



SECOND TREND SURVEY REPORT

2ND DRAFT

MAZIKO PROJECT (NUTRITION FOUNDATIONS FOR MOTHERS AND CHILDREN)

SUBMITTED TO CARE INTERNATIONAL MALAWI
LILONGWE

JUNE 2, 2014

*By: Centre for Public Health Policy Research and Development, P.O. Box 31186,
Capital City, Lilongwe 3, Malawi. Tel: +265 881 209 306 E-mail:
centre.publichealth@yahoo.com*

Table of Contents

EXECUTIVE SUMMARY	4
ACKNOWLEDGEMENT	5
ACRONYMS.....	6
1.0 INTRODUCTION	8
1.1 Survey Rationale	10
1.2 Aim of the Survey	11
1.3 Survey Objectives.....	11
2.0 MATERIALS AND METHODS	12
2.1 Study Design.....	12
2.2 Sampling Design.....	12
2.3 Sample Size Calculation	12
2.3 Adaptation of the Survey Questionnaire	13
2.4 Qualitative Data Collection Methods	14
2.5 Recruitment and Training of Research Assistants.....	14
2.6 Data Collection	14
2.7 Data Entry, Processing and Analysis.....	15
2.8 Approach to Qualitative Data Analysis including Gender Analysis	15
3.0 RESULTS AND DISCUSSION	16
3.1 Social Economic Characteristics of Respondents.....	16
3.2 Social Empowerment and Women Participation	23
3.3 Women’s influence in decision making	25
3.4 Access to Nutrition and Health Services	27
3.5 Water, Hygiene and Sanitation.....	32
3.6 Childhood Illnesses	39
3.7 Under-five Growth Monitoring	42
3.8 Usage of Mosquito Nets.....	43
4.0 HOUSEHOLD DIETARY DIVERSIFICATION	44
4.1 Infant and young child feeding.....	44
4.2 Initiation of Breastfeeding.....	47
4.3 Women Dietary Diversification	48

5.0	CONCLUSION.....	50
6.0	RECOMMENDATIONS	51
7.0	References.....	54
8.0	APPENDICES	56
	Appendix 1 Household Questionnaire for MAZIKO Trend Survey.....	56
	Appendix 2 Focus Group Discussions Guidelines	85
	Appendix 3 Key Informants Interviews	93
	Appendix A: Key Nutrition Results, IYCF, Definitions& Calculationsns	102
	Appendix B: Frequency Table: Household Demographics and Livelihood Characteristics	118

EXECUTIVE SUMMARY

This report presents results of the 2014 second trend survey carried out by CARE Malawi, in March, 2014. The report is the source of information of outcome indicators for children, lactating and pregnant mothers' wellbeing which include health, nutrition, water and sanitation gender and social empowerment. In addition to presenting values for the specific indicators CARE Malawi values the report because it provides valuable information on the status of its activities on women and children in term of access to basic needs such as food, nutrition and health. The report also reveals the progress made over the two years towards the contribution of MAZIKO to the wellbeing of children and caregivers in Kasungu and Dowa.

This report is a product of consultations and dialogue with Kasungu and Dowa project staff, stakeholders such as the community at large, community leaders, government staff and other development partners. The report is also an analysis of both qualitative and quantitative data gathered from the communities and key partners. In order to validate the findings and present a comparative analysis, secondary data and key informant interviews were used before and after the survey and during compilation of the report.

The report is mostly for internal use to help program managers identify implementation gaps and help in strategic decision making for improvement and/or lessons learned externally can be disseminated to partner stakeholders. Data used in this report was collected and analyzed by consultants from Centre for Public Health Policy, Research and Development using strict research protocols. The information can then be used to compare development progress to the end-line of the project implementation.

Malnutrition is manifested directly from dietary intake and infections. The results show that, minimum dietary diversification for infants (6-23 months) and women are 32.1% and 24.7% respectively. Diarrhoea, Malaria and pneumonia prevalence for infants two weeks prior to the survey was 26.8%, 39.1% and 30.4% respectively. It was further revealed that 68.9% get their drinking water from a borehole with a pump and 83.8% can get this water in a distance of less than 30 minutes. Only 10.1 % of the households boil the water for drinking and 18.5 % chlorinates the water making it safe for drinking. The survey also revealed community needs proper sensitization on the child caring practices and nutrition education needs to be intensified and the activities need to target attitude and behaviour change. The community need to understand health, nutrition and women empowerment issues and how they relate to the development interventions in the area.

In conclusion, the lofty cases of childhood illnesses, current food security status and social wellbeing, safe water, hygiene and sanitation situation would not reverse long term effects of malnutrition unless improvements are ensured. MAZIKO project have imparted adequate knowledge on nutrition, health and sanitation issues. More efforts are needed on gender and women empowerment to enforce decision making and positively impact on behaviour and

attitude change on the core MAZIKO philosophy, i.e., activities implemented in the communities.

ACKNOWLEDGEMENT

The Trend Survey was a collaborative effort between CARE Malawi, Canada and USA staff which worked with the Consulting Firm, Centre for Public Health Policy, Research and Development (CPHPRD), to plan and implement the survey as well as to prepare a report.

Appreciations go to the survey team members for competently assisting in revision of the survey instruments, training and leading both qualitative and quantitative data collection in districts and reviewing the report.

Many thanks also go to all the informants and the communities in Dowa and Kasungu for their willingness to provide valuable information and guidance, without which, this survey would not have been possible.

We cannot resist mentioning Lucy Chiyenda, MAZIKO Project Manager, Joseph Maulana, M&E Specialist and the field staff in Dowa and Kasungu districts for their technical and administrative support for the process during the entire period of the survey.

We would like to finally thank Canadian Department of Foreign Affairs and Development (DFATD), formerly known as CIDA, for the financial support without which the survey could not have been successful.

ACRONYMS

ADC	Area Development Committee
ANC	Antenatal Care
ART	Anti-retroviral Therapy
CBCC	Community Based Childcare Centers
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CMAM	Community Management of Acute Malnutrition
CMR	Child Mortality Rate
CONGOMA	Council for Non-Governmental Organizations
CPHPRD	Centre for Public Health Policy, Research and Development
CSC	Community Score Card
CSO	Civil Society Organization
CTC	Community Therapeutic Care
DHO	District Health Office(r)
DHS	Demographic Health Survey
DNHA	Department of Nutrition, HIV and AIDS
EBF	Exclusive Breast Feeding
FGD	Focus Group Discussion
GoM	Government of Malawi
HDD	Household Dietary Diversity
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
I-LIFE	Improving Livelihoods Through increased Food Security

IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
MAD	Minimum Acceptable Diet
MAICC	Mponela AIDS Information Counselling Centre
MDD	Minimum Dietary Diversity
MDG	Millennium Development Goal
MDHS	Malawi Demographic Health Survey
MoGCWS	Ministry of Gender Child Welfare and Community Services
MoH	Ministry of Health
MMF	Minimum Meal Frequency
MNNPSP	Malawi National Nutrition Policy and strategic Plan
NGO	Non Government Organization
OPC	Office of the President and Cabinet
PHAST	Participatory Hygiene and Sanitation Transformation
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother to Child Transmission (HIV)
PPS	Probability Proportional to size
SAA	Social Action and Analysis
TA	Traditional Authority
ToT	Training of Trainers
VDC	Village Development Committee
VHC	Village Health Committee
VSL	Village Savings and Loans
WDD	Women Dietary Diversification

1.0 INTRODUCTION

Under-nutrition is a global phenomenon associated with poverty. It is estimated that over 900 million people worldwide suffer from under-nutrition with the majority 95% from developing countries. In Sub-Saharan Africa, it is estimated that 27% of the population (240 million people) are chronically undernourished (KIT 2013). According to the United Nations 2012 report, in 2011, worldwide 19,000 under five children (UNDER FIVE) die of preventable causes daily. The main direct causes are; the deaths that occur in the neonatal period (age 0-28 days) due to birth complications or infections (40%) and a high burden of infectious diseases among UNDER FIVE children such as malaria, diarrhoea and pneumonia (Liu et al. 2012). Other underlying causes include; poverty, the weak capacity of health systems, poor water and sanitation and malnutrition (Black et al. 2008; Liu et al. 2012).

Good nutrition is one of the vital elements that contribute to good health and economic development of any nation (Horton *et.al*, 2010). Any country wanting to make strides in health care should have nutrition as an important pillar for health promotion. According to the Malawi Demographic and Health Surveys (MDHS) of 2000, 2004 and the Multiple Indicator Cluster Survey (MICS) of 2006, 49.0%, 47.8% and 46.0% of under- five children, respectively, were stunted (2SD). In spite of the slight decrease, stunting remains unacceptably high and sadly the figures have not changed much since 1992 compared to other countries in the Southern Africa Development Cooperation (SADC) region. Similarly, underweight (weight for age) levels have not changed much over the years. The levels were 25.4%, 22.0% and 20.5% according to the MDHS of 2000, 2004 and the MICS of 2006 respectively.

Gender inequity has also been identified as cross cutting factor that aggravates negative health outcomes including Child Mortality Rate (CMR) in the region (MoGCWS 2011). Power disparities between men and women in agriculture, economic and health sectors prevent women empowerment. Yet, women are the primary caregivers and constitute a significant percentage of the population in the region. Both the underlying and basic causes of CMR are in one way or the other fuelled by gender inequities such as gender based violence, power disparities among others. However, malnutrition has been repeatedly cited as a significant underlying cause of CMR associated with infectious diseases (Rice et al. 2000; Caulfield et al. 2004). According to Black et al. (2008) a similar association can be found in the relationship between a low body mass index of pregnant women and the risk of a low birth weight, which in turn is related to neonatal morbidity and mortality. Indeed, in the UNICEF (1999) framework malnutrition and child death are viewed as terms of manifestations of a multi-sectoral development problem that can be analysed in terms of immediate, underlying and basic causes. According to UNICEF the immediate causes are inadequate intake and infectious disease; the underlying causes are household food insecurity, inadequate maternal and child care and inadequate health services and health environment; the basic causes include formal and non-formal institutions, political and ideological superstructure, economic structure and potential resources.

As indicated earlier, CMR have its origin in many factors with malnutrition and gender disparity as significant underlying causes. Therefore, it is crucial to address malnutrition and gender

inequality in order to accomplish the Millennium Development Goals (MDG) 3, 4 and 5 which speak to promoting gender inequality, reduction of CMR and improving maternal health.

Malawi is ranked 171 out of 187 on the Human Development Index (HDI) with 40% of the total population living below the poverty line and unable to meet daily food needs [National Statistical Office (NSO 2008); World Bank 2012). At least 112 children per 1000 live births in Malawi die younger than five years of age and about 60% of deaths among the Under-five children occur within the first year of life with under nutrition as leading cause. Evidence shows that under-five children in Malawi become malnourished mostly from the age of 3 months (some even from or before birth) onwards peaking at 18 months (OPC 2009). The main factor identified is the steep drop in exclusive breastfeeding (EBF) practices after 3 months with only 40.5 % being exclusively breastfed at age 4 to 5 months (MDHS 2011). Within this period complementary feeding is prematurely introduced. Furthermore, poor choices of foods and lack of diversity is recorded due to inadequate knowledge and skills among caregivers and extension workers and other service providers (OPC 2009).

Most caregivers are women. In addition to knowledge and skills gaps, women who also form 70% of the full time farmers do not take full control over the use and ownership of agriculture land, access to credit, training and technology (MoGCWS, 2009). This entails that the primary caregivers are less empowered to ably decide, on proper family planning methods, provide nutritious food to children, and prevent common illnesses among children.

In this regard, Government of Malawi (GoM) over the past years developed policies and programmes focusing at 0-6 month's category to promote EBF, Vitamin A supplementation for children 6-59 months and de-worming targeting children 12-59 months (MNNPSP 2009). Further Government set an agenda to increase women's access to and control over agricultural productive resources and technologies for food and nutrition security (MoGCWS, 2009).

The process of incorporating these policy goals into existing programmes and daily practice has not been easy and well integrated. Further, the roll out of such programmes has been a challenge. The programs on the other hand lack essential follow-up at community level and linkage with programs of other sectors. As such problems of malnutrition coupled by high rates of under- five deaths continued to be registered in some parts of the country.

Therefore, in response to this need CARE Malawi, Mponela AIDS Information Counseling Centre (MAICC) and MALEZA designed a multi-sectorial approach nutrition project locally known as MAZIKO in two districts of Kasungu and Dowa. In these districts, under five children suffers from linear growth retardation, or stunting, with rates as high as 48% in Kasungu and 43% in Dowa (MICS, 2006). The main goal of the project is to improve the nutritional status of under-five children, pregnant and lactating women in a bid to support government efforts to reduce stunting levels in the country within three years starting January, 2012 ending June, 2015. The project strategies include developing the capacities of health and nutrition delivery service providers, government, stakeholders, partners, traditional leadership, and volunteers to improve delivery of services to pregnant and lactating mothers and under five children.

Cognisant of the fact that in most communities women are more food-insecure than men in terms of availability, access, utilisation and stability in the context of social relations of gender, the project draws on a gender and rights approach to fully understand and be able to address issues of nutrition and health inequalities (Kaufman 2004; FAO 2008). The project strengthens social and economic capacities of women and their households to improve nutrition security and food diversity. They also improve hygiene and sanitation to sustain the nutrition outcomes within the target communities. The project seeks to effect good nutrition and related behaviour changes in more than 57,000 men, women, youth and children who are either family members of direct beneficiaries or general community members.

The goal of the project therefore is to improve the nutritional status of under- five children and pregnant and lactating women in the two districts of Malawi. To achieve this goal, the project has four intermediate outcomes namely:

- Improved delivery of nutritional services to pregnant and lactating women and children under five in target districts of Malawi.
- Improved nutritional practices among vulnerable women and men in target districts of Malawi
- Improved local enabling environment to sustain nutrition outcomes within the target areas.
- Increased women's economic and social empowerment in target districts of Malawi.

In addition to the above outcomes the project also addresses nutrition and health inequalities and by reducing gender gaps or discriminations related to Maternal and Child Health (MCH), nutrition and health service access.

1.1 Survey Rationale

The second trend survey for MAZIKO was commissioned with the purpose of tracking progress made from 2013 to 2014. In June 2012 a baseline survey was conducted to establish baseline indicators that would be used to benchmark trends leading to the final evaluation of the project. However, CARE plans to conduct end line evaluation in February 2015, a season that is different from the season when the baseline was conducted. Conducting end line evaluation in February, which is a period when most households do not have adequate food in Malawi will make comparison of results to the baseline indicators difficult since the baseline survey was conducted in June, a period when most households have plenty of foods. In February 2013 a first trend survey was conducted to check on the project progress towards achieving outcomes and inform management decisions. In February 2014 a second trend was commissioned following the same project framework.

The main purpose of this second Trend Survey for MAZIKO Project was to track progress towards the achievement of MAZIKO Project outcomes. MAZIKO Project outlined within its framework four surveys for easy tracking of its indicators. The Project first conducted a baseline survey in 2012 which was aimed at establishing the benchmark indicators. In 2013, a first Trend Survey was commissioned to look at innovative strategies and promising interventions adopted in the course of implementation. In 2014, a second Trend Survey was also commissioned on

similar basis. Both 2013 and 2014 Trend Surveys attempted to understand improved local enabling environment to sustain nutrition outcomes within the target groups.

1.2 Aim of the Survey

The aim of 2014 Trend Survey is to assess progress towards achieving outcomes with reference to the initial survey and inform management decisions for the remainder of the project. Therefore, the Centre for Public Health Policy, Research and Development (CPHPRD) has been contracted by CARE Malawi to conduct a 2014 follow-on Survey to answer the following objects below:

1.3 Survey Objectives

The Specific objectives were as follows:

1. To assess progress towards achieving MAZIKO outcomes that contribute to improved nutrition for pregnant, lactating and under 5 children.
 - a. Key Indicators: EBF, MMF, MDD, MAD, WDD, Household Dietary Diversity, Hygiene practices: Quantitative survey tool to speak to the IYCF and WDD standardized indicators & hygiene indicators, qualitative FGDs and KIIs to speak to access and ability as it relates to each stated indicator.
2. To explore factors that appear to hinder or facilitate improved nutrition for PLW and under-five and if there are changing trends: consider women's empowerment framework of Agency, Relationship and Structure. See below for examples.
 - a. Division of labor at the HH level: Do women have adequate time to breastfeed, prepare nutritious foods for under-fives (or household), and practice good handwashing, etc.? Do they receive support and what does this support look like? What do women desire to see as it relates to division of labor at the HH level?
 - b. Women's Economic activity: Where do women get the money to save? What support are men providing to women who are involved in VSL? What decisions are being made with the money? Who is involved in making the decisions? What do women desire decision-making to look like?
 - c. Hygiene & Sanitation: Is this viewed as a priority within HHs? If so, which practices are prioritized and why? What enables or hinders progress toward prioritized hygiene practices? What does an ideal hygienic household environment look like and who is involved?
 - d. Religious, Social, and Cultural norms: How do these affect HH decision-making and community level nutrition programming (i.e. pregnant women attending public meetings, priorities in food allocation among HH members, decisions about small animal slaughtering and selling, decisions about land allocation and prioritizing the food grown, eating and talking about certain foods based on religious beliefs)
3. To generate lessons learned and key recommendations to guide implementation, direction of the project design and delivery.

2.0 MATERIALS AND METHODS

2.1 Study Design

UNICEF conceptual framework and the CARE International Women Empowerment Model were weighed against MAZIKO Project Trend Survey tools used in the February 2013 to identify gaps on the causes of malnutrition and inform survey design. These guided determination and choice of methodology to use in this Trend Survey. Three methods were employed to obtain data on nutritional status and practices facilitating malnutrition. These include; quantitative, qualitative and observations. Specifically, the quantitative approach aimed at affirming the magnitude of the key indicators of the Project while qualitative methods were used to explore and establish people's attitudes and perceptions regarding the project's activities and to get community's and stakeholders' perceptions and views on the project efficiency, and sustainability. Observations were used to triangulate respondent views with an aim to compare reality to practice. Quantitative data collection tools were adapted from the 2013 trend survey while qualitative data collections tools were developed and employed to obtain data (See Annex 2). These data collection tools were translated in Chichewa, a local dialect spoken by all interviewees. Validation of these data collection tools included conducting dry runs amongst research assistants and further pre-tested them at Nathenje, one of CARE impact areas within Lilongwe District before use. Verbal consent was obtained by research team at both community leadership and household in order to conduct interviews.

2.2 Sampling Design

The Trend Survey adopted a purposive sampling approach to ensure equal gender representation of key population. This approach aimed at maximizing proportional representation as a way to minimize selection bias. The survey used a two-stage random cluster sampling technique. The first level of sampling selected clusters (villages) in each of the impact areas using probability proportional to size (PPS) so that each village had equal chance of being selected. The village level data provided by CARE or the districts was used at this stage. The second level of sampling involved selection of households (HHs) from each selected cluster using a systematic random sampling. The first household was identified. The preceding households were every fifth household from the first one. If the selected household did not have a child, the next household was selected. We picked the clusters where MAZIKO is implementing the interventions.

The first household was selected using spin a pen method at the centre of the village. One household in the direction of the pen was selected randomly to start the interviews. Subsequent households were then systematically selected by going to the nearest household on the right hand side of the main entrance of the previous household's main dwelling house until the required sample size was reached. Note that a household in this survey was defined as people living together and sharing the same cooking pot.

2.3 Sample Size Calculation

The household survey adopted the same sample size used in the 2013 Trend Survey. A minimum sample size of 390 households was targeted for selection in each district giving a total of 736

households. The sampled households were obtained from 30 clusters of 13 households each. To ensure that the sampled clusters were proportionately distributed in the traditional authorities, a proportionate sampling approach was used.

Sample size determination was based on the baseline levels of stunting. Given the prevalence of stunting of 48.9% in Dowa and 40.5% in Kasungu, (OPC, 2009) desired precision of 5%, a design effect of 1.5 normally applied to approximately homogeneous population as sampling was done in each of the districts, and non-response rate of 10%, the required minimum number of children to be sampled for stunting indicators are 627 in Dowa and 605 in Kasungu from 30 clusters in each district. This sample size calculation is based on the following formula

$$n = \left\{ z^2 * \frac{p(1-p)}{d^2} \right\} * \frac{DEFF}{1-NRR}$$

Where n = sample size, z = the risk of error set 1.96; p = expected prevalence set at 48.9% for Dowa and 40.5% for Kasungu; d^2 = relative desired precision set at 5%; NRR=non response rate set at 10%; and DEFF = Design Effect set at 1.5. Using the average of 1.6 children per household as indicated in local surveys, 392 (627/1.6) households were required from 30 clusters in Dowa and Kasungu (we adopt the bigger sample size). Thus, 13 (392/30) households were required in each of the 30 clusters. Hence for the two districts, a total of sample size of 1,254 children and 736 households were included in the study.

2.3 Adaptation of the Survey Questionnaire

The household questionnaire was adopted from the 2013 Trend Survey and revised accordingly with some of the sections on anthropometric measurements being removed. Missing questions for new indicators were included in the revised questionnaires in collaboration with CARE Malawi, Canada and USA project staff. In brief, the household questionnaire had sections on, socioeconomic characteristics, household dietary diversification, hygiene and sanitation among others. The survey questionnaire was administered to pregnant and lactating mothers and fathers/male guardians.

2.4 Qualitative Data Collection Methods

Key stakeholders/informants interviews were held with District Nutritionist, Agriculture Extension Development Officer (AEDO), Health Surveillance Assistants (HSA), Community Promoters (CP), Chiefs, Opinion leaders and members of the District Health Management Team and District Development Committee. Focus Group Discussions (FGDs) were also conducted with community members. Document review was done specifically on nutrition, health, Hygiene and sanitation issues as stipulated in the TORs and cited in the background and introduction sections.

2.5 Recruitment and Training of Research Assistants

A team of 22 research assistants and 4 supervisors were recruited for purposes of data collection in all districts. Of the 22 research assistants, 8 were data clerks. The team members were trained for four days. The training covered survey questionnaire in detail, survey objectives, sampling methodology, interviewing and probing techniques to maintain quality data, and research ethics. As part of the training, a pilot testing was conducted in Nathenje, Lilongwe. All issues noted in the piloting were resolved in plenary.

2.6 Data Collection

Data collection took place for six days. A total of 736 survey household questionnaires were administered; yielding 1, 473 under-fives. For qualitative data, 12 Focus Group Discussions (FGDs) and 16 key informants' interviews were done in the two districts. MAZIKO Project partners in respect districts pre-arranged meetings with respondents and guided research teams to different clusters in each Traditional Authority (TA) where respondents were sampled.

During data collection, daily debriefing meetings were held every evening and all problematic areas were resolved before the next day's data collection. This involved reviewing all questionnaires administered and necessary corrections were made until there were no more problems noted with the interviewer. For those interviewers who had difficult to collect data or skipping questions same day data recalls were conducted in selected households (HHs) to ensure accuracy, consistency and completions. Furthermore, in the field the interviewers were encouraged to check all questionnaires before leaving the village and all necessary corrections were made while in the field. Both quantitative and qualitative interviews lasted between 30-60 minutes. FGDs were audio-recorded and additional written notes were also taken.

2.7 Data Entry, Processing and Analysis

Data entry begun in the field and ended up at CPHPRD central offices where an additional 8 days were needed to complete entry and data cleaning. Eight (8) data entry clerks and 2 supervisors were hired to complete data entry, clean and analyze. Quantitative data was entered in SPSS to analyze frequency distribution of sample characteristics and responses elicited from respondents. Data cleaning was done to correct inconsistencies during data analysis.

2.8 Approach to Qualitative Data Analysis including Gender Analysis

For the qualitative data, the audiotaped interviews were transcribed and translated simultaneously from Chichewa into English by the interviewers using a standardized transcription protocol. Detailed notes were expanded immediately after the interview to capture as much of the content as possible. Two analysts structurally coded data that is directly linked to the questions relating to the key objectives. Codes were reviewed to confirm intercoder reliability. Coding reports were produced for each of the codes, followed by data summaries that describe all themes within each code. An independent analysts provided checks by listening to selected recorders and matched with transcripts and further reviewed the coding frame

Gender Analysis Approach was applied in the qualitative analysis in order to isolate gender issues that were pertinent for this report. Qualitative statements were extracted from each area of project activity and sorted under a selection of CARE's Core Areas of Gender Inquiry. The unit of measurement was the statement (rather than the individual), and statement frequency was measured to determine the extent to which gender equal dynamics, behaviours and attitudes exist among men and women. However, statement percentages did not add up to 100% consistently in this narrative as only the most relevant findings were discussed.

3.0 RESULTS AND DISCUSSION

This section presents findings of the 2014 second Trend Survey outlining the access to nutrition and health services of the under-five and the caregiver, availability of improved sanitary facilities, infant and young child feeding and practises and childhood illness among others. The section further provides key results for access to antenatal care services, water, hygiene and sanitation, household food security, social empowerment and women's participation among others

3.1 Social Economic Characteristics of Respondents

This section presents coverage of the characteristics of households and respondents. The 2014 Trend Survey assessed condition of households, gender and education level of the respondents. It further assessed household's main source of food and income.

Sex, Age and marital status of household heads and respondents

Results show that over 90% of the respondents were female and 9% households were headed by females. This shows no significant change from the findings of 2012 baseline survey that indicated that 90% of the households were headed by men. In addition, it was also noted that 93% of the respondents were married compared to 92.2% in 2012 and 4% were divorced compared to 5.8% in 2012. The finding suggests that the households are still dominated by males as heads which may have an implication on household decision making. Majority of the household heads age range was 20-39 years. Nevertheless, 4% were aged 50 years and above. Of the 736 under five children, 21.7% were between the ages of 0-5months, the larger group was between 6-32 months representing 52.5%. The age group between 24-36 months and 37-59 months were the least, representing 15.2% and 10.6% respectively (See Appendix B)

Size of household

As was noted in the baseline, household size has an implication on use and allocation of resources but also affects labour availability and dependency burden. The 2014 trend survey shows that the average number of people per household was 5 against 5.3 in 2012. Forty two percent of the households have 4 members while 6% have 9 members or more.

Education Level of Household heads and Care giver

According to MICS (2006) education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labour. Further sexual exploitation, promotion of human rights and democracy, protection of the environment, population growth

and the improvement of health and nutrition of children can also be achieved through better education.

One key finding is that 47% of household heads, and 46.1% of -caregivers have at least attended senior primary school (standard 5-8) and 23.8% of household heads have ever attended post primary as compared to only 13.6% of the caregivers. A small proportion of household heads respondents (10.9%) and caregivers (5.2%) attended post-secondary school education. Regardless of this, about 60.7% of caregivers can read and write a percentage while the household heads were 70.8%% (see Figure 3). The results indicate an opportunity for caregivers that are able to read and write for the good of the infants and young children. Below Figure 3 shows a comparative distribution of education levels of household heads and care givers:

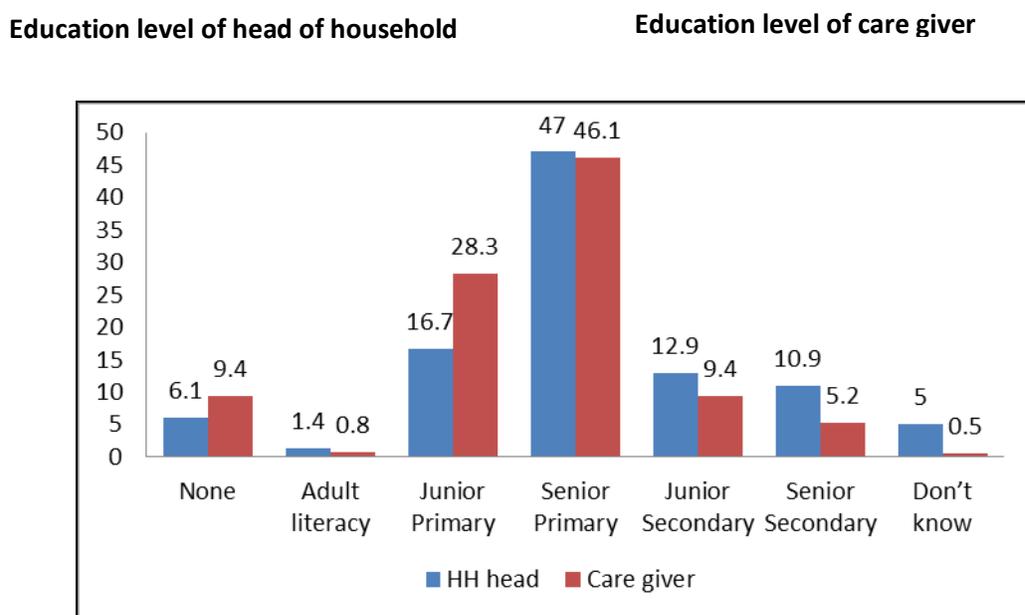


Figure 3 Distribution of Education levels of household heads and Care givers

Occupation Distribution by Household

Occupation determines income levels and socioeconomic status of households which has an impact on nutrition and health status on households. Respondents were asked to mention what they do for a living. One key finding is that there are basically four categories of main sources of income. Farming is the main source of income reported by 66.3% of the household heads and 56.1% caregivers. Caregivers are more into business than household heads representing 23.4% and 14.3% respectively (see Figure 4). Proportionally, a small number of the respondents reported permanent employment as their main occupation; 11.7% among household heads as compared to caregivers 8.4%. Despite that farming is the main source of income for the households in the Dowa and Kasungu, it has challenges in food and income security as it is

typically subsistence and seasonal. Figure 4 below shows the distribution of household heads and caregiver’s main occupation categories:

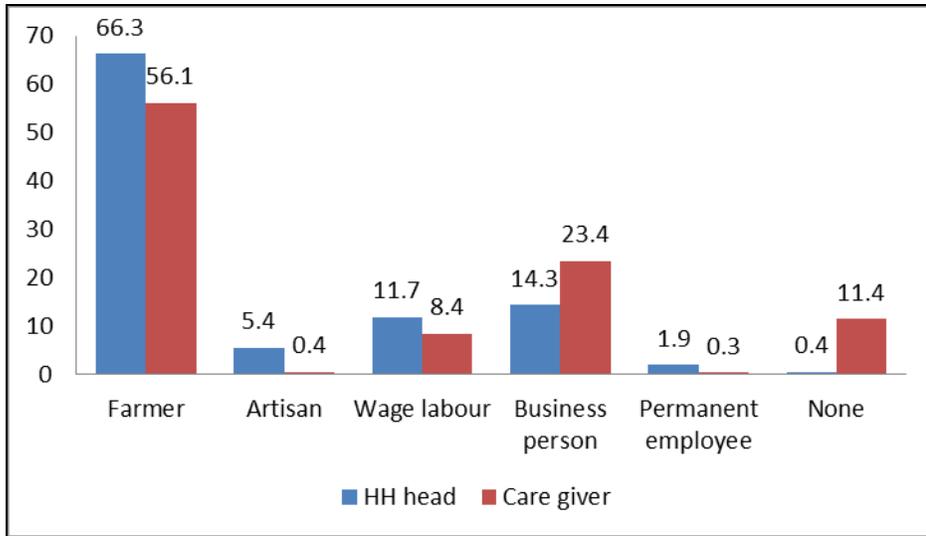


Figure 4 Occupation Distributions by Household

These findings compare to national occupation distribution among household heads and caregivers in geographical farming areas in Malawi, for example, Lilongwe district (MIC 2006). However, they demonstrate a marked shift in occupation categories compared to 2012 Baseline Survey whereby a majority household’s heads represented their main occupation as farming. According to MAZIKO Baseline 2012 Survey caregivers had a lower occupation percent distribution, in other words, artisanship was lowly pegged. The shift in occupation trends observed in 2014 second MAZIKO Trends Survey shows broader occupation distribution categories including artisanship for caregivers. This can be explained in a way that communities are harnessing and broadening socio-economic safety networks derived from VSL innovation and other initiatives of commercial thinking. MAZIKO Project has to view this occupational shifts with positivity especially women involvement in artisanship (5.4%) as an element of women empowerment and household heads diversity in income sourcing.

