

**UNICEF
WORLD FOOD PROGRAMME**

**In collaboration with
the Ministry of Health**

**EVALUATION OF THE
INTEGRATED SUPPLEMENTARY FEEDING
PROGRAMME**

**Mozambique
June 2004**

FINAL VERSION

**A programme realised through
donations from
DFID and USAID**

ACKNOWLEDGEMENTS

This study was planned and implemented collaboratively by the Ministry of Health, UNICEF and WFP. It could not have been achieved without the contribution of a large number of individuals who are hereby sincerely thanked for their time and support. The following individuals had a major contribution in the study:

For the Ministry of Health:

- Dr. Sonia Khan, Head of the Nutrition Department
- Ms. Joaquina Agudo, Nutritionist
- Ms. Luiza Maringe, Nutritionist

For UNICEF:

- Ms. Christiane Rudert, Project Officer, Nutrition & Health
- Ms. Candie Cassabalian, Project Officer, Emergency
- Ms. Lisa Chapman, Project Officer, Health Tete
- Dr. Pierre Martel, Epidemiologist (consultant, study coordinator)
- Ms. Esmeralda C. Mariano, Anthropologist (consultant)
- Ms. Arlette Makobero Meeùs, Supplementary Feeding Programme (consultant)

For WFP:

- Ms. Claire Bader, Consultant for HIV/AIDS
- Ms. Laura Rask, UN Volunteer

The field teams were composed of:

Team leaders:

- Ms. Joaquina Agudo
- Ms. Luiza Maringe
- Ms. Claire Bader
- Ms. Laura Rask
- Ms. Arlette Makobero Meeùs
- Ms. Conceição Borges
- Ms. Esmeralda C. Mariano
- Dr. Pierre Martel

Team members:

- | | |
|--------------------------------|--------------------------|
| - Mr. Edgar Matlombe | - Ms. Isabel de Sousa |
| - Mr. Aurélio Manjante | - Mr. Domingos Razão |
| - Mr. Manuel Victorino | - Mr. Algelo Albano |
| - Ms. Delfina Machai | - Mr. Fernando Domingos |
| - Ms. Ricardina Samuel Monjane | - Mr. Raul Agostinho |
| - Ms. Felizarda Guambe | - Ms. Mariana Sereq |
| - Ms. Judite Albertina Guambe | - Mr. Angelo Racibo |
| - Ms. Olga Mário Chongola | - Mr. Paulino Lourenço |
| - Mr. João Guio | - Mr. Fernando Caetano |
| - Mr. Camissa Assane | - Ms. Linda Sousa |
| - Ms. Patrícia Canote | - Mr. Braz Marcos |
| - Mr. Adriano Manhoca | - Mr. Constantino Nadali |

The qualitative analysis was performed by Ms. Esmeralda C. Mariano. Dr. Pierre Martel made the quantitative analysis and compiled the overall report of the study.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
TABLE OF CONTENTS	ii
EXECUTIVE SUMMARY	iii
1 INTRODUCTION	1
2 METODOLOGY	4
2.1 Quantitative methods	5
2.2 Qualitative methods	7
3 FINDINGS	8
3.1 Programme operations	8
3.1.1 Reported activities	8
3.1.2 Community workers	12
3.1.3 Community leaders	17
3.2 Measured programme activities	17
3.2.1 CSB distribution	18
3.2.2 Vitamin A and mebendazole distribution	20
3.2.3 Participatory education	22
3.2.4 Screening for severe malnutrition	24
3.3 Estimated impact	25
3.3.1 Nutritional status	25
3.3.2 Morbidity	27
3.3.3 Mortality	27
3.3.4 Beliefs, knowledge and practices	28
4 CONCLUSIONS AND RECOMMENDATIONS	31
4.1 Adequacy of the response to the humanitarian situation	31
4.2 Benefits of the programme	32
4.3 Negative impact, constraints and limitations	32
4.4 Recommendations	33
4.5 The way ahead	35

ANNEXES:

- Annex 1: Map of sampled clusters
- Annex 2: Field guide for the cluster survey (Portuguese)
- Annex 3: Household questionnaire for the cluster survey (Portuguese)
- Annex 4: Guidelines for qualitative study (Portuguese)

EXECUTIVE SUMMARY

In 2003, for the 3rd consecutive year, Mozambique, like much of southern Africa, experienced erratic rainfalls, and increased food insecurity. Combined with this, the impact and increase of HIV/AIDS across the country resulted in weakened coping mechanisms and increased burden on households. Results from the last 2003 Vulnerability Assessment (VAC) highlighted the precarious situation of children and women as a consequence of this humanitarian situation, including high numbers of orphans and a large proportion of children not living with one or both of their natural parents. In addition to being generally more vulnerable, the nutritional status of maternal orphans appeared to be deteriorating faster than the general children population.

As a response to the impact of the triple threat of drought, HIV/AIDS and poverty, UNICEF and WFP, upon request of the Ministry of Health, implemented an integrated supplementary feeding programme (ISFP) in 19 districts of 6 provinces through donations from DFID and USAID. The targeting was geographical, based on so-called hot spots districts. The activities implemented in these areas included: a) blanket distribution of CSB (corn soya blend) to children aged 6-59 months and pregnant/lactating women, b) participatory training for improved hygiene, care and nutrition practices, c) vitamin A distribution and de-worming and d) screening for severe malnutrition through MUAC. An evaluation of the ISFP was performed in June 2004, using methodologies both quantitative and qualitative, and is the object of the present report.

Programme operations

The NGOs that participated in the ISFP were Cruz Vermelha de Moçambique, Samaritan Purse, Concelho Cristão de Moçambique, ARA, CARE, World Vision International, Associação dos Agricultores do Vale do Zambeze, Lutheran World Federation and ADRM. Agreements between UNICEF and these NGOs were signed between January and December 2003, but mostly in April, May and August. All NGOs had completed their activities by the end of May 2004.

A total of 133,992 children 6-59m and 69,660 pregnant/lactating women were registered into the programme. Statistics reported by the implementing NGOs point to a mean monthly coverage of registered beneficiaries with CSB of 54% over the period March 2003 to May 2004, with a mean ration of 111gr per covered beneficiary per day (children and women). For vitamin A, a mean coverage at six month intervals of about 30% was reportedly achieved over the same period (39% for the last six months), and of 12% for mebendazole (14% for the last six months). The information provided permits to estimate the mean monthly coverage of MUAC screening of registered children 12-59m at 42%, while participatory education activities reportedly reached a mean of 16% of the registered adult beneficiaries per month (mean of 81 participants per session).

The qualitative survey found that the majority of the over 800 community workers involved had a good knowledge of the programme and its components. The training of these community workers had both theoretical and practical content and included: child nutrition, preparation of the soya mix, household and children hygiene, hygiene of water and food conservation, measurement of MUAC and nutritional surveillance,

as well as prevention and treatment of diarrhoea. Their tasks included the distribution of CSB, the listing of beneficiaries, home visits to the families and education of the mothers, MUAC measurement, and in some cases vitamin A and mebendazole distribution.

There appears to have been a lack of clarity among community workers about participatory education, its instruments and methods. They mostly referred to the 'demonstration poster' as a 'content', a fact which suggests that they had not correctly understood that it is an 'instrument' for participatory education. They nonetheless feel that the use of such posters made comprehension easier. Community workers generally considered positively the involvement of the communities, which they attributed in great part to the good work of the community leaders. However, less than half of them considered that the mobilization of the beneficiaries had been good. They nonetheless felt that the programme had been well implemented and of benefit to the population. Most mothers also considered that their relationship with the community workers had been good. On a less positive note, over a third of the community workers complained that they had not been paid regularly by the NGOs or given the full amount that had been agreed upon, result in lack of motivation. Stated insufficiencies in transportation means for the products and the staff were also mentioned not only by the community workers but by the community leaders as well.

Community leaders were generally informed about the ISFP and had a good knowledge of the target groups. They were often involved in selecting community workers and in elaborating the lists of beneficiaries. About half of the community leaders considered good their relationship with the community workers and implementing agencies. Problems were sometimes caused by the lack of clarity about who had decision power and the lack of involvement of the leaders during implementation. Nonetheless, community leaders generally regard the programme as beneficial to the population in terms of acquired knowledge and improved health conditions of mothers and children.

Measured programme activities

An estimated 85% of the target population was reached in one way or another by the ISFP. Given the extent of the geographical area to be covered, this can be considered as a good, or even excellent, gross coverage. The Southern provinces had a significantly lower coverage than Tete (74% versus 97%). There were, however, large variations in the period and frequency of CSB distribution between areas, linked not only to the time of the signature of the agreement but also to difficulties in making CSB available on a constant basis, which placed a major constraint on implementation.

The CSB supplement was intended to be provided twice a month, or at least once a month, to the eligible families. Most of the NGOs having taken part of the programme for a period of 8 to 11 months, a similar number of distribution rounds was necessary to provide the families with a regular supply. However, less than 15% of the families benefited from six or more distributions. Although quantities for up to two months at a time were provided in some cases to compensate for this irregularity, many of the registered families experienced repeated shortages over the period of the programme. While 80% of eligible families received CSB at least once, only 55% received the product three times or more (about 70% of families that were reached at

least once). Once again, Tete is shown to have done better than the southern provinces. Under the qualitative study, the great majority of women who participated in the focus groups declared having received some form of food assistance from the ISFP or other programmes over the period. Given the prevailing situation, two third had received products under the WFP food-for-work programme. The food thus received constituted the fundamental part of the diet over that period, or was eaten in addition to the regular products.

Low levels (28%) of vitamin A supplementation in children were reached during the last six months (South 41%, Tete 14%). If we consider children without a health card as not covered, the overall coverage is reduced to 21%. Vitamin A coverage at least one time since March 2003 was of 43% for children with a health card and 33% for all children. Such results indicate that vitamin A supplementation was not implemented systematically, particularly in the province of in Tete. De-worming activities had an even lower coverage.

Data from the quantitative survey show that nearly half the households were covered by participatory education activities, with a somewhat higher coverage in the southern provinces. Families with a higher number of CSB distributions had a higher likelihood of having participated in education sessions (66% for families with 3 or more distributions). Overall, 85% of the surveyed families reported having attended two participatory education sessions or less, but recall bias may be large. The qualitative study found that a large majority of the women who participated in the focus groups had attended participatory education sessions, information meetings or health/nutrition related activities.

Gross coverage for MUAC screening (at least one measurement) was of 44%, while only 5% of the surveyed children had reportedly their MUAC measurement taken three times or more from March to June 2003. This figure is much lower than the monthly 42% coverage estimated from NGO reports. Recall bias on the part of the household informants may be large.

Estimated impact

Taking CSB distribution as a proxy for all programme activities, households that had received the product three or more times were taken as the intervention group, and the others as comparison. The differences between the intervention and comparison groups all point towards a positive impact of the ISFP activities: 3.2% versus 5.3% for wasting, 33.4% versus 40.7% for stunting, and 18.5% versus 25.4% for underweight (statistically significant). The intervention group included about 57% of the children of the target areas. Those children benefited from more MUAC screening, from mothers more knowledgeable in health and nutrition issues having participated in interactive education activities, and from a better nutritional status of their pregnant or breastfeeding mothers. They did not, however, receive more vitamin A. It should also be noted that figures for the “comparison” group are all somewhat higher than the estimates of the VAC 2003, suggesting that the population that did not receive significant assistance from the various components of the programme, but lived in the same geographical areas, may be following a downward trend in terms of nutritional status, even though the changes are not dramatic. Additional comparative analysis of the situation of the population in the same geographical areas before the start of the

ISFP – i.e. data from the 2002 VAC – and the situation at the time of this evaluation – will be undertaken at a later stage and circulated as an addendum.

The period prevalence estimates for diarrhoea or fever during the last two weeks preceding the survey are both much lower than those of the 2003 VAC and are comparable between the intervention and comparison groups. Although ISFP activities don't appear to have impacted on the incidence of these pathologies, they may well have had a favourable impact on their outcome (malnutrition and mortality).

Mortality estimates in children under five years of age compare relatively well with those found during the 2003 VAC, although they are slightly higher (68.3/1000 person-years at risk, versus 62.6). Once again, the intervention group (39.6) fares better than the comparison (107.1) group. Although the point estimates are wide apart, the relative smallness of the sample size means that the difference is only borderline significant on the statistical point of view. These results must therefore be interpreted with caution. They nonetheless reinforce the previous findings suggesting that the supplementary feeding programme had a positive impact on the health and survival of children in areas where its activities were reasonably well implemented.

The education themes best remembered by the women who participated in the qualitative study focus groups were: preparation of the CSB, collective and household hygiene, hygiene with water and food preservation, prevention and treatment of diarrhoea, nutrition of children and the construction of latrines. The main causes of diarrhoea were stated as being the lack of hygiene, drinking non-potable water that is not treated or not boiled, eating food that is spoiled or has been kept over from the previous day, and not using a latrine, which is all very much in line with the content of the health education activities. While 70% of the quantitative study respondents whose child had diarrhoea two weeks before stated that they had given him/her an oral rehydration solution, only 29% declared having in practice increased fluids during the same episode. On the other hand, half the breastfeeding mothers said they had breastfeed more often their child sick with diarrhoea. The mothers generally said that a child can be given food from the 2nd, 3rd or 4th month of age, depending on the needs, indicating that that particular message was not well assimilated.

Conclusions

The ISFP was designed to avert excessive morbidity and mortality in the affected populations before they become patent, and appears to have exceeded its initial objectives in areas where it was reasonably well implemented, since it contributed to not only maintain but improve the nutritional status and survival of the children. As far as the targeted populations now enter a more productive agricultural cycle and are able to more fully recover during the next months and years, it can be said that the ISFP was adequate to the humanitarian crisis.

Recommendations include the need: 1) to develop indicators and methodologies to better measure at community level processes that indicate when communities' coping mechanisms are being stretched beyond reasonable limits, so that a timely well targeted intervention can be put in place; 2) to better appreciate the magnitude of the task involved in such programmes and the capacity of the implementing partners; 3) to reinforce supervision; 4) to involve more fully district and local authorities; 5) to provide more support to community workers involved in such programmes in terms of

transport and regular/complete payment of their stipends; and 6) to use community workers with a sufficiently high education level so that they can better understand and implement participatory education methods.

EVALUATION OF THE SUPPLEMENTARY FEEDING PROGRAMME

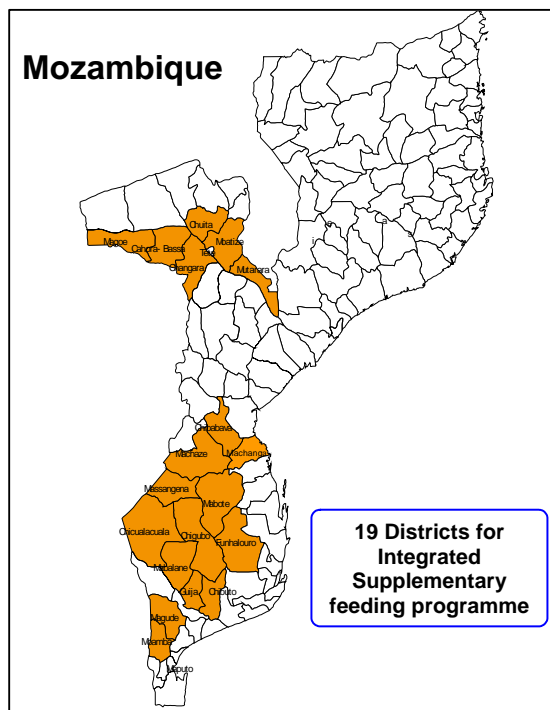
June 2004

1 INTRODUCTION

In 2003, and for the 3rd consecutive year, Mozambique, like much of southern Africa, experienced erratic rainfalls, and increased food insecurity. Combined with this, the impact and increase of HIV/AIDS prevalence rates across the country resulted in weakened coping mechanisms and increased burden on households.

Results from the last 2003 Vulnerability Assessment (VAC) highlighted the precarious situation of children and women as a consequence of this humanitarian situation. An additional analysis of the VAC data found a high mortality rate in children under five, that one in three children suffered from chronic malnutrition (stunting), and that, in the two weeks preceding the assessment, one in four children had suffered from diarrhoea and one in two from fever.

The analysis also showed high numbers of orphaned children in areas affected by the humanitarian situation, as well as a large proportion of children not living with one or both of their natural parents. Orphaned children were shown to be particularly vulnerable, with maternal orphans found to have significantly higher rates of chronic malnutrition, lower access to health care, and a higher likelihood of becoming sick. In addition to being more vulnerable to chronic malnutrition, the nutritional status of maternal orphans appeared to have further deteriorated in comparison to the general children population between November 2002



and May 2003 in relation to stunting (from 46% to 56%) and severe stunting (from 19% to 36%)¹.

