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**COMMUNITY CARE
PROGRAM**



Photo of a Global Survey Corporation data collector taken and provided by GSC.

USAID Community Care Program Baseline Survey Report January 2013

Acknowledgement

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Acronyms

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCP	Community Care Program
CNBS	Comité Nacional de Bioética para a Saúde) Mozambican bioethics committee
CSO	Civil Society Organizations
FGD	Focus Group Discussions
FHI360	Family Health International
GSC	Global Survey Corporation
HBC	Home Based Care
HH	House Holds
KII	Key Informant Interviews
MMAS	Ministry of Women and Social Action
MOH	Ministry of Health
OVC	Orphans and other Vulnerable Children
PHSC	Protection of Human Subjects Committee
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
QOL	Quality of Life
TB	Tuberculosis
USAID	United States Agency for International Development
VSL	Village Savings and Loan

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Introduction/Project overview

The USAID Community Care Program (CCP)¹ is a five-year \$44 million USAID-funded program, implementing an integrated family-based approach and strengthening the community-based response to the HIV and AIDS epidemic in seven provinces in Mozambique. As the prime agency, FHI 360 has the overall responsibility for technical, contractual, and programmatic leadership and coordination. Provincial implementation is shared with and supported by consortium partners Africare and World Relief in Manica and Inhambane provinces, respectively. FHI 360 is the lead agency in Maputo, Niassa, Sofala, Tete and Cabo Delgado provinces. FHI 360 provides cross-cutting technical support in home-based care (HBC), care and support for orphans and vulnerable children (OVC), and referral to prevention of mother to child transmission (PMTCT) services. Project HOPE is a technical partner providing cross-cutting technical support in economic strengthening.

The aim of CCP is to strengthen the community-based response to HIV and AIDS in the seven focus provinces and to improve the health and quality of life (QOL) of people living with HIV (PLHIV), OVC, and pregnant and post-partum women. Working in partnership with civil society organizations (CSOs), the Ministry of Health (MOH), the Ministry of Women and Social Action (MMAS), and the private sector such as mCel, CCP also works to strengthen the government's capacity to coordinate, manage and oversee an integrated continuum of care and support, and, will build the capacity of CSOs to provide comprehensive, community-based care and support services.

To achieve this aim, CCP activities focus on four objectives:

- Strengthening organizational, technical and leadership capacities of CSOs and the public sector to deliver services to PLHIV, OVC and pregnant and post-partum women and their families;
- Strengthening coordination, collaboration, linkages and partnerships within and across sectors to develop efficient and innovative community-based service delivery;
- Increasing the availability, accessibility, and use of family-centered, age-appropriate and gender equitable care and support services for targeted groups; and
- Improving the capacity of vulnerable households to meet their needs in sustainable ways by strengthening their livelihood, caregiving, and health-seeking skills.

These baseline data were collected to inform project implementation and also as a first step in evaluating CCP's achievement of these objectives over time. The baseline study was conducted in 13 selected districts in the seven focus provinces prior to project initiation. A mixed methods design was used to collect baseline evaluation data, including a population-based household survey, key informant interviews (KIIs) and focus group discussions (FGDs), and a CSO capacity assessment, was conducted in each of the study districts. Only the findings from the household survey will be presented in this report.

At the end of CCP, findings from the baseline study will be compared with end-of-project data. *This report presents findings from the baseline study only.*

¹ Initially named the Community Care HIV and AIDS Services Strengthening Project (ComCHASS)

Methods

Study sites

Baseline data were collected from all seven project provinces. Logistical and financial feasibility required limiting baseline data collection to two districts per province--except in Cabo Delgado where CCP is being implemented in only one district—for a total of 13 study districts. One urban and one rural district were purposively selected from each province, except in Cabo Delgado where the only district was Pemba. Study districts (project target districts) also had to have the presence of health units providing pediatric and adult ART and PMTCT services funded by any USG agency. Figure 1 displays the geographic distribution of these provinces and districts.

Figure 1: Data collection locations



Study Objectives

The overall purpose of the study was to gain a greater understanding of the situation that many Mozambicans find themselves in with regards to accessing care and support services. This study was designed to obtain a broad view of the educational, nutritional, general health and economic concerns and issues facing many Mozambicans today. Specifically this study was designed to:

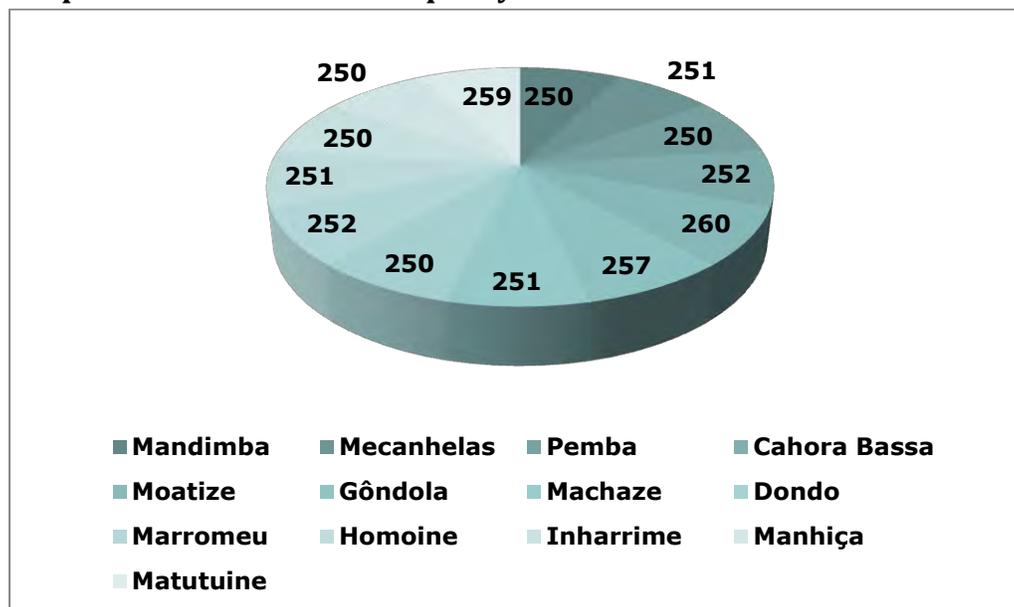
- Assess community-level perceptions, experiences and need of **care and support services** for PLHIV, OVC, pregnant and postpartum women and their households; and
- Assess community-level perceptions, experiences and need of **opportunities to better meet the economic needs** of HHs with PLHIV, OVC and pregnant and post-partum women.

A structured questionnaire was administered to heads of households (HH) in each study district to obtain information on access to services, perceptions and opinions of service providers and quality of care. 'Head of HH' was defined as any adult over the age of 21 that was responsible for making or executing decisions on behalf of the other members of the HH for a period of at least 6 months and could be a husband, wife, mother-in-law, eldest son, or uncle, etc. Young people aged 12 to 20 years could be considered heads of HHs if they had been responsible for decision-making in the family for at least the past six months. HHs in each study community were randomly selected: when a group of data collectors entered the community at the district administrative office, a pen was dropped on the ground and the direction of that pen determined the direction that the enumerators began data collection – each heading in opposite directions. Each enumerator began with the fifth house and progressed through the community selecting every third house afterwards. When a head of HH declined an interview, or was absent, the interviewer again selected the following third house. In most cases, interviews were conducted in the evening when heads of HHs were thought most likely to be at home.

