



Knowledge, Attitudes and Common Practises on Under-nutrition

A Report of Focus Group Discussions from Magway Region, Myanmar

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September 2017

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ACKNOWLEDGEMENTS

This study has been conducted within the framework of the G.R.E.A.T. Project (*Gestione delle Risorse Economiche, Ambientali e del Territorio* – AID 10942/TDH/Myanmar), funded by the Italian Development Agency (AICS) to which we would like to express our deepest gratitude.

The investigation conducted has been carried out with the lead of Progetto Continenti and the constant coordination with the other partners of the project, Terres des hommes – Italy, Positive Action and SARA. Our appreciation goes to all organizations involved and their staff.

In particular we would like to thank the different people that has been involved in various phases of focus groups discussions: Daw Khin Mar Oo, U Than Zaw Oo, Ko Aung Nay Lin, U Soe Lwin, Ko Kyaw Kyaw Lwin, Ma Kyae Hmone, Ko Aung Kyaw Soe, Ko Thet Naing Tun, Ko Zaw Lwin and Ma Thuzar Tun.

Special thanks to Mr. Khaing Htun Soe, who has been an excellent note taker, as well as to Enrico Marulli, Luca Nichetti and Massimo Riva, who supported the whole process. A strong special thanks to Elizabeth Cook, who edited the final report.

Above all, we would like to thank all the respondents (villagers of 29 villages in Magway and Natmauk Townships) who provided us with their valuable time, information and data, without them, which this study would have not been possible.

This report has been prepared under the framework of the G.R.E.A.T. Project (*Gestione delle Risorse Economiche, Ambientali e del Territorio* – AID 10942/TDH/Myanmar), finance by AICS – Italian Agency for Development Cooperation and implemented by Terres des hommes-Italy, Progetto Continenti and Positive Action. However, the views expressed are of the authors, and do not necessarily represent the view of the donors or of the project implementing organizations.

Executive Summary

Objective: The study objective was to assess the knowledge, attitudes and common practices of the nutrition of villagers belonging to two different socio-economic groups. Group I: consisting of village authorities, household heads (males) and health related workers and Group II: caregivers of under-five children) in 29 villages of Magway and Natmauk townships, in order to improve programme design and decision-making.

Study Design: A purposive sampling method (nomination and snow ball sampling) was employed. A validated focus group discussion with semi-structured guidelines was administered to assess knowledge, attitudes and common practices of villagers in the month of June to August 2017.

Study Participants: Several participants have been interviewed in the Magway Township, with 84 respondents in Group I and 81 respondents in Group II. In Natmauk Township 88 respondents in Group I and 90 respondents in Group II participated. In total, 58 focus groups discussions have been conducted in 29 villages.

Study Results: The findings show that the population in Magway Township has a better knowledge regarding issues related to under-nutrition and nutrition compared to the one in Natmauk Township. The attitudes and good practices on basic nutrition however, were considerably low and practiced by few people. The key findings identified were:

1. Low understanding of consequences and magnitude of under-nutrition in the communities
2. High workload, particularly for women, leading to lack of care in nutritional food preparation
3. High degree of culturally-imposed food restrictions: harmful traditions perpetuated by elders, in particular from elder women, are hindering the nutritional status especially of pregnant women
4. A total lack of knowledge of the 1000 days window
5. Low degree of breastfeeding and early introduction of complementary feeding
6. Hygiene: disconnection between knowledge and practice
7. Insufficient knowledge and reluctance towards family planning
8. Increased occurrence of communicable diseases in the target villages

Conclusion and recommendations: The study indicated the need for long-term interventions for improvement of nutrition knowledge in both townships with a particular focus on the villages in Natmauk Township. The main recommendations according to the findings, are to create awareness of the magnitude and consequences of under-nutrition and stunting, health education sessions for nutrition-sensitive issues (including the importance of hygiene knowledge and practices, communicable diseases, family planning etc.) and awareness sessions for nutrition specific issues, such as increase knowledge on basic nutrition, creating understanding on exclusive breastfeeding and optimal complementary feeding.

In terms of target groups, the study suggests to include: (1) youth who are more receptive to change; (2) women in reproductive age; and (3) old women and household heads who have considerable influence on decision making. Additionally, programs need to try to engage also teachers and nurses in supporting activities.

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1. Introduction

The study was conducted from June to August 2017 with the objective to establish a comprehensive understanding about the perception of under-nutrition in villagers from Magway Region (Dry Zone)¹, by retrieving their knowledge, attitudes and common practices. This effort has been led by Progetto Continenti, Terres des hommes-Italy and its partners under the framework of the G.R.E.A.T. project.

The study assessed qualitative findings from 29 villages in two townships (TS) - Magway and Natmawk. The chosen approach was 'Focus Group Discussion' (FGD), since the strength of this method is that this 'forum' creates an open discussion platform between participants, thus eliciting new ideas and explanations, which would not have emerged during an individual or a household interview. The aim of the FGDs was to facilitate interaction and thereby obtains true insights into the perceptions of participants by having them telling their stories and experiences on nutrition, without providing or suggesting any preconceived "anticipated response".

The findings/outcomes from nutrition FGDs will contribute and directly feed into the efforts of the G.R.E.A.T. project to elaborate efficient, relevant and focused activities in the campaign for behavioural change related to nutrition within the Magway Region.



Figure 1 - Magway Region

¹ Dry Zone covers more than 54,000 square km, encompassing 58 townships and spanning from lower Sagaing Region, to the western and central parts of Mandalay Region and most of Magway Region

1.1 Operational Context and Background

The literature review highlights the severity of the undernutrition in Myanmar and particularly in the Magway Region.

Existing literature shows that moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) affects approximately globally 52 millions of children under 5 years (1,2) and most of these vulnerable children are from South East Asian countries, including Myanmar (3,4). The fact that Myanmar is among the most affected countries with more than one-third of children suffering from under-nutrition (1) and the prevalence of under-nutrition among women and children in Myanmar, including the Dry Zone area, remains unacceptably high (1,5). According to the multiple indicator cluster survey done in 2009-2010 (1), more than 35% of children under 5 years are undernourished and too short for their age. According to the survey, anaemia and micronutrient deficiencies prevails for more than 80% of children under 5 years and for the 70% of pregnant women as well (1,2). Other studies (6) in the Dry Zone show that 27.5% of children under 5 years were stunted and 27.2% were wasted². The rate of wasting is of 'high' public health concern and the rate of stunting is of 'medium' public health concern (7). Wrong practices, like early introduction of complementary food to the children, absence of exclusive breastfeeding, unhygienic practices, low education/awareness and inadequate coverage of public healthcare services, were the predisposing factors of the under nutritive status of the children (and pregnant women) in the population of the Dry Zone (1,8,9).

In an initial assessment of villages in Central Dry Zone of Myanmar, PC Myanmar found that the main issues/problems in these areas are: high poverty levels, general food insecurity, under-nutrition of children and lack of awareness on how to practically alleviate and address these problems – refer to Figure 2 to see how some “individuals” are adapting.

For these reasons, the G.R.E.A.T. project is aimed at improving the nutritional conditions and preventing “under nutrition” in the Magway Region. It was therefore needed to obtain the perspectives of the villagers, as mentioned in the introduction above.

The objective of the FGD was also to improve the understanding of the determinants of “under-nutrition”, in order to identify the interventions/activities to be carried out in the behavioural change campaign on nutrition status envisaged by the project.



Figure 2 - Adaptation to water scarcity

² Wasting: Moderate and severe - below minus two standard deviations from median weight for height of reference population.

2. Objective of the study

The main objective was to conduct a study that will enable the project to understand the current knowledge, attitudes and practices of villagers on under-nutrition issues in a comprehensive fashion. Furthermore, the research aimed to obtain and identify which factors influence the villagers' perceptions, in order to gain an understanding of the determinants of "under-nutrition".

The specific objective was to clarify the main reasons behind "under-nutrition" in the project target area. Likewise, the FGD aimed to get a foundation to define in detail the activities leading to nutritional behaviour change within the communities – that are based on expressed needs of the community, in order to create an ownership. Equally, the study aimed to identify possible obstacles for implementation of project activities in the villages.



Figure 3 - Focus Group Discussion

3. Methodology

3.1 Study participants and sampling

A total number of 58 FGDs in 29 villages were conducted in the two townships between the 3rd and the 31st of July 2017. For each village two groups (group 1 and 2) were established, based upon the consideration of homogeneity in terms of their power relations, socioeconomic status and gender. In some FGDs, participants were recruited as nomination and snow-ball sampling, in order to represent target beneficiaries for the project interventions.

The first group (*group 1*) included five to seven participants from three different categories: *village authorities*, *head of households* and *health workers*.

The selection criteria for the group 1 participants: *village authorities* should have experience about health-related issues and common practises (mainly about under-nutrition) and more than 3 years' experience in village administration. Another reason for the selection of village authorities is the conviction that, due to their position and power, they will be important as front figures/champions for potential behaviour change. *Head of households* are married men above 25 years and living in the village for more than 3 years. Male heads of household are important since they are often the decision-makers within the household. *Health workers* (e.g. like old volunteers, auxiliary midwives, midwives and health assistants), who have at least 1 year of health and knowledge experience about health activities and health related needs of the village. They have been selected because of their understanding the villagers' behaviours, of their knowledge and lastly to identify obstacles for implementation of the activities.

The second group (*group 2*) included five to seven participants. The selection criteria for the participants was *caregivers for children* under 5 years, female, aged between 18-60 years, lower-middle and low-income families. Group 2 is important for exploring knowledge, attitudes and practices of caregivers of children under 5 years in order to understand the situation of nutritional activities liked and disliked by caregivers. Furthermore, their perceptions are fundamental to get suggestions for activities, allowing a higher degree of ownership.

3.2 Data collection

The current study used FGD to elicit culturally relevant themes and vocabulary to be used when addressing issues related to under-nutrition. Pilot test interviews were conducted in June 2017 in order to adjust and finalize the questions' guidelines. The final version of the FGD guidelines are enclosed in Annex 3 and Annex 4; the FGD followed the FGD structured guidelines, June 2017.

The two groups were asked to speak in their language of preference, therefore the sessions were conducted in Myanmar language. A moderator, who facilitated the FGDs and a note taker attended all FGDs. All FGDs were audiotaped and hand-written notes were taken. Debriefing was done after each FGD in order to check if the understanding of what was said is shared between the moderator and note taker. Thus, misunderstandings were avoided and a deeper understanding was ensured.

In addition to carrying out the FGDs, a simple demographic data collection (see Annex 2) was taken. This quantitative data provided a clearer picture of the participants' age, education level, and occupation.

3.3 Data management and analysis

The final transcripts of the FGDs were based on transcribed audiotapes, handwritten notes from the FGDs and the debriefings' notes. These findings were analysed using a grounded theory approach, which begins with the careful reading and re-reading of transcribed transcripts. From this, coding schemes of responses have been developed. The two-study report authors independently developed coding schemes, and identified themes by consensus.

3.4 Ethical considerations

Both verbal and written informed consent was obtained from all study respondents prior to participation, which is considered adequate for the collection of non-sensitive information where personal identifiers are not required.



Figure 4 -Participants in Group 2 Focus Group Discussion

3.5 Limitation and encountered difficulties

The discussion in a group as conducted during our study has clearly been the very first experience for most participants and, sometimes, they felt hesitant to talk freely. Also, as the qualitative research approach used in our FGDs was quite time consuming, some of the participants lost their

concentration during discussion. Some even left during the discussions. However, this occurred in less than 10% of the FGDs.

We aimed to include at least 6 participants in the group, however, due to time-constraints/ unavailability of potential participants in the village- we could only speak with 4 or 5 people.

4. Overview of the key finding emerged from the FGDs

The key findings that emerged during the FGDs are documented in Annex 1 and indicated below as bullet points (please refer to the table in Annex 1 for a more comprehensive discussion about the themes and issues emerged from FGDs).

- Low understanding of consequences and magnitude of under-nutrition in the communities
- Lack of, or low knowledge of basic nutrition
- High workload particularly for women leading to lack of care in nutritional preparation
- Food restriction and traditional beliefs leading to under-nutrition. This is particularly due to the overwhelming role played by elders in decision-making
- Low degree of breastfeeding and early introduction of complementary feeding
- Women to be key agents of change
- Hygiene: a disconnection between knowledge and practices
- Insufficient knowledge and reluctance towards family planning
- Increased occurrences of communicable diseases in villages

The overview of the villages FGD discussions in Annex 1 shows the findings are quite similar in the two townships, which is not surprising, given the more or less same cultural context, local belief and social scenario. Likewise, both townships are provided with health services from the same health authorities. Nevertheless, the findings show that Magway TS seems to have a better knowledge regarding issues related to under-nutrition and nutrition in general compared to Natmauk TS. This can be caused by previous NGO health activities in Magway, whereas Natmauk has not (yet) received any external support/activities. The demographic data show also minor differences – refer to the next chapter for more information.

Currently, there are no external health-related activities occurring in any of the target villages. In general, they all expressed a keen and positive interest in nutrition and health related activities. The focus group participants suggested activities related to general health and nutrition (good and bad food), how to take care of children, family planning methods - pros and cons) and hygiene – but also other activities such as distribution of food items, new roads, electricity and water, which may be beyond the scope of this project.

One specific barrier that emerged from the FGDs was cumbersome transportation into the project areas, due to the bad road infrastructure, particularly in the Natmauk Township. Nonetheless, most village authorities (on group 1 from both townships) offered coordination and logistic support. Obviously, these logistic constraints will require good planning in terms of best timing/season for the delivery of the activities.

Further deliberations of the key findings/themes are done in the subsequent chapter 5.