Nonetheless, our data shows that in both Dowa and Kasungu Districts 11.4% caregiver had no occupation. Therefore, future programming needs to seriously consider intensifying initiatives that will see caregivers with no occupation to earn a living. VSL is one economic initiative to be considered to scale to harness communities socio-economic safety nets.

Income Distribution by Household

One key finding is that most household heads had their annual income of 50,000 Malawian Kwacha (MK) or more representing 63.9% compared to 27% caregivers. A majority of caregivers have their annual income of less than 10,000 MK representing 26.9 %). Figure 5 below shows annual income distribution by caregivers and household.

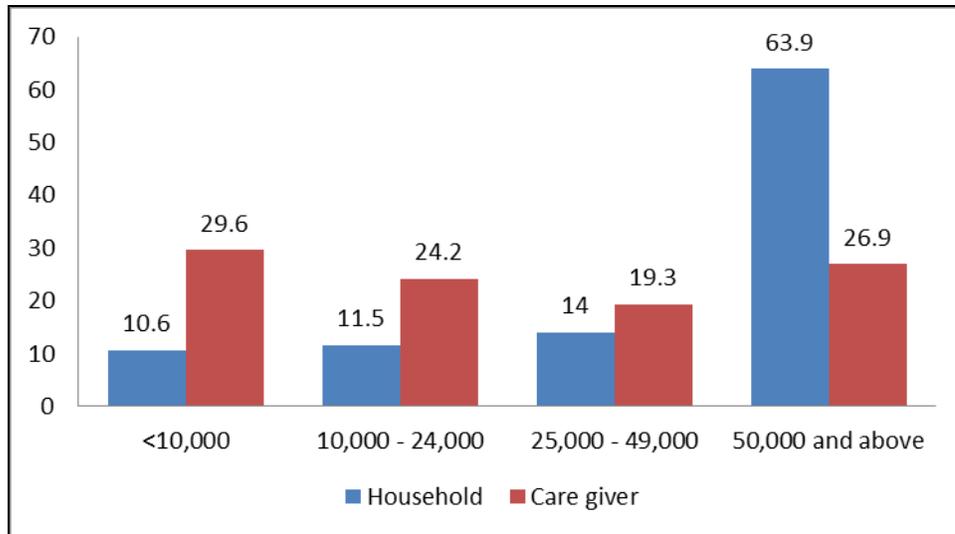


Figure 5 below shows annual income distribution by caregivers and household.

The caregivers have less income bracket compared to household heads due to limited earning opportunities. Indeed, household heads earnings are higher in this society where men dominate decision-making’ and deemed to have wider job alternatives. The program implication of this varied income brackets between household heads and caregivers is that household heads are privileged in decision making on how and when to use money (See Women Empowerment Section Below). Future programming needs to consider alternative initiatives of empowering women with negotiation skills to bargain for better earnings off-set earning imbalance.

Condition of Dwelling Unit

The condition of the dwelling house is a pointer unto the wealth of the household. The households in the sample were categorised according to the condition of the dwelling unit defined in Table 1 below. Only a few conditions were assessed that included the floor, roof and wall. Using a criterion defined by Table 1 below, households were categorized as follows very poor, poor or acceptable depending on the condition of the dwelling unit. Results show that only 27% of all the households can be considered “acceptable” ranging from 44.6% of the wall with burnt brick, 11.8% of the floors cemented and 24% of the roof with iron sheets (See Appendix B)

Table 1: Classification of Status of Dwelling Unit

<i>Classification of Status of dwelling</i>	
<i>Good condition = (item 7 + one or more items 8-13)</i>	
<i>Acceptable =(one item 1-6 + one or more items 8-13)</i>	
<i>Poor = (two items 1-6)</i>	
<i>Very poor (more than 2 items 1-6)</i>	
<i>Cracks/openings in walls 1</i>	<i>Improved dwelling:</i>
<i>No windows 2</i>	<i>Durable walls 8</i>
<i>Windows with broken glass/no glass³</i>	<i>Glass in windows..... 9</i>
<i>Visible holes in the roof..... 4</i>	<i>Solid roof 10</i>
<i>Incomplete roof 5</i>	<i>Secure door 11</i>
<i>Insecure door..... 6</i>	<i>Cement or covered floor..... 12</i>
<i>None of the above..... 7</i>	

The findings show an improvement in the dwelling houses with iron sheets from 10% in 2012 to 24% in 2014. However, caution should be taken in interpreting these findings as we could not segregate the condition of the dwellings by gender.

Ownership of Assets by Household

Using ownership of assets to determine household wealth, the survey team assessed availability assets to determine level of socioeconomic status of households. Results show that 64.7% of the household use a lamp to lighten their homes and 49.3% have a radio, and 46% own bicycles. In addition, 44.8% own a mobile phone, 9.1% solar panel, while the rest [farm carts, televisions, motorcycle and a car] are proportionally owned by 5.2 % households and below. Figure 6 below shows a breakdown of distribution of household wealth by assets:

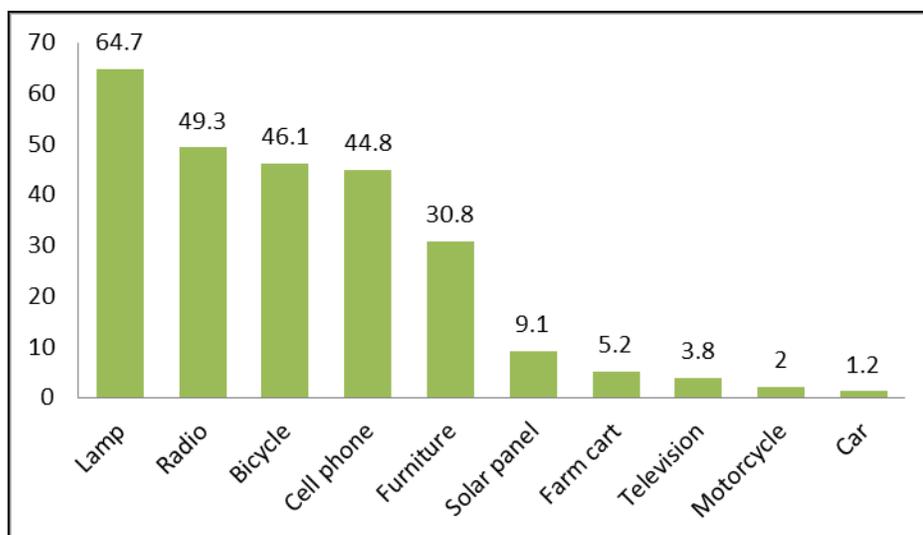


Figure 6: Ownership of assets by household

According to MIC (2006) these data compares with other districts in Malawi for example Lilongwe. However, these wealth distribution are proportionally higher than the overall household wealth distribution in the first MAZIKO 2013 Trends Survey for Kasungu and Dowa Districts. One explanation to this variation is a result of combined economic interventions, e.g., income generation activities intensified by MAZIKO and other development players in these impact areas. This shows that people are able to save for food and possibly disposable income for materials to improve their lifestyle. Future programming need to scale-up current economic initiatives ensure that communities own assets that direct or indirect positively impact on the livelihood of a mother and a child

Food Security and Livestock

Maize as a staple is synonymously used as a base for food security in Malawi. In this trend survey, it was found that, 73% of the respondents depended on their own maize production and only 21.5% could buy maize. Only 3.5% of the households depended on food for work (*ganyu*—temporary work), and 1.1% on food donations. However, maize availability represented only 16.5% compared to 37.5% of households that did not have enough maize throughout the year. About 46% of the households were perceived as constantly food insecure. For instance, on average households could have 23 bags of 50Kgs of either maize or maize flour in their household to last for a year though this is inadequate for an average household of 5 people. Indeed, findings from FGDs and KIIs revealed that most households suffer perpetual food insecurity because a lot of arable land is prioritised for growing cash crops such as tobacco. In this regard, respondents proposed that MAZIKO should consider supporting households with farm inputs for agricultural production to ensure food security.

As regards livestock, the study found that there were different types of livestock owned by households and these included chickens (55%), goats (31.4%), cattle (11.7% and other livestock types which were about 11%. When respondents were asked who owned these, a majority respondents both female and males mentioned household heads. Despite a wide range of available livestock in the households, it is not a direct measure of consumption. Only 6.3% were found to keep the livestock often for food source. Only 42% would occasionally use these livestock units for food at household level but mostly, 51% of the households would not at all use these livestock for food. This finding connotes low consumption of animal fats and proteins among men, women and children at household in general and Under-five and PLWs in particular. Lack of or limited consumption of protein foods is likely to contribute to malnutrition. According to UNICEF conceptual framework (1999) one cause of malnutrition is low food intake.

Indeed, key informants mentioned livestock as a missing component in the overall support on nutrition. One of them had this to say;

We cannot practice what we don't have in our respective households. For example we are encouraged to be taking meat and vegetables every time we have a meal but it becomes tough for us to eat meat as required [...]”(Women, Dowa FGD)

Another key informant further mentioned that livestock was among the package MAZIKO programme planned to provide to communities but never came to realisation. It is therefore, necessary that future programming should focus more on educating communities to utilise proceeds from livestock for food. Further, development programs should consider providing seed livestock to households to kick start livestock entrepreneurship.

3.2 Social Empowerment and Women Participation

Women empowerment is important for the lives of the most vulnerable segment of the population, particularly children. It also has a direct impact on reduction of hunger and provision of basic needs in education, health and income.

Women Participation and Leadership Roles in Community Organization

The study assessed social and women empowerment using women's decision making abilities through their participation in the community development groups and activities. It further assessed membership and level of participation in VSLs. The Trend Survey results showed that 67% of the women were participating in different organizations that ranged from religion, health and nutrition groups, farmer clubs and VSLs among others. The highest percentage of respondents (women/caregivers) belonged to VSL groups representing 54% and the least belonged to seed club representing 1.2%. The average size of the groups was 7. Village savings and loans (VSL) groups are the most chosen groups that women participate in MAZIKO project implementation area (See Figure 7). Almost half of the women are currently in VSL groups at 49.5%. Notably, 43.3% of women were the past members of the VSL groups.

FGDs and KIIs also noted a marked improvement of women participating in the community groups responsible for health and nutrition as compared to the baseline which noted a marked absence of women in these areas (Appendix 4). We further found that, although equality is dominantly (by both interviewers and interviewees) described as equal numbers of women and men present on committees, both women and men demonstrated the greatest degree of reflection on the nature of gender dynamics, reifying gender equality as a phenomenon that has come to influence community participation rather than as an ever-present dynamic that influences women's, men's, girls' and boys' health outcomes.

Although 67% of the women made a decision to join a particular group by themselves only 23% held leadership positions. Similarly, in FGDs, 38% of women's statements indicated that men dominate leadership, or form the majority of leaders. Ten per cent of women's statements also indicated that women and men share leadership, and 35% of statements showed ways in which women lead actively. Women also reflected on why they do not lead, exhibiting classic "blame the victim" language that does not recognise relational or structural barriers to their participation. Some of the women had this to say:

"Us women, we lack confidence in ourselves. We feel we cannot be in such positions, and this makes us run behind the men".

"The other thing that makes women fail... is that we create a lot of excuses. Maybe we are called for a meeting, but we will say we are not going because we are escorting a child to the clinic. That is why men overpower us in these leadership positions."

Women noted that they are more likely to be in leadership positions because “gender” has come to their communities and motivated a change, as if gender dynamics are a new phenomenon and physical influence. Men were more positive than women when describing levels of equality in leadership. Thirty eight per cent of men’s statements see women and men equally leading, and 33% of statements see women dominating leadership or see more women than men leading. Ten per cent of men’s statements mark no change in leadership, and 9% of statements describe women leading in traditional roles. Again, men reified gender equality as something tangible that comes into a community and encourages women and men to work together, women to lead in development activities, and women to participate in public spaces, although with traditional gender roles well preserved.

While clear change is happening at the level of public participation in community groups motivated by development programming, change has yet to become consistent at the relations and structure level in either the household or community spheres. Women and men understand that gender dynamics are a factor, but have yet to understand the difference between real gender equality attached to women’s right to health care and a hierarchical harmony established when both sexes fulfil prescribed roles in an unequal gendered division of labour. Thus, while participation rates in community health groups may have increased since baseline, women’s functional equality to set a community health agenda is still weak. Future programming can build on current gains by incorporating more intentional discussions on what gender equality means at the relations and structure levels, through facilitated processes such as social analysis and action, for example. Figure 7 below shows different types of groups women participate in.

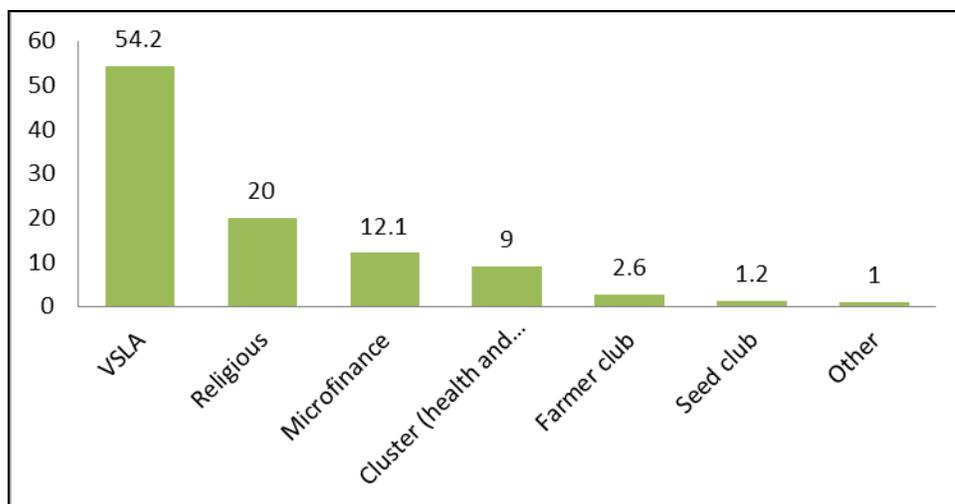


Figure 7 Different types of groups women participate in

3.3 Women's influence in decision making

Ninety percent (90%) of the women also indicated that the groups they belong in are effective in influencing public decision making. This is out of the ordinary since the groups that most of these women belong to are VSL and about 9% of the women belong to health and nutrition group. Figure 8 below outlines the women's opinion on the degree to which; women in their own community can influence household decisions. They personally influence household decision on issues of nutrition, care for children, pregnant and lactating mothers and married women contribute to decision-making around food and health expenditure.

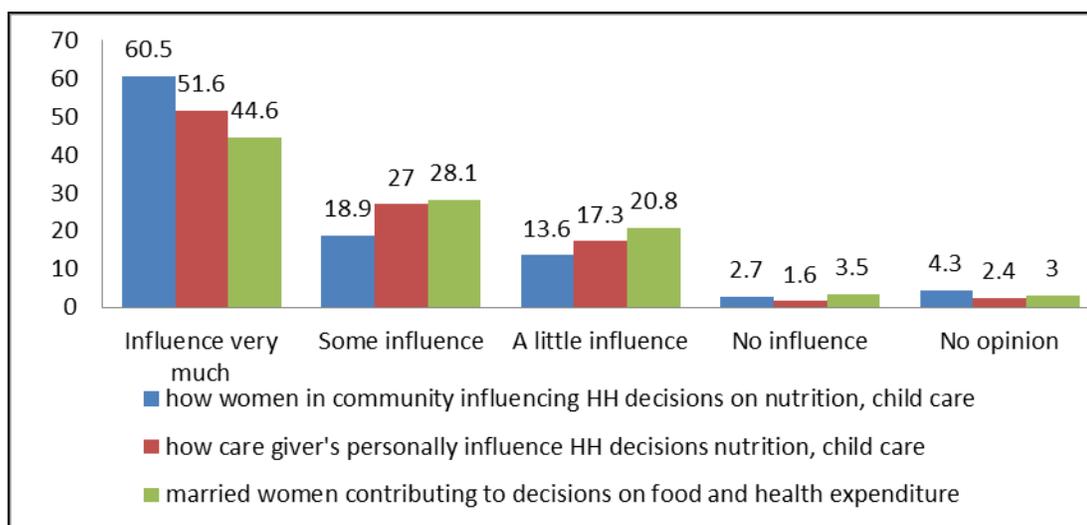


Figure 8 Women's Influence of household decision-making

These findings were also triangulated in the FGDs. It was noted that men continue to be implicated in budget control such that their influence in household nutrition is greater. In 50% of their statements, women described key decision makers as men or the whole family. Ten per cent of women's statements described women as having influence in areas related to the traditional division of labour and another 7% described women as advising men on household purchases. Seventeen per cent of statements illustrate women as having substantial influence over household expenditure and related agendas, and a further 17% describe women as having relative autonomy in decision making.

What Women say about decision making:

"There is no change. Men still dominate in decision making."

"Mostly we just tell the man that there is no soap or relish. We cannot have the authority to take the money to go and buy soap, no."

"When the woman says "Let us do this or that," the man follows her advice in order to see change."

In 10% of men's statements, men described themselves as key decision makers and household heads while in 47% of statements they describe a traditional pattern of consulting with women, with the implication that the prerogative of final say rests with men. Five per cent of statements describe a traditional pattern of women having autonomy over cash gained from petty trade. Nineteen per cent describe both women and men as involved in decision making, with women having the same prerogative as men in terms of final say. Nineteen per cent describe women as having autonomy over decisions that affect PLW and U5 nutrition.

Both women and men, and at the same rate, conceive of situations in which women and men have equal decision making status. While women provide examples of how men dominate in making daily decisions about food purchases and other areas that affect nutrition, they also provide examples (17% of their statements) where they have significant influence over the types of broader farm management decisions that affect the household enabling environment for nutrition and health care. Two examples of positive change towards gender equality were evidenced in FGDs. First, women stated that men were beginning to listen to and respect women more, influenced to change by friends and family. Second, men were able to provide two concrete examples of the way in which participatory and forward budgeting is done in their households, demonstrating transparency that goes beyond consultation.

What Men say about Decision Making:

“I explain about the resources that we have against the time we are supposed to use them. We sit down to discuss how we should effectively spend or utilize our resources. It is up to the woman to say no, we can trip on this one so that we can reach this goal at this time.”

“We husbands do assist a lot in fending for the family... When you do some piece work you have to save something. You help to generate the cash so that when the women go to their group they do not feel ashamed. They have to contribute as the rest contribute so that they do not come back home bitter.”

Qualitative inquiry also assessed on the role of VSLAs in household planning and decision making. Both women's and men's discourse identified VSLAs as a family asset to be used for general livelihoods security rather than an asset to be directed towards women's or children's health. A Community Promoter in T/A Mwase in Kasungu had this to say about the positive impact of VSLs;

“[...] VSLs has led to improvement in the livelihoods status of people in their area such that others are able to pay school fees, hospital bills, buy household assets and do some businesses [...]”.

Again, men described their breadwinning role in ensuring women have the assets to participate in the club, and in factoring any accruing funds into the overall household budget. Overall, while the majority of women do not have sufficient power to make household management decisions favourably for their health, there are strong examples of power sharing and autonomy from which to learn in Dowa and Kasungu. It is recommended that future programming concentrate on cultivating and showcasing women who exercise personal autonomy in decision making and couples who show relative equality in the area as gender change champions.

3.4 Access to Nutrition and Health Services

This section covers issues of maternal health and nutrition and was assessed using availability of different health facilities in the community and distance taken to the nearest facility. It will further outline women attendance to antenatal clinics (ANC), place of delivery and health seeking behavior among other issues. The section will show women's dietary diversification in comparison to the household dietary diversification.

The distance and/or time taken to a health facility will influence an individual's decision and improve health seeking behaviour. In the 2014 second trend survey, 70.8% of the health facilities are situated to a distance of over an hour walk. Only 12.1% of the respondents can access a health facility of less than 30 minutes' walk and 17.1% can take at least an hour to the nearest health facility. This is a concern to a community whose mode of transport is mostly a push bike owned by 46% of the households (See Figure 6). This was more evident in Kasungu District where there are no health facilities in most traditional authorities and the nearest health facility is a district hospital with radius no less than 200 kilometres. It was also reported that, about half of the respondents, 48%, would be visited by a regular outreach/mobile clinic. However, only 43.3% of women take their children to these outreach clinics.

During FGDs, women in Kasungu reported that access to ANC services is limited because the services are located far. They further reported that pregnant women walk long distances to access them. The long walking distance to health facility has a negative impact on women's productivity in term of cost, time to prepare meals, feed and care for children in the households.

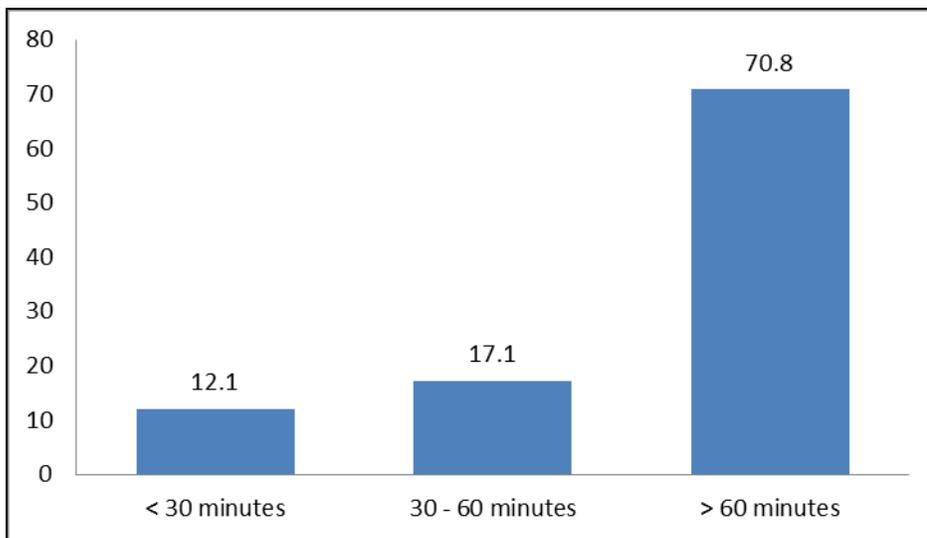


Figure 8: Travel time to health facility

ANC Attendance

Antenatal period presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. WHO recommends a minimum of four antenatal visits based on a review of the effectiveness of different models of ANC. Some key ANC activities include; tetanus immunization (TTV) during pregnancy can be life-saving for both the mother and infant. The prevention and treatment of malaria among pregnant women, (IPT) management of anaemia during pregnancy and treatment of STIs can significantly improve fetal outcomes and improve maternal health. All these services are provided during antenatal care. The 2014 trend survey assessed the number of times pregnant women attended ANC and what time they start ANC.

The proportion of pregnant women who attended ANC during their current or most recent pregnancy was at 97.7%. Out of these, 73.7% received their first ANC services during the first 3 months of pregnancy, 25.1% in their 6-7months of pregnancy and only 1.2% at 8 months. This could be attributed to the distance and time taken to the nearest health facility. Over 25% of mothers would wait till 6 months into pregnancy before seeking ANC services. Fifty four per cent of the women attended the ANC adequately as recommended by WHO. However, it important to note that about over 40% of the women attended ANC less than the recommended time. This indicates that pregnant women understand the need to attend ANC and it an opportunity to acquire such important services.

Similarly, FGDs found that both women and men had gained good knowledge on the benefits of attending ANC which may have prompted them to patronise the service. One woman had this to say

;

An

oth

“I benefit in health services because I know whether my body weight is increasing or decreasing when I go to the ANC”

er key finding from KII shows that males were involved in ANC. Most health centres, for example at Mbingwa Health Centre in Dowa, encourage spouses to escort their wives on their first ANC visit. This could explain why there is a higher percentage of visits in the first 3 months and less in the subsequent visits. Another deterrent for the subsequent visit is the distance to be covered, 70.8% women had to walk no less than an hour to get to the nearest health facility. Figure 9 below shows gestation age at first ANC visit.

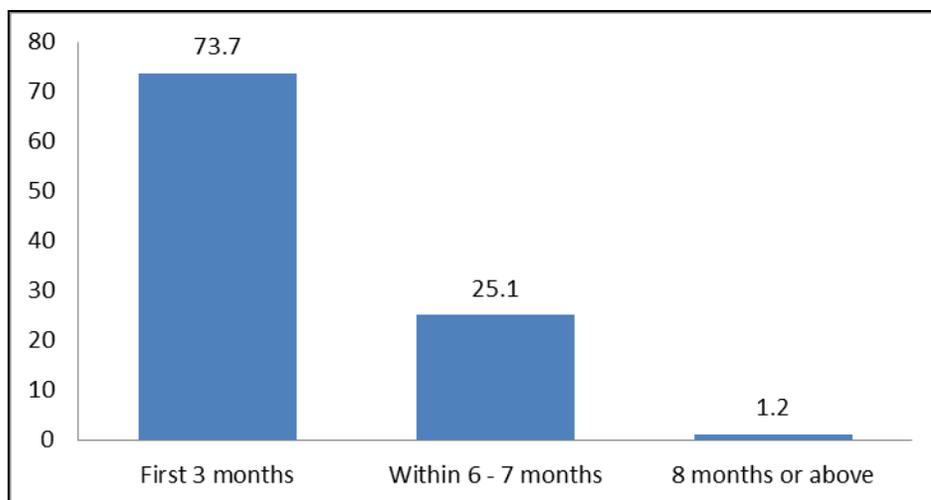


Figure 9: Gestation Age at first ANC attendance

Assisted Deliveries by Provider Type

Mothers attended by skilled birth attendants are measured by the number of deliveries made by the skilled birth attendant. According to WHO, a skilled birth attendant is a health personnel with midwifery qualification. This indicator serves as a proxy measure for quality of care during labour and delivery. This study found that 79% of mothers with children aged 0–23 months whose last birth was attended by a skilled birth attendant and this is higher than the Malawi Demographic Health Survey (MDHS 2010) that captured it at 59.6%. This means that most women are going to the hospital for child delivery. This achievement is in line with the Millennium Development Goal 5, which aims at improving maternal health and having a skilled birth attendant present at birth. This is likely to reduce mortality and morbidity of mothers and babies. Further, UNICEF recognizes that the single most important intervention for safe motherhood is to make sure that a trained provider with midwifery skills is present at every birth; transport is available to referral services and that quality emergency obstetric care is available. Figure (10a and 10b) below shows skilled birth attendants who assisted the mothers with deliveries of their youngest child.

