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FORMATIVE RESEARCH REPORT

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Agreement Officer's Representative

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SUAAHARA

Building Strong & Smart Families

Save the Children · Helen Keller International · Jhpiego, an affiliate of Johns Hopkins University · Johns Hopkins Bloomberg School of Public Health · Center for Communication Programs · Nepali Technical Assistance Group (NTAG)

Executive Summary

Suaahara is a 5 year, USAID-funded project designed to improve the nutrition of women and children living in Nepal. Suaahara tackles undernutrition by examining the variety of factors that contribute to poor nutritional status including poor dietary intake and poor health status. Healthy timing and spacing of pregnancies is also an important part of the project given Suaahara's mandate to reduce stunting among children and anemia and chronic energy deficiency among women. The purpose of this formative research was to describe infant and young child feeding practices, caregiving practices and hygiene behaviors in 6 of the 20 districts in Nepal where Suaahara works. Researchers also identified determinants of those behaviors. Additionally, they identified families' aspirations for their children. This report describes what we learned and how we will apply this learning to improve the nutritional status of women and children.

This study took place in mountainous districts (Bajura, Manang, Rasuwa and Taplejung), the hills (Syangja) and the Terai (Rupandehi). In this study, we used four methods of data collection: 1) focus groups with mothers, fathers and mothers-in-law 2) in-depth interviews with traditional healers, community health workers, model farmers and government officials 3) participant observations of public places and markets, and 4) perceptual mapping, a qualitative technique which measures the factors that individuals use in decision making. As part of this research, in each of six districts we conducted focus groups with mothers, one focus group with fathers and one focus group with mothers-in-law. Per district we conducted in-depth interviews as follows: two with FCHVs, two with health care providers, two with traditional healers, one with village model farmers and one with a local government official. We also conducted 72 hours of participant observation in each of the six districts. Per district, perceptual mapping included 30 mothers, two fathers and 10 mothers-in-law.

A full listing of current practices, barriers, target audiences and behavior change strategies appears at the end of this report and constitutes core recommendations and ways forward. While the focus is on priority behaviors, when delivering interventions, multiple integrated messages related to family planning, maternal and child health, antenatal care, postnatal care, WASH, ENA, agriculture and health services promotion will be provided; not simply the messages for the five priority behaviors.

Summary findings appear below:

Optimal behaviors Suaahara will promote are **initiating breastfeeding immediately after birth or in the first hour of life and avoiding giving the newborn anything except breastmilk in the first few days of life.** Findings from this research show that initiation of breastfeeding is delayed, colostrum is sometimes discarded and prelacteal feeds are common. Barriers include lack of information about the importance of these behaviors. Suaahara will use community mobilization, GALIDRAA,[1] action cards, peer education and radio to reinforce early and exclusive breastfeeding to negotiate for behavior change.

Exclusive breastfeeding means giving only breastmilk to the infant and no other foods or liquids for the first six months of life. Mothers do not feed frequently enough and they introduce other substances before six months of age. Barriers include mothers' perception that they cannot produce

[1] Greets, Asks, Listens, Identifies problems, Discusses, Recommends, Agrees to act, Appointment

enough breastmilk, little or no counseling/lactation management, little support from fathers and mothers-in-law and work outside the household. Suaahara will implement Trials of Improved Practices to identify actions families can take to breastfeed on demand, reduce mothers' workloads and get them nutritious foods. We will use GALIDRAA, action cards, support groups and peer educators to support women. Health workers, medical shop keepers and traditional healers will receive training in counseling.

Problems with **appropriate and timely complementary feeding** include infrequent and premature introduction of thin, watery foods and the use of animal milk. Unhealthy market foods are given to the child and only a few types of healthy foods are provided (rarely eggs and meat). Community mobilization strategies Suaahara will implement include Village Model Farmers to teach families how to grow diverse foods, including chickens, ducks, goats and pigs and positive deviance to show that young children are able to eat and digest eggs and small bits of meat. Suaahara will use interpersonal contact to provide information and improve caregivers' understanding of complementary feeding. We will also collect local recipes for foods that are nutritious and tasty. We will use GALIDRAA to commit families to giving meat and eggs, green leafy vegetables and orange fleshed foods. Support groups will help fathers and mothers-in-law purchase then feed meat and eggs. Radio will provide information to counter beliefs about feeding and to establish optimal complementary feeding as the norm. Radio will also be used to give fathers and mothers-in-law the information they need to feed animal source foods to children.

Mothers should be fed one extra meal during pregnancy and two extra meals during breastfeeding. Mothers receive less food than others. Special or additional foods are not given to pregnant mothers though new mothers are given animal source foods. Food choices are informed by perceptions of "hot" and "cold." "Hot" and "cold" do not refer to temperature of the food but rather "imbalance"—too many "hot" or "cold" foods are perceived to cause imbalance and sickness. VMFs will encourage production of diverse foods. Counseling plus action cards will reinforce eating more diverse foods. One-on-one counseling and groups will be used to encourage giving eggs and meat. Radio will enforce each of these messages and will highlight individuals who have already done so.

