



Food and Agriculture
Organization of the
United Nations



PROGRAMME MDG1c REDUCING HUNGER IN MOZAMBIQUE



CASE STUDY

Nutrition education and social behaviour change communication (SBCC)

Innovative and effective interventions in nutrition education based on the Social Behavior Change Communication approach and community-based service delivery, were implemented under the framework of the MDG1c EU-funded programme with promising results on improved nutrition, health knowledge and practices, that can serve as a basis to scale up Nutrition Education/SBCC programmes.

Rationale

High levels of stunting continue affecting nearly half of the children under five years old in Mozambique (DHS 2011). Several studies show that the immediate causes of the high levels of malnutrition in Mozambique are the inadequate quantity and quality of diet and high incidence rates of infectious diseases, especially in the first 1000 days. According to the DHS 2011, only 41% of children under 6 months are exclusively breastfed, while the diet of children after six months is poor. Only 30% of children aged 6-23 months receive four or more food groups while 41.2% have an adequate meal frequency.

Inadequate infant feeding and hygiene practices, in turn, are closely linked to the low education level of mothers, specially the limited nutrition/health knowledge, misconceptions and socio-cultural beliefs, taboos and practices as highlighted by the formative research carried out in 2015 by WFP.

Based on this analysis, nutrition education and SBCC were incorporated as part of the MDG1c EU-funded programme with the aim **“to promote adequate nutrition and health behaviours to contribute to the improvement of nutritional status of children and women”**. Nutrition education was incorporated as cross cutting issue requiring implementation by the three agencies: Food and Agriculture Organization of the United Nations (FAO), the International Fund for Agricultural Development (IFAD) and United Nations World Food Programme (WFP).

Implementation

Implementation of the nutrition education and SBCC interventions started in 2016 and finalized in 2018, with 2 years of effective implementation in the field. Different modalities were adopted by the three implementing Agencies.

FAO: Adopted the Care-group mothers (Mães Cuidadoras) approach. The Care group is composed of 12 women selected by the communities based on their willingness, availability and capacity to disseminate nutrition and health knowledge and promote adequate practices at household and community level. Each care group mother was responsible to disseminate messages to 10-12 beneficiary mothers and other influential household and community members. Nutrition education was integrated with home vegetable gardening.

IFAD, nutrition education was integrated to productive and market support investments, through the Rural Market Promotion Programme- PROMER, the Artisanal Fisheries Promotion Project-ProPESCA and the PRONEA Programme Support Programme - PSP programmes. PROMER and ProPESCA followed the same care group approach as FAO, yet groups were selected within farmer or fishermen associations and included some men. The target groups were reproductive age women, adolescent girls, men and community leaders both female and male. In the case of PSP, : Agricultural extension workers were trained to disseminate nutrition and health messages in the communities, including the realization of cooking demonstrations. This approach was to a certain extend innovative as a practical way to integrate agriculture and nutrition.

WFP: Adopted fully the SBCC approach which was implemented together with the Health sector (at District level). Health Committees were selected to deliver nutrition and health messages to the communities. Main target groups were Pregnant and Lactating Women, mothers of children under 2 years old, household level influencers such as husbands, grand-mothers, mothers in law and community leaders. Four topics were covered: Malaria prevention, Infant and Young Children Feeding

¹ Health committees are groups of around 20 members (both women and men) selected by the communities, that are recognized and have the potential to deliver nutrition and health messages and promote behavioral changes.

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(IYCF), Care and nutrition during pregnancy and Prevention of Diseases (diarrhea). Inter-personal communication was reinforced by the broadcasting of spots and programmes with the same contents and messages through community radios.

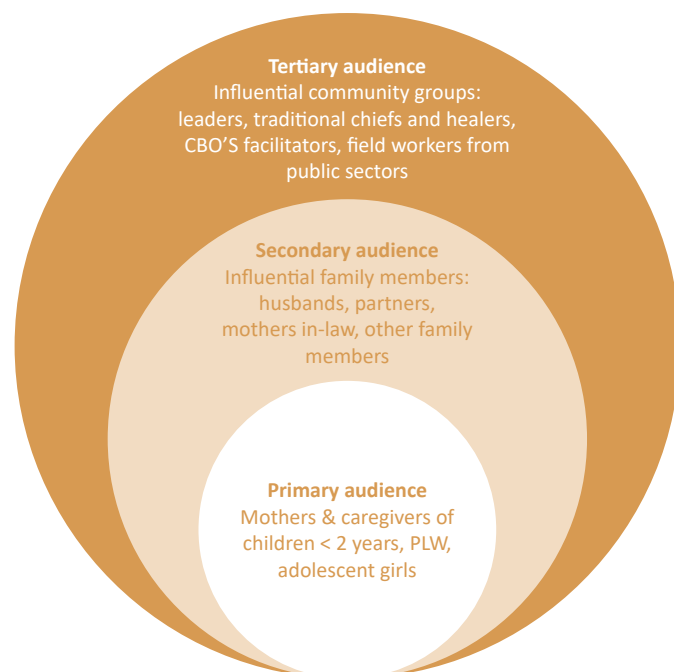
Notwithstanding the different modalities, there were key innovative elements in common that helped to improve efficiency and effectiveness, these were:

