Helpdesk Report

K4D | Knowledge, evidence and learning for development

Social and behaviour change communication interventions in Mozambique

Rachel Cooper
GSDRC, University of Birmingham
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Question

What are the lessons learned from delivering communication interventions aimed at social behavioural change related to family planning, girls' empowerment, WASH and nutrition in Mozambique?

Contents

1. Summary

Social and behaviour change communication (SBCC) is the use of communication to change behaviours by positively influencing knowledge, attitudes and social norms at the individual and community level.[1] Approaches to SBCC include, but are not limited to: media campaigns, peer educators and mentors, small group sessions, community dialogues and events, and digital tools.

This rapid literature review focuses on SBCC interventions in Mozambique across four sectors: family planning (FP); girls' empowerment; water, sanitation and hygiene (WASH), and nutrition. The most common SBCC approaches across the four sectors include:

- **Inter-personal communication**: Peer-to-peer and mentor approaches in schools and communities. Examples include: Programa Geração Biz (PGB) - a national adolescent sexual and reproductive health (ASRH) programme including peer education activities, and the Care Group approach to improving nutrition in pregnant and lactating mothers and children under 5, which is based around small counselling sessions.
- **Community participatory approaches**: Community education and mobilisation sessions are a common approach to hygiene promotion in WASH programmes.
- **SMS based platforms**: two SMS platforms target adolescents with ASRH information, and one platform provides users with nutrition information.
- **Media channels**: these approaches have been used across the four sectors. For example, radio spots have covered issues including FP, gender based violence (GBV), and the importance of exclusive breastfeeding for the first six months.

SBCC interventions are often part of larger programmes, and adopt more than one approach. For example, UNICEF's small towns WASH programme in Nampula Provine combined community participatory approaches with radio and media approaches. Combining approaches allowed different audiences to be reached, and ensured saturation of messaging across groups.

Interpersonal and community participatory approaches are high intensity approaches in terms of resources and time. Their reach can be quite small in comparison to radio and media channels. Evaluations of these approaches, included in this review, include evidence of effectiveness in positively changing knowledge and attitudes, and behaviour change. For example, PGB has reduced the adolescent fertility rate amongst beneficiaries, and hygiene promotion initiatives have increased hand washing, leading to reductions in diarrhoea.

In contrast, radio and media approaches are low intensity and have a larger reach. However, it is harder to measure the impact of these approaches. The 'Ouro Negro' radio show reached approximately 1.5 million listeners between July and November 2016 and rapid audience assessments have measured recall of key messages. Low levels of literacy, and poor access to sources such as TV (especially in rural areas), mean that information in Mozambique is often disseminated through radio (UNICEF, 2018).

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[1] http://ccp.jhu.edu/wp-content/uploads/JHU_Social_and_Behaviour_FULL_OUTLINES_V2.pdf [accessed 19/12/2019].

SMS platforms can have a large reach, but can be resource intensive. For example, peer educators (PEs) have been utilised to register beneficiaries in the mCENAS ASRH platform. There is some evidence that SMS platforms have positively affected knowledge and attitudes.

Evidence base: This review draws on evaluations of SBCC intervention, donor reports, and qualitative evidence collected by implementers and funders. There is a relatively large evidence base for FP and nutrition interventions, and a comparatively smaller one for WASH and girls' empowerment. No lessons learned from integrating WASH and nutrition programming could be found during the course of this review. Although there are examples of nutrition programming including WASH in their counselling interventions, as well as calls for the development of multi-sectoral programmes. For example, in 2017, UNICEF signed a multi-sectoral proposal covering WASH, nutrition, and behaviour change funded by the EU.[2] The programme will work in Nampula and Zambezia Provinces between 2017 and 2021.

Lessons learned from across SBCC interventions in the four sectors in Mozambique

Formative research is important for understanding the sociocultural context and designing SBCC interventions: it is necessary in order to understand the sociocultural context. This includes social and community norms, traditional practices, and stigmas and taboos within the target group or intervention area. Differences across Mozambique, including rural and urban, ethnicity, language, and geographic area should also be considered when designing an intervention. A strong understanding of existing social norms and traditional values can help implementers design effective programmes (USAID, 2019).

Different approaches and tools will be suited to different target groups: low levels of literacy amongst women in rural areas means that pictorial messaging may be more appropriate during PE or counselling sessions in the community. UNICEF's small towns WASH programme found that hygiene promotion approaches used in rural areas are not necessarily suited to peri-urban areas, and need to be combined with other SBCC approaches.

Content development and messaging: across all four sectors and across approaches, the evidence base suggests that it is important to involve target groups in the development of content and messaging. Formative research should also inform content and messaging. Drawing on existing social norms can help messaging to be well-received.

Community mobilisation and ownership is important for interpersonal communication and community participatory approaches: this involves parents, care givers, local community leaders and traditional leaders. For example, potential opposition to PGB, due to stigmas around adolescent sexual activity, were mitigated by community sensitisation and involving community leaders in selecting PEs and monitoring the programme. Facilitating communities to select their own volunteers to be part of the intervention (as PEs, or community counsellors) can lead to better results than programme or local government staff selecting participants. There is some evidence that community ownership can contribute to success of community volunteers and achieving behaviour change (USAID, 2019).

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[2] https://eeas.europa.eu/delegations/mozambique/44861/government-mozambique-support-european-union-and-unicef-working-ensure-child-rights-their_en [accessed 18/12/2019].

Interventions must be aware of the potential for reproducing or reinforcing inequitable gender norms: evidence from the Women's First female empowerment programme suggests that the SBCC intervention reinforced existing stigmas towards girls' sexual activity. This included staff introducing their own biases. In FP programmes there is evidence of community counsellors replicating their own beliefs about IUDs and only promoting certain methods of FP. Within PGB steps were taken between 2006 and 2010 to combat gender inequality in the programme including male Pes holding more leadership roles and gaining more recognition. Gender norms can also affect female participation in FP programmes. For example, motherhood is seen as the realisation of womanhood, therefore girls who are not mothers may not see FP as something for them.

For PE and mentor programmes it is important to value volunteers. Across the sector, programmes offer incentives. These can be in the form of transport to meetings, or school supplies. Lesson learned from Food for Humanity's Care Groups approach to nutrition found that non-monetary incentives can be effective. Women who participated in the programme as Care Group Volunteers (CGVs) reported being more respected by their husbands and in the community due to their role and contributed to volunteer retention.

SBCC interventions should be connected to the government. There is evidence that government involvement in or support for interventions can contribute to effectiveness. This includes incorporation of key messaging into training for teachers and health workers.

Men and boys need to be included in SBCC interventions: a number of interventions included in this review primarily target women and girls. However, formative research has shown that men have an impact on nutrition behaviours in their families. GBV interventions should also target men and young boys in order to tackle social norms.

Interventions should be integrated with other programmes and local services. SBCC generating demand for FP or increasing health seeking behaviour related to nutrition needs to be supported by improved access to services. This includes both availability and removing barriers to access. Hygiene promotion programmes should be integrated into wider WASH programmes.

2. Family planning (FP)

Academic studies and donor assessments

Communication about sexuality is hampered by strict social norms in Mozambique (Frederico et al., 2019). A pilot intervention in the Maxaquene "A" neighbourhood in Maputo city aimed to break down generational barriers in communicating about sexuality in order to facilitate behaviour change (Frederico et al., 2019). The pilot intervention consisted of three weekly one-hour coaching sessions, in which female youth and female adults interacted about sexuality (Frederico et al., 2019). The impact of the intervention was limited by existing cultural taboos and misconceptions on sexuality (Frederico et al., 2019).

The diversity of views and discourses about FP should be considered when designing interventions, and when transmitting information to volunteers delivering SBCC on the ground. Capurchande et al. (2015) undertook a qualitative case study of two Community Health Committees (CHCs) in two districts of Maputo Province (Boane and Ndlavela). CHCs promote FPs in the community through counselling sessions, and collaborate with health workers (Capurchande et al., 2015).

Capurchande et al. (2015) found a heterogeneity of views and practices related to FP, including conflicting views between committee members. Area of difference included contraceptive types, target groups, the desirable number of children per family, and the way FP was represented (Capurchande et al., 2015).

The ways in which committee members view FP, as well as their knowledge and practices, can affect how it is promoted (Capurchande et al., 2015). FP promotion can be derailed by inadequate attention to who is responsible to disseminate the information, cultural differences, diversity of knowledge, quality of training, engagement of committee members and socioeconomic aspirations (Capurchande et al., 2015: 5).

Committee members can share the same misperceptions about FP as community members, and help to perpetuate them (Capurchande et al., 2015). For example, some committee members in Baone counselled that traditional contraceptives, e.g. herbs and amulets, were effective (Capurchande et al., 2015). Amongst committee members who were committed to promoting modern FP methods, those favoured were injections, pills and condoms (Capurchande et al., 2015). Nearly all committee members avoided promoting IUDs and sterilisation (Capurchande et al., 2015). Misconceptions about IUDs and sterilisation are rooted in community beliefs and norms about contraceptives, and some committee members were not comfortable promoting them (Capurchande et al., 2015).