As a response to the impact of the triple threat of drought, HIV/AIDS and poverty, UNICEF and WFP, upon request of the Ministry of Health (MoH), implemented an integrated supplementary feeding programme (ISFP) in 19 districts of 6 provinces through donations from DFID and USAID (shown in the map above). The targeting to address the most vulnerable groups was in this case geographical, based on so-called hot spots districts: districts affected by the drought, with high HIV prevalence, higher level of malnutrition and higher morbidity. In some districts steps were taken to further target the most vulnerable localities (sub-districts level) for the intervention using the same criteria. In February 2003, WFP and UNICEF signed a Memorandum of Understanding (MoU), which was followed by the elaboration of agreements between UNICEF and ten NGOs to implement the ISFP activities through May 2004. The activities implemented in these hot spots areas included:

- a) Blanket distribution of CSB (corn soya blend) to all children aged 6-59 months, as well as pregnant and lactating women in identified vulnerable areas, as per current Government policy².
- b) Participatory training for improved hygiene, care and nutrition practices.
Each district had a team of community workers trained in participatory education relating to good hygiene and nutrition. These teams organised community sessions within each participating village to discuss 1) the signs and symptoms of diarrhoea; 2) the treatment of diarrhoea; 3) the routes of diarrhoea transmission and how to prevent them; 4) food preparation; 5) active feeding and feeding frequency for young infants, in particular sick infants; and 6) diet diversification for young infants and children.
- c) Vitamin A distribution and de-worming (at six months intervals). These activities were gradually introduced into the NGO partners' activity schedule. The NGO community workers provided Vitamin A supplement and mebendazole at the time of the CSB distribution, based on the information registered in the health card of the child.
- d) Screening for severe malnutrition. Measurement of mid-upper arm circumference (MUAC) of children aged 12-59 months was conducted by the community workers at the same time as the CSB distribution and as part of the household visits. Children identified as severely malnourished (MUAC < 11cm) were then referred to the health centre for treatment.

Most of the target areas were also covered over the same period by the food-for-work and school feeding programmes of WFP. In addition, supplementary feeding activities were linked with community based malaria control activities supported in the same districts in the provinces of Tete and Gaza.

¹ Summary of the additional analysis of the demographic, nutrition and health findings, Multi-sectoral assessment of the impact of the humanitarian situation on the lives of Mozambican children and women. November 2003. UNICEF

² Currently, the MoH policy is blanket supplementary feeding for children 6-59 months and pregnant/lactating women. It is believed that targeting individual malnourished children may be a disincentive for the mother or caretaker to feed the children properly using their own resources, and may in fact lead to a child being fed less in order to qualify for the supplementary ration.

As the ISFP drew to a close, an evaluation was conducted with the overall objective: *To evaluate the criteria, appropriateness, value, impact and effectiveness of the ISFP as a response to the triple threat of drought, HIV/AIDS and poverty and use these findings to contribute to the further development of national MoH protocols and policies for ISFPs in Mozambique, as well as for UNICEF and WFP future programming.* The specific objectives were:

- 1) To assess the effectiveness of the process of the Supplementary Feeding Programme in terms of coverage (Vitamin A, de-worming, MUAC screening), CSB distribution, participatory education, implementation arrangements (financial aspects, human resources);
- 2) To assess the impact of the ISFP looking at the nutritional status of children and improved knowledge and practices for diarrhoea prevention and treatment, and for young child feeding;
- 3) To identify the key constraints of the ISFP;
- 4) To analyse the value and appropriateness of the ISFPs in the context of Mozambique, the criteria for the establishment and phasing out ISFP interventions, and to review the efficacy and cost-effectiveness of the ISFP intervention in comparison with other potential alternatives;
- 5) To document lessons learnt for emergency preparedness and for future emergency response (short-term vs long-term) in nutritional interventions, especially in relation to ISFPs, and propose a way forward for future UNICEF/WFP programming to address emergency and underlying causes of malnutrition;
- 6) To contribute to the further development of national MoH protocols and policies on supplementary feeding interventions;
- 7) To contribute to the strengthening of WFP/UNICEF collaboration for nutritional and food security and HIV/AIDS.

2 METODOLOGY

The methodology and questionnaires were developed and pre-tested during a period of two weeks preceding field work, which took place from 4-20 June 2004. Six teams of 4 interviewers each (2 for the qualitative component, 2 for the quantitative) were recruited in the various provinces mostly among health staff, complemented by individuals who had participated in previous multisectoral assessments, and thus had experience in implementing surveys. The seven supervisors were from the Ministry of Health, UNICEF and WFP. The three day training workshop was complemented by a one day 'real conditions' field test in Gaza, immediately followed by a debriefing to make the last adjustments and recommendations before the teams travelled to their respective provinces. The methods used for this evaluation were both quantitative and qualitative. An anthropologist organized and supervised the qualitative component of the study, while an epidemiologist took care of the quantitative part and provided overall supervision as well. The target population was the residents of all the villages and areas ('localidades') in the 19 districts of the ISFP that had been specifically allocated to NGOs as per the agreements signed with UNICEF.

2.1 Quantitative methods

A random sample of the target population was enrolled in a cluster survey for the purpose of measuring the coverage of several components of the programme, to assess the current nutritional status of the population, and attempt to measure the effects/impacts of the supplementation and educational activities. The household questionnaire followed as closely as possible the relevant methodology and indicators used during the second (2002) and third (2003) multisectoral assessments, since those provided, generally speaking, reference/baseline information for this evaluation. Three other structured questionnaires were also developed for the village chiefs, community workers (“activistas”, four per district), as well as district/provincial level authorities (district administrator, district and provincial health directors). These aimed at collecting information on their knowledge and involvement in the ISFP, and to note their comments and recommendations regarding its implementation. Another structured questionnaire assisted in gathering information on the nutrition units of the Health Centre mainly to assess their functioning, the availability of equipment and products, as well as get information on number of cases of malnutrition and respective mortality. Finally, one structured questionnaire was elaborated for the participating NGOs, covering in detail the various components of the ISFP.

A sampling frame was developed comprising all villages in the target areas and their respective populations according to the last Census (1997). Two problems were encountered. Eight (1.2%) of the 653 specified villages could not be localised in the census lists and thus had to be left out of the sampling frame. Thirty nine villages, each with less than 20 households (2331 inhabitants in total), were also removed from the sampling frame. This was done because they could not, if selected, have provided the required number of households and children per cluster. The normal procedure is to merge such small villages with neighbouring villages before sampling the clusters. To do this, however, would have required a small survey of its own to localize the said neighbouring villages, which was not possible (or even justified) under the circumstances. The population of very small villages left out of this survey represents less than 0.4% of the target population. This is described in *Table 1*. In summary, the study population is believed to comprise at least 98% of the target population and to be adequate to provide representative estimates of the same.

Table 1: Study and target populations by province.

Province	Study population	Target population*
Maputo	20,779	21,114
Gaza	134,652	135,416
Inhambane	53,768	54,337
Sofala	85,762	85,830
Manica	41,916	42,008
Tete	297,198	297,701
Overall	634,075	636,406

* Not including 8 villages not found on the census lists (source: INE, Census 1997)

Within the selected areas 60 clusters were chosen at random through systematic sampling, with probability proportional to the size of the population, using the figures of the 1997 census (see map of clusters in *Annex 1*). In each cluster (village), the enumerators were instructed to select households at random, following a pre-determined methodology (random walk method, details in *Annex 2*). The survey of a

cluster was to be considered complete once the number of 45 households or 33 children under five years of age was reached, whichever happened first. A sample of the household questionnaire can be found in *Annex 3*. Copies of all other questionnaires can be obtained on request. The sampling stages are described in the following table.

Table 2: Sampling stages and sampling methods

Stage	List used	Sampling method
One	All villages specifically allocated to NGOs for ISFP implementation, with their respective population as per 1997 census lists.	Systematic sampling of 60 clusters with probability proportional to the size (PPS) of the population of the villages. This is the primary sampling unit (PSU).
Two	All households of the selected villages (clusters).	First household at random, followed by sequential sampling of closest household (up to 45 households per village).
Three	All resident individuals of the selected households.	No sampling. All residents of selected households were included in the survey (until obtaining 33 children under five per cluster).

Each one of the 1547 household questionnaires was double entered in EpiInfo 6.04d (Centres for Disease Control and Prevention, USA, 2001). Second entry was done by a different data entry clerk. The "Validate" component of EpiInfo was then run to identify differences between the two entries. The paper questionnaires were then checked for the right answers and the corresponding mistakes corrected in the database. This process was repeated several times until it was shown that the two entries were identical. This permitted to correct hundred of mistakes made at data entry and to ensure a very high level of correspondence between the information on the questionnaire and in the database. It is estimated that, after validation, data entry errors must be not more than a small fraction of one per cent.

Data entry clerks were instructed to enter the information on the paper questionnaires "as is" except in the following cases: 1) day "15" was to be assumed for incomplete dates where only the month and the year were provided; 2) day "01" and month "07" were to be assumed for incomplete dates where only the year was provided; 3) dates for which the year was not specified were to be left blank; 4) fields with information incompatible with the question were left blank (e.g. a yes or no answer in a field where a numerical information is expected, or a numerical code outside the defined range). These kinds of instructions are standard when data entry is done by non-specialised clerks and permit the rapid processing of large numbers of questionnaires in a short period of time. Cleaning for inconsistencies (as opposed to data entry mistakes) was subsequently done directly from the database, checking sometime the paper questionnaires for some clues as to how to resolve the issues.

Analysis was done on Intercooled Stata 8.2 for Windows (Stata Corporation, Texas, USA, 2004). However, anthropometric indicators were produced with the EpiNut component of Epi Info 6.04d before being exported to Stata for analysis. Sampling

weights were applied during the analysis to adjust for sampling procedures and different response rates.

Data from the other structured questionnaires (56 community leaders, 59 community workers, 36 district/provincial authorities, 13 nutrition units and 15 district/provincial/national NGO representatives) were partly compiled in Epi Info 6.04d and partly analysed directly for the report.

2.2 Qualitative methods

The information was collected in conformity with basic principles of qualitative research, including:

- Definition of target groups and identification of key informants,
- Utilization of both individual and group interviews,
- Participative observation (evaluation of interventions),
- Data analysis and elaboration of report.

The plan was initially to cover 60 clusters in 18 districts of six provinces (Maputo, Gaza, Inhambane, Sofala, Manica and Tete). The study population was composed of 683 individuals: 56 community leaders, 40 community workers (18 women and 22 men) and 587 women (as focus groups). It was intended to interview more community workers but they were sometime absent at the time of the survey, or were involved with other communities not covered by the programme. Overall, 59 focus groups were organized with 587 women between 21 and 30 years of age. The majority were married with a mean of 3.5 children each, 5.2% zero to 6 months old, and 51% 7 months to 5 years of age. Each focus group had between 6 and 12 participants.

The interviews (individual and in group) usually took place at the centre of the village. Community leaders generally helped in the selection of the participants and in organising the sessions. We made a point of informing the community leaders about the evaluation process being implemented and to solicit their collaboration and assistance in mobilizing the community. Most of the interviews with community leaders and the groups of women were conducted in local language, but some were done in Portuguese, when they were sufficiently fluent. Interviews with community workers were mostly done in Portuguese.

Each research team was composed of an interviewer/facilitator and of a secretary in charge of taking notes, but there was flexibility in that. Sometime both team members would take note. At the end of each interview, the team discussed and consolidated the information that had been collected and prepared the report. Each team (qualitative plus quantitative) had a supervisor who was in charge of coordinating all activities and of solving technical and logistical problems. At the end of each day, the supervisor would collect and review the reports of the interviews. Quality control was taking into account the length of the interviews (too short interviews could be superficial), the completeness of the questions addressed (as per the guidelines), and verification of the content of the reported answers.

Frames were developed for the synthesis of the information and their subsequent analysis. One frame was elaborated for each category of interview, which included

all the relevant topics of the guidelines. For yes/no answers, a binary system (0, 1) was used to resume the information obtained. When no information was provided in the report, it was decided to record this as a negative answer, although this could well have resulted from insufficiencies on the part of the interviewer. For open ended questions, all the answers were recorded and subsequently ordered and grouped in accordance with the subjects and contents.

For individual interviews, percentages were calculated in relation to the total number of respondents. For women's focus groups, the reports provided information about the whole group, not individual answers. Consequently, the calculated results refer to the total number of groups. Similar or related answers were often regrouped before estimating percentages. The fact that only two thirds of the expected number of community workers were interviewed was a significant constraint to evaluating information from this group and reduced the possibility to compare their answers with others, especially the groups of women.

The training of twelve team members, from six provinces, took place in Maputo from 1-3 June 2004 and aimed at providing them with instruments for the qualitative survey. The members were selected based on their previous experience in quantitative and/or qualitative surveys and on their expressed interest. Training was done regarding the basic principles of qualitative methods, the importance of qualitative surveys, survey techniques, role play for the conduct of simulated interviews and testing of the guidelines, the elaboration and presentation of reports by the several teams, discussions and synthesis. On the second day of the training, pre-testing was performed in Motaze, district of Magude, where the programme had been implemented. A group discussion with six women took place and individual interviews were performed with two community workers and a community leader. This permitted to improve the guidelines, as well as clarify and standardise the information collection process. It also helped to evaluate the capacity of the team members, to observe their behaviour and interaction with the interviewees, to test the quality of the collected information and to estimate the time needed for the interviews and the elaboration of the reports. During the last day, the groups completed their reports, which they then presented in plenary sessions for discussion. The function of each team member was defined, as well as the duration of interviews. Certain questions in the guidelines were modified and corrected, and explanations given as necessary.

It is worth noting that a full report for the qualitative part of the study has been elaborated and is available, of which only selected portions have been included in this report.

3 FINDINGS

3.1 Programme operations

3.1.1 Reported activities

The timing of key events of programme implementation are summarised in *Table 3*. The information in this table was gathered by UNICEF as part of its monitoring activities. The blank cells reflect the difficulty in collecting information from some of

the partners. The participating NGOs were: Cruz Vermelha de Moçambique (CVM), Samaritan Purse (SP), Concelho Cristão de Moçambique (CCM), ARA, CARE, World Vision International (WVI), Associação dos Agricultores do Vale do Zambeze (ZAA), Lutheran World Federation (LWF) and ADRM. Agreements between UNICEF and the NGOs were signed between January and December 2003, but mostly in April, May and August. Some agreements were extended at a later date, but all NGOs had completed their activities by the end of May 2004, date at which the programme was closed. Community workers ('activistas') for the programme were either elements already involved in the NGO's activities or specially recruited for this purpose. As can be seen, in some cases their training started even before the agreement was actually signed. There were two distinct training components, the first covering the logistic of the programme (registration process, distribution, screening, etc.), the second regarding participatory education. All NGOs, except CVM, used the same participatory education material and techniques. A selected number of community workers took part in a specific training workshop for this purpose. In most cases, these same community workers trained later on the rest of their colleagues, so that all could be involved in this activity.

Table 4 shows the number of beneficiaries covered; the quantities of CSB, vitamin A and mebendazole distributed; the number of children screened for MUAC; and the number of people having benefited from participatory education, by month, as reported by participating NGOs. As shown in the first column, 133,992 children 6-59m and 69,660 pregnant or lactating women were registered into the programme at the peak of the activities towards the end of 2003. Considering that about 15% of the population are expected to be in this age groups and the target population already presented in *Table 1*, the expected number would be around 95,500 children. The Instituto Nacional de Estatísticas (INE) has projected an 18% population increase in the national population between 1997, the year of the census, and 2004. Consequently, the target population could now be around 113,000, suggesting about 19% over-registration of children in the programme. This is roughly equivalent to adding all the 5 year old children into the programme. In our sample, we found 30% of the women population (five year old and over) either breastfeeding or pregnant. That would suggest about 100,000 eligible women in the target population, and that about 70% of this target group was actually registered in the programme.

Table 3: Timing of key events of the programme (all numbers refer to months of 2003).

Province	District	NGO	AGR	CTR	PTR	REG	CSB	VIT	MEB	EDU	SCR
Maputo	Magude	CVM	08				11				
Gaza	Moamba	CVM	08				11				
	Chicualacuala	SP	04	02	02	03	07	06		05	05
	Chigubo	SP	04	02	02	05	05	05		04	05
	Guija	SP	04	02	02	03	05	05		04	05
	Chibuto	CCM	04	06		06	08	09		09	08
	Massangena	CCM	04	06		06	08	09		09	08
	Mabalane	ARA	12								
Inhambane	Funhalouro	CARE	05	07	07	07	08	09		09	09
	Mabote	CARE	05	07	07	07	09	09		09	09
Sofala	Machanga	CVM	08				11				11
	Chibabava	CVM	08				11				11
Manica	Machaze	CVM	08				11			11	12
Tete	Mutarara	CVM	08				12				
	Cahora Bassa	WVI	01	02	03	02	03	05	10	03	03
		WVI	01	02	03	02	03	05	10	03	03
	Changara	ZAA	04	04	06	04	07	08		07	09
		WVI	01	02	03	02	03	05	10	03	03
	Moatize	WVI	01	02	03	02	03	05	10	03	03
	Magoé	LWF	05	04	06	04	11	10	10	10	10
ADRM		05	04	06	04	05	07	10		07	
Chiuta	CCM	08				11				11	

*AGR= Agreement signed, CTR= Training of community workers, PTR= Training in participatory education, REG= Registration of beneficiaries, CSB= First distribution of CSB, VIT= First distribution of vitamin A, MEB= First distribution of mebendazole, EDU= First sessions of participatory education, SCR= First malnutrition screening activities.

Analysing further *Table 4*, it can be estimated that the mean coverage of registered beneficiaries with CSB was 54%, giving a mean ration of 111gr per covered beneficiary per day (children and women) over the period March 2003 to May 2004. However, sharing with other family members has also to be taken into consideration. For vitamin A, considering that a dose is to be given to children 6-59m every 6 months, one sixth of the registered population would be expected to be covered every month. Summary data in *Table 4* suggest that a mean coverage of about 30% was achieved over the whole period. Looking, however, at the last six months, a coverage of 39% is expected. In the same way, a coverage of 12% for mebendazole can be estimated for the whole period, and of 14% for the last six months.