5. Comprehensive discussion of key findings

The identified key findings are to most extent, aligned to the objective of this study. In this chapter, we single out ‘key gaps’ between knowledge and behaviour. Such gaps, or lack of actual action on known “good practices”, are those that are most important to “close” during the project intervention.

5.1 Demographics of the target areas

The demographic data from the FGDs’ participants show that the two townships, Magway and Natmauk, are quite similar in terms of education and occupation. Nonetheless, the data shows that Magway TS group 1 (MTG1) do seems to have a slightly higher education level than Natmauk Group 1. From Annex 2 – the table below illustrate this difference:

| Educational level (Group 1) | Magway TS | Natmauk TS |
|------------------------------------|------------------|-------------------|
| No formal education | 6 % | 18 % |
| Grade 1-5 | 20 % | 35 % |
| Grade 6-9 | 20 % | 30 % |
| Grade 10-11 | 37 % | 10 % |
| Bachelor’s degree | 12 % | 7 % |
| Master’s Degree | 5 % | 0 % |

It can be seen that 37% of Group 1 in Magway reached an education up to grade 10/11 and 17% have a university degree, whereas the same number are respectively 10% and 7% in Natmauk.

Group 2 from the two townships has a more similar education level. The majority (60%) in Magway group 2 have between grade 1 to grade 5 and (2%) has non-formal education or is illiterate. In Natmauk the majority (62%) of group 2 have an education level between grade-1 to grade 5 but significant higher percentage (12%) has non-formal education or is illiterate. Participants with grade 10-11 (or a bachelor’s degree) are higher in Magway (21%) compared with Natmauk (8%).

| Educational level (Group 2) | Magway TS | Natmauk TS |
|------------------------------------|------------------|-------------------|
| Illiterate | 1 % | 4 % |
| No formal education | 1 % | 8 % |
| Grade 1-5 | 60 % | 62 % |
| Grade 6-9 | 16 % | 18 % |
| Grade 10-11 | 17 % | 7 % |
| Bachelor’s degree | 4 % | 1 % |

Lastly, the data indicates that Group 1 in both townships have higher education levels compared to Group 2, which is really not surprising considering the gender aspects and the distribution of participants in the two groups.

The main occupation for all groups in both townships is farming. Nonetheless, there are clearly more participants in the FGDs in Magway with a health background (11%) compared with Natmauk (only 2%).

5.2 Perceptions of under-nutrition

The study shows a substantial variation in the villages/focus groups on the perception of the presence of under-nutrition – e.g. in some villages the awareness of under-nutrition was significant and present, whereas in neighbouring villages the awareness was much less. However, the findings demonstrate again, that in general villagers/focus groups in Magway TS are more aware about under-nutrition compared to Natmauk – and most groups (both MTG1 and MTG2) indicated that about 1/3 of the villages suffer from under nutrition, whereas there is not such a clear “response” from focus groups in Natmauk TS. The reason for this is likely to be that Magway TS have had health-related activities about 3 years back, providing the population with more knowledge and awareness on the issue of under-nutrition. The higher education level, as mentioned before, in Magway TS is undoubtedly also contributing to this better and more pronounced understanding in comparison with Natmauk TS.

Similarly, findings from MTG1 and NTG1 indicated a better understanding of under-nutrition, which naturally is explained by the presence of health workers in the group and possibly also by the higher education level compared to MTG2 and NTG2.

Generally, all the groups expressed that they have experienced a shortage of food in their village. Nonetheless, not all the groups related this shortage of food with the possibility or risk of under-nutrition. Some expressed a belief that it was normal for their families to be small and it had no bearing on their working ability. This clearly points out the lack of knowledge about under-nutrition, but also the misunderstanding of the term under-nutrition and its consequences. These findings point to the necessity of activities that addresses why good nutrition is so important and the impact and consequences that prevails on the individuals, households and communities if under-nutrition become widespread and significant.



5.3 Understanding the causes of under-nutrition

The causes of under-nutrition mentioned in the different focus group were quite similar and uniform. The groups perceived **poverty** as the main cause or root for under-nutrition. Poverty obviously results in lack of money to buy food and likewise poverty is associated with many of the following findings.

High workload: Women and mothers are seen as the main players in both food preparation and prevention of under-nutrition. Therefore, it appears as though the problem occurs when their workload is too much to handle. The rain and the winter seasons are the busiest time, where the villagers have to work in the fields to ensure a proper crop/harvest, which will provide them with money for the entire year. It is crucial for the families' financial situation and there is a need for everybody to work in the fields. The consequence is lack of time for the women to prepare proper meals for their families and, further, the mothers are not able to breastfeed their children during the day. This subject will be discussed later in section 5.5 below.

The paradox is that the summer season is associated with less work, but at the same time it is characterized by water scarcity, often inadequate income hence less food availability/variation and accessibility. These conditions make the villagers vulnerable to suffering from under-nutrition during the hot early summer months.

Food restriction: The FGDs revealed that despite of some knowledge about healthy foods to eat under pregnancy and when lactating, many women restrict the intake of certain useful food items. Elderly women (such as grand-mothers) beliefs on these matters are particularly strong and listened to. Our findings also suggest that women are balancing between two different sets of practices and beliefs, which at times comes in conflict. The women want to eat all varieties of food, but other family members do not allow them to.

Therefore, future activities and interventions should introduce modern knowledge on nutrition but, at the same time, also address and initiate discussions on traditional “mal-practices” and how to alleviate these in order to help women be better able to access safe care and improve their own and their children's health.

An interesting division between group 1 and 2 was that the general belief in MTG1 and NTG1 is that pregnant women eat less during pregnancy, because they are afraid of developing large babies and consequently having a difficult delivery. These concerns were not mentioned in MTG2 and NTG2: on the contrary, the women expressed concerns about giving birth to small babies, which they related to be more vulnerable to diseases. In addition, group 2 participants were very well aware that smaller women (undernourished) could easier have complications during delivery. It is difficult to interpret the reason causing these discrepancies between group 1 and 2, but it could be related to cultural norms and beliefs. Nevertheless, it is essential to send a strong message about the importance of good nutrition, particularly for pregnant and breastfeeding women, since the children's growth depend on this and also for their own health³ (10).

Diseases: The findings show some knowledge about communicable diseases. All the participants have experienced malaria, dengue, TB and diarrhoea. However, the findings also revealed a weaker understanding of the interlinkages between communicable diseases and under-nutrition; in the sense that a person who suffers from under-nutrition is more likely to get diseases, that the diseases

³ https://myanmar.savethechildren.net/sites/myanmar.savethechildren.net/files/library/LEARN%20Facilitator%27s%20Guide_2015_1.pdf

can be more severe and he/she might take longer to recover. This suggests a ***lack of knowledge*** concerning the benefits of good nutrition. Overall basic nutrition knowledge to prevent diseases in general should be taken in consideration for future designing of project activities (see also section 5.9 below).

In general, findings show that there are vulnerable communities in the target areas, which at present are highly suffering from under-nutrition and this is likely to continue unless interventions are being carried out.

5.4 Poor knowledge of the basics of nutrition

There seems to be a substantial divide between Magway TS and Natmauk TS on the understanding of basic nutrition. Most of the MTG2s were able to state the classification of food groups but very few of the NTG2s had ever heard about food groups. Again, this is most likely explained by the previous NGO health related activities in Magway. Nevertheless, the findings suggest a need for more knowledge of basic nutrition even in Magway TS, also taking section 5.3 in consideration. The findings reveal the perception/opinion that women are not able to cook proper (healthy) meals because of the lack of time. Therefore, addressing this lack of knowledge on how and with what to prepare a proper meal will be useful. The FGDs also revealed the importance to identify and address some of the cultural norms and beliefs (food restrictions) that are extremely harmful. For example, the findings indicate that such cultural norms/beliefs hinder the provision of quality food for pregnant and lactating women.

Learning the causes of under-nutrition and what consequences under-nutrition can cause now and in the future, is paramount. As well, how good nutrition is the foundation of good health and the understanding of the importance to represent all food groups in the meals is important to include as key messages. Lastly, to prevent and reduce undernutrition it is essential to ensure that mothers are fully aware on how they can optimally feed themselves and their children.



5.5 Low degree of exclusive breastfeeding and early introduction of complementary feeding

The findings from the FGDs show that women are familiar with the principles of the first hour after birth⁴ and aware of the benefits of the first milk (*colostrum* - it is a practice to feed the new-born with colostrum). Breastfeeding is a common practice within the villages and the mothers recognize the benefits of breastfeeding.

However, shortly after, mothers face barriers to exclusive breastfeeding due to the need to return to work outside of the home, which causes low rate for exclusive breastfeeding (up to 6 months). Consequently, it is challenging to maintain exclusive breastfeeding during the first 6 months,

⁴Baby's first breastfeed and mother-baby and family bonding

thereby putting infants at risk of malnutrition and poor health outcomes. Another barrier to exclusive breastfeeding is that mothers and grandmothers believe that exclusive breastfeeding is not sufficient for babies and solid foods and water are necessary, if not even better.

The knowledge of complementary feeding is poor. In general, women would introduce complementary feeding, when their child is 2-3 months old and thereafter, would only breastfeed 2-3 times a day or less. This practice is most likely related to living conditions, cultural norms and lack of knowledge. On the other hand, most of the mothers continue to breastfeed for more than two years. The FGD participants have never heard about the first 1000 days window (from women's pregnancy until the child's second birthday). Therefore, knowledge and awareness of the damage done during the first two years and the largely irreversible and devastating impact on the child's future potential, even if a child's nutrition status improves after the age of two (11), is a key message to "get across".

None of the villages had the habit of using artificial or cow milk, because they could not afford it. In general, the answers points to that the practice is not based on knowledge of how beneficial the breastmilk is compared to artificial or cow milk, but more due to economic factors. This means they might consider buying artificial if they could afford it. So, this is again an important message.

As mentioned above, even though mothers know about the benefits of breastfeeding, more nuanced communication messages (targeting the first six months of a child's life, complementary feeding and the first 1000 days of a child's life) should be emphasized. Stunting is a risk factor for diminished survival, childhood and adult health, learning capacity, and productivity (11,12). This knowledge and the fact that 35% of all children aged under five are stunted in their communities urge for further efforts (1) .

Furthermore, there is a need for focus to be on the daily conditions of pregnant and breast-feeding women, which are generally equal to other "none child caring" women. Although the focus groups revealed both reflections and concerns about pregnant and lactating women's conditions in everyday life, it was the common opinion that this is not possible to change due to their daily (poor) living conditions and the need for everybody to work. It is important to clarify and focus on the possible consequences of choosing to let pregnant and breast-feeding women to participate in daily work in the fields so much, and so quickly after birth, and what significance it may have for the entire household in the future. The effects of mothers 'nutritional' status on her baby's growth, low birth weight, indicating poor maternal nutrition and health status (and a strong precursor for future stunting and poor health outcomes of the child (13)), are important topics for communities. Future activities for nutritional behaviour change should plan to interact with mothers or other caregivers in order to understand their barriers to change and work with them, and other family members, to seek commitment to change. For this reason, activities should not only focus on mothers, but also on other household and community members, including husbands, mothers-in-law, grandmothers and community leaders.

5.6 Women are key agents of change

The FGD findings show that the role of the women related to improvement of nutrition is central for a number of reasons:

- (1) Women are the primary caregivers within the household
- (2) There are increased nutritional requirements during pregnancy and lactation
- (3) Women seem to reduce their own consumption as a coping strategy when food is insecure and less available⁵
- (4) The importance of breastfeeding and correct choices of complementary feeding of children under the age of 2 years
- (5) Women are the main decision-makers on food and household expenditure.

This emphasises that women are key agents of change on key factors, which will have an impact on the improved nutrition security at the individual and household levels. The empowerment and inclusion of women should be central and cross-cutting themes, which should be considered throughout the design of all components of the future activities and interventions aiming at a nutritional behaviour change within the communities.

5.7 Hygiene - disconnection between knowledge and practice

In general, MTG2 and NTG2 showed knowledge about basic hygiene precautions, such as washing with soap before eating and after defecation. They had knowledge of clean and dirty water and an awareness on how to clean and disinfect water by boiling it.

However, households without latrines use open defecation in fields. Particularly in Natmauk TS there seem still to be a substantial number households without latrines and therefore practice usage in both fields and streams. Several people of the NTG2 mentioned the problem of villagers using the stream for defecation and urination, which are the same streams that are water source downstream for the households. In addition, NTG2s described outbreaks of diarrhoea; health staff have provided information on how to prevent such outbreaks, but clearly an effective approach to this still seems to be missing. Most of the NTG2s were aware of the importance that the fly-proof latrines, such as VIP latrines (see Figure 5), play in prevention of diarrhoea and expressed wish for flue-proof latrines for all households. Likewise, most group 2 participants could identify what can cause diarrhoea and when and where to seek help if affected. The findings also discovered different practises among sick children with diarrhoea – such as some would give food and water to them, whereas others would not. This obviously emphasizes that more knowledge is needed on how to take care of sick children.

⁵ The women would prioritize giving food first to the men, then children and lastly herself, which makes the mother vulnerable when shortage of food occurs.