The sample

The sample size of 250 interviews per district was calculated to detect a 15% change over time assuming a 50% baseline level for any indicator, using a one-tailed test with 80% power, 95% confidence, a design effect of 1.7, and a 10% non-response rate. This target was surpassed with a total of 3,283 HHs participating in this study, 33 more.

Graph 1: Distribution of Sample by District



Survey administration and quality control

The head of HH survey took approximately 45 minutes to one hour to administer. Questions were asked in Portuguese or the local language depending on participant preference. Interviews were

administered in participants' homes after she/he was read the Informed Consent Form, signed the form and received a copy.

At the completion of each day of interviewing, the supervising interviewer within each province and her/his team reviewed the completed questionnaires and discussed questions and concerns about the day's interviews. Queries were addressed using field notes; if necessary, interviewers returned to HHs for clarification. To assure data quality, the supervising interviewer performed random checks on the survey sample to confirm that they were interviewed as reported.

Informed consent

Participants in the interviews were consented prior to the interview. Assent was sought from youth heads of HHs in the survey and consent was provided by her/his block leader (responsible for 10 houses where the HH head resides).

Implementation

Survey data were collected by the external research organization, Global Survey Corporation (GSC) in consultation with FHI 360 and its other provincial lead partners. Interviewers were hired on the basis of demonstrated capacity in community-based survey administration experience, fluency in Portuguese and the relevant local languages.

Interviewers were trained on the study protocol and data collection instruments and helped to pre-test the instruments. Training was led by GSC and supported by FHI 360, provincial lead partner's agencies and Project HOPE. The one-week interviewer training included: 1) the ethics of research – confidentiality and obtaining voluntary informed consent; 2) discussion of the protocol; 3) discussion of the relevant cultural contexts for data collection; 4) review of team member roles; 5) review of study instruments and informed consent procedures; and 6) pre-testing the data collection instruments and process in one district of Maputo province.

GSC led the data collection activities in each district and the GSC team leader provided overall supervision before, during and after data collection, while the PI provided guidance to GSC. The FHI 360 Community Mobilization Officer supervised the community engagement process, contacting all stakeholders involved in the study.

Data management

After survey forms were reviewed they were maintained in a locked box in each district under the responsibility of the supervisor of the data collectors. All forms were sent to Maputo for data entry and storage after the data collection was completed in each province.

All forms and field notes will be stored for five years after the end of the study and shredded or burned at the end of the storage period.

Epidata was used to create screens for data entry and verification for high accuracy data capture and management. After entry, reports were generated using SPSS Statistics v 17.0 for basic logic, range, and missing data checks. After all data were entered and cleaned, the data were locked for analysis.

Data analysis

Data from the head of HH survey were analyzed using SPSS v17. Means, ranges, standard deviations and percentages were calculated for continuous variables while frequencies and percentages were calculated for categorical variables. Results are presented as they related to each survey objective.

Ethics

Ethical approvals were obtained from FHI 360's Protection of Human Subjects Committee (PHSC) and the Comité Nacional de Bioética para a Saúde (CNBS) of Mozambique. The informed consent process was conducted in Portuguese or in the appropriate local language. All participants were asked to sign or provide a thumb print to indicate their consent to participate. Signed informed consent documents were filed separately from the transcript and survey files in Maputo.

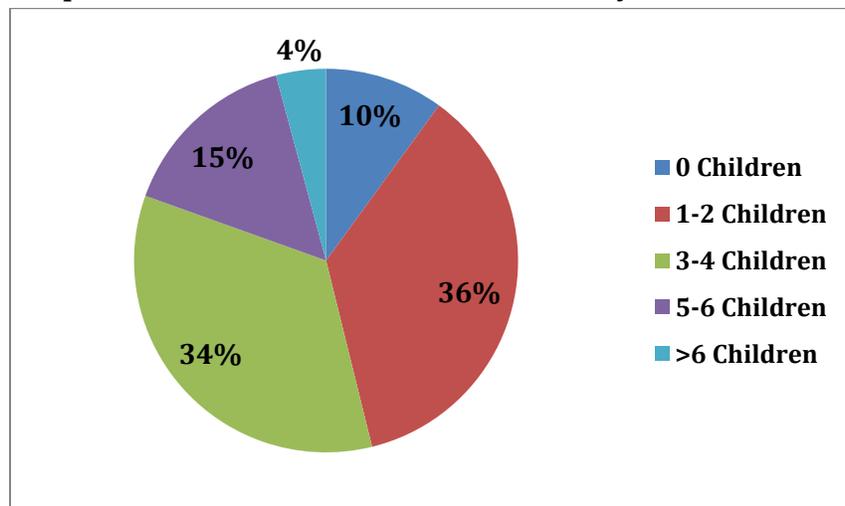
While some of the survey questions were considered sensitive, especially those related to the health and HIV status, there were no adverse events during this study.

Survey Results

Demographic and household characteristics

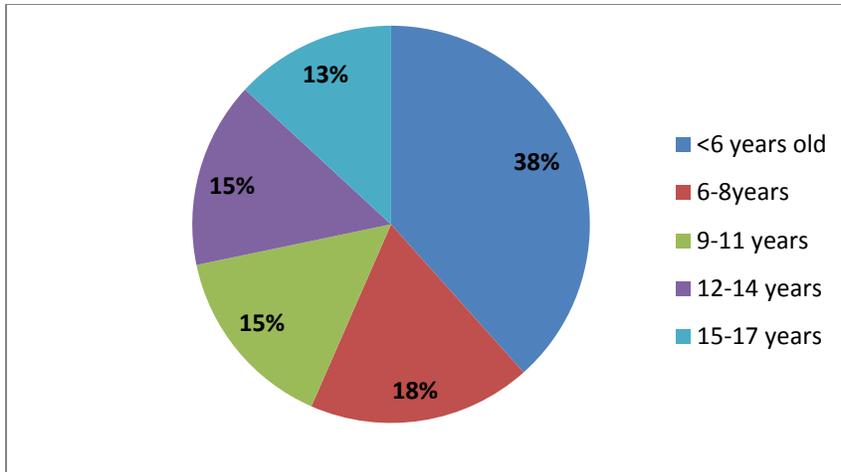
In the 3,283 surveyed HH, there were a total of 8,341 adults and 9,551 children (0-17 years old). There was an average of 5.5 individuals/HH overall and 2.9 children living. There were 2,952 HH with children and 331 HH without children. Only 5 of the households interviewed were headed by someone under the age of 18 and three of these households were sets of single males living alone.

Graph 2: The number of Children in surveyed households



Sixty-three percent of HHs with children had children 0 to 4 years and 79% had children 5-17 years. Overall, the less than 6 age group made up 38% of all children, leaving 62% of the children to be of school age.

Graph 3: Children's Age Breakdown



In this sample, there were a total of 433 (13.1%) single headed households, of which 83% were female and 17% were male ($p < .01$).

The average age of all adults living in these HH is 34 years of age and ranges from 18 to 95 years old.

Slightly more adult women than men live in the surveyed HHs (54% vs. 46%), while the children (17 years or less) were evenly split between boys and girls. Most adults (63.3%) are in a marital union (defined as cohabitating as a couple conservatively for one year without interruption) and only 8% are considered to be in a civil/legal marriages. The remainder are single (13.5%), widow/widower (9.9%) and divorced/separated (5.3%).

There were 1,690 (17.7%) children in the surveyed homes who were identified as orphans; 10% are paternal orphans, 4% are maternal orphans and 3% double orphans. A very small proportion of heads of HH did not know the status of the children they were caring for, 1.1%. Of the 93% of children whose mother is still alive 84% live with her. At the same time, not only are slightly fewer fathers alive (86%) but fewer children are living with him (67%). Sixty-seven percent of the children living in the HHs were the biological children of the survey respondents, with 12% being grandchildren and 8% being nephews or nieces.