Reported activities further permit to estimate the mean monthly coverage of MUAC screening of registered children 12-59m at about 42%, while participatory education activities can be estimated to have reached 16% of the registered adult beneficiaries per month. The mean number of participants per participatory education session, according to reported figures, is estimated at 81.

Table 4: Number of beneficiaries covered, quantities of CSB, vitamin A and mebendazole distributed, as well as number of children screened for MUAC and number of people having benefited from participatory education, by month, as reported by participating NGOs.

Period	Beneficiaries covered		Products distributed			Activities implemented	
	children 6-59m	Women preg/lac	CSB tons	Vit A doses	Meben-dazole doses	MUAC screening (% < 11cm)	Particip. education (# sessions)
Mar 03	28,731	16,219	97.3	-	-	2,088 (1.8%)	9,094 (??)
Apr 03	9,721	5,083	39.2	-	-	3,446 (5.0%)	4,575 (26)
May 03	51,991	27,657	195.8	1,815	0	8,586 (3.8%)	7,140 (51)
Jun 03	29,956	17,328	202.6	3,612	0	9,760 (1.1%)	7,275 (50)
Jul 03	59,405	29,095	285.0	3,559	0	9,710 (0.3%)	10,195 (31)
Aug 03	100,512	48,358	450.4	3,383	1,098	20458 (12.0%)	9,295 (83)
Sep 03	106,182	52,103	489.5	6,867	0	22,603 (8.6%)	21,918 (181)
Oct 03	55,670	26,920	288.7	5,055	9,853	37,097 (4.3%)	8,824 (159)
Nov 03	94,866	45,694	574.8	1,664	339	38,208 (2.4%)	13,512 (190)
Dec 03	81,662	40,094	808.4	2,752	500	63,706 (0.6%)	11,820 (215)
Jan 04	115,951	59,595	504.0	2,682	1,573	31,723 (0.6%)	1,907 (214)
Feb 04	115,951	59,595	570.0	16,426	1,263	44,916 (0.4%)	19,126 (447)
Mar 04	112,857	59,271	646.5	2,839	363	45,827 (0.5%)	12,937 (216)
Apr 04	81,391	39,568	551.8	2,160	332	38,975 (0.5%)	14,257 (122)
May 04	72,886	35,531	428.0	1,347	6,106	28,691 (0.3%)	19,211 (118)
Total (cumulative)	1,089,030	562,111	5485.5	54,161	21,427	405794 (2.2%)	171086 (2103)
Mean per month	72,602	37,474	365.7	3,610	1,428	27,053	11,406
	133,992	69,660	◀Number of registered beneficiaries at peak of activities				

Taking a closer look at the reported proportion of children with MUAC below 11cm, an overall figure of 2.2% is obtained. The correspondence between MUAC and wasting is not narrow and depends in part on the proportion of older and younger children in the sample. As a comparison, it can be reported that during the second multisectoral assessment (2002), 3.0% children 6-59m were found with MUAC \leq 11cm which corresponded with a moderate or severe wasting (weight for height) rate of 6.4%. However, the months of August and September 2003 stand out with very high figures of 12.0% and 8.6% respectively, together with a sharp increase in the number of screened children. This increase coincides with the initiation of MUAC screening activities of CCM in two districts of the province of Gaza. In the district of Chibuto, CCM reported severe malnutrition rates (MUAC<11cm) of 24%, 20%, 10% for the months of August, September and October respectively. In the district of Massangena, rates of 71%, 55% and 44% were reported over the same period, suddenly going down to 5% in November. These are by far the highest rates reported by any of the NGOs involved in the ISFP. Levels such as those found in Massangena would point to an extremely severe emergency and most likely correspond to errors of measurement. This also casts a doubt about the accuracy of the figures reported for Chibuto by community workers probably trained under similar conditions. This is not to say, obviously, that those populations were not suffering from problems of nutrition during that period.

Table 5 shows the number of children that were admitted for severe malnutrition in 12 health centres. Blank cells indicate that information was not available. As can be seen, the months of August and September were not especially high in Chibuto. Unfortunately, there is no information available for Massangena. Moatize and Cahora-Bassa show very high case-fatality rates, but this is in relation to a relatively few number of cases and may not be representative. The fact that, in Mozambique, very severe underlying pathology is often associated with severe malnutrition must also be taken into consideration. Our questionnaire to the nutrition units also tried to determine the number of children referred monthly by the ISFP community workers, but no such records had been kept at district level. All the surveyed units had been receiving stocks of therapeutic milk F-100 and F-75 during the period under study. However, Changara, Machaze, Cahora-Bassa, Mágoe and Moatize reported to be short of one or both types of milk at the time of the survey.

Table 5: Number of children admitted for severe malnutrition in 12 health centres of the ISFP districts by month, plus case-fatality rates.

Health Centre \ Period	Chibuto	Funhalouro	Mabote	Moamba	Changara	Machaze	Machanga	Chiuta	Cahora-Bassa	Magoe	Moatize	Mutarara
Jan-03	11	2	0	6	7		1	3	0	0	12	13
Feb-03	12	1	0	2	4		2		0	1	15	7
Mar-03	13	2	0	2	8		1	5	0	1	18	14
Apr-03	15	2	2	3	10		3	5	0	0	29	9
May-03	13	2	0	0	5		4	1	0	1	18	14
Jun-03	20	2	3	1	7		1		0	2	16	12
Jul-03	10	0	0	3	5		3	0		0	14	15
Aug-03	7	0	3	0	3		0	1		0	6	4
Sep-03	11	2	0	1	6		0	4	0	0	5	4
Oct-03	15	0	1	1	6		2	0	0	3	7	7
Nov-03	8	2	1	2	10		0	6	0	0	4	6
Dec-03	6	0	0	1	6		2	5	2	1		7
Jan-04	10	0	0	2	6	0		2	0	1		20
Feb-04	13	1	2	0	0	0		2	0	1		21
Mar-04	24	1	0	0	2	1		4	0	1	7	5
Apr-04	24	2	0	1	8	1		6	4	1	4	14
May-04	18	0	3	1	11	1		0	0	1	5	18
Total	230	19	15	26	104	3	19	44	6	14	160	190
CFR*	20%	0%	20%	8%	10%	100%	26%	16%	50%	0%	6%	14%

* CFR= case-fatality rate

3.1.2 Community workers

Community workers ('activistas') were the backbone of programme implementation. Over 800 of them were trained during the course of the ISFP and involved in beneficiary registration, mobilization, distribution of the products and health education. Ninety-one of them were specifically trained in participatory education, a knowledge which they subsequently passed on to a large proportion of their colleagues.

The qualitative survey found that 53% of those that were interviewed were working exclusively in the area of residence, 36% worked also in other localities, and 11% worked exclusively outside their area of residence. 57% of the community workers interviewed had been chosen by a community leader, while the others were previously working for the implementing NGOs. The majority (90%) had a good knowledge of the programmes and its components, although each community worker was not necessarily involved in all activities. It was possible to identify three categories of community workers, the ‘generalist’ working in his/her area of residence, the ‘specialist’ working in different localities, and the ‘super-activista’ with supervisory functions and responsible for the distribution and administration of vitamin A and mebendazole. However, vitamin A was sometime given directly at the health units by the respective staff.

The training of community workers had both theoretical and practical content and included:

- Child nutrition (components, quantities, preparation) (85%)
- Preparation of the soya mix (77%)
- Household and children hygiene (50%)
- Hygiene of water and conservation of food (22%)
- Measurement of MUAC and nutritional surveillance (47%)
- Prevention and treatment of diarrhoea (37%)

Programme activities referred to by the community workers included: the distribution of CSB (67%), the listing of beneficiaries (35%), home visits to the beneficiaries and education of the mothers (35%), MUAC measurement (25%), vitamin A (20%) and mebendazole distribution (12%). 20% of community workers stated that the vitamin A and the mebendazole were not being distributed in their area.

There was not much clarity among community workers about participatory education, and its instruments and methods for the transmission of information. 52% of the community workers consider that the participatory method was useful because:

- The mothers asked questions and participated actively,
- The mothers gave their experience on various themes,
- The community learned how to differentiate what is ‘good’ and what is ‘bad’,
- The mothers understood easily and were able to show what they had learned.

Difficulties indicated by a number of community workers in relation to implementing participatory education included:

- Lack of teaching material (posters, manuals),
- Lack of a proper place to teach the mothers,
- Low participation of the mothers busy in the fields,
- Difficulties the mothers had in interpreting the images,
- Difficulties the mothers had in understanding the messages.

The ‘demonstration poster’ was referred to by the community workers as a ‘content’, a fact which suggest that they had not correctly understood that it is an ‘instrument’

for participatory education. They nonetheless feel that the use of posters made comprehension easier. The women, on their side, generally considered that their relationship with the community workers was positive (83%) due to the methods of communication they used. 62% found that they were efficient because they used the local language, were patient and explained clearly, used posters to communicate their messages, which they understood. Community workers generally (85%) considered positively the involvement of the community, which they attributed mostly to the good work of the community leaders, and 42% considered that the mobilization of the beneficiaries had been good. They also generally (82%) expressed that the programme was well implemented and was of benefit to the population, such as reduced hunger and malnutrition (40%), improved growth for children (57%), and reduced number of cases of diarrhoea (20%).

For the quantitative component of this study, a structured questionnaire was applied to 59 community workers to obtain information about their knowledge, operation modalities, training and comments regarding the ISFP. These are summarised in *Table 6*. Note that the table does not provide specific information about 3 NGOs for which less than 4 community workers were interviewed, i.e. ARA, LWF and ZAA. However, the overall figure includes the information provided by all community workers interviewed, including three from the above mentioned NGOs.

UNICEF informed that all children in the targeted age group were to receive CSB without respect to their having or not a health card. Information collected during the survey indicates, however, that the NGOs involved operated differently in that respect. ADRM and CARE seem to have been specific about providing CSB only to children with health cards, while other NGOs were apparently less definite. Some community workers said that CSB was, in principle, to be given only to children with a health card but that this condition was not adhered to strictly when they were operating in villages far away from a health unit. Some NGOs made arrangements with the District Health Directorates to provide health cards directly to children that did not have them, while others referred the child to a health unit for that purpose. All this may have accounted for the relatively high proportion of children with a health card (79%) encountered during the survey, which facilitated greatly the assessment of some components of the programme.

Similar differences can also be noted in relation to pregnant women. In some instances, a pre-natal consultation card was required, in others, it was sufficient that the woman was visibly pregnant. Criteria seem to have been less clear in the case of lactating women. Generally, it appears that it was sufficient for the mother to bring her child and state that she was breastfeeding in order to be registered for CSB. Many of the community workers stated that this was so as long as the child was less than 5 years old.

In relation to the quantity of CSB attributed per person and per day, the majority of community workers stated correctly the amount of 200gr for children 6-59m and 150gr for pregnant or lactating women. If we examine the numbers by NGO, however, important variations can be seen. This may reflect adjustments made in accordance to quantities of CSB available, ambiguities resulting from variations in the period of time covered in each distribution (e.g. providing for 2 months instead of 15

days at a time), or difficulties in understanding or accepting that adult women were to receive less than small children. As far as the quality of the CSB is concerned, 10% of the community workers interviewed stated that occasionally the product they were distributing had changed taste or had gone off, especially towards the end of the programme (data not shown). This could have been related to the CSB having been in the warehouses for a long time and/or that CSB from different providers had a different composition (especially in sugar) and taste.

Concerning training, 53% of interviewed community workers stated to have received a one to three day formation, while CARE and Samaritan Purse appear to have provided for longer training periods. The number of times supervisors met with the community workers was variable. Samaritan Purse and World Vision International show higher numbers of supervision visits; they were also among the NGOs that started implementation earlier.

Over a third of the community workers complained that they were not paid regularly. CARE and Samaritan Purse performed best in this respect, with 100% of their interviewed community workers satisfied about the regularity of payment. Issues of money were often a cause of debate. Several community workers complained that they were not given the full amount that had been agreed upon. It appears that in a number of cases, activities were occasionally suspended by some NGOs for different periods of time during which the community workers would not receive payment. This was a cause of frustration since this eventuality was reportedly not contemplated in their contracts. In other cases, community workers stated that they had not been paid even for periods they had actually worked. Twenty two percent of community workers stated that their NGO still owed them some money (data not shown).

Stated insufficiencies in transportation means for either the products or the staff were also common (37%). WVI appears to have performed best in this respect, followed by ADRM and Samaritan Purse. Several community workers complained of having to walk long distances on foot or to have to pay for transport out of their own pocket in order to reach distant villages. The issue of not getting any extra allowance for days spent out of their place of residence was also raised by a number of community workers, while others complained not to have received the bicycles they had been promised.

On the other hand, the greatest majority of community workers stated that they felt the work they had been doing was valuable and useful, as this happened during a period when the populations were famished. They generally believed that the intervention had positive effects on the nutritional status of the population, and in improving health and hygiene.

Table 6: Summary table of community workers knowledge, operations, training and support, overall and by NGO*.

Component	Overall	ADRM	CARE	CCM	CVM	SP	WVI
number of community workers interviewed	59	4	8	7	18	8	11
KNOWLEDGE ABOUT TARGET BENEFICIARIES							
Good	61%	50%	63%	57%	72%	63%	55%
Acceptable	36%	50%	37%	43%	22%	25%	45%
Bad	3%	0%	0%	0%	6%	12%	0%
COULD CHILDREN WITHOUT A HEALTH CARD RECEIVE CSB							
No	51%	100%	88%	43%	38%	50%	36%
Yes	47%	0%	12%	57%	62%	50%	55%
Don't know	2%	0%	0%	0%	0%	0%	9%
COULD A PREGNANT WOMAN WITHOUT A PRE-NATAL CARD RECEIVE CSB							
No	54%	100%	75%	43%	50%	25%	45%
Yes	46%	0%	25%	57%	50%	75%	55%
FROM WHAT PERIOD COULD A PREGNANT WOMAN START RECEIVING CSB							
Any time	54%	50%	50%	71%	69%	50%	45%
2 nd trimester	32%	25%	38%	29%	19%	25%	55%
3 rd trimester	7%	25%	0%	0%	0%	13%	0%
Don't know	7%	0%	12%	0%	12%	12%	0%
A LACTATING WOMAN COULD RECEIVE CSB UNTIL HER CHILD WAS HOW OLD							
Up to 3 or 6 months of age	16%	0%	0%	14%	31%	25%	0%
Up to 1 year of age	4%	0%	0%	0%	6%	0%	0%
Up to 2 years of age	39%	75%	25%	57%	32%	25%	55%
Any age / other answers	39%	25%	75%	29%	25%	38%	45%
Don't know	2%	0%	0%	0%	6%	12%	0%
HOW MUCH CSB PER DAY WAS A CHILD TO RECEIVE							
100-150gr, or 3 table spoons	29%	0%	0%	0%	56%	60%	18%
200gr, or 6 table spoons	39%	100%	83%	29%	6%	20%	64%
300-400gr, or 12 table spoons	13%	0%	0%	57%	0%	0%	9%
Don't know	19%	0%	17%	14%	38%	0%	9%
HOW MUCH CSB PER DAY WAS A PREGNANT OR LACTATING WOMAN TO RECEIVE							
100gr	10%	0%	0%	0%	31%	0%	0%
(133) 150 (167)gr	48%	75%	86%	0%	25%	40%	82%
200-400gr, or 9 table spoons	25%	25%	0%	86%	6%	40%	18%
Don't know	17%	0%	14%	14%	38%	20%	0%
NUMBER OF DAYS OF TRAINING RECEIVED BY COMMUNITY WORKERS							
1-3 days	53%	75%	25%	100%	44%	0%	91%
4-7 days	29%	25%	63%	0%	28%	75%	0%
8 days or more	14%	0%	12%	0%	22%	13%	9%
Don't remember	4%	0%	0%	0%	6%	12%	0%
NUMBER OF TIMES COMMUNITY WORKERS MET WITH THEIR SUPERVISORS							
1-5 times	47%	100%	13%	0%	100%	25%	0%
6-10 times	34%	0%	75%	100%	0%	13%	55%
11 times or more	19%	0%	12%	0%	0%	62%	45%
COMMUNITY WORKERS PAID REGULARLY							
No	63%	100%	0%	43%	89%	0%	100%
Yes	37%	0%	100%	57%	11%	100%	0%
LACK OF TRANSPORTATION MEANS FOR CSB OR COMMUNITY WORKERS							
No	63%	75%	50%	43%	44%	75%	91%
Yes	37%	25%	50%	57%	56%	25%	9%

* Specific information about ARA, LWF and ZAA is not provided due to small number of interviewees.

3.1.3 Community leaders

According to the qualitative survey findings, practically all community leaders (86%) had knowledge about the ISFP but linked it mostly with the distribution of CSB (soya). A few of them appeared not to have been involved by the implementing agency, especially when the CSB was not distributed in the village itself. Community leaders were often involved in selecting the community workers and in elaborating the lists of beneficiaries. 64% of the those interviewed had a good knowledge of the target groups although they were often unclear about the age limits of the groups involved. 66% knew who was the implementing agency, the others knowing only the name of the contact person or attributing the activities to the Health sector.