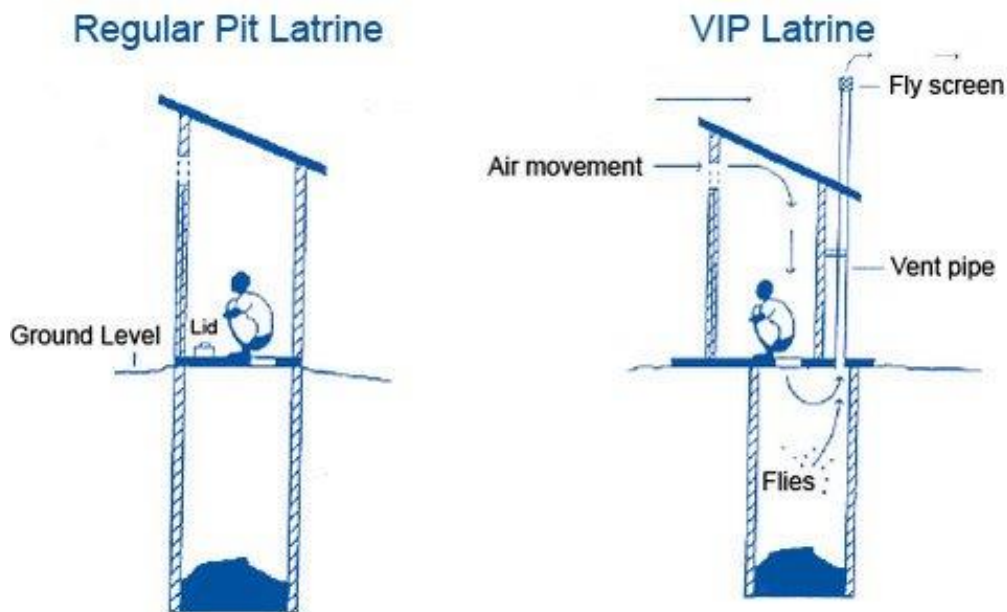


Figure 5 - Ventilated Improved Pit Latrines

The findings also revealed a practice of giving water directly from bore-wells, or surface streams to new-born babies. In spite of awareness of the benefits of boiled water, this was not done as a common and continued practice - most likely as it requires both water and firewood, adding extra cost or might not always be easy available – see Figure 6.

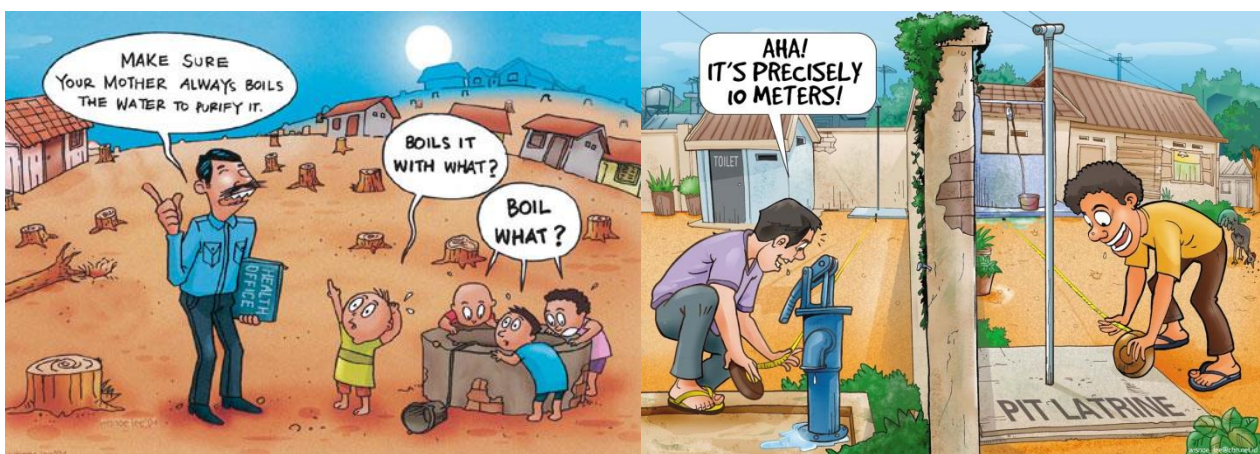


Figure 6 - Some typically used hygiene and sanitation messages

In fact, they would only boil the water if the child has diarrhoea which, of course, is too late. It is therefore essential to address hygiene and sanitary practices due to the risk of intestinal infections and diarrhoea, which also increases the risk of malnutrition (14).

It appears that the knowledge of basic of hygiene and sanitation is not always followed with practices and behaviours in the two townships. Hygiene, sanitation education and awareness on

avoidance of open defecation should be provided as part of an overall strategy to improve nutrition security. Also, alternative methods to boil water will be needed.

5.8 Family planning (FP)

Appropriate family planning is important for the health of women and children by preventing pregnancies that occur too early or too late in life, extending the period between births (which has an impact on the nutritional status of both mother and children) and limiting the number of children for reducing financial burden (15).

All FGDs had knowledge about some family planning (FP) methods (mostly injections, pills, implants and intrauterine devices). Although the groups expressed benefits in terms of socio-economic factors, such as too many children could have a negative influence and strain on the family's economic conditions (which could lead to less food/health problems in general), most groups still expressed some reluctance to family planning methods, because women experienced tiredness, weakness – and in some cases weight lost. Some women even expressed the fear of gaining weight as a negative side effect of family planning, which of course is odd considering the discussions above on under-nutrition. The reason for this reservation towards family planning could be peer pressure or the side-effects, or the feeling of the non-necessity of family planning methods. In fact, the conclusion from many discussions was that family planning has no real benefits and is not good for health of the women (some villages claimed they had stopped using FP for these reasons). On the other hand - and therefore fairly remarkable - many of the focus groups actually suggested activities/health discussions about family planning to learn more, even groups who showed most aversion towards FP.

5.9 Communicable Diseases

The findings suggested a high number of people suffering from Hepatitis B. This could be related to the fact that some villagers rely on 'quack' doctors for treatment of diseases/sickness. Such quacks do not have any official medical education and hepatitis B is often seen to be spreading through needles used for more than one person. Of course, Hepatitis B could also be transmitted due to unprotected sex, but it seems less likely when referring to the demographic data, which shows that majority of the villagers are farmers living and working in the villages. Regardless of the reasons for the transmission of the disease, future planned activities should include information about how Hepatitis B is transmitted and which precaution should be taken.

Likewise, the occurrence of TB infected villagers was mentioned in the focus groups. Again – here it will be important to increase the knowledge about the most common symptoms of TB, how to react if they experience any symptoms – and how TB generally is treated.

Furthermore, the focus group participants did mention the presence of malaria and dengue fever. Information regarding how to protect against malaria and dengue should be spread with special emphasize on protection of children and pregnant women by using a mosquito net. Protecting

themselves from diseases will reduce the chance of family members, especially children, of becoming ill and suffering from under nutrition.

Raising awareness on the communicable diseases prevalent in the area will be highly useful - especially considering that none of the village is currently receiving any health-related services.

6. Recommendations

In order to achieve nutritional behavioural change within the communities, it is recommended that G.R.E.A.T. project should strengthen nutrition programming through the following overall approaches:

- Timing of interventions – the right season and timing should be taken into consideration keeping the “*First Do No Harm*” principle in mind
- It is important to be on time with pre-announcement of health activities, since not all the villagers will hear the message from the village speakers, because they are in the field working. Therefore, villagers need to know well in advance when health activities are planned so they can organize accordingly
- All campaign sessions should use illustrative posters, practical demonstrations and exercises to improve the learning process. In addition, all activities should evidently be based on a participatory approach, in order to create ownership leading to nutritional behaviour change

The following key recommendations have emerged from the FGDs and the analysing exercise in the previous chapter:

- 1) Create awareness of the magnitude and consequences of under-nutrition and stunting:** Health discussions in the entire village should address under-nutrition and stunting in order to create awareness of the magnitude and consequences of under-nutrition and stunting for the communities for a longer term-perspective, and how to break the vicious cycle of under-nutrition. Furthermore, strong messages in this awareness campaign should include how to discover under-nutrition and the vulnerability of pregnant women and children towards under-nutrition.
- 2) Define causes of under-nutrition:** An open and frank discussion on the causes of under-nutrition (such as poverty, high workload, food restriction, diseases, and lack of knowledge) should be conducted. Such an initial exercise should also be used as a planning tool for more detailed planning on how to make the subsequent intervention more specific to the exact problems of each village.
- 3) Determine basic Nutrition and hygiene:** Health discussions in the houses of the village leaders (or other locations) should be conducted on basic nutrition. These discussions should be combined with illustrative posters, demonstrations and concrete examples. Recipes should be provided with recommendations and participatory cooking sessions to women based on market availability and price of food products in order to achieve a sufficient meal. Likewise, focus on adapting adult diets for child consumption (not spicy, not sour) to facilitate greater dietary diversity among children, and supporting an optimised complementary feeding (recipes for food mixtures). Community gardens should be

established and opportunities for animal husbandry should be explored, to increase access to cheap vegetables and sources of proteins.

- 4) **Health talks for education and reproductive groups:** Health talks about basic nutrition and hygiene should be conducted in the cooperation with the Ministry of Education, as permission is required. Schools have a wide reach and can influence families and communities, respond to both long-term and immediate needs, and complement community initiatives. Often children or youth can be strong advocates for better practice upon the adult population and weed out the ill practices of their parents and grandparents – see Figure 7. Therefore, talking with adolescents about health (ages 14-20), can be a useful method to provide young people with knowledge about basic nutrition, hygiene and family planning.

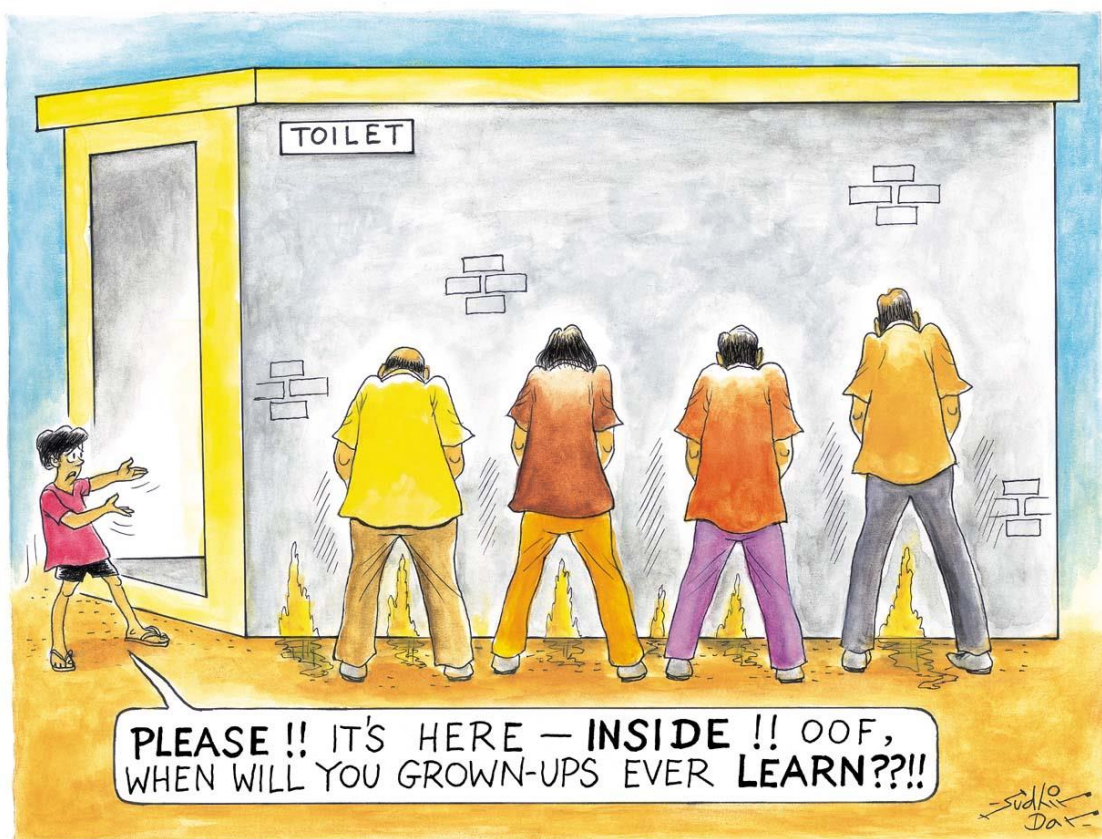


Figure 7 - When will they ever learn?

- 5) **Promote exclusive breastfeeding and optimal complementary feeding:** Strong messages in support of exclusive and continued breastfeeding. Target pregnant women diet-related support (address food restrictions) and postpartum women for exclusive breastfeeding support. Involvement from pregnancy will help to reach the child at the beginning of the first 1000 critical days, and will also help to build trust with the mothers and facilitate postnatal

counselling on breastfeeding and complementary feeding practices. Focus on interactive learning and simulations to reinforce existing knowledge. Communicate the dangers of bottle-feeding and give other liquids/foods to infants under 6 months. Activities should be coordinated with midwives, nurses, and other health workers on messaging and counselling. Skilled birth attendants/auxiliary midwives should be included in trainings since they help to deliver children in the community. Support mothers/primary caregivers (e.g. grandmothers) who participate in group discussions. Conduct discussions within these groups to learn more about local attitudes towards exclusive and continued breastfeeding.

- 6) **Childcare during sickness:** Conduct health talks about how to take care of children, preparation of nutrition during sickness and what kind of diet would be mostly beneficial.
- 7) **Hygiene and practice – behaviour:** Hygiene precaution (e.g. hand wash practices, food preparation and storage hygiene) should be conducted. Incorporate hygiene messaging (illustrated with posters and practical demonstrations) into other sessions which are related to the area (e.g. water and household and hygienic food preparation). Health talks for the whole village about basic hygiene, sanitation and related precautions. Emphasize the connection between poor hygiene and sanitation with illness and diseases and the increased risk of malnutrition (e.g. intestinal infections).
- 8) **Family planning methods:** Have discussions on different family planning methods – weighing the pros and cons. Emphasize about the important reasons and benefits of family planning. The apparently negative attitudes towards FP presently existing in the area should also be addressed and discussed openly: these should be conducted as discussions for women groups alone, due to the possible taboo and potential uneasiness to talk. Nonetheless, the importance and influence that family planning have on the nutritional status of women and children in general should be discussed with the whole village.
- 9) **Knowledge of communicable diseases:** Health talks should be conducted to provide villagers with knowledge and awareness about hepatitis B, TB, malaria and dengue diseases, how they spread - how to react - how to prevent.

