical, with little content related to community-level SBCC.

The estimated proportion of mothers or caregivers eligible to participate in program activities that were reached by the CHVs or *animadoras* varied between 5 percent and 30 percent. There were several reasons for low coverage. The primary reason was the number of beneficiaries depended on the level of staffing possible given a project’s funding. For example, ADRA had the capacity to support 2,880 CHVs that, in turn, were responsible for a maximum of 15 families each. Therefore, ADRA could theoretically reach approximately 43,200 beneficiary families through the CHVs. The number of beneficiaries reached by ADRA in health and nutrition in 2010 was 38,750 and the number of proposed beneficiaries in health and nutrition according to the project proposal was over 56,000 out of a total population of 100,000.⁶⁴ Therefore, the overall beneficiary coverage was relatively low. WV provided other reasons for low coverage, including dropouts of CHVs and large distances between CHV homes and beneficiaries’ homes that make access to beneficiaries difficult.

One strategy for increasing coverage is to graduate beneficiaries from the program and allow new beneficiaries to participate in program activities. Some of the mother groups that were encountered could be candidates for graduation, allowing the volunteers to move on to other groups that had not achieved such high levels of behavior change. Graduating groups could be converted into radio-listening groups, provided that the local community radio stations broadcast programs that can keep these “graduated” groups engaged and learning additional practices. A radio-listening/-production club model worthy of possible emulation and adaptation was that employed by Development Communication Trust in Chiradzulu District, Malawi. In addition to organizing listening groups of CHVs, this project sent sound technicians to record some of their meetings and then edited the recording of these meetings into effective programming that was broadcast on a leading national commercial radio station.

While there is not a specific coverage target documented in the literature with which to predict a ‘tipping point’ of behavior change, it is clear from the assessment that MYAP partners were spread fairly widely across several districts and in pockets of communities throughout those districts. In SBCC literature, a factor in successful behavior change interventions is exposure to messages at various levels. As evidenced by the socio-ecological model, individuals are influenced directly or indirectly by partners, peers, family, community leaders, and others who shape community and gender norms, and access to and demand for existing services. All of these are encapsulated by a larger

⁶⁴ ADRA International/Mozambique. 2008. *Osanzaya Zambezia (Make Zambezia Happy)*, ADRA’s Income Generation Program (IGP) Multi-Year Assistance Program (MYAP) Proposal Application, July 2008, p. 6; ADRA International/Mozambique. 2010. *Fiscal Year 2010 Annual Results Report*, October 2010, p. 10.

enabling environment which includes policies and regulations, religion and economic conditions, for example. For optimal behavior change to occur at the individual or household level, change has to also happen at each of those influencer levels. More effective change is likely to happen, therefore, if resources are directed to focus on these various levels within communities as opposed to only one level in many different communities.

To ensure that the most vulnerable communities are covered by program activities, the MYAP partners could prioritize communities based on food security, production, and income generation, as well as nutrition and health practices. Prioritization could help the MYAP partners to better utilize their resources and target audiences at various levels to create an enabling environment to support and ignite change. For example, SBCC efforts can be maximized by identifying and targeting key influencers in communities and early adopters of behaviors. The Diffusion of Innovations model, which has been tested in public health interventions since the 1960s, states that three key factors usually determine whether a particular trend will 'tip' into wide-scale popularity: 1) the idea or innovation needs some influential early adopters or champions; 2) the innovation needs to have a quality or attributes that people find compelling; and 3) the broader physical and social environment has to support the innovation. This can be used in conjunction with Social Cognitive Theory which stipulates that individuals are able to learn new behaviors by observing and modeling others, and that learning is more likely if the person has high self-efficacy (i.e. confidence in their ability to do the action) and response efficacy (i.e. confidence that behavior will produce the desired outcome). In order to use these models/theories, however, efforts need to be concentrated in order to utilize key influencers.

Assisting communities to plan coverage strategies and timelines for graduation could also address the issue of coverage and ultimately to establish criteria for a community's graduation from the program. A number of communities had created community maps as part of their planning exercises. The mapping exercise could be linked to coverage strategies, allowing the community planners to determine where to begin their projects and how to see the goal of 100 percent coverage in a chronological framework.

It is not apparent that the MYAP partners have adequately considered gender issues in relation to the impact of project interventions on women beneficiaries, especially those that are pregnant or with children under 2 years of age. As a part of the intervention process, staff should analyze the impact of project activities on women and adjust interventions as necessary to support women and "do no harm" with regard to women's position in the family and community, burden of labor, and decision making.

Key Recommendations

- Train staff in SBCC, particularly interpersonal communication or SBCC communication techniques.
- Future programs should consider:
 - Focusing coverage in order to harness resources and utilize various influencer levels in communities, which will enable programs to apply proven psycho-social theories and models.
 - Implementing a plan for the basic training and mentorship of management and technical/supervisory staff in SBCC and communication methods.
 - Developing curricula in SBCC and communication methods for management and technical/supervisory staff and field workers.
 - Implementing a plan for building the capacity of field workers and volunteers in SBCC and communication methods.
 - Deploying instructors adept in SBCC methods to teach SBCC and communication methods at all levels, rather than relying on the cascade approach to training.

- Improving frequency of supervision and developing/adapting supervision checklists to ensure that key aspects of the defined SBCC strategy are supervised/monitored, including integration of project components (nutrition, agriculture, health) and gender issues.
- Employing synchronous “best-to-many” distance learning techniques, such as those described in “Re-Inventing Health Care Training in the Developing World: The Case for Satellite Applications in Rural Environments.”⁶⁵ In “best-to-many” techniques, participants learn directly from the best teachers available in the country. This contrasts to cascade learning, where the quality of teaching and learning success deteriorates with each successive cascade.
- USAID/Mozambique may also consider developing a tool to assist its staff to evaluate whether proposals and programs are following state-of-the-art practice in design and implementation of SBCC program components, modeled on the C-planning process discussed in this report.

9.5 Evaluating and Replanning

According to the documentation made available to the SBCC assessment team, the MYAP partners were not monitoring the progress of many key behaviors that they promoted through BCC activities. **Table 15** compares the key behaviors promoted and if the MYAP partner had corresponding monitoring indicators.

Table 15. Key Behaviors Promoted and Corresponding Monitoring Indicators

	Key behavior promoted by MYAP			Has monitoring indicators related to key behavior		
	ADRA	WV	SC	ADRA	WV	SC
Exclusive breastfeeding infants are 6 months of age	Y	Y	Y	Y	Y	Y
Optimal complementary feeding	Y	Y	Y	Y	Y	Y
Optimal hygiene and healthy environment practices	Y	Y	Y	N	Y	Y
Consumption of balanced diet	Y	Y	Y	N	N	N
Optimal nutritional care of sick and severely malnourished children	Y	Y	Y	N	N	N
Optimal nutritional intake through food during pregnancy	Y	Y	Y	N	N	N
Optimal practices to prevent and treat malaria	Y	Y	Y	Y	N	N
Optimal practices to prevent and treat diarrhea	Y	Y	Y	Y	Y	N
Optimal nutritional care of people with HIV or prolonged illness	Y	Y	Y	N	N	N
Consumption of foods rich in vitamin A	Y	Y	Y	N	N	N
Children given vitamin A supplementation every 6 months	Y	Y	Y	N	N	Y
Postpartum women given vitamin A supplementation	Y	Y	N	N	N	N
Recognition of importance of growth monitoring	Y	N	N	N	N	N
Recognition of danger signs for sick children	Y	N	N	N	N	N

⁶⁵ Haridasan, K.; Rangajaran, S.; and Pirio, G. 2009. “Re-Inventing Health Care Training in the Developing World: The Case for Satellite Applications in Rural Environments.” *Online Journal of Space Communications*.

Pregnant women consume daily iron and folic acid tablets during at least 6 months of gestation, and 3 more months after delivery	N	Y	N	N	N	N
Optimal care seeking for children with respiratory tract infection	N	?	Y	N	Y	N
Correct processing of bitter cassava	N	N	Y	N	N	N
Storage and conservation of seeds and foods	N	N	Y	N	N	N
Drying and conservation of fruits and green leafy vegetables	N	N	Y	N	N	N

Note: “No” responses are shaded in light gray. “?” represents information that was not obtained from MYAP partner.