Community leaders considered good their relationship with the community workers in 54% of cases, 48% in respect of the implementing agency. Problems were sometime caused by the lack of clarity of who had decision power, the exclusion of the leader from the implementation, or his lack of information about the quantities distributed. On a number of occasions, community leaders who had not been involved in the implementation had to intervene to solve problems of lack of coordination between the population and the community workers.

Community leaders generally regard the programme as beneficial to the population in terms of acquired knowledge, improved health conditions of mothers and children. Over half of them specifically referred how the mothers learned about how to prepare meals under hygienic conditions, how to keep the house and the children clean, how to conserve water, filter it or boil it before consumption, etc.

When asked about difficulties that occurred during programme implementation, community leaders referred about problem with the inscription of beneficiaries, with the logistic of the distribution and with the coordination with the implementing agency. Regarding the conditions of the community workers, they specifically mentioned their problems of transport which prevented all targeted villages to be reached, and the delay in the payment of their subsidies which resulted in their lack of motivation.

3.2 Measured programme activities

In the agreements they signed, every NGO was given a list of areas ('localidades'), each regrouping a number of villages, which they had to cover systematically. The sampling frame of the cluster survey was drawn from the list of all villages that were meant to be covered. It is thus possible to estimate from the sample of surveyed villages the actual coverage of the programme in terms of population and villages. This calculation is based on the number of sampled villages that declared, during the cluster survey, having been included in the CSB distribution, since this activity was, in practice, the backbone of the programme to which all other were linked.

Overall, 51 of the 60 clusters (villages) surveyed had benefited from at least one distribution of CSB. Because the villages to be surveyed were sampled with probability proportional to the size of the population (1997 Census), this means that an estimated 85% (and not less than 73%) of the target population was reached in one way or another by the programme. Given the extent of the geographical area to be covered, this can be considered as a good, or even excellent, gross coverage. Results

by area are shown in *Table 7* and indicate that the South (74%) had a significantly lower coverage than Tete (97%). Estimates of target villages coverage were also calculated taking into account the population of the sampled villages and are presented in the same table. They are similar to those of the target population and suggest that the implementers of the programme outreached to small and large villages in a similar way.

Table 7: Coverage of target population and target villages by the supplementary feeding programme, by region.

Region	n	Coverage of target population (95% CI ¹)	Coverage of target villages (95% CI)
Overall	60	85.0% (73.4 – 92.9)	84.2% (65.7 – 93.7)
Tete	29	96.6% (82.2 – 99.9)	96.4% (76.0 – 99.6)
South ²	31	74.2% (55.4 – 88.1)	70.0% (42.0 – 88.2)

¹CI = confidence interval

²South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

3.2.1 CSB distribution

The statistics just mentioned above refer to CSB distribution as the component of reference for programme coverage. There were, however, large variations in the period and frequency of CSB distribution between areas. This can be first appreciated from *Table 3* that shows how different NGOs started distribution at different time. This was not only linked to the time of the signature of the agreement. Another important factor was the fact that the CSB was not made available for distribution on an immediate and regular basis due to difficulties faced by WFP in sourcing the product. This placed a major constraint on implementation, and was a source of frustration and disorganization in the field. On a number of instances, it was found that programme activities had been slowed down or even suspended when CSB was not available. It was not possible, however, to establish how often this had been the case.

According to the information collected, 82% of the families in the target areas were eligible to receive CSB, i.e. had a child 6-59m, a lactating mother and/or a pregnant woman. *Figure 1* shows the number of CSB distributions reported by those eligible families that were interviewed during the cluster survey. When the interviewed family member could not remember exactly how many times the family had received CSB, the median for the village was used. The CSB supplement was intended to be provided twice a month, or at least once a month, to the eligible families in the amount of 200g/day per child 6-59m, plus 150g/day per breastfeeding and pregnant woman in the household. Most of the NGOs having taken part of the programme for a period of 8 to 11 months, a similar number of distribution rounds was necessary to provide the families with a regular supply. However, less than 15% of the families benefited from six or more distributions. Although quantities for up to two months at a time were provided in some cases to compensate for this irregularity, many of the registered families experienced repeated shortages over the period of the programme. This uneven distribution also turned practically impossible to estimate if the families had received the expected quantities of CSB for the number of eligible members.

Figure 1: Number of CSB distributions reported by the surveyed eligible families.

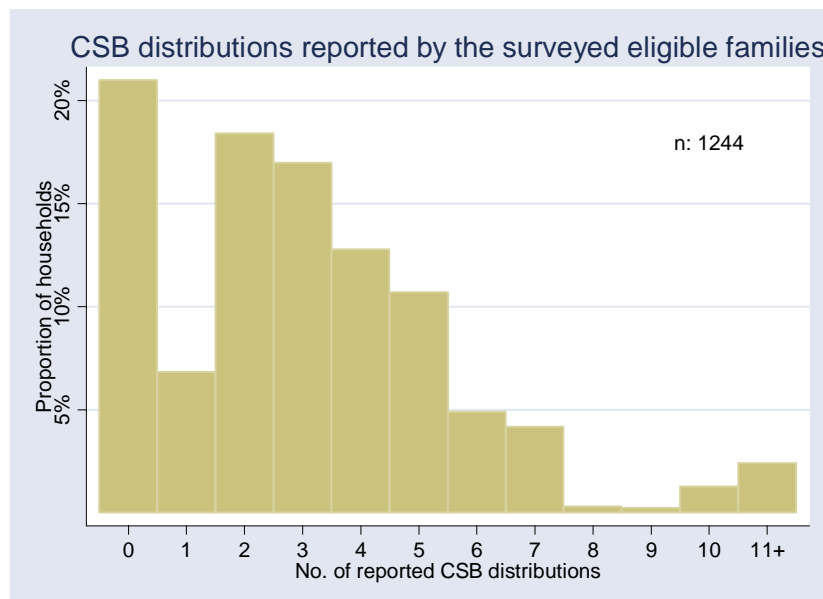


Table 8 shows the coverage estimates for the eligible families of the target population with at least one or three distributions of CSB. While 80% of eligible families received CSB at least once, only 55% received the product three times or more (about 70% of families that were reached at least once). Once again, Tete is shown to have done better than the southern provinces. Since it is not likely that one or two distributions of the product could have significantly affected the nutritional status of the target population, this has negative implications in terms of programme impact for nearly half of the eligible families.

Table 8: Coverage of eligible families in the target population by at least one or three distributions of CSB, by region.

Region d.e. ¹ ≈ 14	n	At least <u>one</u> distribution of CSB (95% CI ²)	At least <u>three</u> distributions of CSB (95% CI)
Overall	1251	80.4% (70.5 – 87.5)	54.8% (43.9 – 65.2)
Tete	620	89.7% (78.3 – 95.4)	64.8% (50.0 – 77.2)
South ³	631	69.3% (52.9 – 82.0)	42.8% (28.2 – 58.8)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

Questions were asked about who ate CSB in the family. A total of 64% of the families who had received the product reported that CSB had also been eaten by children outside the target group (5-15y). Further, 61% also admitted that adult men and non-pregnant/lactating women had consumed the product. This does not come as a surprise given the already known customs and habits of the families in these regions. It has nonetheless implications on the desired nutritional impact of this intervention on the target groups.

The benefiting families were also questioned about having or not sold part of the CSB they had received. Less than 2% responded affirmatively and it is believed that, since the distribution occurred in a period during which families were experiencing a severe shortage of alimentary products, this reflects the reality.

Under the qualitative study, the great majority (91%) of women who participated in the focus groups declared having received some form of food assistance: corn 71%, oil 64%, beans 57%, soya 50%, rice 24%, sorghum 19% or peas 17%. Given the prevailing situation, 67% had received those products under the food-for-work programme and these were mostly eaten by the recipient families themselves (90%). The food products thus received constituted the fundamental part of the diet over that period (57%), or was eaten in addition to the regular products (16%). Very few women (5%) stated that the products received had induced permanent changes in their dietary habits.

Many of the interviewed women stated that they had to walk long distances, sometime 20 km, or pay for transport in order to receive 2 kg of CSB, since the distribution was not always done in the village itself, and the roads were sometime inaccessible. There were also cases where families did not receive the CSB because they were in their fields or away from the village, and the population had not been duly advised of the day of the distribution. At times the CSB provided was not sufficient to cover all the registered beneficiaries of the village, and on some occasions the CSB tasted bitter or had gone off. Instances of community workers selling CSB was also reported.

3.2.2 Vitamin A and mebendazole distribution

The doses of vitamin A received either from the health services or through the supplementary feeding programme activities were both recorded on the health card of the child in the same way. It was, consequently, impossible to discriminate between the two sources during the survey. The following results therefore reflect both the vitamin A supplementation status of the children 6-59m whatever may be the source.

Table 9 shows a markedly low level of vitamin A supplementation coverage during the last six months preceding the survey. Only 28% of children 6-59m overall with a health card were adequately covered, this figure being 41% for the southern provinces, but only 14% for Tete. If we consider children without a health card as not covered, the overall coverage is reduced to 21%. This is despite a relatively high card retention rate of 79% found in this survey (68% in Tete, 88% in the southern provinces). The VAC of 2003 had found a coverage of 63% among children with a health card but the response rate was so low that those results were not considered representative of the population. The overall results of *Table 9* are compatible with the NGOs' activity report figures presented in *Table 4*.

Table 9: Percentage of children 6-59m having received a dose of vitamin A during the last six months preceding the survey, or at any time since March 2003, by health card status and by group.

Group d.e. ¹ ≈ 6	n (with card)	Vitamin A supplementation Children with card		Vitamin A supplementation All children ³	
		Last 6 months (95% CI ²)	Since March 2003 (95% CI)	Last 6 months (95% CI ²)	Since March 2003 (95% CI)
Overall	1393	28.0% (22.3 – 34.5)	43.2% (36.4 – 50.3)	21.0% (16.7 – 26.2)	32.5% (27.1 – 38.5)
Tete	556	14.3% (10.0 – 20.0)	26.2% (20.1 – 33.3)	9.5% (6.5 – 13.6)	16.9% (12.9 – 21.9)
South ⁴	837	40.9% (32.6 – 49.6)	59.1% (50.4 – 67.4)	31.9% (25.7 – 38.8)	47.1% (40.4 – 54.0)
No CSB distribution	249	30.8% (18.2 – 47.1)	46.4% (31.6 – 61.9)	19.2% (12.4 – 28.5)	31.7% (21.0 – 44.7)
1-2 CSB distributions	344	31.7% (20.7 – 45.2)	46.9% (34.2 – 60.1)	25.8% (16.9 – 37.3)	37.2% (26.9 – 48.9)
3+ CSB distributions	783	25.6% (19.1 – 33.4)	40.4% (32.6 – 48.8)	19.9% (14.6 – 26.7)	31.3% (24.6 – 38.9)
<3 CSB distributions	593	31.3% (22.5 – 41.7)	46.7% (36.7 – 57.0)	23.0% (16.7 – 30.7)	34.8% (27.0 – 43.6)

¹d.e. = design effect

²CI = confidence interval

³Counting children without card as not having received vitamin A

⁴South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

The same table also presents information about vitamin A coverage at least one time since March 2003, i.e. during the whole period of the ISFP, which is of 43% for children with a health card and 33% for all children. The lower part of the table shows coverage figures according to the number of CSB distributions received by the eligible families. The relatively small differences in coverage in these cases are not statistically significant.

Such results indicate that vitamin A supplementation was not implemented systematically by some of the NGOs, particularly in the province of in Tete. This is confirmed by the fact that the results were not higher in the areas having had three or more rounds of CSB distribution. It also suggests the possibility that the health services in that province may have relaxed their routine activities while counting on the community workers of the ISFP to cover the children of these areas. A more in-depth analysis of this issue would be warranted as the Ministry of Health and UNICEF have been considering the possibility of using NGOs to increase coverage of vitamin A in the country.

De-worming activities were contemplated in the contracts of only some of the NGOs and this activity started late in 2003. This is reportedly due to a long delay in releasing the stock of tablets of mebendazole from customs. *Table 10* shows very low coverage for this activity in all areas.

Table 10: Percentage of children 6-59m having received a dose of mebendazole during the last six months preceding the survey, by health card status and by region.

Region d.e. ¹ ≈ 6	n (with card)	Mebendazole supplementation ² Children with card (95% CI ³)	Mebendazole supplementation All children ⁴ (95% CI)
Overall	1377	4.9% (2.8 – 8.5)	3.9% (2.1 – 6.9)
Tete	549	1.7% (0.7 – 4.2)	1.3% (0.5 – 3.3)
South ⁵	828	7.9% (4.2 – 14.3)	6.3% (3.3 – 11.8)

¹d.e. = design effect²At least one dose of mebendazole in the last six months³CI = confidence interval⁴Counting children without card as not having received mebendazole in the last six months⁵South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

3.2.3 Participatory education

UNICEF explained that all diarrhoea and nutrition participatory education topics were intended to be covered in a single three-hour session under the orientation of designated community workers specifically trained for the purpose. However, information collected during the study indicate that participatory education was an on-going process over the whole period of the programme and that, at least in some areas, a cascade training to other community workers was implemented so that they could be involved in the process.

The number of households covered by activities of participatory education was estimated from two questions in the survey questionnaire. One asking if any member of the household had participated in educational meetings were images were used interactively, and then how many meetings. It was obvious that the population could not always make the difference between such educational activities done by the community workers of the ISFP and others, as was evidenced by the enumeration of such themes as malaria, HIV/AIDS, etc. The results presented in *Table 11* may thus be a bit higher than reality on that account, as far as the ISFP education activities are concerned. However, recall biases may have been important as the person being interviewed during the household survey was not necessarily the one who would have attended the participatory education sessions, and may thus have provided incorrect and/or incomplete information on this topic.

Data show that nearly half the households were covered by this activity with a somewhat higher coverage in the southern provinces. Households without members eligible for CSB distribution had a coverage of only 15%. This is most likely a reflection of the fact that these education activities were often linked with the distribution of CSB. This is supported by the observation that higher numbers of CSB distributions to a family corresponded to a higher likelihood of having participated in education sessions (66% for families with 3 or more distributions). As shown in *Figure 2*, 85% of the surveyed families reportedly attended two participatory education sessions or less. Comparing these results with those of *Figure 1* suggests that some CSB distribution rounds were associated with participatory education activities while others were not.

Table 11: Percentage of all households having taken part at least once in participatory education meetings, by region and type of household.

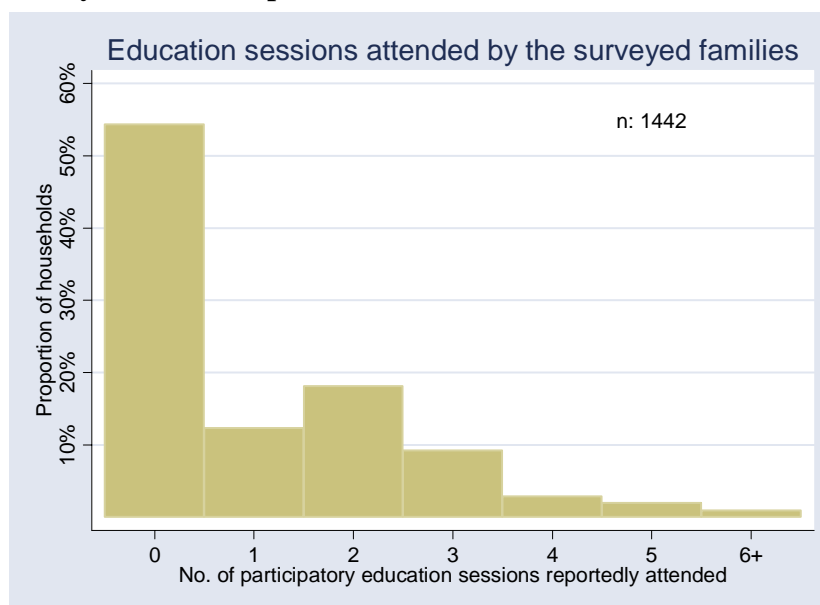
Region/Type of household d.e. ¹ ≈ 5	n	Households having attended participatory education (95% CI ²)
Overall	1497	46.7% (39.7 – 53.8)
Tete	787	40.4% (31.6 – 49.9)
South ³	710	54.2% (44.1 – 63.9)
Households without members eligible for CSB distribution	249	15.2% (9.5 – 23.5)
Households with members eligible for CSB distribution	1248	53.0% (45.8 – 60.1)
No CSB distribution	441	16.0% (11.0 – 22.7)
1-2 CSB distributions	333	48.7% (37.4 – 60.2)
3+ CSB distributions	691	65.6% (57.6 – 72.9)
<3 CSB distributions	774	30.3% (23.3 – 38.2)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

Figure 2: Number of participatory education sessions the surveyed families reported to have attended.



It is difficult to compare the figures obtained here with those of *Table 4*, since the first refers to families and the second to individuals. However, one would have expected that a coverage of 16% of the targeted individuals per month would have resulted in a larger number of families being reached and/or a higher number of sessions attended.

The qualitative study found that a large majority (90%) of the women who participated in the focus groups had attended participatory education sessions, information meetings or health/nutrition related activities, 85% of which were reportedly related to the ISFP.

3.2.4 Screening for severe malnutrition

The supplementary feeding programme also included screening through mid-upper arm circumference (MUAC) for all children 12-59m. Children with a MUAC inferior to 11cm were to be referred to the nearest health centre for further evaluation. Since MUAC measurements are not routinely carried out by the health services, this should reflect well the activities performed within the ISFP.