7. Further required activities

The immediate tasks ahead of the project are:

- To discuss internally about the conclusions and recommendations which have emerged from the FGDs and this report
- Prioritize key themes, problems and constraints in the target areas
- Develop a list of possible fast track intervention activities
- Develop a list and description of detailed project activities (content, timing, length, resources needed and budget)
- Develop sequencing and timing of all activities (including overall project implementation plan, staff assignment and scheduling charts)
- Develop an aligned overall budget for the project implementation
- Develop project awareness activity material such as posters, learning leaflets, exercises in a format and use language which is 100% understandable to the local communities

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Annex 1: Overview and summary of focal group discussions



| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|--|
| Perceptions of under nutrition | Magway Township Group 1 (MTG1) | <p><i>"..At least ¼ of our village HH did not get enough food..." (FGD 6)</i></p> <p><i>"The mothers and children are smaller than their peers. So they may be suffering of under-nutrition..." (FGD 12)</i></p> | <p>In general, the perception from MTG1 assumed that approximately 30% of their villagers suffer from under-nutrition.</p> <p>The perception of under-nutrition was often combined with a small percentage of women and children.</p> |
| | Natmauk Township group 1 (NTG1) | <p><i>"...Our village has no households with under-nutrition..." (FGD 19)</i></p> <p><i>"...More than half of mothers and children in our village did not get enough food. They may suffer of under-nutrition..." (FGD 29)</i></p> | <p>There is no consistency for NTG1 perception of under-nutrition, some do not think the village has any villagers suffering from under nutrition and others tell about the experience of lack of food, which could cause under-nutrition.</p> <p>Some NTG1 experience lack of food in some households, where the mother and children could be suffering of under-nutrition.</p> |
| | Magway Township group 2 (MTG2) | <p><i>"...Young mothers and children can be prone to under-nutrition..." (FGD 6)</i></p> <p><i>"...One third of our village could have households with under nutrition..." (FGD 5)</i></p> | <p>The MTG2s had mixed views about whether under-nutrition was present in the village.</p> <p>Most of the MTG2 agree that around 1/3 of villagers suffer from under-nutrition and few have not seen or heard about under-nutrition.</p> <p>Generally, young children or mothers have the possibility to suffer from under-nutrition.</p> |
| | Natmauk Township | <i>"... We think there will be no under-nutrition. But some of them did not get</i> | The NTG2s have different perceptions as to whether people in their village suffer from under-nutrition. Some of the villagers have not |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|-----------------------------------|---|--|
| | group 2 (NTG2) | <p><i>enough food mainly because of poverty...” (FGD 15)</i></p> <p><i>“...Two third of our village could have households with under-nutrition...” (FGD 23)</i></p> | <p>heard or seen any suffering from under-nutrition, but at the same time know about the about lack of food for some families.</p> <p>Other NTG2s believe that around two third of the villages could be suffering.</p> |
| Causes of under nutrition | Magway Township group 1 (MTG1) | <p><i>“...Some mothers cannot breastfeed their children. Mothers are so busy and have to work the whole day. They cannot take care of their children, and children do not get enough care...” (FGD 3)</i></p> <p><i>“...Traditional beliefs can create food restrictions which can lead to under-nutrition of mothers and children...” (FGD 9)</i></p> <p><i>“...They (pregnant mothers) are afraid of having big babies. If they eat so much food, the child will be big and (they think) this will be a problem for a normal delivery...” (FGD 12)</i></p> <p><i>“...They have to cook with available resources. Some of them have knowledge about nutrition but they cannot practice according to their knowledge because of</i></p> | <p>The MTG1 correlate under-nutrition as a consequence of poverty. The women have too much of a high workload, and therefore are not able to breastfeed sufficiently and take care of their children properly.</p> <p>Food restrictions based on traditional beliefs causes under-nutrition of pregnant women.</p> <p>Women will eat less food during pregnancy due to the fear of having a big baby, which could lead to a complicated delivery.</p> <p>Poor knowledge about nutrition and health related issues amongst the villagers.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|---|
| | | <i>limitations, like income and time availability..." (FGD 1)</i> | |
| | Natmauk Township group 1 (NTG1) | <p><i>"...Food restriction of mothers. Mothers did not eat beef and pork. They also avoided vegetables up to the child's age of 6 months. Traditional belief can cause food restriction and that can lead to under-nutrition of mothers and children..." (FGD 20)</i></p> <p><i>"...Some mothers cannot breastfeed their children well. Mothers are so busy and have to work the whole day... They cannot take care of their children..." (FGD 27)</i></p> <p><i>"...Food restriction of mothers because they (pregnant mothers) are afraid of having big babies..." (FGD 15)</i></p> <p><i>"...I was saying that if you do not have money how you will buy good things [nutritious food]? ..." (FGD 20)</i></p> | <p>NTG1 shows that food restrictions caused from traditional beliefs can lead to diseases and under nutrition.</p> <p>Pregnant women are eating less food, because they are afraid of having big babies.</p> <p>Mothers are too busy working and therefore not able to breastfeed their children, and they will not get enough care.</p> <p>The NTG1 also related poor knowledge of how to take care of babies as a cause for under nutrition.</p> <p>Poverty is preventing villagers from buying healthy food.</p> |
| | Magway Township | <i>"...Nutritional taboo is that we do not eat beef, frog, mushroom, pork or bitter gourd. We found that our elders did not</i> | MTG2 mean that food restriction for lactating mothers and pregnant women can cause under nutrition. Some express they are prevented from eating varied |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------|---|--|
| | group 2 (MTG2) | <p><i>eat them, and if we eat them we will have skin disease...." (FGD 12)</i></p> <p><i>"...We want to eat all the varieties of food but our family did not allow us to. They are worried for diseases and we have to restrict our food ..." (FGD 14)</i></p> <p><i>"...Mothers from poor economic conditions (half of our village) have to work up to delivery time and sometimes they work up to 7 or 8 months of pregnancy. They work again at the three months of their children. But mothers from rich families, they can rest more than that..." (FGD 5)</i></p> <p><i>"... [We can come home] if the work place is near, if far we cannot [come], then [we] breastfeed only when the day is over..." (FGD 11)</i></p> <p><i>"...I wake up in the morning, sweep the compound, fetch water and breastfeed the child. Then I prepare the porridge for breakfast so that the others can go to school. I will be in the farm till 4 pm when</i></p> | <p>The pregnant women who do not get enough food risk giving birth to babies with low weight.</p> <p>The women have a high workload and therefore they are not able to breastfeed enough and take care of the children, which could cause children to be undernourished.</p> <p>Poverty: needs to work a lot to get enough money to buy food</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|--|
| | | <p><i>I get back home I remember I have had no time to attend to the child since morning, [at that time] I try to sort the vegetables, fetch the water, cook, bathe the children and prepare them for bed. The only time I rest is when I get to bed...." (FGD 9)</i></p> <p><i>"...How do we know? Whether [she, neighbours or relatives] takes care or not, we leave the child and go. If we did not go for one day, we will have to face problems for money..." (FGD 7)</i></p> <p><i>"...Who will give me food if I keep sitting [at home]? We have to buy food day by day after getting money. If not, we cannot buy it..." (mother from poor family) (FGD 7)</i></p> | |
| | Natmauk Township group 2 (NTG2) | <p><i>"...Food restrictions may be present. We don't know the causes of under-nutrition..." (FGD 18)</i></p> <p><i>"...Sometimes, children lost their appetite and they did not eat rice and curry. We (mothers) are busy and we don't know</i></p> | All NTG2 believe that food restrictions could be a cause for under-nutrition for both children, mothers and pregnant women. They experienced food restriction in pregnancy. They did not eat beef, mushrooms and pork. For vegetables, they said that they ate only water grass and pumpkin shoot. They tell that even if they want to eat all food items the families will not allow them. The grandmother is often the decision makers for these restrictions. |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|--------------------------------|---|---|
| | | <p><i>how to do in that case. We let them eat snacks that they want..." (FGD 22)</i></p> <p><i>"...Some of the mothers did not eat enough food during pregnancy so low birth weight children will be born. After that, the child will be so small...hum..." (FGD 19)</i></p> <p><i>"...When you leave your child with neighbours, they won't give the child food at the appropriate time. They will concentrate on performing their household chores while the child stays hungry. By this, the child becomes weak..." (FGD 22)</i></p> <p><i>"... My child is smaller than his peers... You know, my whole family is skinny but very active. It is a family trait..." (FGD 23)</i></p> | <p>The NTG2 also express that women are too busy working and are not able to breastfeed more than 3 times a day. They believe that this causes children to be small.</p> <p>Some NTG2 express the importance of taking care in pregnancy and that small women will give birth to small babies. These babies get diseases.</p> <p>The high workload (fieldwork) forces mothers to leave the care of their babies to others, who will not take proper care of the children, leaving the children in danger.</p> <p>Some NTG2 also tell that members from some families are born small and skinny, but still able to work and do well.</p> <p>Some expressed a conviction that it was normal for their families to be small, and it had no bearing on their working ability.</p> |
| Conditions of health information/awareness activities | Magway Township group 1 (MTG1) | <p><i>"...Health talks are not conducted in our village by the health department. We want you to do similar kind of health talks. Health assistants and midwives (from governmental department), who have duty for our village, come for</i></p> | <p>MTG1 tells there has not been health talks delivered by the Health department.</p> <p>The MTG1 only see the midwife when she comes to give immunization vaccinations.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|---|
| | | <i>immunization but they cannot conduct health talks for the whole village..." (FGD 7)</i> | There has been NGO who had health related activities in the past. |
| | Natmauk Township group 1 (NTG1) | <p><i>"...We had no NGO services for health before. Midwives who has also duty for our village did not come for health talks. She did immunization activity..." (FGD 15)</i></p> <p><i>"...Health assistant (from governmental department) who has duty for our village cannot conduct health talks for the whole village. We haven't seen him..." (FGD 16)</i></p> | <p>There has not been health talks conducted in villages and NTG1 villages rarely see the health staff (some have never see the health assistant). They do see the midwife when she comes to give immunization vaccinations.</p> <p>There have not been any NGOs working with health-related activities in this township.</p> |
| | Magway Township group 2 | <i>"...They (NGO and health department) will announce the time of health talks with the speaker. But we cannot know the exact time because most of the time, we are in the field. We have to work from 9am to 12pm and then after 2 to 5 pm. So, we are in the field and we don't know the time of the health talk..." (FGD 1)</i> | <p>The women are missing some health talks because they are not receiving notice about them.</p> <p>Most of the women have never seen the health assistant. They see the health staff when they get a vaccination.</p> <p>There has been health-related NGO activities 3 years ago</p> |