Most of the MYAP monitoring indicators were related to whether a behavior was being practiced. However, attitudes and beliefs change before people adopt new behaviors. Therefore, it is useful to monitor attitudes and beliefs in addition to the actual behaviors. For example, when beliefs and attitudes are changing but behavior is not, barriers to behavior change may not be sufficiently addressed by the SBCC program or there has not been enough time for the behavior to become a “habit.”

Monitoring results need to be disaggregated enough to inform programmatic decisions. Monitoring should provide information about geographic or supervision areas (e.g., communities, districts) with low and high performance based on the completion of planned activities and the progress of behavior change among beneficiaries. For example, knowing that the estimate of exclusive breastfeeding for District X is 20 percent and for District Y is 90 percent is more informative than only knowing the overall program area for the two districts (55 percent). In this case, the program manager would know to concentrate on improving activities in District X.

Routinely collected information on program outputs provides information on if activities are being implemented at the community and district levels. However, the MYAP partner monitoring surveys among beneficiaries need to be carefully designed to provide information about outcomes at practical supervision levels so that improvements can be made to program activities. Commonly used cluster sampling designs are usually only representative of the entire program population and cannot provide disaggregated information. A survey using a LQAS design generally can provide more disaggregated information than more commonly used cluster designs, for example, at the district level rather than only the level of the entire program area. Therefore, the results of a survey using LQAS can be more helpful to managers to make programmatic decisions. The MYAP partners were trained to use LQAS for monitoring. However, for different reasons, all of the partners faced difficulties using LQAS. It is not clear if there was not sufficient preparation or additional technical support was needed for partners to use LQAS for monitoring.

Key Recommendations

- Align monitoring indicators with key behaviors being promoted.
- Investigate the barriers to using LQAS and other methods of gathering monitoring indicators at disaggregated levels.

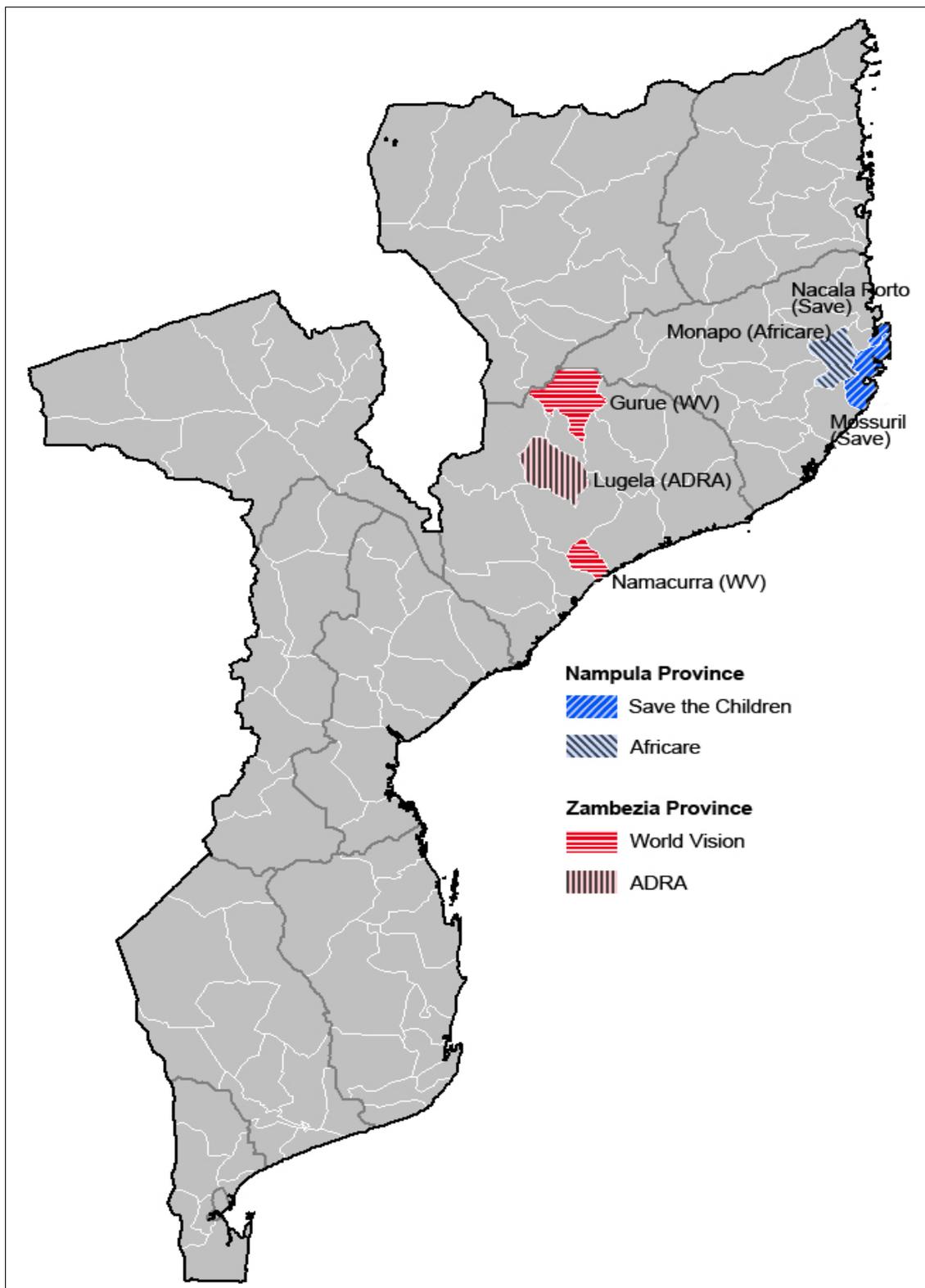
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Annex 1. Map of Provinces and Districts for SBCC Team Field Visits



Annex 2. Field Work Schedule for SBCC Team

Sunday, Oct 30	Monday, Oct 31	Tuesday, Nov 1	Wednesday, Nov 2	Thursday, Nov 3	Friday, Nov 4	Saturday, Nov 5
<p>1:30 pm Arrival SBCC consultant Gregory Pirio Maputo</p>	<p>7:15 am Flight to Quelimane delayed to 9:15 pm</p> <p>11:00 am–5:30 pm Team meeting, FANTA-2 office</p> <p>9:15 pm Depart for Quelimane</p>	<p>8:30 am Meeting with WV Team, Quelimane</p> <p>10:30 am Meeting with Director, DPS</p> <p>2:00 pm Visit to Chinde CHC, Namacurra</p>	<p>8:00 am Meeting with ADRA Team, Mocuba</p> <p>9:00 am Meeting with Director, SDSMAS Lugela</p> <p>10:30 am Visit to 3 de Fevereiro CHC, Lugela</p> <p>2:00 pm Nassabao CHC, Lugela</p>	<p>8:00 am Meeting with WV Team, Gurue</p> <p>9:30 am Meeting with Director Representative, SDSMAS Gurue</p> <p>12:00 pm Nanzua CHC, Gurue</p> <p>3:00 pm Moripa CHC, Gurue</p>	<p>8:00 am Cresci CHC, Gurue</p> <p>1:00 pm Murrimo CHC, Gurue</p>	<p>9:00 am Depart for Nampula</p> <p>3:00 pm Arrival in Nampula</p>

Sunday, Nov 6	Monday, Nov 7	Tuesday, Nov 8	Wednesday, Nov 9	Thursday, Nov 10	Friday, Nov 11	Saturday, Nov 12
	<p>8:30 am Meeting with Save the Children Team, Nampula</p> <p>11:00 am Meeting with Africare Team, Nampula</p> <p>2:00 pm Meeting with Director, DPS Nampula</p> <p>3:00 pm Meeting with Save the Children M&E and Agriculture Coordinators, Nampula</p>	<p>10:00 am Napala community, Monapo</p> <p>2:00 pm Sanhote community, Monapo</p>	<p>9:30 am Namassica Community, Nacala Porto</p> <p>1:30 pm Murrupelane Community, Nacala Porto</p>	<p>9:00 am Pedereira Community, Mussoril</p> <p>1:30pm Munda Community, Mossuril</p>	<p>8:00 am SBCC Team meeting, Ilha de Moçambique</p> <p>1:00 pm Debrief with MYAP Team (Save the Children and Africare), Nampula</p> <p>3:30 pm Debrief with Director, DPS Nampula</p>	<p>3:30 pm Depart from Nampula to Maputo</p> <p>6:20 pm Arrival in Maputo</p>