With respect to **appropriate and timely care seeking for antenatal care, delivery and post-natal care,** women go to health posts for antenatal care (ANC) but many deliver at home and rarely go for post-natal care (PNC) because of inadequate facilities, shame, work load and lack of knowledge about services. Suaahara will promote PNC during celebrations. We will use TIPS to help mothers seek ANC, PNC and health services for delivery. We will negotiate greater sharing of workload between mothers, husbands and in-laws. We will strengthen the IPC skills of health care providers, medical shop keepers and others.

Families should **feed the child as much or more foods and liquids during illness and for two weeks thereafter,** but parents feed children less. Barriers include lack of time and lack of information about providing extra, nutritious food during and after illness. In counseling, field staff and health workers will emphasize the "stickiness" of healthy foods and the need to make dal thicker. Positive deviants will be highlighted. Medical shop keepers and traditional healers will be given information about feeding the sick child and radio will showcase families that practice these behaviors. **Families should eliminate open defecation. They should wash their hands at critical points.** In our

study, handwashing was not practiced regularly. Children played on unclean surfaces such as on dirt floors. Family members were apathetic toward cleanliness and felt that soap was expensive. Suaahara will mobilize communities through school handwashing programs, building coops and mats and CLTS/ODF. We will use GALIDRAA to negotiate reduced workloads for women and support groups that demonstrate proper hygiene and provide individuals the opportunity to practice handwashing over and over again. In-service training of health workers, medical shop keepers and traditional healers will help them demonstrate handwashing when families seek healthcare. Radio will convey messages about the importance of handwashing and that laundry soap can be used for handwashing.

Families should space births at least three years apart. Couples mentioned injection methods frequently but oral contraceptives and condoms were mentioned only occasionally. Barriers include shyness with health care providers and lack of men's involvement in family planning. Health care providers were unaware of the methods their clients—and in particular, dalits—used. Suaahara will use action cards to help families address barriers to using family planning. Groups will build the confidence of mothers and husbands about speaking to health care providers. Radio will focus on building confidence to negotiate the use of family planning.

Background

Suaahara is the largest single-country nutrition program in the developing world—and one of the few that tackles poor nutrition in an integrated fashion. *Suaahara* is funded by USAID and works hand-in-hand with the Government of Nepal. *Suaahara* will make lasting improvements to nutrition in 20 of Nepal's 75 districts. It does so by working in an integrated fashion in four areas known to influence the nutrition of women and children: nutrition; agriculture; water, sanitation and hygiene; and health services promotion. Suaahara also works in social and behavior change communication (including community mobilization, interpersonal counseling and media); gender equity and social inclusion; and monitoring and evaluation). The project aims to reduce the following among children:

- Stunting
- Wasting
- Underweight
- Anemia

Suaahara will also reduce anemia and underweight among women.

The overall goal of *Suaahara* is to improve and sustain health and well-being through:

- Greater practice of optimal health and nutrition behaviors at the household and community level
- Increased use of quality nutrition and health services by women and children
- Increased production and consumption of diverse and nutritious foods by women and their families
- Strengthened coordination on nutrition between government and other stakeholders

Suaahara focuses on improving health and nutrition-related behaviors at the household level through promotion of Essential Nutrition Actions (ENA), particularly Infant and Young Child Feeding (IYCF), increased access to nutritious foods, improved quality of health care, better child spacing and greater equity for women and increased access to opportunities for marginalized groups, i.e., excluded castes and those who are poverty-stricken. The program assists the government in strengthening the

capacity of health workers and also incorporates Essential Hygiene Actions (EHA) into the project's ENA framework.