| Themes/co ding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|--|
| | | <i>"...We have not seen the health assistant who has duty for our village. He has not been (here)..." (FGD 12)</i> | |
| | Natmauk Township group 2 (NTG2) | <p><i>"...We have never had NGO services for health before. The midwife who has also duty for our village did not come for a health talk. She did immunization activity, only. We want you to do similiar kinds of health talks..." (FGD 25)</i></p> <p><i>"...in some villages, quacks give injections to children after 9 months..."(FGD 15)</i></p> | <p>All the NTG2 mentioned that there was no health talk conducted in their villages before. The health assistant, who has duty for their villages, did not conduct health talks for the whole villages.</p> <p>In some of the villages, they have never seen health assistants.</p> <p>The midwife is not giving health talks, she is only giving the immunization.</p> <p>The NTG2 tells that they get injections from the quacks, who are treating the diseases. Some quacks give vaccinations to children after 9 months.</p> <p>There have not been any NGO working on health. Some NTG2 mention that TDH had been working with clean water.</p> |
| Interest in health information/ awareness activities | Magway Township group 1 (MTG1) | <i>"...Face to face talks and community talks are the best...the village authority's cooperation is essential. If authorities ask villagers to come to the health talk, they will come surely... Health talks should be conducted at village authority's home... need wide enough place..." (FGD 4)</i> | All the MTG1 are interested in health awareness activities. Timing and seasons of the year are important to consider for these activities. The rainy and winter season are busy times, when the villagers are working in the fields. So, in these two seasons, health activities can be conducted at lunchtime (12 PM to 2 PM). During the summer season, they will be available the whole day. |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| | | <p><i>"...In March, April and May, you can call and conduct (health talks) any time. In the summer season, we are free the whole day..." (FGD 9)</i></p> <p><i>"... 12- 2pm is the best time to conduct (health talks)."</i></p> <p><i>"For the other seasons (apart from summer season), we are so busy with our work. We have to work mainly in rainy season and winter for the whole year for our money. If we miss this time, we will be hungry for the whole year..." (FGD 11)</i></p> | <p>Most of the MTG1 suggested the house of the village leader as the best place to conduct health activities</p> <p>MTG1 preferred face to face talks. The pamphlets are not a good way, since many of the villages are illiterate or have poor reading skills.</p> <p>Some MTG1 suggested a combination of both could improve their knowledge.</p> |
| | Natmauk Township group 1 (NTG1) | <p><i>"...The house of the village leader is the best place for health talks. Cool and wide enough. We can be at our primary school at the weekend, not in school days..." (FGD 26)</i></p> <p><i>"...In March, April and May, any time. But for the other seasons, we are so busy with our work. 12 pm to 2 pm is the best time..." (FGD 17)</i></p> | <p>The NTG1 are interested in health talks. They would prefer in the afternoon, because they are busy during the day, especially during winter and rainy season. In the summer-time it could be any time.</p> <p>The house of the village leader would be a good location for health talks, some villages also suggested the school.</p> <p>Face to face is preferred and videos with health messages can be useful too. But written things should be avoided because of illiteracy and poor reading skills.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|---|
| | | <p><i>"...In summer season, we are free the whole day and can rest..." (FGD 21)</i></p> <p><i>"...For pamphlets, most of the villagers cannot read properly..." (FGD 23)</i></p> | Pamphlets are not good idea since some of the villagers could not read properly. |
| | Magway Township group 2 (MTG2) | <p><i>"...We are so interested to listen to health talks..." (FGD 9)</i></p> <p><i>"...Face to face discussions for health talks are the best, because we can ask and, we can get clear message back..." (FGD 6)</i></p> | <p>The MTG2 are expressing interest for health talks. They prefer face to face, because then they can ask questions to clarify the messages.</p> <p>Video could also be an idea.</p> <p>The best timing is in the afternoon after 4 pm, before that they would be busy with work. In summer season the whole day is possible, because they do not have work.</p> <p>The house of the village leader is a good place for these activities.</p> |
| | Natmauk Township group 2 (NTG2) | <p><i>"...If we hear about good health, we are very eager to come..." (FGD 29)</i></p> | <p>The NTG2 express the interest in health talks, they are very eager to hear and learn more about how to get a better health.</p> <p>They are very busy working in the in the rainy and winter seasons. These are the seasons where they have to earn money for the whole year. Here the best timing would be in the evening after 4/5pm. Summer season is the best timing, because they will be free from work the whole day.</p> <p>Some NTG2 suggest the house of the village leader as the best place to conduct health talks. Other villagers suggest the monastery, because it is wide enough and monks cannot hear the noise.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|--|
| | | | <p>NTG2 prefer the health talks to be done face to face, in that way they are able to ask for clarification and the messages will be clearer.</p> <p>They also like to watch videos with health messages.</p> |
| About changing behaviour | Magway Township group 1 (MTG1) | <p><i>"...Responsibility for change is by (people) themselves... Knowledge should be shared between villagers (if one gets knowledge from somewhere) ...If staff from project come and teach us repeatedly, they will be followed..." (FGD 3)</i></p> | <p>In general, MTG1 think that changing behaviour is done individually. Many limitations like poor knowledge and poverty can make it difficult.</p> <p>Mothers and wives are the key people for nutrition, since they are the decision makers for food preparation.</p> <p>Practical teaching repeatedly (to show how to cook and with what), could be a way to change behaviour.</p> |
| | Natmauk Township group 1 (NTG1) | <p><i>"...For nutrition, mothers and wives are the key to change... household heads need to cooperate as well...This way, we can prevent under-nutrition..." (FGD17)</i></p> <p><i>"...If the project can give good messages, village leaders need to tell villagers to follow strictly..." (FGD 18)</i></p> <p><i>"...School health talks are the best for nutrition..." (FGD 26)</i></p> | <p>In general, NTG1 explain that mothers and wives are the key people to change behaviours about nutrition. They should have the knowledge and ability to do the practical part (how to cook, and with what). Still it is important that the head of the household support and cooperate to the changes.</p> <p>Some NTG1 suggest that someone should come and do demonstrations repeatedly - in that way the mothers/wives will learn.</p> <p>If the project can give good messages, (advice coming from health authorities or NGOs about health issues), then village leaders would tell the villagers, which could prevent under-nutrition.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|--|
| | | | School health talks for nutrition is also suggested, because sometimes it is easier to learn early in life. |
| | Magway Township group 2 (MTG2) | <p><i>"...No one can influence them to change. They will nod their heads in front of you but they will not obey just like you say behind you. So, you need to tell pros and cons of one message..." (FGD 6)</i></p> <p><i>"...No one can influence them to change... But we will need neighbours that share knowledge between them..." (FGD 5)</i></p> | <p>It is up to the individual to change their behaviour. Nobody else can change them.</p> <p>MTG2 believe it is difficult to change behaviour and it is good to share knowledge between one another.</p> |
| | Natmauk Township group 2 (NTG2) | <p><i>"...For behaviour change, the person has to follow himself or herself. No one can influence them to change. But we will need an environment of knowledge sharing..." (FGD 15)</i></p> <p><i>"...For behaviour change, incentives are needed. If you give things, they will be interested..." (FGD 15)</i></p> <p><i>"...To make children eat all kinds of food, we have to make them to eat in company. If he eats with neighbours, he eats more</i></p> | <p>Generally, all of the NTG2 said that it is very difficult to change. Some NTG2s suggests to give incentives because it could make them interested in changing behaviours.</p> <p>Even if they have the desire to change their behaviour, they do not have the options or money to buy food.</p> <p>Most of the NTG2 mean that people have to follow themselves - nobody can influence them. But it is important to develop a sharing environment.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|---|
| | | <i>and more. Sometimes, he eats food that he did not like..." (FGD 22)</i> | |
| Communicable diseases and under nutrition | Magway Township group 1 (MTG1) | <p><i>"...Diarrhoea is caused by expired fruits and foods. Also by the food with flies... Yes, diarrhoea and under-nutrition are inter-linked. If a child is well nourished he/she cannot suffer from diarrhoea. Because enough nutrition can give enough immunity. So, immunity can prevent communicable diseases..." (FGD 2)</i></p> <p><i>"...We did not think that nutrition and communicable diseases will be related..."(FGD 6)</i></p> | <p>MTG1 have knowledge about some communicable diseases: dengue, malaria, TB and diarrhoea.</p> <p>But the MTG1 are divided in the perception of whether communicable diseases and under nutrition are related or not.</p> |
| | Natmauk Township group 1 (NTG1) | <p><i>"...Communicable diseases are diarrhoea, dengue and malaria..." (FGD19)</i></p> <p><i>"...We think that nutrition and communicable diseases are related... If you have under-nutrition, there will be diseases. But diseases cannot cause under-nutrition..."(FGD 26)</i></p> <p><i>"...75% of the villagers use fly proof latrines. But some of the villagers urinate</i></p> | <p>All the NTG1 are aware of some of the communicable diseases like diarrhoea, dengue, malaria and TB. They have experienced them all in the village, especially TB, dengue and malaria.</p> <p>Some NTG1 had an outbreak of diarrhoea 2 years ago.</p> <p>There is a different perception of whether under-nutrition and communicable diseases are related or not in NTG1.</p> <p>Most of NTG1 estimate that 50-75% of the latrines in villages are fly proof.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| | | <p>and defecate in streams and fields. They don't want to follow orders..." (FGD 20)</p> <p><i>"... We do not think that nutrition and communicable diseases are related. We can encounter diseases regardless of our nutrition. Under-nutrition cannot cause diseases..."(FGD 23)</i></p> | <p>Still some of the villagers go to the fields and streams for urination and defecation. They do not follow the discipline set by village leaders.</p> |
| | Magway Township group 2 (MTG2) | <p><i>"... Nutrition and communicable disease are not interlinked. Under-nutrition cannot cause diseases and diseases cannot cause under-nutrition..." (FGD 8)</i></p> <p><i>"...Enough nutrition and communicable disease are interlinked. If we have enough nutrition, we cannot get communicable diseases..." (FGD 5)</i></p> <p><i>"...We have TB patients apparently. We have many hepatitis B patients..." (FGD 10)</i></p> | <p>There is no consensus between the MTG2, whether communicable diseases and under nutrition are related.</p> <p>They do not have many outbreaks in the villages, but diarrhoea is something they experience.</p> <p>They have heard that many suffer from TB and Hepatitis B.</p> |
| | Natmauk Township group 2 (NTG2) | <p><i>"... Nutrition and communicable diseases are not interlinked. Under-nutrition cannot cause diseases and diseases</i></p> | <p>There is division between whether communicable diseases and under-nutrition is related.</p> <p>Some NTG2 say they do not know what communicable diseases is and how to protect themselves from them.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------|--|---|
| | | <p><i>cannot provoke under-nutrition..." (FGD 18)</i></p> <p><i>"...Stream water is better than tube well water because they are clear and we can see up to the bottom. We drink water directly from the stream. Children also drink water from the stream directly..." (FGD 15)</i></p> <p><i>"...Enough nutrition and communicable disease are interlinked. If you have under-nutrition there will be diseases and diseases can cause under-nutrition as well..." (FGD 29)</i></p> <p><i>"...If our children have diarrhoea, effective home treatment is to give ORS as much as we can.</i></p> <p><i>If children have more than 3 diarrhoea episodes, we will go to the clinic. We knew that. Last two years ago, there is diarrhoea outbreaks, health staff come and teach us..." (FGD 23)</i></p> | <p>Some NTG2 explain that when people suffer from under-nutrition, they can get diseases which can lead to further under-nutrition.</p> <p>There have not been many outbreaks but NTG2 experience TB patients and many hepatitis B patients.</p> <p>A few of the NTG2 mentioned that they had children who died from diarrhoea. Since then the health department staff have been to some of the villages and teach about seeking help if having 3 bouts of diarrhoea and that ORS is good to give in case of diarrhoea.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| Immunization | Magway Township group 1 (MTG1) | <i>"...If the mothers did not come to the place of vaccination, the village leaders and midwives go and call them house to house. So, almost all of the children got immunization..." (Group 4)</i> | <p>The MTG1 explain that approximately 80% of children are immunized, since the last couple of years. There has been a strong national focus to get mothers and children vaccinated.</p> <p>The MTG1 explain that the villagers feel more comfortable and safe in the hospitals/health centres.</p> <p>They also see and agree about the good benefits of immunization.</p> |
| | Natmauk Township group 1 (NTG1) | <i>"...Nowadays, mothers are not afraid to go to clinic and hospitals, they are familiar with health staff and health messages. They also obey to the good messages..." (FGD 18)</i> | <p>All the NTG1 estimated that around 75%-100% of their villages were fully immunized.</p> <p>The midwives have told all the benefits of immunization.</p> <p>When they go to the hospital for the illness of children, health staff will ask them whether they have immunized their children or not, because some diseases occur from no immunization.</p> <p>They have shared the messages to each other in the village.</p> <p>NTG1 tells that the villagers are more used to the health staff nowadays and trust their health messages - they will listen to good health messages.</p> |
| Food preparation and food security of | Magway Township group 1 (MTG1) | <i>"...Mothers are key for food preparation. Fathers will not be involved in food preparation. (Only) a few will be..." (FGD 10)</i> | <p>MTG1 explain that mothers and wives are key people in food preparation. The men are busy working in the field.</p> <p>In busy seasons (rain and winter seasons) the workload is so high and everybody has to work long hours in the fields. This causes lack of time for women to cook properly. Summertime has less of a variety</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| the household | | <i>"...If they have so much workload, they cannot cook. In summer, we are free because of no work but we do not earn much money. At this time, we have little food..." (FGD 7)</i> | of food and also no accessibility. Also, the villagers have less money to buy. |
| | Natmauk Township group 1 (NTG1) | <p><i>"...Money is the issue. If economic instability occurs, we cannot get enough food. In our villages, food availability and food accessibility are another issue..." (FGD 22)</i></p> <p><i>"...In the summer season, we have no work, and food insecurity occurs at this time..." (FGD 7)</i></p> <p><i>"...In the busy time, we usually eat rice with oil and salt..." (FGD 11)</i></p> <p><i>"...If health of family members is not OK, the economy is also destroyed..." (FGD 13)</i></p> | <p>According to NTG1, mothers the key people for food preparation. Sometimes, grandmothers will have influence on their decisions.</p> <p>Poverty is the main issue. If there is economic instability, they cannot buy or have access to enough food.</p> <p>Food availability and food accessibility occurs at times especially in the summer.</p> <p>In summer-time they suffer from food insecurity more because of lack of work and lack of money.</p> <p>In winter, they have difficulty to cook because of harvesting time and they eat rice with salt and oil at times.</p> <p>The health of the family members is important for the economy. If there is an illness within the family, members cannot work properly and this will influence the economy.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|--|---------------------------------|--|---|
| Perception about responsibilities for the prevention, risks and consequences | Magway Township group 1 (MTG1) | <p><i>"...Mothers and families... government and health staff has a responsibility to prevent under-nutrition..." (FGD 14)</i></p> <p><i>"...Mothers have the main responsibility to prevent under-nutrition..." (FGD 8)</i></p> <p><i>"...If children did not get enough food, they will suffer from under-development physically and mentally, as it will be easy to catch diseases..." (FGD 14)</i></p> | <p>Mothers have the main responsibility for prevention of under-nutrition, because they are the decision makers for food preparation.</p> <p>The groups also believes that the government health department have a responsibility to provide villages with health staff to deliver health messages.</p> <p>They are aware of the consequence of under-nutrition, as it could affect the physical and mental development of children.</p> <p>Economic instability can occur when adults suffers, since they would be weak and tired, and therefore not able to work properly.</p> |
| | Natmauk Township group 1 (NTG1) | <p><i>"...Mothers in our village have to work as soon as after delivery (hum... maybe after 3 months of the child). So, they cannot take care their child..." (FGD 20)</i></p> | <p>NTG1 explain that mothers have the main responsibility to prevent under-nutrition. But mothers in their villages have to work in the field after approximately 3 months from the delivery. This is a problem, because then they cannot take proper care of the child.</p> <p>They think that the government and health departments also have some responsibility in preventing under-nutrition. They should come more often to the village.</p> <p>In their villages, they do not have a midwife staying in the villages and they have to depend on auxiliary midwives and quacks.</p> |