There were also **gender differences in how committee members promote FP**. For example, female members were less likely to promote having more than five children than male members (Capurchande et al., 2015). Men were more likely to promote large family sizes, due to social norms about masculinity and beliefs about family subsistence (Capurchande et al., 2015).

Training for volunteers is extremely important. Differences in training may explain why more committee members in Ndavela acted according to expectation than those in Boane (Capurchande et al., 2015). For example, a clear strategy for counselling was implemented to reach schools and households in Ndlavela (Capurchande et al., 2015). Committee members in Ndlavela received 3 months training by NGO Pathfinder International, including information and strategies to promote sexual and reproductive health (SRH) (Capurchande et al., 2015). In contrast, CHCs in Boane received one week of oral instruction at the local healthcare centre (Capurchande et al., 2015).

Geographic differences, such as rural or urban intervention settings, may impact how active volunteers are. Capurchande et al. (2015) found that committee members in Ndlavela were more likely to pursue their role than in Boane. This could be associated with geography, sociocultural background, and differences in training location (Capurchande et al., 2015). Boane is more rural than Ndlavela, and its residents are more deeply influenced by traditional, social and religious norms.

USAID FP assessment

The sociocultural context in which FP is situated needs to be considered when formulating SBCC strategies (USAID, 2012). SBCC interventions to generate demand for FP need to address the social and cultural norms that inhibit FP use (USAID, 2012). A 2012 assessment of FP in Mozambique identified women lacking access to health services and options in life as the most vulnerable and in need of support (USAID, 2012). It also argues that

more attention to the sexual and reproductive rights of women should inform future SBCC programming (USAID, 2012).

SBCC should highlight the maternal and child health benefits of FP (USAID, 2012). FP messaging should be integrated with child survival and maternal health communication campaigns (USAID, 2012). USAID programming has supported the work of CHCs. Committees include teachers, religious leaders, traditional healers, traditional birth attendants, and other influential community leaders (USAID, 2012). USAID has supported CHCs to increase their awareness of the importance of FP for maternal and child health (USAID, 2012).

Special attention needs to be given to youth and men (USAID, 2012). Messages and activities are not always tailored to these groups (USAID, 2012).

There are concerns about the use of volunteers to deliver SBCC, and generate demand for FP (USAID, 2012). These include: long-term dedication to the work; sustainability of a voluntary system to generate meaningful FP demand, and the effects of a lack of materials to assist them in their work or incentives to do their work (USAID, 2012).

Interpersonal and community participatory approaches

Programa Geracao Biz

Programa Geração Biz (PGB) launched in 1999 in Zambezia and Maputo City, and was scaled-up nationwide by 2007 (Nguyen et al., 2019). Its primary target population is in-school and out-of-school youth aged between 10 and 24 years old (Nguyen et al., 2019). The programme aims to improve reproductive health knowledge, attitudes and behaviours; prevent HIV; reduce incidence of early or unintended pregnancies, and improve gender-equitable norms (Nguyen et al., 2019). Secondary populations reached through the programme include parents, teachers, health providers, and the general community (Nguyen et al., 2019).

The programme includes a number of components: SBCC; peer education and support; adolescent safe spaces; capacity building of user organisations; policy and advocacy; curriculum-based reproductive health (RH) education for both in-school and out-of-school populations; strengthening youth friendly adolescent sexual and reproductive health (ASRH) services and strengthening community linkages to them, and community group engagement (Nguyen et al., 2019).

Peer educators (PEs) are extremely important part of the programme (Chandra-Mouli et al., 2015; UNFPA, 2011):

- 16,000 PEs were trained between 1999 and 2010.
- Voluntary PEs are selected via interview and receive 80 hours of training.
- Training includes communication for behaviour change, competencies on SRH and HIV, skills on M&E, planning, social skills and diversity, and liaison.
- Once training is complete, PEs are formally introduced to schools and communities to implement activities.
- PE activities include: awareness raising on STIs and HIV/AIDS; teaching about consequences of early pregnancy; providing condoms and counselling on SRH; referring

young people to youth friendly health services (YFHS) for further help, and helping young people develop SRH skills including the ability to plan and manage their SRH.

- PEs also undertook TV and radio appearances, special meetings, theatre, and featured in local newspapers.
- Community-based PEs facilitate conversations about SRH, and provided referrals to adolescent friendly health services for out-of-school youth.

Examples of the programme's impact include (UNFPA, 2011; Chandra-Mouli et al., 2015:

- Reduction in average school pregnancies by 78.4% between 2005 and 2010;
- Anecdotal evidence of behaviour change includes examples of communities discussing the consequences of unwanted pregnancies;
- A programme evaluation conducted in 2011 found that the proportion of respondents who used contraception was slightly higher amongst those who had been exposed to PGB (57%), versus the overall study population (53%); respondents who had been exposed to PGB were also had higher knowledge of modern contraceptive methods and somewhat more positive attitudes to condom use; and adolescent girls exposed to PGB were more likely to access AFHS.

Research is important for both programme design and programme adaptation. For example, there was a surge in the number of pregnancies in schools covered by the programme in 2006 and 2007 (UNFPA, 2011). A study was conducted to explain the reasons behind the fact, and it was found that girls were having unprotected sex with older people during the school long vacation. As a response, PGB widened its range of themes to include intergenerational sex as a threat to young people's health. Girls were equipped with information and skills to deal with older men who courted them for sex (UNFPA, 2011). Average school pregnancies fell from 4.66 in 2006, to 0.55 in 2010 (UNFPA, 2011).

Community ownership and mobilisation is integral when implementing a programme that is not compatible with local norms. Open discussion of sexuality and of sexual and reproductive, especially for unmarried youth, is not compatible with local norms and there are stigma and taboos attached to SRH (Chandra-Mouli et al., 2015; UNFPA, 2011). Community mobilisation helped to reduce community opposition to the programme, and included (UNFPA, 2011):

- Public sensitisation campaigns presenting PGB as a programme that sought to complement parents' efforts to educate their children to adopt safe sexual behaviour.
- Involving community leaders in crucial aspects of the programme, e.g. in selecting youth to become PEs. There are examples of faith leaders allowing PEs to use their churches for activities.
- In some places, as in Zambézia, where community ownership seemed an elusive target, PGB started to turn to a special category of PEs. Parents, teachers, media professionals and DJs were trained as supporting PEs, participating side by side with young PEs in the regular PE training.
- Community and school leaders were encouraged to monitor the work of their PEs.

The stigma related to sexual and reproductive health issues also affected programme implementation and gender equity within the programme (UNFPA, 2011; Chandra-Mouli et

al., 2015. Early PEs and health providers experienced difficulties including name calling, angry parents, and PEs not being allowed to put on their educational plays in communities. Recruiting and retaining female PEs suffered a number of difficulties including: social norms which identify SRH education as more suitable for boys than girls, and female PEs facing public ridicule (UNFPA, 2011).

Routine monitoring found that there were more male PEs than female ones, and a 2006 study found that more girls than boys dropped out of the PE programme (UNFPA, 2011; Chandra-Mouli et al., 2015). Gender inequality in the programme reflected gender bias among community and school leaders, who played a substantial role in selecting PEs (UNFPA, 2011). Recruitment and retention of girls was also affected by a lack of specific strategies to recruit, train or follow-up to increase the involvement of girls; girls' share of leadership responsibilities was low (38% against 62%), and boys outnumbered girls in achievements and in public recognition in the programme (UNFPA, 2011).

PGB took a number of steps to address gender equality in the PE component. These included sensitising community and school leaders on the need to recruit girls; rotating leadership roles by gender at the local level; increasing girls' recognition in the programme (which helped reluctant fathers to become supportive of their daughters' involvement), and creating a more supportive environment for female participation (UNFPA, 2011). Creating a supportive environment included: recruiting girls along with their friends, as research shows girls were more likely to join and stay if their friends were also in the programme; introducing income generation opportunities for girls (helping parents to overcome opposition to involvement), and instituting social support network for female PEs (UNFPA, 2011).

By 2010, girls still represented approximately 45% of PEs (UNFPA, 2011). However, male and female retention rates were roughly similar, suggesting that as gender bias decreased other factors became more important in explaining retention levels (UNFPA, 2011).

Incentives for PEs were developed in response to requests from PEs themselves, who argued they would help retention (UNFPA, 2011). Incentives include free school materials, exemption from registration fees, free meals and transport for PGB meetings, and sports materials for two associations per province (UNFPA, 2011). Incentives are provided by the Ministries of Education, and Youth and Sport (UNFPA, 2011).

Government support for the programme was integral. PGB was designed and implemented with the Ministries of Health, Education, and Youth and Sports (Nguyen et al., 2019). For example, the Ministry of Youth and Sports manages the community-based PE activities (Nguyen et al., 2019). The Ministry of Health (MoH) has integrated PGB into its School and Adolescent Health Programme (UNFPA, 2011). In 2011, the Government of Mozambique decided to promote PGB as a model programme nationally (UNFPA, 2011). During scale-up of the programme nationally, inter-sectoral meetings across ministries helped to ensure that programme activities were integrated into each ministry's operating budget (Nguyen et al., 2019).