Gross coverage for this activity was overall of 44%, as shown in *Table 12*, with a somewhat smaller percentage for the southern provinces (not statistically significant). MUAC measurements were meant to be taken monthly in order to provide for rapid intervention in case of severe acute malnutrition. *Figure 3* shows that only 5% of the surveyed children had reportedly their MUAC measurement taken three times or more from March to June 2003. Such a low coverage would greatly reduce the capability of the programme for timely detection of malnutrition cases. This figure is much lower than the monthly 42% coverage estimated from *Table 4*. Although over-reporting remains a possibility, recall biases can once again greatly affect the coverage estimates since there were no records to verify the number of times a child was taken MUAC and this information depended entirely on the respondent's awareness and memory. MUAC measurements appear to have often been performed on the occasion of the distribution of CSB, but were also reported to be done during home visits. We unfortunately don't have statistics on this last activity, although several community workers confirmed that they were involved in it.

Table 12: Percentage of children 12-59m that had at least one mid-upper arm circumference (MUAC) measurement since March 2003.

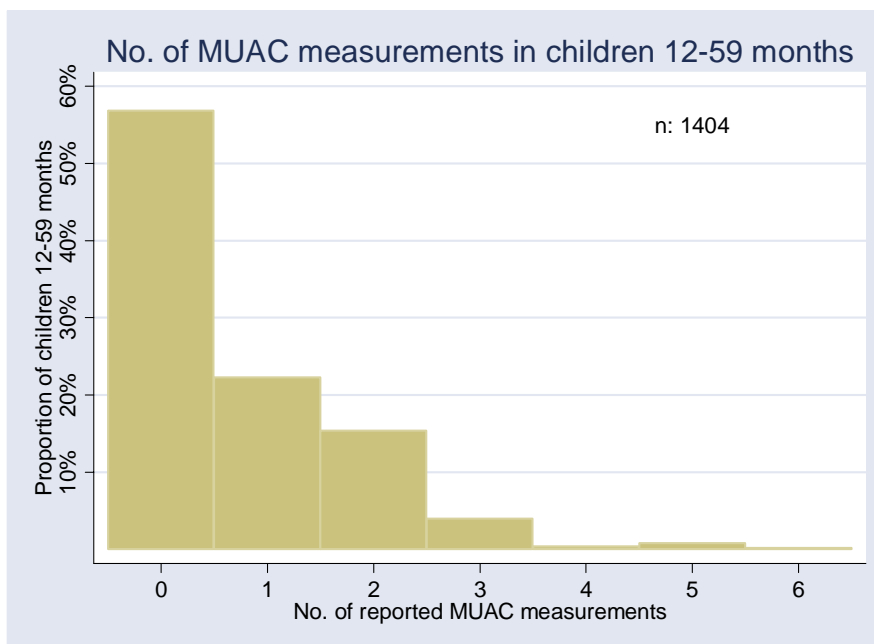
Region d.e. ¹ ≈ 11	n	Screening of severe malnutrition in children 12-59m through MUAC (95% CI ²)
Overall	1404	43.6% (35.3 – 52.4)
Tete	718	50.1% (38.8 – 61.5)
South ³	686	37.6% (26.2 – 50.4)
No CSB distribution	236	8.6% (4.8 – 14.8)
1-2 CSB distributions	352	45.3% (31.2 – 60.3)
3+ CSB distributions	801	53.5% (44.4 – 62.4)
<3 CSB distributions	588	30.2% (20.0 – 42.8)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

Figure 3: Number of MUAC measurements since March 2003 per child 12-59m.



3.3 Estimated impact

3.3.1 Nutritional status

Table 13 permits to appreciate the overall nutritional status of the children 6-59m in the target population as well as to estimate the impact of programme interventions. It was considered for this purpose that households in which CSB had not been distributed, or had received it only once or twice, were barely benefited by the programme activities, and could be used as a comparison group. Those covered by three or more rounds of distribution were considered as the intervention group. CSB distribution, in this case, was a proxy for coverage by the various programme activities, not only CSB supplementation. Even then, data is also provided for eligible households that did not receive any CSB, and for those that received only 1 or 2 distributions, but these tend to be less useful as a comparison group because of their relatively small sample size leading to low precision (wide confidence intervals) estimates.

The figures point overall to an acceptable level of wasting (4.1%) in the children population, a high level of stunting (36.4%), and a high level of underweight (21.5%) as well. These overall results are only very slightly lower than those found in the 2003 VAC which was conducted in the same period of the year, i.e. 4.3% wasting, 37.6% stunting, and 23.9% underweight. It is important, however, to note the differences between the intervention and comparison groups. They all point towards a positive impact of the supplementary feeding programme activities: 3.2% vs 5.3% for wasting ($p=0.07$, borderline significant), 33.4% vs 40.7% for stunting ($p=0.04$, borderline significant), and 18.5% vs 25.4% for underweight ($p=0.004$, significant). The intervention group included about 57% of the children of the target areas. Those children benefited from more MUAC screening, from mothers more knowledgeable

in health and nutrition issues having participated in interactive education activities (both differences are statistically significant), and from a better nutritional status of their pregnant or breastfeeding mothers. They did not, however, receive more vitamin A (possibly less, though the difference is not statistically significant). It should also be noted that figures for the “comparison” group are all somewhat higher than the estimates of 2003, suggesting that the population that did not receive significant assistance from the various components of the programme, but lived in the same geographical areas, may be following a downward trend in terms of nutritional status, even though the changes are not dramatic. Table 14 summarizes these findings as per WHO international classification.

Table 13: Prevalence of wasting, stunting and underweight in children 6-59m, by region and intervention group.

Region/Intervention group d.e. ¹ ≈ 1-2	n	Moderate + severe (<-2 SD) (95% CI ²)	Severe (<-3 SD) (95% CI)
WASTING (low whz)			
Overall	1606	4.1% (3.0 – 5.4)	1.1% (0.7 – 1.8)
Tete	743	2.6% (1.6 – 4.1)	0.6% (0.2 – 1.5)
South ³	863	5.5% (3.9 – 7.6)	1.7% (1.0 – 2.7)
Households with no CSB distribution	291	5.4% (3.1 – 9.1)	1.2% (0.6 – 2.6)
Households with 1-2 CSB distributions	389	5.2% (2.8 – 9.7)	0.9% (0.3 – 2.9)
Households with 3+ CSB distributions	907	3.2% (2.2 – 4.6)	1.1% (0.6 – 2.0)
Households with <3 CSB distributions	680	5.3% (3.4 – 8.1)	1.0% (0.5 – 2.1)
STUNTING (low haz)			
Overall	1588	36.4% (32.8 – 40.1)	11.8% (9.8 – 14.2)
Tete	739	35.7% (29.8 – 42.1)	13.1% (10.2 – 16.8)
South	849	37.0% (32.9 – 41.2)	10.6% (8.0 – 14.0)
Households with no CSB distribution	281	37.2% (32.0 – 42.8)	11.0% (7.0 – 17.1)
Households with 1-2 CSB distributions	387	43.1% (34.6 – 52.0)	12.8% (8.9 – 18.2)
Households with 3+ CSB distributions	902	33.4% (29.5 – 37.5)	11.6% (9.3 – 14.4)
Households with <3 CSB distributions	668	40.7% (34.9 – 46.7)	12.1% (9.0 – 16.0)
UNDERWEIGHT (low waz)			
Overall	1623	21.5% (18.9 – 24.4)	4.7% (3.6 – 6.2)
Tete	753	21.9% (18.2 – 26.2)	4.6% (3.0 – 6.9)
South	870	21.1% (17.6 – 25.1)	4.8% (3.3 – 6.9)
Households with no CSB distribution	289	22.6% (18.5 – 27.2)	5.2% (3.0 – 8.9)
Households with 1-2 CSB distributions	395	27.4% (22.0 – 33.5)	6.3% (3.5 – 11.0)
Households with 3+ CSB distributions	921	18.5% (15.5 – 22.0)	3.8% (2.6 – 5.5)
Households with <3 CSB distributions	684	25.4% (21.7 – 29.4)	5.8% (3.9 – 8.8)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

Table 14: Malnutrition level of children 6-59m according to WHO classification, by intervention vs comparison groups.

Type of malnutrition	Level of malnutrition as per WHO international classification	
	Intervention group (3+ CSB distr.)	Comparison group (<3 CSB distr.)
Wasting	Acceptable	Moderate
Stunting	High	Very high
Underweight	Moderate	High

3.3.2 Morbidity

Table 15 shows period prevalence estimates for diarrhoea or fever during the last two weeks preceding the survey. The results are much lower than those of the 2003 VAC (28%). We don't have enough information to explain why it is so. A possible explanation is the epidemic character of these pathologies. The fact that the intervention and comparison groups show similar levels suggests that the ISFP activities did not impact on the incidence of diarrhoea and fever. The results of the previous section suggest, however, that they could have had a favourable impact on the outcome of these pathologies.

Table 15: Period prevalence of diarrhoeal diseases or fever (in last 2 weeks) in children 6-59m by region and intervention group.

Region/Intervention group d.e. ¹ ≈ 2-3	n	Period prevalence of diarrhoea (95% CI ²)	Period prevalence of fever (95% CI)
Overall	2007	9.6% (7.4 – 12.5)	22.6% (18.1 – 27.9)
Tete	966	7.6% (5.4 – 10.5)	17.5% (12.7 – 23.6)
South ³	1041	11.6% (7.9 – 16.6)	27.5% (20.5 – 35.7)
Households with no CSB distribution	320	12.7% (7.1 – 21.8)	23.6% (14.2 – 36.4)
Households with 1-2 CSB distributions	447	7.7% (4.3 – 13.6)	24.1% (13.9 – 38.4)
Households with 3+ CSB distributions	1033	10.6% (7.2 – 15.2)	22.5% (17.6 – 28.4)
Households with <3 CSB distributions	767	9.8% (6.3 – 15.0)	23.8% (16.3 – 33.5)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

3.3.3 Mortality

Table 16 shows the annual mortality rates per 1000 inhabitants overall and for children under five years. It is important, from the start, to remember that the sample size used in this survey is not sufficiently large for calculation of mortality rates with good precision. This results in lack of precision for the estimate, which is translated into large confidence intervals. Further, the questionnaire probed only about the deaths that occurred during the three-month period preceding the survey. In calculating “annual” mortality rates, the number of deaths over three months has been multiplied by four to estimate the number of deaths over the year. Consequently, the assumption here is that mortality over the year remains constant, which may not be the case. The results represent in fact “annual” gross mortality rates for the period April-June of the year 2004. It is also necessary to keep in mind that such a survey is subject to recall bias, in that all deaths may not have been recorded. It has been reported that in these kinds of interviews there is a tendency for caretakers to under-

report the death of very young children. Interviewers were reminded of this during the training and requested to probe carefully about infant deaths.

Table 16: Annual mortality rates per 1000 inhabitants, per region and intervention group, overall and for under five years old.

Region/Intervention group d.e. ¹ ≈ 1.4	n (hh)	Mortality per 1000 All ages (95% CI ²)	Mortality per 1000 0-4y (95% CI)	Mortality per 1000 5y+ (95% CI)
Overall	1526	33.0 (23.1 – 42.9)	68.3 (40.9 – 95.7)	22.0 (14.0 – 29.9)
Tete	797	33.8 (18.7 – 48.9)	69.6 (27.9 – 111.3)	21.9 (9.8 – 34.1)
South ³	729	32.3 (18.7 – 48.9)	66.4 (31.6 – 101.3)	22.0 (11.6 – 32.4)
Households with no CSB distribution	452	52.9 (29.8 – 75.9)	148.0 (56.7 – 239.3)	33.2 (15.6 – 50.8)
Households with 1-2 CSB distributions	334	27.4 (12.4 – 42.3)	77.3 (28.6 – 125.9)	10.2 (1.6 – 18.8)
Households with 3+ CSB distributions	699	25.5 (13.0 – 38.1)	39.6 (13.0 – 66.3)	20.4 (9.3 – 31.5)
Households with <3 CSB distributions	786	40.6 (25.9 – 55.4)	107.1 (55.3 – 158.8)	22.8 (12.7 – 32.8)

¹d.e. = design effect

²CI = confidence interval

³South = Maputo, Gaza, Inhambane, Manica and Sofala provinces

The results compare relatively well with those found during the 2003 VAC, although the point estimate of the mortality rate in under-fives is slightly higher (68.3 vs 62.6). The southern provinces have similar rates to Tete. This is not the case, however, between comparison and intervention groups. Estimates are markedly lower for the households that benefited from at least three distribution of CSB. While the difference is not statistically significant in the “all ages” group ($p=0.13$), it is large enough in the under-fives group to reach border significance ($p=0.03$). It can also be seen that practically all the variation in mortality rates is concentrated in the under-fives, since the mortality rates for the 5 years and older group show little variation. These results should be taken with caution due to the small sample size. They are based on the assumption that the population was stable over the three-month period under study. They nonetheless reinforce the previous findings suggesting that the supplementary feeding programme had a positive impact on the health and survival of children in areas where its activities were reasonably well implemented.

3.3.4 Beliefs, knowledge and practices

The household questionnaire included a number of questions to assess the beliefs, knowledge and practices of one respondent per family, preferable a mother of a child under five years of age. These are summarised below. It can be seen that among those who said to have participated in participatory education meetings, the themes best remembered were those about diarrhoea and hygiene, while those on child nutrition were mentioned less often. Exclusive breastfeeding is believed to be adequate for a period of 4 to 6 months by 69.9% of respondents. The notion of the need of numerous small meals for a child six months and older is still poorly appreciated, or difficult to accommodate within the life style of the rural populations.

Table 17: Percentage of sampled participants that referred to the main themes of participatory education (n= 663).

Main themes of participatory education	Mentioned
Diarrhoea: transmission	34.2%
Diarrhoea: prevention	35.3%
Diarrhoea: management	25.5%
Hygiene: washing of hands	42.1%
Hygiene: boiling of water	24.4%
Hygiene: disposal of faeces	26.7%
Hygiene: care of animals	8.0%
Child nutrition: exclusive breastfeeding 4-6 months	9.7%
Child nutrition: reinforced porridges	14.3%
Child nutrition: giving small portions at a time	12.4%
Child nutrition: giving several small meals	15.7%
Child nutrition: feeding of a sick child	18.3%

Table 18: Sampled respondents' beliefs about how many months a child should be exclusively breastfed (n= 1189).

Months	Percentage of respondents
1-3 months	26.7%
4 months	33.7%
5 months	14.4%
6 months	20.8%
7-8 months	1.9%
9+ months	2.5%

Table 19: Sampled respondents' beliefs about how many meals per day a child of six months should be given (n= 1201).

Months	Percentage of respondents
1 meal	17.8%
2 meals	39.9%
3 meals	39.2%
4 meals	2.1%
5 meals	0.8%
6 meals	0.3%

Respondents (mostly mothers) whose young child had diarrhoea anytime during the two weeks preceding the survey were asked how much liquid, food, or breast milk they had given the child during that episode. Results are shown in *Table 20*. Although 69.8% stated that they had given the child an oral rehydration solution (ORS) either from the hospital or prepared at home, the notion that more liquid is needed is still not consistently applied in practice. It seems, however, that half the mothers understand the need to breastfeed more often a child sick with diarrhoea.

Table 20: Practices of mothers when their child had diarrhoea during the last two weeks preceding the survey.

Practices	n	None	Less	As usual	More
Gave liquids	179	12.9%	21.8%	36.3%	29.1%
Gave food	179	5.0%	35.8%	36.3%	22.9%
Gave breast milk (if still BF)	95	1.1%	14.7%	33.7%	50.5%

The qualitative study showed results generally in harmony with those of the quantitative study reported above. The themes remembered by the women who participated in the (qualitative study) focus groups were:

- Preparation of the CSB (69%)
- Collective and household hygiene (57%)
- Hygiene with water and food preservation (38%)
- Prevention and treatment of diarrhoea (26%)
- Nutrition of children (22%)
- Construction of latrines (15%)

Asked about the main causes of diarrhoea, the response given were:

- Lack of hygiene (45%)
- Drinking non-potable water that is not treated or not boiled (43%)
- Eating food that is spoiled or from the previous day (21%)
- Lack of latrines (9%)
- The non respect of sexual post-partum taboos (3%)

The information about water of bad quality being a source of diseases was given by the women who had attended participatory education sessions. Flies were said to be the most important transmission vector for diarrhoea. The mothers who had participated in the sessions explained that the fly “comes out of the latrine and sits on the food”, and in this way transmits diarrhoea; while the other mothers generally did not know how diarrhoea was transmitted.