| Themes/co ding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|--|---|---|
| Vulnerability when insure of food in household | Magway Township group 1 (MGT1) | <i>"...If they suffer from food insecurity, parents will not eat and they will give food to their children... hum... Especially mothers, because they will give food to their husbands as they have to work for income and they think that their children need food..." (FGD 13)</i> | MGT1 says that the mothers are most vulnerable, because they give priority to husbands and children when insecure of food in households. If they are pregnant, then they are in danger of giving birth to small children. |
| | Natmauk Township group 1 (NTG1) | <i>"...Mothers are especially most vulnerable. If there is not enough food, they will give more food to other family members. If children did not get enough food, they will suffer under development physically and mentally. It is easy to get diseases. If pregnant mothers suffer from under-nutrition, children in the womb will be small..." (FGD 21)</i> <i>"...If they (pregnant mothers) did not get enough food, they will be weak and tired. So they cannot work well or deliver well. If healthcare costs are high, finally, economic instability can occur..." (FGD 20)</i> | Mothers are vulnerable. They prioritize to give food to the husbands and the children. If mothers do not get enough food, they will be weak and tired and not able to work well. Pregnant women will be in danger of not delivering normally, which can cause big healthcare costs and economic instability can occur. Furthermore, if mothers suffer from under-nutrition, the child would be small. Children who suffer from under-nutrition could develop less physically and mentally, and will be vulnerable to diseases. |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| Barriers and villagers' participation | Magway Township group 1 (MTG1) | <i>"...They will get knowledge but (this) to become a practice is a big challenge..." (FGD 2)</i> | MTG1 did not see many barriers for our activities, but changing practices is difficult. But they would help as much as they can, especially in terms of labour. |
| | Natmauk Township group 1 (NTG1) | <i>"...We did not see so many barriers for your activities and our suggested activities. We will help as much as we can..." (FGD 23)</i> | NTG1 think transportation (bad roads and remote location of villages) could be a problem for future activities. Apart from this, there will be no barriers. They would help as much as they can. They are willing to help in organizing villagers and they will help in labour. |
| Family nutrition and complementary feeding to children | Magway Township group 2 (MTG2) | <p><i>"...50% of our villagers will give food before 6 months. Starting from 2 to 3 months, for their good health..." (FGD13)</i></p> <p><i>"...We know about (3) food groups but we cannot arrange meals with these food groups. We are so busy and most of the time, we cannot buy because no one come and sell meat and vegetables. So, at this time we have money to buy food, but we cannot..." (FGD 4)</i></p> <p><i>"...the amount and frequency of foods during pregnancy and before pregnancy in</i></p> | <p>The MTG2 thinks it is good for the child's health to give complementary food early. They start around 2-4 months old.</p> <p>Nobody from MTG2 have heard about the first 1000 days.</p> <p>Most of the MTG2 have heard about the three food groups.</p> <p>They eat eggs nearly every day. They eat meat approximately twice a week.</p> <p>They eat many vegetables in the rainy season, but in the other season much less, due to availability and accessibility, also because of lack of money to buy.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| | | <p><i>my house and nearby are not different. I worry about food sufficiency for my family members, especially those who are engaged in agricultural activities because they have always to work..." (FGD 10)</i></p> <p><i>"...About eating, so many ladies want to be selective. Especially because of peer pressure. So, they end up failing to get what their bodies need..." (FGD 10)</i></p> <p><i>"...We have not heard of this kind of first 1000 days. No one tells us...The midwife should be telling us, right?" (FGD 12)</i></p> | |
| | Natmauk Township group 2 (NTG2) | <p><i>"...We haven't heard about food groups...." (FGD 24)</i></p> <p><i>"...Mothers are the mainly responsible for food preparation of HH. Sometimes, grand-mothers prepare food for children. Actually, the whole family has responsibility for food preparation..." (FGD 27)</i></p> <p><i>"...Sometimes, we cannot buy because no one comes to sell meat and vegetables. So,</i></p> | <p>According to NTG2 mothers is the main person responsible for food preparation. Sometimes, grandmothers would also prepare food for the children. Some of the NTG2 conclude that the whole family is responsible.</p> <p>Most of the NTG2 have no knowledge of the three food groups. They eat egg almost every day and meat around twice a week. They eat plenty of vegetables in the rainy season, but in the other seasons they experience a lack of vegetable and nobody comes to sell them.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|--------------------------------|---|---|
| | | <p><i>at this time we have money to buy but we cannot..." (FGD 21)</i></p> <p><i>"...We have not heard this kind of first 1000 days. No one tells us..." (FGD 20)</i></p> <p><i>"... Complementary feeding starts at 2- 3 months for their good health..." (FGD 24)</i></p> | <p>They think that half of the mothers in their villages give complementary feeding to children below 6 months and start around 2-3 months, because they believe it is good for the child's health.</p> |
| Breast feeding practice | Magway Township group 2 (MTG2) | <p><i>"...We used to breastfeed until the child wanted (may be up to 5 years). We did not use artificial feeding like milk and cow milk for children in our villages. We cannot afford it..." (FGD 14)</i></p> <p><i>"...When we have just given birth, we do the very first breastfeeding. Breast milk has something good it adds to the infant's body. That is what we know..." (FGD 9)</i></p> <p><i>"...They can breastfeed only three-times a day to their children because of their work. Because of this, the children are small..." (FGD 4)</i></p> <p><i>"...Mothers work up to 7 and 8 months of pregnancy. They work again when the children are three months old..." (FGD 13)</i></p> | <p>MTG2 tell it is a habit to breastfeed up to 2 years of age or more.</p> <p>The MTG2 knows that the colostrum is very important for the new-born child.</p> <p>Because of high workload (work in fields), they are only breastfeeding 3 times a day, and they start working after delivery (3-4 months).</p> <p>Artificial milk or cow's milk is not used to feed children, because they cannot afford it</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|---|
| | Natmauk Township group 2 (NTG2) | <p><i>"...We usually used to breastfeed until the child wants..." (FGD 24)</i></p> <p><i>"...We gave colostrum to all of our children. We knew it is good for our children..." (FGD 26)</i></p> <p><i>"...Actually, we listen to health talks from the radio and we got pregnant after these talks, and we knew that we have to give colostrum to our children..." (FGD 27)</i></p> | <p>All NTG2 are breastfeeding the children up to 2 - 5 years old (as long as the child want).</p> <p>They are giving the colostrum to the new-born children. Some have heard the health message from the radio.</p> |
| Daily life for pregnant and lactating mothers | Magway Township group 2 (MTG2) | <i>"...Mothers from poor households, they (half of our village) have to work up to delivery time and sometimes they work up to 7 and 8 months. They work again when their children are three months old. But mothers from rich families, they can rest more than that..." (FGD 2)</i> | The MTG2 explain that daily life for pregnant and lactating mothers is not much different from other women. At the same time, they are well aware that these women should be protected - they need more rest. How much they can rest depends on the families' economic situation. |
| | Natmauk Township group 2 (NTG2) | <i>"...Pregnant mothers and lactating mothers have to work the same as ordinary mothers. But mothers from rich families, they can rest more than that..." (FGD 17)</i> | Pregnant women and mothers work the same hours, starting from 4AM in the morning to evening at 6PM. They work very late in their pregnancy (up to 8 months). – The workload depends on the family's financial situation. For poor families, the mothers and pregnant women have to work more. After delivery, they have to work again at 2 -3 months of the children age. |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|---|
| | | | |
| Consequences of under nutrition | Magway Township group 2 (MTG2) | <i>"...If children did not get enough food, they will suffer from under-development both physically and mentally. Easy to get diseases. If mothers suffer from under-nutrition, the child in the womb will be small. Mothers cannot deliver and can die because of under-nutrition..." (FGD 7)</i> | <p>The majority of MTG2 knows that under-nutrition has big consequences for childrens' development.</p> <p>They expressed concerns for the danger of poverty, if the mother does not get enough food, then she would not be able to work properly and the family will earn less money.</p> <p>Women, who suffers from under-nutrition, would often give birth to babies with low weight and the delivery could be difficult and dangerous for the women.</p> |
| | Natmauk Township group 2 (NTG2) | <i>"...If children did not get enough food, they will suffer from under-development physically and mentally. (It will be) easy to get diseases. If mothers suffer from under-nutrition, the child in the womb will be small. Pregnant mothers cannot deliver, and can die because of under-nutrition..." (FGD 19)</i> | <p>NTG2 say that the children will be small after diseases and if the child is small, it is getting more diseases.</p> <p>If the child does not get enough food, they will suffer from under development physically and mentally, and then they will get sickness easily.</p> <p>If the pregnant woman suffers from under nutrition, she will deliver a small baby.</p> <p>Pregnant women who suffer from under-nutrition can have difficulties during delivery, and maybe die.</p> |
| Hygiene and diarrhoea | Magway Township | <i>"...If there is more than 3 days of diarrhoea, we usually go to the hospital..." (FGD 5)</i> | The MTG2 were well aware that diarrhoea can be dangerous and the need to seek help for treatment. |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|--|---|
| | group 2 (MTG2) | <p><i>"...We drink water directly from the well. We gave the children this water. If they have diarrhoea, we will boil the water..." (FGD 5)</i></p> <p><i>"...We will give more foods for children with diarrhoea..." (FGD 11)</i></p> <p><i>"...We wash our hands before eating and after defecation. We always use soap. Soap is available everywhere for a low cost..." (FGD 12)</i></p> | <p>They also show knowledge about the importance having clean water and how to clean it. They are using water for drinking and household directly from the well, also to new-born babies and children.</p> <p>They would give boiled water if the baby/child has diarrhoea. There were different opinions in MTG2, whether to give food when a child has diarrhoea or not.</p> <p>Washing hands before eating and after defecation is a custom in villages.</p> <p>Many of the villagers have fly proof latrines, otherwise they would go to the fields. Some expressed difficulties, as latrines and water are far away.</p> |
| | Natmauk Township group 2 (NTG2) | <p><i>"...We don't have enough fly proof latrines and communicable diseases like diarrhoea occur very often..." (FGD 29)</i></p> <p><i>"...If the children have more than 3 episodes (diarrhoea), we will go to the clinic. We knew that..." (FGD 21)</i></p> <p><i>"...We will give little food to a child with diarrhoea..." (FGD 21)</i></p> <p><i>"...We wash our hands before eating and after defecation. We always use soap."</i></p> | <p>Some of the NTG2 express that they do not have enough fly proof latrines and communicable diseases like diarrhoea occurs very often.</p> <p>All the NTG2 are well aware of the fact that, if they or the children have 3 days of diarrhoea, they have to go to the clinic.</p> <p>Most of the NTG2 would give a child with diarrhoea less food</p> <p>They said that diarrhoea can transmit from unclean water, food with flies and unclean latrines.</p> <p>They mentioned that unclean water is a breeding ground for mosquitos.</p> |

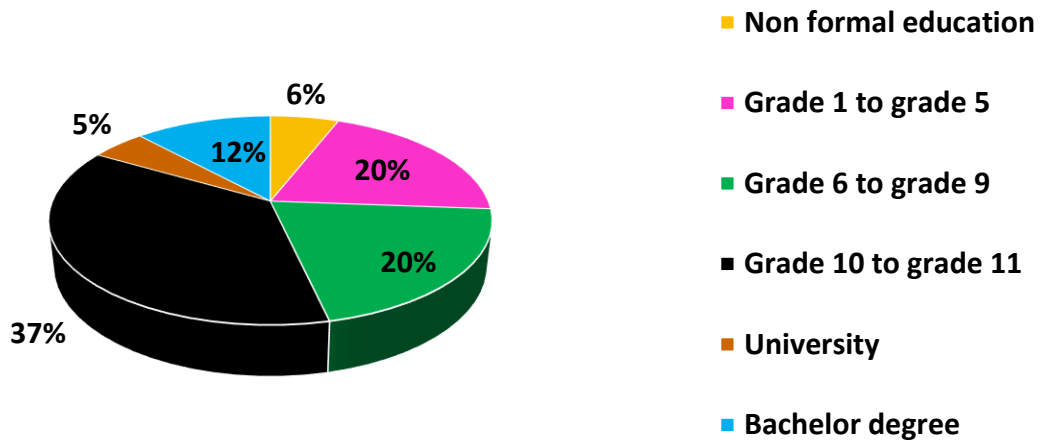
| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|--------------------------------|--|--|
| | | <p><i>Soap is available everywhere for a low cost..." (FGD 20)</i></p> <p><i>"...Two years ago, we had (diarrhoea) outbreaks where health staff come and taught us about the importance of good hygiene. But the villagers did not follow it..." (FGD 23)</i></p> <p><i>"...We drink water directly from the well..." (FGD 25)</i></p> <p><i>"...We gave water soon as after birth. This water comes directly from the well and we gave boiling water when child suffers from diarrhoea..." (FGD 19)</i></p> | <p>They said that clean water is boiled water or water treated with medicines. If they want to get clean water, they will boil the water and they said that this is the best.</p> <p>They are giving water to newborn babies and it is directly from the well. They only boil water for old people.</p> <p>They would boil water when the child suffers from diarrhoea.</p> <p>Some of the villages had outbreaks of diarrhoea two years ago, and health staff told them about the importance of hygiene. But some villagers did not follow their instructions.</p> <p>They drink water directly from the well or stream.</p> <p>They wash their hands regularly before eating and after defecation.</p> <p>They also use soap as it is available everywhere for a low cost.</p> <p>They said that the water sources and latrines are too far.</p> |
| Family planning (FP) and nutritional status | Magway Township group 2 (MTG2) | <p><i>"...if you do family planning, you can give enough food to your children..." (FGD 1)</i></p> <p><i>"...Family planning has no benefits at all. So, we (two mothers) stopped using it..." (FGD 3)</i></p> | <p>MTG2 have knowledge about some of the family planning methods and they are using some (mostly pills and injections). Some MTG2 also talk about the economic benefits, as many children are expensive to feed.</p> <p>In general, they believe that FP is not good for health as they have experienced weakness and tiredness. Some people claimed they stopped using FP for these reasons.</p> |

| Themes/coding Authorities (group 1) and Children Caregivers (group 2) | Township and Focus Groups | Quotes | Summary of the FGDs |
|---|---------------------------------|---|--|
| | | | Still many of the MTG2 wished to learn more about FP methods. |
| | Natmauk Township group 2 (NTG2) | <p><i>"...Family planning and good nutrition is inter-linked. Including economy- if you have many children, there will be poverty. But family planning methods are not good for health. Some mothers become thin or some becomes fat after using family planning methods..." (FGD 29)</i></p> <p><i>"...But family planning methods are not good for health. We suffer weakness and tiredness. This is not good for our children, we think..." (FGD 24)</i></p> | <p>The NTG2 were aware of family planning methods and some expressed economic benefits (having too many children can be hard on the family's economy).</p> <p>At the same time, many of the NTG2 expressed that they feel weak and tired after family planning methods, and they did not see the benefit for them or for the children.</p> |