The adoption of SBCC as a main approach

SBCC is considered as a process which is interactive, research oriented, planned and strategic that aims to change individual behaviors and social conditions that determine such behaviors. It addresses “tipping points” to change behavior at individual, community and social levels. Tipping points refer to the dynamics of social changes, where trends rapidly evolve into permanent changes. In the case of improving nutrition outcomes, this change often materializes at the community level in the form of social mobilization for improved nutritional practices, services and an overall enhanced nutrition-enabling environment. In the experience of MDG1c, the adoption of the SBCC approach resulted in greater community mobilization by involving not only mothers, but influential people at household and community levels that have become active disseminators of nutrition knowledge and promoters of behavior change, thus increasing the intervention’s effectiveness. that determine behavior change, being this one of the factors that helped to improve effectiveness.

Various levels of audiences

Nutrition and health messages were addressed not only to the mothers or the main child’s caregivers but strategically also to members of the households and communities that have



the power to influence mother’s choices and decisions. The involvement of influential members allowed that the same key messages and knowledge are widespread in the communities, counteracting in some way the effect of miss-conceptions and taboos, which increased the effectiveness. Engaging different audiences is also critical to sustain behavior changes.

Different communication channels but the same messages:

Same messages were disseminated through inter-personal communication and mass media, leveraging the effects and avoiding contradictions and confusion. Topics and messages were aligned to the Health sector priorities to ensure ownership.

Education materials and methods tailored to the context

Different types of printed education materials to support the inter-personal communication were developed. A crucial element in the development of educational materials was their adaptability to the conditions of low literacy and the culture of the final audience.

Education materials for the SBCC-WFP intervention were developed jointly with the communities and included mostly images, photographs and drawings rather than text. FAO also produced graphic materials for the CBOs and district staff. FAO and IFAD gave more emphasis to experiential learning, making use of practical demonstrations (cooking and hand washing demonstrations, home gardening practices). Experiential learning and graphic materials deemed to be very appropriate for the context of the communities, according to the perceptions of staff from sectors interviewed during the evaluation.

Achievements and contribution to outcomes

In the three cases there is evidence that the interventions resulted in significant outputs and outcomes in terms of creation of capacities at community level and improved nutrition and health knowledge and practices.

Main outputs

Capacities to deliver nutrition education and/or SBCC were developed at district and community levels.

During the two years of implementation of the nutrition education components, the following was achieved:

- WFP-SBCC Intervention: 91 health committees (HC) were revitalized or established in 5 districts² in Manica province, with a total of 1512 members trained in nutrition and health topics. HCs reached an estimated 15,000 people (mothers, PLW, men, etc.).
- FAO-Nutrition education and home gardening: 280 Care groups with 2800 Care Group Mothers were established and trained in 7 districts. Care groups reached an estimate of 31,226 beneficiary mothers and their communities.. In addition, 144 staff from seven Community Based Organizations (CBOs) 60 district and provincial level staff

² Guro, Barue, Sussundenga, Mossurize e Machaze.

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from agriculture, education and health sectors were trained in nutrition. A total of 33,396 home gardens were installed by beneficiary mothers, including high nutritive value and bio-fortified vegetable crops.

- IFAD-PSP: 307 agriculture extension workers at central, provincial and district levels were trained on basic nutrition. They reached around 4,800 women and men in the communities.
- IFAD-PROMER: Over 50 technicians from governmental institutions (DNDR, SDAE, SDMAS and SDJECTs), local service providers and PROMER were trained on nutrition education and nutrition sensitive programming. 60 voluntary groups of mothers were also trained in nutrition. They reached 5,631 women, adolescents and men with nutrition education sessions and cooking demonstrations.
- ProPESCA: 522 peer mothers groups in 6 coastal provinces were trained in nutrition, who delivered nutrition education sessions to 11,062 women and men and 1,950 adolescents.
- For all cases, programme targets were achieved or exceeded.

Outcomes

There is qualitative and quantitative evidence on significant improvements in nutrition and health knowledge among beneficiaries. There were important effects on improvement of hygiene and sanitation practices and household dietary diversity, but lower effects on IYCF. Factors such the short period of implementation and other social and economic barriers made difficult the adoption of adequate infant feeding practices.

WFP-SBCC:

- Improvements (ranging from 20% to 40% increase compared to the baseline) in the knowledge on topics such as: malaria symptoms and prevention methods, causes of diarrhea, critical times for handwashing, pregnancy emergencies and care measures³.
- Improvement of around 20% in the use of closed latrines and washing child's and own hands after child's defecation.
- Knowledge improvement and behavior change on IYCF was not significant mainly due to the shorter implementation time (less than 1 year)⁴.