Preventive measures were said to be:

- Clean the dishes and kitchen utensils (36%)
- Keep the surrounding clean (36%)
- Construct and use a latrine (34%)
- Cover the food and the water recipients (34%)
- Wash hands before meals (31%)
- Clean thoroughly the food before cooking (29%)
- Bury feces (17%)

Treatments for diarrhoea were stated to be:

- Take ORS (oral rehydration solution) (64%)
- Go to hospital (43%)
- Increase the quantity of liquids (24%)
- Give oral rehydration solution on the way to the hospital (17%)

Traditional treatments, including home remedies and visits to the traditional healer, were reported by 21% of the mothers that participated in the focus groups. Although

they were relatively few, it is significant to mention that some of the mothers (7%) stated that they should reduce the quantity of fluids when a child has diarrhoea. On a more positive note, 90% of the participating women knew about ORS and stated that its purpose was:

- To treat diarrhoea (59%)
- To compensate the lost body fluids (17%)
- To increase the blood in the body (3%)

All the above suggest that the participatory education sessions on diarrhoeal diseases were well assimilated. Issues related with the introduction of food other than breastmilk to the young children were less well understood. The mothers said that a child can be given food from the 2nd, 3rd or 4th month, depending on the needs. The mothers believe that a child that cries a lot is either sick or hungry, and they tend to calm the child by giving light porridges (72%). The frequency with which porridges are given to children below 6 months depends on the quantity of milk the mother has, but is generally said to be once or twice a day. From 7th months up to 5 years of age, the children continue to eat more consistent porridges (of corn, millet and sorghum), and progressively get to consume the same food as the adults, which includes not only cereals but also greens, meat and fish. At that age, the children take two or three meals a day, the frequency depending on the financial means of the family, and if they accompany or not the mother to the fields.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 Adequacy of the response to the humanitarian situation

The question has been raised about how adequate was a short term supplementary feeding programme to address a prolonged crisis whose underlying causes are understood to be poverty, chronic food insecurity and HIV/AIDS. None of those who were consulted during this evaluation, at whatever level, believed that such a response was the best single solution to these problems. Government, bi-lateral and multi-lateral organizations, as well as NGOs are all involved in mid- and/or long-term programmes that try to address these problems in a more consistent and sustainable way. That they are not always successful reflect the complexity of the issues involved together with a deeply ingrained resistance to change. That such long-term efforts must be pursued and turned more effective is universally acknowledged.

A more difficult question is at what point should short-term emergency relief activities be implemented side-by-side with, or sometime even take precedence over, long-term interventions. Severe emergencies during which both children and adults die in large numbers are clear cases that no one disputes. However, the ISFP was put in place at a time when government and several organizations felt that the coping mechanisms of populations chronically affected by deep poverty and HIV/AIDS were about to reach their limit following consecutive years of flood and drought. This conclusion was reached on the basis of results from a number of multi-sectoral assessments implemented since 2002, as well as information from various sectors, including agriculture and health. The ISFP was designed to avert excessive morbidity and mortality in these populations before they become patent, hence the questioning about its adequacy. Had the populations' coping mechanisms really reached their limit? Otherwise, what morbidity/mortality rates should be reached before special interventions are justified?

It will never be possible to find out conclusively what would have happened to the target populations if the ISFP had not been put in place along other concurrent interventions. The findings of this evaluation suggest that children of families living in similar conditions that were not covered by the ISFP, or received limited benefits from it (the comparison group), may well be following a slow downward nutritional trend and experiencing high mortality. On the opposite, children of families that were reasonably well reached by the ISFP (the intervention group) have shown an improved nutritional status and have experienced less mortality than either the comparison group or the general population of related geographical areas where the third multi-sectoral assessment had been conducted in 2003. If the above findings indeed correspond to reality and are not confounded by other factors, it can be said that the ISFP has exceeded its initial objectives since it contributed to not only maintain but improve the nutritional status and survival of the children.

As far as the targeted populations now enter a more productive agricultural cycle and are able to recover during the next months and years from the stress sustained by their coping mechanisms, it can be said that the ISFP was adequate to the humanitarian crisis. Even in the event of good agricultural production over the next few years, it remains to be shown to what extent the impact of HIV/AIDS will allow this recovery to be complete. In order, however, to state if this intervention was the ‘most’ adequate, other types of interventions, not studied during this evaluation, would need to be closely examined.

In drawing conclusions about the ISFP, one should keep in mind that it had originally been designed to include a wider range of activities, such as water and sanitation, support to EPI services, special protection, etc., that did not receive funding and, consequently, could not be implemented.

4.2 Benefits of the programme

Those children that were reasonably well covered by the programme benefited from more MUAC screening, from mothers more knowledgeable in health and nutrition issues having participated in interactive education activities, and from a better nutritional status of their pregnant or breastfeeding mothers. A proportion of them also received a vitamin A supplement, a vitamin that has been shown to have potentially a strong impact on morbidity and mortality. Unmeasured nutritional benefits to the eligible mothers can also be assumed. To these must be added the psychological comfort that the affected populations surely felt in seeing that their government and other organizations were caring about them during a time of severe hardship.

4.3 Negative impact, constraints and limitations

The low vitamin A coverage that was found in the ISFP areas (lower than what was measured before the start of the programme) suggest a possibility that the staff of the Ministry of Health may have relaxed their routine supplementation activities, possibly by trusting that the children would be covered under the activities of the programme. This has not been conclusively demonstrated, however, and needs to be verified.

The implementation of the ISFP would have seemed an excellent occasion to strengthen HIV/AIDS education activities in the targeted populations, especially that

an army of community workers trained in participatory education was being employed. That such a theme was not included can be seen as a lost opportunity. However, some are of the opinion that not every forum or gathering of community members is appropriate to discuss HIV/AIDS in a meaningful way. Further, at the time of the implementation of the ISFP, participatory education modules on HIV/AIDS were still being developed and were not yet ready for use on a large scale.

The massive logistic effort needed to cover populations often thinly dispersed over such a large geographical area seems to have been underestimated. Problem started right at the beginning with limitations in the timely procurement of the CSB and mebendazole and remained very real even once the products were made available. Difficulties in transport and overall capacity of certain NGOs hampered distribution, monitoring and educational activities. The final result was that only about half the target population was reasonably covered by the programme.

4.4 Recommendations

- 1) The adequacy, efficiency and effectiveness of such a programme should be compared with other types of intervention in order to orient national policies. DFID has suggested that this consultancy be followed up by a steering group led by the Ministry of Health and with the participation of key SETSAN member organisations for this purpose.
- 2) Indicators of acute malnutrition (wasting) and mortality will usually come too late when the crisis is already reaching a high peak. Analyses of populations of the area and elsewhere have shown that wasting is not a sensitive indicator of deteriorating nutritional status in children and that it will reach alarming levels only during very severe crises (UNICEF NIPSA report, May 2003). There is a need to develop indicators and methodologies to better measure at community level processes that indicate when communities' coping mechanisms are being stretched beyond reasonable limits. Coping mechanisms were not studied in any detail during this evaluation, as they would have added considerable complexity to the study.

However, the last vulnerability assessment (VAC 2004) refers that the following activities are manifest amongst the surveyed populations in times of difficulties: selling animals, eating "hunger" plants, passing a day without eating, purchasing food (instead of using what they would usually produce), making loans, changing agricultural practices, and migrating. These responses will vary according to the area and type of households being affected. A qualitative study can clarify the conditions under which these behaviours and others are manifested, and the severity of the stress to which they correspond. A 'coping' index can then be built to classify geographical areas according to the intensity of the stress the families are experiencing. Populations reaching a given level of stress could be put under a blanket ISFP. The same method could then be used to determine when the programme can be terminated. Such a system would be useful when the causes of stress are shared by a large proportion of a given population. When this is not the case, targeting at individual or household levels would be preferred.

- 3) Blanket supplementary feeding appears to be logistically more feasible and culturally more appropriate than targeted supplementary feeding under the circumstances that prevailed during this intervention, where levels of severe wasting were relatively low. The present policy of the Ministry of Health is

consequently supported. Other settings with high prevalences of severe wasting could require more targeted interventions and specialised services for the affected children.

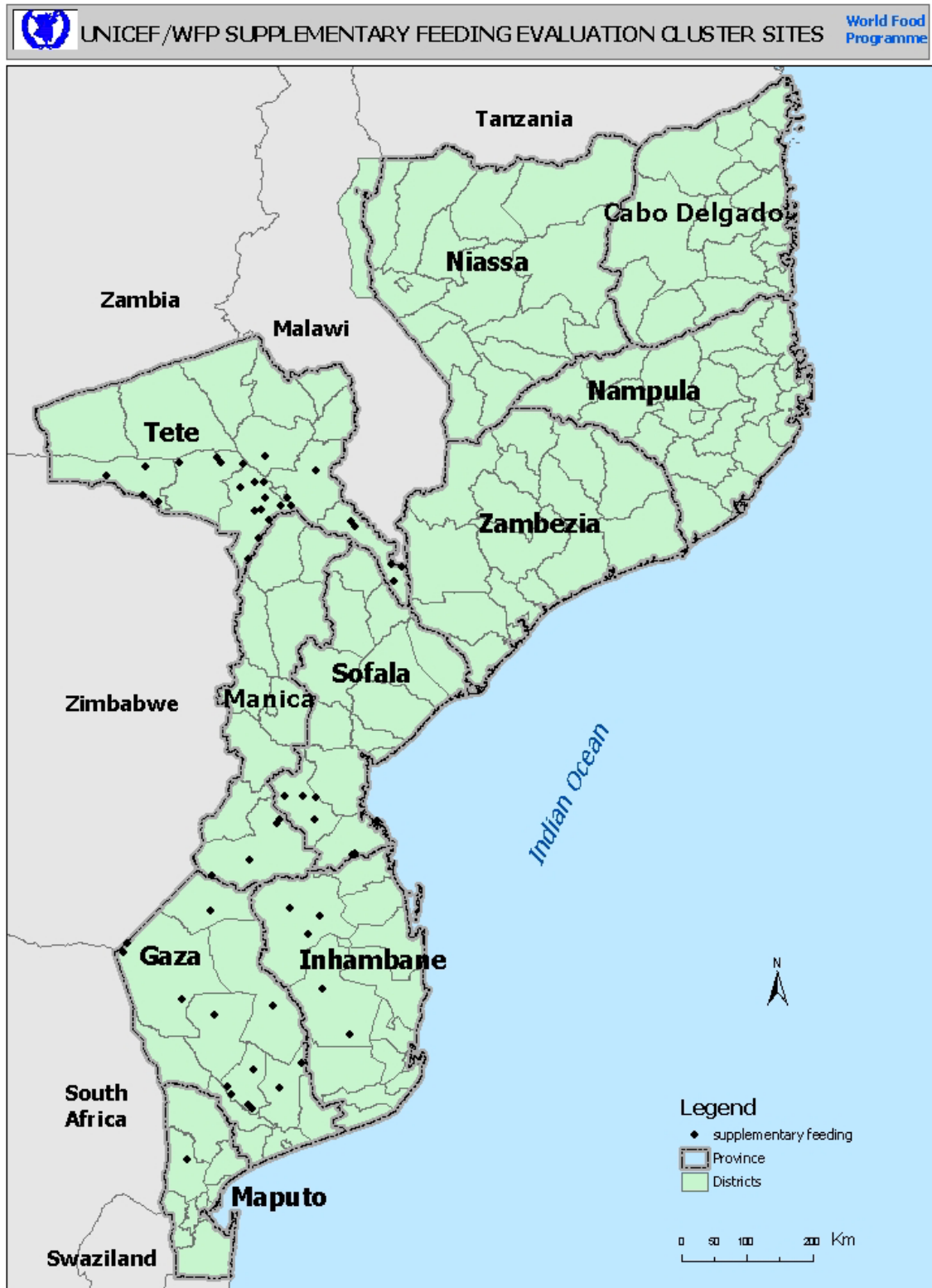
- 4) Many of the communities that were reached by the ISFP were also being targeted during the same period by other types of intervention such as the food-for-work programme of WFP. This was not by accident and contributed to give to the affected communities a complement of interventions to overcome the crisis. It was suggested that, in such cases, one way to reduce the consumption of CSB by other non-eligible members of the family would be to make sure that the other 'ordinary' food products were distributed to the family just before the CSB rations were handed over.
- 5) The inclusion of a water and sanitation component would be most welcome and would make such a programme even more 'integrated'. It should be noted that such a component had originally been planned but could not be implemented due to the non availability of funds.
- 6) The ISFP implementation was generally weak, with only half the target population being reasonably well covered. Future programmes of this kind must better appreciate the magnitude of the task and the capacity of the implementing partners, especially regarding the fact that some rural populations are very thinly spread and difficult to access. Supervision needs to be reinforced and should involve more fully district and local authorities.
- 7) Such programmes would benefit from a more systematic involvement of district level authorities even in the planning phase. While the national and even provincial authorities are usually duly informed and involved at an early stage, this process has generally not scaled down so well to the district level. District administrators could already be involved during negotiations with the relevant NGOs. Beside taking advantage of their knowledge of the district, this would empower them to take a more active role during implementation.
- 8) More care must be taken in paying regularly (and completely) the community workers and providing them with adequate means of transportation. Using community workers with a higher level of schooling could also improve the quality of their work, including the adequate use of participatory education methods. The selection process for community workers would profit from the involvement of the health sector, who often uses trained volunteers during its campaigns.
- 9) The ISFP appears to have had a positive impact in improving the nutritional status of children and reducing mortality when the target populations were reasonably well covered. This impact was measurable even when the ration was shared amongst non-targeted family members and supply was not constant over the period of interest. This is not to say that the CSB was the only factor for such an impact, as it was not possible in this evaluation to identify which components were the most essential. These findings nonetheless could have implications for future similar programmes and suggest that it may be possible to simplify the logistic of distribution of food supplements when other components such a health education have a continuous and prolonged effect.

4.5 The way ahead

- 1) There seems to be a consensus about terminating blanket supplementary feeding at this time while continuing monitoring closely the humanitarian situation of the affected populations. However, WFP is presently considering the appropriateness of establishing a seasonal ‘hunger season’ intervention to support the most vulnerable populations. If such a course of action is shown to be desirable, UNICEF is ready to work in collaboration with WFP to ensure that a suitable array of interventions for the well-being and survival of children and women are part of such a programme.
- 2) The annual VAC will continue to provide information on the vulnerability of the populations of the areas that benefited from the ISFP and others. UNICEF is ready to continue collaborating with the VAC so that it can better monitor the humanitarian situation, covers potential ‘hot spots’ that may not have been well covered in the past (HIV corridors), and includes adequate nutritional and survival indicators for children and women.
- 3) In areas of continuing vulnerability, UNICEF is considering entering into partnership with the Government and NGOs already operating in these areas to deploy long term community based interventions that can contribute to improve child survival, such as increasing outreach of health services through the establishment of monthly health days and the development of community health councils.
- 4) The Ministry of Health is in the process of finalising a National Strategic Plan for Nutrition which will include Government policies for assisting populations in need. Although it is still in a draft form, it proposes to include targeted supplementary feeding for children showing growth faltering, as well as to other ‘children in need of special care’ (crianças de atenção especial), such as those being discharged from nutritional rehabilitation units, HIV positive children and other children in need whose HIV status is unknown. Specific proposals are also currently being elaborated for the care of children with HIV/AIDS. UNICEF is open to the idea of providing support to such programmes as warranted.

ANNEXES

MAP OF SAMPLED CLUSTERS



* Map kindly provided by WFP.

Avaliação do Programa de Suplementação Alimentar – Junho 2004

GUIÃO DOS INQUERIDORES

VERSAO FINAL

POR FAVOR , LEIA ESTE GUIÃO COM MUITO CUIDADO E VÁRIAS
VEZES.

CONSERVE-O CONSIGO SEMPRE DURANTE TODO O INQUÉRITO.

(Baseado no guião do VAC 2003)

INTRODUÇÃO

Este estudo tem por propósito contribuir para a avaliação do programa de suplementação alimentar implementado em área seleccionadas de seis províncias do país (19 distritos) desde Março de 2003. Comporte uma parte qualitativa e uma parte quantitativa. Este guião refere-se principalmente ao inquérito casa-a-casa da parte quantitativa.

Um total de 60 aglomerados tem sido escolhidos ao acaso e são distribuídos em 18 distritos das 6 províncias beneficiadas pelo programa. Um aglomerado é, por exemplo, uma aldeia ou uma parte de uma vila. Em cada um destes aglomerados, serão entrevistados 33 crianças de menos de 5 anos ou um máximo de 45 agregados familiares (casas).

A principal diferença entre este inquérito e o inquérito nutricional tradicional está na sua implementação. Enquanto que o inquérito nutricional apenas considera as crianças entre 6 a 59 meses de idade e não considera os agregados familiares em que este grupo não está representado, aqui todos os agregados familiares são de interesse, independentemente da ausência ou da presença das crianças entre 6 a 59 meses de idade. Por outras palavras, quando chegar a um agregado familiar com ou sem crianças entre 6-59 meses, deve sempre fazer a entrevista.

Encontrará neste guião:

- (i) Informação detalhada sobre a **amostragem**: como seleccionar os agregados familiares a serem entrevistados no aglomerado; quando fechar o aglomerado;
- (ii) Directivas sobre algumas perguntas;
- (iii) Instruções específicas sobre as **medições antropométricas**.

CONTACTO INICIAL

Ao chegar a um local ou aldeia onde se vão efectuar o inquerito, convém primeiro estabelecer contacto com as autoridades locais a fim de explicar o propósito e as modalidades do inquérito, e assegurar a sua colaboração. Se possível, é conveniente fazer este contacto na véspera do próprio inquérito a fim de aumentar as chances de encontrar as pessoas em casa.

AMOSTRAGEM DOS AGREGADOS E DAS CRIANÇAS

Comentário Geral

Os inquéritos utilizam uma metodologia específica, que deve ser seguida com rigor a fim de se obter resultados úteis e fieis. Principalmente, **a amostra feita no início do inquérito nunca deve ser alterada**, isto é, cada aglomerado escolhido faz parte do inquérito e nunca pode ser substituído por outro. Caso fôr impossível para uma equipa implementar o inquérito num dos aglomerados escolhidos, este ficará sem ser feito e não será substituído. O mesmo se aplica aos agregados familiares dentro de cada aglomerado. Um agregado familiar escolhido segundo a metodologia do inquérito nunca pode ser substituído por outro independentemente do motivo. O máximo esforço deve ser feito para implementar o inquérito em todos os aglomerados escolhidos, e dentro de cada aglomerado, incluir cada agregado familiar e cada criança escolhida.