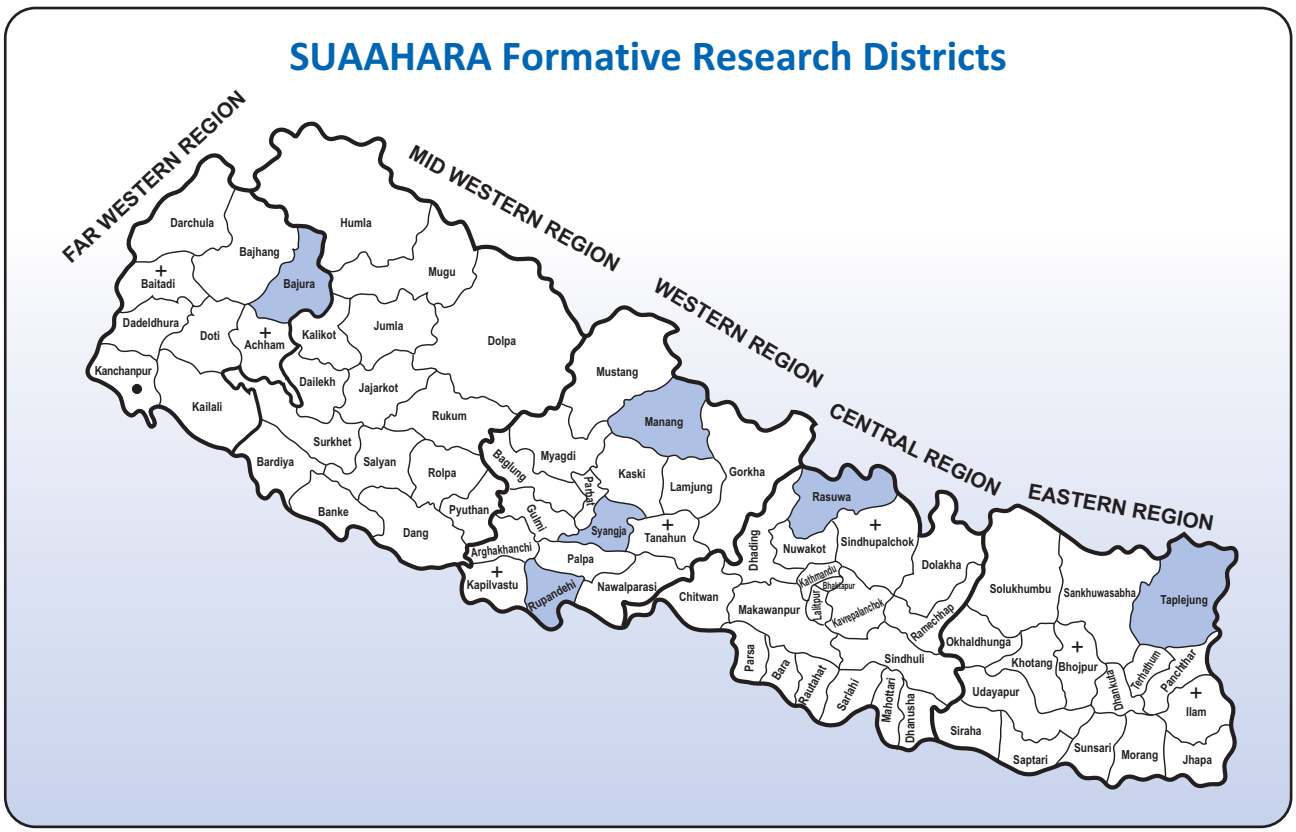
Objectives of the study

The purpose of the formative research was to describe infant and young child feeding practices, hygiene behaviors and caregiving practices as well as identify families' aspirations for their children in 6 of the 20 districts in Nepal where *Suaahara* works. Researchers also attempted to identify determinants of those behaviors. This report describes what we learned and how we will apply this learning to improve the nutritional status of women and children. These results have informed decisions about how best to appeal to families to encourage them to adopt new practices known to affect the nutritional status of women and children. These results have also been used to help *Suaahara* better understand the extent to which families practiced optimal infant and young child feeding behaviors as well as hygiene and other behaviors and, to the extent possible, focus behavior change strategies on the facilitators and barriers to engaging in these practices.

Topics covered include infant and young child feeding (early initiation of breastfeeding, avoiding prelacteals, exclusive breastfeeding, complementary feeding), maternal nutrition, maternal health, care giving (especially feeding the sick child), hygiene and sanitation, family planning and sources where individuals obtain information.

Sample, Research Methods and Limitations

This study took place in mountainous districts (Bajura, Manang, Rasuwa and Taplejung), the hills (Syangja) and the Terai (Rupandehi). Districts included in the formative research are shown below.



Research Methods and Sample

Four methods of data collection were used: 1) focus group discussions (FGD) with mothers, fathers and mothers-in-law 2) in-depth interviews (IDI) with traditional healers, community health workers, model farmers and government officials 3) participant observations of public places and markets, and 4) perceptual mapping, a qualitative technique which measures the factors that individuals use in decision making. All methodologies and tools were pre-tested in Tistung and Makwanpur and refinements were made and then piloted in Rasuwa. Informed consent was sought before any data collection was conducted and all conversations were in local languages and then translated into English.

Table 1: Methods and Sample

Method	Sample	Sample size
FGD	Mothers w/children less than one year of age	2/district (one marginalized and non marginalized)
	Fathers w/infants and young children	1/district
	MILS (grandmothers)	1/district
IDI	FCHV	2/district
	Health service providers	2/district
	Traditional healers	2/district
	Model farmers	1/district
	Local government official	1/district
72 hour participant observation	Community	1/district
Perceptual Mapping	Mothers	30/district
	Fathers	20/district
	MILS (grandmothers)	10/district

The study sites and samples were chosen purposefully to satisfy certain criteria, for example, the districts were chosen to be inclusive of the different regions of the country. Similarly, study sites within districts were chosen to maximize diversity of practices, perceptions and normative behaviors of residents. Participants were chosen to represent diverse views from both majority and minority cultures. Given the intent of research and methods, findings are meant to provide in-depth understanding about phenomena observed in each of the study sites rather than to be applied more broadly.

Findings

Early Initiation of Breastfeeding and Avoiding Pre-lacteals for Newborns

OPTIMAL BEHAVIORS: Initiate breastfeeding immediately or in the first hour of life and avoid giving the newborn anything except breastmilk in the first few days of life.

CURRENT PRACTICES

Breastfeeding begins anywhere from half an hour after delivery to three to five days later. Timing varies within and across districts. There is no fixed time for initiating breastfeeding. Mothers begin

breastfeeding depending on place of delivery, perceptions about whether their milk has "come in" and traditional beliefs about when to begin breastfeeding.