Annex 3. Assessment Instruments

Interview Guide: Provincial and District Public Health Officials

1. What is the relationship between the public health sector and the MYAP partners?
Probe: How could cooperation be improved?
2. Describe the training, including counseling training that is offered to clinical staff on nutrition.
Probe: Is there nutrition training related to antenatal care? Please describe.
Probe: Is there nutrition training related to postpartum care? Please describe.
Probe: Is there nutrition training for cases of malnutrition? Please describe.
3. Are there supportive materials that clinicians use in nutrition counseling? If so, please describe.
Probe: What additional materials would be helpful?
4. What other support do partners provide to the public health sector?
Probe: Community health workers escorting pregnant women to ANC visits.
 - a. Are there areas for improvement?
5. Describe the relationship between partners with regard to mobile brigade deployment?
Probe: How could cooperation be improved?
6. What is your sense of the MYAP partners' accomplishments? Have there been noted successes? If so, why have they been successful?
7. What might be the major barriers, if any, to achieving the nutritional goals?
Prompts: Pregnant and lactating women, caregivers of children under 2 or 5, PLHIV

Interview Guide: Community Health Volunteers

1. Can you describe what kind of training you have received in the area of proper nutrition, sanitation, and hygiene?
2. Did you receive a certificate? Do you have an ID?
3. Can you describe how and when you approach mothers to explain good nutritional practices?
Prompts: Household visits, group meetings, mobile brigade mobilization, on market days, theater performances
4. Do you have *cartazes* or *folhetas* that you use to explain good practices to mothers?
5. What other materials (objects) might you use in your activities?
Prompts: Long Lasting Insecticidal Nets LLINs, wash basin, cooking pot
6. How do you know if a child is at risk of malnutrition?
7. How do you decide to refer a child to nutrition rehabilitation?
8. What members of a family do you talk to about good nutrition and hygiene?
9. What do you tell pregnant mothers?
10. What do you tell breastfeeding mothers?
11. What are the signs of malnutrition in a child?
12. When should a mother be taking a child to a health facility?
13. How is cooking organized in a family?
Do families have access to the types of food that they need?
14. Where do they get it?
 - a. If not, why? Who makes the decision to purchase food?

15. What types of food do you encourage pregnant and lactating women to eat to improve their nutrition?
16. What types of food do you tell mothers to prepare for young children? What age?
17. Are there women that don't take your advice? What might be the reasons for that?
18. Do you have HIV-positive individuals in your community? What are you telling them? Does the community provide any support for these households?

Interview Guide: Targeted Beneficiaries

1. What do you differ as a result of being part of the mothers/fathers (or mothers) group?
2. How often do you meet? How often do you have contact with CHV (community health worker or *animadoras*)? Has this been helpful to you?

Rapid Assessment Questionnaire of SBCC Knowledge

Nutrition, breastfeeding, and complementary feeding

1. Did you breastfeed your child? How long after birth did you put your child to the breast?
2. Are you still breastfeeding your child? How many months did you breastfeed your child? Did you feed your child anything else while you were breastfeeding?
3. At what age (months) did you start giving the child foods other than breast milk?
4. When the child last had diarrhea, did you give him/her the same, more, or less food or liquids?
5. Can you tell me any foods rich in vitamin A?
6. How many times did your child eat yesterday? What did the child eat yesterday?

Sanitation and hygiene

7. What do you use to wash your hands?
8. When do you wash your hands? After or before what activities?

Malaria prevention

9. Do you have an insecticide treated mosquito net in your home? How many? Who slept under it last night?
10. Do you have any open water containers outside your house?

Agriculture practices

11. Did you use any conservation agriculture techniques in your field last year (mulching, minimal till, crop rotation)? If yes, in the fields with conservation agriculture techniques was the crop yield greater or less than in the fields with traditional methods?
12. What crops did you grow to eat? (Corn, manioc, vegetables)
13. What crops did you grow to sell? What did you purchase with the money from those sales?
14. Were there any months or weeks last year that your family did not have enough food to eat?
15. If yes, what did you do in that situation?

Interview Guide: Partner Staff

Activities to date, including trainings, community activities

1. Can you give an overview of your SBCC activities?

Staffing structure and technical capacity of staff responsible for SBCC activities

2. Within your organization who is responsible for SBCC activities?

Prompt: Ask staff members about training in SBCC

Supervision of field workers

3. What sorts of measures have you put into place to supervise activities of community workers?

Monitoring and evaluation activities

4. Can you describe your system for M&E?
5. Identify specific approaches, materials, and activities (“promising practices”) that are or appear to be having an impact on promoting positive nutrition practices and behaviors among target populations.
6. You have applied a HEARTH Positive Deviance approach in your SBCC activities. Can you describe how this works? What criteria do you use for selecting a community to participate?

SC: You have applied a “modified” Positive Deviance approach in your SBCC activities. Can you describe how this works?

7. Describe the training that both community health networks and community health volunteers/*animadoras* undergo? Duration, frequency, and content.
8. What kinds of communication activities do the CHCs and the CHVs/*animadoras* engage in?

Estimated coverage using available program monitoring data as possible

9. In terms of SBCC issues relating to nutrition, hygiene, sanitation, care seeking, and disease prevention, what can you tell us about population coverage?
10. Where can reports be found on activity coverage? Do you have any maps that will illustrate the communities reached?
11. Do you have measurements of behavior change? Are there some areas where change is more robust? If so, how do you explain the difference?

Activities to date, including trainings, community activities

12. What is the ratio of CHVs/*animadoras* to households?
13. Do CHVs/*animadoras* or members of CHCs receive any compensation?
14. Do CHCs/CHCs receive training?

Prompt: CHCs Are to represent their constituencies vis-à-vis government entities.

Empowerment or leadership training to hone skills and increase knowledge in dealing with government entities.

15. How are members of farmer associations receiving health and nutrition training? What are the key technical messages?
16. What’s your approach to farmers? How have farmers responded?

Prompts: Planting, storage, and marketing practices?

17. How has the health facility staff been incorporated into SBCC activities? What sorts of training have they received? In IPC? Any work aids distributed?

SC: How does the project participate in the Community Management of Acute Malnutrition (*tratamento de desnutricao na comunidade*)? What are the SBCC opportunities at these points of contract?

18. Where do the children identified as malnourished go for rehabilitation?
19. Please describe the mobile brigades. How do they work, that is, what type of activities do they engage in? Who participates in them? How have they been trained?
20. What are the activities of the mothers/fathers groups?
21. Has there been any formative research to determine appropriate target audiences, influencers, barriers to behavior change, and personal and group triggers for change?
22. Whom do you consider to be the influential person/opinion makers in the community?
23. How have the health facility staff been incorporated in SBCC training? How are they being trained in the treatment of malnutrition?

ADRA: Describe the training that both CHCs and CHVs undergo? Duration, frequency, and content.

What kinds of communication activities do the CHCs and the CHVs engage in? In terms of SBCC issues relating to nutrition, hygiene, sanitation, care seeking, and disease prevention, what can you tell us about population coverage?

24. Please show examples of the BCC materials, t-shirts, caps, bags, ID cards, and certificates that are in use with the CHCs and CHVs. How are they used?
25. How did you determine the appropriateness of the BCC materials? Was there pretesting involved? Consultation with MISAU?
26. What is the status of the handover of the CHVs to the DDS?
27. Please describe the radio programs or spots that you airing. What radio stations are carrying this? In which languages? How do you design the training? Has there been training for radio programming personnel? What are the topics? What have been the key messages? Has the community been participating in programming?
28. How are you making use of theater performances? What kind of training have the performers received?
29. Do you have outreach to community leaders, including traditional leaders, church leaders, and mosque leaders? Are there organized women's or parent's groups associated with churches or mosques?
30. What do you tell people when there is no food surplus due to drought?

Interview Guide: Agricultural Field Workers

1. Can you describe what advice you are telling families (farmers) about:
 - a. Types of crops to grow and why
 - b. Improved storage methods
 - c. Marketing techniques
2. How is the community responding to this advice?

Prompt: Barriers
3. Do you have a secret to motivating families (farmers) to adopt change?
4. What kind of support are you getting to counsel families?
5. What other support or materials would be useful to you?
6. Who is important in the decision making? Mother, father, extended family member?
7. When is it that you have opportunities to convey this information?

8. Is any programming taking place on radio? What type of programming is this? Are people in the community listening to this?
9. What type of training have you received in communicating with farmers and their families?