Como seleccionar os agregados familiares (HH) para serem entrevistados, assim que tenha chegado ao aglomerado (aldeia ou parte da vila)?

É necessário seguir a seguinte metodologia de maneira rigorosa. Não se pode alterá-la mesmo que certas casas estejam distantes ou sejam de difícil acesso. Se houver alterações, a amostra deixa de ser representativa da população estudada:

1. Ir ao centro da aldeia ou do bairro.
2. Deixar cair verticalmente uma caneta, ponta para baixo, desde a altura dos olhos até ao chão. Isto tem que ser feito de **uma só vez**. Não se deve repetir. Andar na direcção mostrada pela caneta até ao limite da aldeia ou do bairro, numerando sucessivamente todas as casas que se encontram na linha mostrada pela caneta.
Escolher ao acaso um número entre 1 e o número total de casas utilizando a folha de números aleatórios. Um dos membros da equipa fecha os olhos e toca a folha num ponto ao acaso. Lê-se a cifra mais perto do ponto e a segunda cifra logo à direita da primeira. Se o número indicado fôr "00" ou se fôr maior que o número total de casas, deve ler as duas cifras logo à direita das primeiras duas, e assim sucessivamente até

obter um número válido. Quando se chega ao fim duma linha, passa-se para a outra linha a seguir.

Se as casas fôrem distantes umas das outras, e a distância até ao limite da aldeia fôr muito grande, escolhe-se aleatoriamente um número entre 01 e 10 para determinar a casa onde se começa a trabalhar. A casa que tem o número escolhido é a primeira a ser inquirida.

Vá até à casa escolhida. Explique à família o propósito e a importância do inquérito e peça a sua colaboração. Se a família aceitar colaborar, complete o questionário.

3. Depois de terminar a primeira família, vá até à próxima casa: **aquela cuja porta fica mais perto da porta da casa donde estiver a sair**. Quando terminar esta família, vá uma vez mais até à próxima casa: aquela cuja porta fica mais perto da porta da casa donde estiver a sair (menos as casas já inquiridas). E assim sucessivamente.

Como seleccionar as crianças que devem ser medidas, após ter seleccionado os agregados familiares?

- ♦ Em cada agregado familiar, após ter preenchido a capa do questionário (página 1), deve perguntar o nome de todas as crianças com menos de 5 anos de idade. Logo a seguir, deve pedir o nome de todos os outros membros do agregado familiar, começando pelo chefe da família. Depois, vai preencher os dados de cada criança (páginas 2 e 3) e, a seguir, dos outros membros (páginas 4 e 5). Vai completar o inquérito preenchendo as páginas 6 e 7.

Somente as crianças de 6 a 59 meses vão ser medidas. Se não se conhecer exactamente a idade da criança, deve medir todas as crianças *com menos de 100 cm, excepto os bebês com menos de 6 meses de idade. A única exceção são as crianças deficientes, cujas medições NÃO serão registadas. Se quiser, para evitar que estas crianças se sintam rejeitadas, pode medi-las, mas NÃO escreva estes dados em baixo da pagina 2 ou 3 do questionário. Contudo, todos os outros dados excepto peso e altura devem ser preenchidos.*

Nota: Tenha o cuidado de não incluir a criança que seja visitante, pois ela não faz parte do agregado da família-

Quando parar o inquérito no aglomerado, ou por outras palavras, quando pode considerar o aglomerado como terminado?

Deve fechar o aglomerado, quando tiver atingido a meta de 33 crianças com menos de cinco anos de idade.

Se, depois de ter inquirido já 45 agregados familiares do aglomerado, ainda não tiver atingido a meta de 33 crianças, também DEVE FECHAR o aglomerado.

Por outras palavras, há dois critérios para fechar o aglomerado:

1. Já ter incluído 33 Crianças pelo menos nas Páginas 2 e 3 do questionário,
- OU
2. Já ter inquirido 45 famílias.

O que fazer se.....?

SE após explicar bem, a família recusar-se a colaborar: escreva na primeira página, nas observações “*Recusou*”.

Mas neste caso, tente pelo menos saber se nessa família vive alguma criança menores de 5 anos de idade. Se sim, tente, se possível, obter informações básicas sobre essas crianças (idade, sexo, etc.) assim como sobre os outros membros da família.

Estas crianças não inquiridas FAZEM PARTE das 33 crianças do aglomerado, e esta casa faz parte dos 45 agregados familiares do aglomerado.

SE uma das crianças menores de 5 anos estiver ausente: peça para irem buscá-la se possível, ou vá até onde ela estiver, ou então combine com a família um outro tempo para voltar. Se após suficientes esforços não conseguir ver e medir esta criança, escreva na capa do questionário nas observações “*A criança com o número XX estava Ausente*”. Mesmo se a criança não é medida, tente obter as outras informações sobre esta criança. Pedir para ver o cartão de vacinação. Esta criança também FAZ PARTE das 33 crianças do aglomerado.

SE ninguém estiver numa das casas escolhidas, pode se pedir informações aos vizinhos para saber a localização da família. Tente combinar uma outra altura para voltar ou vá até onde ela estiver. Se após suficientes esforços não conseguir encontrar este agregado, deve mesmo se assim incluir esta casa no inquérito, e escreva na primeira página do questionário,

nas observações “*Ninguém em casa*”.

Pode se pedir informações aos vizinhos para saber se moram aí crianças de 6 a 59 meses, a idade e o sexo de cada uma delas. Tente obter o máximo de informação possível através dos vizinhos, sobre estas crianças.

Nota: Esta situação deve ser considerada uma excepção! Se na sua aldeia, encontrar muitas casas sem os seus habitantes, discuta o assunto com o seu supervisor. Se por exemplo, os habitantes tiverem ido a machamba, é melhor ir procura-los nesse lugar.

SE houver qualquer criança de 6 a 59 meses que não consegue medir, é importante preencher o máximo possível a folha (página 2 ou 3), com as outras informações pedidas.

Esta criança também FAZ PARTE das 33 crianças do aglomerado mesmo se não fôr medida! Escreva na capa do questionário a observação “*A criança com o número XX, não pôde ser medida pelas seguintes razões...*” Por exemplo: Se a criança estiver muito doente ou muito agitada ou se a mãe recusar que seja medida,..

DIRECTIVAS SOBRE CADA PERGUNTA

O questionário deve sempre ser preenchido a lápis, a fim de se poder fazer correções quando necessário.

PÁGINA 1

1. Preencha com cuidado toda a informação administrative solicitada:
 - ♦ Província, distrito, localidade, aldeia
 - ♦ Data
 - ♦ Número da equipa.

2. Escreva o número do aglomerado. Como este inquérito abrange um máximo de 60 aglomerados, este número NUNCA pode exceder a 60. **TODOS OS AGLOMERADOS JÁ TÊM OS SEUS NÚMEROS DE IDENTIFICAÇÃO.** Pergunte-o ao seu supervisor. Note que este mesmo número do aglomerado tem de ser registado cuidadosamente, em cada questionário preenchido no contexto do aglomerado. **Por outras palavras, todas as famílias visitadas num aglomerado, devem ABSOLUTAMENTE compartilhar o mesmo número do aglomerado.**

3. Escreva o número do **agregado familiar**. De facto, cada um dos agregados familiares visitados receberá um número de identificação dentro do aglomerado. Isto significa que o primeiro agregado visitado terá o número 01, o Segundo o número 02, etc, até um máximo de 45. Como de qualquer modo o aglomerado nunca vai considerar mais do que 45 agregados familiares (mesmo que a meta de 33 crianças menores de 5 anos de idade não tenha sido atingida), este número NÃO PODE exceder 45.

4. Observações: Por favor, indique aqui todas as observações, que achar relevantes para a interpretação dos dados colectados.

PÁGINAS 2 e SEGUINTEs

- ♦ Em cada agregado familiar, após ter preenchido a capa do questionário (página 1), deve perguntar o nome de todas as crianças com menos de 5 anos de idade. Logo a seguir, deve pedir o nome de todos os outros membros do agregado familiar, começando pelo chefe da família. Depois, vai preencher os dados de cada criança (páginas 2 e 3) e, a seguir, dos outros membros (páginas 4 e 5). Vai completar o inquérito preenchendo as páginas 6 e 7.

!!! Por favor siga as seguintes definições de caso !!!

Agregado familiar: É uma ou mais pessoas ligadas ou não por laços de parentesco que vivem na mesma casa, comem juntas e compartilham a maior parte das despesas da casa.

Chefe do agregado: é o que lida diariamente com a gestão do agregado familiar, que toma as decisões numa base diária. Note que neste caso, um trabalhador emigrante NÃO PODE ser considerado como o Chefe de família, embora possa ser apresentado pelo entrevistado como tal, se fôr o pai da família. Tenha o cuidado de FAZER A PERGUNTA CORRECTAMENTE.

Membro do agregado: É o individuo que vive habitualmente no agregado familiar, presente ou ausente na altura do inquérito.

CUIDADO:

Os empregados que estejam a ocupar dependências ou quartos são considerados membros do agregados.

O trabalhador emigrante não é considerado como membro do agregado.

Os inquilinos que estejam a ocupar dependências ou quartos são considerados membros do agregados somente se comem com a família. Senão, constituem um aglomerado independente (que deve também ser inquerido).

DATA DE NASCIMENTO DA CRIANÇA

Esta é a data de nascimento da criança a ser inquerida. Deve pedir para ver o cartão de saúde da criança e copiar a data de nascimento ali indicada. Se a criança não tiver cartão de saúde, escreva a data de nascimento que a mãe ou um outro membro da família indicar. Se não saber o dia exacto, pelo menos tenta identificar o mês e o ano de nascimento, ajudado, se necessário, pelo calendário. Se não consegue

identificar o mês de nascimento, pelo menos tenta indicar o ano de nascimento.

3.3.1 Secção C Antropometria

17 PESO

Escreva aqui o peso da criança com 0.1 kg de precisão (por exemplo: 12.6, 08.1, 15.0). Se o peso em kg fôr exacto (sem decimais), escreva um "0" no espaço após o ponto.

Se a criança não tiver sido pesada, deixe este quadrado **em branco**, e indique o porquê na seccão de observações da primeira pagina.

18 ALTURA / COMPRIMENTO

Escreva aqui o comprimento/ a altura da criança com 0.1 cm de precisão (por exemplo: 115.3, 098.2, 123.0). Se o comprimento em cm fôr exacto (sem decimais), escreva um "0" no espaço após o ponto.

Se a criança não tiver sido medida, deixe este quadrado **em branco** e indique as razões na seccão de observações da primeira página.

19 EDEMA

Escreva "+" se a criança tiver edema, "--" se a criança não tiver edema, "?" se não sabe se a criança tem ou não tem edema.

Técnicas de Medição para a Antropometria

TÉCNICAS DE MEDIÇÃO

É necessário seguir as técnicas de medição rigorosamente. É fácil fazer erros, mesmo quando uma pessoa tem experiência. Por isto é necessário ter muita concentração quando fizer as medições. A medição do comprimento/altura é particularmente sensível, e uma pequena diferença pode resultar numa classificação errada da criança.

Peso

1. Pendurar a balança de maneira que ela fique ao nível dos olhos da pessoa que vai fazer a leitura.
2. Pendurar a calça à balança e ajustar o zero. Retirar a calça da balança.

3. Passa os seus braços através dos buracos de perna da calça. Com assistência da mãe, apanha os pés da criança e puxa-los pelos buracos de perna da calça. Uma alça da calça deve ficar por frente da criança e a outra por trás.
4. Pendura a criança à balança com ajuda da mãe. Nunca se deve carregar a criança somente pelas alças da calça. Deixar gradualmente a criança pendurada à balança.
5. Quando a criança estiver completamente solta, pega a balança e, logo que o ponteiro da balança tiver parado de mexer, diz em voz alta o peso com 0.1 kg de precisão (por exemplo: 12 vírgula 7 kilos).
6. O assistente logo escreve a lápis o peso na folha de registo.
7. Tire a criança da balança com ajuda da mãe. Nunca se deve carregar a criança somente pelas alças da calça.
8. O assistente mostra imediatamente a folha de registo à pessoa que tomou o peso para confirmar.

Comprimento (criança deitada)

Para as crianças com menos de 2 anos de idade (ou, se não se sabe exactamente a idade, com menos de 85 cm de comprimento).

1. Coloca o altímetro horizontalmente no chão num lugar plano (ou em cima duma mesa sólida).
2. A mãe deve descalçar a criança e, se necessário, tirar o que tiver na cabeça podendo dificultar uma boa medição.
3. O assistente ajoelha-se no chão e fica com os joelhos perto da base do altímetro. Deve colocar a folha de registo e o lápis por perto.
4. A pessoa que faz a medição ajoelha-se no chão do lado direito da criança de maneira a poder pegar a tábua do altímetro com a mão direita.
5. Com a ajuda da mãe, deitar gradualmente a criança em cima do altímetro, cabeça em direcção da base do altímetro. A mãe deve ficar por perto para acalmar a criança.
6. O assistente coloca uma mão de cada lado da cabeça da criança, aplica a cabeça da criança contra a base do altímetro e endireita a cabeça da criança para que a sua linha de visão ficasse directamente para cima. O assistente deve olhar directamente nos olhos da criança.
7. A pessoa que faz a medição deve verificar que o corpo da criança está bem contra o altímetro e bem centrado. Coloca a mão esquerda em cima dos joelhos da criança e faz pressão firme contra o altímetro. Com a mão

direita, coloca firmemente a tábua do altímetro contra os calcanhares da criança. A planta dos pés deve ser bem vertical.

8. Quando se tem certeza que a posição da criança é correcta, a pessoa que faz a medição lê em voz alta o comprimento com 0.1 cm de precisão (por exemplo: 23 vírgula 6 centímetros).
9. O assistente larga a criança e logo escreve a lápis o comprimento na folha de registo.
10. O assistente mostra imediatamente a folha de registo à pessoa que fez a medição para confirmar.

Altura (criança em pé)

Para as crianças entre 24 e 59 meses de idade (ou, se não se sabe a idade, com menos de 100 mas com 85 cm de comprimento ou mais).

1. Coloca o altímetro verticalmente num lugar plano contra uma parede, uma mesa ou uma árvore, até ficar bem seguro.
2. A mãe deve descalçar a criança e, se necessário, tirar o que tiver na cabeça podendo dificultar uma boa medição.
3. O assistente coloca a folha de registo no chão em frente do altímetro, ajuda a criança a ficar em pé na base do altímetro, e ajoelha-se no chão do lado direito da criança.
4. A pessoa que faz a medição coloca-se do lado esquerdo da criança, pondo o joelho esquerdo no chão.
5. O assistente coloca os pés da criança juntos bem contra a base do altímetro e bem no centro. Coloca a mão direita contra as pernas da criança acima dos tornozelos. Coloca a mão esquerda contra os joelhos da criança fazendo pressão firme contra o altímetro. Verifica que as pernas da criança são rectas, que os calcanhares são contra a base do altímetro e diz “pronto”.
6. A pessoa que faz a medição pede à criança para olhar em frente para ele; certifica que a linha de visão da criança está bem horizontal; coloca a mão esquerda no queixo da criança (sem cobrir a boca nem as orelhas); verifica que os ombros da criança são ao mesmo nível, que os braços pendem de cada lado, e que o corpo da criança (cabeça, ombros, nádegas, calcanhares) está bem contra o altímetro.
7. Com a mão direita, faz descer a tábua do altímetro contra a cabeça da criança, cuidando de bem aplanar os cabelos em cima da cabeça.

8. Quando se tem certeza que a posição da criança esta correcta, a pessoa que faz a medição lê em voz alta a altura com 0.1 cm de precisão (por exemplo: 87 vírgula 0 centímetros).
O assistente larga a criança e logo escreve a lápis a altura na folha de registo.
9. O assistente mostra imediatamente a folha de registo à pessoa que fez a medição para confirmar.