FAO-Nutrition Education:

- Qualitative observations by the evaluation team during the field visits indicate knowledge improvement in key nutrition topics such as exclusive breast feeding, preparation of enriched porridges for children among mothers.

- The consumption frequency (number of days consumed in the last 7 days) of vegetables rich in Vitamina A (green leafy or orange vegetable) was significantly higher among beneficiary households. The Food Consumption Score was 10.5 points higher among beneficiaries of FAO-Nutrition education and home gardens compared to the control group. There was no significant difference in the infant feeding practices (dietary diversity and minimum frequency)⁵.

PROMER:

- The final evaluation of the intervention showed an increase by around 12% in the proportion of women and adolescent girls that achieved the minimum dietary diversity, and 21% in the percentage of children 6-23 months consuming adequate diversity of foods⁶.

Best practices and lessons learned

1. Delivery of the same messages through different sources and channels leverage the effect on knowledge improvement and improved practices.

All institutional and community agents and radio programmes delivered the same messages on few key prioritized topics (child nutrition, mother nutrition, hygiene and sanitation, disease prevention, household diet).

2. The Social Behaviour Change Communication SBCC approach facilitates sustained nutrition/health awareness.

This approach has been proved to be effective to increase nutrition awareness, as found in the programme's Result Components impact evaluations. However, to produce higher impact on behaviours, the intervention should be implemented continuously for longer time (MDG 1c nutrition education components were implemented only for 1-2 years)

3. Some quality elements of the design and implementation of nutrition education programmes are:

- formative research that identify enabling and hindering factors for improved practices and help to ensure cultural sensitivity and feasibility of recommended practices,
- participatory development of materials allows to design education materials that are more suitable and accepted by the communities,
- In the context of low literacy, experiential learning (learning by doing) (cooking demonstration, practical sessions on home gardening, hand washing practices), visual learning materials and use of community radios is more adapted.

³ WFP (2018). The Social Behaviour Change Communication Project in Manica Province. Implementation Report.

⁴ WFP 2017, SBCC Impact evaluation

⁵ SETSAN 2018, Community level impact evaluation.

⁶ PROMER (2018). Relatório da Avaliação final do Projecto. Sub-componente de Educação Nutricional

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- strong monitoring and evaluation system are important to collect and analyze information, that can be used to adjust the programme or build evidence on which approaches are more or less effective.

4. Involvement of key stakeholders and alignment with national priorities and strategies guarantee ownership.

National stakeholders, but more importantly provincial and district level stakeholders from sectors such as Health, Education, Agriculture, together with NGOs and CBOs were involved since the beginning. This significantly improved the ownership, consequently improving the implementation and opening windows for continuity of the interventions.

5. Harmonization, coordination and common approach among implementing stakeholders is key, to build synergies, seek complementarity but most important to avoid delivering contradictory messages to the population.

6. Community mobilization through community actors increases coverage rapidly.

The experience of MDG1c in working with community actors such as Health Committees and Care group mothers has demonstrated that they can be more efficient in delivering nutrition messages and promoting behaviour changes, and most importantly they are trusted by the communities. This is an interesting move from agency driven to community centered service delivery.

7. Nutrition education as stand-alone intervention is necessary but not sufficient to ensure adoption of improved practices and final contribution to improved nutrition.

MDG1c experience has proved that despite that women (and men) improved their nutrition awareness, adoption of improved practices is still low, this because of barriers that constraint the adoption of such practices. These barriers are related to the limited access to nutritious food round the year, lack of income to buy essential hygiene goods (i.e soap), women heavy workload, higher number of children, among other things. This points to the need that nutrition education needs to be integrated with other interventions (food production, income generation, family planning, community child care facilities, etc.) to produce maximum impacts. Integration of nutrition education with home gardening is an example of how access to nutritious food can be improved, facilitating adoption of improved nutrition practices.

Opportunities and challenges for sustainability

- New initiatives such as the new phase of PROMER for 2019 onwards and FAO new project are considering nutrition education as key components. In the case of FAO, incorporation of nutrition education as part of the Farmer Field Schools approach is being designed for sub-sequent implementation.
- At national level, the framework of the national programmes such as PAMRDC and the National Social Behaviour Change Strategy represent an opportunity to continue the implementation, scale up and to adapt the experiences, best practices and lessons learnt of the Programme MDG1c.
- One of the challenges to sustain the voluntary work of community agents is the issue of provision of incentives. The appropriateness of monetary or non-monetary incentives to sustain motivation is still under discussion and depends on the context. In the case of MDG1c, community agents were motivated by the status gained in their communities by performing voluntary work. However, they appreciated any type of additional incentives. Incentives such as identification (t-shirts, capulanas, caps), and bicycles and radios (in the case of WFP) were provided to facilitate their work and were highly appreciated.
- Sustainability of the work of community agents depends also on continuous institutional support in terms of refreshing training, monitoring, supervision, provision of materials, etc. Health, Education and Agriculture sectors could provide this support, but one of the constraints is the limited resources.