Annex 4. World Vision Materials and Key Messages

Topic area	Message in Portuguese	Message in English	Source	
Exclusive breastfeeding	O leite materno é o melhor para o seu bebé <ul style="list-style-type: none"> • Tem tudo o que o bebé precisa incluindo água • Protege contra infecções 	Breast milk is the best for your baby <ul style="list-style-type: none"> • It has everything that the baby needs including water • It protects against infections 	Poster “O Leite Materno é o Melhor para o seu Bebê,” MISAU/Nutrição, AusAID, and WV	
	Dê somente leite do peito nos primeiros 6 meses	Give only breast milk in the first 6 months		
	Não há horário para se amamentar; quanto mais o bebé mamar, mais leite a mãe produzirá	There is no schedule to breastfeed; the more the baby suckles, the more milk the mother will produce		WV Training package, pp. 18–19
	O leite de peito nunca se estraga e nunca é impróprio para o bebé	Breast milk never spoils and never is unsuitable for the baby		“Aleitamento Materno Exclusivo Durante os Primeiros 6 Meses,”
	O leite continua a ser importante para o crescimento do bebé, até aos 2 anos	Breast milk continues to be important for the baby’s growth until 2 years of age		Session 2, Basic Nutrition Package. MISAU/Nutrição, September 2007
	Crianças exclusivamente amamentadas até aos 6 meses, tornam-se saudáveis e inteligentes na vida adulta	Children exclusively breastfed until 6 months become healthier and smarter in adult life		
	O leite que sai nos primeiros dias, é um líquido amarelado que contém substâncias que ajudam a proteger o bebé contra infecções; por isso é importante dar de mamar logo após o parto	The milk that comes out in the first 6 days is a yellowish liquid that contains substances that help protect the baby against infections; therefore, it is important to breastfeed soon after delivery		Poster “O Leite Materno é o Melhor para o seu Bebê,” MISAU/Nutrição, AusAID, and WV
	Em cada mamada, a criança deve ser amamentada durante tempo suficiente (até que ela largue o peito sozinha)	At each feed, the child must be fed for long enough (until he/she dismisses the breast alone)		
Complementary feeding	Apartir dos 6 meses a criança precisa de outros tipos de alimentos para além do leite materno	From 6 months of age the child needs other types of foods besides breast milk.	WV Training package, p. 11	
	As papas devem ser enriquecidas e espessas, pois assim a concentração de energia e nutrientes é mais	Porridges must be enriched and thick, as this provides more energy and nutrient concentration		
	A criança precisa de comer no seu próprio prato para garantir que ela coma uma quantidade suficiente	The child needs to eat from his/her own plate to ensure that he/she eats a sufficient amount		
Balanced diet	Composta por uma maior quantidade de Alimentos de Base e, enriquecida com os seguintes alimentos acompanhantes: <ul style="list-style-type: none"> • Alimentos construtores • Alimentos protectores • Alimentos altamente energéticos 	Composed of a larger quantity of base foods and enriched with the following accompaniments: <ul style="list-style-type: none"> • Constructing foods • Protecting foods • Highly energetic foods 	WV Training package, pp. 2–3	

Topic area	Message in Portuguese	Message in English	Source
	Para ter boa saúde, coma diariamente um alimento de cada grupo !	For good health, eat one food of each group daily!	
	Alimentacao Equilibrada Exemplos: <ul style="list-style-type: none"> • Chima de milho com caril de couves com amendoim • Arroz com caril de peixe • Chima de mapira com caril de feijão • Xiguinha: mandioca, amendoim, folhas verdes e coco • Mucapata: arroz, feijão jugo e leite de côco 	Balanced diet Examples: <ul style="list-style-type: none"> • Maize meal with cabbage and peanut sauce • Rice with fish sauce • Sorghum meal with bean sauce • <i>Xiguinha</i>: manioc, peanuts, green vegetable leaves, and coconut • <i>Mucapata</i>: rice, bambarra groundnuts, and coconut milk 	
Diet and the pregnant and lactating woman	A mulher deve ter uma alimentação equilibrada (quantidade e qualidade)	The woman must have a balanced diet (quantity and quality)	WV Training package, p. 5 “Alimentação Equilibrada da Família, com Destaque para a Mulher Grávida,” Session 5, Basic Nutrition Package, MISAU/Nutrição, September 2006
	Devido ao seu estado ela tem necessidades nutricionais aumentadas	Because of her state, she has incremented nutritional needs	
	A mulher deve comer pelos menos 3 refeições/dia, ter pequenos lanches entre refeições (ex: banana, mandioca, batata-doce, pão, papaia, farinha de mandioca torrada c/amendoim torrado e açúcar, maçaroca, etc.)	The woman should eat at least three meals per day, have small snacks between meals (e.g., banana, manioc, sweet potato, bread, papaya, toasted manioc flour with toasted peanuts and sugar, sweet corn, etc.)	
	Toda a mulher precisa de receber diariamente comprimidos de ferro e ácido fólico durante pelo menos 6 meses na gravidez, mais 3 meses após o parto	Every woman needs to receive daily iron and folic acid tablets during at least 6 months of gestation, and 3 more months after delivery	
	Diminuir o trabalho pesado nos últimos 3 meses da gravidez, para poupar energia; pedir ajuda ao marido, as amigas ou outros familiares	Decrease heavy work during the last 3 months of gestation, to save energy; ask for the help from the husband, girlfriends, and other family members	
	Sempre que possível usar rede mosquiteira tratada com insecticida, para evitar picada de mosquito, causador da malária	As many times as possible, use insecticide treated mosquito nets to avoid malaria causing-mosquito bites	
	A mãe que amamenta deve-se alimentar bem para ela própria e para produzir leite para o seu bebé	The mother who breastfeeds should eat properly for herself and to produce milk for her baby	
	Beber muitos líquidos na amamentação por ex. água, sumos de frutas, sopas, leite conforme as possibilidades	Drink a lot of liquids during lactation, e.g., water, fruit juice, soups, milk, depending on resources	
	A mulher grávida não deve beber bebidas alcoólicas nem	The pregnant woman must not drink alcoholic beverages or	

Topic area	Message in Portuguese	Message in English	Source
	fumar, isto pode prejudicar o crescimento do bebé	smoke, this can negatively affect the growth of the baby	
Diet and the sick child	A criança doente deve continuar a ser alimentado.	The sick child should continue to be fed.	WV Training package, p. 2
	Deve se dar pequenas quantidades de comida varias vezes ao dia	Small amounts of food should be given several times a day	
	Para criança com diarreia, aumentar o número de o consumo de liquidos, para evitar a desidratação	For children with diarrhea, increase the number of the consumption of liquids, to avoid dehydration	
	Após a doença e necessário a recuperação rápida do peso e a energia perdida; por isso, e necessário aumentar o número de refeições (mais uma refeição extra por dia) durante 1 a 2 semanas após a doença	After illness there is need for rapid recuperation of weight and energy lost; therefore, it is necessary to increase the number of meals (one more extra meal per day) during 1–2 weeks after illness	
	E importante levar a criança doente a US para controle e avaliação do seu estado de saude	It is important to take the sick child to the health center for monitoring and assessment of his/her health state.	
	Após doença continuar a levar crianças ao controle de peso	After illness continue to take children for growth monitoring	
	E importante lavar sempre as mãos e utensilos antes de preparar ou servir os alimentos, assim como usar sempre água limpa, para previnir a diarreia	It is important to always wash hands and utensils before preparing or serving food, as well as always using clean water to prevent diarrhea	