HOUSEHOLD QUESTIONNAIRE

Avaliação do projecto de Suplementação Alimentar Junho 2004

Província: _____

Distrito: _____

Data: de Junho de 2004

P. Adminin.: _____

Aldeia: _____

Equipa no:

N° AGLOMERADO

N° AGREGADO FAMILIAR

No. de crianças < 5 anos
neste agregado familiar:

01 - 60

PARA O SUPERVISOR:

Nome do supervisor:

Este questionário:

-- É completo

-- Precisa completar

-- Precisa corrigir

-- Fica incompleto

1a

2a

3a

DIRECÇÕES PARA SEGUNDA VISITA:

Comentários do supervisor:

OBSERVAÇÕES:

Assinatura do supervisor:

PARA TODAS AS CRIANÇAS COM MENOS DE CINCO ANOS													
Escreve o nome de cada criança que reside habitualmente neste agregado familiar:													
1	1.....			2.....			3.....						
2	Perguntar à mãe se o [NOME] tem cartão de saúde? (pede ver o cartão)												
	<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?						
3	Qual é a data de nascimento do [NOME]?												
	dd mm aa			dd mm aa			dd mm aa						
	data nascimento			data nascimento			data nascimento						
4	O [NOME] é do SEXO?												
	<input type="checkbox"/> M_F_?			<input type="checkbox"/> M_F_?			<input type="checkbox"/> M_F_?						
5	O [NOME] é REGISTADO para receber CSB (soya)?												
	<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?						
6	O [NOME] AMAMENTOU até quantos meses?												
	0=nunca, 88=ainda, 99=n/s			0=nunca, 88=ainda, 99=n/s			0=nunca, 88=ainda, 99=n/s						
7	O [NOME] teve FEBRE alguma vez durante as duas últimas semanas?												
	<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?						
8	O [NOME] teve DIARREIA alguma vez durante as duas últimas semanas?												
	<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?						
Se não tiver tido diarreia, vai para a pergunta 13.													
9	Durante a diarreia, deu ao [NOME] menos LÍQUIDOS de que o costume, o mesmo, ou mais?												
	0=nada			0=3_9			0=3_9			0=3_9			
10	Durante a diarreia, deu ao [NOME] menos COMIDA de que o costume, o mesmo, ou mais?												
	1=menos			0=3_9			0=3_9			0=3_9			
	2=mesmo			0=3_9			0=3_9			0=3_9			
11	Durante a diarreia, deu de AMAMENTAR ao [NOME] menos de que o costume, o mesmo, ou mais?												
	3=mais			0=3_9			0=3_9			0=3_9			
	9=n/s			0=3_9			0=3_9			0=3_9			
12	Durante a diarreia, deu ao [NOME] solução oral?												
	<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?			<input type="checkbox"/> S_N_?						
13	O [NOME] foi medido no braço quantas vezes desde Março de 2003?												
	0=nunca, 99=n/s			0=nunca, 99=n/s			0=nunca, 99=n/s						
14	O [NOME] recebeu VITAMINA A desde Março de 2003?												
	mm aa			mm aa			mm aa						
	última dose (01/01=nunca)			última dose (01/01=nunca)			última dose (01/01=nunca)						
15	O [NOME] recebeu MEBENDAZOLE desde Março de 2003?												
	mm aa			mm aa			mm aa						
	última dose (01/01=nunca)			última dose (01/01=nunca)			última dose (01/01=nunca)						
16	ESCREVE TODOS OS PESOS REGISTRADOS NO CARTÃO DE SAÚDE DESDE JANEIRO DE 2003:												
01.03	. kg	10.03	. kg	01.03	. kg	10.03	. kg	01.03	. kg	10.03	. kg	01.03	. kg
02.03	. kg	11.03	. kg	02.03	. kg	11.03	. kg	02.03	. kg	11.03	. kg	02.03	. kg
03.03	. kg	12.03	. kg	03.03	. kg	12.03	. kg	03.03	. kg	12.03	. kg	03.03	. kg
04.03	. kg	01.04	. kg	04.03	. kg	01.04	. kg	04.03	. kg	01.04	. kg	04.03	. kg
05.03	. kg	02.04	. kg	05.03	. kg	02.04	. kg	05.03	. kg	02.04	. kg	05.03	. kg
06.03	. kg	03.04	. kg	06.03	. kg	03.04	. kg	06.03	. kg	03.04	. kg	06.03	. kg
07.03	. kg	04.04	. kg	07.03	. kg	04.04	. kg	07.03	. kg	04.04	. kg	07.03	. kg
08.03	. kg	05.04	. kg	08.03	. kg	05.04	. kg	08.03	. kg	05.04	. kg	08.03	. kg
09.03	. kg	06.04	. kg	09.03	. kg	06.04	. kg	09.03	. kg	06.04	. kg	09.03	. kg
17	PESO CRIANÇAS DE 6-59 MESES			PESO			PESO			PESO			
	. kg			. kg			. kg			. kg			
18	ALTURA			ALTURA			ALTURA			ALTURA			
	. cm			. cm			. cm			. cm			
19	EDEMA BILATERAL			EDEMA BILATERAL			EDEMA BILATERAL			EDEMA BILATERAL			
	--+_?			--+_?			--+_?			--+_?			

* page 3 is continuation of page 2 for three more children

PARA TODAS AS PESSOAS COM 5 ANOS E MAIS											
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	1-Chefe	2	3	4	5	6	7	8	9	10	
	20. Quantos anos completou o [NOME] no seu ultimo aniversario?										
IDADE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
ANO	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
GRUPO	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	1 [5-17]		2 [18-59]		3 [60+]						
	21. O [NOME] é do sexo?										
M/F/ ?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	22. O [NOME] é registado para receber CSB (soya)?										
S/N/ ?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	23. O [NOME] está grávida?					SÓ PARA MULHERES DE 12 ANOS E MAIS					
S/N/ ?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	24. Se sim, de quantos meses?										
MESES	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Escreva os nomes de todas as pessoas que normamente vivem e comem juntas neste agregado

Preencher SÓ UM destes :
 IDADE em ANOS COMPLETOS
 ANO DO NASCIMENTO
 GRUPO ETÁRIO

* page 5 is continuation of page 4 for ten more household members

MORTALIDADE25. Nos últimos três meses, alguém faleceu neste agregado? S_N_?**26. SE SIM, preenche o quadro?**

Grupos etários:

1= 00 - 04 anos

2= 05 - 14 anos

3= 15 - 49 anos

4= 50+ anos

Sexo	IDADE (preencher só uma coluna)			Estava doente por mais de 3 meses ? S_N_?
	M/F/?	IDADE	ANO NASCIM.	
A				
B				
C				
D				
E				

CSB27. Fez-se distribuição de CSB (soya) nesta aldeia desde Março de 2003? S_N_?**SE NÃO houve distribuição de CSB, vai para a pergunta 38.**28. Quantas pessoas foram registadas para receber CSB (soya) neste agregado? pessoas**SE NINGUÉM foi registado para CSB, vai para a pergunta 37.**

29. Quando é que receberam CSB (soya) pela PRIMERIA VEZ desde Março de 2003?

mm aa

SE NUNCA RECEBEU CSB, vai para a pergunta 37.

(01/01=nunca, 09/09=n/s)

30. Que quantidade de CSB (soya) receberam naquela PRIMERIA VEZ? kg

mm aa

31. Quando é que receberam CSB (soya) pela ÚLTIMA VEZ desde Março de 2003?

mm aa

(01/01=uma só vez, 09/09=n/s)

32. Que quantidade de CSB (soya) receberam naquela ÚLTIMA VEZ? kg (0=não houve segunda vez)33. Quantas vezes no total receberam CSB (soya) desde Março de 2003? vezes (99=n/s)

34. Quem comeu CSB (soya) neste agregado?

NÃO LER as respostas**Marcar todas respostas dadas**

- | | | |
|---|--------------------------|--------------------------------------------------------------|
| A | <input type="checkbox"/> | O grupo alvo (crianças <5 anos, mulheres grávidas/lactantes) |
| B | <input type="checkbox"/> | Crianças de 5 anos e mais, e jovens <15 anos |
| C | <input type="checkbox"/> | Adultos fora do grupo alvo com 15 anos ou mais |
| D | <input type="checkbox"/> | Ninguém |
| E | <input type="checkbox"/> | Não sabe |

35. Venderam o CSB (soya)? S_N_?**36. SE SIM, porque?**37. Quanto tempo leva para andar até o ponto de distribuição do CSB (soya)? hh mm (09/09=n/s)

EDUCAÇÃO PARTICIPATIVA

38. Alguém neste agregado participou em reuniões de educação participativa (com imagens) desde Março de 2003?

S_N_?

39. **SE SIM, quantas?** reuniões (99=n/s)

Se possível, fazer as restantes perguntas para uma mulher do agregado que tem crianças <5 anos. Senão, fazer a uma outra pessoa que cuida das crianças, ou outra.

40. O entrevistado é uma mulher com crianças <5 anos? S_N_?

41. O entrevistado participou em reuniões de educação participativa (com imagens)?

S_N_?

42. **SE SIM, de que assuntos falaram?**

NÃO LER as respostas

Marcar todas as respostas dadas

A	<input type="checkbox"/>	DIARREIA: como se APANHA
B	<input type="checkbox"/>	DIARREIA: como PREVENIR
C	<input type="checkbox"/>	DIARREIA: como TRATAR
D	<input type="checkbox"/>	Higiene: importância de LAVAR AS MÃOS, os pratos, etc.
E	<input type="checkbox"/>	Higiene: importância de FERVER ÁGUA
F	<input type="checkbox"/>	Higiene: importância de USAR LATRINA, ou enterrar fezes
G	<input type="checkbox"/>	Higiene: importância de ENCURLALAR OS ANIMAIS domésticos
H	<input type="checkbox"/>	Alimentação: dar somente o PEITO ATÉ 4 A 6 MESES
I	<input type="checkbox"/>	Alimentação: como preparar PAPAS EQUILIBRADAS para as crianças
J	<input type="checkbox"/>	Alimentação: preparar PEQUENAS QUANTIDADES de papa de cada vez
K	<input type="checkbox"/>	Alimentação: dar VÁRIAS PEQUENAS REFEIÇÕES para a criança
L	<input type="checkbox"/>	Alimentação: como ALIMENTAR UMA CRIANÇA DOENTE
M	<input type="checkbox"/>	CSB: como PREPARAR O CSB (soya)
N	<input type="checkbox"/>	Outro:
O	<input type="checkbox"/>	Outro:
P	<input type="checkbox"/>	Outro:
Q	<input type="checkbox"/>	Não se lembra / Não sabe

43. Durante quantos meses deve uma criança tomar somente o peito da mãe sem mais nada?

meses
(99=n/s)

44. Quantas refeições por dia deve uma criança de 6 meses tomar, se tiver possibilidade?

refeições
(99=n/s)

NÃO ESQUECE DE MEDIR TODAS AS CRIANÇAS DE 6-59 MESES.

PROGRAMA DE DISTRIBUIÇÃO SUPLEMENTAR DE ALIMENTOS
AVALIAÇÃO QUALITATIVA
GUIÃO DE ENTREVISTA PROFUNDA INDIVIDUAL
LÍDER COMUNITÁRIO

Introdução:

- Saudação
- Apresentação dos pesquisadores (Nomes)
- Explicação das características e objectivos da pesquisa (estamos a fazer um trabalho para a UNICEF...)
- Recolha de dados pessoais do líder.
- Informação sobre a duração do encontro (45 minutos).
- Identificação do local.

Distrito _____ Posto Administrativo _____ Localidade _____ Aldeia _____

1. Nome do pesquisador (a) _____ Função durante a entrevista _____

2. Nome do pesquisador (a) _____ Função durante a entrevista _____

Data da entrevista ____/____/____ Duração: Início _____ fim _____

Observações _____

Controle do Supervisor _____

Dados biográficos do (a) entrevistado (a)

Nome	Estado civil	Idade	Função

Conhecimento do programa e das actividades

1. Esta comunidade já beneficiou de algum programa de saúde? Que tipo?
2. Quem o implementou?
3. A quais faixas populacionais era dirigido?
4. Como faziam a identificação e selecção dos beneficiários?
5. Que tipos de acções foram desenvolvidas?
6. Quais foram os objectivos do programa?

Implementação e efeitos do programa

7. Tiveram alguma dificuldade ao longo do programa? De que tipo?
8. Como foi o relacionamento entre os líderes, activistas e as ONGs durante as varias fases do programa?
9. Pensa que o programa foi bem implementado? Porque?
10. Em que medida acha que trouxe beneficios para a população?
11. Em que medida acha que a população, as mães em particular, adquiriram conhecimentos?
12. Reconhece alguns sinais de mudança de comportamento entre a população em relação a:
 - Cuidados de higiene pessoal
 - Manuseamento e confecção de alimentos
 - Conservação e consumo da água
13. Quais recomendações tem para melhorar o programa e como pensa que deveriam ser realizados outros programas similares?

Terminamos: Muito obrigado!

PROGRAMA DE DISTRIBUIÇÃO SUPLEMENTAR DE ALIMENTOS
AVALIAÇÃO QUALITATIVA
GUIÃO DE ENTREVISTA PROFUNDA INDIVIDUAL
ACTIVISTA

Introdução:

- Saudação
- Apresentação dos pesquisadores (Nome)
- Explicação das características e objectivos da pesquisa (estamos a fazer um trabalho para a UNICEF...)
- Recolha de dados pessoais do activista.
- Informação sobre a duração do encontro (1 hora).
- Identificação do local.

Distrito _____ Posto Administrativo _____ Localidade _____ Aldeia _____

1. Nome do pesquisador (a) _____ Função durante a entrevista _____

2. Nome do pesquisador (a) _____ Função durante a entrevista _____

Data da entrevista ____/____/____ Duração: Início _____ fim _____

Observações _____

Controle do Supervisor _____

Dados biográficos do (a) entrevistado (a)

Nome	Estado civil	Idade	Função

Seleção e formação do activista

1. Participou no programa como activista, poderia descrever as suas principais actividades?
2. Participou em todas as fases? Quais?
3. Trabalhou na área onde tem residência?
4. Como foi recrutado? Que tipo de contrato tinha?
5. Teve que fazer algum curso? Quem o organizou e como era estruturado?
6. Quais eram os conteúdos da educação participativa?
7. Como foi o seu relacionamento com os líderes comunitários e as ONGs implementadoras do programa?
8. Quais foram as principais dificuldades relacionadas com o recrutamento e a sua formação?

Implementação do programa

9. Acha que o programa foi bem implementado? Porque?
10. De que forma os activistas conseguiram envolver a comunidade?
11. Acha que a metodologia participativa foi útil e porquê? Qual foi a aceitação da população?
12. Quais foram os problemas encontrados na formação participativa da população?
13. Como foi o seu relacionamento com os beneficiários?
14. Em que medida acha que o programa trouxe benefícios para a população?
15. Os que receberam algum benefício foram as pessoas identificadas e registadas?
16. Pensa que a distribuição de alimentos e medicamentos foi eficaz e abrangente?
17. Que recomendações tem para a implementação de futuros programas?

Terminamos: Muito obrigado!

PROGRAMA DE DISTRIBUIÇÃO SUPLEMENTAR DE ALIMENTOS
AVALIAÇÃO QUALITATIVA
GUIÃO DE ENTREVISTA SEMI-ESTRUTURADA

GRUPO DE MULHERES

Introdução:

- Saudação
- Apresentação da equipa (Nomes)
- Explicação das características e objectivos da pesquisa (estamos a fazer um trabalho para a UNICEF...)
- Solicitação da colaboração de todas as participantes na discussão (dizendo que todas as informações e opiniões são úteis e serão consideradas).
- Recolha de dados pessoais de cada uma das participantes.
- Informação sobre a duração do encontro (cerca de duas horas).
- Identificação do local.

Distrito _____ Posto Administrativo _____ Localidade _____ Aldeia _____

1. Nome do pesquisador (a) _____ Função durante a entrevista _____

2. Nome do pesquisador (a) _____ Função durante a entrevista _____

3. Nome do pesquisador (a) _____ Função durante a entrevista _____

Data da entrevista ____/____/____ Duração: Início _____ fim _____

Observações _____

Controle do Supervisor _____

Dados biográficos das entrevistadas

Nome	Estado civil Tipo casamento	Idade	Está grávida: sim não	N. ° filhos total	Dos 0 à 6 meses	Dos 7 meses à 5 anos	Actividades
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Mulheres

Educação participativa

1. Participaram em cursos, actividades, seminarios sobre saúde e nutrição?
2. Quem organizou e quais foram os conteúdos?
3. Como foi o vosso relacionamento com os activistas?
4. A forma de comunicar usada pelos activistas foi eficaz? Porque?
5. (Se foi no âmbito do PSA) Qual são as vossas opiniões e sugestões sobre o seu funcionamento?

Conhecimentos sobre higiene, alimentação e saúde

6. Quais as doenças infantis mais comuns nesta área?
7. Conhecem quais são as causas da diarreia? Como se transmite?
8. Como se previne?
9. Acham que a diarreia tem cura?
10. O que costumam fazer quando as vossas crianças têm diarreia? (dar mais agua, dar menos de beber).
11. Quais os alimentos considerados bons e maus para a criança com diarreia?
12. Conhecem algum tratamento tradicional para diarreia? Qual é e como se processa?
13. Onde costumam ir quando as vossas crianças têm problemas de diarreia ou outras doenças?
14. Já ouviu falar de sais de rehidratação oral (SRO)? Para que servem?
15. Já ouviu falar de mebendazol? Como/Onde?
16. Já fez uso disso? Em que circunstancias?
17. Quais são os principais alimentos produzidos nesta zona?
18. Existem alguns alimentos que fazem mal à mulher, ao homem e às crianças? Quais, em quais circunstâncias e porque?
19. Durante quanto tempo as mães amamentam?
20. Quando é que uma mãe deveria acabar de amamentar e começar a dar outra comida para criança?
21. Em casa tem diferenças na alimentação dos adultos e das crianças?
22. O que comem, quanto e com qual frequência as vossas crianças? (verificar de acordo com as idades)
23. Já receberam algum beneficio alimentar ou de outro tipo por parte de alguma organização ou instituição? O que receberam?
24. Como e porque receberam tal beneficio?
25. Como utilizaram o que receberam? Venderam ou trocaram alguma coisa? Porque?
26. Os alimentos recebidos integraram ou foram a parte fundamental da vossa dieta alimentar quotidiana?
27. Os alimentos recebidos alteraram os hábitos alimentares seus ou da sua família?

Terminamos. Muito Obrigado!