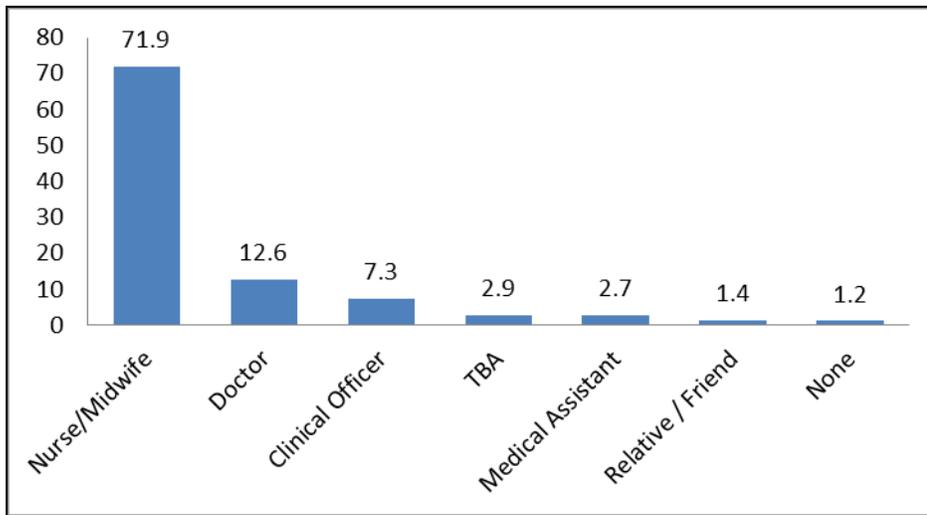


Figure 10 (a) assisted delivery by provider type

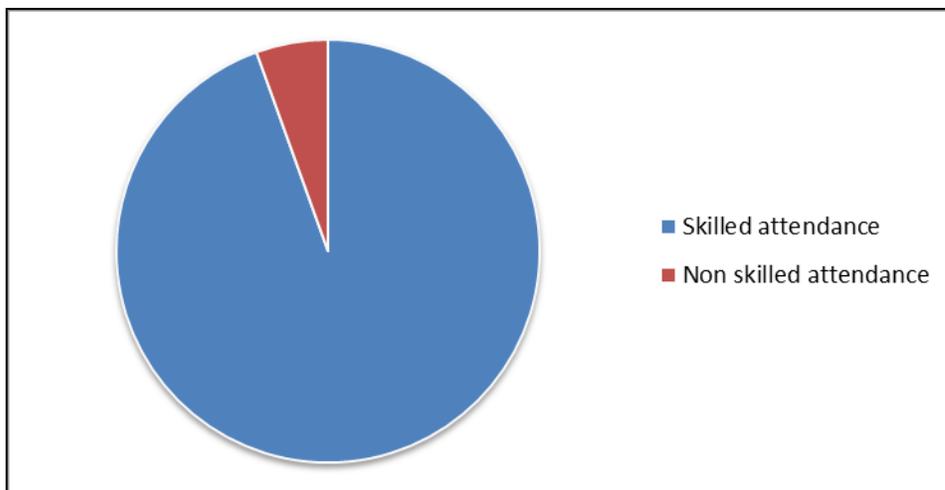


Figure 10 (b) Assisted Delivery by Provider type

One key finding is despite a larger number of births being attended by skilled health personnel, most mothers would clearly distinguish which type of skilled provider attended to them. They were a clear overwrap among women to distinguish between a nurse, a doctor and clinical officer. All of these from women's attending antenatal perspective were, 'doctors or nurses'. Therefore, data on provider type must be interpreted with caution. Nevertheless, it was also revealed that in most areas there are no health centres, and pre-cautionally, most deliveries are done at a district hospital. This might confirm that these deliveries were done by skilled health personnel.

In addition, health seeking behaviour among the respondent was assessed and it was noted that 84.5% would first take the sick to a health facility and 14.5% would take the sick to a traditional healer, spiritual healer or do nothing and treat the sick at home (see Figure 11). It was also noted that 55.3% of the decisions to take a sick child to a health facility is done by both men and women and 25% of the decisions are done by women and 16.8% of the decisions are done by the men in households. It is noteworthy that 70.4% of the women reported to be satisfied with health services offered at the different facilities to which women attend. Figures 12a and 12b below shows Decision maker in taking a sick child to a health facility and Satisfaction with health services respectively.

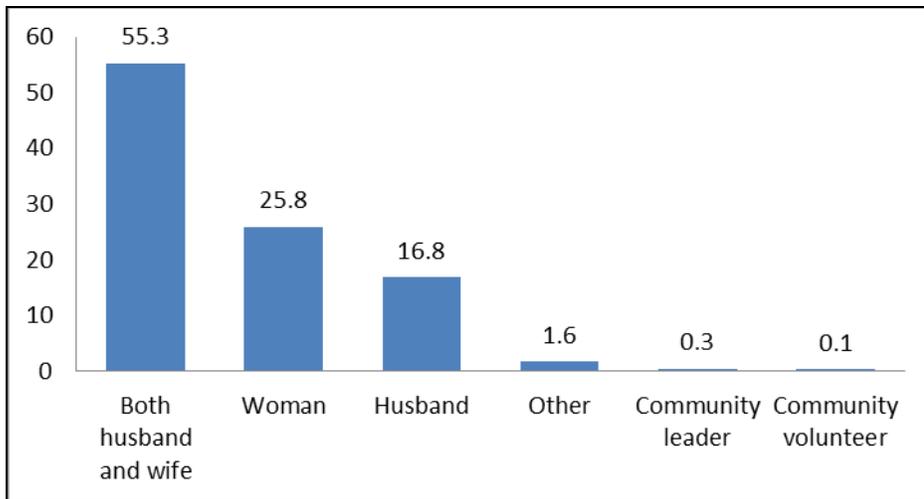


Figure 11 (a) Decision maker in taking a sick child to a health facility

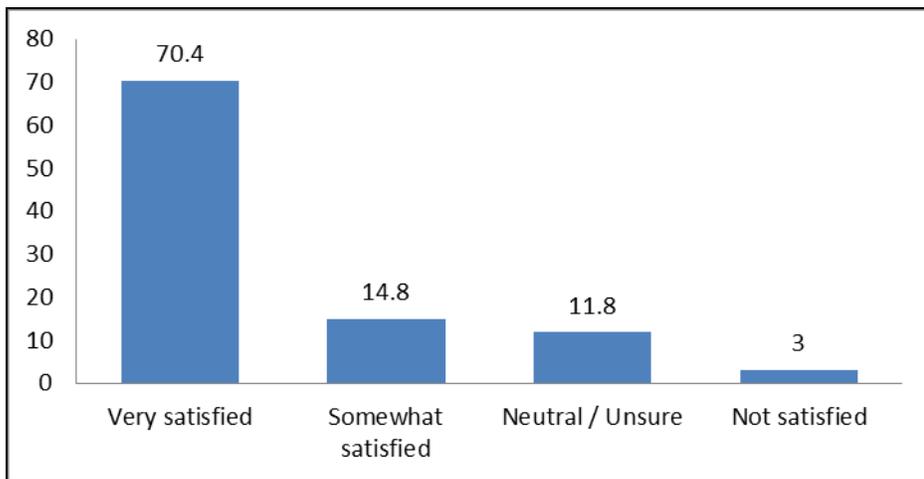


Figure 11 (b) Satisfaction with health services

Findings from KII revealed that some households still seek treatment from spiritual healers to the extent that they get admitted, for example in T/A Chakhadza in Dowa, where spiritual healers admit under-fives and PLWs. This has an implication on prompt health seeking behaviour. Future programming should focus on early health seeking behaviour and deliberate attempt to collaborate with traditional and spiritual healers.

3.5 Water, Hygiene and Sanitation

Access to drinking water and basic sanitation is a fundamental need and a human right vital for the dignity and health of all people. This is vital for the good health, survival, growth and development of a child. The health and economic benefits of improved water supply to households and individuals are well documented. The amount of time spent fetching water will have implications for the amount of water that a household makes available to its members. The international community assumes that if the time invested in fetching water is longer than 30 minutes, the satisfaction of basic water needs is compromised. However, these basic necessities of life remain a luxury to many especially the poor.

The health burden due to many of the common illnesses such as diarrhoea and other water related diseases such as ascariasis, dracunculiasis, hookworm, schistosomiasis and trachoma can be reduced drastically if majority of people have access to both safe drinking water and good sanitation. In addition to its association with disease, access to safe drinking water may be particularly important for women and children, especially in rural areas, who bear the primary responsibility for carrying water, often for long distances. Water collection is considered to be women's work. Time spent in fetching water for the household prevents women from concentrating on other tasks, and takes away opportunities for social and economic development of the community. The MDG number 7 aims at reducing by half the proportion of people without sustainable access to safe drinking water and basic sanitation between 1990 and 2015. The World Fit for Children goal also calls for a reduction in the proportion of households without access to hygienic sanitation facilities and affordable safe drinking water by at least one-third.

Water Sources

The Trend Survey results indicate that the main source of drinking water in the impact areas was bore hole with a pump where 68.9% of the respondents draw their water. Figure 12 below indicates the sources of drinking water in the community.

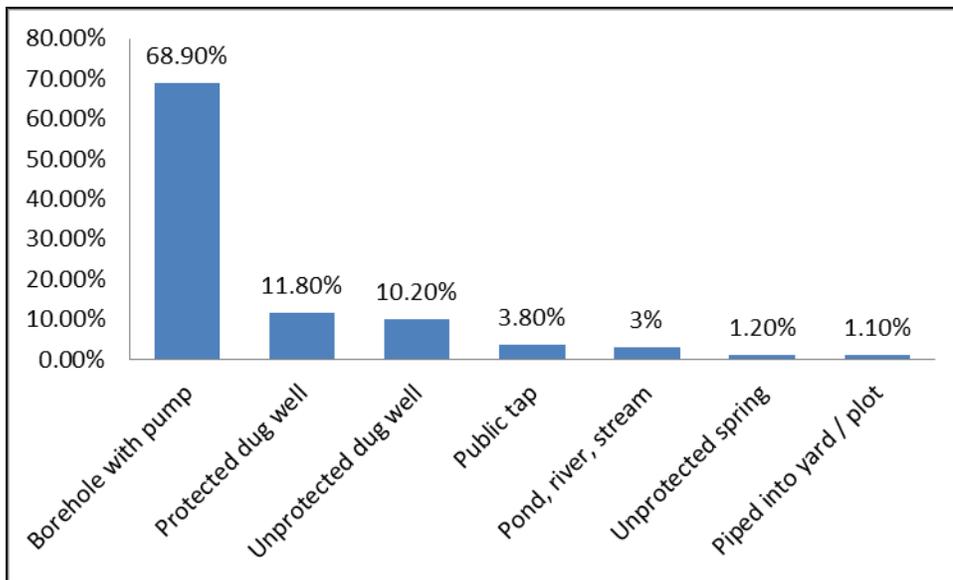


Figure 12: Household main source of drinking water

The findings show that at least 14.4% of the respondents drink water from unprotected sources. It was also noted that most households have their main source of water close to the dwelling places, 68.9% draw water from a distance that they can walk in less than 30 minutes. Although boreholes are regarded as the main sources of water for most households, findings from FGDs and KIIs revealed that these boreholes are few and far apart against the population such that they spend hours at the water drawing point because of long queues. Some also walk long distances to reach the borehole points.

Regarding water treatment, the survey found that only 18.5% of the household make their drinking water safe through chlorination. FGD and KII findings noted that the communities did not treat water because chlorine was not always available. This finding is quiet contrary to the prior knowledge that MAZIKO distributes chlorine for household's water treatment. It is important to note that 44.3% of households keep their water in a covered container while 2.4% of the households feel it is not required and 24.7% do not do anything .Figure 13 below shows ways of making water safe .

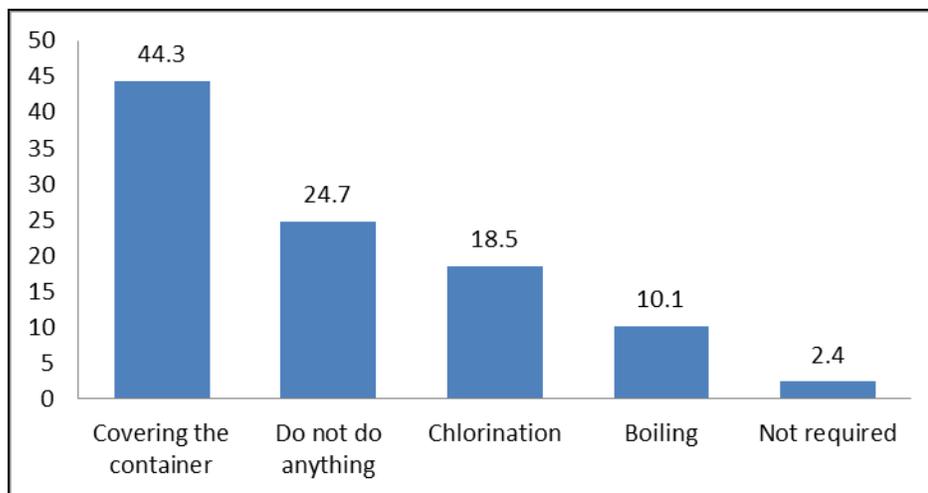


Figure 13 **Methods of making water safe for drinking**

The study noted that, although households are able to access water, poor treatment and unsafe sources of water remain a challenge leading to water contamination. It was observed that most households preferred to have a lot of water of average quality than little water of very good quality. In this survey, access to water was computed using two complex indicators which were used to determine protected drinking water sources and time to source of drinking water. Therefore, the lack of water to ensure a minimum of hygiene causes even more problems than does the consumption of relatively poor quality water.

Hygiene and Sanitation facilities

Sanitation was also assessed using the different indicators that included use of improved sanitation facilities for defecation, non-defecation, and hand washing facilities. According to the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (2004), a household is classified as having an improved toilet if the toilet is used only by members of one household (i.e., it is not shared with other households) and if the facility used by the household separates the waste from human contact. An improved sanitation facility is one that hygienically separates human excreta from human contact. Improved sanitation facilities include: flush or pour-flush to piped sewer system, septic tank or pit latrine, ventilated improved pit latrine, pit latrine with slab and composting toilet. Sanitation is also measured using the non-defecation facilities. This indicator measures access to improved sanitation facilities, which are not latrines/toilets. This indicator focuses on other aspects of household hygiene. Availability of soap/ash at the household level is crucial for hand washing behaviour and its link to diarrhoea and other infections transmitted by unwashed hands. In this survey, a household was considered using improved sanitation facilities for non-defecation if they had all of the following facilities; a rubbish pit, clean water storage container, soap or ash for washing hands, plate drying rack, cloth drying line, rubbish pit among other facilities.

The results show that only 27.9% of the households have a plate drying rack, at least 71% and 84% of households had a cloth drying line and a bathing shelter respectively. The results also

showed that 63.6% of the household had rubbish pit and about 51% of these were purposely dug for use as rubbish pit. Most important is that 87.3% of the households use a toilet for defecation. However, 80.6% of these toilets are the traditional pit latrines. According to the qualitative findings the use of toilets has been reinforced by community leadership who issue penalties and fines to those that do not practice hygiene and sanitation. For example, in Kasungu, T/A Mwase and Dowa a Group Village Headman at TA Dzoole mentioned that they inspect each and every household to ensure that they have and use latrines. They impose fines for non-compliant households for example, banning those families from participation in social events, paying penalties e.g. chicken, goat and sometimes the chiefs declare that people should not eat any food during funeral if that particular bereaved family does not have a toilet.

Further, an HSA at Mbingwa health Centre in Dowa mentioned that they too are reinforcing construction and use of toilets in their work with Concern Universal – an organization that is supporting with rehabilitation and sinking of boreholes in the area. As a selection criteria, for village to access this support, Concern Universal and the Health Centre priorities villages with good sanitary practices for their support. The HSA indicated that this has encouraged most villages and their heads to improve their sanitation practices so that they are supported with rehabilitation, maintenance and sinking of boreholes in their area. Thirty three percent of the households share their toilets with other households and 41 % have a hand washing facility located near the toilet. Figure 14 below indicates the different types of toilets used.

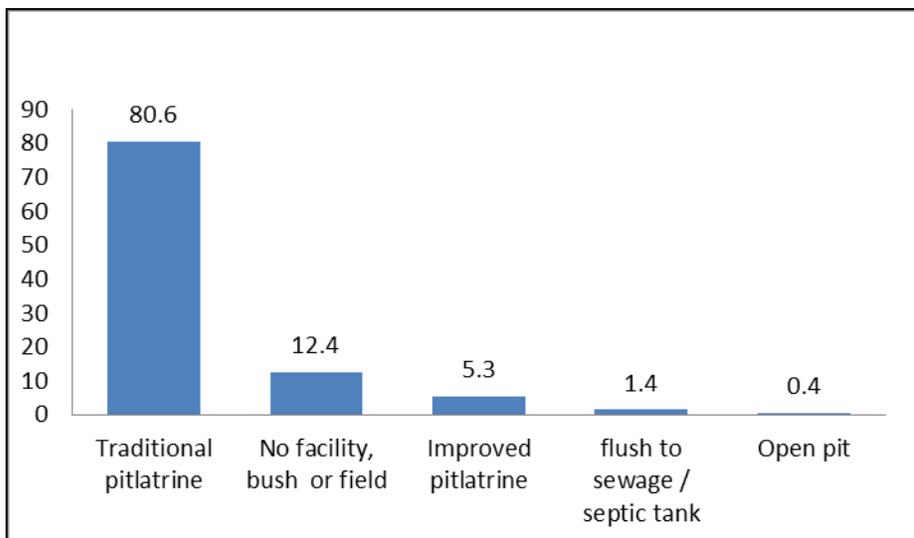


Figure 14: Type of toilet facility used by household

Nonetheless, 12.4% of the households continue open defecation and own no toilet facility. One way to explain this is that in TA Kayemebe in Dowa District there are cultural beliefs that restrict pregnant women in their third trimester not to use toilets. It is believed that women in advance pregnancy might lose their babies by delivering in a toilet. Below Figure 15 shows a picture of on the pit latrine in Dowa District



Figure 15: A picture of a pit latrine in Dowa District

Figure 15 shows a picture of a pit latrine women in advanced pregnancy are restricted use for fear that they might lose their babies by accidentally delivering a in there.

Future programming needs to focus on education on the importance of use of pit latrines with women and community as culture custodians. Consider scale-up punitive measures used by Chiefs in selected parts of Dowa and Kasungu District to enforce households to have and use a toilet.

Further, in Dowa and Kasungu Districts, the common hand washing facilities were containers, cups and tippy taps. Results show 41% of the households have a hand washing facility located near toilets/latrines and 91.2% are reported to be washing their hands soon after leaving a toilet/latrine while only 37% do so before food preparation and cooking. Figure 16below show practices and intervals of hand washing

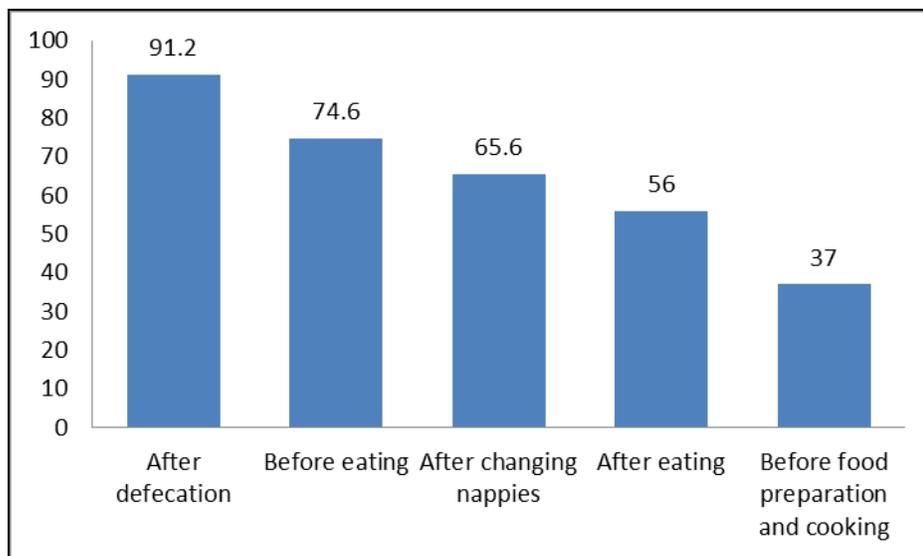


Figure 16: Practices and intervals of hand washing

According to interviewers' observations although the tippy taps were available in a majority of the households, they appeared dry showing prolonged non-use. Nonetheless, a majority of the respondents differed in frequency of use of hand apparatus; some said they used the facilities whilst others said they did not because of access to water is challenging. It was argued by some respondents that hand washing is not a priority use for water. During FGDs women it was reported that,

“When we go to the maize garden we do not take water with us as such we don't wash hands after changing baby nappies and breastfeeding. We just make sure we don't contaminate our hands. Yyou can see that the practice of washing hands here becomes a problem” (Kasungu Women FGD)

Further, it was also worrying to note that approximately half of the respondents, representing 53% always use soap to wash hands after defecation. According to FGD findings, availability of soap was mentioned as a challenge for most households. One woman had this to say;

“We don't wash our hands with soap because it is not available every time instead we use ash.”

Figure 17 below shows points at which hand washing practices occur

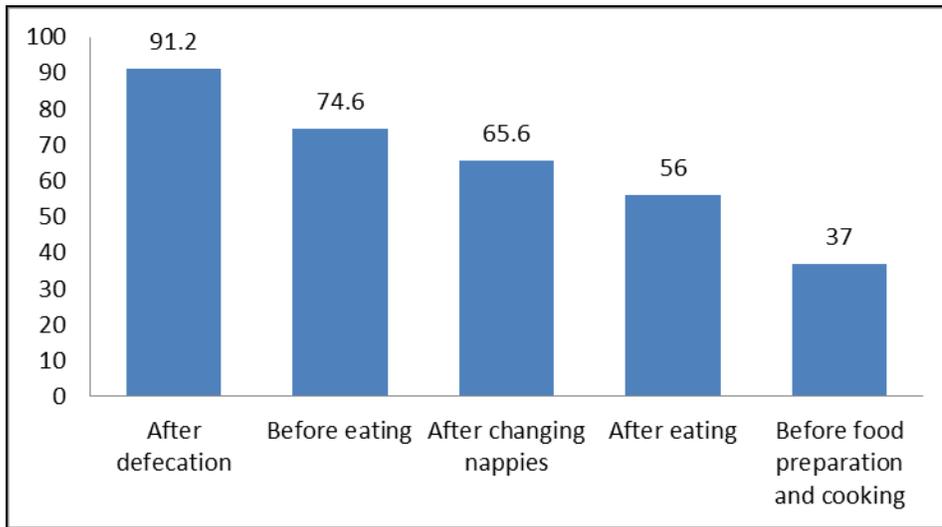


Figure 17: Times at which Hand washing practices take place

Among men, 44.8% would wash hand always with disinfectants after defecation. Among girls and boys, there were no major variations on hand washing after defecation, 33.6% for girls and 32.9% for boys. The girls in most households are also caregivers to children and other vulnerable groups with and/or without the presence of a primary caregiver. Figure 18 below Hand washing practices by gender

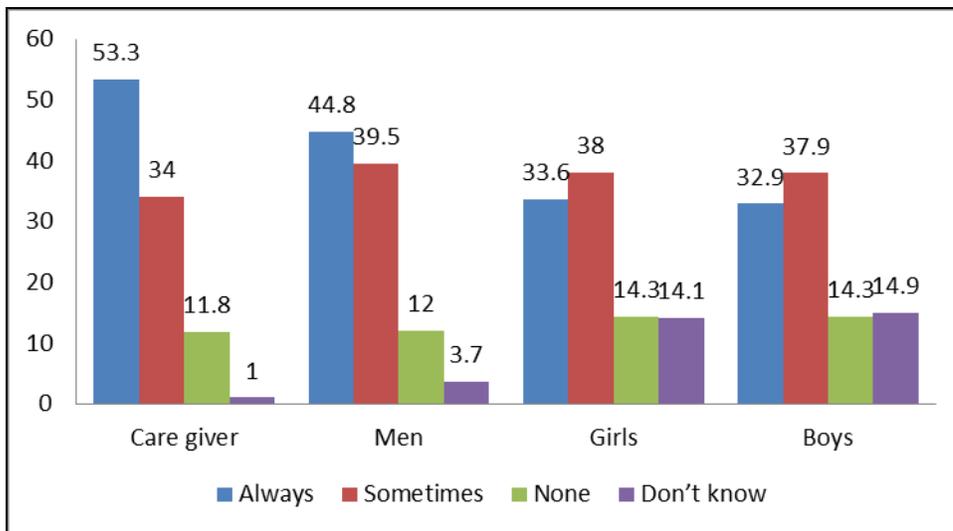


Figure 18 Hand washing practices and use of disinfectants by gender

The inconsistent hand washing practice implies that the communities are still at a greater risk of contracting communicable diseases through cross contamination. Future programming need to consider intensifying health education and improved water access to ensure consistent hand washing habits.

3.6 Childhood Illnesses

The common childhood illnesses assessed were fever (malaria), diarrhoea and acute respiratory infection (Pneumonia). The 2014 trend survey also analyzed possible mode of treatment to common childhood infections. Figure 19 below presents the prevalence of different childhood illnesses in the two districts.

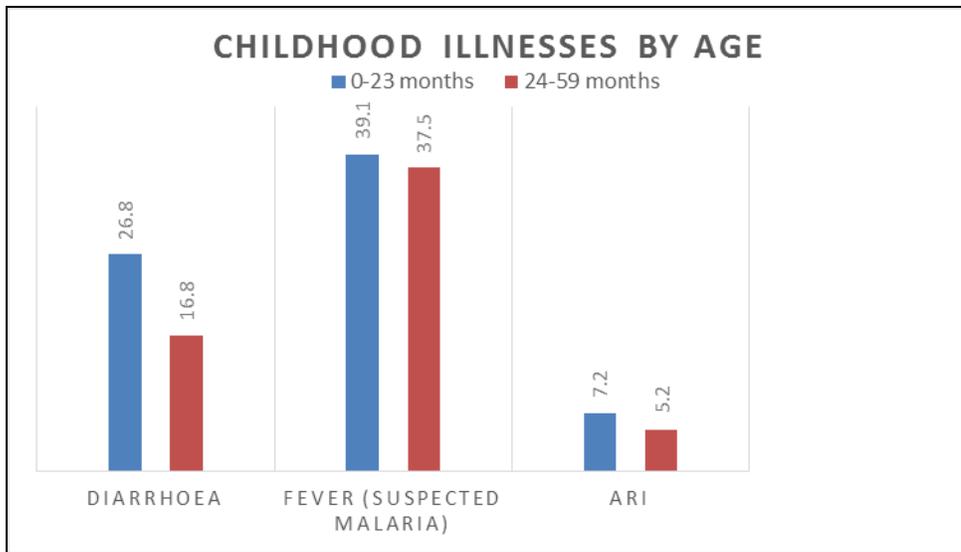


Figure 19 Common childhood infections.

a) *Fever (episodes of malaria)*

This indicator measures the prevalence of recent episodes of fever in children 0-59 months. According to WHO (2008), areas with high malaria endemicity (hyper-endemic) such as Malawi, fever is primarily caused by malaria infection. Therefore this indicator can be used as a proxy measure of malaria prevalence. However, this proxy indicator has a limitation. In malaria hyper-endemic areas, fever can also be caused by other infectious agents. Thus WHO no longer recommends the use of this measure as a proxy for malaria prevalence but the use of clinical or biomarker evidence. In contexts where MAZIKO project is implemented access to this diagnostic capacity is infrequent hence the use of fever as a determinant for Malaria incidence.

Figure 19 shows that the prevalence of fever is 39.1% higher in infants age bracket of 0-23 months than the age bracket of 24-59 months representing 37.5%. This is only a proxy of

malaria though the actual figures according to MDHS 2010 are estimated to be as low as 35%. Despite 91.6% households owning mosquito nets, 89.4% are those with infants and young children, it was not a direct measure of mosquito net usage. It was noted that only 15.9% of mothers and children sleep under a mosquito net compared 79.6% utilisation by all family members (See Appendix B). It reported that most of the mosquito nets were from health facilities and MAZIKO through ITBN and these were long lasting insecticides nets (LLITN).

As regards treatment, it is important to note that 79.8 % of the young children were taken to a healthy facility for malaria treatment, compared to 76.4% of the infants. The difference between the two is statistically insignificant. Respondents also reported purchase of medicine for fever (19.8% infants and 20.2% Children) whilst 2.1% did nothing and 1% sought traditional medicine. Figure 20 below shows care givers response to fever.

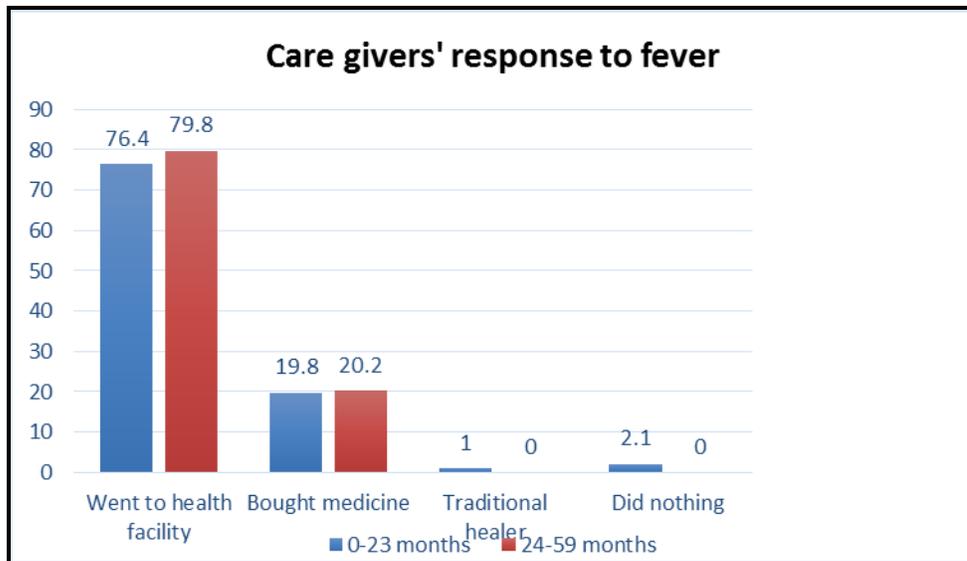


Figure 20 Fever (malaria) treatments

b) Prevalence of Diarrhoea

Diarrhoea in children under 5 is a direct measure of morbidity or illness. This indicator measures diarrhoea prevalence in children under-five and is a useful indicator of safe water supply availability. As such it is one of the most important indicators to measure the contribution of MAZIKO developmental interventions on hygiene, water and sanitation towards improving the physical health status of children. This indicator is also a useful proxy indicator of community-wide water and sanitation conditions. In infants diarrhoea prevalence can be considered as a measure for safe water supply at the household level but for older children, it reflects a wider community-level access to safe water.

Data shows that prevalence of diarrhoea is at 26.8% in infants and 16.8% in young children,

which is lower than MDHS 2010 estimates projected at 40% but also lower than the 2012 Baseline Survey (Dowa 60% Kasungu 40%). This trend shows a substantial decline in diarrhoea prevalence in both districts. However, in the 2014 trend survey, there is no significant statistical difference between boys and girls diarrhoea prevalence estimated at 26.9% and 26.2% respectively. The successful trend can be attributed to improved hygiene in selected communities within MAZIKO impact areas. Future programming need to consider intensifying current MAZIKO interventions aimed at improving hygiene practices.