Thirty-seven percent of the head of households have never been to school. At the same time 27.6% of all other adults in the HHs surveyed had never been to school. Among the children, 85% of the school age children are currently enrolled in school.

The main activities that take up adults' time in this sample were farm work with livestock (27%), employment in a formal organization (19%) and informal (employment) activities (20%).

Table 1: Basic demographics of HHs participating in the survey

Variable	Adults	Children
HH Mean age	34	7.9
Age range	18-95	>1 – 17
Head of HH mean age	37	16 (5 children)
Age range	18-91	14-17
HH Sex	M 46% F 54%	M 51% F 49%
Head of HH sex	M 38.2% F 61.6%	M 80% (4 children) F 20% (1 child)
Head of HH Marital Status		
Married or in Union	71.3%	NA
Single	13.5%	NA
Separated/divorced	5.3%	NA
Widow/Widower	9.9%	NA
Mean number People per household	2.5	2.9
Relationship to head of HH		
Spouse	44%	.14% (13 girls)
Biological child	21.3%	67%
Other	12.9%	4.2%
Brother or sister	8.7%	5%
Mother or father	6.3%	NA
Niece or Nephew	3.4%	8%
Grandchild	1.7%	12%
Non-biologic adult child	1.2%	4%
Head of HH Education		
No schooling	37.8%	School age children not in school - 15%
EP1 ²	17.5	School age children currently enrolled – 85%
EP2	20.3	
Secondary 1º Ciclo	13.3	
Secondary 2º Ciclo	7.4%	
> Secondary school	2.9%	
Orphan status		
	% Maternal	3.5%
	% Paternal	10.3%
	% Double	2.9%
Children lives with Mother or Father		
	% Lives with Mother	84%
	% Lives with Father	67%

² EP 1 (Grades 1 to 5); EP2 (Grades 6 and 7); Secondary 1º Ciclo (Grades 8 to 10); Secondary 2º Ciclo (Grades 11 and 12).

Eligibility for services

Registration of births allows for the child to access basic services such as education, health and social benefits. It is also important because it is the main document required for the child to be issued with a Poverty Certificate. This is a certificate that permits the child to access the above services without having to pay for them. The births of 76% of the children in the surveyed HHs had been registered. None of the children in the surveyed HHs had a Poverty Certificate.

Schooling

Approximately 5,922 (62%) of the children in this survey are of school age. Of these, 85.3% (5,052) were enrolled in school. Reasons for the 15% not enrolled included:

1. Lack of money for tuition (22%)
2. Child did not want to go (20%)
3. Child is ill (6%)
4. Child works (5%)
5. Child is taking care of other children (3%)

Approximately 12% of the children enrolled in school (607) missed one or more days in the two weeks prior to the survey. Among those, 42% reported illness as the main reason for their absenteeism from school (255).

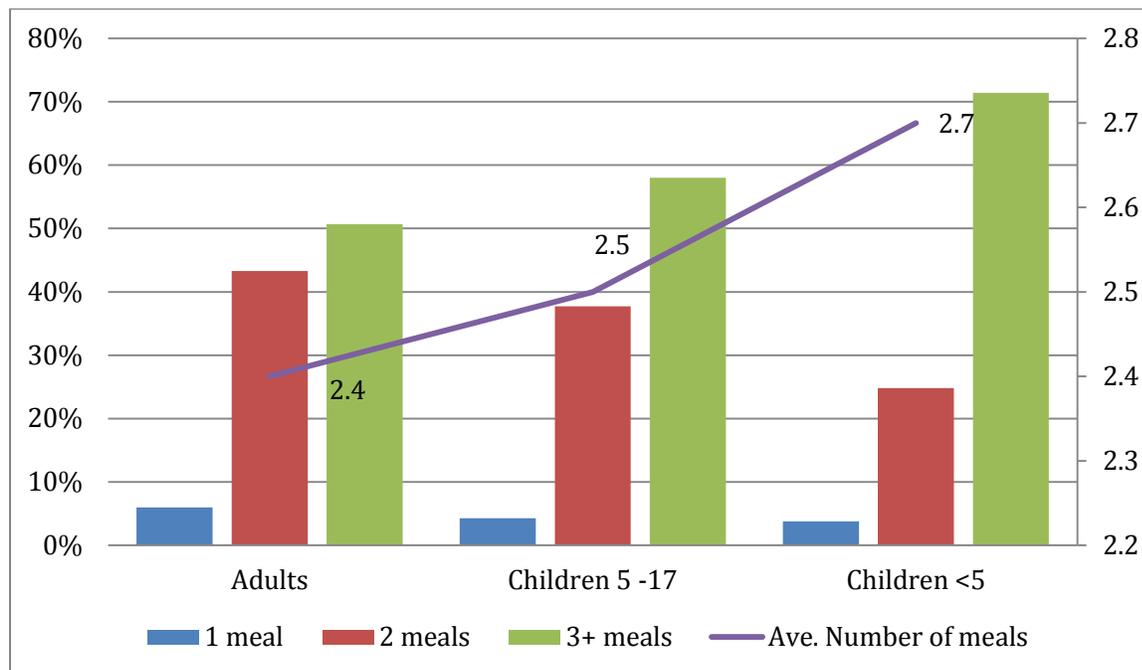
General health

When the survey respondents were asked to assess the health of the members of their HHs, they rated the health of 68% of the adults and 76% of the children as 'good.' In the three-month period prior to the survey, 8% of the adults in the surveyed HH had not been able to carry out their normal activities at some point due to illness. This percentage was notably higher in Dondo (17%) and Pemba (12%). The percent of children who had been ill for at least 3 months during the year prior to the survey was 3% overall and ranged from 1% in Inharrime to 7% in Pemba.