Population Services International (PSI)

Aquele Papo

Launched in August 2019, Aquele Papo includes a 13 minute film (The Talk), a music video, website, and Facebook page.[3] It tells the story of two young people as they navigate SRH issues. The film is shown in schools, cinemas, on a popular adolescent TV show, and across PSI facilitated service delivery 'pop up' events.

Pop up events reached over 6,000 young people in the first five weeks. They combine interactive sessions, with the option to engage in youth friendly contraceptive counselling if attendees choose. Two in five young people who underwent counselling adopted a method of contraception.

Ignite

The programme aims to increase informed demand for SRH services by girls and young women[4] (ignite, 2019). It implements a PE approach in schools. In 2018 it reached 125,686 adolescent girls with peer-to-peer sessions including information on sexuality, HIV, STIs, pregnancy, and contraceptives. Changes were made to the programme in 2018, following values exploration sessions with PEs working in different schools. A number of changes were made to the programme. These included recruiting peer PEs from different school grades; developing new ICE materials in conjunction with adolescent girls to ensure messaging was targeted at youth, and including school counsellors in schools teams to ensure a more permanent presence in the school health corners as well as support for the PE activities (ignite, 2019: 3-4).

Parents' objections to the programme affected activities in 2018. Part of ignite's programme involves increasing access to contraception through youth friendly health centres (ignite, 2019). As part of this, the programme was operating services in 60 schools (ignite, 2019). This ceased in 2018 due to parents' objections (ignite, 2019). PSI tackled this by involving parents and care givers in youth activities in late 2018 and moving to providing services through delivery points in front of schools as agreed with school management (ignite, 2019).

Vale-a-Pena[5]

Behaviour change requires a number of things including generating the demand for FP and ensuring that services are available. Funded by UK AID, Vale-a-Pena applies the Adolescents 360 youth-powered approach to determine what leads to lasting adolescent and youth SRH behaviour change. Situation analysis highlights the role of misinformation about

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[3] The information in this subsection is derived from PSI's webpage: https://www.psi.org/2019/10/taking-the-talk-to-the-big-screen/ [accessed 16/12/2019].

[4] This programme is also active in Haiti, India, Cote d'Ivoire, and Kenya.

[5] http://a360learninghub.org/mozambique/ [accessed 16/12/2019].

contraception, which leads to youth not seeing contraception as "in service of their immediate needs".

Behaviour change requires[6]:

- **Addressing socio-cultural pressures on youth**: this includes social norms around girls marrying after the onset on puberty, motherhood making you a 'full woman," and engaging boys and men so they can be contraceptive allies.
- **Building and supporting provider capacity**.
- **Fostering an enabling environment**: including engaging madronas (who lead initiation rites), religious leaders, and traditional healers; as well as female relatives, midwives and traditional birth attendants, in strategies to promote AYSRH services. All of these play a role in educating young people about sexuality; sustaining change requires building on key moments communities already known and embraced.
- **Addressing public sector barriers**: including stock outs and long waiting times, as well as a lack of youth-friendly services.
- **Improving the quality of and access to trusted SRH information**: inaccurate and inconsistent messaging diminishes the efficacy of SBCC campaigns.

Attempts to reach mothers and engage them to discuss SRH with their daughters failed[7]. Vale-a-Pena developed kit bags, including pamphlets and condoms in a first iteration, and then also including invites to adolescent-focused mobile events in a second iteration. However, the kits were not effective at generating dialogue. Mothers were concerned that initiating conversations about SRH would give their daughters permission to engage in sexual activity. Additionally, mothers were not willing to pay for the kits, as most of the items are free from health facilities; mothers wanted something that would speak for them, and not all mothers can read.

Parental buy-in meetings for a pilot intervention including mobile events were crucial for success[8]. Mobile events including a series of sessions for girls on entrepreneurial skills and life planning, followed by an interactive health session linking their dreams and the choices they make. All sessions led to an opt-out counselling sessions with an on-site nurse. During pilot activities 396 girls in rural areas were reached, and 43% of eligible girls (211 who had had their first menstruation) went for FP services on the same days as the events.

Mobile Platforms

m CENAS!

This text message intervention targets youth between 15 and 24, both male and female, and those with and without children (E2A, 2015). The programme's aim is to increase knowledge about contraceptive methods, dispel myths, and address common barriers youth face regarding

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[6] http://a360learninghub.org/mozambique-market-failures/ [accessed 16/12/2019].

[7] The following information is derived from an article on Vale-a-Pena's website: http://a360learninghub.org/reaching-mothers-we-thought-it-was-in-the-bag/ [accessed 16/12/2019].

[8] https://www.thinkplace.co.ke/work/demand-creation-model-family-planning-services [accessed 16/12/2019].

contraceptive use (E2A, 2015). It was piloted in two provinces in 2014 and reached 2,005 youth (Amado, 2018). In 2018, 9,066 youth across six provinces were enrolled.

Youth receive story messages three times a week for eight weeks, followed by contraceptive information messages three times a week for four weeks (E2A, 2015). Youth are also able to access a menu of frequently asked SRH and contractive method information messages, and access a youth friendly hotline (E2A, 2015). The intervention is integrated into a larger programme, including interpersonal communication with peer educators and small groups (E2A, 2015). Initially peer educators facilitated enrolment (Amado, 2018).

A 2015 evaluation using baseline and endline questionnaires found that the intervention has increased knowledge and positively affected attitudes and beliefs amongst users (E2A, 2015). For example, at endline 57.7% of males without children had medium-high knowledge of three or more contraceptive methods, compared to 30.9% at baseline (E2A, 2015). Perceptions on safety, ease of use and effectiveness of contraceptive methods improved significantly for both male and female youth, with or without children (E2A, 2015). There were significant declines in the percentage of youth who believed that using a contraceptive method would make it more difficult to have children afterwards.

In terms of attitudes there were significant increases in the percentage of youth who agreed it was fine for a young woman, either married and unmarried, to use a method other than condoms (E2A, 2015). There was also a significant increase in percentage of youth without children who view contraception as a way to increase further education opportunities (E2A, 2015).

In terms of adopting new behaviours, amongst female youth, only the use of male condom increased significantly, and only amongst females with children (E2A, 2015). For male youth, current use only increased significantly for partner's use of combined oral pill (E2A, 2015).

Lessons learned from the intervention include (Amado, 2018):

- **Use of a local script-writer, story-based messages, text message slang, and participatory design process with youth was essential**. A Pathways to Change game was used with youth to gather information about barriers and facilitators of contraceptive use and to generate initial story ideas. Two stories were developed: one for parenting, and one for non-parenting youth.
- **SMS is an acceptable and feasible method to deliver sensitive and confidential SRH information for young people**. The target audience for the intervention was youth with their own mobile phone and the ability to use SMS.
- **Integrating SMS interventions within larger service delivery projects** is critical to ensure supply for demand.
- **Scaled-up SMS projects can become costly**: there is a need for business models and market research on willingness to pay for sustainability. Experience from both the pilot and the scale-up phases suggest that youth might be willing to pay for the service.

SMS BIZ/U-Report[9]

The SMS BIZ/U-Report platform targets adolescents and youth aged 10-24 years, and provides peer counselling over the phone. The platform is supported by the government though PGB, and by UNCEIF, UNFPA and other partners. Users can access counselling from trained PEs, respond to polls and report issues related to SRH, HIV, violence and sexual abuse and child marriage. Each case is given a code, so that counsellors can follow-up until a case is resolved whilst ensuring the service is anonymous.

Between its launch in October 2015 and the end of 2017, over 130,000 adolescents and youth registered to use the platform either for counselling or to take part in SMS polls on different topics. Approximately 44% of users are female, and the platform piloted new ways to encourage girls and young women to use the service, especially in rural areas. This included a girl-to-girl invitation system and polls on female issues such as menstruation.

The programme is currently being rolled out nationally. Youth activists visit schools to raise awareness of the platform.

Value for money: it costs USD 2 per year to reach one adolescent with peer counselling.

Qualitative feedback from users includes that:

- the programme is able to overcome cultural taboos about talking SRH issues, because it is over the phone. A mobile based platform helps adolescents and youth 'feel free to talk'.
- Users feel more confident negotiating with intimate partners after using the platform.
- The three most discussed topics are: sexuality, FP and pregnancy, and HIV.

3. Girls' empowerment

Rapariga Biz

This UN joint programme aims to reach 1 million adolescent girls across Mozambique by 2020 (UN, no date). During the first year of implementation (2016-2017) the programme reached four districts in Nampula Province and three districts in Zambezia Province (UN, n.d). Rapariga Biz complements PGB (outlined in section 2). For example, Rapariga Biz mentors reach girls directly through Safe Space sessions, whilst PGB PEs reach the same girls through sensitisation activities about adolescent sexual and reproductive health in school and the community (UN, n.d).