In previous generations, colostrum was discarded. However, across all districts, all types of respondents noted a change in the feeding of colostrum. Colostrum was considered to be nutritious and valuable and Female Community Health Volunteers (FCHV) and doctors advised mothers to give it.

Traditionally, the following prelacteals are given to newborns: local alcohol and ghee in mountainous regions and something sweet such as honey or honey mixed with mustard oil in the hills and Terai. There are differences in prelacteals by district: in Taplejung, Rasuwa and Manang, mothers and grandmothers give butter, ghee, local beer or some sweet substance such as honey prior to breastfeeding. In Bajura and Syangja, respondents insisted that prelacteals are not given. According to responses from FGDs with mothers in Rupandehi, giving food before initiating breastfeeding has declined compared to previous generations. Respondents believed that ghee and honey stimulate sucking by the child. Ghee was believed to be nutritious for babies and was thought to lubricate their throats.

BARRIERS
New mothers were generally not aware of the importance of beginning breastfeeding immediately after delivery.

OPPORTUNITIES
While mothers were not aware of the importance of beginning breastfeeding immediately after delivery, they were knowledgeable about the importance of colostrum and breastfeeding exclusively.

Exclusive Breastfeeding

OPTIMAL BEHAVIOR: Give only breastmilk to the infant and no other foods or liquids for the first six months of life.

CURRENT PRACTICES
The duration of each breastfeeding session ranged from 5-30 minutes. Babies were breastfed anywhere from two to six times a day, with exceptional cases of 15-20 times a day. Breastfeeding frequency decreased after six months when most babies started eating complementary food.

Frequently, mothers reported breastfeeding less and introducing other foods and liquids before the child was six months old.

During warmer months, babies were fed water to satisfy their thirst.

Mothers generally breastfed on demand.

BARRIERS
The frequency and length of breastfeeding depended on how mothers understood babies' signals to be fed including cries, burps and urination. Mothers said they fed babies from both breasts as

long as possible. When the breast got 'painful,' babies were transferred to the other breast. When mothers returned to work outside the household, frequency of breastfeeding dropped to two to three times a day.

In Manang and Rasuwa, there was a belief that breastmilk was only sufficient up to 3 months of age. In these two districts, mothers breastfed until three months of age with solids introduced immediately thereafter.

There was a widespread perception and fear among mothers that they were not able to produce enough milk for their babies. In particular, mothers were concerned about having to work too much without sufficient nutrition or liquid intake. They were also worried about whether the child would latch on to the breast.

Counseling and lactation management were generally absent.

Other mothers and mothers-in-law were the primary source of information on breastfeeding. This may perpetuate certain myths about breastfeeding (including the belief that mothers are not producing enough milk).

There is also a widespread belief that after about three or four months, infants need other types of foods (in addition to breast milk).

Other barriers to exclusive breastfeeding included 1) the perception that after the first few months, breastmilk alone was not enough for the baby and that ghee, *litto*, *khole*, Horlicks biscuits ought to be given to complement breastmilk 2) mothers' work outside the household which prevents them from breastfeeding during the day, and 3) lack of support from fathers and mothers-in-law.

Some families in the Terai fed water or other fluids to babies before six months of age because they worried that the baby would be thirsty due to warm weather.

OPPORTUNITIES

Awareness that newborns and infants should be breastfed exclusively for the first six months after birth existed across all districts.

Mothers were positive about the benefits of breastfeeding their children.

Mothers-in-law, sisters-in-law and husbands can enable breastfeeding by taking a few key actions such as ensuring that mothers work less, get rest and eat additional nutritious foods.

FCHVs and other volunteers in the community are trusted sources of information and can provide critical advice.

In some cases, grandmothers took babies to the field or wherever the mother was working so that babies could be breastfed.

Complementary Feeding

This section is organized around the essential elements of complementary feeding, often referred to as FATVAH: **Frequency** of feeding, **Amount** of food, **Texture**, **Variety**, **Active** (responsive) feeding and **Hygiene**. Hygiene is addressed in another section.

BEHAVIORS

Frequency

Caregivers rarely gave complementary foods frequently enough.

Girls and boys began eating complementary foods at five months and six months, respectively.

Amount

Parents felt that giving young children lots of foods—even if foods were nutritionally inferior—was enough to keep children well-nourished.

Texture

The consistency of food given to young children was often very thin and watery.

Variety

About the time mothers began breastfeeding less, mothers and other caretakers began giving children cow's milk and buffalo milk instead or, in some cases, they prepared powdered milk. Likewise, mothers gave babies foods in addition to breastmilk when they thought breastmilk was not enough and when they thought infants were capable of swallowing solid food.

Mothers and grandmothers all described *litto* and *jaulo* as the primary complementary foods they gave infants and young children.

Many also said they gave babies foods they could buy in the market.

There was a lack of diversity in the foods parents gave their children. In particular, children rarely received animal source foods. Meat, fish and egg consumption was most commonly reported in Rupandehi. In Bajura, parents felt that children's capacity for digesting meat and eggs was limited.