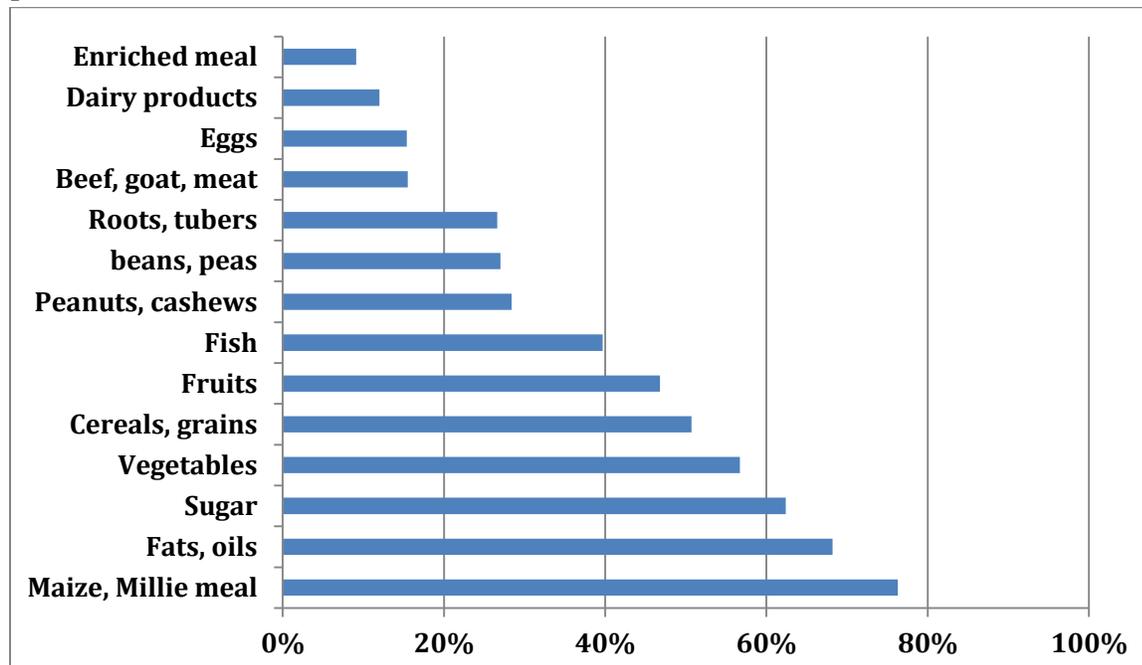
Nutritional intake

Within seven days prior to the survey, the most commonly consumed foods included maize (76% of HH), fats/oils/butter (68%), sugar (62%), vegetables (57%), fruits (47%) and fish (40%). Among the surveyed HHs, 51% of the adults had three or more meals the day before the survey, 43% had 2 and 6% had 1. Children in both age groups had more meals than adults overall.

Graph 4: Children under 5 tend to have 3 or more meals a day more often than older children or adults.



Graph 5: Types of foods consumed during the 7 days prior to the survey, all provinces



Out of the total survey sample 7% of the families never resorted to any coping strategies in order to secure access to food. Of the 93% who did, 78% relied on less expensive food at some point in the week, 76% reduced the number of meals eaten in a day at least once in the week, and 71% limited

the size of the portions they and their family ate. Families were least likely to skip an entire day of eating (82% never did this) and sending family members elsewhere to eat (80% never did this).

Table 2: Coping strategies HHs used to secure access to food

	Never	Seldom (1-2 days a week)	Sometimes (2-3 days a week)	Often (4-6 days a week)	Daily
Skip entire days without eating?	82%	11%	6%	2%	0%
Limit portion size at mealtimes?	39%	31%	24%	5%	2%
Reduce number of meals eaten per day?	34%	25%	26%	9%	4%
Borrow food or rely on help from friend or relatives?	58%	18%	19%	4%	1%
Rely on less expensive or less preferred foods?	32%	23%	26%	12%	8%
Purchase/borrow food on credit?	74%	12%	10%	4%	1%
Gather unusual types or amounts of food wild food/hunt?	76%	15%	7%	2%	1%
Harvest immature crops (e.g. green not-fully mature maize)?	60%	18%	18%	3%	1%
Send household members to eat elsewhere?	80%	10%	8%	1%	1%
Send household members to beg for food?	74%	13%	12%	1%	1%
Reduce adult consumption so children can eat?	51%	22%	22%	4%	1%
Rely on casual labor for food?	65%	15%	13%	6%	2%

Child protection

Abuse of children can be physical, sexual or moral/psychological. However, physical force is perceived as a normal part of childrearing in Mozambique, as is shouting and verbal punishment – necessary to correct misbehavior, as a study by Save the Children Sweden in Mozambique on Corporal punishment, showed that people perceived corporal punishment as “.....*necessary part of upbringing and education. Children learn from a smacking or a beating to respect their parents and teachers, to distinguish right from wrong, to obey rules and work hard. Without corporal punishment children will be spoilt and undisciplined...*”³ Sixty-three percent of heads of HH with children know whom to ask for assistance or support against child abuse (ranging from Inhambane at 95% to Pemba at 41%, $p < .01$). There were few cases of child abuse reported in the survey with about 16% of those reporting some type of violence stating that they had sought support or help at some point in time.

³ Ending Corporal Punishment of Children in Mozambique, Save the Children Sweden 2010.

In total, 166 households reported that a child in that household was the victim of some form of violence, (5% reported physical abuse of children living in their household and less than 1% reported child sexual violence, with virtually no overlap between these two groups). Five percent reported psychological or verbal abuse of children in their HHs. Reports of child abuse are typically underreported and, in spite of a relatively high number who know where to go to obtain help, only 22 of the overall total of 166 victims (13%) received any form of assistance. It is likely that these events are underreported because of the social stigma attached to them.

HIV/AIDS

Almost all survey respondents were *aware* of HIV/AIDS (99.3%). Their information about HIV/AIDS came from the community - 64%, from the radio - 45%, from community health talks - 42%, Television - 28%, school - 14%, and from other sources - 42%. In the two participating districts in Niassa province, 82% of respondents had heard about HIV/AIDS from some source in the community. Overall about a third of the respondents knew someone with HIV/AIDS. At the district level this proportion was highest in Matutuine (51%).

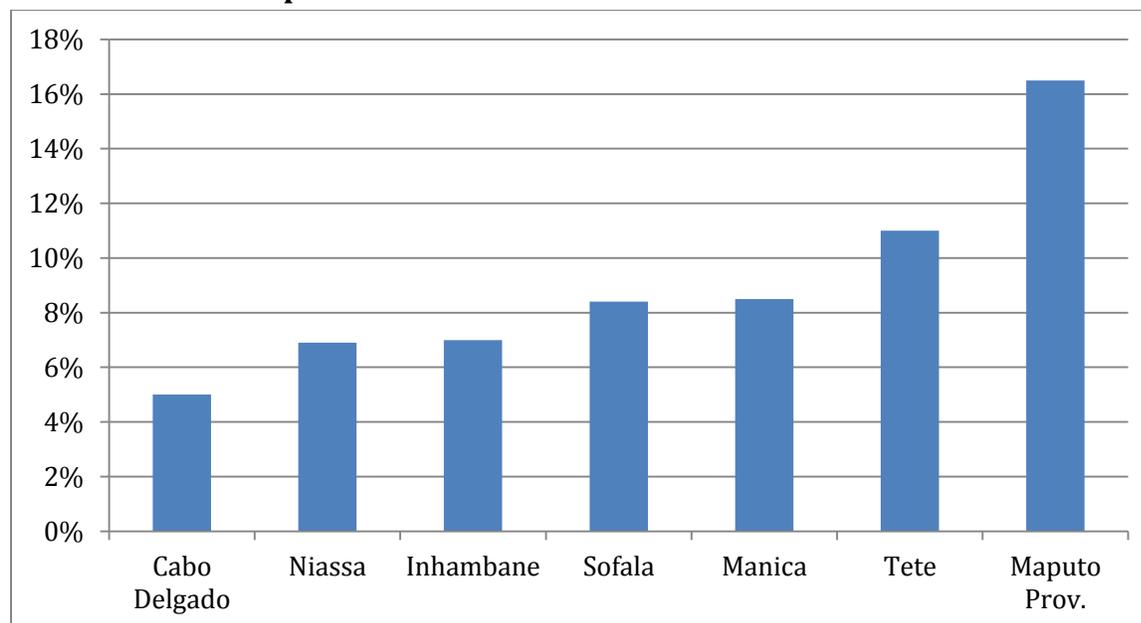
Table 3: Different ways people have learned about HIV/AIDS

How did you hear about HIV/AIDS?	Province							Total
	Niassa	Cabo Delgado	Tete	Manica	Sofala	Inhambane	Maputo Province	
Dramas	29.3%	44.5%	43.8%	46.7%	32.6%	46.8%	52.6%	42.2%
In School	14.2%	8.9%	8.6%	22.2%	9.3%	23.4%	9.0%	14.0%
In the Community	82.0%	66.8%	57.4%	64.4%	60.8%	62.0%	58.6%	64.3%
On Television	9.8%	63.6%	24.4%	26.3%	18.3%	32.4%	40.4%	28.2%
Radio	57.5%	73.3%	35.8%	50.7%	48.5%	25.2%	36.5%	44.7%

Differences between highest and lowest provincial levels within each channel are significant at the .01 level.