Effective treatment of diarrhea among under- five Children

This indicator measures the prevalence of appropriate management with oral rehydration therapy (ORT) of children age 0-59 months with diarrhea in the past two weeks. Diarrhea treatment using low osmolality- Oral Rehydration Solution (ORS) and zinc is recommended by the WHO and is important for attaining the MDG goals. Scaling up of this important intervention is well underway. In this survey, use of ORT and uptake of appropriate treatment for the child was assessed. Effective treatment for diarrhea was at 45.2% in infants and lower in young children at 32.6%. There were still variation on ORT administration to the infants by sex and it was 48% in boys and 42.1% in females. Figure 21 below indicates the treatment seeking behavior for diarrhea in the area.

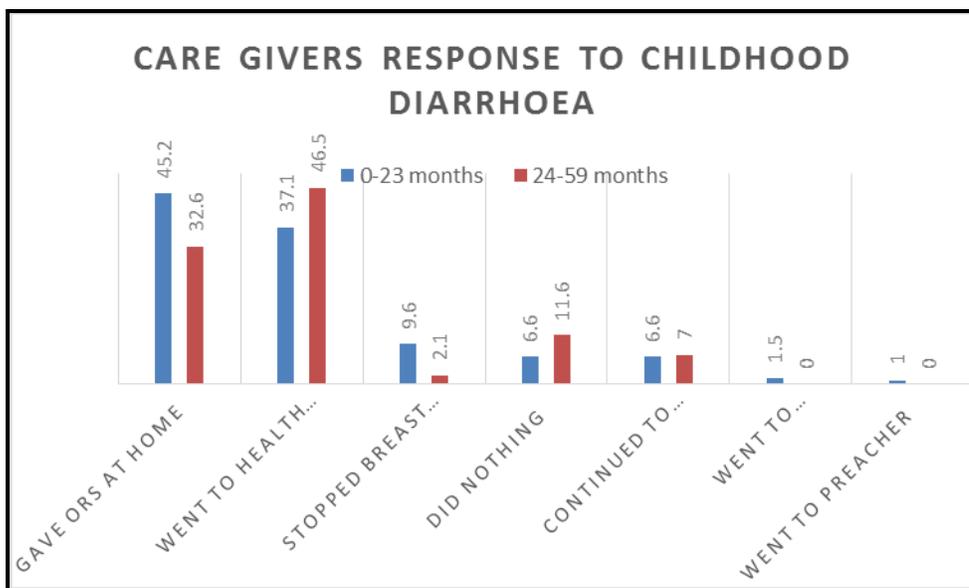


Figure 21 caregiver’s response to diarrhea.

The results shows that a substantial improvement in how mothers are managing under-five children with diarrhea, for example, approximately 88.3% mother continued breastfeeding their children during diarrheal episodes compared to (12.9% in Dowa and 16.3% in Kasungu) in 2012 Baseline Survey. These practices are based on myths by mothers who believe that when a child

has diarrhea, stopping of breast feeding would stop diarrhea. These feeding practices may contribute to increased prevalence of under nutrition among under-five children despite having diversity of foods in their diet. Future programming needs to enhance positive practices and address barriers to effective management of diarrhea in under-five to reduce malnutrition.

c) Prevalence of Pneumonia among under-five Children

This indicator measures the prevalence of children less than 5 years who have acute respiratory infection (ARI) with signs of ‘presumed pneumonia’. Presumed pneumonia is defined as fast breathing rate, in-drawing ribs, and nasal flaring and cough. Sometimes the combination of these signs is termed “danger signs” of pneumonia. Data shows that prevalence of presumed pneumonia is at 7.2% in infants and is 5.2% in young children.

Almost 30.4% of the sick infants received medication compared to 36% of young children who suffered from ARI (See Appendix B). Data shows that out of the children who sought care at a health facility, 74.2% were infants and 77.8% children. This health seeking behaviour may be attributed to mothers’ inability to detect early symptoms of pneumonia and untimely health seeking behavior. It is difficult for most caregivers to detect early signs of pneumonia through cough, sneezes and they many at times await for serious difficult breathing signs to take the child to a health facility. The variation in treatment received can best be explained by the children’s outcome. Nevertheless, future programming has to emphasise health education on early detection of symptoms and enhance earlier health seeking behaviour. Figure 22 below shows different treatments sought for ARI in the implementation areas.

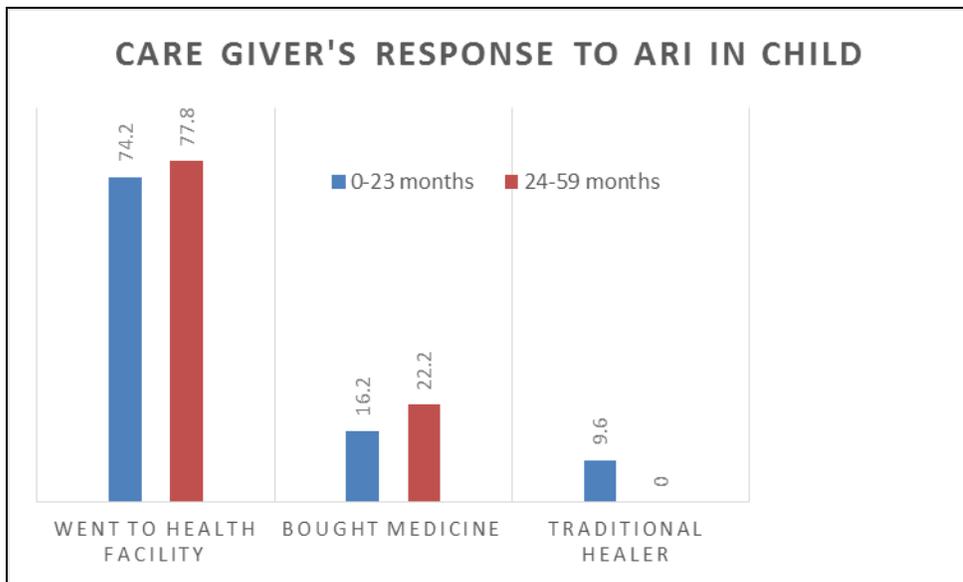


Figure 22: Effective treatment of the ARI.

3.7 Under-five Growth Monitoring

Growth monitoring and promotion facilities offer different services pertaining to the health of the mother and that of a child. The services offered include checking anthropometrically the nutrition status of the child (weight, height and MUAC measurements), provision and coverage of essential vaccines and vitamin, mineral supplementation and de-worming among other services. The 2014 Trend Survey found that 96.5% of the infants aged 0-5 months were taken to growth monitoring centers to access different services compared to 3.5% of the 6-18 months older infants. In addition mothers/caregivers continued to take their under-five children for growth monitoring registering 91% for infants (0-23 months) and 88.7% for young children (24-59 months). De wormers are given to infants and children from 6 months to 59 months. About sixty five percent of the young children had received de-worming drugs within 6 months prior to the survey compared to only 50.5% of the infants. FGDs findings show that Maziko project has facilitated the provision of growth monitoring services in the communities that are far from health facilities through mobile clinics. This may have increased the number of Under-five children receiving essential vaccines and vitamins.

3.8 Usage of Mosquito Nets

The ownership and use of both treated and untreated mosquito nets is the primary prevention strategy for reducing malaria transmission in Malawi. The Insecticide Treated Nets (ITN) policy includes free distribution of ITNs for pregnant women at their first visit to an antenatal care (ANC) clinic, for children born in health facilities, and for children attending their first visit under the Expanded Programme on Immunisation (EPI), if an ITN was not received at birth (MDHS,2010). To increase coverage, timely mass ITN distribution campaigns are conducted and Malawi has been moving to the use of long-lasting insecticidal nets (LLINs), which are heavy duty and pre-treated. This section presents the 2014 Trend Survey findings at the household level on the ownership and use of mosquito nets, particularly by children under age 5 and pregnant women.

It was found that over 90% of household with under-five children owned a mosquito net. Of these 94% were owned by household with infants and 91% by households with young children and were sourced from hospital. Approximately 1% of the mosquito nets are bought by households while 4.6% to 9.2% are received as a donation from NGOs and projects including MAZIKO. It was also noted that 85-90% of these mosquito nets were pre-treated for effective use in the households.

The National Malaria Control Programme (NMCP) estimated to at least 80 percent of children under age 5 and pregnant women sleep under ITNs (including LLINs) by 2010. During the Trend Survey, 10% of mothers with young children and 2% of mothers with infants were pregnant. Of these over 90% had slept under a mosquito net the previous night prior to the survey. Further, it was noted that a very small proportion of children sleep under a mosquito net alone (3.5% and 1.8% for young children and infants respectively).

Only about 4.5% of the households had infants and 8.8% had young children respectively sleeping under a mosquito net. The proportion of mothers and their children sleeping under a mosquito net was minimal. Those mothers with infants representing 14.1% and 13.7% for those

with young children had slept under a mosquito net the night prior to the survey. It was therefore noted that the mosquito nets were mostly used by all the family members at 79.6 % than infants and 74.6 those with young children (See Appendix B).

This implies that mothers and children who are the key target for distribution of mosquito net are deprived, hence an increase in malaria/fever amongst this target group. Therefore future programmes should aim at intensifying education on the importance of mothers and children sleeping under a mosquito net unlike the rest of the family members.

4.0 HOUSEHOLD DIETARY DIVERSIFICATION

4.1 Infant and young child feeding

Infant and Young Child Feeding (IYCF) practices include three components for children aged 6-23 months. In addition to continuing breastfeeding, from age 6 months children should be fed solid/semi-solid foods a minimum number of times a day. As a child ages the number of food groups introduced and the frequency of feeding should increase. For the average, healthy breastfed child, solid/semisolid foods should be provided two to three times per day at age 6-8 months and three to four times per day from age 9-23 months, with an additional snack being offered one to two times per day, as desired. The minimum feeding frequencies are based upon the energy needs from complementary foods according to age-specific total daily energy requirements; minus the average energy intake from breast milk for children in developing countries for example Malawi. However, feeding frequencies greater than necessary may lead to the displacement of breast milk. Although it is internationally recommended that infants should be breastfed for up to two years, some infants are not breastfed and therefore do not receive the benefits of breastfeeding, while others stop breastfeeding before age. Results of this Trend Survey indicate meal frequencies of children 6-23 months at 63.7% and are better in children breastfeeding than non-breastfeeding infants. This pre-disposes the non-breast feeding infants and making them more vulnerable than their counterparts (See Appendix A).

In Figure 20 below results shows the rate of exclusive breastfeeding, initiation of breastfeeding and the minimum acceptable diet of a child. One key finding is only 24% of children (6-23 months) receive minimum acceptable diet and inadequate dietary intake is a direct cause of malnutrition. There were no major variations in sex. It is noteworthy that over 92% of the infants are put to the breast within 1 hour after birth, and there is a high probability of utilizing colostrum. Taking into consideration that most births are taking place in a health facility where consumption of colostrum is promoted. The study team found that that bottle feeding is not prominent. Only 8% of the infants were bottle fed, this is important because mothers prefer to breast feed than to bottle feed. This is important for child health, nutrition and survival. Figure 23 below shows feeding practices of children 6-23 months

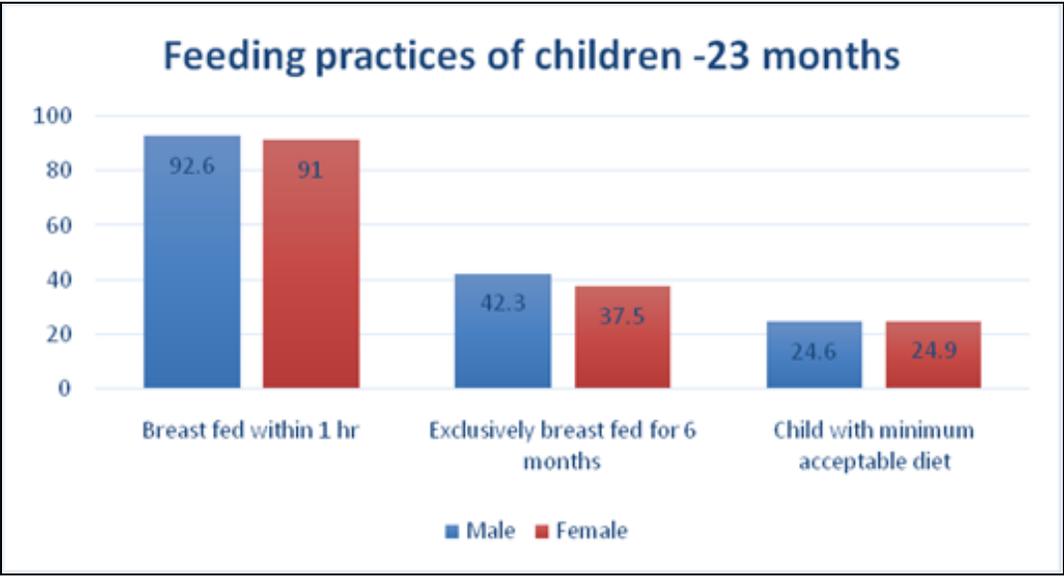


Figure 23: Infant and Young child feeding.

Appropriate nutrition includes feeding children a variety of foods to ensure that nutrient requirements are met. Studies have shown that plant-based complementary foods by themselves are insufficient to meet the needs for micronutrients. Therefore, it has been advised that meat, poultry, fish, or eggs should be eaten daily, or as often as possible. Vegetarian diets may not meet children’s nutrient requirements unless supplements or fortified products are used. Vitamin A-rich fruits and vegetables should be consumed daily. Children’s diets should also include adequate fat content. Fat is important in the diets of infants and young children because it provides essential fatty acids, facilitates absorption of fat-soluble vitamins (such as vitamin A), and enhances dietary energy, density, and palatability. Tea and coffee contain compounds that inhibit iron absorption and are not recommended for children. Sugary drinks and excessive juice consumption should be avoided because, other than energy, they contribute little to the diet and as a result decrease the child’s appetite for more nutritious foods. Figure 24 below represents the child’s dietary diversification.

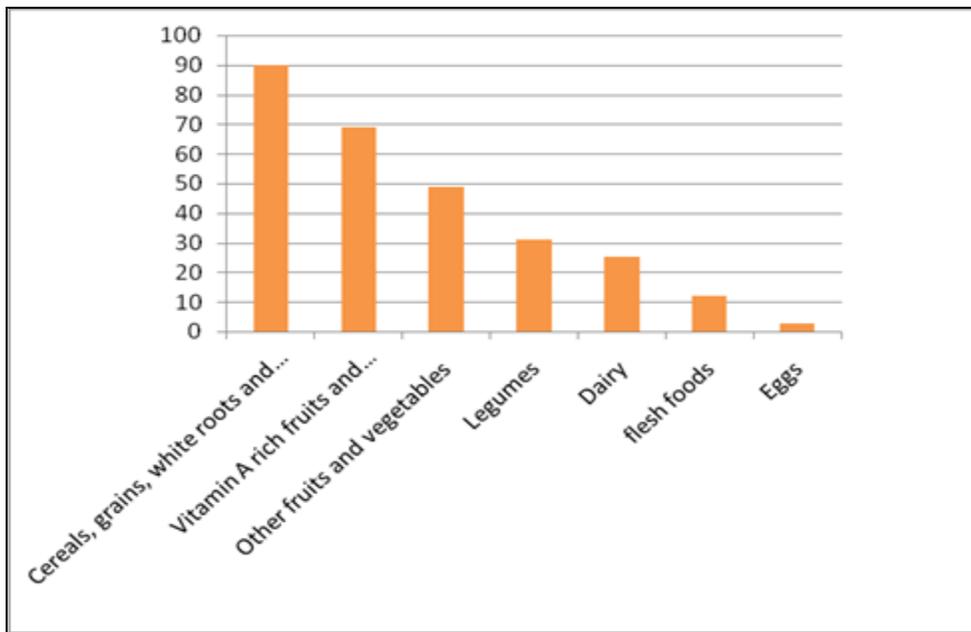


Figure 24: Child’s dietary diversification.

Results further indicates the minimum dietary diversification for infants 6-23 months is as low as 32% and it is higher in non-breastfed infants 63.7% and 31% in breastfed infants. Minimum acceptable diet is at 24.8% and 24.6% in breastfed infants (Appendix A) and results are a cause of concern especially when only 12% of the infants consumed iron rich or fortified foods 24 hrs prior to the survey.

Breastfed children age 6-23 months should receive animal-source foods and vitamin A-rich fruits and vegetables daily. Because first foods almost universally include a grain- or tuber-based staple, it is unlikely that young children who eat foods from two or fewer food groups will receive both an animal-source food and a vitamin A-rich fruit or vegetable. Therefore, four food groups are considered the minimum appropriate number of food groups for breastfed infants. When assessing IYCF, make sure children’s feeding practices met minimum standards with respect to food diversity (i.e., the number of food groups consumed), feeding frequency (i.e., the number of times the child was fed), and the consumption of breast milk or other milk or milk products.

Exclusive breastfeeding (EBF) is defined as the proportion of infants under 6 months of age who are receiving breast milk, and not receiving any other fluids or foods, with the exception of oral rehydration solution, vitamins and mineral supplements. During the survey mothers of children aged 6 months or less were asked to recall the any other foods or drink/liquids which were given to the child except those prescribed from the hospital. Results show that only about 40% of children under the age 6 months were exclusively breastfed which is lower when compared to 49% of the children exclusively breastfed in the last 2013 Trend Survey and much lower than 71.4% of the children of the same age who were exclusively breastfed at national level (MDHS,

2010). However, there were no major variations in terms of sex, 42 % were male and 38% were female.

Breastfeeding exclusively protects children against major causes of death like ARI and diarrhoea. Childhood illnesses and death rates can increase 20-fold in these situations because of high levels of exposure to infections, poor hygiene and inadequate feeding care. This means that, over half of the children in MAZIKO implementation area might be predisposed to malnutrition. There is need to necessitate deliberate efforts in the area to reinforce EBF for the early life of infants which is crucial in an area which the situation could not improve with the available feeding practices.

4.2 Initiation of Breastfeeding

Early initiation of breastfeeding is encouraged for a number of reasons. Mothers benefit from early suckling because it stimulates breast milk production and facilitates the release of oxytocin, which helps the uterus to contract and reduces postpartum blood loss. The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also fosters bonding between mother and child. The results of the 2014 Trend Survey show that 91 % of all the children born in the two years before the survey were put to the breast as their first food. There were no major variations in sex of the infants at 92% in females and 91% in males and it ranged from 90-94 confidence intervals. It also considers the prevalence of the practice of pre-lacteal feeding which, is discouraged because it limits the frequency of breastfeeding by the infant and exposes the baby to the risk of infection. In this case, it shows might not be in existence in the area, considering number of births taking place at a health facility. This poses as an opportunity, the mothers understand the need of the early initiation of breastfeeding in infants. Further awareness and behavior change interventions are further needed in the area to foster continued EBF in the early 6 months of life and proper feeding practices. Early initiation of breastfeeding in the last 2013 trend survey was at 84% and 94% nationally in the MDHS report of 2010.

Individual dietary diversification and meal frequency of under- five children is an indicator of how much attention women give to their children. It may also explain caregivers' knowledge and empowerment among other issues to sustain desirable/adequate nutritional status of a child. Nutritional status of an individual is a direct result of dietary intake and health status among other underlying and basic causes of malnutrition. Looking at dietary diversification (See Appendix A), it can be concluded that diets in Dowa and Kasungu are predominately plant based and there is little or no dietary diversification for over half of the child's population. caregivers in Dowa district demonstrated that protein based foods are scarce and expensive that is why they are rarely consumed citing that although MAZIKO committed to providing livestock as protein based alternate diets that has not happened. Bio-availability of nutrients from plant based food sources are generally affected by choices, combinations and mode of preparation, thus leading to mal-absorption of nutrients for use in the body. The Bio available vitamins and minerals would be able to build the children's immunity and stimulate growth. This further explains the prevalence of different infectious diseases amongst children in the area. Malnutrition increases

the susceptibility and severity of infections in children such as diarrhoea, ARI, Malaria and measles. Through the survey results it has been observed that consumption of staples and vegetables does not translate to improved nutritional status, all the food groups are needed for adequate nutritional wellbeing. Chronic malnutrition is undesirable for child’s health and development as envisaged through the existing high prevalence of stunting of 43% and 47% in Kasungu and Dowa respectively

4.3 Women Dietary Diversification

This indicator measures the average number of different food groups consumed by a woman per day. As a measure of dietary diversification, an increase in number of food groups consumed per meal enhances the nutritional status of an individual, arising from eating wide variety of foods providing combined nutrient dense. A woman is considered to having an adequate diversified diet if she consumes a meal from a combination of the different food groups at least four. The Malawi food guides uses the six food groups and the six food groups comprising a meal include energy (staple) foods, animal protein foods, plant protein (legume) foods, vegetables, fats and oils, and fruits. Refer to appendix A for the details of the recommended dietary diversification score for women. The results have shown that the average individual dietary diversity for women is (5 or more food groups) 24.7%. Out of these, those who met the recommended minimum dietary diversity together with their children were 60.7% and 39.3% were those women who met their recommended minimum dietary diversification but their infants did not. Seventy eight percent of the women did not meet their minimum dietary diversification and their 6-23 months infants also did not meet the MDD. Figures 25a below indicates the women’s food consumption patterns and Figure 25b provides a summary of the women minimum dietary diversification.

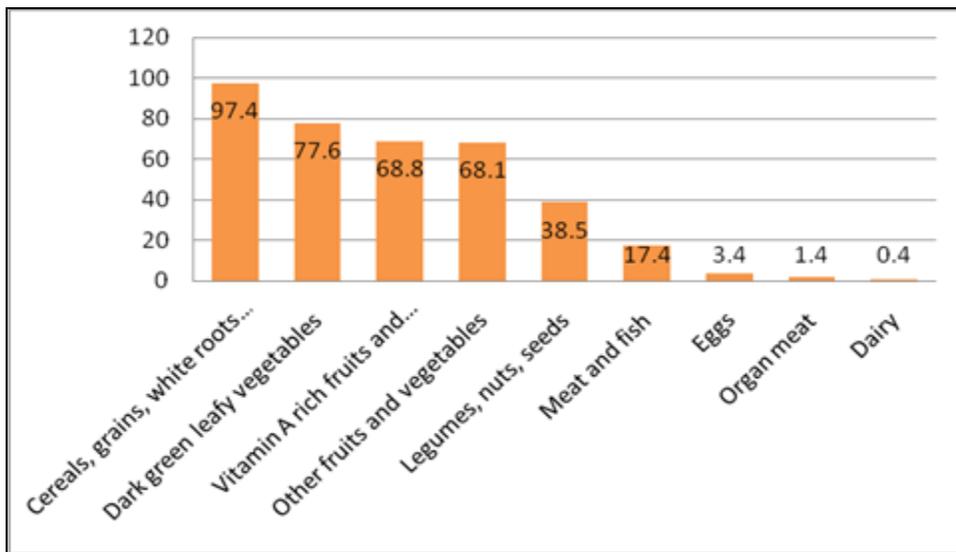


Figure 22a: Women’s food consumption pattern

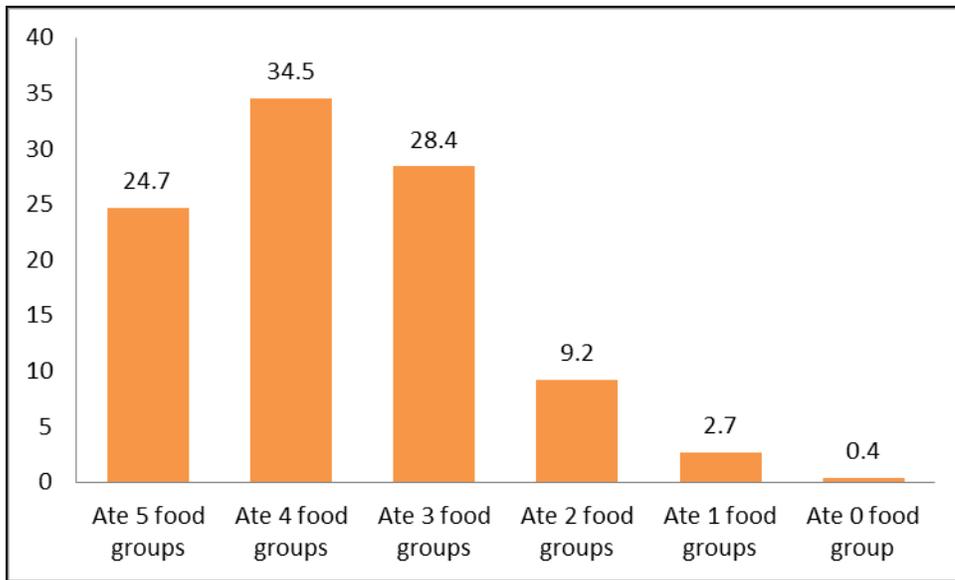


Figure 22b: Women minimum dietary diversification

There only 24.7% of women who ate from 5 food groups, 34.5% from 4 groups showing most women are not diversifying their diets. It is rather difficult for the children to diversify the diets. The mean diversity scores for households ranged from poorest 3.5, 3.95 lower middle poor, 4.30 middle, 4.59 upper middle to 4.91 highest (See Appendix A). The household's dietary scores and food consumption patterns their diets are solely plant based with very minimum diversification; the situation is the same as of women and children minimum diversity scores.

5.0 CONCLUSION

Based on the survey results, it can be concluded that the quality of life among children and women in the MAZIKO impact areas is not worse than the average rural Malawi population. There is however cause for concern given the relative investment made in current impact areas. There is also evidence that most outcome indicators have improved such as women participation in groups and holding leadership positions. However, their participation has not directly resulted in real change whereby women are fully empowered to make household decisions on use of finances and assets to improve their nutritional and health status. There is need to intensify attitude and behaviour change interventions for evident impacts in the area. There is need for MAZIKO project to focus on “learning outcomes” rather than merely promoting access to interventions. It is also apparent from the survey that caregivers are not able to appreciate other services offered due to levels of food insecurity, power, poverty and gender and women empowerment. This could be an opportunity for MAZIKO to entrench the Citizen Voice and Action approach to social accountability. Through this approach, caregivers can be empowered to engage with power holders and demand for quality public services.

It is the recommendation of the consulting team that program management uses this report to inform alignment of designs to the strategy. The food based nutrition intervention is a long term strategy and multi-sectoral, therefore, three years of implementation appear inadequate to show sustainable, tangible and evident impacts.

6.0 RECOMMENDATIONS

Coverage

Coverage (geographical and thematic) for MAZIKO project was noted as an issue of concern. Geographically, it was noted that MAZIKO had spread itself thinly with too many impact areas, for example TAs some of which are far apart but within a short period of interventions time. Thematically, as noted above, there are several factors that compound on human nutrition beyond ensuring food and nutrition security. In order to achieve maximum impact, it requires putting together comprehensive and long term strategy. Future programming of Maziko should consider all these capacity, realistic service duration and partnership to benefit from varying institutional synergies at a district and community levels. In other words, there are other players who could supplement program efforts by providing MAZIKO essential services gap, e.g. safe water, food security, as well as other social economic programmes that complement nutrition security.

Socioeconomic Interventions

Future programming needs to scale-up current economic initiatives to ensure communities own assets that direct or indirect positively impact on the livelihood of a mother and a child. As it was noted, most households suffer perpetual food insecurity because a lot of arable land is prioritised for growing cash crops such as tobacco, MAZIKO should consider supporting households with farm inputs to maximize agricultural production on the limited arable in custody of these communities to ensure food security. These farm inputs might include; seed livestock to households to kick start livestock entrepreneurship.

Gender and Women Participation

Future programming should build on current gains by incorporating more intentional discussions on what gender equality means at the relations and structure levels, through facilitated processes such as social analysis and action, for example.

In order to sustain gains in gender and women empowerment, future programming should concentrate on cultivating and showcasing women who exercise personal autonomy in decision making and couples who show relative equality in the area as gender change champions.

Dietary Diversification

Maziko should for the remaining period towards phase out emphasize on proper food combinations, dietary diversification and modification through nutrition education, agriculture diversification and women empowerment in the areas emphasizing on behavior change interventions to attain greater impact. The programme should emphasise on deliberate efforts

that promote dietary diversification like trainings, campaigns and displays. There is need to encourage diversification within food groups so as to reduce shock and cases of specific food shortages.

As the programme scale-up and at the same time winds their program in the communities there is need to deliberately create a platform of stakeholders coordination that can help reinforce consumption of nutrient rich foods such as foods from animals, fruits and oils and fats. This can be achieved through sustainable pluralistic and empowered demand driven service delivery

Childhood Illnesses

Future programming needs to enhance positive practices and address barriers to effective management of diarrhea in under-five to reduce malnutrition. Health education is another area that needs enhancing to enable proper management of childhood diseases within the communities. For example, education on early detection of symptoms of common childhood illnesses, importance of mothers and children sleeping under a mosquito net for malaria prevention and enhance earlier health seeking behavior is vital.

Capacity Building and Sustainability

Despite the fact that Maziko was commended for its community based approach and performance in nutritional programmes especially with the deployment of CPs as front liners in communities, concerns were raised on the fact that not all CPs benefitted from this training. For instance, in Dowa District it was mentioned that out of 169 CPs recruited; only 60 were trained within the two years period using 2 out of 5 training modules. Additionally, CPs experienced a challenge to impart knowledge and skills to the LPs / Vas who are the next layer of operational personnel for the project thereby compromising the quality of information and skills to the targeted households and communities. In order to avert these operational challenges, future programming may consider to:

- d) Devise realistic capacity building programmes/training for the field personnel based on its capacity levels to adequately train and manage the community front line officers.
- e) Consider if indeed the next layer of field personnel (lead persons, lead farmers, village agents) is very essential and how best to build the capacities of these cadres so that they are efficient and effective like the CPs. A suggestion was made that in preparation for phase out; MAZIKO should consider building some form of leadership and coordination focal points for the CPs. Currently each CP operates as an entity of some kind with the MAZIKO staff as the point of converging. How about in the absence of MAZIKO, what will happen of the CPs.
- f) Strengthen collaboration and coordination at the operation level with field staff such as AEDOs, HSA and ensure their active participation in Maziko programmes to ensure sustainability after phase out.
- g) Strengthen collaboration, linkages and partnership with other stakeholders within the districts to maximize district partnership synergies so as to provide comprehensive

nutritional support to the impact areas. For example, mention was made on the existence of a District Nutrition Coordinating Committee Dowa District that MAZIKO appear not to have actively taken advantage to engage to advance it goals.

