# Case Study 4D.

# Mozambique — Promoting healthy lifestyles through 'model families'

## Context

In Mozambique, an estimated 45% of deaths among children under five years of age is linked to malnutrition. The current national stunting prevalence for children under five is 43% — among the highest in the world (IFPRI, 2014). A malnourished child is less likely to perform well in school and is susceptible to infections and chronic diseases in adulthood. On the other hand, it is estimated that well-nourished children contribute to wealth by boosting the national gross domestic product (GDP) to up to 11%.

Malnutrition also has an impact on a country's society and economic growth. Every year in Mozambique, an estimated Mozambican meticais (MZN) 16 billion of GDP is lost due to malnutrition because of loss of productivity (UNICEF). As of July 2015 this would be equivalent to more than USD 416 million.

Although access to safe water, sanitation and hygiene (WASH) is at the heart of the sustainable economic and social development of a nation, Mozambique is unlikely to reach the Millennium Development Goal targets for access to safe water and basic sanitation. Since 1990, total sanitation coverage has increased to 21%, but the disparity between urban and rural coverage remains great: 44% urban vs 11% rural. In Mozambique, 40% of people still practice open defecation, down from 66% in 1990. The lack of improved sanitation costs Mozambique about MZN 4 billion a year, due to premature deaths, medical costs and loss of productivity.

Safe water supply coverage is low at 49%, with a large disparity between urban coverage (80%) and rural coverage (35%). The challenge of upgrading WASH conditions in small towns is huge; they represent about 15% of Mozambique's urban population — nearly 2 million people. Although these towns are strategic for development, safe water and sanitation services have lagged far behind investments in large cities or even in surrounding rural areas (UNICEF).

Knowledge in fields such as WASH and Nutrition, and the beliefs and attitudes that shape behaviors are, to a large extent, rooted in local cultures and traditions and transmitted and

sustained by community institutions and opinion leaders, as well as religious leaders. UNICEF has been engaging with different opinion leaders through strategic alliances, interpersonal communication and the sharing of information for awareness creation.

The low level of literacy (especially among females) means that access to information is mainly oral, highlighting the importance of community-level communication, especially radio broadcasts in local languages and face-to-face communication (UNICEF).

## Activities

Through the model family strategy, UNICEF and other actors are aiming at promoting healthy lifestyles among families. According to the strategy, a family is given 'model family' status if it adopts a set of hygiene and sanitation practices (availability and proper use of latrines, use of tippy tap, employment of household water treatment and water storage, a corner set aside for washing and drying utensils) together with other health aspects such as use of mosquito nets and whether the family has children under five years of age. The status of a child's health card is checked and similarly, a pregnant woman's health card will be checked to assess whether she has had regular prenatal checks.

## Results

The model family strategy is new in Mozambique and therefore results of its impact are yet to be documented. However, key lessons can be drawn from Ethiopia, where this approach has been implemented with significant success.

In Ethiopia, the model families program is a key component of the community health workers program. Families are selected and trained for a period of four months, after which they receive visits to check if they have implemented at least 75% of the planned behavior. If they have done so, they receive certification as a model family.

In 2011, a study was carried out to evaluate the results, sustainability and challenges of this program. The study showed that the model families program in Ethiopia had a positive effect on the acquisition of new behaviors. However, there were challenges in changing some behaviors. The key results from the study are shown below.

- More model family households had latrines than non-model families (82.7% vs 36.8%).
- The presence of treated mosquito nets was significantly higher in model families than in non-model families (66.9% vs 53.3%).
- The rate of use of contraceptive methods was significantly higher in model families than in non-model families (32.3% vs 18.5%).
- Women of model families were significantly more likely to have used antenatal services (47.3% vs 35.2%), as were their husbands (42.3% vs 35.8%).

## Lessons learned

The model family strategy can be adopted more widely to promote key Nutrition and WASH practices among target households. An integrated monitoring tool should be developed, with key

parameters to be observed in both programs. This will promote synergized WASH and Nutrition programming at service delivery and household level.

## References

International Food Policy Research Institute (2014): *Global Nutrition Report 2014: Nutrition Country Profile Mozambique*. Washington: IFPRI.

UNICEF information on Mozambique available at:

http://www.unicef.org.mz/en/our-work/what-we-do/nutrition/

http://www.unicef.org.mz/en/our-work/what-we-do/water-sanitation-hygiene/

http://www.unicef.org.mz/en/our-work/what-we-do/communication-advocacy-and-participation/