Hanitzsch et al., (2018) argue that the innovative part of the Rapariga Biz is the shift from a peer-to-peer approach to a longer-term relationship between mentors and youth. Mentoring by trained volunteers, as opposed to PE interventions, establishes a strong relationship between students/adolescents and their mentors, thus leveraging pointed and longer-term support in critical life situations (Hanitzsch et al., 2018).

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[9] The information in this sub-section is derived from UNICEF's Mozambique's webpage: https://www.unicef.org/mozambique/en/adolescent-social-norms [accessed 16/12/2019].

The programme focuses on the promotion and protection of sexual and reproductive health and rights (SRHR) for girls and young women (UN, n.d). Linking youth relevant sectors promotes youth understanding of FP, and strengthens their ability to take control of their own lives, especially young women (Hanitzsch et al., 2018). The programme also has a strong focus on gender equality, early motherhood and marriage, and gender based violence (GBV) (Hanitzsch et al., 2018).

The programme's SBCC activities include (UN, n.d):

- **Safe Space Model:** including safe spaces, girls' network, mentorship to influence attitudes and behaviours, and promotion of life skills. Mentors are normally young women from the same community, who are enrolled in secondary school. Mentors receive training in a number of areas including social mobilisation, communication for behaviour change and SRHR, and ongoing support through bimonthly meetings with other mentors led by a district focal point. Mentors have been enrolled in SMS Biz so they can receive on-the-spot information. Two take home notebooks have been developed for girls being mentored in the programme to consolidate their learning;
- **Promotion of SRHR through the media**: this includes episodes of the radio show Ouro Negro addressing SRHR, GBV, HIV and child marriage broadcast on 70 radio stations; teen media producers involved in the production of weekly programmes on Radio Mozambique in the two provinces, as well as programmes on community radio and on TVM television channel. Teen media producers have received training including manuals on different issues;
- **Community engagement/dialogue** including families, community and religious leaders, boys and men on SRHR, but also issues including keeping girls and young women in school and for out-of-school girls to return to school.
- Supporting the design of a comprehensive sexuality education curriculum and training teachers.
- An economic empowerment project in Nampula Province.

Results within the first year of implementation include (UN, n.d):

- 23,518 adolescent girls reached and 783 mentors trained.
- 2,750 adolescent girls supported to re/enroll in school. The most vulnerable were supported to obtain school materials.
- 1.5 million listeners (approximately 25% of the total number of radio listeners in Mozambique) reached by Ouro Negro. Two rapid audience assessments conducted via SMS found that audience satisfaction with the programme was high (over 90%).
- 26,000 new users of SMS Biz registered.
- 56 initial meetings with community leaders and 80 community meetings held.

Results potentially related to behaviour change include: the adolescent fertility rate in the programme was 54% lower than the national rate in 2016 (UN, n.d) There were only 322 new marriages amongst those reached by the programme, compared to 23,518 in 2016 (UN, n.d).

Lessons learned and challenges include (UN, n.d; Hanitzsch et al., 2018: 10-11):

- A focus on girls and young women can run the risk of boys and young men feeling 'left out'. This could lead to an imbalance that undermines the ability of girls and young women to utilise new skills in intimate relationships.

- Challenges in monitoring the quality of sessions in the Safe Spaces.

- Need for psychosocial support for mentors who are effected by the complex and emotional situations of the beneficiaries.

- Not all mentors and beneficiaries listen to the radio programmes. There is an opportunity to include them as part of the content for Safe Space sessions, and ensure mentors are promoting them in sessions and in community events.

- Ensure complementarity and synergies of approaches and messaging across the intervention.

- Issues that directly influence girls' SRHR, such as initiation rites and high school drop-out rates, should be addressed in community dialogues.

- Out-of-school youth are not captured by the programmes in Zambezia Province.

- It is recommended to establish multi-professional support groups where teachers and health care providers can exchange and learn from each other on how to address and tackle challenges, with regards to their role as educators and supporters of adolescents in critical life situations.

- There were delays to the distribution of a comprehensive teaching and learning package for primary schools relating to enabling and empowering girls to respond to child marriage and child abuse (UN, n.d). This was due to changes in Ministry of Education policy prioritising child protection interventions being implemented through school councils.

Women First

Women First was a combined economic and social empowerment intervention implemented in Zambezia between 2010 and 2015 (Burke et al., 2019). The intervention was designed to reduce adolescent girls' risk of HIV and GBV, improve school attendance, and empower girls (Lenzi et al., 2018).

The intervention included training girls and young women to sell products door-to-door (Burke et al., 2019). Products included soap and ingredients to bake cakes (Burke et al., 2019). Participants paid the intervention a portion of their sales in order to receive the next kit (Burke et al., 2019). Once a girl or young women had sold her third kit she was considered a graduate and eligible to receive a bicycle (Burke et al., 2019). In some of the communities, the intervention introduced a microfinance initiative to provide access to loans for business capital (Burke et al., 2019).

Initially, the intervention targeted adult women. However, over time it began targeting vulnerable girls aged between 13 and 17 (Burke et al., 2019). Vulnerable girls were defined as: having lost one or both parents, living in a child-headed household, and engaging in transactional sex or other HIV-risk behaviours (Burke et al., 2019). For adolescent girls, the intervention included (Burke et al., 2019):

- Implementation of a curriculum designed to reduce vulnerability to HIV, and a locally-tailored GBV curriculum.

- Facilitator-led group education sessions, covering topics including gender norms for boys and girls, how to communicate with adults and partners, puberty, pregnancy and HIV prevention, amongst others.
- Encouraging girls to remain in school.

A qualitative study conducted in 2015/16 as part of a longitudinal, mixed methods evaluation of the intervention found that (Burke et al., 2019):

- Girls were invited to participate by community leaders in conjunction with intervention staff and current Women First adult participants. Once invited, individual refusal rates were near zero. More girls wanted to participate than there were spots available.
- The business component increased girls' financial resources during the intervention. However, over half the girls were not able to continue their businesses once the intervention ended.
- About one-third of girls interviewed after the intervention had ended were in school, compared to half during the intervention.
- The intervention had positive effects on girls' risky sexual behaviour (e.g. reducing girls' engagement in transactional sex, or sex with multiple partners). However, once the intervention ended, these effects were only sustainable for girls who maintained their businesses and incomes.
- Some participants reported using condoms and negotiating condoms with their partners. However, whilst many girls described wanting to or intending to use condoms or other FP in the future, most did not. Reasons for not being able to use condoms included that they are married, their husbands refuse to, and they trust their husbands.
- Girls' knowledge around GBV appeared quite superficial. However, participants did report changes in community members' understanding or knowledge of GBV-related topics including what constitutes GBV.
- Whilst awareness of HIV and GBV remained high amongst community members there was limited evidence that this translated into reduced high-risk sexual practices among girls in the community who had not participated in the intervention.
- There is some evidence that the intervention changed household and community norms, with regard to how men perceive and treat girls.

There is some qualitative evidence that the intervention reinforced or perpetuated inequitable gender norms towards girls and women, including stigma towards girls' sexual activity (Burke et al., 2019). Negative attitudes to girls' sexual activity seem to have been transmitted by the intervention (Burke et al., 2019).

Perceptions of girls' improved 'respectfulness' emerged as an unanticipated effect of the intervention (Lenzi et al., 2019). Girls interviewed for the evaluation reported learning during the sessions that premarital sex was wrong or bad, and that girls who engaged in it garnered less respect (Burke et al., 2019). These views were generally aligned with existing gender norms (Linzi et al., 2019). Evaluation respondents stated that the Women First programme had contributed to girls' learning to be respectful (Linzi et al., 2019).

Lessons learned relevant to SBCC that could be applied to future programmes include (Burke et al., 2019; Linzi et al., 2019):

- Formative research is necessary to understand existing gender norms, and the degree to which girls and communities position themselves as rigidly aligned with prevailing norms.
- Programmes should take steps to ensure that staff are not introducing their own biases, especially reinforcing inequitable gender norms during implementation.
- Education component, especially related to GBV, should be expanded to others in the community, especially men.
- Educational content should be enhanced to go beyond listing types of GBV to provide participants with a deeper understanding. This includes critical reflection and challenging social norms that are accepting of violence.
- Interventions should include components targeting the broader community: key influencers, community leaders, and persons who have direct relationships with girls e.g. parents, teachers and family members.
- Interventions that promote gender equity should consider working with younger girls and with young men and boys. Gender norms are inculcated at an early age.

HOPEM

HOPEM is a non-profit organisation with about 25 member organisations and activists from Mozambican civil society (Jones et al., 2015). It is unique in its focus on men (Jones et al., 2015). Interventions aim to engage men to question discriminatory ways of thinking and acting related to masculinity and building alternative identities (Jones et al., 2015).