Topic area	Message in Portuguese	Message in English	Source
Vitamin A	Vitamina A é essencial para bom crescimento, boa visão, previne contra doenças infecciosas, é importante para a saúde	Vitamin A is essential for good growth, good eyesight, prevents from infectious diseases, is important for health	“Suplementação Adequada com Vitamina A às Crianças e Mulheres no Pós-Parto.” Session 6, Basic Nutrition Package. MISAU/Nutrition Department, September 2006 WV Training package, p. 14
	Leve a sua criança à U.S, de 6 em 6 meses, para receber vitamina A	Take your child to the health center every 6 months, to receive vitamin A	
	Dê a sua criança diariamente um alimento rico em vitamina A, como a papaia, manga, abóbora, batata doce de polpa alaranjada, cenoura, folhas verdes, peixinho, ovo e fígado	Give your child one food rich in vitamin A daily, such as papaya, mango, pumpkin, orange flesh sweet potato, carrot, green leaves, small fish, eggs, and liver	
	Alimentos vegetais ricos em vitamina A, devem ser cozinhados com óleo, amendoim ou côco	Vegetable foods rich in vitamin A should be cooked with oil, peanuts, or coconut	
	Suplemente a mãe no pós-parto com vitamina A, aumentando assim concentração de vitamina A no leite materno e consequente/te os níveis no bebé	Supplement the mother with vitamin A in postpartum care, increasing in this way the vitamin A concentration in the mother’s breast milk and, consequently, the levels in the baby	
	Quanto mais cedo a dose de vitamina A for administrada à mãe, mais cedo os níveis de vitamina A da mãe e do bebé melhoram	The earlier the vitamin A dose is administered to the mother, the earlier the levels of vitamin A of mother and baby improve	
Food hygiene	Lave sempre as mãos com água e sabão: <ul style="list-style-type: none"> • Antes de preparar os alimentos • Depois de usar a casa de banho/latrina • Depois de pegar alimentos crus ou mudar a fralda do bebé • Depois de tocar em animais 	Always wash your hands with water and soap: <ul style="list-style-type: none"> • Before preparing food • After using the toilet/latrine • After handling raw food or changing the baby’s nappy • After touching animals 	“Cinco Mensagens Chave para Higiene dos Alimentos,” Ministry of Health Angola/WHO (Poster)
	Lave com água limpa e sabão todas as superfícies e equipamentos usados na preparação dos alimentos	Wash with clean water and soap all surfaces and equipment used in the preparation of food	
	Lave com água limpa e sabão todos os espaços e utensílios usados na preparação dos alimentos	Wash with clean water and soap all spaces and utensils used in the preparation of food	
	Separe sempre os alimentos crus dos cozidos e prontos para consumo	Always separate raw food from food that has been cooked and is ready for consumption	
	Use diferentes equipamentos e utensílios, como facas ou tábuas de cortar, para manipular carne, frango, peixe e outros alimentos	Use different equipment and utensils, such as knives and chopping boards, to manipulate meat, chicken, fish, and other foods	

Topic area	Message in Portuguese	Message in English	Source
	Conserve os alimentos em recipientes separados para evitar o contacto entre os alimentos crus e cozidos	Conserve foods in separate containers to avoid contact between raw and cooked foods	
	Coza bem os alimentos, como carne, frango, ovos e peixe ou outros mariscos	Cook foods well, such as meat, chicken, eggs, and fish or other seafood	
	Ferva os alimentos como sopas e refogados/caril a uma temperatura de 70°C	Boil foods such as soups and sauces at a temperature of 70°C	
	Coza as carnes vermelhas e o frango até que o molho fique claro e não rosado	Cook red meats and chicken until the juices run clear and not pink	
	Aqueça sempre e muito bem os alimentos cozidos	Always heat and heat well cooked foods	
	Não deixe alimentos á temperatura ambiente por mais de 2 horas	Don't leave foods at room temperature for more than 2 hours	
	Coloque na geleira o mais rápido possível os alimentos cozidos e os alimentos que estragam facilmente	Put cooked foods and foods that spoil easily in the refrigerator as soon as possible	
	Mantenha a comida cozida sempre quente	Always keep cooked food hot	
	Não guarde comida por muito tempo, mesmo que seja na geleira	Do not store food for too long, even if in the refrigerator	
	Prepare sempre os alimentos das crianças quando estas vão comer e as sobras não devem ser guardadas	Always prepare children's food when they are going to eat it and do not store the leftovers; do not thaw foods at room temperature	
	Não descongele os alimentos à temperatura ambiente	Do not thaw foods at room temperature	
	Consuma sempre água fervida ou tratada	Always consume boiled or treated water	
	Seleccione alimentos frescos	Select fresh foods	
	Para sua segurança, consuma alimentos já processados e limpos, como leite pasteurizado	For your safety, consume foods already processed and clean, such as pasteurized milk	
	Lave as frutas e as hortaliças, especialmente quando estas forem consumidas cruas	Wash fruits and vegetables, especially when they are consumed raw	
	Não utilize alimentos depois da data de validade	Do not use foods after their "best before" date	

Annex 5. Save the Children MYAP Materials and Key Messages

Topic area	Message in Portuguese	Message in English	Source
Exclusive breastfeeding	Leite do peito é o melhor alimento para o bebé	Breast milk is the best food for the baby	"Mensagens Chaves de Nutrição," SANA, version 2, August 2009 "Guião de Nutrição Comunitária para Promotores de Nutrição," SANA, June 2009
	Dê colostro (leite amarelo) porque protege o bebé das doenças; e como a primeira vacina e contém tudo que o bebé precisa	Give colostrum (yellow milk) because it protects the baby from illness; it is like the first vaccine and contains all that the baby needs	
	Leite do peito sózinho é o melhor alimento até a Criança tiver 6 meses; não precisa outras comidas ou líquidos como água para satisfazer a sede	Breast milk alone is the best food until the child is 6 months old; he/she does not need other foods or liquids like water to satisfy thirst	
	Mulheres grávidas podem amamentar; o leite do peito da mulher grávida está limpo	Pregnant women can breastfeed; the breast milk of a pregnant woman is clean	
	Aleitamento materno exclusivo pode ajudar a retardar a próxima gravidez	Exclusive breastfeeding can help to delay the next pregnancy	
	Crianças com menos de 6 meses que tomam água e outras comidas ficam doentes; assim tem que ir mais vezes ao posto de saúde	Children under 6 months that drink water and eat other foods get sick; then they need to go the health post more frequently	
	Dar só e só leite do peito sem outros líquidos incluindo água antes 6 meses	Give only breast milk and breast milk alone without other liquids, including water, before 6 months	
Complementary feeding	<p><i>Até aos 6 meses:</i></p> <ul style="list-style-type: none"> • Amamentar ao peito tantas vezes quanto a criança quiser, de dia e de noite, pelo menos 8 vezes por dia • Não dar nenhuma outra comida ou líquido (sumo, papa, água) 	<p><i>Up to 6 months:</i></p> <ul style="list-style-type: none"> • Feed from the breast as many times as the child wants, during day and night, at least 8 times a day • Do not give any other food or liquid (juice, porridge, water) 	"Guião de Nutrição Comunitária para Promotores de Nutrição," SANA, June 2009
	<p><i>Dos 6 aos 12 meses:</i></p> <ul style="list-style-type: none"> • Amamentar ao peito tantas vezes, quanto a criança quiser • Introduzir papas enriquecidas, utilizando alimentos disponíveis • No intervalo das refeições, dar frutas frescas, batata doce • A partir dos 7- 9 meses de idade, introduzir gradualmente a comida da família, 3 vezes 	<p><i>From 6 to 12 months:</i></p> <ul style="list-style-type: none"> • Feed from the breast as many times as the child wants • Introduce enriched porridges, using available foods • In between meals, give fresh fruits, sweet potato • From 7 to 9 months of age, gradually introduce family foods, 3 times 	

Topic area	Message in Portuguese	Message in English	Source
	<p><i>Dos 12 meses aos 2 anos:</i></p> <ul style="list-style-type: none"> • Amamentar ao peito quantas vezes a criança quiser • Manter o esquema dos 6–12 meses e aumentar gradualmente a quantidade • Se a criança mama o peito, dar outra comida 3 vezes ao dia • A primeira refeição do dia deve ser umas papas enriquecidas 	<p><i>From 12 months to 2 years:</i></p> <ul style="list-style-type: none"> • Feed from the breast as many times as the child wants • Maintain the scheme of 6–12 months, gradually increasing the quantity • If the child is breastfed, give other foods 3 times a day • The first meal of the day must be enriched porridge 	
	Medidas da comida por dia para diferentes idades da criança	Measure food per day for different child age groups – see graphic with cups and spoons	
	Depois dos 6 meses a criança deve comer frutas no intervalo ou com as papas cada dia, e dar sempre o leite do peito	After 6 months of age, the child must eat fruits in between or with porridges each day and always give breast milk	“Mensagens Chaves para Animadoras de Nutrição,” SANA, September 2009
Enriched porridges	Logo após 6 meses, põe 2 colheres de amendoim torrado e pilado nas papas	Soon after 6 months of age, put 2 tablespoons of toasted and ground peanuts or sesame in porridges	“Mensagens Chaves de Nutrição,” SANA, version 2, August 2009
	Dê de comer 5 vezes por dia porque a criança tem barriga pequena	Give food to eat 5 times per day because a child has a small stomach	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	Crianças devem comer frutas ou batata doce alaranjada cozida durante os intervalos	Children should eat fruits or cooked orange sweet potato between meals	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	Aos 7 meses pode comer a comida da família; deve comer no seu próprio prato, porque se comer junto no prato da família, não há de comer suficiente	At 7 months, the child can eat family foods; the child should be given his/her own plate, because if he/she eats together with the family plate, he/she will not have enough to eat	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	A partir dos 6 meses a criança deve comer papas e fruta esmagada	From 6 months of age, the child should eat porridges and mashed fruits	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	As papas devem ser enriquecidas com óleo, amendoim torrado, coco, verduras, ovo, feijão, etc.	Porridges should be enriched with oil, toasted peanuts, coconut, greens, eggs, beans, etc.	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	A partir dos 7 meses a criança deveria comer uma refeição da família, além de papas, frutas e leite do peito	From 7 months of age, the child should eat one family meal in addition to porridges, fruits, and breast milk.	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
As papas fermentadas são boas, agradáveis e atenuam a diarreia	Fermented porridges are good, enjoyable and attenuate diarrhea		