Very young children were not usually offered meat and other animal source foods such as eggs because of concerns that they could not digest them and eating animal source foods could result in illness.

In Syangja, mothers said they started giving eggs and meat when infants were eight to nine months old when mothers felt their babies could digest them. In Bajura, respondents reported that meat and fish were not given until babies could grow teeth. In Taplejung, some mothers said that they did not give young children eggs because they believed eggs would make children sick. When meat was given, it was usually in soup.

Active

Children were often left to their own devices when mothers worked outside the home. To stop babies from crying or to attract babies' attention, mothers often provided biscuits or instant noodles.

BARRIERS

Frequency

Most families gave complementary foods three times a day (range: two to five times/day). There was no mention of increased frequency of feeding as young children grew older.

People thought of complementary food as the food given to babies when breastfeeding was not enough. Complementary food was given to satisfy babies' hunger and to make babies strong.

Numerous respondents felt that if they ate a lot of food frequently even if that food was not regarded as nutritious, they would be well nourished.

Rice feeding ceremonies (known as *posni*) reinforced the premature introduction of complementary foods for girls (but not boys). The exception was Bajura where respondents reported that both girls and boys were fed at 6 months of age.

Amount

Families thought that the quantity of foods consumed was at least as important as their quality.

Texture

People did not actively look for new ways to prepare food in forms that babies could eat. Vegetables can be steamed or boiled and mashed so that children can swallow them, but this was not mentioned in any of the interviews and discussions.

Variety

We found that even though families knew that vitamins were important, they did not know how to determine whether products actually had vitamins. Consequently, babies were missing out on certain items they needed to grow such as animal source foods and green leafy vegetables. A list of foods commonly given in each of the 6 districts as well as foods regarded as nutritious is available upon request.

People equated vitamins with nutrition. During FGDs, respondents used these terms interchangeably.

Overtly, families were less concerned about the nutritional value of food they gave family members and more interested in consuming foods that were tasty—even if such foods were not healthy.

'Hard' foods were thought to be difficult for babies to swallow. Foods classified as very 'cold' or very "hot" were thought to cause a variety of health problems. Foods considered hard to digest and sour food items were also avoided.

Mothers preferred to feed children market items, especially biscuits and instant noodles, because they were 'tasty' and were advertised as 'having vitamins.' Fruits were often difficult to find in the markets and many people perceived fruit as something city residents consume.

Meat was available but too costly for most families. In Rasuwa, boys were given priority over girls when feeding eggs.

Fathers emphasized animal source food such as eggs and meat more than mothers did. In Manang, fathers mentioned that mothers wanted to feed meat to their children.

During participant observation, researchers noted that some households ate one type of food continuously until it was no longer available. They then moved on to other types of foods. There was little evidence that families ate more diverse foods at any point in the year.

Many nutritious grains such as barley, millet and maize were being replaced by nutritionally inferior white rice—especially in the hills and mountains. Respondents sometimes mentioned that a shift toward a rice-based diet was considered 'progressive.' Likewise, foods that previous generation consumed such as millet and nettles were thought to be inferior to what is eaten now, and in particular, rice and pulses.

Many people thought food sold in the market was better than what they can produce at home.

Active

Whether a child ate what the mother offered and how much the child ate depended on the interaction between the mother and the child while feeding. Based on participant observation, it was clear that mothers were too busy to bond with their children.

Mothers-in-law and fathers purchased most foods. Mothers were responsible for cooking and feeding.

OPPORTUNITIES

Frequency

It is important that communication interventions promote increased frequency of feeding over the months as babies grow older.

Amount

Did not emerge as a theme.

Texture

Communications with families should promote making food thicker. This will be a priority in year 3 of *Suaahara*.

Variety

Given that lack of time and inconvenience were frequently cited as barriers to preparing healthy foods, recipes that are easy and quick to prepare are more likely to be adopted and should be

promoted—both through media and during community mobilization and interpersonal counseling.

Roads have increased community members' access to markets where powdered milk, noodles, biscuits and chocolates are abundant. However, some healthy foods—including meat, eggs and milk—are also available.

During interpersonal counseling, taste should be a major emphasis. The nutritional qualities of foods should also be emphasized but behavior change is most likely to occur when outreach workers appeal to families' desires to eat tasty foods. Likewise, mass media should emphasize taste.

Once caretakers felt that children could digest meat, mothers described animal source foods as something that they aspired to feed them. This provides an opportunity to encourage mothers and fathers (especially because fathers ultimately influence the foods purchased) to give small bits of meat to children at earlier ages. Household visits, support groups and radio should be used to encourage giving animal source foods. More specifically, when outreach workers negotiate improved complementary feeding, they should appeal to families' desire to feed children meat. Outreach workers should also negotiate for the introduction of softened meats shortly after 6 months of age rather than 24 months of age which is when most children begin receiving meat.

Increasingly, many communities are cultivating new types of vegetables. These should be encouraged through *Suaahara's* Village Model Farming program, during household visits and through community mobilization. In particular, outreach workers should encourage families to grow green leafy vegetables, orange-fleshed foods and other colorful crops so that they are available to women and children.