Annex 2: Demographic in Magway and Natmauk Townships

Village authorities (Magway)

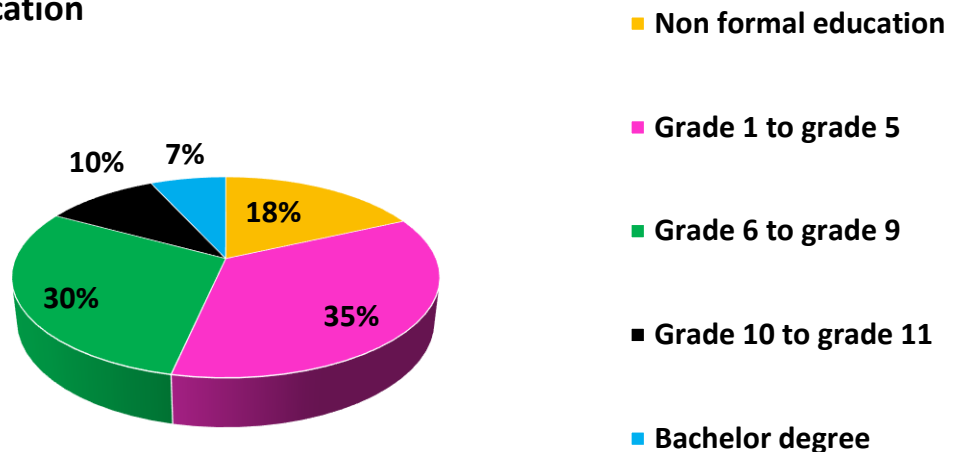
Level of education



The Majority (37%) of the authorities attended grade 10 to 11. (6%) of authorities got non-formal education. Few of them (5%) attended university level education. (12%) of the authorities are bachelor degree holders.

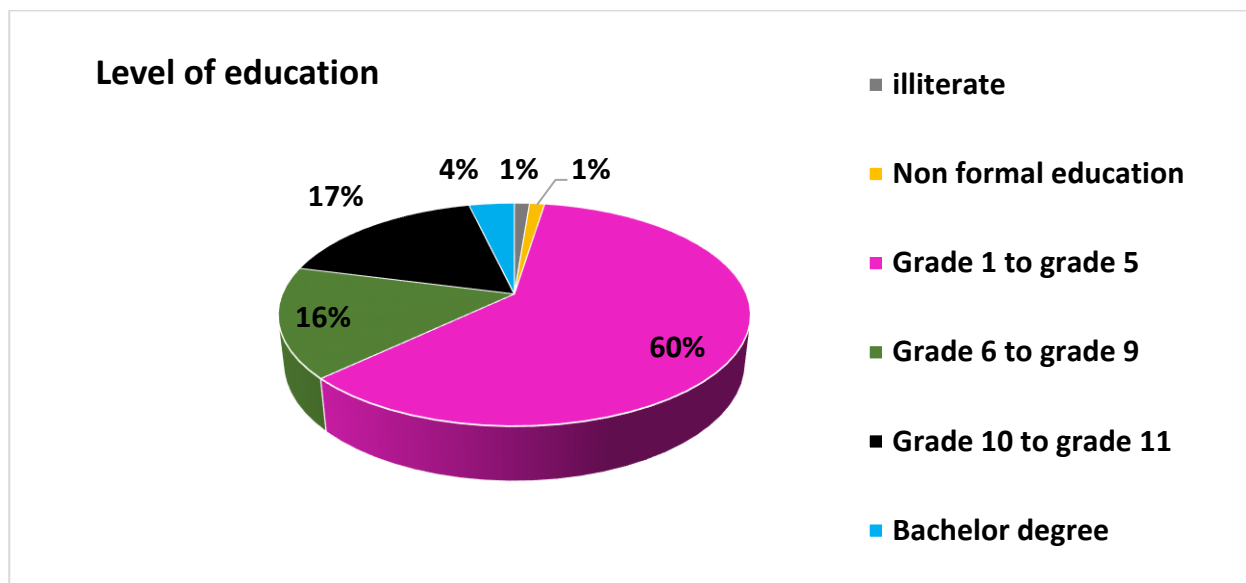
Village authorities (Natmauk)

Level of education



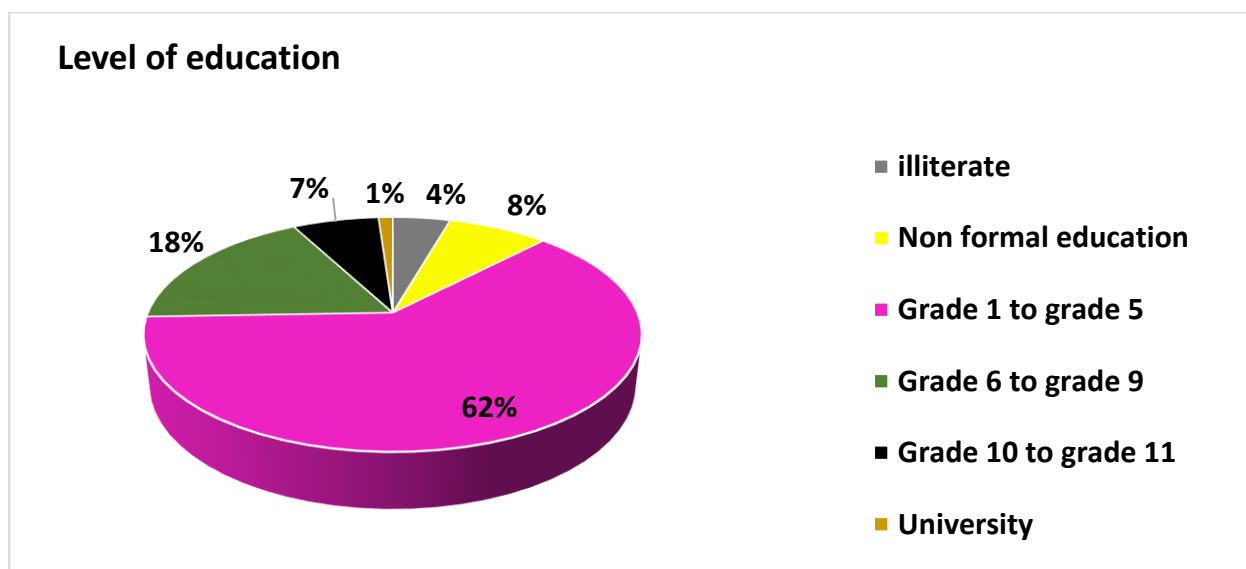
Most of the authorities (35%) completed grade 1 to grade 5. (18%) of authorities received non-formal education. (7%) of the authorities are bachelor degree holders.

Care givers (Magway)



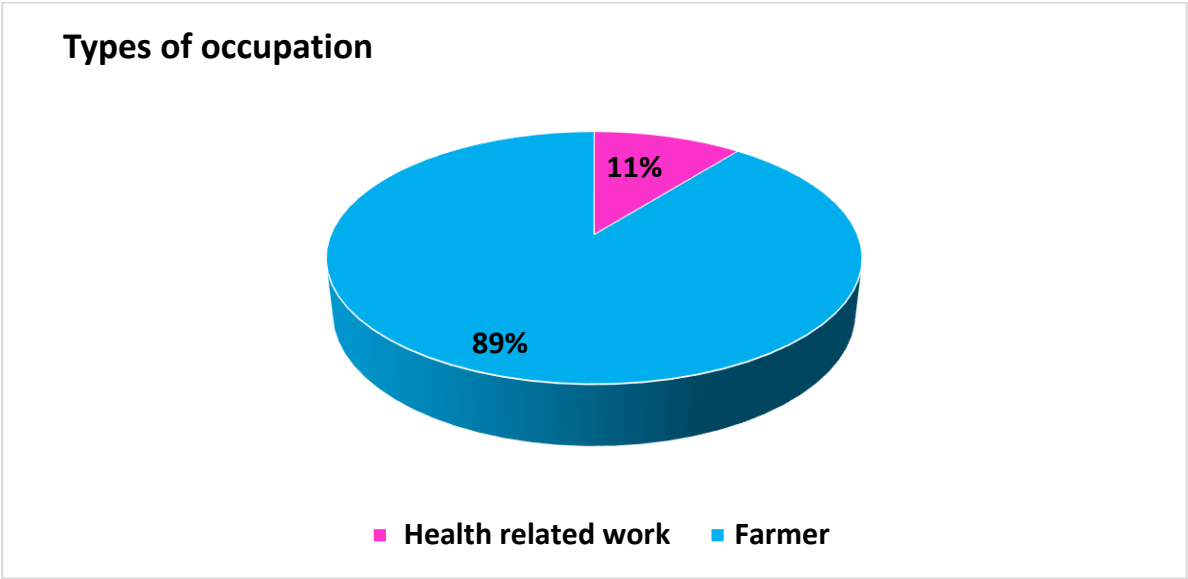
The Majority (60%) are grade 1 to grade 5 and (1%) of mothers received non-formal education. Illiteracy is only (1%).

Care givers (Natmauk)



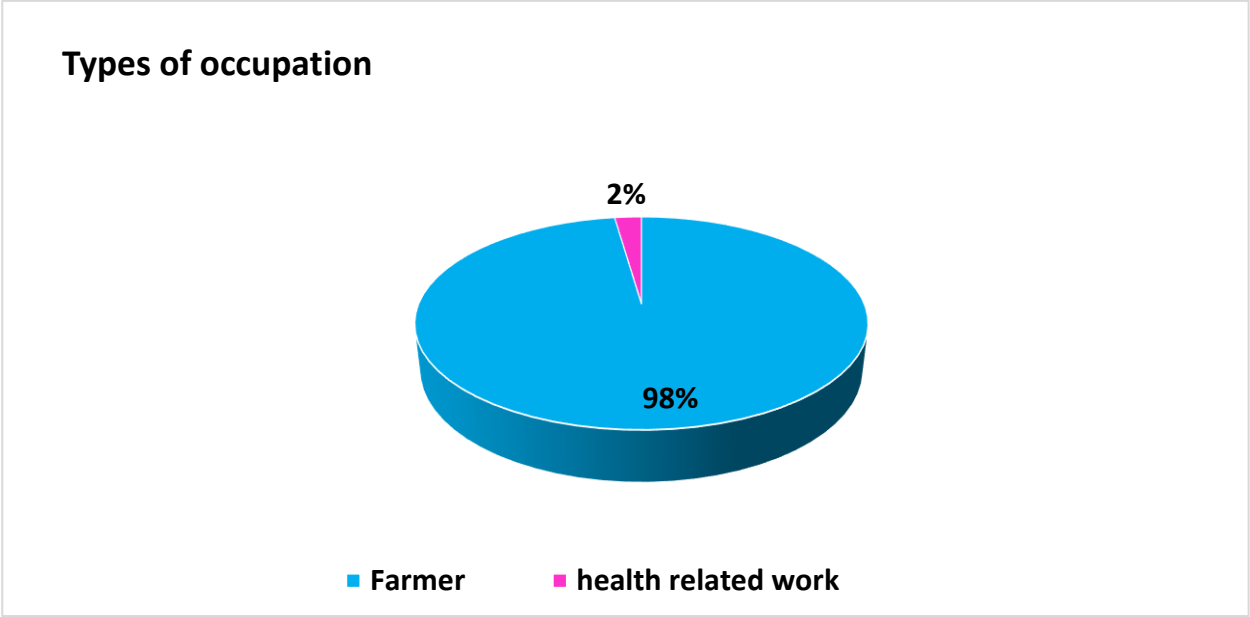
Majority (62%) of care givers reach only between grade 1 to grade 5 and (8%) of mothers got non-formal education. Illiteracy is the (4%).

Village authorities (Magway)



The Majority (89%) of the authorities are farmers. The rest (11%) have health related work.

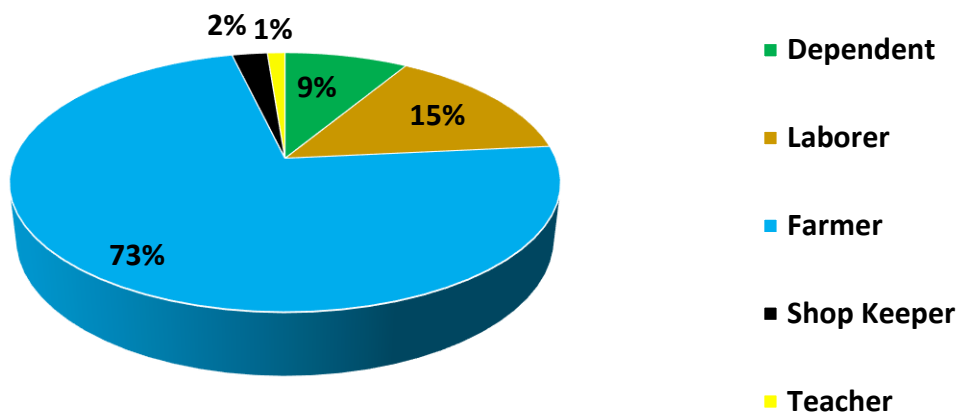
Village authorities (Natmauk)



Most of the authorities (98%) are farmers and the rest (2%) have health related work.