Topic area	Message in Portuguese	Message in English	Source
Prevention of diarrhea	É importante lavar as mãos antes de comer, preparar comida, depois de fazer necessidades, e depois de voltar da machamba	It is important to wash hands before eating and preparing food, after defecating/urinating, and after returning from the fields	“Mensagens Chaves de Nutrição,” SANA, version 2, August 2009
	Os pais devem ajudar a construir uma lavaloiça e uma latrina	Parents should help construct a sink to wash dishes and a latrine	
	As moscas transmitem as doenças; para evitar moscas e doenças, sempre deve tapar a comida e os recipientes de água	Flies transmit illnesses; to avoid flies and illnesses, always cover food and water storage containers	
	Lavar as mãos: Deve-se esfregar bem as mãos com água corrente e secar ao ar livre ou com um pano limpo	Washing hands: Hands should be well scrubbed with flowing water and dried at open air or with a clean cloth	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009
	Quando lavar as mãos: <ul style="list-style-type: none"> • Depois de fazer necessidades • Antes de cozinhar e comer. • Depois de ter contacto com pessoas doentes • Depois de voltar da machamba. • Antes de preparar comida 	When to wash hands: <ul style="list-style-type: none"> • After defecating/urinating • After cooking and eating • After touching sick people • After returning from the fields • Before preparing food 	
	Usar uma latrina <ul style="list-style-type: none"> • A melhor maneira de prevenir a doença é de usar uma latrina; se a família não pode construir uma latrina, deve enterrar as fezes numa cova, mas não muito perto da casa 	Using a latrine <ul style="list-style-type: none"> • The best way to prevent illness is to use a latrine; if the family cannot construct a latrine, they must bury the feces in a pit, but not too close to the house 	
	Usar uma lava-loiça	Use a sink to wash dishes	
	Tapar a comida; se não tapam, as moscas podem pousar e causar doenças	Cover the food; if food is not covered, flies can sit on food and cause illness	
Treatment of diarrhea	Crianças bem nutridas podem lutar contra infecções, melhor que as crianças malnutridas	Well-nourished children can fight against infections better than malnourished children	“Mensagens Chaves de Nutrição,” SANA, version 2, August 2009
	Crianças com diarreia podem morrer porque não bebem suficientes líquidos; assim, deve dar muitos líquidos, comidas e continue a dar leite do peito	Children with diarrhea can die because they do not drink sufficient liquids; therefore, you should give much liquid, foods and continue to breastfeed	
	Se uma criança com menos de 6 meses ficar com diarreia, deve aumentar o número de vezes cada dia que dá o leite do peito; pode dar SORO, mas com água fervida	If a child under 6 months of age has diarrhea, you should increase the number of times per day that breast milk is given; you can give oral rehydration salts (ORS), but with boiled water	“Guião de Nutrição Comunitária para Promotores de Nutrição,” SANA, June 2009

Topic area	Message in Portuguese	Message in English	Source
	Quando a criança começa a recuperar-se da diarreia, dê uma refeição extra por dia, para ela recuperar rapidamente.	When a child starts to recover from diarrhea, give an extra meal per day so that he/she recovers rapidly	
	Dar mais líquidos	Give more liquids	"Guião de Nutrição Comunitária para Promotores de Nutrição," SANA, June 2009
	Continuar a dar leite do peito	Continue to breastfeed	
	Dar SORO caseiro na base de cereal	Give homemade cereal-based ORS	
	Durante a diarreia, continuar a dar de comer como normalmente	During the diarrheal episode, continue to give food to eat as usual	
	Depois da diarreia severa (mais de 3 vezes por dia), precisa uma refeição extra por uma semana inteira	After severe diarrhea (more than 3 times per day), there is need for an extra meal for an entire week	
	Depois da diarreia prolongada, precisa uma refeição extra por um mês ou dar a refeição extra até pesar mais que antes da diarreia	After prolonged diarrhea, there is need for an extra meal for a month or give the extra meal until weight is higher than before the diarrheal episode	
Hygiene and healthy environment	Higiene são os cuidados de limpeza que devemos ter com o nosso corpo, a nossa casa e com a nossa alimentação	Hygiene is the care that we must have with the cleansing of our body, our house, and our food	
	Devemos ter cuidados com higiene e limpeza para evitar doenças	We must have care with hygiene and cleansing to avoid illness	
	Devemos sempre lavar as mãos antes de preparar alimentos, e depois de usar a latrina ou casa de banho	We must always wash our hands before preparing food, and after using the latrine or the bathroom	
	Usar água limpa e proteger alimentos	Use clean water and protect food	
	Construir, usar correctamente, e limpa a latrina	Construct, use correctly, and clean the latrine	
	Fazer buracos de lixo para deitar o lixo	Dig a pit to dispose of the garbage	
	Esta família não tem boa higiene e saneamento; assim as crianças ficam mal-nutridas e com muitas doenças	This family does not have good hygiene and sanitation; in this way children become malnourished and very ill	"Mensagens Chaves para Animadoras de Nutrição," SANA, September 2009
	Esta família tem boa higiene e bom saneamento; assim toda a família fica feliz, bem nutrida e saudável	This family has good hygiene and sanitation; in this way the whole family is happy, well nourished, and healthy	

Topic area	Message in Portuguese	Message in English	Source
Child malnutrition	A falta de crescimento é o primeiro sinal de malnutrição	Lack of growth is the first sign of malnutrition	"Guião de Nutrição Comunitária para Promotores de Nutrição," SANA, June 2009
	A malnutrição acontece quando: <ul style="list-style-type: none"> • A criança foi desmamada bruscamente • As papas e a comida da família são introduzidas tardiamente • A alimentação é insuficiente em quantidade e qualidade • A criança tem doenças que podem causar malnutrição, por exemplo: diarreia, malária, sarampo 	Malnutrition occurs when: <ul style="list-style-type: none"> • The child is weaned abruptly • Porridges and family foods are introduced late • Food is insufficient in quality and quantity • The child has illnesses that can cause malnutrition, such as diarrhea, malaria, measles 	
	Quando uma criança não come papas enriquecidas com outros alimentos, não tem bom crescimento	When a child does not eat porridges enriched with other foods, the child does not grow well	
Balanced diet	Principalmente mulheres grávidas, mães e crianças devem comer mais hortaliças ou caril	Especialmente pregnant women, mothers, and children should eat more vegetables or sauces	"Mensagens Chaves de Nutrição, 2ºpacote," SANA. "Guião de Nutrição Comunitária para Promotores de Nutrição, 2ºtreino," SANA "Guião de Nutrição Comunitária para Promotores de Nutrição, 2ºtreino," SANA
	Escolher cereais como mexoeira, milho, e mapira para semear, colher, e depois comer	Choose cereals like <i>mexoeira</i> , corn, and <i>mapira</i> to sow, harvest, and then eat	
	Durante o intervalo das principais refeições, as frutas são os melhores alimentos para as crianças	In between main meals, fruits are the best foods for children	
	Comer mais alimentos com gorduras como amendoim, gergelim e óleo	Eat more foods with fats like peanuts, sesame, and oil	
Nutrition during pregnancy	Uma mulher grávida deve ganhar mais ou menos 10 kg durante a sua gravidez; para fazer isso, ela precisa de comer mais do que o habitual	A pregnant woman should gain about 10 kg during pregnancy; to do that, she needs to eat more than usual	"Mensagens Chaves de Nutrição, 2ºpacote," SANA
	Mais comida e refeições equilibradas durante a gravidez podem acertar que a mulher tenha um bebé saudável; menos problemas durante o parto e que ela também fica saudável	More food and balanced meals during pregnancy can ensure that the woman has a healthy baby, fewer problems during delivery, and that she stays healthy	"Guião de Nutrição Comunitária para