The focus is often on young, educated men as they will play a role as opinion makers in the future (Jones et al., 2015). Limitations to HOPEM's work include: reporting on results (it is hard to measure advocacy for changing attitudes) and reach (the organisation is active in Maputo) (Jones et al., 2015).

Working with Concern and Promundo, HOPEM has developed the Clube de Dialogos methodology to engage men as partners and allies alongside women in challenging gender norms, promoting equality and improving nutrition[10]. This was part of a larger DFID funded project *Linking Agribusiness and Nutrition.* The project is active in Manica and Zambezia Provinces.

An initial barrier analysis revealed that men were the primary influencers on two key nutrition related behaviours: exclusive breastfeeding and children receiving a minimum acceptable diet. Formative research revealed that both men and women face social pressures to conform to gender norms, expectations and practices. Social norms pose a barrier to improved health and nutrition. For example, nutrition is seen as 'women's business'.

Clube de Dialogos are gender transformative group workshops. Concern argue that men are motivated to attend to by their desire to have a happy and healthy family. Educational sessions support men to understand how inequitable gender norms and perceptions can negatively affect their lives and those of their female partners and children. Men are given opportunities to reflect on these prevailing notions of gender and masculinity, and on how these

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[10] The information in this subsection is derived from: https://men-care.org/2016/11/15/engaging-men-gender-equitable-fathers-caregivers-reduce-malnutrition-mozambique/ [accessed 17/12/2019].

norms may have inhibited their ability to fully engage as fathers and caregivers. Then, they are supported in exploring and developing healthier alternatives.

4. WASH

The One Million Initiative, 2006-2013

A 2012 evaluation analysing panel survey data for 1,600 households found that sanitation training had a strong impact on latrine ownership and on the health of both adults and older children (Elbers et al., 2012). Increasing access to water points had a sizeable impact on the use of improved water sources and the health of children up to 3 years old (Elbers et al., 2012).

The One Million Initiative was launched in 2006 by the Government of Mozambique, UNICEF and the Government of the Netherlands. It combines creation or rehabilitation of improved communal water sources and a version of the Community Led Total Sanitation (CLTS) approach, including hygiene and sanitation promotion aimed at ending open defecation (Elbers et al., 2012). The Initiative covers 18 districts across three provinces (Manica, Sofala and Tete).

Evidence of behaviour change include (Elbers et al., 2012):

- More than 95% of adults from households with a latrine also use it, but only two thirds of children do.
- Some households in the sample already owned latrines before the programme. However, the evaluation estimates that the CLTS training convinced around 21% of household who would otherwise not have built a latrine to do so.
- The training had a positive but not significant effect on proper handwashing (defined as washing with soap or ash): for example, whilst all adults in the survey reported that they wash their hands at critical times, people rarely reported using soap or ash.
- The CLTS training motivated non-user households to start using improved water sources in communities where improved water points were or became available.

Once improved water sources are available in a community, it is important to focus on the hygiene component (Elbers et al., 2012). The health impacts of improved water sources could be diminished by the bacterial contamination that occurs between the source and the point/time of use (Elbers et al., 2012).

Diocese of Niassa

The Diocese's hygiene promotion programme was implemented in two districts (one in Niassa and one in Zambezia) between 2013 and 2016, reaching 180 villages. A 2016 evaluation concluded that the programme was successful and generated significant behaviour change (Walker, 2016). The Diocese has used the model developed during its WASH programme to create an integrated approach to community development including nutrition and HIV (Walker, 2016).

The programme had ready access to committed community volunteers (Walker, 2016). The programme grew out of requests from Equipas de Vida, church-based community groups of volunteers (Beale & Vander Meule, 2015). Communities largely self-identified to be part of the programme (Walker, 2016). Whilst it initially responded to requests from Equipas da Vida

communities, the programme was promoted in a non-discriminatory basis and worked with all members of a community regardless of faith, and in communities that are not predominately Anglican (Walker, 2016).

The intervention includes (Beale & Vander Meule, 2015; Walker, 2016):

- "Animators" are selected by their community and receive training from 5 programme staff. Animators take on the role voluntarily, but receive a bicycle to enable them to travel between community and to training meetings. There is a gender imbalance of animators, with 80% being men. One of the role requirements is literacy in written Portuguese, which more men are likely to have than women due to their higher levels of schooling.
- Animators work with their communities to select one woman to serve as a water and sanitation counsellor for every 10 households in the village. Counsellors visit every household disseminating hygiene promotion messaging.
- Hygiene education includes six modules covering topics such as hand washing, building latrines, and treating diarrhoea. Each theme is accompanied by a poster which are primarily pictorial due to low literacy rates
- Field workers and programme managers visit each community every six weeks during the rollout of the hygiene promotion programme.
- Establishing hygiene committees including five men and five women. Committees organise cleaning days, collect maintenance fees, and continue hygiene education.
- Hygiene promotion in schools by programme staff.
- Theatre performances by theatre groups made up of Animators and Counsellors.

Results from baseline and endline surveys show (Walker, 2016):

- Increase in handwashing after defecating from 24% to 66%;
- Increase in respondents pouring water on hands to wash them from 7% to 93%;
- Increase from 37% having a latrine to 84%;
- At baseline, 55% of respondents were unsure of the causes of diarrhoea; at endline, 0% were unsure.
- At baseline, 13% reported a death of a child in the last 12 months from diarrhoea. At endline this was 7%.

Valuing volunteers is important for mobilisation (Beale & Vander Meule, 2015). A series of measures were implemented to encourage animators and counsellors to complete their work (Beale & Vander Meule, 2015). These included badges, certificates, and booklets with space for a sticker for each theme (Beale & Vander Meule, 2015). There is anecdotal evidence that these incentives increased attendance at trainings, and that some counsellors arranged to work each other fields to free them up to teach in the afternoons (Beale & Vander Meule, 2015: 5).

Clear guidance is needed to ensure consistency of messaging at the household level (Beale & Vander Meule, 2015). Post implementation visits at the end of the pilot phase found some distortions of messaging. Steps to resolve this included developing more detailed activity plans for field workers training animators; key messages for each theme appeared in the animators' booklets so they can refer to them during training, and simplification of counsellors' posters (Beale & Vander Meule, 2015).

Interventions need to take into account variations in context and adapt to these (Beale & Vander Meule, 2015). For example, in one intervention area houses are clustered close together in a community with farms on the outside, in another area houses are adjourned to farmland so it is harder to travel around a community (Beale & Vander Meule, 2015). Zambezia is relatively underdeveloped in comparison to other intervention areas and was more open to new ideas, which contributed to increased up-take of the new training (Walker, 2016). In comparison, there was reduced uptake of the programme in Lichanga, particularly in terms of community-led ownership of water sources (Walker, 2016). This may be due to longer term involvement of Anglican Church and its history of providing and maintaining facilities (Walker, 2016). Related to this, communities have lower WASH and health needs, which may mean they do not have the same motivations for behaviour change (Walker, 2016).

Recommendations from the 2016 evaluation for improving the programme include (Walker, 2016):

- Adjusting the structure to provide equal opportunities for women to become Animators;
- Regularly briefing relevant government departments on project plans, activities and results, and
- Gender equality and disability inclusion is part of training for programme staff and becomes a core part of programme implementation.

International Water and Sanitation Centre

Integrated WASH approach is needed, as hygiene promotion interventions are more effective in the context of water and sanitation infrastructure improvement (Potter et al., 2013). A hygiene promotion initiative (HPI) in four districts of Zambezia province was implemented between 2007 and 2011. The project's overall objective was to reduce water related diseases (Potter et al., 2013). The HPI was active in 30 communities and 20 schools. It included:

- Establishing and training water committees.
- Training community activists/Animators in Participatory Hygiene and Sanitation Transformation (PHAST) and CLTS.
- Animators conducting community education sessions on handwashing behaviour.
- Model latrines for three households in each community.
- Training of two local artisans/bricklayers from each community from each community in the techniques and skills needed for latrine construction, so that each community had the capability to build latrines.
- School hygiene promotion activities.
- Local district government involvement in liaising with and encouraging communities to participate and in monitoring activities.

Potter et al. (2013) evaluated the effectiveness of the HPI using three indicators: (1) faecal containment and latrine use; (2) handwashing with soap or substitute at critical moments, and, (3) use of safe drinking water source and management of drinking water at the household level. Evidence of behaviour change as a result of the intervention included (Potter et al., 2013):

- An increase in improved hygiene behaviour between 2007 and 2011. The number of households with a latrine increased from 31% to 73% and use of latrines increased from 31% to 73%. There were significant changes in the numbers using improved water sources (increase from 40.3% to 86.4%) and in washing containers before water is collected (increase from 55.3% to 99.6%).

- For the three indicators households were ranked as not effective, limited, basic and improved: For indicator 1 there was an increase from 45.5% at baseline to 88% at endline of households at the limited effectiveness level, and a decrease from 54.3% to 6.4% of households at the not effective level.

- For indicator 3 there was an increase in the percentage of households in the improved level from 20.8% at baseline to 78.8% at endline.