7.0 References

1. Black, R.E., Allen, L.H., Bhutta, Z.A., Caulfield, L.E., de Onis, M., Ezzati, M., Mathers, C and Rivera, J(2008). Maternal and child under nutrition: global and regional exposure and health consequences. *The Lancet*, 371 January, pp.243-260.
2. Caulfield, L.E., Onis, M. De, Blösser, M. and Black, R.E (2004).Under nutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles. *American Journal for Clinical Nutrition*, 80 pp.193-198
3. Kaufman, M. 2004. Transforming our initiatives for gender equality by addressing and involving men and boys: a framework for analysis and action In: Ruxton, S. ed. *Gender equality and men: learning from practice*. London: Oxfam.
4. Liu, L., Johnson, H.L., Cousens, S., Perin, J., Scott, S., Lawn, J.E., Rudan, I., Campbell, H., Cibulskis, R., Li, M., Mathers, C. and Black, R.E. 2012. Global, regional, and national causes of child mortality: An updated systematic analysis for 2010 with time trends since 2000. *The Lancet*, 379 May, pp.2151-2161.
5. National Statistical Office (2008).*2008 Population And Housing Census Preliminary Report*. Government Print, Zomba. [Online] Available: http://www.nsomalawi.mw/images/stories/data_on_line/demography/census_2008/Main%20Report/Census%20Main%20Report.pdf[Accessed 8 February 2013)
6. National Statistical Office (NSO) and ICF Macro Malawi *Demographic and Health Survey (2010)*.Government Print, Zomba.
7. Office of the President and Cabinet; Department of Nutrition, HIV and AIDS 2009 Malawi *National Nutrition Policy and Strategic Plan 2007-2011*. Lilongwe: [Online] Available at: <http://www.standardsfacility.org/Files/EconAnalysis/Malawi/18%20Malawi%20National%20Nutrition%20Policy%20Strategic%20Plan%202009.pdf> [Accessed November 30, 2013].

8. Royal Tropical Institute, KIT 2013. Food security and *reducing* malnutrition in urban areas: the challenge of identifying cost-effective and sustainable value chain interventions. *Royal Tropical Institute Policy Brief 2: Urban nutrition*. January 2013
9. UNICEF (2013) The UNICEF conceptual framework of cause of malnutrition. [Online] Available: <http://www.unicef.org/nutrition/training/2.5/4.html>
10. World Bank (2012). *Health expenditure, total (% of GDP)* [Online] Available: <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> [Accessed August 9 2013]
11. OPC 2009; Nutrition Policy and Strategic Plan, OPC: Department of Nutrition and HIV/AIDS
12. MDHS 2011; National Statistical Office and Macro
13. MICS 2006. National Statistics Office and UNICEF

8.0 APPENDICES

Appendix 1 Household Questionnaire for MAZIKO Trend Survey

Household Questionnaire for MAZIKO Trend Survey

MARCH-APRIL, 2014

Kupempha Chilorezo

Ine ndine.....ndikugwira ntchito ndi bungwe la MAZIKO limene likugwira ntchito mdela lino. Ndabwera kuti ndicheze nanu pa nkhani za ulimi, Chakudya, zaumoyo, za ukhondo wa panyumba, kusamala ana, za chuma ndi chitukuko cha pakhomu. Zomwe tikambirane pano zidzathandizila a MAZIKO kugwira ntchitoyi moyenela komanso ndi zachisinsi.

Kodi ndinu womasuka kuti ticheze nanu?

Ngati wavomera, chezani. Ngati wakana, athokozeni ndipo pitani nyumba ina.

MAZIKO SURVEY WITH CARE MARCH 2014			
MODULE A : IDENTIFICATION			
ID: /_/_/_/_/_/_/_/_/		Malawi	
A1	Date: day/month/year /___/___/2014	A6	Household No.: /___/___/
A2	Name of District:	A7	Name of Enumerator:..... Phone:.....
A3	Name of T.A:	A8	Name of Supervisor:.....

A4	Name of GVH.....	A9	Name of Respondent:
A5	Name of village.....:	A10	Age of Respondent /___/___/Years
		A11	Name of Data entry clerk: Phone:..... Time Start:.....

MODULE B : HOUSEHOLD SOCIO-ECONOMIC CHARACTERISTICS
Household Composition

B1	Name of Household Head (<i>Decision maker</i>) Kodi mutu wa banja lino ndi ndani?	Name :
B2	Sex of Household Head Kodi ndi Mwamuna kapena Mkazi?	Male.....1 Female2
B3	Age of Household Head (<i>in completed years</i>) Nanga ali ndi zaka zingati?	Age /_/_/ in years Unknown.....99
B4	Marital Status of Household Head Kodi ali pa banja?	Currently Married – monogamous.....1 Currently Married – polygamous..... 2 Widowed.....3 Divorced.....4 Single.....5 Orphan (under 18 years of age)..... 6 Separated 7
B5	Relationship of caregiver/respondent to household head Pali ubale wanji pakati pa inu ndi mutu wa banja?	Self1 Spouse2 Relative.....3 Domestic worker.....4 Other - specify.....88
B5.1	<i>Instruction: Observe general status of the households and surrounding</i> What is used for roofing How is the floor done What is the wall made up of?	Glass thatched.....1 Iron sheets.....2 Cemented.....1 Mud smeared.....2 Burnt bricks.....1 Mud walls.....2 (Including unburnt bricks)
B5.2	<i>House Assets</i>	Bicycle Yes.....1.....No.....2

		Farm cart	Yes.....1.....No.....2
		Furniture	Yes.....1.....No.....2
		Cell phone	Yes.....1.....No.....2
		Radio	Yes.....1.....No.....2
		TV	Yes.....1.....No.....2
		Car	Yes.....1.....No.....2
		Solar panel	Yes.....1.....No.....2
		Motor cycle	Yes.....1.....No.....2
		Lamp	Yes.....1.....No.....2
		Specify others.....	

In answering B6 to B9 exclude visitors (< 2 weeks)

B6	Total Number of members in this HH	Male /___/	Female /___/	Total /___/
B7	Total Number of children 0 to 23 months (< 2 years)	Male /___/	Female /___/	Total /___/
B8	Total Number of children 24 to 59 months (<5yrs)	Male /___/	Female /___/	Total /___/
B9	Total Number of people 15 to 49yrs	Male /___/	Female /___/	Total /___/

Education

B10	Household Head can read or write Kodi mutu wa banja amatha kulemba ndi kuwerenga?	Yes.....1 No.....2
B11	Level of Education of Household Head Nanga analekeza kalasi yanji?	Adult literacy.....1 Junior Primary (Std 1-4).....2 Senior Primary (Std 5-8).....3

		Junior Secondary (Form1-2).....4 Senior Secondary (Form 3-4)5 Tertiary.....6 Don't know.....7 None8 Other – specify.....88
B12	Caregiver can read and write Kodi inuyo mumatha kulemba ndi kuwerenga?	Yes1 No.....2
B13	Level of Education of Caregiver Nanga munalekeza kalasi yanji?	Adult literacy.....1 Junior Primary (Std 1-4).....2 Senior Primary (Std 5-8).....3 Junior Secondary (Form1-2).....4 Senior Secondary (Form 3-4)5 Tertiary.....6 Don't know.....7 None8 Other – specify.....88
SOCIAL EMPOWERMENT AND WOMEN'S PARTICIPATION		
B14	Are you a member of any community based organisations, associations and community development groups? (<i>eg financial, religious, farmer club, village savings, health and nutrition</i>) Kodi ndinu membala wa gulu lina lirilonse? (mwachitsanzo : mpingo, chitukuko, kusunga ndi kubwereketsa ndalama)	Yes.....1 No.....2 (IF no, go to B20)
B15	What kind of group is it? Kodi ndi gulu lanji?	<i>Microfinance (okongoza)..... 1</i> <i>Religious2</i> <i>Farmer club3</i> <i>seed club4</i> <i>Village savings and loans.....5</i>

		Cluster (Health and nutrition).....6 Other specify88
B15A	How many women and men take part in the group? Ndi amuna angati amene amatenga nawo mbali mu magulumu?	Men..... Women.....
B16	Who decided that you should be a member of this organisation? Kodi anakupangirani chisankho cholowa m'gululi/m'bungwe ndani?	Myself.....1 My husband.....2 Community leaders.....3 Someone else.....4
B17	Do you hold a leadership position in the group(s)? Kodi muli ndi Udindo m'gululi?	Yes.....1 No.....2
B18	How would you rate your level of participation (e.g. ask number of meetings /activities in last month or 3 months and how many attended) in the group? Kodi mumatengapo gawo lalikulu bwanji pa zochitika m'gululi?	>75% Very active.....1 >=50% Active.....2 <50% A little active.....3 0% Not active4
B19	Is this group effective in influencing public decisions regarding women's concerns and interests? (probe with an example) Kodi mukuganiza kuti gululi liri ndi mphamvu zotani polimbikitsa ntchito zokhudza amayi?	Effective.....1 Not effective.....2
B20	In your opinion, to what degree can women in your community influence household decision on issues of nutrition and care for children, pregnant or lactating women? Kodi mmaganizo anu, amayi ali ndi mphamvu zotani pa nkhani zopititsa patsogolo kudya koyenera ndi kusamalira ana, amayi oyembekezera komanso amayi oyamwitsa mmudzi muno?	Very much.....1 Some influence.....2 A little influence.....3

		Not at all.....4 No opinion5
B21	In your opinion, to what degree do you personally influence household decision on issues of nutrition and care for children, pregnant or lactating women? Kodi mmaganizo anu, inuyo muli ndi mphamvu zotani potengapo mbali pa nkhani zakudya ndi kusamalira ana, amayi oyembekezera ndi oyamwitsa mnyumba mwanu?	Very much.....1 Some influence.....2 A little influence.....3 Not at all.....4 No opinion5
B22	In your opinion, to what degree do married women contribute to decision making around food and health expenditures? Kodi mmaganizo anu, amayi a pabanja ali ndi mphamvu zotani potengapo mbali pa kagwiritsidwe ka ndalama pa nkhani ya zakudya ndi za umoyo mdera lino?	Very much.....1 Some influence.....2 A little influence.....3 Not at all.....4 No opinion5
B23	Are you currently a member of the Village Savings and Loan Group? Kodi muli mgulu losunga ndi kubwereketsa ndalama?	Yes.....1 No.....2
B24	In the past, have you been a member of the Village Savings and Loan Group? Kodi m'mbuyomu, munakhalapo mgulu losunga ndi kubwereketsa ndalama? Mwabwelekako ndalama zingati mu gululi komaliza?	Yes.....1 No.....2 MK :.....

Access to Health		
<i>Tsopano ndikufusani nkhani yokhudza za umoyo ndi chipatala</i>		
B25	How long does it take you to get to health centre?	

	Kodi mukayenda pansi mumatenga nthawi yayitali bwanji kuti mukafike ku chipatala chapafupi ndi mudzi wanu?	Less than 30 minutes.....1 One hour.....2 More than one hour.....3
B26	Does a regular outreach/mobile clinic come to your village? Kodi chipatala choyendayenda chimafika mmudzi muno?	Yes.....1 No.....2
B27	Have you ever taken your underfive child to the outreach/mobile clinic? Kodi munayamba mwapitapo ndi mwana wanu ochepera zaka zisanu ku chipatala choyendayenda?	Yes.....1 No.....2
B28	Do you have a village clinic? <i>(e.g. HSA with simple drugs)</i> Kodi mmudzi muno muli chipatala komwe ana amalandirako chithandizo?	Yes.....1 No.....2
B29	When you were pregnant did you attend antenatal clinic? Kodi nthawi imene munali oyembekezera munapitapo ku sikelo ya amayi?	Yes.....1 No.....2 If No, go to B33 Not applicable.....3
B30	When did you start attending antenatal clinic when you were pregnant?	Within first (0-12 wks) 3 months.....1 Within 6-7 months (24-29 wks).....2 At 8 months above (30-33+ wks).....3
B31	How many times did you attend antenatal clinic during the previous pregnancy? Nanga munapitapo kangati?	One.....1 Two.....2 Three.....3 Four and above.....4
B32	Who assisted with the delivery of your youngest child? PROBE: Anyone else? Anyone else?	Doctor.....1 Clinical Officer.....2

	<i>(If no previous pregnancy, do not ask this question)</i>	Nurse/Midwife 3 Traditional birth attendant..... 4 Ward Attendant..... 5 Medical Assistant.....6 Relative/friend.....7 No one.....99 Other (SPECIFY).....88
B33	If you or any member of your household is sick, where do you first seek help (treatment)? Kodi inu kapena wina aliyense mnyumba mwanu akadwala chithandizo choyamba cha mankhwala mumakapeza kuti? (Circle all answers)	Health Centre/clinic/Hospital..... 1 Traditional Healer.....2 Treated at home.....3 Spiritual Healer.....4 Do nothing.....5 Other specify.....88
B34	Who makes the decision to take a sick child to a health centre? Kodi ndi ndani amene amapanga chiganizo kuti mupite ndi mwana ku chipatala pamene wadwala?	Self..... 1 Husband.....2 Both wife and husband.....3 Community leaders.....4 Community Volunteer.....5 Other – specify.....88
B35	Are you satisfied with the services provided at the health clinics? Kodi mumakhutira ndi chithandizo chomwe mumalandira ku chipatala?	Yes (very satisfied)..... 1 Yes (somewhat satisfied).....2 Neutral/Unsure.....3 No (unsatisfied).....4

Household Occupation		
B36	Household Head Main Occupation(Mark all that apply)	Farmer.....1

	Kodi ndi njira iti yomwe wankulu (mutu) wa pabanja pano amadalira kuti apeze ndalama?	Artisan (carpentry/tinsmith).....2 Wage labourer/worker.....3 Business person.....4	Permanent employee.....5 None.....6 Other – specify.....88
B37	Caregiver’s Main Occupation(Mark all that apply) Kodi osamala pakhomo (mlezi) amadalira ntchito yanji kuti apeze ndalama panyumba pano?	Farmer.....1 Artisan (carpentry/tinsmith).....2 Wage labourer/worker.....3 Business person.....4	Permanent employee.....5 None.....6 Other – specify.....88
B38	Current Household Main Source of staple food(Mark all that apply) Kodi ndi njira iti yomwe mukudalira popeza Chakudya?	Own Food production.....1 Purchased food.....2 Borrowed food.....3 Food gift.....4 Food Aid.....5 Food for work (include ganyu).....6 Other – specify.....88	
B39	How much income do you personally make in a year? (refers to caregiver)	Below MK10,000.001	

	Kodi mumapeza ndalama zingati pa chaka panokha?	MK10,000.00 to MK24,000.002 MK25,000.00 to MK49,000.00..... 3 MK50, 000.00 and above..... 4
B40	How much income does this HH make in a year? Kodi pakhomo pano mumapeza ndalama zingati pa chaka chimodzi	Below MK10,000.001 MK10,000.00 to MK24,000.002 MK25,000.00 to MK49,000.00.....3 MK50, 000.00 and above.....4
B41	How much of your House Hold income proportion is spent on feeding your family per month? Kodi pa chaka ndi gawo lalikulu bwanji la ndalama zanu lomwe mumagwiritsa ntchito kudyetsera banja lanu?	All.....1 More than half.....2 Less than half.....3 None.....4 Don't know.....5
B42	What proportion of your total HH income is spent on health? Kodi pa chaka ndi gawo lalikulu bwanji la ndalama zanu lomwe mumagwiritsa ntchito kuthandizira za umoyo wa banja lanu?	More than half.....1 Less than half.....2 None.....3 Don't know.....4

B43a	<p>Do you have maize available all year through?</p> <p>Kodi mumakhala ndi chimanga chokwanira chaka chonse?</p>	<p>Yes always have it....1, Yes sometimes have it.....2, Not at all we never have it.....3 If No "3" skip to B43c</p>
B43b	<p>How many bags of maize are currently available? If "Yes" above?</p> <p>(only ask if "yes" above</p> <p>Panopa, muli ndi matumba angati achimanga panopa?</p>	<p>/___/___/___/ (50kg bags)</p>
B43c	<p>How much of the following livestock's does the household has:</p> <p>Kodi muli ndi ziweto zingati za mtundu uwu?</p> <p>a. Chickens</p> <p>b. Goats</p> <p>c. Cattle</p> <p>d. Other, specify</p>	<p>a. /___/___/___/</p> <p>b. /___/___/___/</p> <p>c. /___/___/___/</p> <p>d. /___/___/___/</p>
B43d	<p>How often do you use the livestock for your household food?</p> <p>Kodi mumapha ziweto izi mowilikiza motani kuti mudyepakhomo panu?</p>	<p>Not at all.....1</p> <p>Always.....2</p> <p>Sometimes.....3</p>

MODULE C: HOUSEHOLD DIETARY DIVERSITY

Instructions: Start with the first food or drink consumed in the morning by someone in the household and go systematically through 24 hours. When the respondent has finished, probe for meals and snacks not mentioned by

asking “anything else?” and “what about [insert group - if no items in that group were mentioned]”

Enumerator Read: Now I would like to ask you specifically about the food that **anyone in your household** ate yesterday during the day and night. Please describe the foods and drinks (this includes meals and snacks) that your household ate yesterday from the time you got up to the time you went to sleep at night. Let’s start with when your household first woke up. When you first woke up, did anyone eat or drink anything? [Underline the items she lists]. Did anyone eat or drink anything after that? [Underline the items she lists]. What about after that? Continue this process until she says nobody in the household ate or drink anything else yesterday during the day or night.

****Households: include foods eaten by any member of the household, and exclude purchased and eaten outside the home*

Tsopano tikambirane zakudya kapena zakumwa zimene munadya dzulo pa khomo pano kuyambira mmawa, masana mpaka madzulo. Chonde tchulani zakudya ndi zakumwa zones zomwe zinadyedwa pakhomo pano kuchokera nthawi imene munadzuka mpaka pamene mumagona usiku. Tiyanba nthawi imene munadzuka, alipo aliyense anadya chilichonse? Aliponso anadya kapena kumwa chilichonse atadya izo?(funsani mobwelezabweleza mpaka yankho lake likhale “Palibe amene anadya kapena kumwa zimenezo)

Izi ndi zakudya zimene zinadyedwa pakhomo koma osati zakudya zodyera kwina

Question Number	Food group	Examples	YES = 1 NO = 0
C1	CEREALS	Nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat	
C2	VITAMIN A RICH VEGETABLES AND TUBERS	Pumpkin, carrots, sweet potatoes that are orange inside	
C3	WHITE TUBERS AND ROOTS	White potatoes, white yams, cassava, or foods made from these.	
C4	DARK GREEN LEAFY VEGETABLES	Dark green/leafy vegetables, including wild ones + locally available vitamin-A rich leaves such as cassava leaves, sweet potato leaves, pumpkin leaves etc.	
C5	OTHER VEGETABLES	Other vegetables (e.g. tomato, onion, eggplant) including wild vegetables	

C6	VITAMIN A RICH FRUITS	Ripe mangoes, papaya, peaches	
C7	OTHER FRUITS	Other fruits, including wild fruits	
C8	ORGAN MEAT (IRON-RICH)	Liver, kidney, heart or other organ meats or blood-based foods	
C9	FLESH MEATS	Beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds	
C10	EGGS	Any types of eggs eaten	
C11	FISH	Fresh or dried fish	
C12	LEGUMES, NUTS AND SEEDS	Beans, peas, lentils, groundnuts, soya beans, pumpkin and sunflower seeds or foods made from these	
C13	INSECTS	Insect larvae, lake fly, ants, grasshoppers	
C14	MILK AND MILK PRODUCTS	Milk, cheese, yoghurt or other milk products e.g. chambiko	
C15	OILS AND FATS	Cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat	
C16	SWEETS	Sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies	
C17	SPICES, CONDIMENTS,	Spices (soy sauce, hot sauce, etc) Condiments (black/white pepper, salt)	
C18	BEVERAGES	coffee, tea, alcoholic beverages (masese, mtonjani, kachasu, Chibuku),	
C19	How many times did you eat the whole day yesterday? Kodi dzulo munadya kangati tsiku lonse ?		Once.....1 Twice.....2 Thrice.....3 Four times....4

MODULE D: WATER AND SANITATION(Please, Observe)

D1	What is the main source of drinking water for members of your household?	Piped water in dwelling.....1
----	---	-------------------------------

	Kodi pakhomo panu pano ndikuti kumene mumadalira kutunga madzi akumwa?	Piped into yard or plot.....2 Public tap.....3 Borehole with pump.....4 Protected dug well.....5 Protected spring.....6 Rainwater collection.....7 Unprotected dug well.....8 Unprotected spring.....9 Pond, river or stream.....10 Tanker-truck, vendor.....11 Other – specify.....88
D2	How long does it take to go there, get water, and come back? Kodi zimakutengerani nthawi yaitali bwanji kupita ndi kubwera kokatunga madzi?	Number of minutes...../___/___/ Water on premises..... Yes.....1 No.....2 Don't Know.....99
D3	How do you make water safe for drinking in your household? Kodi pa nyumba pano mumachita chiyani kuti madzi akumwa akhale otetezedwa? (multiple answers)	Boiling1 Chlorination.....2 Covering the container.....3 Not required.....4 Do not do anything.....5 Other – specify.....88
D4	Does your household have a plate drying rack? Kodi panyumba panu muli ndi thandala loyanikapo Ziwiya za kukhitchini?	Yes.....1 No.....2

D5	Does your household have a bathing shelter? Kodi panyumba pano muli ndi chanjausi (bafa) losambiramo?	Yes.....1 No.....2
D6	Does your household have a drying line? Kodi muli ndi chingwe/chikwewo choyanikapo zovala?	Yes.....1 No.....2
D7	Does your household use a toilet? Kodi panyumba panu pano mumagwiritsa ntchito chimbudzi?	Yes.....1 No.....2
D8	What kind of toilet facility does your household use? Kodi chimbudzi chomwe mumagwiritsa ntchito pa nyumba panu ndi chamtundu wanji?	Flush to sewage system or septic tank.....1 Improved pit latrine (e.g. VIP).....2 Traditional pit latrine.....3 Open pit.....4 Bucket.....5 No facilities or bush or field.....6 Other- specify88 If no facilities or bush, jump to D 12
D9	Do you share toilet with another household? Kodi pali mabanja ena amene amagwiritsa nawo ntchito chimbudzicho?	Yes.....1 No.....2
D10	Does the toilet have a hand washing facility located near it? (<i>observe</i>) Kodi chimbudzicho chili ndi chipangizo chosambira mmanja (Yang'anani)?	Yes.....1 No.....2 (If No, go to D12)
D11	What type of hand washing facility is located near the toilet? (<i>observe</i>)	Tippy Tap.....1 Cup and container.....2

	Kodi chipangizo chosambila m`manjacho ndi chotani (Yang'anani)?	Outside tap.....3 Other – specify.....88
D12	When do you wash hands? (Circle all answers mentioned) Kodi ndi nthawi ziti zomwe munthu amayenera kusamba mmanja?	After defecation1 After changing nappies.....2 Before food preparation and cooking.....3 Before eating.....4 After eating.....5
D13	Do you wash your hands with disinfectants after defecation (using a toilet)? Kodi mumasamba m`manja ndi sopo /phulusa /mankhwala alionse mukadzithandiza ?	Yes, always.....1 Yes, sometimes2 No.....3 Do not know.....4
D14	Do men wash their hands with disinfectants after using a toilet? Kodi azibambo amasamba m`manja ndi sopo /phulusa /mankhwala alionse mukachoka ku chimbuzi?	Yes, always.....1 Yes, sometimes2 No.....3 Do not know.....4
D15	Do girls wash their hands with disinfectants after using a toilet? Kodi atsikana amasamba m`manja ndi sopo /phulusa /mankhwala alionse mukachoka ku chimbuzi?	Yes, always.....1 Yes, sometimes2 No.....3 Do not know.....4
D16	Do boys wash their hands with disinfectants after using a toilet? Kodi anyamata amasamba m`manja ndi sopo /phulusa /mankhwala alionse mukachoka ku chimbuzi?	Yes, always.....1 Yes, sometimes2 No.....3 Do not know.....4
D17	Does your household have a rubbish pit? Kodi panyumba panu muli ndi dzenje lotayamo zinyalala?	Yes.....1 No.....2 Do not know.....3

		(If No - go to EA23.1)
D 18	Is the rubbish pit purposely dug?	Yes.....1
	Kodi dzenjelo adakumbira kutayamo zinyalala?	No.....2
		Do not know.....3

EA 23 WOMENS'S DIETARY DIVERSITY

Instructions: *Start with the first food or drink consumed in the morning by someone in the household and go systematically through 24 hours. When the respondent has finished, probe for meals and snacks not mentioned by asking "anything else?" and "what about [insert group - if no items in that group were mentioned]"*

Enumerator Read: Now I would like to ask you specifically about the food that **anyone in your household** ate yesterday during the day and night. Please describe the foods and drinks (this includes meals and snacks) that your household ate yesterday from the time you got up to the time you went to sleep at night. Let's start with when your household first woke up. When you first woke up, did anyone eat or drink anything? [Underline the items she lists]. Did anyone eat or drink anything after that? [Underline the items she lists]. What about after that? Continue this process until she says nobody in the household ate or drink anything else yesterday during the day or night.

****Households: include foods eaten by any member of the household, and exclude purchased and eaten outside the home*

Tsopano tikambirane zakudya kapena zakumwa zimene munadya dzulo pa khomo pano kuyambira mmawa, masana mpaka madzulo. Chonde tchulani zakudya ndi zakumwa zones zomwe zinadyedwa pakhomo pano kuchokera nthawi imene munadzuka mpaka pamene mumagona usiku. Tiyamba nthawi imene munadzuka, alipo aliyense anadya chilichonse? Aliponso anadya kapena kumwa chilichonse atadya izo?(funsani mobwelezabweleza mpaka yankho lake likhale "Palibe amene anadya kapena kumwa zimenezo)

Question Number	Food group	Examples	Yes = 1 No = 0
EA23.1	CEREALS	Nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat	
EA23.2	VITAMIN A RICH VEGETABLES, TUBERS	Pumpkin, carrots, sweet potatoes that are orange inside,	
EA23.3	WHITE TUBERS AND ROOTS	White potatoes, white yams, cassava, or foods made from these.	
EA23.4	DARK GREEN LEAFY VEGETABLES	Dark green/leafy vegetables, including wild ones + locally available vitamin-A rich leaves such as cassava leaves, pumpkin leaves, sweet potato leaves. etc.	

EA23.5	OTHER VEGETABLES	Other vegetables (e.g. tomato, onion, eggplant) , including wild vegetables	
EA23.6	VITAMIN A RICH FRUITS	Ripe mangoes, papaya, peaches	
EA23.7	OTHER FRUITS	Other fruits, including wild fruits	
EA23.8	ORGAN MEAT (IRON-RICH)	Liver, kidney, heart or other organ meats or blood-based foods	
EA23.9	FLESH MEATS	Beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds	
EA23.10	EGGS	Any types of eggs eaten	
EA23.11	FISH	Fresh or dried fish	
EA23.12	LEGUMES, NUTS & SEEDS	Beans, peas, lentils, groundnuts, soyabeans, pumpkin and sunflower seeds or foods made from these	
EA23.13	INSECTS	Insect larvae, lake fly, ants, grasshoppers	
EA23.14	MILK AND MILK PRODUCTS	Milk, cheese, yoghurt or other milk products e.g. chambiko, breast milk	
EA23.15	OILS AND FATS	Cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat	
EA23.16	SWEETS	Sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies	
EA23.17	SPICES, CONDIMENTS	Spices (soy sauce, hot sauce, etc) Condiments (black/white pepper, salt)	
EA23.18	BEVERAGES	coffee, tea, thobwa, Fanta, Cocacola, Fizzes, super dip	
EA23.19	<p>How many times did you eat the whole day yesterday?</p> <p>Kodi dzulo munadya kangati tsiku lonse ?</p>		<p>Once.....1</p> <p>Twice.....2</p> <p>Thrice.....3</p> <p>Four times....4</p>

MODULE E: INFANT/CHILD FEEDING

(Applicable to all children 0-59 months of the household)

Question No.			Child 1	Child 2	Child 3
E1	Name of child Dzina la mwana				
E2	Date of birth (Day/month/year)				
E3	Age (completed months)				
E4	Sex	Male.....1 Female2			
E5	Mother / Caregiver Age (in completed years)	/__/_/			
Breastfeeding (for children aged 0 to 59 Months only)					
E6	Has "Child Name" ever been breastfed? Kodi mwanayi anayamwapo?	Yes1 No.....2 Don't know/forgotten.....3	If No, go to E9	If No, go to E9	If No, go to E9
E7	How long after birth was the child "Childs Name" first put to the breast? Kodi mwana wanu munamuika kubere patapita nthawi yaitali bwanji atabadwa?	Within the first hour.....1 After the first hour.....2 Don't know/forgotten.....3			
E8	Has "Child Name" received the first milk (colostrum)? Kodi mwanayu adayamwa mkaka oyambilira kutuluka (wachikasu) atangobadwa?	Yes1 No.....2 Don't know/forgotten.....3			

E9	At what age did you start giving the child “Childs name” other food in addition to breast milk? Kodi mwana wanu munayamba kumupatsa zakudya zina ali ndi miyezi ingati?	months	/ / /	/ / /	/ / /
E10	Is “Child Name” still breastfed? Kodi mwana wanu akuyamwabe?	Yes1 No.....2 (go to E13)	/ / /	/ / /	/ / /
E11	How many times did you breastfeed “Child Name” yesterday during the day and at night? Kodi mwana wanuyi munamuyamwitsa kangati dzulo kuyambira mmawa mpaka madzulo?	Number of times_____	/ / /	/ / /	/ / /
E12	Has “Child Name” ever been bottle-fed? Kodi mwanayi munamumwetsapo mkaka wa m’botolo?	Yes1 No.....2 Don’t know/forgotten.....3	/ / /	/ / /	/ / /
E13	Has “Child Name” ever been given ORS(Oral REHYDRATION SOLUTION) yesterday, during the day or night? Kodi mwanayi munamupatsapo madzi a shuga ndi mchere kuti muwonjezere madzi a mthupi mwake dzulo masana kapena usiku?	Yes1 No.....2 Don’t know/forgotten.....3	/ / /	/ / /	/ / /
E14	Has “Child Name” Drink or eat Vitamin or mineral supplement supplements or any medicines yesterday, during the day or night? Kodi mwanayi munamupatsapo mavitamini, kapena michere ya mthupi kapena mankhwala dzulo masana kapena usiku?	Yes1 No.....2 Don’t know/forgotten.....3	/ / /	/ / /	/ / /

E15	<p>Kodi Chibadwire mwana wanu munamupatsapo zakumwa izi? <i>(ask for each item and mark it)</i></p> <p>Yes.....1 No.....2 Don't know/forgotten.....3</p> <p>Palinso zakumwa zina? If yes,specify..... How many times did 'Child name' drink liquids yesterday? Kodi zakumwazi anamwa kangati dzulo?</p>	Plain water			
		Sweetened/flavoured water			
		Tea or infusion	/_/_/	/_/_/	/_/_/
		Fruit juice	/_/_/	/_/_/	/_/_/
		Infant formula	/_/_/	/_/_/	/_/_/
		- If yes, # of times	__times	__times	__times
		Mkaka wa ana			
		If "Yes" number of times	/_/_/	/_/_/	/_/_/
			__times	__times	__times
		Tinned, powdered or fresh milk	/_/_/	/_/_/	/_/_/
- If yes, # of times	__times	__times	__times		
	msuzi				
	thin porridge	/_/_/_/	/_/_/_/	/_/_/_/	
	Number of times.....				