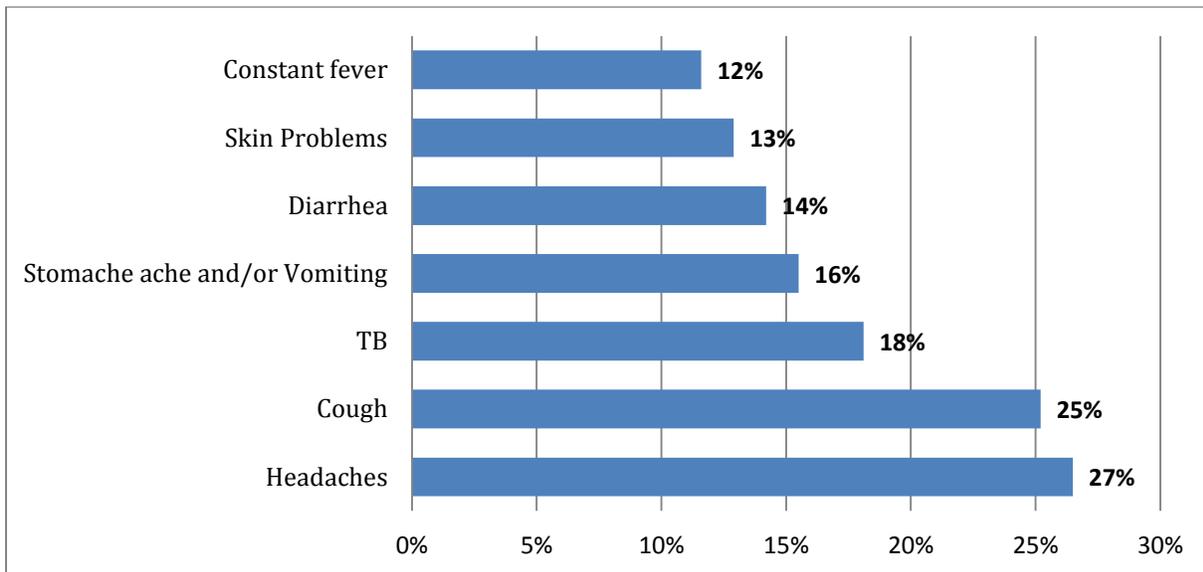
Looking at all HHs, 279 (9.5%) of the respondents self-reported the presence of PLHIV within their HH; either themselves alone (147-4.5%), both themselves and at least one other person (74-2.3%), or not themselves but at least one other person (58-1.8%). A greater percentage of HHs headed by women (11%) reported having a PLHIV living in the HH compared to those headed by men (7%), $p < .01$. Out of all PLHIV HH, 72% are women and 28% are men. The presence of a PLHIV living in the house ranges from a low of 5% in Cabo Delgado to a high of 17% in Maputo Province, $p < .01$. Fifty-six percent of the HHs with PLHIV had a paternal orphan residing with them and 24% had a maternal orphan in residence.

Graph 6: The highest rates of self-reporting that a person with HIV lives in the household is in Maputo Province



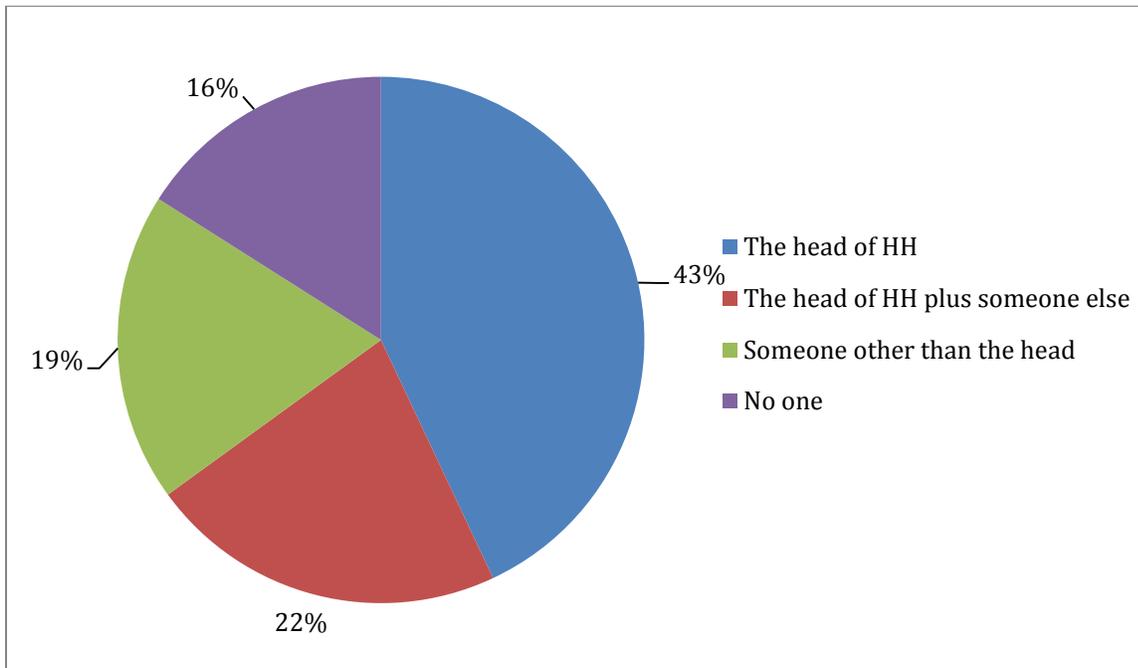
Of those households with a PLHIV living there, 55% had been ill at least three months out of the previous year. Ninety-one percent of PLHIV who had been sick at any point during the year sought medical care at government hospitals (57.6%) and government health centers or clinics (45.5%); the percentages equal more than 100% as a result of multiple visits that took patients to different sites. The top two issues PLHIV identified as chronic problems (lasted for 3 or more months) were headaches (27%) and coughing (25%). TB was reported by 18% of the PLHIV. Inharrime district had the lowest percentage of PLHIV seeking health care (72%). Among the 26 PLHIV family members who did not go for care of any illnesses over the past year, their main reason was that they believed that their illness was not serious enough (7 people, 27%) another 3 PLHIV said that they did not have enough money (12%).

Graph 7: Top health issues PLHIVs reported experiencing for 3 or more months at a time



Eighty-four percent of the 234 HHs where there was a PLHIV living reported that the PLHIV was receiving ART and 88% of these did not have an interruption in their ART use during the 12 months prior to the survey; 6% stopped and restarted while another 6% stopped and never restarted. ART was accessed in a government run central district level hospital by 51% of the HHs and 41% of HH accessed their ART at a local government run health facility. More PLHIV HH headed by men than women have someone in that HH receiving ART (91% vs. 81%, $p < .05$). In these ART HHs, 43% of the time the only member who is a PLHIV is the head of household, in 22% of the ART HHs the person on ART is the head of HH plus one other person in the household is living with HIV, and in 19% of the cases there is a person in the HH living with HIV but it is not the head.