Despite participating in handwashing promotion activities at school and community level, children showed less improvement in handwashing than adults (Potter et al., 2013). At endline, only 49.8% of children were in the basic/improved level compared to 66.8% of adults (Potter et al., 2013). The greatest changes in handwashing behaviour for both adults and children were in the percentage using non re-contaminated water for handwashing and the use of soap or a substitute (Potter et al., 2013).

Value for money: the cost per person for the implementer was USD 4.92 per year (Potter et al., 2013). No household cost information was collected during the study, although the use of soap for handwashing is expected to incur a cost for households (Potter et al., 2013).

Potter et al. (2013) argue that for a cost of USD 4.92 per person per year, the intervention delivered a 5% increase in basic faecal containment and latrine use, a 28% increase in basic handwashing, and a 57% increase in basic drinking water management.

Mixed approaches

UNICEF

The design of sanitation programmes in small towns has to be flexible and context specific (Thomas & Alvestegui, 2015). UNICEF's small towns WASH programme in Ribaue and Rapale towns in Nampula Province (launched in 2012) started with an initial set of proposed actions, which evolved based of the characteristics of the town, baseline results, the Sanitation Master Plan, willingness to pay for sanitation surveys, and barriers to improved sanitation analysis. Baseline data found a lack of demand for sanitation products and services. This acted as a barrier to households purchasing latrines (Thomas & Alvestegui, 2015). Demand generation for sanitation was key to the programme.

Rural sanitation mobilisation tools are applicable in the small town context but may need to be supplemented with other demand-generation approaches (Thomas & Alvestegui, 2015). The lack of homogeneity, disbursement of population, difficulties in congregating the community, difference in behaviours (open defecation vs upgrading), made it necessary to supplement traditional community mobilisation techniques with a broader communications and demand generation campaign. This would help to ensure saturation of messages, and the ability to differentially target populations in a community with varying baseline behaviours (Thomas & Alvestegui, 2015).

Using approaches in waves meant that most communities in a town received at least two of the four strategies (Thomas & Alvestegui, 2015). The four strategies were (Thomas & Alvestegui, 2015):

- CLTS vs PHAST: CLTS was used in the more rural areas of the town which still practised open defecation, whilst PHAST was used in more urban areas to promote upgrading sanitation facilities. Use of these two approaches creation a baseline level of awareness in communities that other communication channels were able to build on.
- 'Mixed media' channels: community radio sessions included children, local leaders, and debate on sanitation and hygiene. Mobile units recorded and broadcast videos with the communities. These channels enhance the visibility and credibility of the WASH programme, and provided broader information to the communities.
- A sanitation competition between neighbourhoods challenged block leaders to mobilise their blocks to have the highest levels of improved latrines.
- Advocacy with key political/decision makers: a sanitation champion is elected within the municipal sanitation working group and tasked with advocating for funding and prioritisation of a sanitation Master Plan.

In addition, sanitation business development was supported in both towns (Thomas & Alvestegui, 2015).

Results by the end of 2014 included 14,000 households had onsite sanitation, 16,050 people had new handwashing facilities and public sanitation facilities had capacity for 1,730 people including 575 persons with disabilities (Thomas & Alvestegui, 2015).

5. Nutrition

Academic studies

Kodish et al. (2015) argue that **formative research is integral for developing behaviour change communication strategies for nutrition interventions**. Their case study of undertaking formative research to inform a stunting prevention intervention in Cabo Delgado Province as part of the Scaling-Up Nutrition initiative illustrates how differences in the target population can inform audience segmentation (Kodish et al., 2015).

It necessary to consider cultural heterogeneity when developing an effective intervention (Kodish et al., 2015). Formative research conducted by Kodish et al. (2015) explored local perceptions and behaviours around food and illness among the Macua, Mwani and Maconde ethnic groups. They found that geographic differences drove sociocultural characteristics amongst the three groups (Kodish et al., 2015). This allowed for segmentation of the population into two distinct audiences for SBCC based communications (Kodish et al.,2015).

Cultural-sensitive SBCC is important (Picolo et al.'s 2019). Picolo et al.'s (2019) case study includes lessons learned from vitamin A supplementation, micronutrient powders, and food-based strategy interventions in two provinces. It argues that cultural-sensitive SBCC is important to promote acceptance and use of micronutrient powders (Picolo et al., 2019). For example, demand generation can be achieved through songs, theatre, cooking demonstrations, group talks, home visits, and community leaders (Picolo et al., 2019).

Maternal and Child Survival Programme (MCSP)

In Mozambique this USAID funded global programme has worked to scale-up preventative and curative nutrition interventions at the facility and community level in Nampula and Sofala Provinces since 2016 (Picolo et al., 2019). Between October 2016 and June 2018, the programme reached 2.9 million children between 6 and 59 months old with nutrition interventions at the facility and community level, including (Picolo et al. 2019):

- SBCC activities;
- Vitamin A and micronutrient powders supplementation;
- Nutrition screening and referral, and
- Treatment of acute malnutrition.

Formative research is important for developing key messages. Assessment of data derived from MCSP-led trials of improved practices revealed the cultural beliefs and perceptions that drive complementary feeding practices in Northern Mozambique (Picolo et al., 2019). This data was used to develop key nutrition counselling messages addressing key challenges mothers' face, and recipes for cooking demonstrations as part of project implementation (Picolo et al., 2019).

Other SBCC activities included MCSP-developed songs based on key infant and young child feeding (IYCF) messages, which were recorded and rolled out for entertainment education across the province (Picolo et al., 2019). MCSP also trained health providers in IYCF counselling, and equipped health facilities and communities with the MoH's IYCF community counselling package (Picolo et al., 2019).

Care Group approaches

Food for Humanity

Implemented in Sofala Province between 2005 and 2010 and funded by USAID, the NGO's Care Group approach to tackle malnutrition in Mozambique involves (Davis et al., 2013)[11]:

- Community leaders help the NGO to identify all pregnant women and mothers of children under 24 months in the project area;
- Care Group Volunteers (CGV) are identified: volunteers are women.
- 12 CGVs meet every two weeks in a Care Group with a paid health promoter for lessons on hygiene, health and care. Each meeting teaches a new lesson as well as reviewing the previous lesson. Messaging primarily focuses on nutrition (breast feeding, appropriate complementary feeding) but also includes WASH, health warning signs during pregnancy and among young children, and preventative care including vaccinations.

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[11] A brief summary of the approach is also available here: https://www.impact.upenn.edu/our-analysis/opportunities-to-achieve-impact/child-survival-guidance-for-donors/care-group-programs-improving-child-health-and-nutrition/ [accessed 12/12/2019].

- Each CGV then meets and shares the learning with a cohort of 12 beneficiary mothers, using a combination of group meetings and home visits, over a two week period. It takes approximately 2 years to deliver the entire set of 24 messages.
- Paid promoters participate in quarterly training workshops.
- Quarterly community meetings targeted men and community leaders.
- Messages are developed collaboratively by international and local staff, drawing on formative research studies.

The project had two main components: nutrition (70%) and control of diarrhoea diseases (30%) (Perry, 2010).

Results: The programme had 219,617 direct beneficiaries, and reached 1.1 million, through methods including 78% of beneficiary women had someone else present during home visits.[12]

Baseline and endline surveys included approximately 100 mothers with children 0-11 months and 100 mothers with children 12-23 months (Davis et al., 2013). Project evaluation also included focus group discussions (Davis et al., 2013). Findings include (Davis et al., 2013; Perry, 2010):[13]

- 29% reduction in under-five mortality (estimated at 4,590 lives saved) and 37% reduction in child underweight;
- Rapid changes in health behaviours: Exclusive breastfeeding for the first six months more than doubled, hand washing increased by 50%, use of oral rehydration salts for diarrhoea treatment increased by 41%, and the number of mothers who could recognise three or more signs of childhood illness tripled.
- The average annual rate of decline in undernutrition in intervention areas was 2.2% compared to 0.4 – 0.6% nationwide.
- Qualitative evidence collected from focus group discussions included: children have fewer illnesses and are better nourished and less likely to die; community leaders were supportive of the project and helpful to the volunteers; increase in the utilisation of health facilities; increase in household cleanliness, increase in hand washing with soap/ash, and constructing latrines and tippy taps; and, marked increase in the use of specific nutritious foods for children after six months of age.

Value for money: the annual cost per year of a direct beneficiary was USD 2.78 (Perry, 2010). The estimated cost per life saved was USD 664, and the cost per disability-adjusted life year (DALY) was USD 22 (Perry, 2010). As such the project is "among the most cost-effective child survival projects ever implemented at scale" (Perry, 2013: 3).

Lessons Learned (Perry et al., 2013; Davis et al., 2013)[14]

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[12] https://www.impact.upenn.edu/our-analysis/opportunities-to-achieve-impact/child-survival-guidance-for-donors/care-group-programs-improving-child-health-and-nutrition/ [accessed 12/12/2019].