Topic area	Message in Portuguese	Message in English	Source
	A mulher grávida deve comer 3 vezes por dia; é importante comer peixe, ovos, feijão, amendoim, folhas verdes e frutas	The pregnant woman should eat three times per day; it is important to eat fish, eggs, beans, peanuts, green vegetable leaves, and fruits	Promotores de Nutrição, 2ºtreino," SANA
	Se a mulher descansa 2 à 3 anos entre gravidez, ela tem tempo para cuidar do seu bebê e pode recuperar totalmente do parto	If the woman rests 2 to 3 years between pregnancies, she has time to take care of her baby and can recover totally from delivery	
	Ir a unidade sanitária aos 3 meses para a consulta pré-natal, depois cada mês	Go to the health center at 3 months for the antenatal consult, and then each month	"Guião de Nutrição Comunitária para Promotores de Nutrição, 2ºtreino," SANA
	Deve ter tempo para descansar, para poupar energia/força/ekuro	Must have time to rest, to save energy/strength/ekuro	
	Deve alimentar se bem em qualidade e quantidade suficiente (3 refeições principais e lanches aos intervalos)	Must eat well in sufficient quality and quantity (three main meals and snacks in between)	
	A partir dos 6 meses de gravidez deve reduzir o volume ou carga de trabalho	From 6 months of gestation onward, must reduce the volume or load of work	
	Deve ter uma boa higiene	Must have good hygiene	
	Todo estado anormal da mulher grávida deve ir a unidade sanitária, e deve dar parto na unidade sanitária	Every time a pregnant woman experiences an abnormal state during pregnancy, she must go to the health center, and delivery should occur at the health center	
Malaria	Sempre usar rede mosquiteira, principalmente mulheres grávidas, lactantes e crianças	Always use mosquito net, especially pregnant and lactating women and children	"Mensagens Chaves de Nutrição, 2ºpacote," SANA
	Cortar o capim em volta da casa	Trim the grass around the house	
	Usar aterro sanitário, ou enterrar o lixo	Use a sanitary landfill, or bury the garbage	
	Tapar recipientes de água	Cover water recipients	
	Tapar charcos de água perto da casa, manter o ambiente seco	Cover water puddles close to the house, maintain a dry environment	
	Levar a criança a US sempre que tiver sintomas de malária	Take the child to the health center every time he/she has symptoms of malaria	

Topic area	Message in Portuguese	Message in English	Source
Respiratory tract infection	Deve levar a criança à unidade sanitária se: <ul style="list-style-type: none"> • A criança respira mais rápido do que o normal • A criança tem tosse e dificuldades de respirar ou as asas do nariz estão a movimentar-se • A criança não consegue beber ou mamar • A criança está inconsciente 	Must take the child to the health when: <ul style="list-style-type: none"> • The child breathes more rapidly than usual • The child has cough and difficulty in breathing or the wings of the nose are moving • The child cannot drink or suckle • The child is unconscious 	“Mensagens Chaves de Nutrição, 2ºpacote,” SANA “Guião de Nutrição Comunitária para Promotores de Nutrição, 2ºtreino,” SANA
Correct processing of manioc	Nunca come mandioca amarga não correctamente processada	Never eat bitter manioc that has not been correctly processed	“Guião de Nutrição Comunitária para Promotores de Nutrição, 2ºtreino,” SANA
	Processamento de mandioca: <ul style="list-style-type: none"> • Método de ralagem • Método de fermentação amontoa • Mandioca seca ao sol • Método de embebição 	Processing manioc: <ul style="list-style-type: none"> • Grating method • Piling fermentation method • Sun-dried manioc • Soaking method 	
Diet and prolonged illness	Deve-se comer mais peixe, feijão, gergelim, amendoim, castanha e carne	Must eat more fish, beans, sesame, peanuts, cashew nuts, and meat	“Guião de Nutrição Comunitária para Promotores de Nutrição, 3ºpacote,” SANA
	Deve-se comer as 3 principais refeições por dia e ainda comer pequenas refeições durante o intervalo das principais refeições	Must eat the three main meals per day and also eat small meals in between main meals	
	Beber muita água, chá, maheu, sumos, e leite de côco durante o intervalo e depois de comer	Drink much water, tea, <i>maheu</i> , juices, and coconut milk in between and after meals	
	Comer ou preparar as refeições com sementes de abóbora e comer alho crú	Eat or prepare the meals with pumpkin seeds and eat raw garlic	
Storage and conservation of seeds and foods	As famílias que conservam e consomem frutas e folhas verdes não de ficar mais fortes e saudáveis que as que não conservam	Families that conserve and consume fruits and green vegetable leaves will become stronger and healthier than those that do not conserve.	“Guião de Nutrição Comunitária para Promotores de Nutrição, 3ºpacote,” SANA
	Conserve e guarde as sementes com cinza para ter suficiente na próxima campanha	Conserve and store the seed with ash to have enough for the next campaign	

Topic area	Message in Portuguese	Message in English	Source
Vitamin A rich food	Alimentos ricos em vitamina A: <ul style="list-style-type: none"> • Leite • Gema de ovo • Fígado • Peixe pequeno • Folhas verdes escuras • Cenoura • Papaia • Manga • Abóbora • Algumas frutas silvestres 	Foods rich in vitamin A: <ul style="list-style-type: none"> • Milk • Egg yolk • Liver • Small fish • Dark green vegetable leaves • Carrot • Papaya • Mango • Pumpkin • Some wild fruits 	“Guião de Nutrição Comunitária para Promotores de Nutrição, 3ºpacote,” SANA
	As frutas e verduras tem nutrientes que protegem o corpo; são necessárias para prevenir doenças	Fruits and vegetables have nutrients that protect the body; they are necessary to prevent illness	
	As crianças devem comer uma fruta todos os dias durante o intervalo	Children should eat one fruit every day during the break	
	As verduras e frutas de cores mais escuros tem mais vitaminas que as de cores claros	Vegetables and fruits of dark color have more vitamins that vegetables of light colors	
	Se cozinhar as verduras muito tempo, hão de perder os nutrientes e vitaminas	If you cook vegetables for too long, they will lose nutrients and vitamins	
	É bom comer as verduras cruas; tem mais vitaminas quando são cruas	It is good to eat raw vegetables; they have more vitamins when they are raw	
Drying and conservation of fruits and green leafy vegetables	È importante conservar as frutas e folhas, para servir no tempo que é difícil encontrar	It is important to conserve the fruits and leaves, to eat at times when it is difficult to find them	“Guião de Nutrição Comunitária para Promotores de Nutrição, 3ºpacote,” SANA
	Temos que comer mais frutas e folhas (matapa) para ficarmos mais forte e saudável	We have to eat more fruits and leaves (manioc leaves) to be stronger and healthier	
	As folhas e frutas de cores mais escuras, têm mais vitaminas	The leaves and fruits of darker color have more vitamins	

Annex 6. Adventist Development and Relief Agency Supervision Tools

SUPERVISION FORM FOR USE BY HEALTH DISTRICT SUPERVISORS (PORTUGUESE)

GUÍA DE SUPERVISÃO - FACILITADOR										
Distrito:				Nome do Supervisor:						
Datas de Supervisão				1	2	3	4	5	6	Comentários/Recomendações
Sessões de Treinamento										
1	FAC tem um plano de treinamento.									
2	FAC usa metodologias participativas.									
3	FAC usa materiais educativos adequados.									
4	FAC prepara materiais necessários com antecipação.									
5	FAC apresenta as mensagens chaves claramente.									
6	FAC cobre e enfoca no tópico.									
7	FAC promove a participação de todos os participantes.									
8	FAC responde as perguntas levantadas pelos participantes.									
9	FAC se faz entender.									
10	FAC avalia compreensão dos participantes.									
11	Participantes são colocados de forma a ver uns aos outros.									
12	FAC fala com voz audível.									
13	O local de treinamento tem um ambiente apropriado.									
14	FAC controla a presença de participantes.									
15	Participantes demonstram compreensão das lições compartilhadas.									
Controle de Crescimento Infantil/Promoção										
16	FAC sabe como medir o peso das crianças.									
17	FAC sabe como preencher o CSI.									
18	FAC sabe como identificar o estado nutricional das crianças.									
19	FAC dá aconselhamento apropriado para as mães/responsáveis.									
Supervisão										