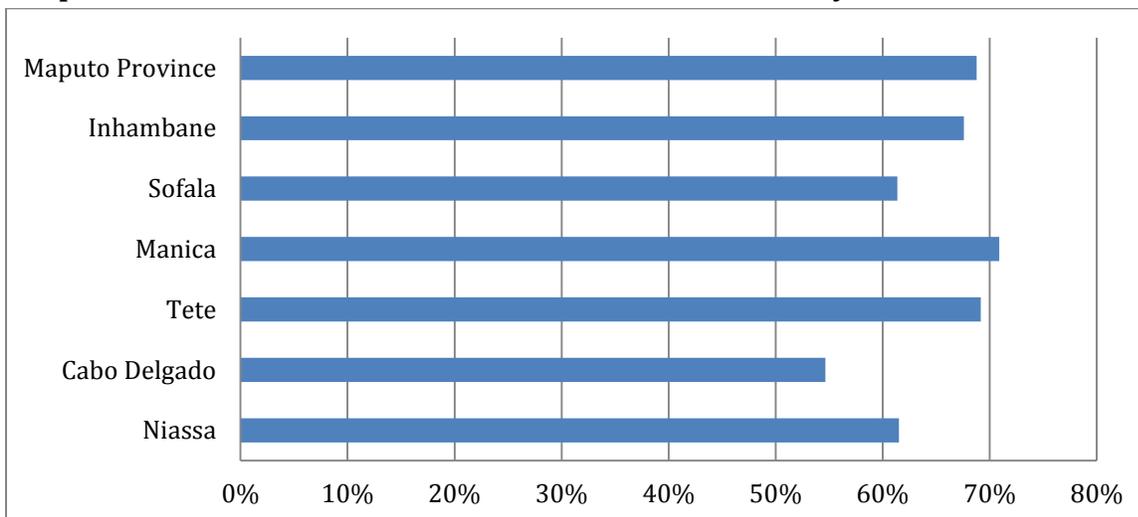
Graph 8: Who is on ARV therapy in HH with PLHIV?



HIV Counseling and Testing

Nearly 66% of respondents had ever been *tested* for HIV/AIDS, with a higher percentage of women (72%) having been tested compared to men (56%). Overall, heads of HH reported that 43% of other HH members had been tested for HIV. This ran from a low of 35% in Niassa to a high of 52% in Tete, $p < .01$). Approximately 96% of those tested received their results (this does not vary significantly by province).

Graph 9: Percent of heads of HHs who have been tested by Province



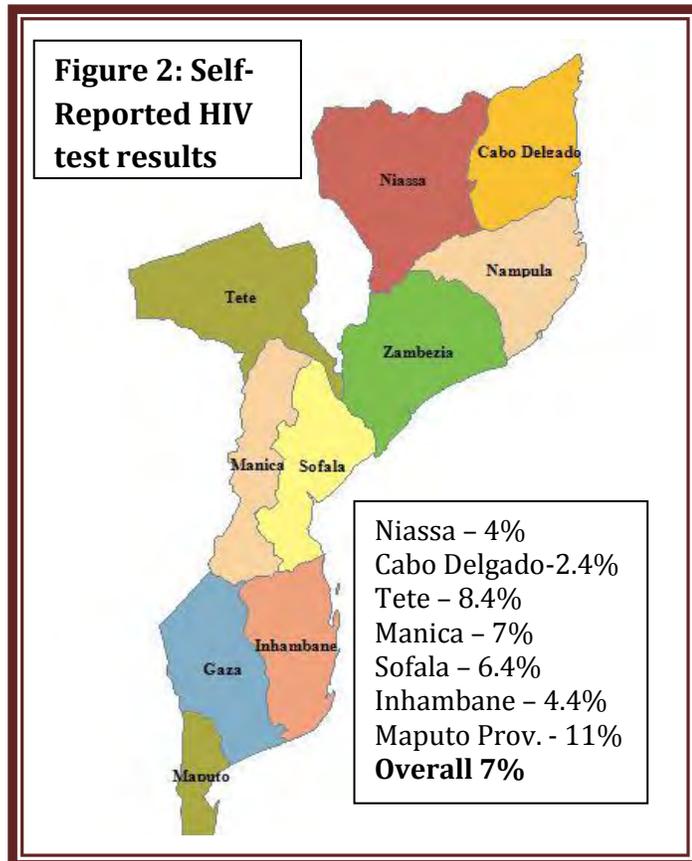
Very few of the households, 148 HH (5%), stated that they had taken a child exposed to HIV to have an HIV test. This ranged from a low of 2.3% of HH referring exposed children for testing in Inhambane to a high of 8.2% of HH in Niassa reporting HIV exposed children being sent for testing, $p < .01$.

In HH where the head of household had already been tested for HIV, 7% reported they had sent a child exposed to HIV to be tested. Within HH where at least one person is a PLHIV, 29% of heads of HH had sent a child exposed to HIV for an HIV test, $p < .01$.

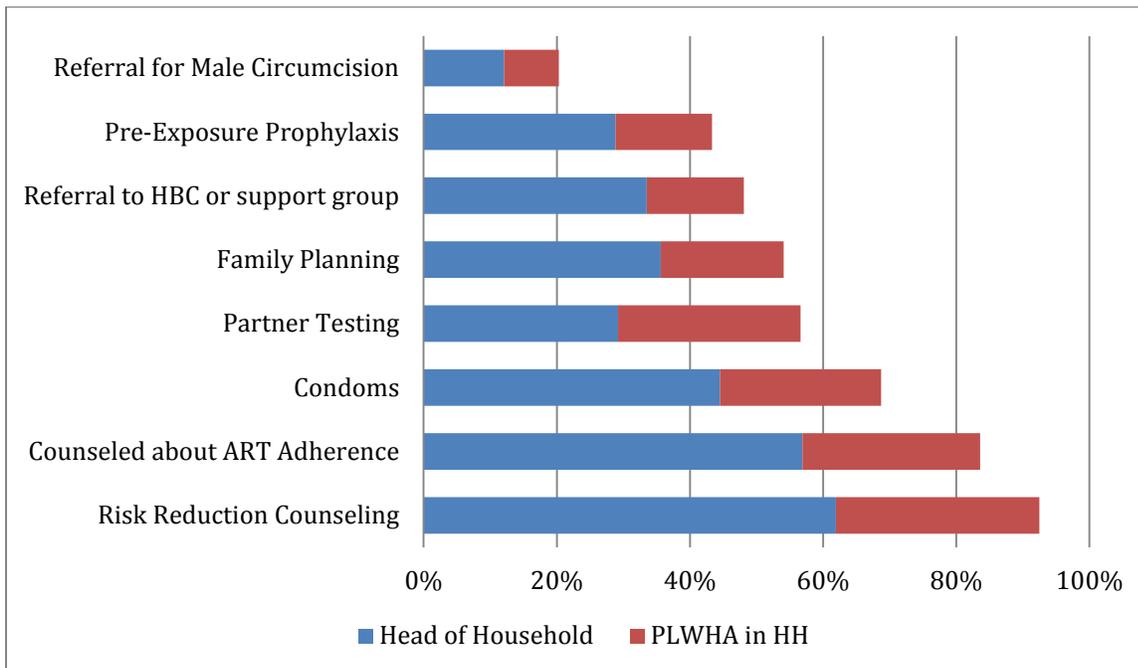
Overall, 34% of the respondents said that they knew someone who was HIV positive. Across all sites, 7% of the heads of HH self-disclosed that they were HIV positive (see Fig 2). Higher rates of self-reported HIV positive status were reported in the south of the country: Manhiça (17%) and Matutuine (16.3%), while the lowest self-reported rates were in Inharrime (4%), Pemba (5%), and Mandimba (6%).