[13] https://www.spring-nutrition.org/publications/case-studies/care-group-reducing-malnutrition-and-child-deaths-mozambique [accessed 12/12/2019].

[14] https://www.spring-nutrition.org/publications/case-studies/care-group-reducing-malnutrition-and-child-deaths-mozambique [accessed 12/12/2019].

- Small, frequent group meetings created ownership and a sense of empowerment in women beneficiaries and CGVs.

- Non-monetary incentives for participation could be successful: CGVs reported being more respected due to their involvement in the programme: 64% reported being more respected by community leaders and 61% by their husbands. Less than 1% of volunteers quit due to a stated lack of material incentives (volunteer retention overall was 5%).

- Having mothers choose the CGVs results in a higher likelihood of behaviour change. 44% of volunteers were elected by their mothers group, with the remainder selected by community leaders or promoters. Volunteers who were elected by their peers were 2.7 times more likely to serve for the entire length of the project.

- Organising beneficiaries into small groups with close links to community leaders and health facility staff can help create new norms about accessing health services. CGVs act as a hub or links between mothers and health facility staff.

- Keeping CGVs workload small means they can 'cover beneficiaries well'. Volunteers met with 90% of beneficiary households every other week. This high level of repeated contact probably helps to develop the relationships necessary for behaviour change, and break down barriers to behaviour change.

- Formative research helps to select key behaviours and their determinants: adequate resources should be allocated to this.

- Monitoring and evaluation throughout the project can help to guide project activities and keep the project 'on track': mini knowledge, practice and coverage surveys were conducted once or twice year with 95 beneficiary mothers across the 7 districts by promotors in areas outside their supervision.

- Advocacy with the MoH: project leaders actively promoted the project's progress to officials.

- The number of health facility births increased by 172% in Area A of the project. Initial prenatal and follow-up prenatal consultations at health facilities increased by 76% and 94% respectively. Data was not available for Area B.

- At the end of the project only 3% of CGVs had accepting attitudes to domestic violence against 24% of the beneficiary mothers.

World Relief

An Expanded Impact Child Survival Project implemented between 2005 and 2009 in five rural districts of Gaza Province, was funded by USAID (Perry et al., 2009). The project served a population of 247,002 people, reaching every household with basic education (Perry et al., 2009). There were six health topics covered over a two year period: diarrhoea, malaria, nutrition, STDs and HIV/AIDS, immunisations, and pneumonia detection and treatment (Perry et al., 2009).

World Relief's Care Group model included (Perry et al., 2009):

- Each CGV is responsible for 10 families.
- CGVs organised into Care Groups and receive training and supervision from paid Animators. Animators were usually local residents. This meant a number of animators

had low levels of literacy due to low literacy levels in the project area. Animators received three months of training at the project office.

- Created Pastoral Leaders/Traditional Healer Groups and trained them in community based integrated management of childhood illnesses (C-IMCI) and to reinforce behaviour change messaging in the community.

- Created and trained Village Health Committees to raise health awareness and encourage local health-related problem solving and decision-making.

- Employed a team of experienced Coordinators and Supervisors to train, manage, supervise and problem solve within the target districts. Each one supervised five to six Animators.

- Established regular communication links among CGVs, Village Health Committees, staff at health facilities, MoH directors and staff, and the Project Management Team.

- Trained community health workers (Socorristas) in collaboration with the MoH, placing them in new health posts in the communities in which health services had been previously hard to access.

In 2006, the project introduced the Hearth approach to tackling malnutrition in the community (Perry et al., 2009). This approach included mothers of malnourished children under 5 taking part in one-month long programme (Perry et al., 2009). The programme included two weeks of daily group sessions run by CGVs and the local Animator, and two weeks of daily home visits by the CGVs (Perry et al., 2009).

However, the Hearth programme was not carried forward into the second half of the project (Perry et al., 2009). Project leadership decided that malnourished children could be more effectively detected and treated on a one-on-one basis than in group sessions (Perry et al., 2009). Nutrition messaging continued to be part of the second half of the project through the care groups (Perry et al., 2009).

Project results include (Perry et al., 2009):

- Increase from 17% to 80% of mothers with a child under 6 months who were exclusively breastfeeding.

- Increases in percentage of children receiving treatment within 24 hours for pneumonia and fever (suspected malaria) from 10% to 64% and 17% to 62%, respectively.

- One-third reduction in under 5 mortality.

- 3.7 fold increase in number of women with a young child using modern FP.

- The percentage of caretakers who washed their hands before food preparation, before child feeding, and after defecation increased from 3% at baseline to 30% at the time of the final evaluation. The percentage of children with diarrhoea who had been treated with oral rehydration therapy increased from 54% to 71%.

- During focus groups participants reported that the number of children with severe malnutrition had declined.

- Successfully scaling up an effective model for community-based primary health care for improving child health.

- Indications from focus group discussions that village level activities will continue after the end of the project, as beneficiaries can 'see the benefit'.

Lessons learned related to SBCC include (Perry et al., 2009):

- **SBCC can have positive impacts on social cohesion**: traditional beliefs linked disease and interpersonal issues, e.g. jealousy or revenge. The trainings helped to delinked disease and interpersonal issues. However, traditional beliefs can make it more difficult to promote health behaviours and practices.

- **The Care Group model is effective** because it is a simple and straightforward way of engaging local people in their health problems, relying on peer-to-peer education among women, and ensuring that every household is engaged.

- **Empowering those in the community, especially women, and creating opportunities for local people to meaningful participate in the project, was crucial to success**. For example, treating community leaders as partners from the outset meant that when difficulties arose they provided crucial support to the project.

- Also of critical importance were the **well-designed and simplified educational messages** and the pedagogical process for teaching these messages to the staff and to the mothers in the community.

- **Animators should be selected from the village in which they will work**.

FAO[15]

The FAO, supported by the EU, is implementing a five year programme (2013-2019) to address the underlying causes of malnutrition. The programme integrates nutrition education, SBCC and home gardens (so mothers have access to the foods they need to support a healthy diet for their children). It primarily targets women of childbearing age at the community level (FAO, 2019). By the end of 2018, the programme had reached 31,000 mothers in 7 districts in three provinces (Zambezia, Manica and Sofala).

There is qualitative evidence (individual accounts) of behaviour change including women reporting that they are enriching porridge for their children, therefore applying the learning from the training (FAO, 2019).[16] Whilst the programme targets mothers, there is a case study of a women beneficiary whose husband has begun to attend the education sessions with her.[17]

An anecdotal account of lessons learned from a local government nutrition technician includes:[18]

- Involving and integrating the government, as local government are active in the communities;

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[15] Information in this section is derived from FAO Mozambique's 2018 Annual report and the webpages: http://www.fao.org/fao-stories/article/en/c/1099430/ & http://www.fao.org/mozambique/news/detail-events/en/c/1023552 [accessed 10/12/2019].

[16] More qualitative evidence is available here: http://www.fao.org/mozambique/news/detail-events/en/c/1185075/ [accessed 10/12/2019].

[17] http://www.fao.org/mozambique/news/detail-events/en/c/1185075/ [accessed 10/12/2019].

[18] http://www.fao.org/mozambique/news/detail-events/en/c/1185075/ [accessed 10/12/2019].

- Before working with a community, "it is necessary to know their habits and integrate them in the way of negotiating the behaviour change with them to improve negative and harmful habits";
- Identify community leaders in a new community and sensitise them first, to get their support and cooperation. This makes it easier to reach out and help the community, and
- Parents, husbands and grandparents are influential for the adoption of appropriate diets and healthy practices. It is important to involve them and reach them with messages.

Programme activities include (FAO, 2019):

- Training 'care mothers' groups.
- Using a behaviour change approach, these care groups conduct weekly training sessions for vulnerable women in their community sharing their learning about nutrition and home gardens.
- Training sessions include cooking demonstrations aimed at promoting diversified diet and enriched porridges for children using locally produced foods.
- Development of a training package, including a training manual for trainers and counselling cards for use in sessions at the community level.

In 2018, FAO also developed training and education materials to build the capacities of partners in relation to healthy eating habits and child feeding (FAO, 2019). These have been used to promote teaching nutrition in primary schools, reaching 50,000 primary school pupils (FAO, 2019). FAO also worked directly, in 2018, with 7 community based organisations to develop and implement training programmes on nutrition and home gardens for 70 community level promotors and 2,800 care group mothers, as well as district level technical staff from the sectors of agriculture, health and education (FAO, 2019).

World Vision

World Vision's community based SBCC programme, PDH (Positive deviance/Hearth) aims to rehabilitate malnourished under 5 children in their own homes, using local resources and knowledge (Baik, 2019). A core World Vision programme, it is implemented in 30 countries including in Inteta, Mozambique[19].