--	--	--	--	--	--

Complementary and young child feeding (0- 59 months only)					
			Child 1	Child 2	Child 3
E16	Name of child (0-59 months) Dzina la mwana			
E17	Date of birth (Day/month/year)				
E18	Age (completed months)				
E19	Sex	Male.....1 Female2			
E20	Age of mother (complete years)	/ ___/ ___/years			
E21	Did "Child Name" receive food yesterday? Kodi mwanayu munamupatsa chakudya dzulo?	Yes1 No.....2			
E22	Apart from breastfeeding, how many times did "Child Name" receive food yesterday day and night? Kodi mwanayu anadya kangati dzulo kuchokera mmawa kufika madzulo?	Once.....1 Twice.....2 Three times.....3	Four times.....4 Five times.....5		

			More than five times.....6			
--	--	--	----------------------------	--	--	--

E23 CHILD'S DIETARY DIVERSITY

Instructions: *Start with the first food or drink consumed in the morning by someone in the household and go systematically through 24 hours. When the respondent has finished, probe for meals and snacks not mentioned by asking “anything else?” and “what about [insert group - if no items in that group were mentioned]”*

Enumerator Read: Now I would like to ask you specifically about the food that **anyone in your household** ate yesterday during the day and night. Please describe the foods and drinks (this includes meals and snacks) that your household ate yesterday from the time you got up to the time you went to sleep at night. Let's start with when your household first woke up. When you first woke up, did anyone eat or drink anything? [Underline the items she lists]. Did anyone eat or drink anything after that? [Underline the items she lists]. What about after that? Continue this process until she says nobody in the household ate or drink anything else yesterday during the day or night.

***Households: include foods eaten by any member of the household, and exclude purchased and eaten outside the home

Tsopano tikambirane zakudya kapena zakumwa zimene munadya dzulo pa khomo pano kuyambira mmawa, masana mpaka madzulo. Chonde tchulani zakudya ndi zakumwa zones zomwe zinadyedwa pakhomo pano kuchokera nthawi imene munadzuka mpaka pamene mumagona usiku. Tiyamba nthawi imene munadzuka, alipo aliyense anadya chilichonse? Aliponso anadya kapena kumwa chilichonse atadya izo?(funsani mobwelezabweleza mpaka yankho lake likhale “Palibe amene anadya kapena kumwa zimenezo)

Question Number	Food group	Examples	Yes = 1 No = 0		
			Child 1	Child 2	Child 3
E23.1	CEREALS	Nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat			
E23.2	VITAMIN A RICH VEGETABLES AND TUBERS	Pumpkin, carrots, sweet potatoes that are orange inside,			
E23.3	WHITE TUBERS AND ROOTS	White potatoes, white yams, cassava, or foods made from these.			
E23.4	VITAMIN A RICH FRUITS	Ripe mangoes, papaya, peaches			

E23.5	DARK GREEN LEAFY VEGETABLES	Dark green/leafy vegetables, including wild ones + locally available vitamin-A rich leaves such as cassava leaves, pumpkin leaves, sweet potato leaves. etc			
E23.6	OTHER VEGETABLES	Other vegetables (e.g. tomato, onion, eggplant) , including wild vegetables			
E23.7	OTHER FRUITS	Other fruits, including wild fruits			
E23.8	ORGAN MEAT (IRON-RICH)	Liver, kidney, heart or other organ meats or blood-based foods			
E23.9	FLESH MEATS	Beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds			
E23.10	EGGS	Any types of eggs eaten			
E23.11	FISH	Fresh or dried fish			
E23.12	LEGUMES, NUTS & SEEDS	Beans, peas, lentils, groundnuts, soyabeans, pumpkin and sunflower seeds or foods made from these			
E23.13	INSECTS	Insect larvae, lake fly, ants, grasshoppers			
E23.14	MILK AND MILK PRODUCTS	Milk, cheese, yoghurt or other milk products e.g. chambiko, breast milk			
E23.15	OILS AND FATS	Cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat			
E23.16	SWEETS	Sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies			
E23.17	SPICES, CONDIMENTS	Spices (soy sauce, hot sauce, etc) Condiments (black/white pepper, salt)			
E23.18	BEVERAGES	coffee, tea, thobwa, Fanta, Cocacola, Fizzes, super dip			
E23.19	How many times did the child eat solids/semi-solid food yesterday? Kodi anadya kangati dzulo?		Number of times.....		

MODULE F : CHILDHOOD ILLNESSES & CARING PRACTICES

Children Recent Morbidity and Caring Practices

F1	In the past 2 weeks, did any child between 0 - 59 months have diarrhoea? Kodi pa ma sabata awiri apitawa alipo mwana aliyese	Yes.....1	No.....2	If no diarrhoea,
----	---	-----------	----------	------------------

	ochepera zaka zisanu anadwalapo matenda otsekula m'mimba?		go to F3
F2	<p>If the child had diarrhoea, what did you do?</p> <p>Kodi munachita chiyani pamene mwanayu anatsogola mmimba ?</p>	<p>Continued to breastfed/increased food intake.....1</p> <p>Stopped breastfeeding/giving food.....2</p> <p>Gave salt and water (ORS) at home.....3</p> <p>Went to church/preacher4</p> <p>Went to traditional healer.....5</p> <p>Went to a health centre-post/hospital.....6</p> <p>Did nothing.....7</p> <p>Other (specify)88</p>	
F3	<p>In the past 2 weeks, did any child between 0 - 59 months have fever with chills?</p> <p>Kodi pa ma sabata awiri apitawa alipo mwana aliyese ochepera zaka zisanu anadwalapo matenda otentha thupi ndi zingwangwa (Malungo)?</p>	<p>Yes.....1</p> <p>No.....2</p>	If no go to F5
F4	<p>If the child had malaria (fever with chills), what did you do?</p> <p>Kodi munachita chiyani pamene mwanayu anadwala malungo ?</p>	<p>Went to health facility for medication.....1</p> <p>Bought medicine and gave to child.....2</p> <p>Went to a Traditional Healer.....3</p> <p>Did nothing.....4</p> <p>Other (Specify).....88</p>	
F4.1	<p>In the past two weeks, did any child between 0-59 months have fever with difficulty in breathing?</p> <p>Kodi pa masabata awiri apitawo alipo mwana aliyense ochepera zaka zisanu anadwalapo matenda a zibayo?</p>	<p>Yes.....1</p> <p>No.....2</p>	If No go to F5

F4.2	If “yes”, did it receive any medication? Ngati anadwalapo, analandira mankhwala?	Yes.....1 No.....2	
F4.3	If “yes” where did the child receive medication? Kodi analandira mankhwala kuti?	Went to health facility for medication.....1 Bought medicine and gave to child.....2 Went to a Traditional Healer.....3 Did nothing.....4 Other (Specify).....88	
MOSQUITO NET USAGE			
F5	Does your household have any mosquito nets that can be used while sleeping? Kodi panyumba panu pano muli ndi masikito wogonamo?	Yes1 No.....2	If no, go to Module G
F6	Where did you get these nets? Kodi masikitowa munawapeza kuti?	Health Facility.....1 Bought from shop.....2 Received from NGO.....3 Others (Specify).....88	
F7	Who regularly sleeps under the mosquito nets? Kodi ndi ndani yemwe amagona mmasikito nthawi ndi nthawi?	Father.....1 Mother.....2 Father and Mother.....3 Mother and child.....4 Children only.....5 All family members.....6	

F8	When you got the net was it already soaked in a liquid to repel mosquitoes? Pamene munalandira masikitowa, kodi adanyikidwa mmankhwala othawitsa udzuudzu?	Yes.....1 No.....2 Don't know/forgotten.....3	
F9	Are there any pregnant women in the household? Kodi pali amayi oyembekezera pa khomo pano? If 'none' go to F11	Self.....1 Another woman.....2 None.....3	
F10	If yes, did she/they sleep under the net last night? Ngati alipo, kodi anagona mmasikito usiku wapitawu?	Yes.....1 No.....2	
F11	At what age did you start taking your children for under-five clinic? Kodi ana anu amayamba sikelo ali msinkhu wanji?	Months / ___ / ___ /	
F12	At what age did you stop taking your children to underfive clinic? Kodi m'masiya kupita ku sikelo ndi ana ali msinkhu wanji?	Months / ___ / ___ / Not yet.....	
F13	Are you still visiting "Growth Monitoring Clinics" for any of your under-five children? Kodi panopa alipo ana anu ochepera zaka zisanu omwe akupita ku sikelo?	Yes1 No.....2	
F14	Have any of the children received de-worming drugs in the past 6 months? Kodi miyezi 6 yapitayi alipo ana anu omwe alandirapo mankhwala a njoka za mmimba?	Yes1 No.....2	

Mafunso athu athera pomwepa. Zikomo kwambiri potenga nawo mbali mukafukufuku uyu, zikomo

Time End:

Name of Enumerator _____ **Signature** _____ **Date** ___ / ___ / ___

Name of Supervisor _____ **Signature** _____ **Date** ___ / ___ / ___

OBSERVATIONS:

Appendix 2 FOCUS GROUP DISCUSSIONS GUIDELINES FOR WOMEN

FGD for Women

MAZIKO PROJECT TREND SURVEY

FEBRUARY-MARCH 2014

FOCUS GROUP DISCUSSIONS GUIDELINES

SELECTION CRITERIA & PROCESS:

KUSANKHA KWAKE

- ***Women who are members of clusters (also likely members of Maziko VSLs)***
- ***Amayi omwe ndi mamembala a kalasta (omweso ndi mamembala a Maziko VSLs)***
- ***Spouses of women in Group 1***
- ***Amuna awo a azimayi mu Group1***

(Women FGD Guide)

1. NUTRITION KNOWLEDGE & PRACTICES

ZOMWE MUMADZIWA NDI KUCHITA ZOKHUDZA MADYEDWE

- Which maternal and child nutrition practices do you know about? ****(Inquire so that practices are specific and not general.*
 - ***Mumadziwa chiyani za madyedwe amayi ndi ana? (Funsani kuti anene zokhazo zomwe iwo amachita osati za ena onse)***
- Which of these or others do you practice? Why? Do you receive any support?
****(Inquire for specific types of support during pregnancy, during first 5 months child is born, and then from 6 months and beyond – see objectives section with known enablers and barriers, listen for these)*

Ndi ziti zomwe inu mumachita? Chifukwa chiani? Mumalandira thandizo lililonse?*(funsani za thandizo lomwe amalandira ali ndi pakati, patatha miyezi isanu chibadwire cha mwana komaso patatha miyezi isanu ndi umodzi kupita mtsogolo)***

- Which one do you not practice? Why not?
****(Inquire for specific times such as pregnancy, during first 5 months child is born, and then from 6 months and beyond – see objectives section with known enablers and barriers, listen for these)*

Ndiziti zomwe simumachita? Chifukwa cha chiyani? **(Funsani nthawi yomwe samapanga zimenezo monga nthawi yomwe ali oyembekezera, miyezi isanu mwana atangobadwa kapena patatha miyezi isanu ndi umodzi chibadwire cha mwana)**

2. NUTRITION SERVICES

CHITHANDIZO CHA MADYEDWE

- What nutrition services are available to pregnant and lactating women and children U5
Ndi chithandizo chanji cha madyedwe chomwe chimapezeka kwa amayi oyembekezera, oyamwitsa ndi ana osakwana zaka zisanu
- Who is providing these services?
 - **Amapereka chithandizochi ndi ndani?**
- Who is using these services? Why?
 - **Amagwiritsa ntchito chithandizochi ndi ndani? Chifukwa cha chiani?**
- Who is not using these services? Why not?
 - **Samagwiritsa ntchito chithandizochi ndi ndani? Chifukwa cha chiani?**
- Who is involved in decisions about using/accessing these services? (Probe to find out what roles men and women play)
 - **Ndindani amene amapereka ulamuliro/chilolezo wogwiritsa ntchito kapena kulandira chithandizochi? (fufuzani kuti mudziwe gawo lomwe abambo ndi amayi amatengapo)**

3. WATER, HYGIENE AND SANITATION

UKHONDO WA PAKHOMO NDI MADZI

- What hygiene and sanitation practices do you know about?
 - **Mumadziwa chiani za ukhondo wa pakhomo?**
Which of these do you practice? Why? *** (probe around factors included in the objectives section)
 - **Ndi ziti mwa zimenezi zomwe inu mumachita? Chifukwa chiani?**
- Which of these do you not practice? Why not? *** (probe around factors included in the objectives section)
 - Ndi ziti mwa zimenezi zomwe inu simuchita? Chifukwa chiani?
- Do community leaders take part in developing plans for water and sanitation and health education in your community? How would you describe their performance? (very satisfactory=1, Satisfactory=2, not satisfactory=3).
 - Kodi atsogoleri a mmdera lino amatenga nawo mbali popanga mapulani a madzi, ukhondo wa pakhomo ndi kuphunzitsa anthu za umoyo kudera lanu? Munganene kuti kagwiridwe kawo kantchito ndi kotani (kokwanira kwambiri=1, kokwanira=2 kosakwanira=3).
- What roles do men and women have in managing water and sanitary facilities in the community?
 - Abambo ndi amayi ali ndi udindo wanji pankhani yosamalira madzi ndi malo azaukhondo mudera?

4. WOMEN'S LEADERSHIP & HOUSEHOLD DECISION-MAKING

UTSOGOLERI WA AMAYI NDI KULAMULIRA PA BANJA

- What leadership roles do women play in this community?
 - **Ndi mbali yanji ya utsogoleri yomwe amayi amatenga mudera lino?**
- What is the proportion of women to men in positions of leadership in this community? Have you seen any changes in this?
 - **kuyerekeza ndi abambo, ndi amayi ochulika bwanji amene ali pa udindo wa utsogoleri ku dera lino? Mwaonapo kusintha kuli konse pa izi?**
- How are decisions made in households in your community about how to spend money? Who is involved? Have you seen any changes in how this happens? (Probe: Does it matter who is bringing the money into the HH? Does it matter what it will be used for?)
 - **Kudera lino, malamulo akagwiritsidwe ntchito ka ndalama pa banja amapangidwa bwanji? Amakhudzidwa/ amapanga malamulo ndi ndani? Mwaona kusintha kuli konse pa momwe zimenezi zimachitikira? (fufuzani: kodi zili ndi ntchito kuti amabweretsa ndalama pakhomo ndi ndani? Zili ndi ntchito kuti ndalamayo igwiritsidwa ntchito yanji?)**
- In your opinion, to what degree do you contribute to decision making around food and health expenditures? What does this look like?
 - **Mukuganiza kuti mumathandizira kwambiri bwanji pa ulamuliro wa ndalama zogwiritsa ntchito pa zakudya ndi zaumoyo? Zimenezi zikusonyeza chiani?**

5. RELIGIOUS, SOCIAL, AND CULTURAL NORMS

ZAUZIMU, CHIKHALIDWE NDI MIYAMBO

- Can you tell more about what is regarded as a norm in households practices in XXX area as regards to:
 - **Mungandiuzeko zomwe zimatengedwa ngati chikhalidwe mmabanja ku dera la XXX pa nkhani za:**
 - HH decision-making and community level nutrition programming (i.e. pregnant women attending public meetings, and why is that?)
 - **ulamuliro pabanja ndi kudera pa dongosolo la madyedwe (monga; amayi apakati kupezeka pa misonkhano, chifukwa chiani?**
 - Priorities in food allocation among HH members, and why is that?
 - **Kagawidwe ka zakudya kwa anthu pabanja? chifukwa chiani?**
 - Decisions about small animal slaughtering and selling, decisions about land allocation? Why is that?
 - **Ulamuliro pakupha ndi kugulitsa ziweto zazing'onozing'ono, kugawa malo. Chifukwa chiani?**

- Do you think it important to improve these practices and beliefs? If yes, how can this be done? If so, no, why is that?
- **Mukuganiza kuti ndikofunikira kukonza zikhaliidwe ndi zikhilipiro zimenezi? Ngati ndi choncho, zingachitike bwanji? Ngati sichoncho, ndi chifukwa chiani?**

FOCUS GROUP DISCUSSION GUIDE FOR MEN

1. NUTRITION KNOWLEDGE & PRACTICES

ZOMWE MUMADZIWA NDI KUCHITA ZOKHUDZA MADYEDWE

- Which maternal and child nutrition practices do you know about?

*** (Inquire so that practices are specific and not general)

- Mumadziwa chiyani za madyedwe a amayi ndi ana?

***** (Funsani kuti anene zokhazo zomwe iwo amachita osati za ena onse)

- Which of these are practiced in your household? Why? How do you support these practices?

*** (Inquire for specific types of support during pregnancy, during first 5 months of child, and then from 6 months and beyond – see objectives section with known enablers and barriers, listen for these)

- Ndiziti mwa izo zomwe mumapanga pa banja lanu? Chifukwa chiani? Mumatani kuti zimenezi zizichitika?

***** (funsani za thandizo lomwe amalandira amayi a pakati, patatha miyezi isanu chibadwire cha mwana komaso patatha miyezi isanu ndi umodzi kupita mtsogolo)

- Which of these are not practiced in your household? Why not?

*** (Inquire for specific times such as pregnancy, during first 5 months child is born, and then from 6 months and beyond – see objectives section with known enablers and barriers, listen for these)

- Ndiziti mwa izi zomwe simumachita pa banja lanu? Chifukwa cha chiyani?

*** (Funsani nthawi yomwe samapanga zimenezo monga nthawi yomwe ali oyembekezera, miyezi isanu mwana atangobadwa kapena patatha miyezi isanu ndi umodzi chibadwire cha mwana)

2. NUTRITION SERVICES (10-15 MINUTES)

CHITHANDIZO CHA MADYEDWE (MPHINDI KHUMI- KHUMI NDI ZISANU)

- What nutrition services are available to pregnant and lactating women and children U5?
 - Ndi chithandizo chanji cha madyedwe chomwe chimapezeka kwa amayi oyembekezera, oyamwitsa ndi ana osakwana zaka zisanu.
- Who is providing these services?
 - Amapereka chithandizochi ndi ndani?
- Who is using these services? Why?
 - Akugwiritsa ntchito chithandizochi ndi ndani? Chifukwa cha chiani?
- Who is not using these services? Why not?
 - Sakugwiritsa ntchito chithandizochi ndi ndani? Chifukwa cha chiani?

- Who is involved in decisions about using/accessing these services?
*** (Probe to find out what roles men and women play)
 - **Ndindani amene amapereka ulamuliro/chilolezo wogwiritsa ntchito kapena kulandira chithandizochi? (fufuzani kuti mudziwe gawo lomwe abambo ndi amayi amatengapo)**

○

3. WATER, HYGIENE AND SANITATION

UKHONDO WA PAKHOMO NDI MADZI

- What hygiene and sanitation practices do you know about?
 - **Mumadziwa chiani za ukhondo wa pakhomo?**
- Which of these do you practice? Why? *** (probe around factors included in the objectives section)
 - **Ndi ziti mwa zimenezi zomwe inu mumachita? Chifukwa chiani?**
- Which of these do you not practice? Why not? *** (probe around factors included in the objectives section)
 - **Ndi ziti mwa zimenezi zomwe inu simuchita? Chifukwa chiani?**
-
- Do community leaders take part in developing plans for water and sanitation and health education in your community? How would you describe their performance? (very satisfactory=1, Satisfactory=2, not satisfactory=3).
 - **Kodi atsogoleri a mmdera lino amatenga nawo mbali popanga mapulani a madzi, ukhondo wa pakhomo ndi kuphunzitsa anthu za umoyo kudera lanu? Munganene kuti kagwiridwe kawo kantchito ndi kotani (kokwanira kwambiri=1, kokwanira=2 kosakwanira=3).**
- What roles do men and women have in managing water and sanitary facilities in the community?
 - **Abambo ndi amayi ali ndi gawo lanji pakusamalira madzi ndi ukhondo wa pakhomo mmadera?**

4. Women's Leadership & Household Decision-making

Utsogoleri wa amayi ndi kulamulira pa banja

5.

- What leadership roles do women play in this community?
 - **Ndi mbali yanji ya utsogoleri yomwe amayi amatenga mudera lino?**
-
- What is the proportion of women to men in positions of leadership in this community? Have you seen any changes in this?
 - **kuyerekeza ndi abambo, ndi amayi ochulika bwanji amene ali pa udindo wa utsogoleri ku dera lino? Mwaonapo kusintha kuli konse pa izi?**

- How are decisions made in households in your community about how to spend money? Who is involved? Have you seen any changes in how this happens? (Probe: Does it matter who is bringing the money into the HH? Does it matter what it will be used for?)
 - **Kudera lino, malamulo akagwiritsidwe ntchito ka ndalama pa banja amapangidwa bwanji? Amakhudzidwa/ amapanga malamulo ndi ndani? Mwaona kusintha kuli konse pa momwe zimenezi zimachitikira? (fufuzani: kodi zili ndi ntchito kuti amabweretsa ndalama pakhomo ndi ndani? Zili ndi ntchito kuti ndalamayo igwiritsidwa ntchito yanji?)**
- In your opinion, to what degree do you contribute to decision making around food and health expenditures? What does this look like?
 - **Mukuganiza kuti mumathandizira kwambiri bwanji pa ulamuliro wa ndalama zogwiritsa ntchito pa zakudya ndi zaumoyo? Zimenezi zikusonyeza chiani?**

1. RELIGIOUS, SOCIAL, AND CULTURAL NORMS

ZAUZIMU, CHIKHALIDWE NDI MIYAMBO

- Can you please tell about what is regarded as a norm in households practices in XXX area as regards to:
- **Mungandiuzeke zomwe zimatengedwa ngati chikhalidwe mmabanja ku dera la XXX pa nkhani za**
 - HH decision-making and community level nutrition programming (i.e. pregnant women attending public meetings, and why is that?)
 - **Ulamuliro pabanja ndi kudera pa dongosolo la madyedwe (monga; amayi apakati kupezeka pa misonkhano, chifukwa chiani?**
 -
 - Priorities in food allocation among HH members, and why is that?
 - **Kagawidwe ka zakudya kwa anthu pabanja? chifukwa chiani?**
 -
 - Decisions about small animal slaughtering and selling, decisions about land allocation? Why is that?
 - **Ulamuliro pakupha ndi kugulitsa ziweto zazing'onozing'ono, kugawa malo. Chifukwa chiani**
- Do you think it is important to improve these practices and beliefs? If yes, how can this be done? If no, why is that? Tell me more about it.
 - **Mukuganiza kuti ndikofunikira kukonza zikhalidwe ndi zikhulupiriro zimenezi? Ngati ndi choncho, zingachitike bwanji? Ngati sichoncho, ndi chifukwa chiani**

FOCUS GROUP GUIDE FOR KEY INFORMANT INTERVIEW – DISTRICT NUTRITIONIST.

MAZIKO PROJECT TREND SURVEY

FEBRUARY-MARCH 2014

KEY INFORMANT INTERVIEW – DISTRICT NUTRITIONIST

Name of Respondent _____

Age of Respondent _____

1. What are the nutrition programmes being implemented in the district?
2. What do you know about Maziko Project?
3. How does the Maziko project fit into the district nutrition strategy and plans?
4. What role do you have in the Maziko project?
5. What are the enabling factors in nutrition programming in this district?
6. What are the common barriers of nutrition programme in the district?
7. What are the specific challenges for the participation of men and women in the nutrition and health programmes?
8. What coordination mechanisms do you have in the district related to nutrition programme?
9. Do you work with NGOs or CBOs implementing related programmes in the district?
10. How do these work with MAZIKO project?
11. What roles have been taken by men and women in Madziko project?
12. In your opinion how has MAZIKOproject improved the nutrition and health status of women and children in the district?
13. Do you think women's access to health and nutrition services have improved, explain?
14. What areas do you recommend for Maziko Project to consider for improvement?
15. What are some of the issues Maziko need to consider in its exit plan for sustaining programme effectiveness that are within the scope of the project?
16. What are your expectations of Maziko Project as they move towards their last year of operation?

Appendix 3 ; Key Informants Interviews

KEY INFORMANT INTERVIEW – Frontline staff: HSAs, AEDOs, CDAs

MAZIKO PROJECT TREND SURVEY

FEBRUARY-MARCH 2014

KEY INFORMANT INTERVIEW – Frontline staff: HSAs, AEDOs, CDAs

1. What nutrition programmes are being implemented in your impact areas?
2. What do you know about Maziko Project?
3. How does the Maziko project fit into work plan?
4. What role do you have in the Maziko project?
5. What are the enabling factors in nutrition programme in your catchment area?
6. What are the common barriers of nutrition programme in your area?
7. What are the specific challenges for the participation of men and women in the nutrition and health programmes?
8. How do you work with NGOs and CBOs implementing related programmes in the district?
9. How do these organisations work with MAZIKO project?
10. What roles have been taken by men and women in Madziko project?
11. What are the specific challenges for the participation of both men and women in nutrition and health related programmes?
12. In your opinion how has Madziko project improved the nutrition and health status of women and children in your area?
13. Do you think women's access to health and nutrition services have improved in your area, explain?
14. What areas do you recommend for Maziko Project to consider for improvement?
15. What are some of the issues Maziko need to consider in its exit plan for sustaining programme effectiveness that are within the scope of the project?
16. What are your expectations of Maziko Project as they move towards their last year of operation?

KEY INFORMANT INTERVIEWS- For other Organizations (Programme Manager, field staff)

MAZIKO PROJECT TREND SURVEY

FEBRUARY-MARCH 2014

KEY INFORMANT INTERVIEWS

A. For other Organizations (Programme Manager, field staff)

What is your understanding of Maziko project?

B. Roles in similar activities

1. a) What are other similar nutrition and MCH activities/projects being implementing in your impact communities/area?
b) Indicate the time period if the project(s) has/have closed.
c) Briefly, what activities are implemented?
2. What do you find are the biggest gender challenges affecting
 - a) Women and men's access to nutrition and health services?
 - b) Participation in community groups/development activities?
 - c) Family decision making?

C. Advocacy & Strategic Partnerships

1. Do you have linkages and collaboration with other external or internal related programmes, NGOs or CBOs and Government?
- 2.
3. Explain the linkage mechanism establish between your organisation and CBO/NGOs in your area?
4. How these other has structures supported Maziko Project?

D. B. Efficiency

1. How can Maziko project best be implemented successfully bearing in mind the cultural and traditional factors in the project areas?
2. In your opinion is maziko project bringing in any positive changes in its impact areas?

E. C. Sustainability

1. What mechanisms could be put in place to ensure sustainability of the project impact?

2. What issues do you think will still be sustainable if Maziko project ends?
3. What are some of the issues Maziko need to consider in its exit plan for programme sustainability?
4. What would it take to replicate and stream line MAZIKO Project into District nutrition agenda for-the program sustainability

KEY INFORMANT INTERVIEWS MAZIKO FIELD STAFF (CARE & MAICC & MALEZA Field officers)

MAZIKO PROJECT TREND SURVEY

FEBRUARY-MARCH 2014

KEY INFORMANT INTERVIEWS MAZIKO FIELD STAFF (CARE & MAICC & MALEZA Field officers)

1. What is your understanding of Maziko project?
2. What are other projects that have complimented the initiatives of Maziko?
3. What are your specific roles you perform?
4. Tell us more about projects interventions and implementation?
5. Can you tell me what you like most about your job?
6. Are there MAZIKO achievements you may wish to share?(probe any achievement related to gender)
7. Can you tell me what makes you job easy to do? This may be influenced by the community, the project, or anything else.
8. In performing your roles and responsibility as a field officer are they challenges you have encountered? If so, what are they? How did you attempt to resolve them? (also probe challenges related to gender)
9. What environmental challenges you see in your community that affect the Maziko program?
10. Is there anything else you would like to share?

Appendix 4 Gender Analysis Data base

A Snapshot of Gender Relations Influencing PLW and U5 Health and Nutrition

The purpose of this section is to highlight the current nature of key gender dynamics influencing PLW and U5 health and nutrition and related service access, and to provide recommendations for future programming.