Community Support

Approximately 92% of all PLHIV HH received some sort of support from a community organization in the area of HIV and AIDS. Among those who received support, 93% HH received counseling on how to reduce risk, 69% were supplied with condoms, and 57% were assessed for their own need or their partner's need to be tested for HIV. Fifty-five percent received counseling on safer pregnancy or were sent to family planning services. Eighty-four percent of the cases counseled about adherence to ART and 48% were referred to HBC, a support group or a pre/posttest support group. Twenty percent were educated on the effectiveness of male circumcision. An additional 44% said someone in the house had received pre-exposure prophylaxis. There was no difference overall when looking at the gender of the head of HH and whether or not PLHIVs in the HH received some form of support.

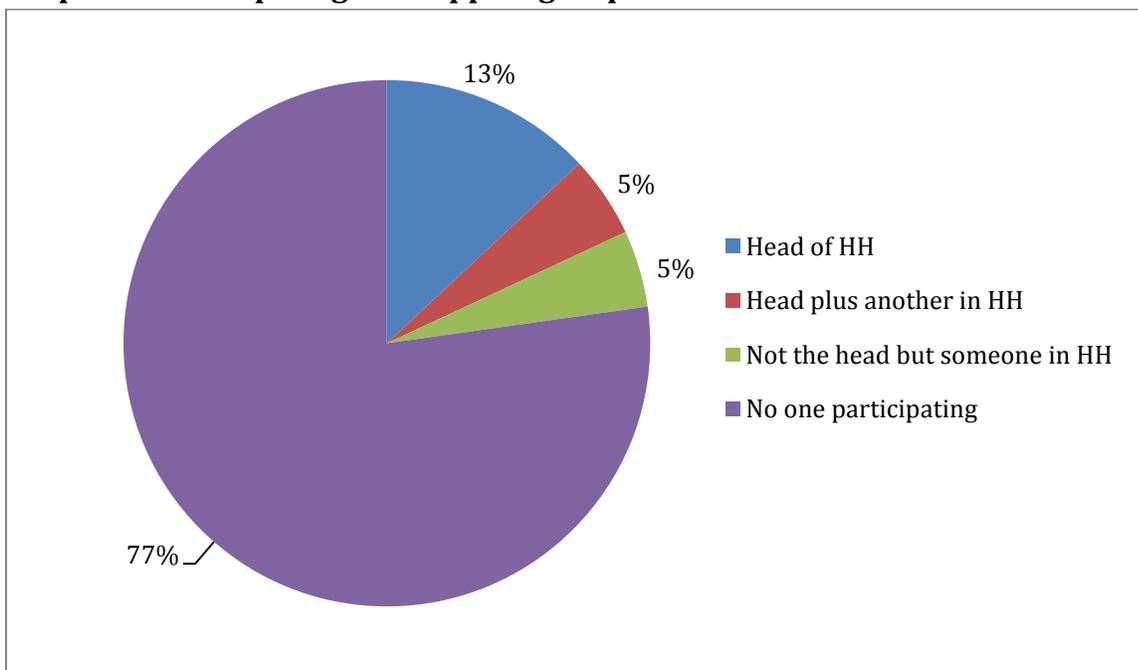


Graph 10: Types of services PLHIV reported getting from community organizations over the last 12 months



Twenty-three percent of HHs with PLHIV on ART have someone participating in a support group for PLHIVs, there is no difference by gender of head of HH.

Graph 11: Participating in a support group for PLHIVs



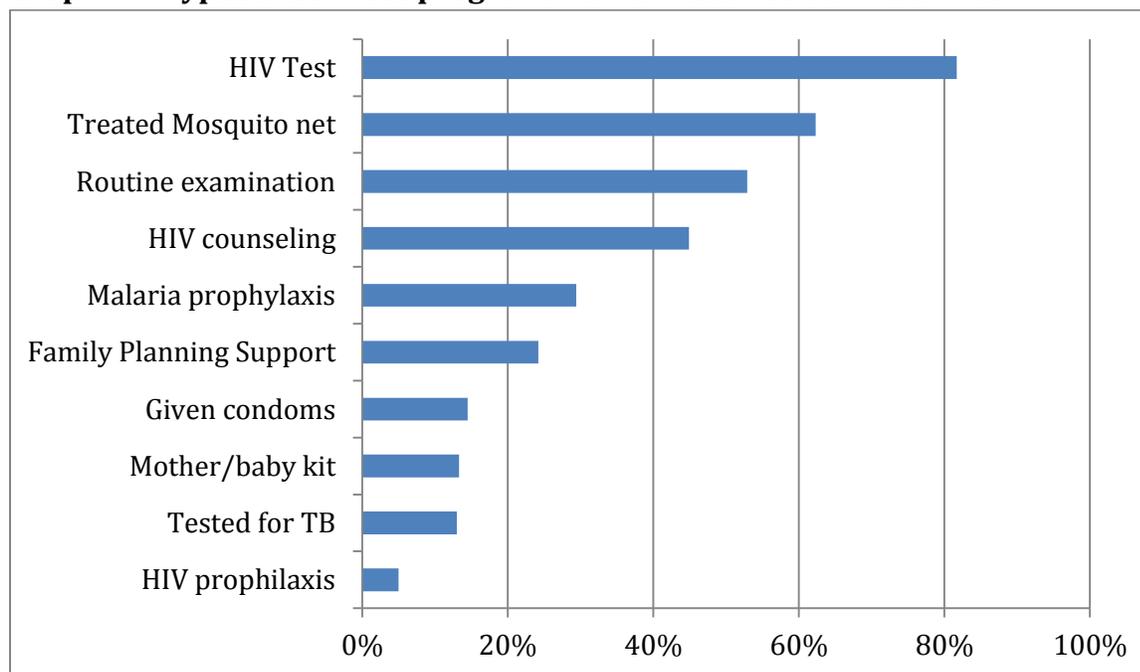
Among HH with someone on ART, 41% received adherence support from a community organization for ART.

Very few households reported that they received any type of support from a community group or organization. Only 8% of HH reported that someone from a community group or organization recommended that someone in their HH seek medical assistance. In addition, a small percent of HH report any other type of assistance with medical care; 4% reported help with medical fees, 1% stated that they had been accompanied to a health facility, and <1% received support with transport to a clinic.

Pregnant and postpartum women

Twenty four percent of the surveyed households had a pregnant woman in the HH. Eleven percent of 802 HH with pregnant members also have PLHIV. Twenty seven percent of 279 HH with PLHIV had pregnant women living there. Ninety percent of HH with pregnant women used pre-natal services (no variation by province). While 90% of the pregnant women attended an antenatal care (ANC) clinic only 82% of those women were tested for HIV. Furthermore, only 45% said that they received any counseling around HIV and only 24% received information and counseling on family planning. Furthermore, only 13% of pregnant women had been screened for TB at some point during the pregnancy.

Graph 12: Types of services pregnant women received at ANC clinics



Treated Mosquito Net use

More than half of the children in the surveyed HH (58%) sleep under a treated mosquito net. While this did not vary by the sex of the head of household there are some variations by province. In Inhambane province 81% of heads of HH stated that the children slept under treated mosquito nets and in Tete Province only 46% reported that the children slept under treated mosquito nets ($p < .01$).

Of the 802 HH with pregnant women living in them, 78% of heads of HH reported that the pregnant woman in their house constantly sleeps under a treated mosquito net. Again, this did not vary by the gender of the head of HH but did vary by province; Inhambane 90% vs. Tete 64%, $p > .01$.