The programme's starting point is that despite limited resources, some families manage to raise well-nourished children (positive deviance from the norm) (Baik, 2019). The PDH approach is based on identifying what positive deviant families are doing differently in terms of feeding, hygiene, caring and/or health seeking practices from the parents of malnourished children in the same community (Baik, 2019). Steps in the approach include (Baik, 2019):

- Situation analysis conducted in the local community to identify major challenges contributing to malnutrition.
- Positive deviance inquiry undertaken to identify local solutions and practices to address those challenges. This informs six key Hearth messages and the development of Hearth

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[19] https://www.worldvision.com.au/supporter-stories/returning-to-a-healthier-community-in-mozambique [accessed 10/12/2019].

menus. These messages are shared with both hearth caregiver groups, and more broadly through existing mother support groups and other community associations.

- Hearth sessions are conducted by two volunteers daily over 10-12 days with 6-10 caregivers per group. Caregivers bring set ingredients and meals are prepared according to the Hearth menus and fed to beneficiary children. PD practices are discussed at the same time.

- Volunteers visit Hearth group caregivers in their homes two or three days per week over two weeks to assess progress, overcome barriers and re-emphasise PD practices.

- Children who do not recover are re-enrolled or referred to the health facility if there is an underlying illness. Regular growth-monitoring is conducted in the community to track children's progress and identify new cases of malnutrition.

- Depending on the context, PDH links up with programmes for other sectors, e.g. WASH.

Value for money

Across the PDH programme as a whole, the cost per child per year decreases as more children are included in the project (Baik, 2019). Cost per child decreases from USD 17 to USD 8 when beneficiaries increase from 750 to 1,400 (Baik, 2019). Around 90% of project costs are required for the early stages of implementation: training and human resources development (Baik, 2019). Hearth sessions themselves are not costly to implement (Baik, 2019).

Results and lessons learned

A 2010 evaluation of eight countries in the programme across Asia, Africa, and Latin America identified a number of challenges (Baik, 2019). At the aggregate level these include: high number of cascade trainings, which diluted critical technical details; delayed implementation post-training, which compromised programme quality; lack of standardised training curriculum for trainers; missed essential elements in programme implementation; lack of standardised supervision tools, and poor systems for data monitoring and analysis. In addition, there were several criticisms by donors at the time, including the labour-intensive nature of PDH; the need for a high level of technical input; the need to focus on a small scale to ensure effectiveness; difficulties in implementation for staff and volunteers; lack of success of PDH in food-insecure areas; the targeting of only a small population of malnourished households, and low graduation rates (Baik, 2019).

World Vision undertook a number of improvements to the PDH programme including: standardising training content and implementation of SBCC and improving monitoring and evaluation (Baik, 2019).

Mozambique[20]*:* implemented in Inteta, the PDH programme involves training community based volunteers, both female and male. Training for PDH volunteers included: preparing enriched porridge, the importance of hand-washing and how to construct and use latrines. The programme targeted children from 0 to 36 months. Beneficiaries are monitored for three months after the hearth sessions end. A pair of PDH volunteers monitor 5 children.

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[20] Information in this sub-section is derived from https://www.worldvision.com.au/supporter-stories/returning-to-a-healthier-community-in-mozambique [accessed 12/12/2019].

A case study by a male PDH volunteer states that he lets women know he is coming before he visits them, as it is not appropriate for men to visit married women at home whilst they are alone. The same case study also includes anecdotal evidence that more people in the community have built latrines, and that incidences of cholera have decreased.

A 2014 case study of children in a Hearth group in Inteta (the sample size is unclear) found that one year after starting the programme (Dias & Baik, 2014):

- 80.1% of the children were healthy compared to baseline (day 1 of the programme), and
- Only 1.2% of the children were severely malnourished, compared to 15.5% at baseline.

Mixed approaches

UNICEF

The *Improving Child Nutrition in Four Countries in Sub-Saharan Africa 2013-2017* included activities in Mozambique. The project aimed to scale up nutrition interventions, using principles aligned with the SUN movement, and reduce undernutrition (ACT for Performance BV, 2017).[21] As part of this, the project aimed to "reach communities with evidence-based interventions from different sectors and support the adoption by communities of healthy nutrition behaviour" (ACT, 2017: 13).

The project focused on Manica, Sofala, Tete and Zambezia provinces, as well as national level activities (ACT, 2017). SBCC activities included: the 'Ouro Negro' national radio drama; community events, and interpersonal communications (ACT, 2017). SBCC related achievements during the project included:

- 1.5 million listeners (approx. 30% of the potential audience) across the country to Ouro Negro which included breast feeding communications;
- Trained health workers, non-clinical staff, teachers and students on providing support for early initiation of breastfeeding;
- Trained teachers and health workers in approximately 20 districts in the four target provinces on adolescent nutrition;
- A joint programme with UNFPA and WHO, where adolescent nutrition is being incorporated, including Information, Education and Communication (IEC) materials development, nutrition messaging through SMS, and mentorship programmes.

A 2017 evaluation of the project found that implementation was costly, and did not necessarily influence long term outcomes such as stunting and wasting (ACT, 2017). Issues include (ACT, 2017):

- Whilst gender and equity were integrated into the project design, equity analyses were not adapted into activities during implementation. However, the project did target areas where unmet needs were the highest.

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[21] Hereafter ACT (2017).

- The project was designed to build on the achievements of WASH interventions in the selected regions, but was not able to integrate joint multi-sectoral sensitive agriculture activities in Mozambique. WASH is crucial for the prevention of stunting and the ICYN counselling materials emphasised these aspects. UNICEF supported training of agricultural extension workers using the ICYN counselling materials, however, links with other sectors – including agriculture – must be enhanced.

Conclusions and lessons learned across the four countries, relevant to SBCC, include (ACT, 2017):

- Actors with expertise in SBCC were not always included in the planning process for the project.
- The project packaged together a range of interventions, including SBCC, which previously had been implemented in a piecemeal fashion.
- The project used new models for behaviour change communication activities. However, the report does not detail what these are.
- In all four countries, men were receptive to sensitisation campaigns. They participated in sessions and cooking demonstrations, and supported their wives in establishing and maintaining home gardens, caring for malnourished children, and looking after animals received from small livestock activities. In Rwanda, some men served as "ambassadors" by sharing their experiences and influence with other households – enhancing compliance with project objectives and local ownership.

The 2017 evaluation argues that a stronger multi-sectoral approach is needed (ACT, 2017).

World Food Programme

The *Social and Behaviour Change Communication Project*, funded by the EU, is active in Manica Province. The project is a sub-component of a larger EU project implemented between 2013 and 2019. It aims to reduce child malnutrition and mortality by promoting beneficial health and nutrition practices in four areas: maternal health and nutrition, IYCF, malaria prevention and WASH (Gyori et al., 2017). The project has two components (Gyori et al., 2017):

- **Interpersonal communication**: training community health committee members, who in turn train community members. Expected reach: 44,640 (14,400 community members every 6 months plus 1,440 committee members)
- **Mass media communication**: short-duration radio broadcasts reaching 162,000 women and 217,000 men.

The project is implemented with three treatment intensities (Gyori et al., 2017):

- interpersonal training and mass media communication (districts of Báruè, Guro, Machaze, Mossurize and Sussundenga);
- mass media communication only (districts of Tambara and Manica), and
- a comparison group, with no intervention at all (districts of Macossa and Gondola).

The project included formative research before implementation to assess levels of knowledge in Manica about topics relevant to child health and nutrition (Gyori et al., 2017). This found that that practices often fail to follow medical recommendations (Gyori et al., 2017). A baseline report was

undertaken in order to compare with endline data and produce an impact evaluation (Gyori et al., 2017). Endline data and the impact evaluation are not currently publicly available.

Mass media challenges

As part of the project, representatives from community radio stations based in Manica were trained in the theory and implementation of SBCC (WFP, 2018). Local radio stations broadcast radio spots and debates discussing breastfeeding, malaria prevention and treatment, maternal nutrition, and complementary feeding of children (WFP, 2018). Radio spots and debates were broadcast in local languages (WFP, 2018).

However, the project's baseline study found that 60% of households in the project area did not have access to a radio at all (Gyori et al., 2017). Only 28% of households had access to radio at home, and 29% had access to radio outside the home: although these two may overlap (Gyori et al., 2017). Consequently, a large share of the targeted individuals may not be reached by the mass communication component of the project[22].

Mobile platforms

mNutrition

mNutrition is active in eight countries in sub-Saharan Africa including Mozambique (Viljoen & Wacker, 2018). Users can access nutrition messaging via their mobile phones including text message reminders about nutrition practices and notifications about attending health clinics (Viljoen & Wacker, 2018).

Content was developed through a human-centred design and iterative product optimisation approach across all eight countries, leveraging findings from business intelligence, user experience research, and M&E user feedback surveys (Viljoen & Wacker, 2018).

Lessons learned at the aggregate level include (Viljoen & Wacker, 2018):

- Government support and endorsement is essential for establishing trusted and quality services. As such, it is important to engage governments early in the project.
- Community health workers or other agents can be effective at marketing the service and signing up users, particularly those who are less tech savvy.

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[22] https://ipcig.org/pt-br/how-mozambique-harnesses-power-mass-communication-improve-health-and-nutrition-children [accessed 10/12/2019].

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