Data Collection and Analysis Approach and Methods

This is an analysis of focus group discussions (FGDs) conducted to qualify project progress in health, nutrition and water and sanitation knowledge and practice, service delivery, asset transfer, community group leadership and support by Maziko staff with men-only and women-only groups in Kasungu and Dowa. Qualitative statements were extracted from each area of project activity and sorted under a selection of CARE's Core Areas of Gender Inquiry as pictured in Figure 1. The unit of measurement is the statement (rather than the individual), and statement frequency is measured to determine the extent to which gender equal dynamics, behaviours and attitudes exist among men and women. Statement percentages will not add up to 100% consistently in this narrative as only the most relevant findings are discussed. It is not possible to compare the status described in this report to the one described in either the Maziko baseline or first trend survey due to different data collection and reporting methods. This report, therefore, compares progress described against progress that should ideally be seen at this stage in an MNCH project focusing on strengthening community mechanisms to support nutrition and health service delivery. The report focuses on two areas:

- equal reach of project and government counterpart nutrition services, and
- the extent to which gender dynamics in benefit control, decision making, leadership, division of labour and aspirations facilitate greater nutrition and health for PLW and children U5.

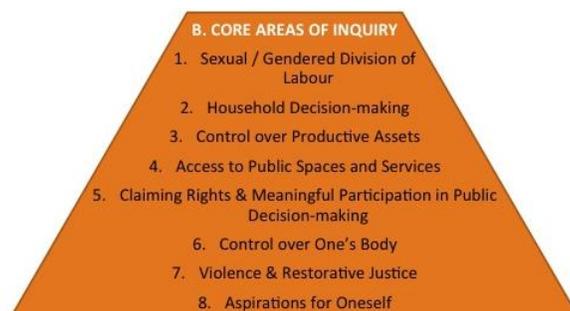


Figure 1: CARE's Core Areas of Gender Inquiry

Are Appropriate Nutrition Services Reaching Women and Men Equally?

Appropriate services are reaching women and men, but this has yet to translate into a high value for service delivery as one of women's rights. This pattern of equating "benefit" with physical assets continued in inquiry regarding the extent to which women and men benefitted equally from project activities. In addition, both women and men defined benefit as something accruing to families in general rather than to women, men, boys and girls at different rates. In this way, a primacy of benefit to a patriarchal structure remains.

Thirty two percent of women’s statements discuss support from clinics, health surveillance assistants, community promoters, and government services, and 14% of statements described Maziko’s health service provision. Service quality, or the ability of services to meet women’s health needs in a respectful and professional manner, was not probed. In both instances, interviewers were required to prompt women to define health service delivery as a benefit. Women were more likely to equate benefit with a tangible item such as the food security inputs Maziko provided (18% of statements). Eighteen percent of statements referred to physical assistance from other NGOs and 10% described no support.

In contrast, only 7% of men’s statements listed health services as a project benefit. Just over 10% described women receiving services from a government clinic or the project, and 22% described the types of physical assets household have received. About 20% of statements claimed no support from the project. The bulk of men’s statements (37%), however, were given over to describing the types of knowledge they have learned from Maziko. Men were able to describe ideal feeding regimens for infants and young children, ideal support to pregnant and lactating spouses and other health and nutrition messages. This high frequency demonstrates good project progress in reaching men with required information about women’s and children’s health. Both women and men are able to describe appropriate health care practices, women consistently accurately and men mostly accurately. This shows that the project is equally reaching women and men with MNCH knowledge.

Twenty percent of women’s statements describe project activities as generally benefitting the family. Thirty three percent describe them benefitting women, 20% describe benefits to children and 27% describe benefits to men. In other words, 14% more women’s statements show that women perceive either the family or men benefitting from the project rather than themselves. Women listed maternal health services and mosquito nets as the greatest benefits to themselves and soy beans as the greatest benefit to children. Men’s statements focused on benefits for the village (31% of statements) or the family (38%) rather than children (12%), women (12%) or men (6%). Men listed physical assets and monetary savings as the greatest benefits to themselves and general development as the greatest benefit to the village. ***These results point to a need to engage in awareness raising regarding women’s tangible right to health care. Physical benefits can be prioritised to focus directly on health service access.***

How do Gender Dynamics in Core Areas of Inquiry Influence PLW and U5 Nutrition and Health Service Access?

Can Women Make Autonomous Decisions to Assure their Health?

Focus group discussions tested the extent to which women are involved in the types of household decisions (budgeting, food purchases) that influence their nutrition. With clear exceptions, men

What Women say About Benefits

I benefit from health services because now I know whether my body weight is increasing or decreasing when I go to the antenatal clinic.

My husband saves money. Instead of using it for transport to go to the clinic, the woman just goes there on foot. So he benefits.”

What Men Say About Benefits

If the woman is not sick, the husband will be able to go to do piece work so that he can find money to buy

continue to be implicated in budget control such that their influence in household nutrition is greater. Contrast with Section 3.4 will show that this is not linked to their taking up a greater role in reproductive tasks, but with dominant breadwinning roles. FGDs under this heading also show the ways in which beneficiaries (both women and men) use VSLAs as a general household asset not necessarily related to PLW or U5 health care access or nutrition.

In 50% of their statements, women describe key decision makers as men or the whole family. Ten percent of women's statements describe women as having influence in areas related to the traditional division of labour and another 7% describe women as advising men on household purchases. Seventeen percent of statements illustrate women as having substantial influence over household expenditure and related agendas, and a further 17% describe women as having relative autonomy in decision making.

In 10% of men's statements, men describe themselves as key decision makers and household heads. In 47% of statements they describe a traditional pattern of consulting with women, with the implication that the prerogative of final say rests with men. Five percent of statements describe a traditional pattern of women having autonomy over cash gained from petty trade. Nineteen percent describe both women and men as involved in decision making, with women having the same prerogative as men in terms of final say. Nineteen percent describe women as having autonomy over decisions that affect PLW and U5 nutrition.

Both women and men, and at the same rate, conceive of situations in which women and men have equal decision making status. While women provide examples of how men dominate in making daily decisions about food purchases and other areas that affect nutrition, they also provide examples (17% of their statements) where they have significant influence over the types of broader farm management decisions that affect the household enabling environment for nutrition and health care. Two examples of positive change towards gender equality were evidenced in FGDs. First, women stated that men were beginning to listen to and respect women more, influenced to change by friends and family. Second, men were able to provide two concrete examples of the way in which participatory and forward budgeting is done in their households, demonstrating transparency that goes beyond consultation.

FGDs in this section also touched on the role of VSLAs in household planning and decision making. Both women's and men's discourse identified VSLAs as a family asset to be used for general livelihoods security rather than an asset to be directed towards women's or children's health. Again, men describe their breadwinning role in ensuring women have the assets to participate in

What Women say About Decision Making

There is no change. Men still dominate in decision making.

Mostly we just tell the man that there is no soap or relish. We cannot have the authority to take the money to go and buy soap, no.

When the woman says "Let us do this or that," the man follows her advice in order to see change.

What Men Say About Decision Making

I explain about the resources that we have against the time we are supposed to use them. We sit down to discuss how we should effectively spend or utilize our resources. It is up to the woman to say no, we can trip on this one so that we can reach this goal at this time.

We husbands do assist a lot in fending for the family... When you do some piece work you have to safe something. You help to generate the cash so that when the women go to their group they do not feel ashamed. They have to contribute as the rest contribute so that they do not come back home bitter.

the club, and in factoring any accruing funds into the overall household budget.

Overall, the section shows that while the majority of women do not have sufficient power to make household management decisions favourably for their health, there are strong examples of power sharing and autonomy from which to learn in Dowa and Kasungu. *It is recommended that future programming concentrate on cultivating and showcasing women who exercise personal autonomy in decision making and couples who show relative equality in the area as gender change champions.*

Do Women and Men Lead Equally in Community Health Initiatives?

More change in gender dynamics is evidenced at the community level. FGDs tested the extent to which women are taking a part in leading community groups responsible for health and nutrition. The baseline noted a marked absence of women in this area. Although equality is dominantly (by both interviewers and interviewees) described as equal numbers of women and men present on committees, both women and men demonstrated the greatest degree of reflection on the nature of gender dynamics in this section, reifying gender equality as a phenomenon that has come to influence community participation rather than as an ever-present dynamic that influences women's, men's, girls' and boys' health outcomes.

Thirty-eight percent of women's statements indicate that men dominate leadership, or that men form the majority of leaders. Ten percent of women's statements indicate that women and men share leadership, and 35% of statements show ways in which women lead actively. Women also reflected on why they do not lead, exhibiting classic "blame the victim" language that does not recognise relational or structural barriers to their participation. Women noted that they are more likely to be in leadership positions because "gender" has come to their communities and motivated a change, as if gender dynamics are a new phenomenon and physical influence. Women's conceptions of what gender equality is were not probed to identify potential nuances.

Women's Reasons for Their Leadership Absence

Us women, we lack confidence in ourselves. We feel we cannot be in such positions, and this makes us run behind the men.

The other thing that makes women fail... is that we create a lot of excuses. Maybe we are called for a meeting, but we will say we are not going because we are escorting a child to the clinic. That is why men

Men Describe Women's Leadership Roles

Women are taking part in teaching people about good farming practices so that they can have adequate food for nutrition... Women are taking these leadership roles because they know that for a family to be active to participate in development activities, there is a need for unity and tolerance so they do all these things in order to make good families.

Women and men teach people together because there

Men were more positive than women when describing levels of equality in leadership. Thirty eight percent of men's statements see women and men equally leading, and 33% of statements see women dominating leadership or see more women than men leading. Ten percent of men's statements mark no change in leadership, and 9% of statements describe women leading in traditional roles. Again, men reified gender equality as something tangible that comes into a community and encourages women and men to work together, women to lead in development activities, and

women to participate in public spaces, although with traditional gender roles well preserved.

While clear change is happening at the level of public participation in community groups motivated by development programming, change has yet to become consistent at the relations and structure level in either the household or community spheres. Women and men understand that gender dynamics are a factor, but have yet to understand the difference between real gender equality attached to women's right to health care and a hierarchical harmony established when both sexes fulfill prescribed roles in an unequal gendered division of labour. Thus, while participation rates in community health groups may have increased since baseline, women's functional equality to set a community health agenda is still weak. ***Future programming can build on current gains by incorporating more intentional discussions on what gender equality means at the relations and structure levels, through facilitated processes such as social analysis and action, for example.***

Does the Division of Labour Promote Healthy Behaviours?

This section combined all statements regarding what women and men do in terms of household nutrition, community water and sanitation, exclusive breastfeeding (EBF), and any other health care role. Interviews strongly linked division of labour to women's (and men's) ability to comply with and support healthy IYCF and maternal care behaviours. The gender division of labour has not changed substantively enough to provide space for either women or men to take up the healthy behaviours the project is promoting.

Fourty three percent of women's statements and 64% of men's statements described a traditional division of labour, either at the household level, or with women working and men supervising in community groups. This calls into question the nature of the gender equality described in Section 3.2. Three percent of women's statements and 6% of men's statements described men as taking on non-traditional or reproductive labour on a routine basis. In seven percent of statements, women indicated they had enough time to practice hygiene and EBF with another 21% of statements showing that they had no time. Except for specific down times in the seasonal round, women consider themselves too busy to practice the health behaviours promoted by the project. Only 6% of men's statements indicated ways in which they are supporting women to access health services. While fewer than five of men's 47 statements described the current division of labour as an injustice, about ten of men's statements asserted that it was physically impossible for men to take on childcare responsibilities. ***It is recommended that future programming focus on ways in which men can support their wives both in terms of health service access and in terms of reproductive labour, with exchange visits to the homes of current male champions.***

Women on the Current Division of Labour

...those of us who work alone, we are many. Those who assist their wives are few, and we admire them. I see that many women are like me. We are not supported...

We have very little time, especially in this farming season. We wake up in the morning... we haven't swept the surroundings, we haven't drawn water, we haven't cleaned the house or the kitchen... When breastfeeding the child, we haven't washed our hands...

A Male Champion on the Division of Labour

Everything can be done by anyone in the household. For example, if the man is not married, he is able to do anything in the household but the moment he gets married he feels that the work of the family is for the woman only.... We really need to change.

Aspirations

Discussion in this section demonstrate the need for further dialogue across the sexes. One hundred percent of women's statements discussed heavy workloads and a desire for men to share and contribute to reproductive labour equally. In 29% of men's statements, men acknowledged that women were interested in a more equal division of labour. Another 29% described women as satisfied with division of labour, decision making roles and related gender dynamics at the household level. The remainder described women as too demanding because they expect men to engage in reproductive labour regardless of women's health or reproductive status. *As this and other sections show, future programming can capitalise on current gains by bringing women and men together to learn from one another and to discuss gender issues more deeply.*

Appendix A : IYCF (Key Nutrition Results Definitions and Calculation

APPENDIX A: Key Nutrition Results, Definitions & Calculations *ns*

Results

Key Indicators		Intervention Area			
		N	n	%	CI
IYCF Indicators					
IO2	IYCF 1: Early Initiation of Breast Feeding (0-23 months)	992	845	85.2	()
IO2	IYCF 2: Exclusive Breast Feeding (0-5 months)	200	107	53.5	()
IO2	IYCF 3: Minimum Dietary Diversity (6-23 months)	507	373	73.5	()
IO2	IYCF 4: Minimum Meal Frequency (6-23 months)	507	336	66.2	()
IO2	IYCF 5: Minimum Acceptable Diet (6-23 months)				()
	IYCF 6: Iron Rich or Fortified Solid/Semi-solid Foods (6-23 months)				()
	IYCF 7: Bottle Feeding (0-23 months)	524	68	12.9	()
Women and Household Dietary Diversity Indicators					
8	WDD: Women's Dietary Diversity (4 or more food groups)	992	550	55.2	()
9	HDDS: Household Dietary Diversity Score (mean score)	992	778	76.4	()
	% of <u>women who met minimum dietary diversity needs</u> and both 6-23 month old child did not meet minimum needs	845	350	41.4	()
	% of <u>women who met minimum dietary diversity standard</u> whose 6-23 month old child also met minimum dietary diversity standard	845	625	73.9	()
	% of <u>women who did not meet</u> minimum dietary diversity standard whose 6-23 month old child also did not meet minimum dietary diversity standard	147	75	51	()
	% of <u>women who did not meet</u> minimum dietary diversity standard whose 6-23 month old child <u>did meet</u> minimum dietary diversity standard	147	17	11.5	()
Hygiene and Child Health Indicators					
IO3	% of HHs drinking from improved water sources ¹	992	839	84.6	()
	% of HHs utilizing improved sanitation/toilette facility ²	992	882	88.9	()
IO3	% of infants (0-59 months) with diarrhea in the last two week	992	240	24.2	()

¹Improved drinking water sources include: piped water into dwelling or plot or yard (QD1 p.15 responses 1 or 2), Public tap/standpipe (QD1 p.15 response 3), Tubewell/borehole (QD1 p.15 response 4), Protected dug well (QD1 p.15 response 5), Protected spring (QD1 p.15 response 6), and Rainwater collection (QD1 p.15 response 7)

²Improved sanitation facilities include: Flush/pour flush to a piped sewer system or septic tank or pit latrine or unknown place (QD8 p.16 response 1), VIP latrine (QD8 p.16 response 2), or any "other" responses stated as pit latrine with slab or composting toilette.

IO3	% of infants (0-59 months) with diarrhea in the last two weeks who were treated with ORT	992	103	10.4	()
IO3	% of children with symptoms of ARI treated by health facility or health provider	992	295	29.7	()

Key Indicators– disaggregated by sex	Total N / %	Male n / %	Female n / %
IYCF 1: Early Initiation of Breast Feeding (0-23 months)	736/74.1	428/58.1	308/41.8
IYCF 2: Exclusive Breast Feeding (0-5 months)	200/100	62/31	138/69
IYCF 3: Minimum Dietary Diversity (6-23 months)	507/100		
IYCF 4: Minimum Meal Frequency (6-23 months)			
IYCF 5: Minimum Acceptable Diet (6-23 months)			
IYCF 6: Iron Rich or Fortified Solid/Semi-solid Foods (6-23 months)			
IYCF 7: Bottle Feeding (0-23 months)	524/100	9/1.7	6/1.1
% of infants (0-59 months) with diarrhea in the last two week	992/100	124/12.5	115/11.5
% of infants (0-59 months) with diarrhea in the last two weeks who were treated with ORT	731/100	57/7.7	45/6.1
% of children with symptoms of ARI treated by health facility or health provider			

Definitions & Calculations with further disaggregation

1. Timely initiation of breastfeeding³

The timely initiation of breastfeeding (BF) indicator, putting the infant to the breast within 1 hour of birth, to be calculated using the following formula.

$$\frac{\text{Children 0 – 23 months who were put to the breast within 1 hour of birth}}{\text{Total number of (live) children 0 – 23 months of age}}$$

Table 1.1 Timely initiation of breastfeeding (children 0 -23 months)

Initiation of breastfeeding	n	%
Immediately or within the hour		
After the 1 st hour		

³Reference q. E7 pg.21

Do not know/remember		
	Total (N)	100%

2. Exclusive Breastfeeding⁴

The exclusive breastfeeding indicator was calculated using the following formula. The definition of exclusive breastfeeding (EBF) allows the inclusion of ORS and/or vitamins.

$$\frac{\text{Infants 0 – 5 months who received only breast milk during the previous 24 hours}}{\text{Total number of infants 0 – 5 months of age}}$$

Table 2.1 Exclusive breastfeeding by age group

Excusive Breastfeeding	N	n	%
% of infants 0 to 5 mos exclusively breastfed			
% of infants 2 to 3 mos exclusively breastfed			
% of infants 4 to 5 mos exclusively breastfed			

Table 2.2 Feeding practices (during previous 24 hours)of infants 0 – 5 months ?

	In the last 24 hours (yesterday during the day or at night)	N	n	%
E11	infants who were breastfed	736	720	97.8
E11	infants who were not breastfed	736	118	14.0
E13	infants who received oral rehydration salt/ORS	736	94	9.5
E14	infants who received vitamin drops or other medicine drops			
E15	infants who received plain water	736	521	52.5
E15	infants who received sweetened/flavored water	736	192	21.3

⁴ Requires consumption of only breastmilk in the previous 24 hours, with exception of ORS and/or vitamins found in q. E13 & E14 on p22. Therefore, must have “no” to all liquids in q. E15 on p24, no to E21, and no consistently to E23.1-E23.19.

E15	infants who received tea or infusion	736	212	28.8
E15	infants who received fruit juice	736	178	24.1
E15	infants who received infant formula <ul style="list-style-type: none"> • Of those who received, # of times • Range (_-) ----Mean = _._ _ 			
E15	infants who received yogurt <ul style="list-style-type: none"> • Of those who received, # of times • Range (_-) ----Mean = _._ _ 			
E15	infants who received milk (fresh, tinned, powder) <ul style="list-style-type: none"> • Of those who received, # of times • Range (_-) ----Mean = _._ _ 			
E15	infants who received thin porridge (that is, porridge that cannot be fed by hand)			
E15	of infants who received any other liquids	736	488	66.3
E23.1	infants to were fed from <u>cereals</u> (nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat)	736		
E23.2	infants who were fed any <u>Vit A rich vegetables and tubers</u> (pumpkin, carrots, sweet potatoes that are orange inside)	736	422	57.3
E23.3	infants who were fed any <u>white tubers and roots</u> (white potatoes, white yams, cassava, or foods made from these)	736	59	8.6
E23.4	infants who were fed any <u>Vit A rich fruits</u> ripe mangoes, papayas, pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside	736	42	5.7
E23.5	infants who were fed <u>dark green, leafy vegetables</u> like kale, spinach or amaranth leaves	736	459	62.3
E23.6	infants who were fed any <u>other vegetables</u> (tomato, onion, eggplant, other including wild vegetables)	736	397	53.9
E23.7	infants who were fed any <u>other fruits</u> (other fruits, including wild fruits)	736	93	12.6
E23.8	Infants who were fed any <u>organ meats</u> (liver, kidney, heart or other organ meats or blood-based foods)	736	24	3.2
E23.9	Infants who were fed any <u>flesh food</u> (beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds)	736	42	5.7
E23.10	Infants who were fed any <u>eggs</u> (any type of eggs eaten)	736	23	3.1
E23.11	Infants who were fed any <u>fish</u> (any fresh or dried fish)	736	47	6.3

E23.12	Infants who were fed any <u>legumes, nuts, or seeds</u> (beans, peas, lentils, groundnuts, soyabeans, pumpkin and sunflower seeds or foods made from these)	736	267	36.2
E23.13	Infants who were fed any <u>insects</u> (insect larvae, lake fly, ants, grasshoppers)	736	10	1.3
E23.14	Infants who were fed any <u>milk and milk products</u> (milk, cheese, yoghurt or other milk products e.g. chambiko, breastmilk)	736	199	27
E23.15	Infants who were fed any <u>oils and fats</u> (cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat)	736	268	34.4
E23.16	Infants who were fed <u>sweets</u> (sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies)	736	257	34.9
E23.17	Infants who were fed <u>spices, condiments</u> (soy sauce, hot sauce, black/white pepper, salt)	736	362	49.1
E23.18	Infants who consumed <u>beverages</u> (coffee, tea, Fanta, Coca-Cola, fixes, super dip)	736	155	21
Total number infants 0 to 5 months N =				

3. Minimum Dietary Diversity

Minimum dietary diversity is defined as the proportion of children 6–23 months of age who receive foods from 4 or more food groups and is calculated using the following formula:

$$\frac{\text{Children 6–23 months of age who received foods from } \geq 4 \text{ food groups during the previous day}}{\text{Children 6–23 months of age}}$$

Table 3.1 Proportion of infants who received minimum dietary diversity (food from 4 or more food groups) total and by breastfeeding practice

Proportion of children 6-23 months who meet Minimum Dietary Diversity	N	n	%
% All children 6 – 23 months who received minimum dietary diversity			
% Breastfed children 6 – 23 months who received minimum dietary diversity			
% Non- breastfed children 6 – 23 months who received minimum dietary diversity			

Table 3.2 Complementary foods eaten by children 6-23 months yesterday by food group

FoodGroups (using the FAO standardized 7 groups for children’s MDD)	n	%
---	---	---

Cereals, Grains, or white roots and tubers ⁵		
Vitamin A Rich fruits and vegetables ⁶		
Other Fruits and Vegetables ⁷		
Flesh foods (meats +organ meat+fish) ⁸		
Eggs ⁹		
Legumes ¹⁰		
Dairy ¹¹		
Total (N)		

Table 3.3 Complementary foods eaten by children(6-23) months yesterday by **food items**

Complementary food items	N	n	%
Child consumed <u>cereals</u> (nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat)			
Child consumed <u>Vit A rich vegetables and tubers</u> (pumpkin, carrots, sweet potatoes that are orange inside)			
Child consumed <u>white tubers and roots</u> (white potatoes, white yams, cassava, or foods made from these)			
Child consumed <u>Vit A rich fruits</u> ripe mangoes, papayas, pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside			
Child consumed <u>dark green, leafy vegetables</u> like kale, spinach or amaranth leaves			
Child consumed <u>other vegetables</u> (tomato, onion, eggplant, other including wild vegetables)			
Child consumed <u>other fruits</u> (other fruits, including wild fruits)			
Child consumed <u>organ meats</u> (liver, kidney, heart or other organ meats or blood-based foods)			
Child consumed <u>flesh food</u> (beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds)			
Child consumed <u>eggs</u> (any type of eggs eaten)			
Child consumed <u>fish</u> (any fresh or dried fish)			
Child consumed <u>legumes, nuts, or seeds</u> (beans, peas, lentils, groundnuts, soyabeans, pumpkin and sunflower seeds or foods made from these)			
Child consumed <u>insects</u> (insect larvae, lake fly, ants, grasshoppers)			

⁵Cereals: Qs E23.1 and E23.3 on pgs. 25-26 make up this group

⁶ Vit A rich fruits and vegetables: Qs E23.2, E23.4, and E23.5 on pg. 26 make up this group

⁷ Other Fruits and Vegetables: Qs E23.6 and E23.7 on pg. 26 make up this group

⁸ Flesh foods (meats + organ meat + fish): Qs E23.8, E23.9, E23.11, E23.13 on pg. 26 make up this group.

⁹ Eggs: QE23.10 on pg. 26 makes up this group

¹⁰ Legumes: QE23.12 on pg. 26 makes up this group

¹¹ Dairy: QE23.14 on pg. 26 makes up this group

Child consumed <u>milk and milk products</u> (milk, cheese, yoghurt or other milk products e.g. chambiko, breastmilk)			
Child consumed <u>oils and fats</u> (cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat)			
Child consumed <u>sweets</u> (sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies)			
Child consumed <u>spices, condiments</u> (soy sauce, hot sauce, black/white pepper, salt)			
Child consumed <u>beverages</u> (coffee, tea, Fanta, Coca-Cola, fixes, super dip)			

4. Minimum Meal Frequency¹²

The minimum meal frequency, number of meals or feeding episodes consumed by the child during the previous day or night, is a proxy for adequate energy intake from complementary foods of the child based on the following minimum times according to age and breastfeeding status. In the case of breastfed children it includes non-liquid foods and for non-breastfed children also includes milk feeds. The minimum feeding frequency definitions are:

- 2 times for breastfed infants 6 – 8 months
- 3 times for breastfed infants 9 – 23 months
- 4 times for non-breastfed infants 6 – 23 months

“Meals” include meals and snacks other than trivial amounts, which was explored in the 24-hour recall facilitating the answer to question 21 of the survey.

This indicator is calculated from the following 2 formulas:

Breastfed children 6–23 months of age who received solid, semi-solid or soft foods
 the minimum number of times or more during the previous day

Breastfed children 6–23 months of age

&

Non-breastfed children 6–23 months of age who received solid, semi-solid or soft foods or
 milk feeds the minimum number of times or more during the previous day

Non-breastfed children 6–23 months of age

¹²Reference q. QE22 pg. 24
 2nd

Table 4.1 Percent of children 6 – 23 months with minimal meal frequency by breastfeeding practice and intervention site

Proportion of children 6-23 months who meet minimum meal frequency (by breastfeeding status)	N	n	%
% ALL children 6 – 23 months who received minimum meal frequency			
% Breastfed children 6 – 23 months who received minimum meal frequency			
% Non- breastfed children 6 – 23 months who received minimum meal frequency			

5. Minimal Acceptable Diet¹³

Minimal acceptable diet is a composite indicator that measures breastfed and non-breastfed children differently to determine the proportion of children 6-23 months who received a minimal acceptable diet respective to their breastfeeding status and consumption of milk-feeds. The following formulas are used:

Breastfed children 6–23 months¹⁴ of age who had at least the minimum dietary diversity
and the minimum meal frequency during the previous day
 Breastfed children 6–23 months of age

and

Non-breastfed children 6–23 months¹⁵ of age who received at least 2 milk feedings, met minimum
dietary diversity excluding dairy group, and met the minimum meal frequency during the previous day
 Non-breastfed children 6–23 months of age

Table 5.1 Proportion of children 6 – 23 months with minimal acceptable diet by breastfeeding practice and intervention area

Proportion of children 6-23 months who meet minimum acceptable diet (by breastfeeding status)	N	n	%
% All children 6 – 23 months who received minimum acceptable diet			

¹³ Reference CARE’s “IYCF Practices *Collecting and Using Data: A Step-by-Step Guide*”, page 99-100 for detailed instructions. Reference

¹⁴ For breastfed children, the calculations needed to determine minimum acceptable diet have been done (they are minimum dietary diversity and minimum meal frequency – each child with a positive score on both of these will score positively on this summary indicator).

¹⁵ For non-breastfed children, dietary diversity has to be re-calculated using a 6 food group score which simply removes dairy as a group. Reference QE15 for # of times child received infant formula, milk, or yogurt.

% Breastfed children 6 – 23 months who received minimum acceptable diet			
% Non- breastfed children 6 – 23 months who received minimum acceptable diet			

6. Consumption of iron-rich foods (does not include iron-fortified foods)

The consumption of iron-rich foods measures the proportion of children 6–23 months of age is calculated using the following formula:

$$\frac{\text{Children 6–23 months of age who received an iron-rich food during the previous day}}{\text{Children 6–23 months of age}}$$

Table 6.1 Proportion of children 6-23 months consuming iron-rich foods during previous day

Proportion of children 6-23 months consuming iron-rich or iron-fortified foods in previous 24 hours	N	n	%
% children 6-23 months who consumed any iron-rich foods*			
% children 6 – 11 months who consumed any iron-rich foods*			
% children 12 – 24 months who consumed any iron-rich foods*			

* iron rich foods include flesh foods (organ meats, meat including fowl, fish)

7. Bottle Feeding¹⁶

Table 7.1 Proportion of children 0 – 23 months who were fed with a feeding bottle

Proportion of children 0 – 23 months who were fed with a feeding bottle	N	n	%
% children 0 – 5 months who were fed with a feeding bottle			
% children 6 - 11 months who were fed with a feeding bottle			
% children 12 – 23 months who were fed with a feeding bottle			

¹⁶Reference Q E12
 2nd

8. Women's Dietary Diversity

Women's dietary diversity is defined as the proportion of women [with children U2¹⁷] who ate foods from 4 or more food groups and is calculated using the following formula:

$$\frac{\text{Women with children U2 who ate foods from } \geq 4 \text{ food groups during the previous day}}{\text{Women with children U2}}$$

Table 8.1 Proportion of women who meet minimum dietary diversity needs (4 or more groups)

Proportion of women who meet minimum dietary diversity needs	N	n	%
% women who ate from four or more food groups in the previous 24 hours			
% women who ate from 3 food groups in the previous 24 hours			
% women who ate from 2 food groups in the previous 24 hours			
% women who ate from 1 food group in the previous 24 hours			
% women who ate from 0 food groups in the previous 24 hours			

Table 8.2 Food eaten by women with children U2 by food group

FoodGroups (using the FAO standardized 9 groups for WDD)	n	%
1. Cereals, grains, white roots and tubers (i.e. starchy staples) ¹⁸	959	96.7
2. Vitamin A rich fruits and vegetables ¹⁹	104	10.8
3. Dark green leafy vegetables ²⁰	759	76.5
4. Other fruits and vegetables ²¹	660	66.5
5. Organ meat ²²	11	1.1
6. Meat and fish ²³	163	16.4
7. Eggs ²⁴	31	3.1
8. Legumes, nuts, seeds ²⁵	380	38.3

¹⁷ For the purposes of this survey, the women interviewed are mothers or caregivers of children under two.