Household Economics

Among all HHs in the survey, the most important sources of income were reported to be formal salaries (36%), small businesses (19%), production of cash crops (12%), occasional work or odd jobs (10%), and production or sale of food (7%). Over 90% reported a second source of income and almost 50% of the HHs reported a third source of income to augment the first.

Table 4: Top forms of family income

The most important	The 2nd most important	The 3rd most important
Formal salary/wage/rents 36%	Production of cash crops 26%	Production of cash crops 23%
Small business 19%	Small business 22%	Occasional works/odd jobs 20%
Production of cash crops 12%	Production/ sale of food crops 14%	Small business 14%
Occasional works/ odd jobs 10%	Occasional works/ odd jobs 14%	
Production/ sale of food crops 7%		

These sources of income can be grouped into 4 main categories:

- 1) Formal wage earner (56% of HH)
- 2) Self-production of goods (23% of HH)
- 3) Sporadic provision of services (17% of HH)
- 4) Receiving external assistance (5% of HH)

Women are slightly more likely than men to be engaged in formal wage earning (57% vs. 54%) and self-production of goods (24% vs. 21%), while men are slightly more likely to be involved in sporadic provision of services (19% vs. 16%) and receiving external assistance (5% vs. 3%). These do vary by province. Sofala is most likely to have formal wage earners (65%) while Niassa is the least likely (37%), $p < .01$. Niassa is most likely to have HH engaged in self-production of goods (50%) while Cabo Delgado and Inhambane, both with 14% of HH reporting self-production of goods, is the least likely, $p < .01$.

The main expenditure for most households was food (86%). Soap and other HH items was identified as the second main expense by 43% of the HH and clothing was identified as the third largest expense by 21% of HH.

Respondents were asked where they get economic support. Seventy-seven percent said they received no economic support. Women heads of HH are more likely to have reported assistance than male headed households (26% vs. 19%, $p < .01$). Of the 23% who did receive assistance, it was in the form of food (65%), money (43%), treated mosquito nets (16%) and clothing/bedding (7%).

External sources of support were received from relatives (63%), some public institutions (20%) or neighbors (13%).

Of the total HH sample, 14% stated that they had borrowed money during the 3 months prior to the survey. Of those who had borrowed money, 52% got that money from a relative or friend, 24% borrowed it from neighbors and 15% had borrowed from a bank. The main reason for borrowing the money was to buy food (35.8%), to invest in business (20%) and to improve or build a home (16%). Sixteen percent of men compared to 13% of women had ever asked for a loan, $p < .01$.

Respondents also were asked about their productive assets (assets used to earn income) and non-productive assets. The most commonly owned productive assets included hoes (81%), machete (59%) and axes (48%). Seventeen percent had no productive assets and 9% had no unproductive assets. The most common unproductive assets included chairs (80%), tables (68.8%) and beds (68.3%). Mobile phones are owned by 60% of all households, interestingly some phones were categorized as productive assets (11%) and others were categorized as nonproductive assets (62%). Only 12% of HH had purchased goods in the past three months. Three percent of the total sample had sold assets to buy food, pay for daily expenses or because of an emergency.

Key findings

It appears that families are remaining relatively intact. Most heads of households are in long-term marriages (traditional and/or legal) and only 13% of all heads of HH are single heads of HH. Also at least two-thirds of all the children in the homes are the biological children of the head of HH with only 18% of the children being orphaned and only 3% being a double orphan. In addition, three fourths of all births are registered.

Among all of the children in these HHs nearly two-thirds are of school age and 85% of these are actually enrolled and attending school. There are very low levels of violence against children being reported here. However, this is probably grossly under-reported and requires further investigation due to the gravity of this issue. Furthermore, only 58% of children slept under a treated mosquito net.

Only 58% of all adults ate at least 3 meals a day and the top three food items they consumed were Mille meal, fats such as oils and butter, and sugar; none of which are considered to be nutritionally high quality foods. Children tend to be provided with more food than adults, as more of them than adults ate at least three meals a day. Nearly all families had to resort to some form of coping strategy to secure access to food. The top three strategies were: Cut out most expensive types of food, reduce the number of meals per day, and cut down on portion sizes.

With regards to HIV, nearly all people have knowledge of HIV and how it is spread and prevented. Approximately one third of all heads of HH know someone with HIV or AIDS. The three main sources of information about HIV are: 1) the community at large, 2) the radio, and 3) community health talks. The sources of information vary by provinces and so this would be important to pay attention to when developing prevention messages and strategies.

Overall, approximately 10% of HH have at least 1 person in the house who is living with HIV. There are slightly more female headed HH than male headed HH with a PLHIV living in the house. Within all of the HH with a PLHIV, just over half of them reported that a PLHIV living in the HH was ill for 3 or more consecutive months during the past year. This rose to approximately 85% of households with someone who is on ARV therapy. Also within the HH with a PLHIV nearly all of them reported that that person sought medical assistance in a government operated hospital or clinic. The top three reasons for seeking medical assistance where for: headaches, coughs, and TB.

Approximately two-thirds of the heads of HH had been tested for HIV at some point in the past. However, only 44% of the household members had ever been tested for HIV. In addition, in all HH only 5% of children had ever been tested for HIV. This percent increases, to 7%, if the head of HH has already been tested and to 29% if there is at least one PLHIV living in the HH.

Regarding community support, nearly all households with a PLHIV living in it reported that they had received some sort of support for HIV prevention. The top types of support were in the form of Risk Reduction Counseling, provision of condoms, and risk assessment tied to a referral for HIV testing. However, within PLHIV HH only 55% reported that they received any counseling or referral for Family Planning services.

While large numbers of HH with PLHIV reported receiving counseling and education about the importance of adherence to medication, only 41% of HH with a person actively on ARV therapy received any direct support for adherence. Furthermore, only 8% of PLHIV HHs reported that someone from a community organization recommended that they go to a hospital or clinic and only 5% received any support to go for assistance.

While 90% of all pregnant women reportedly attended ANC services, not all were tested for HIV and fewer were counseled about HIV and even fewer received any information or were counseled about Family Planning. Only 13% of pregnant women were screened for TB, only 13% received a Mother/Baby kit and only 5% were provided with HIV prophylaxis.

While the main expenditure in these HH is food, nearly 50% of the adults in these HH eat less than 3 meals a day. In spite of high levels of poverty in Mozambique, three quarters of these families do not receive any economic support and they do not have the Poverty Certificate that will allow them to receive additional forms of support. Only 14% of the HHs borrowed money in the past 3 months, it was mostly from family members and the number one reason for borrowing was to secure food.

Recommendations

Care and support services

- Continue the focus on families and couples
- Increase community awareness about the importance of obtaining a poverty certificate.
- Increase community mobilization/sensitization on birth registration for children.
- Strengthen referral to clinical and community HIV counseling and testing, especially for children.
- Establish stronger collaboration at the district level among service providers for referral to various services. For example, from communities to:
 - PMTCT and ART
 - Family Planning
 - TB screening
 - Nutrition Rehabilitation
- Increase community awareness of, and linkages to, clinical and community services.
- Assure community based services such as HBC and psychosocial support are sufficient to meet the existing needs.
- Strengthen nutritional education and counseling.
- Increase community based adherence support for PLWHA on ART
- The high rate of cell phones in HH (60%) may indicate that mobile phones could be used to send relevant messages about service availability.

Opportunities to meet economic needs

- Expand VS&L Group opportunities to help meet economic need for food and ongoing family support