People were generally open to eating foods that were new or not commonly eaten—especially if they thought that they were beneficial for mothers and children.

Families were particularly interested in consuming tasty, nutritious foods such as fruits, milk, meat, ghee, eggs, beans and rice. People's desire for home-cooked tasty foods provides an opportunity to encourage families to try new recipes.

While mothers-in-law, neighbors and FCHVs maintained harmful beliefs about complementary feeding (for example, that eggs should not be fed to babies before one year because they are difficult for the child to digest), they also had great knowledge about traditional, healthier complementary foods. Their wisdom should be highlighted in home visits and group discussions. They could also be spotlighted in radio programs.

Active

Mothers-in-law often took care of infants and young children when mothers were at work. This provides an opportunity to help mothers-in-law feed responsively. As such, behavior change strategies should help *all* caregivers learn about what needs to be fed and how. Interpersonal counseling should also help mothers-in-law practice new responsive feeding behaviors.

Maternal Nutrition

OPTIMAL BEHAVIOR (Pregnancy): Feed one extra meal during pregnancy.

CURRENT PRACTICES

Mothers normally eat last and as such often receive less food than other family members.

Special or additional food is normally not prepared for pregnant mothers.

Choice of foods consumed during pregnancy is based in part upon perception of "hot" or "cold" qualities with "hot" foods largely avoided during pregnancy (some "cold" foods are also avoided).

BARRIERS

Feeding practices during pregnancy, often dependent on household income.

Pregnant women are not viewed as a top priority.

Restrictions on food eaten during pregnancy and after delivery were described in all regions.

Reasons given by women and traditional healers for avoiding certain foods included concerns that prohibited food items could lead to miscarriage, birth defects and weakness, as well as the common cold and pneumonia.

OPPORTUNITIES

People are aware of the need for nutritious foods during pregnancy, and they have positive attitudes toward such foods, but discrepancies exist when it comes to actual practices. Though many agree that foods consumed during pregnancy tend to be the same ones eaten at other times, there are a few items that are added or removed from the list of every day foods. People generally agree that the quantity of food should increase and that foods should contain 'vitamins'. Items frequently described as containing vitamins included yellow fruits, milk, meat, ghee, egg and beans.

The list of 'cold food' and 'hot food' in a particular community, the reason behind those categorizations, age-specific food texture, and the implication of such categorization on feeding practices will be taken into close consideration when developing strategies to influence changes in feeding practices. Activities should focus on suggesting healthy foods and recipes as well as ideas for storing nutritious and locally available "hot" and 'cold' foods such that whatever the season, mothers and children have continuous access to nutritious foods.

In general, animal source foods are considered nutritious, and are described as necessary for mothers immediately after delivery. The idea of providing animal source foods to women after delivery was common in all of the districts.

Though animal source foods were discussed widely in the case of post-delivery feeding, it was less evident in discussions about what was needed for pregnant women.

OPTIMAL BEHAVIOR (Post-Pregnancy): Give mothers two extra meals during breastfeeding.

CURRENT PRACTICES

Families prioritize giving women special foods after delivery more than they do during pregnancy.

Family members, especially husbands, make preparations for post-delivery feeding. Providing new mothers with animal source food during the post-delivery period is a common tradition.

The most common animal source foods given after delivery are chicken, soup, milk and ghee.

Chicken and ghee tend to be eaten with rice.

Feeding practices during the post-delivery period are influenced by what is deemed useful for increasing breast milk production so that the child can be fed adequately.

In mountain regions, local beer ('*jaand*) is thought to increase breast milk production. In some of the communities, families start preparing local beer after six months of pregnancy so that it is ready for mothers after delivery. In addition to local beer, cow's milk and ghee are also thought to help mothers produce more breast milk.

Feeding practices depend on people's perception of whether food items are "cold', "hot" or "neutral'. Many respondents said that lactating mothers should avoid green vegetables and pumpkin because
these are considered "cold food' and may cause illness for the nursing child.

BARRIERS

Provision of special or additional food after delivery usually lasts a couple of days or weeks.

Caste-related food restrictions prevent women from including some animal source foods in their diet (Brahmin and Chhetri).

Lack of local meat shops requires slaughtering a whole animal (goat) which is too expensive.

OPPORTUNITIES

Respondents described three main reasons for feeding women special foods after delivery. The first is to promote recovery of the mother's health. The second is to nourish babies and help them grow strong through food consumed by mothers. Many people felt that mothers' diet after pregnancy greatly affected children's health, disease and immunity. The third reason to give special foods is to promote adequate breastmilk production.

There is a common understanding that mothers should be careful about their own feeding practices after birth so that they do not adversely affect their children's health.

Antenatal and Post-natal Care

OPTIMAL BEHAVIORS: Appropriate and timely care seeking for antenatal care (ANC; four+ visits), delivery and post-natal care (PNC).

CURRENT PRACTICES

Many women visited health posts regularly and demanded high quality health services from the government.

Many mothers received ANC but mothers, fathers and mothers-in-law did not mention anything about going to a health facility for PNC. During focus groups, when asked specifically about PNC, mothers responded that they went to health facilities for immunization and for micro-nutrient supplements.