Care givers (Magway)

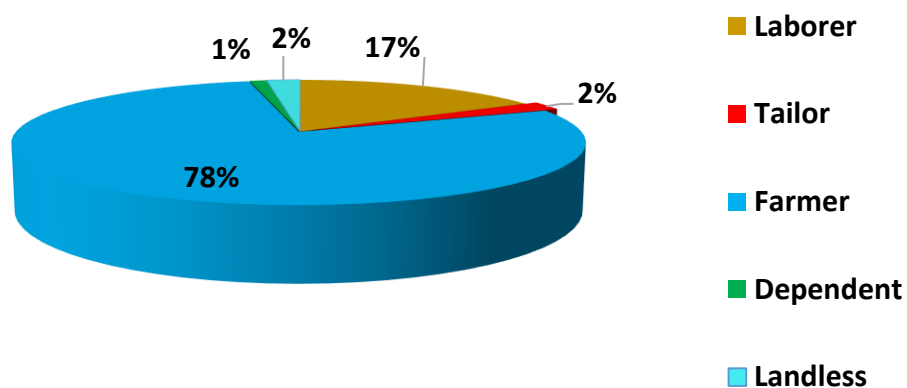
Types of occupation



The majority (73%) are farmers and (15%) are laborers.

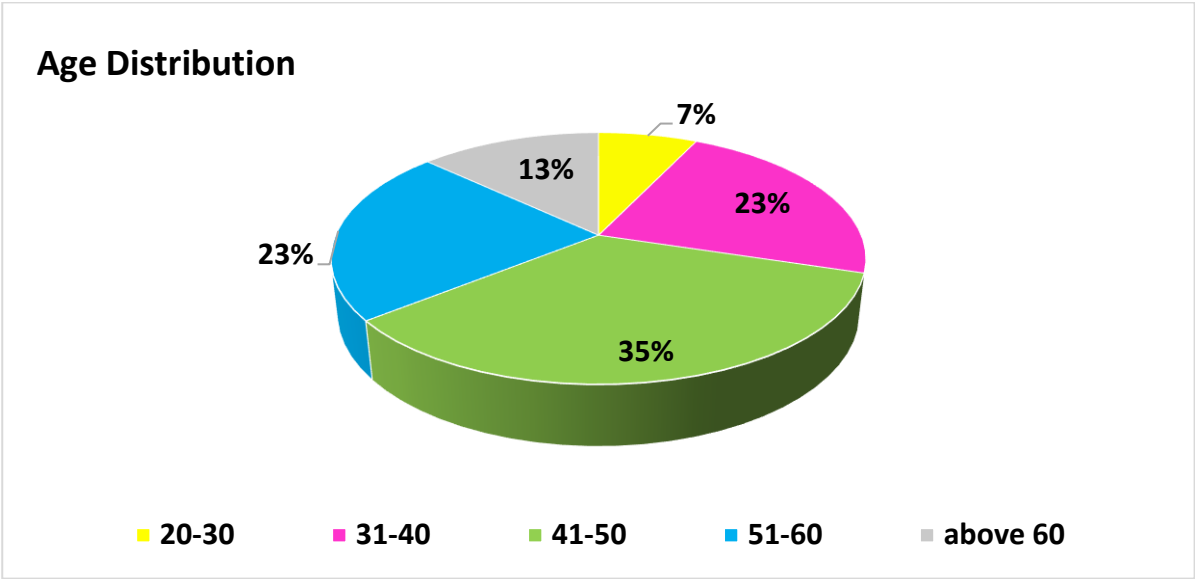
Care givers (Natmauk)

Types of occupation



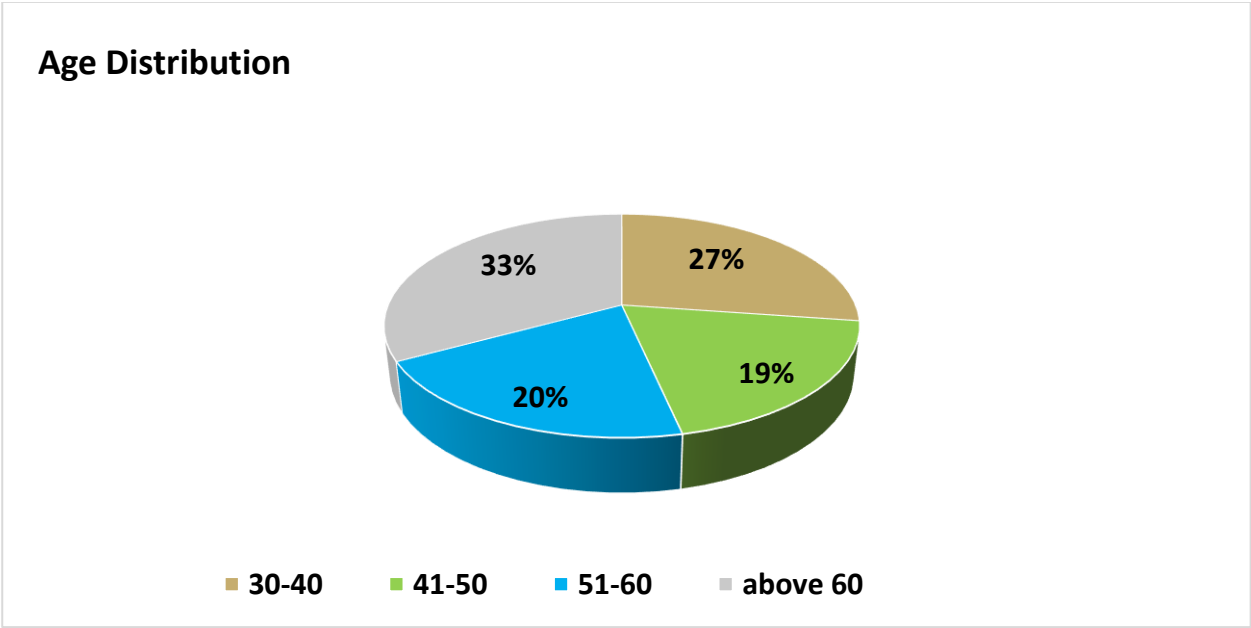
The Majority (78%) are farmers and (17%) are labourers.

Village authorities (Magway)



The Majority (35%) of the authorities are aged between 41-50. Few of them (7%) are 20-30.

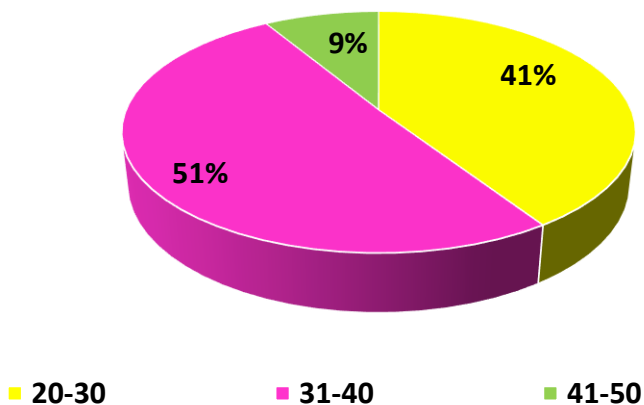
Village Authorities (Natmauk)



Most of the village authorities (33%) ages are above 60.

Care givers (Magway)

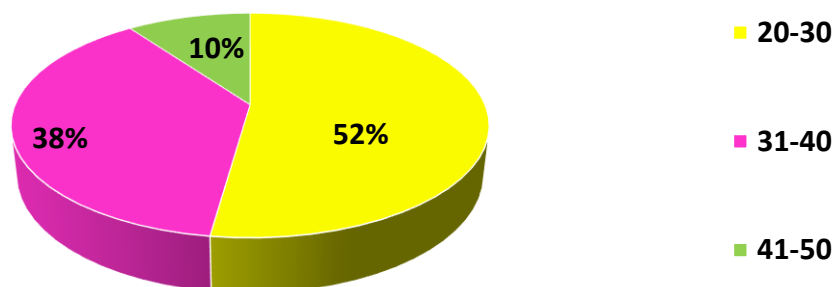
Age distribution



More than half (51%) are between the ages of 31-40 and the least (9%) ages are from 41-50.

Care givers (Natmauk)

Age distribution



More than half of the mothers (52%) are from the ages of 20-30.

Annex 3: Interview Guidelines for Group 1

Introduction and preliminary questions (group 1)

- What do you think about the topic – nutrition – that we have to discuss today?
- According to you, what are the reasons for under-nutrition?

1. Conditions of health information/awareness activities by health professionals

- How frequent did health professionals come and conduct health activities in your village?
- Are there any activities? What are they?

2. Interest in health information/awareness activities by health professionals

- Are villagers interested in listening about health issues? Why?
- Are there any events (campaign, video show, health talk, eye-catching etc.) that you found villagers willingly to attend in the past?
- Where would be a good place to conduct health information/awareness activity?
- Who will be the important persons to change the behaviour/attitude of the HH? - Why/how?

3. Illness/diseases in villages concerning nutrition, hygiene & immunization

- How about immunization status, care for hygiene and fly proof latrine status in your village?
Could you explain more?
- What kind of illness occurs mostly in village? Why this is happened?
- How does that effect the nutrition?
- How could we/you prevent these situations in the future?

4. Food security of the House Hold (HH)

- When and how can nutritional status of HH be in danger? (Like disaster, outbreak, economic crisis...)
- Do you think most of HH in your village get sufficient nutrition? Why?
- Who will be the most vulnerable in HH when there is limited food? Why?

5. Perception about responsibilities for risk and consequences

- Does your village have risks for under-nutrition? – How and why?

- What could be the health consequences of under-nutrition?
- According to you, who should take the responsibility for protecting the children from under-nutrition? *Please explain.*

6. Suggestions for nutritional program

- What would you like to suggest to improve the nutritional status of villagers and to be free of any complications of under nutrition?
- What could be the role of villagers?
- What could be the role of government & organizations (us)?

7. Barriers

- What could make it difficult to perform these suggested activities to prevent under-nutrition?
- How can we overcome?

8. Let's summarize some of the key points from our discussion. Is there anything else to add?

9. Do you have any questions?

Thank you for taking time to talk to us!!

Annex 4: Interview Guidelines for Group 2

Introduction and Preliminary questions (group 2)

- What do you think about the topic – nutrition – that we have to discuss today?
- In this community, who makes the decisions about food preparation of the children in family?

1. Conditions of health information/awareness activities by health professionals

- How frequent did health professionals come and conduct health activities on nutrition in your village?
- Are there any activities? What are they?

2. Interest in health information/awareness activities by health professionals

- How many people came and listened about health information? Why?
- Are there any events (campaign, video show, health talk, eye-catching etc.) that you found villagers willingly to come in the past? Why?
- Could you please kindly share the health education information that you heard in the past? Among them, are there any information that you found unclear in the past? And what would you like to hear more? (Immunization, hygiene, food preparation...)
- Where would be a good place to conduct health information/awareness activity?
- Who will be the important persons to change the behaviour/attitude of the HH? - Why/how?

3. Knowledge about breast feeding and early feeding for children

- Do mothers in this village usually breastfeed – For how long? Why? Or why not?
- Do mothers use artificial breast-feeding in children? Why? Or why not?
- Do mothers in this village usually give the first milk - colostrum to the new born child? Why? Or why not?
- When should children start consuming food other than breast milk? Why?
- When will mothers start to give drinking water to their child in your village? Why?
- Have you heard about the first 1000 days of child nutrition? And what does that mean?

- How is the daily life of pregnant women and mothers?

4. Knowledge and practices about family nutrition

- How many main food groups are there to achieve good nutrition?
- Do you usually eat green leafy vegetables? How frequently per week? Why?
- What did you eat for breakfast and lunch today? Can you recall what curries were in yesterday's dinner?
- How many times per week do villagers eat meat/eggs? Why?
- Have you heard of under-nutrition? - What does it mean?
- Why do you think some of the children and pregnant mothers suffer from under-nutrition?
- What can happen to them after under-nutrition?

5. Outbreak and nutritional status.

- When and how can the nutritional status of HH be disturbed?
- What kind of illness occurs mostly in villages?
- Why did it happen?
- Do you know which diseases there are in rain, summer and winter seasons?

6. Knowledge about hygiene and diarrhoea

- What are the reasons that can cause diarrhoea?
- What can happen after diarrhoea?
- Where will you usually go if your children suffer from diarrhoea? Why?
- How would you take care of children with diarrhoea?
- What do you understand by "safe water" & "unsafe water"?
- Which diseases can you get from unsafe water?
- What can you do if you want to transform unsafe water to safe water?
- When do you usually wash your hands?
- What do you use to wash your hands?
- Where do you usually go for urination & defecation?

- How far is the latrines and water sources in your HH?

7. Family planning and nutritional status

- What is family planning?
- What is the role of family planning for better nutrition of the children?

8. Suggestions for nutrition program

- What would you like to suggest to our organization to do to improve the nutritional status of villagers?
- What could be the role of villagers?

9. Let's summarize some of the key points from our discussion. Is there anything else that you would like to add?

10. Do you have any questions?

Thank you so much to everyone who took the time to talk to us!!