20	FAC supervisiona VSC pelo menos 1 vez ao mês.							
21	FAC usa a Guia de Supervisão.							
22	FAC visita o CSC pelo menos 1 vez por mês.							
23	DP/AD são implementados adequadamente.							
Coordenação com Autoridades Locais e Pessoal de Saúde								
24	FAC apresenta seu trabalho junto à liderança comunitária.							
25	FAC coordena atividades com as estruturas de saúde locais.							
Sustentabilidade								
26	VSC são apoiados pela comunidade.							
27	CSC ativos e funcionando adequadamente.							
28	Famílias participam ativamente das atividades do programa.							
29	Há integração com outros componentes do programa							
Sistema de Monitoramento								
30	FAC conhece sua área de ação, apresentando mapas, população, estruturas de saúde, distribuição dos RH de saúde e cobertura do programa.							
31	FAC tem informação atualizada e documentada.							
32	FAC apresenta informação consistente.							
33	FAC trabalha de acordo ao Plano de Trabalho Mensal.							
34	FAC conhece os indicadores do programa e seus respectivos indicadores.							
35	FAC dá seguimento aos formatos do VSC e valida a informação.							
36	FAC apresenta informação com documentos que a comprovam.							
37	FAC utiliza adequadamente os formatos oficiais do programa.							
38	FAC usa informação para a tomada de decisões.							
39	FAC participa ativamente das reuniões trimestrais de planejamento.							
Legenda: 0: Não 1: Sim 2: Parcialmente 3: Não supervisionado 4: Não aplicável								
Data								
Tempo de Supervisão								
Avaliação do Desempenho								
Assinatura do VSC								
Assinatura do Facilitador								

SUPERVISION FORM FOR USE BY HEALTH TECHNICIANS (PORTUGUESE)

GUÍA DE SUPERVISÃO - VSC							
Distrito:							
Nome do VSC:							
Datas de Supervisão		1	2	3	4	5	6
1	VSC usa metodologias participativas.						
2	VSC apresenta as mensagens chaves claramente.						
3	VSC cobre o tópico.						
4	VSC enfoca no tópico.						
5	VSC promove a participação de todos os participantes.						
6	VSC responde as perguntas levantadas.						
7	VSC se faz entender.						
8	VSC usa recursos visuais quando possível.						
9	VSC avalia compreensão dos participantes.						
10	Participantes são colocados de forma a ver uns aos outros.						
11	VSC fala com voz audível.						
12	VSC busca participantes ausentes.						
13	Participantes perguntam, dão opiniões e sugestões.						
	No. de participantes na reunião.						
14	Participantes prestam atenção apresentando interesse.						
15	O local de treinamento tem um ambiente apropriado.						
16	VSC faz visitas domiciliarias.						
17	VSC faz seguimento das mães que necessitam apoio.						
18	A comunidade tem um local apropriado para o CCI/P						
	VSC participa das sessões de CCI/P.						
19	VSC cuida apropriadamente dos materiais educativos e de CCI/P.						

20	As crianças tem o CSI.							
21	VSC sabe como medir o peso das crianças.							
22	VSC sabe como preencher o CSI.							
23	VSC sabe como identificar o estado nutricional das crianças.							
24	VSC dá aconselhamento apropriado para as mães/responsáveis.							
25	VSC compartilha a situação nutricional com a comunidade.							
26	VSC apoia efetivamente nas sessões DP/AD.							

Coordenação com Autoridades Locais e Pessoal de Saúde

27	No. de casos referidos para os Estruturas de Saúde.							
28	VSC apresenta seu trabalho para a liderança comunitária.							
29	VSC participa ativamente do CSC.							

Seguimento dos Formatos

30	VSC escreve com letra legível.							
31	VSC tem os formatos em dia.							
32	VSC preenche os formatos corretamente.							
33	VSC apresenta consistência nas informação.							

Legenda: 0: Não 1: Sim 2: Parcialmente 3: Não supervisionado 4: Não aplicável

Data								
Tempo de Supervisão								
Avaliação do Desempenho								
Assinatura do VSC								
Assinatura do Facilitador								

Annex 7. World Vision Supervision Tools

SUPERVISION FORM FOR USE BY HEALTH TECHNICIANS (PORTUGUESE)

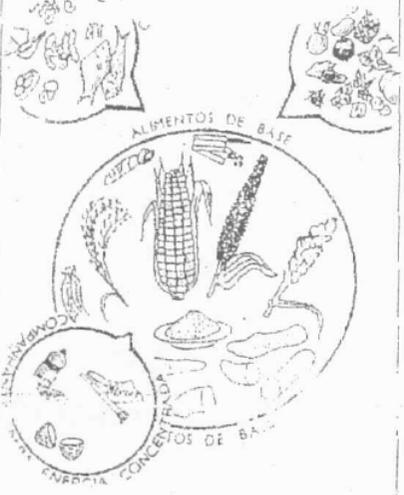
GUIÃO DE SUPERVISÃO - TREINADOR						
Distrito:		Nome do Supervisor:				
Datas de Supervisão		1	2	3	4	Comentários/Recomendações
1	Tem um plano de treinamento.					
2	Usa metodologias participativas.					
3	Usa materiais educativos adequados.					
4	Prepara materiais necessários com antecipação.					
5	Apresenta as mensagens chaves claramente.					
6	Cobre e enfoca no tópico.					
7	Promove a participação de todos os participantes.					
8	Responde as perguntas levantadas pelos participantes.					
9	Faz-se entender.					
10	Avalia a compreensão dos participantes.					
11	Os participantes são colocados de forma a ver uns aos outros.					
12	Fala com voz audível.					
13	O local de treinamento tem um ambiente apropriado.					
14	Controla a presença de participantes.					
15	Os participantes demonstram compreensão das lições compartilhadas.					
16	Sabe como medir o peso das crianças.					
17	Sabe como preencher o caderno de peso.					
18	Sabe como identificar o estado nutricional das crianças.					
19	Dá aconselhamento apropriado para as mães/responsáveis.					
20	Supervisiona os voluntarios e auxiliares pelo menos 1 vez ao mês.					

22	Visita o CLC pelo menos 1 vez por mês.					
Coordenação com Autoridades Locais e Pessoal de Saúde						
23	Apresenta seu trabalho junto à liderança comunitária.					
24	Coordena as actividades com as estruturas de saúde locais.					
Sustentabilidade						
25	VSC são apoiados pela comunidade.					
26	CLC são activos e funcionam adequadamente.					
27	As famílias participam activamente das actividades do programa.					
28	Há integração com outros componentes do programa					
Sistema de Monitoramento						
29	Conhece sua área de acção, apresentando mapas, população, estruturas de saúde, distribuição dos RH de saúde e cobertura do programa.					
30	Tem informação actualizada e documentada.					
31	Apresenta informação consistente.					
32	Trabalha de acordo ao Plano de Trabalho Mensal.					
33	Conhece os indicadores do programa e seus respectivos indicadores.					
34	Dá seguimento as formações do VSC e valida a informação.					
35	Apresenta informação com documentos que a comprovam.					
36	Utiliza adequadamente os formatos oficiais do programa.					
37	Usa informação para a tomada de decisões.					
38	Participa activamente das reuniões mensais de planeamento.					
Legenda: 0: Não 1: Sim 2: Parcialmente 3: Não supervisionado 4: Não aplicável						
Data						
Tempo de Supervisão						
Avaliação do Desempenho						
Assinatura do Treinador						

Annex 8. Community-Level Reporting Forms

World Vision

FICHA DE RESUMO MENSAL DE DADOS COMUNITÁRIOS
 Mês de----- Conselho de----- Ano-----
Projecto Ocluvela/saúde

<p>4 grupo de alimentos</p>  <p>ALIMENTOS DE BASE</p> <p>COZINHA</p> <p>CONCENTROS DE BASE</p> <p>ENERGIA</p>	<p>Batata doce de polpa alaranjada</p>  <p>Folhas de Batata-doce</p>	<p>Diarreia na criança</p> 	<p>Malária</p> 
Total de sessões-----	Total de sessões-----	Total de sessões-----	Total de sessões-----
H M	H M	H M	H M