Respondents indicated that most deliveries still took place at home and that families usually only took women to an institution for delivery if there was a problem.

BARRIERS

Lack of adequate facilities and lack of medicines were described as reasons for not seeking care at health posts. Women often expressed feeling shy about going to the health post. Moreover, they were sometimes made to feel ashamed. Other barriers to accessing ANC were illiteracy and being too busy with work.

People expressed lots of different opinions about the behavior of health care providers at health posts and hospitals. In some communities, their experiences were quite negative. Some mothers said they were not treated well and were sometimes scolded for asking questions. Mothers explained that the way mothers and other family members dressed often determined how they were treated in health posts and in hospitals. Some fathers were concerned about physical exploitation of their wives by clinical staff.

The most frequently cited reasons for delivering at home (a common occurrence) were:

- Health workers and other health center staff treated mothers poorly which made mothers feel uncomfortable; consequently, mothers preferred to deliver at home
- When mothers felt pregnancy was 'simple,' they saw going to the health post as unnecessary
- In some cases, women viewed pregnancy as a 'natural process' that does not require the use of health services
- Some mothers did not know about the services provided at health centers and how services could address risks during pregnancy
- Delivering at some health facilities was perceived as no better than home delivery. Mothers cited the absence of skilled health workers and the lack of equipment at health centers as reasons for delivering at home
- Distance to health facilities had a large impact on families' decisions about where to deliver. In focus group discussions conducted in urban or semi-urban areas where health facilities were close by, mothers reported that many deliveries occurred in health facilities

- In Bajura, incentives provided by the health facility (for example, transportation allowance), motivated mothers to deliver in health facilities. However, this did not come up in discussions in the 5 other districts

OPPORTUNITIES
Pregnant women reported that they normally visited health facilities with their mothers-in-law, husbands, sisters, neighbors and friends. Since one of the main barriers to getting ANC is shyness, it is important that husbands accompany wives for ANC visits.

If a pregnant woman went for a first ANC visit, she was more likely to seek additional ANC. In focus group discussions, mothers in all districts reported that during pregnancy, mothers usually visited health facilities three to four times.

Though home deliveries still occur, people were generally positive about delivering in health centers. Respondents reported that the current generation is much more likely to deliver in hospitals and health facilities than previous generations.

Respondents in many communities described local networks for arranging support for home-based deliveries. Normally, people invited local midwives or neighbors who were experienced at helping mothers deliver. Often, FCHVs assisted in delivery. If family members thought that the delivery might be difficult or complicated, they tended to take mothers to health facilities when labor pain began, and in some cases before labor started.

Many mothers felt that people who were 'modern' and 'educated' and lived in cities took women to health facilities for delivery. They were also positive toward such practices.

In some areas such as Manang, there is a tradition of sending expectant mothers to their maternal home for delivery. This provided an increased level of comfort for the mother.

Feeding During Illness

OPTIMAL BEHAVIOR: Feed the child as much or more during illness episodes and for two weeks thereafter.

CURRENT PRACTICES
Parents tend to feed children less during sickness though from the research it wasn't clear whether mothers gave as much breastmilk and other fluids.

When extra food is given it is often stopped as soon as the child is better, rather than continuing for an extra two weeks to build up the strength of the child.

Starchy foods, lentil soup, milk and "light" foods are often given to sick children.

BARRIERS
Mothers are busy and may not be able to provide care for the sick child.

Awareness among mothers, fathers, and grandmothers about the need to provide extra, nutritious food during and after illness was low.

Sick children experience loss of appetite, and mothers do not know how to address this issue.

OPPORTUNITIES
People, especially mothers and grandmothers, still visit traditional healers, and these healers can be a route to provide correct information about the care of sick children.

Many traditional healers report that they refer families with sick children to health posts or to hospitals if they know that they will not be able to cure them. Their main concern is for the sick children to return to normal health.

In the case of diarrhea, people were aware of the importance of liquids and oral rehydration therapy, in particular about feeding Jeevan Jal.

Sanitation and Hygiene

OPTIMAL BEHAVIORS: Eliminate open defecation, wash hands at critical points, practice hygienic food preparation and storage.

CURRENT PRACTICES
Handwashing was not practiced regularly.

Researchers observed unhygienic conditions in many communities. Living in close proximity to cattle and poultry was pervasive. In many communities, children were observed playing on unclean surfaces.

BARRIERS
Some FCHVs, Health Post officials and government officials described households as apathetic toward the cleanliness of their surroundings.

Lack of hand bar soap was a common barrier. Soap was described as expensive and was viewed as an "extra," a "luxury" item.

Heavy workload made it difficult to prioritize household hygiene. Another area of concern was the hygiene level of other caretakers. Children were often taken care of by their grandparents, aunts, uncles or even older siblings. Since parents were usually busy with their work, they could not check whether their children were fed by hands that were cleaned by water and soap.

Sometimes, community members thought that a baby's feces were not dangerous to caregivers. However, babies' feces are often more pathogenic than the feces of adults. Consequently, messages about the need to dispose of babies' feces properly will be an important part of *Suaahara's* work.