¹⁸ Cereals: Q E23.1 and E23.3 on pg. 19 make up this group

¹⁹ Vit A rich fruits and vegetables: E23.3, E23.6 on pg. 19 make up this group

²⁰ Dark green leafy vegetables: E23.4 on pg. 19 makes up this group

²¹ Other fruits and vegetables: E23.5, E23.7 on pg. 19 make up this group

²² Organ meat: E23.8 on pg. 19 makes up this group

²³ Meat and fish: E23.9, E23.11, E 23.13 on pg. 19 make up this group

²⁴ Eggs: E23.10 on pg. 19 makes up this group

²⁵ Legumes, nuts, seeds: E23.1 on pg. 19 makes up this group

9. Milk and milk products (i.e. dairy) ²⁶	0	0.0
Total (N)		

Table 8.3 Food eaten by women with children U2 by food items

Food items	N	n	%
Woman consumed <u>cereals</u> (nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat)	992	948	95.6
Woman consumed <u>Vit A rich vegetables and tubers</u> (pumpkin, carrots, sweet potatoes that are orange inside)	992	695	70.1
Woman consumed <u>white tubers and roots</u> (white potatoes, white yams, cassava, or foods made from these)	992	73	7.4
Woman consumed <u>dark green, leafy vegetables</u> like kale, spinach or amaranth leaves	992	759	76.5
Woman consumed <u>other vegetables</u> (tomato, onion, eggplant, other including wild vegetables)	992	634	63.9
Woman consumed <u>Vit A rich fruits</u> ripe mangoes, papayas, pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside	992	39	3.9
Woman consumed <u>other fruits</u> (other fruits, including wild fruits)	992	149	15.0
Woman consumed <u>organ meats</u> (liver, kidney, heart or other organ meats or blood-based foods)	992	11	1.1
Woman consumed <u>flesh food</u> (beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds)	992	70	7.1
Woman consumed <u>eggs</u> (any type of eggs eaten)	992	31	3.1
Woman consumed <u>fish</u> (any fresh or dried fish)	992	89	9.0
Woman consumed <u>legumes, nuts, or seeds</u> (beans, peas, lentils, groundnuts, soybeans, pumpkin and sunflower seeds or foods made from these)	992	380	38.3
Woman consumed <u>insects</u> (insect larvae, lake fly, ants, grasshoppers)	992	10	1.0
Woman consumed <u>milk and milk products</u> (milk, cheese, yoghurt or other milk products e.g. chambiko, breastmilk)	992	0	0.0
Woman consumed <u>oils and fats</u> (cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat)	992	377	38.0
Woman consumed <u>sweets</u> (sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies)	992	288	29.0

²⁶ Milk and milk products (i.e. dairy): E23.14 on pg. 19 makes up this group
2nd

Woman consumed <u>spices, condiments</u> (soy sauce, hot sauce, black/white pepper, salt)	992	506	51.0
Woman consumed <u>beverages</u> (coffee, tea, Fanta, Coca-Cola, fixes, super dip)	982	163	16.6

9. Household Dietary Diversity

Household dietary diversity is not determined by a cut-off point nor is there a standard number of groups that would indicate adequate or inadequate dietary diversity within a household. Therefore, we broke it down into 12 groups per FAO guidelines and used the mean score or distribution of scores for analytical purposes and to set program targets²⁷. For comparative purposes, HDDS was stratified using a wealth scale determined by the socio-economic section of the HH survey²⁸.

Table 9.1 Household Dietary Diversity Score among households with women who have children U2

Quintile	Mean score	N	n	%
All households				
Households in the lower wealth tertile				
Households in the upper wealth tertile				

Table 9.2 Household food consumption by group among households with women who have children U2

FoodGroups (using the FAO standardized 12 groups for HDDS)	n	%
1. Cereals ²⁹	963	97.1
2. White tubers and roots ³⁰	67	6.8
3. Vegetables ³¹	956	96.4
4. Fruits ³²	179	18.0
5. Meat ³³	79	8.0
6. Fish and other Seafood ³⁴	108	10.9
7. Eggs ³⁵	28	2.8
8. Legumes, nuts, seeds ³⁶	434	43.8
9. Milk and milk products (i.e. dairy) ³⁷	60	6.1

²⁷ Source: *Guidelines for Measuring Household and Individual Dietary Diversity*, FAO 2011.

²⁸ PLEASE DOCUMENT HOW YOU LOOKED AT WEALTH AND CREATED LOWER AND HIGHER TERTILES

²⁹ Cereals: C1 on pg.13

³⁰ White tubers and roots: C3 on pg. 14

³¹ Vegetables: C2, C4, C5 on pg. 14

³² Fruits: C6, C7 on pg. 14

³³ Meat: C8, C9, C13 on pg. 14

³⁴ Fish and other Seafood: C11 on pg. 14

³⁵ Eggs: C10 on pg. 14

³⁶ Legumes, nuts, seeds: C12 on pg. 14

³⁷ Dairy: C14 on pg. 14

10. Oils and fats ³⁸	401	40.4
11. Sweets ³⁹	275	27.7
12. Spices, condiments and beverages ⁴⁰	603	60.8
Total (N)		

Table 9.3 Household food consumption **by item** among households with women who have children U2

Food items	N	n	%
A HH member consumed <u>cereals</u> (nsima, porridge, rice, bread, thobwa or any other foods made from millet, sorghum, maize, rice, wheat)		963	97.1
A HH member consumed <u>Vit A rich vegetables and tubers</u> (pumpkin, carrots, sweet potatoes that are orange inside)	992	679	68.5
A HH member consumed <u>white tubers and roots</u> (white potatoes, white yams, cassava, or foods made from these)	992	67	6.8
A HH member consumed <u>dark green, leafy vegetables</u> like kale, spinach or amaranth leaves	992	789	79.5
A HH member consumed <u>other vegetables</u> (tomato, onion, eggplant, other including wild vegetables)	992	718	72.4
A HH member consumed <u>Vit A rich fruits</u> ripe mangoes, papayas, pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside	992	38	3.8
A HH member consumed <u>other fruits</u> (other fruits, including wild fruits)	992	146	14.7
A HH member consumed <u>organ meats</u> (liver, kidney, heart or other organ meats or blood-based foods)	992	9	0.9
A HH member consumed <u>flesh food</u> (beef, pork, lamb, goat, rabbit, wild game, chicken, duck, or other birds)	992	55	5.5
A HH member consumed <u>eggs</u> (any type of eggs eaten)	992	28	2.8
A HH member consumed <u>fish</u> (any fresh or dried fish)	992	108	10.9
A HH member consumed <u>legumes, nuts, or seeds</u> (beans, peas, lentils, groundnuts, soybeans, pumpkin and sunflower seeds or foods made from these)	992	434	43.8
A HH member consumed <u>insects</u> (insect larvae, lake fly, ants, grasshoppers)	992	16	1.6
A HH member consumed <u>milk and milk products</u> (milk, cheese, yoghurt or other milk products e.g. chambiko, breastmilk)	992	60	6.1

³⁸ Oils and fats: C15 on pg. 15

³⁹ Sweets: C16 on pg. 15

⁴⁰ Spices, condiments, beverages: C17, C18, on pg. 15

Maziko: Nutrition Foundations for Mothers and Children
 CARE Malawi – 2014 Trend Survey Report

A HH member consumed <u>oils and fats</u> (cooking oil, palm oil, fats, margarine or butter added to food or used for cooking, including animal fat)	992	401	40.4
A HH member consumed <u>sweets</u> (sugar, sugar cane, honey, sweetened soda or sugary foods such as chocolates, sweets or candies)	992	275	27.7
A HH member consumed <u>spices, condiments</u> (soy sauce, hot sauce, black/white pepper, salt)	992	517	52.1
A HH member consumed <u>beverages</u> (coffee, tea, Fanta, Coca-Cola, fixes, super dip)	992	161	16.2

Table 9.4 Comparing women’s and her (6-23 month) child’s food consumption by food group regardless of what other HH members ate

*Use 9 food group breakdown for comparative purposes⁴¹

Dietary Diversity comparison between women only for and their children					
Food Groups	Woman and child ate	Neither woman nor child ate	Woman ate, but child did not eat	Child ate, but woman did not eat	Total
1 “Starchy Staples” (i.e. cereals, grains or other white starchy roots and tubers)	n=	n=	n=	n=	N=
2 Vitamin A rich fruits and vegetables	n=	n=	n=	n=	N=
3 Dark green leafy vegetables	n=	n=	n=	n=	N=
4 Other fruits and vegetables	n=	n=	n=	n=	N=
5 Organ meat	n=	n=	n=	n=	N=
6 Meat and fish	n=	n=	n=	n=	N=
7 Eggs	n=	n=	n=	n=	N=
8 Legumes, nuts, seeds	n=	n=	n=	n=	N=
9 Dairy	n=	n=	n=	n=	N=

⁴¹This requires calculating a 9 group breakdown for children and households (from original 7 group and 12 group breakdowns previously required)

Table 9.2 Comparing women’s and her (6-23 month) child’s food consumption by **food group** with households where food group was reportedly eaten by someone in the HH – purpose is to understand where there is variation among who is eating what and to do more targeted programming with this information. *Use 9 food group breakdown for comparative purposes

Dietary Diversity comparison between women, children, and other HH members					
Food Groups		EATEN IN HH & Woman and child ate	EATEN IN HH & Neither woman nor child ate	EATEN IN HH & Woman ate, but child did not eat	EATEN & Child woman d
1	“Starchy Staples” (i.e. cereals, grains or other white starchy roots and tubers)	n=	n=	n=	n=
2	Vitamin A rich fruits and vegetables	n=	n=	n=	n=
3	Dark green leafy vegetables	n=	n=	n=	n=
4	Other fruits and vegetables	n=	n=	n=	n=
5	Organ meat	n=	n=	n=	n=
6	Meat and fish	n=	n=	n=	n=
7	Eggs	n=	n=	n=	n=
8	Legumes, nuts, seeds	n=	n=	n=	n=
9	Dairy	n=	n=	n=	n=

k

Appendix B: Frequency Table: Household Demographics and Livelihood Characteristics

Appendix **TBD – Frequency Table**

Table I: Household Demographics and Livelihood Characteristics

Midterm Frequencies: Household socio-economic characteristics			
Q.	Variables/Indicators & Response Options	All	
		#	%
B2	Sex of Household Head	N = 736	
		Male	671 91.2
		Female	65 8.8
B3	Age of Household Head Range (-) years	N = 736	
		18-19	12 1.6
		20-29	286 38.9
		30-39	319 43.3
		40-49	88 12.0
		50 or >	31 4.2
B4	Marital Status of Household Head	N = 736	
		Married	682 92.7
		Single	11 1.5
		Divorced	27 3.7
		Separated	8 1.1
		Widowed	8 1.1
B5	Relationship of correspondent to household head	N = 736	
		Self	73 9.9
		Spouse	637 86.5
		Relative	26 3.5
		Domestic Worker	0 0.0
		Other	0 0.0
B5.1	Roof material	N = 736	
		Glass thatched	557 75.7
		Iron sheets	179 24.3
		Cemented	0 0.0
		Mud smeared	0 0.0
		Burnt bricks	0 0.0
		Mud walls (including unburnt bricks)	0 0.0
B5.1	Floor material	N = 736	
		Glass thatched	0 0.0
		Iron sheets	0 0.0
		Cemented	87 11.8
		Mud smeared	649 88.2
		Burnt bricks	0 0.0
		Mud walls (including unburnt bricks)	0 0.0
B5.1	Wall material	N = 736	
		Glass thatched	0 0.0
		Iron sheets	0 0.0
		Cemented	0 0.0
		Mud smeared	408 55.4
		Burnt bricks	328 44.6
		Mud walls (including unburnt bricks)	0 0.0
B5.2	Household Assets	N = 736	

	<i>*multiple responses allowable</i>	Bicycle	339	46.1
		Farm cart	38	5.2
		Furniture	227	30.8
		Cell phone	330	44.8
		Radio	363	49.3
		TV	28	3.8
		Car	9	1.2
		Solar panel	67	9.1
		Motorcycle	15	2.0
		Lamp	476	64.7
		Other	0	0.0
B6	Total number of HH members		N = 736	
		(4 or <) Members	307	41.7
		(5-8) Members	384	52.2
		(9 or >) Members	45	6.1
		Average HH size = 5 members		
B7	Total number of children 0 to 59 months		N = 992	
		(0-5) months	215	21.7
		(6-23) months	521	52.5
		(24-36) months	151	15.2
		(37-59) months	105	10.6
B8	Total number of children 0 to 23 months (< 2 yrs)		N = 736	
		(0-5) months	215	29.2
		(6-11) months	181	24.6
		(12-17) months	181	24.6
		(18-23) months	159	21.6
EDUCATION				
B10	Household Head can read or write		N = 736	
		Yes	592	19.6
		No	144	80.4
B11	Household head education level		N = 736	
		Adult literacy	10	1.4
		Junior Primary (Std 1-4)	123	16.7
		Senior Primary (Std 5-8)	346	47.0
		Junior Secondary (Form 1-2)	95	12.9
		Senior Secondary (Form 3-4)	80	10.9
		Don't know	37	5.0
		None	45	6.1
		Other	0	0.0
B12	Caregiver can read and write		N = 736	
		Yes	482	65.5
		No	254	34.5
B13	Level of education of caregiver		N = 736	
		Adult literacy	6	0.8
		Junior Primary (Std 1-4)	208	28.3
		Senior Primary (Std 5-8)	339	46.1
		Junior Secondary (Form 1-2)	69	9.4
		Senior Secondary (Form 3-4)	38	5.2
		Don't know	4	0.5
		None	69	9.4

		Other	3	0.4
LIVELIHOOD				
B36	Household Head main occupation <i>*multiple responses allowable</i>		N = 736	
	Farmer	488		66.3
	Artisan (carpentry/tinsmith)	40		5.4
	Wage labourer/worker	86		11.7
	Business person	106		14.3
	Permanent employee	14		1.9
	None	3		0.4
	Other (specify)	0		0.0
B37	Caregiver's main occupation <i>*multiple responses allowable</i>		N = 736	
	Farmer	413		56.1
	Artisan (carpentry/tinsmith)	3		0.4
	Wage labourer/worker	62		8.4
	Business person	172		23.4
	Permanent employee	2		0.3
	None	84		11.4
	Other (specify)	0		0.0
B38	Household's main sources of staple food <i>*multiple responses allowable</i>		N = 736	
	Own food production	535		72.7
	Purchase food	158		21.5
	Borrowed food	5		0.7
	Food gift	4		0.5
	Food aid	8		1.1
	Food for work (includes ganyu)	26		3.5
	Other (specify)	0		0.0
B39	Woman's reported annual income (in MK)		N = 736	
	<10,000	218		29.6
	10,000-24,000	178		24.2
	25,000-49,000	142		19.3
	50,000 or more	198		26.9
B40	Household reported annual income		N = 736	
	<10,000	78		10.6
	10,000-24,000	85		11.5
	25,000-49,000	103		14.0
	50,000 or more	470		63.9
B41	Estimated proportion of household income spent on feeding the household per month⁴²		N = 736	
	All	28		3.8
	More than half	397		53.9
	Less than half	242		32.9
	None	14		1.9
	Don't know	55		7.5
B42	Estimated proportion of household income spent on health⁴³		N = 736	
	All	0		0.0
	More than half	62		8.4
	Less than half	580		78.8
	None	32		4.3
	Don't know	62		8.4
B43a	Household's availability to maize throughout the year		N = 736	

⁴² This should not be used to interpret financial security, livelihood status, or nutritional status of a household.

⁴³ This should not be used to interpret financial security, livelihood status, or nutritional status of a household.

	Always	122	16.5
	Sometimes	276	37.5
	Not at all, we never have it	338	45.9
B43b	If ever available, average number of bags currently available in HH	Range (0 - 1000) Avg. # bags= 23.53	
B43c	How many of the following livestock the HH has⁴⁴ <i>*multiple responses allowable</i>	N= 736	
	Chickens	405	55.0
	Goats	231	31.4
	Cattle	86	11.7
	Other, specify	81	11.0
B34d	How often do you use the livestock your HH has for a household food source	N= 736	
	Not at all / never	376	51.1
	Always	46	6.3
	Sometimes	314	42.7

Table 2: Social Empowerment and Women's Participation

Midterm Frequencies: Women's Empowerment and Social Participation			
Q.	Variables/Indicators & Response Options (children 0-23 months)	All	
		#	%
B14	Woman who are members of CBO, association and/or community development group (eg. financial, religious, farmer club, village savings, health and nutrition) Yes No	N = 736 494 242	 67.1 32.9
B15	Of women who belong to group(s) (*yes to B14), what type of group is it? Microfinance Religious Farmer club Seed club VSLA Cluster (health and nutrition) Other - Specify	N = 494 60 98 13 6 268 44 5	 12.1 20.0 2.6 1.2 54.2 9.0 1.0
B15a	Average size of group(s) (including both men and women members)	Avg. Group Size = 7	
B16	Who decided that you should be a member of this organization? Myself My husband Community Leader(s) Someone else	N = 504 338 91 49 26	 67.0 18.0 10.0 5.0
B17	Women who hold a leadership positive in the group(s) Yes No	N = 689 156 533	 22.6 77.4
B18	Women's rating of their participation level ⁴⁵ in group Very Active Active A little active	N = 475 176 169	 37.0 35.6

⁴⁴ "Has" was not defined as owns versus a type of co-owning or sharing – should not be interpreted as owning

⁴⁵ Definition of "participation": Participation level was probed and/or confirmed by asking number of meetings attended or activities participated in versus actual meetings or activities held over the last 3 months. >75% of meetings/activities=very active; >50%-<75%=active; <50%=a little active; 0%=not active.

		Not active	111	23.4
			19	4.0
B19	Women's reported opinion of group effective at influencing public decisions regarding women's concerns and interests		N = 472	
		Effective	424	90.0
		Not effective	48	10.0
B20	Women's reported opinion of the degree to which <i>women</i> in their own community influence⁴⁶ household decisions on issues of nutrition and care for children & PLW		N = 736	
		Influence very much	445	60.5
		Some influence	139	18.9
		A little influence	100	13.6
		No influence	20	2.7
		No opinion	32	4.3
B21	Women's reported opinion of the degree to which <i>they</i> personally influence household decisions on issues of nutrition and care for children and PLW.		N = 736	
		Influence very much	380	51.6
		Some influence	199	27.0
		A little influence	127	17.3
		No influence	12	1.6
		No opinion	18	2.4
B22	Women's reported opinion of the degree to which married women contribute to decision-making around food and health expenditures		N = 736	
		Influence very much	328	44.6
		Some influence	207	28.1
		A little influence	153	20.8
		No influence	26	3.5
		No opinion	22	3.0
B23	Women's current membership in Village Savings and Loans Groups		N = 736	
		Yes	364	49.5
		No	372	50.5
B24	Women's past membership in Village Savings and Loans Groups		N = 736	
		Yes	319	43.3
		No	417	56.7

Table 3: Access to Health Services

Midterm Frequencies: Women's access to healthcare				
Q.	Variables/Indicators & Responses	All		
		#	%	
B25	Amount of time it takes to get to health centre	N = 736		
	Less than 30 minutes	89	12.1	
	One hour	126	17.1	
	More than one hour	521	70.8	
B26	Women who report their village receives regular outreach from a mobile/clinic	N = 736		
	Yes	355	48.2	
	No	381	51.8	
B27	Women who report ever taking their child to the outreach/mobile clinic	N = 736		
	Yes	319	43.3	

⁴⁶ Influence was not defined and left to women's interpretation.

	No	417	56.7
B28	Women who report their village to have a village clinic	N = 736	
	Yes	386	52.4
	No	350	47.6
B29	Women who ever attended antenatal clinic during their current or most recent pregnancy	N = 736	
	Yes	719	97.7
	No	17	2.3
B30	Of women who ever attended ANC, point in their pregnancy when they received their first visit	N = 726	
	Within first 3 months (0-12 wks)	535	73.7
	Within 6-7 months (24-29 wks)	182	25.1
	At 8 months above (30-33+wks)	9	1.2
B31	Of women who ever attended ANC, # of times they received ANC during their current or most recent pregnancy	N = 729	
	One	16	2.2
	Two	34	4.7
	Three	284	38.9
	Four or more	395	54.2
B32	Women's report of who assisted the delivery of their youngest child <i>*multiple responses allowable</i>	N = 736	
	Doctor	93	12.6
	Clinical Officer	54	7.3
	Nurse/midwife	529	71.9
	Traditional birth attendant	21	2.9
	Ward attendant	0.0	0.0
	Medical assistant	20	2.7
	Relative/friend	10	1.4
	No one	9	1.2
B33	Where the HH first seeks help (treatment) if the woman or any member of the household is sick. *multiple responses allowable	N = 736	
	Health Centre/Clinic/Hospital	622	84.5
	Traditional healer	7	1.0
	Treated at home	95	12.9
	Spiritual Healer	2	0.3
	Do nothing	1	0.1
B34	Who makes the decision whether or not to take a sick child to a health center	N = 736	
	Myself (the woman)	190	25.8
	Husband	124	16.8
	Both wife and husband	407	55.3
	Community leader(s)	2	0.3
	Community volunteer(s)	1	0.1
	Other (specify)	12	1.6
B35	Women's report of satisfaction of services provided at the health clinics	N = 736	
	Very satisfied	518	70.4
	Somewhat satisfied	109	14.8
	Neutral/Unsure	87	11.8
	Not satisfied	22	3.0

Table 4: Water and Sanitation

Midterm Frequencies: Water and Sanitation		
Q.	Variables/Indicators & Responses	All

		#	%
D1	Households main source of drinking water <i>*multiple responses not allowable</i>	N = 736	
	Piped water in dwelling	0	0.0
	Piped into yard or plot	8	1.1
	Public tap	28	3.8
	Borehole with pump	507	68.9
	Protected dug well	87	11.8
	Protected spring	0	0.0
	Rainwater collection	0	0.0
	Unprotected dug well	75	10.2
	Unprotected spring	9	1.2
	Pond, river, or stream	22	3.0
	Tanker-truck, vendor	0	0.0
Other (specify)	0	0.0	
D2	Amount of time it takes to go to main drinking water source, get water, and return to household	N = 736	
	Less than 30 minutes	617	83.8
	More than 30 minutes	119	16.2
D3	How do you make water safe for drinking in your household	N = 736	
	Boiling	74	10.1
	Chlorination	136	18.5
	Covering the container	326	44.3
	Not required	18	2.4
	Do not do anything	181	24.7
	Other (specify)	0	0.0
D4	Does your household have a plate drying rack?	N = 736	
	Yes No	205 531	27.9 72.1
D5	Does your household have a bathing shelter?	N = 736	
	Yes No	618 118	84.0 16.0
D6	Does your household have a drying line?	N = 736	
	Yes No	525 211	71.3 28.7
D7	Does your household use a toilette?	N = 736	
	Yes No	612 124	83.2 16.8
D8	What kind of toilette facility does your household use?	N = 736	
	Flush to sewage systems or septic tank	10	1.4
	Improved pit latrine (e.g. VIP)	39	5.3
	Traditional pit latrine	593	80.6
	Open pit	3	0.4
	Bucket	0	0.0
No facilities, bush, or field	910	12.4	
D9	Do you share a toilette with another household? (observational)	N = 736	
	Yes No	249 487	33.8 66.2
D10	Does the toilette have a hand washing facility located near it? (observational)	N = 736	
	Yes No	302 434	41.0 59.0
D11	What type of hand washing facility is located near the toilette? (observational)	N = 288	
	Tippy tap	60	20.8

	Cup and container	214	74.4
	Outside tap	4	1.4
	Other (specify)	10	3.5
D12	When do you wash hands? <i>*multiple responses allowable</i>	N = 736	
	After defecation	671	91.2
	After changing nappies	483	65.6
	Before food prep and cooking	272	37.0
	Before eating	549	74.6
	After eating	412	56.0
D13	Do you wash your hands with disinfectants after defecation?	N = 736	
	Yes, always	392	53.3
	Yes, sometimes	250	34.0
	No	87	11.8
	Do not know	7	1.0
D14	Do men wash their hands with disinfectants after defecation?	N = 736	
	Yes, always	330	44.8
	Yes, sometimes	291	39.5
	No	88	12.0
	Do not know	27	3.7
D15	Do girls wash their hands with disinfectants after defecation?	N = 736	
	Yes, always	247	33.6
	Yes, sometimes	280	38.0
	No	105	14.3
	Do not know	104	14.1
D16	Do boys wash their hands with disinfectants after defecation?	N = 736	
	Yes, always	242	32.9
	Yes, sometimes	279	37.9
	No	105	14.3
	Do not know	110	14.9
D17	Does your household have a rubbish pit?	N = 736	
	Yes	468	63.6
	No	268	36.4
	Don't know	0	0.0
D18	Is the rubbish put purposely dug?	N = 736	
	Yes	377	51.2
	No	333	45.2
	Don't know	26	3.5

Table 5: Childhood Illnesses & Caring Practices

Midterm Frequencies: Childhood Illnesses & Caring Practices					
Q.		Children 0-23 months, N=736		Children 24-59 months, N= 256	
		#	%	#	%
F1	Children with diarrhea in the past 2 weeks	N=736		N=256	
	Yes	197	26.8	43	16.8
	No	539	73.2	213	83.2
F2	Caretaker's response to child with diarrhea	N=197		N=43	
	Continued to breastfeed/increased food intake	13	6.6	3	7.0
	Stopped breastfeeding/giving food	19	9.6	9	2.1
	Gave salt and water (ORS) at home	89	45.2	14	32.6
	Went to church/preacher	2	1.0	0	0.0
	Went to traditional healer	3	1.5	0	0.0
	Went to a health center-post/hospital	73	37.1	20	46.5

	Did nothing	13	6.6	5	11.6
F3	In the past 2 weeks, did <i>any</i> child between 0-59 months have fever with chills?	N= 736		N=256	
	Yes	288	39.1	96	37.5
	No	448	60.9	160	62.5
F4	If the child had malaria (fever with chills), what did you do?	N= 288		N=94	
	Went to health facility for medication	220	76.4	75	79.8
	Bought medicine and gave to child	57	19.8	19	20.2
	Went to a traditional healer	3	1.0	0	0.0
	Did nothing	6	2.1	0	0.0
	Other	2	0.7	0	0.0
F4.1	In the past two weeks, did any child have fever with difficulty breathing?	N= 596		N=229	
	Yes	43	7.2	12	5.2
	No	553	92.8	217	94.8
F4.2	If yes, did it receive any medication	N= 102		N=25	
	Yes	31	30.4	9	36.0
	No	71	69.6	16	64.0
F4.3	If yes, where did the child receive medication?	N= 31		N=9	
	Went to health facility for medication	23	74.2	7	77.8
	Bought medicine and gave to child	5	16.2	2	22.2
	Went to a traditional healer	3	9.6	0	0.0
	Did nothing	0	0.0	0	0.0
F5	Does your household have any mosquito nets that can be used while sleeping?	N=736		N=256	
	Yes	674	91.6	229	89.4
	No	62	8.4	27	10.6
F6	Where did you get these nets?	N=671		N=226	
	Health facility	631	94.1	206	91.2
	Bought from shop	9	1.3	1	0.4
	Received from NGO	31	4.6	19	9.2
	Other (specify)	0	0.0	0	0.0
F7	Who regularly sleeps under the mosquito nets?	N=672		N=227	
	Father/mother	30	4.5	20	8.8
	Mother and child	95	14.1	31	13.7
	Children only	12	1.8	8	3.5
	All family members	535	79.6	168	74.0
F8	When you got the net was it already soaked in a liquid to repel mosquitos?	N=671		N=227	
	Yes	574	85.5	205	90.3
	No	97	14.5	22	9.7
F9	Are there any pregnant women in the household?	N=726		N=250	
	Self	9	1.3	25	10.0
	Another woman	10	1.4	1	0.4
	None	726	97.4	224	89.6
F10	If yes, did she/they sleep under the net last night?	N=736		N=250	
	Yes	31	4.2	26	10.4
	None	705	95.8	224	89.6
F11	At what age did you start taking your children for under-five clinic?	N= 736			
	(0-5) months	710	96.5	N/A	N/A
	(6-18) months	26	3.5		
F13	Are you still visiting "Growth Monitoring Clinics" for any	N=736		N=256	

	of your under-five children?				
	Yes	670	91.0	227	88.7
	No	66	9.0	29	11.3
F14	Have any of the children received de-worming drugs in the past 6 months?	N=736		N=256	
	Yes	372	50.5	167	65.2
	No	364	49.5	89	34.8

Table6: Child (6-23 months & 24-59 months) Dietary Intake (multiple responses allowed)

Midterm Frequencies: Childhood Illnesses & Caring Practices					
Q.	Food Items as grouped in questionnaire (for details of each item below, reference final questionnaire tool)	Children 6-23 months, N=521		Children 24-59 months, N=256	
		#	%	#	%
E23.1	CEREALS	463	88.9	241	94.1
E23.2	VITAMIN A RICH VEGETABLES AND TUBERS	243	46.6	156	60.9
E23.3	WHITE TUBERS AND ROOTS	36	6.9	20	7.8
E23.4	VITAMINE A RICH FRUITS	21	4.0	20	7.8
E23.5	DARK GREEN LEAFY VEGETABLES	278	53.4	153	59.8
E23.6	OTHER VEGETABLES	242	46.4	130	50.8
E23.7	OTHER FRUITS	47	9.0	39	15.2
E23.8	ORGAN MEAT (IRON-RICH)	11	2.1	6	2.9
E23.9	FLESH MEATS	25	4.8	15	5.9
E23.10	EGGS	15	2.9	6	2.3
E23.11	FISH	23	4.4	19	7.4
E23.12	LEGUMES, NUTS, & SEEDS	161	30.9	89	34.8
E23.13	INSECTS	8	1.5	1	0.4
E23.14	MILK AND MILK PRODUCTS	132	25.3	19	7.4
E23.15	OILS & FATS	154	29.6	98	38.3
E23.16	SWEETS	157	30.1	78	30.5
E23.17	SPICES, CONDIMENTS	242	46.4	98	38.3
E23.18	BEVERAGES	95	18.2	48	18.8