OPPORTUNITIES
While households were generally apathetic toward the cleanliness of their surroundings, mothers' knowledge of the importance of washing hands with soap and water before feeding children was high.

Water was described as necessary to clean hands and was considered to be available in households in all districts except Bajura.

Many households had soap of the type usually used for doing laundry but not hand bar soap. Laundry soap can be promoted as an option for hand-washing.

Radio and other communications should include messages about sanitation and hygiene related to food preparation.

Safely disposing of the baby's feces in a toilet and caretakers washing hands with soap after cleaning a baby's bottom will be emphasized during interpersonal contacts with families and through radio messages.

Family Planning

OPTIMAL BEHAVIOR: Space births at least three years apart.

CURRENT PRACTICES
Injection methods were mentioned several times and oral contraceptives and condoms occasionally.

BARRIERS
Shyness posed a significant barrier to women discussing family planning methods with both their husbands and with health care providers.

Family planning was generally viewed as a woman's concern; men usually have little involvement.

Some respondents said that husbands and family members opposed a woman's use of birth control if she had not yet produced a son.

Women have little negotiation power.

Health care providers cited lack of knowledge and awareness about family planning methods especially among marginalized communities (dalit).

Illiterate women felt uncomfortable going to a provider to access modern methods due to poor treatment by clinicians.

FCHVs only mentioned counseling women about family planning—they usually did not involve husbands in the conversation as they did not come as a couple.

OPPORTUNITIES

Many people expressed the view that having fewer children meant that they would be able to provide those children with a better education. This desire could be used to engage husbands more in family planning.

Awareness and knowledge about family planning methods is high in the general population and a focus can be placed specifically on reaching marginalized and vulnerable populations.

Grandmothers also had a generally high level of awareness about family planning and most viewed fewer children as a positive trend.

FCHVs described providing information about family planning as one of their roles in the community, and most said that the women they met received the information very positively.

Sources of health information

Sources of information for maternal and child health and nutrition were husbands, mothers-in-law, FCHVs, radio/TV advertisements, neighbors, events to raise awareness, traditional healers, community health volunteers and health workers. Interpersonal communication appears to be the most prominent source of information. Contrary to expectation, broadcast media did not feature prominently in any of the discussions.

Table 2: Sources and Types of Information provided

Source	Type of information these sources provide
Mothers-in-law	Child feeding, childcare, food during pregnancy
FCHVs	Information about health systems and services
Clinicians	Illness (infrequent advice related to child health and nutrition)
Traditional healers	Food during and after pregnancy, child feeding, illnesses in general
Radio/TV	Breastfeeding and (rarely) immunization

FCHVs and traditional healers

FCHVs and traditional healers play important roles as sources of health information because they are well known in the community and often, according to many respondents, are more convenient to access than health centers. Many respondents said they received advice regarding the health of their children. FCHVs and traditional healers described counseling parents on a wide variety of topics including nutrition, care during illness, and hygiene and sanitation. FCHVs played a particularly important role in conveying information to pregnant women about accessing pre-natal care and about vitamin supplements as well as taking children for immunization. Traditional healers were generally consulted in the case of illness, particularly if the illness was thought to have an underlying spiritual cause.

We found that in some areas, FCHVs and traditional healers focused exclusively on mothers (ignoring husbands and mothers-in-law) and sometimes only provided information. In some cases, this

information was limited to the importance of immunizing children. In addition, mothers-in-law were often the source of incorrect information. Participants sometimes commented on poor and disrespectful treatment by health workers.

The vast majority of FCHVs and traditional healers indicated a desire for further training and resources as well as opportunities to improve skills. Traditional healers generally described a very positive view of modern medicine and said that in the case of illnesses they could not cure, they referred patients to the health center. Mothers-in-law were generally very open to learning new information and making changes that they saw as beneficial for children. In some areas, health workers were highly regarded. Consequently, these individuals could serve as a model for others. Radio is currently underutilized as a way of sharing correct health information and engaging audiences through entertainment education.

Motivations for behavior change

An important part of encouraging families to change behaviors is to understand what motivates them. While *Suaahara's* ultimate goal is to improve the nutritional status of women and children, respondents rarely mentioned this as an aspiration. Rather, they mentioned two motivators: 1) the importance of education in increasing children's opportunities in life, and 2) openness to change. As with other successful behavior change projects, these themes will be emphasized in *Suaahara's* media as well as during household and community-level interventions.

Two major themes that emerged from research in all six districts were that 1) fathers were not very involved in the everyday lives of their children, often because they migrated elsewhere for work, and 2) mothers-in-law welcomed the social changes happening around them. Given their role in the family (which often overshadows the role of mothers), mothers-in-law can be instrumental in changing behaviors, in part, by serving as positive role models and in part by more fully engaging them in community-based activities.

Conclusions

Behaviors known to improve the nutritional status of women and children were rarely practiced by individuals in this study. Families faced a variety of barriers that prevented them from engaging in these practices. *Suaahara* will use a variety of proven approaches to improving practices. Community mobilization strategies designed to improve practices include the Village Model Farmer approach, Community Led Total Sanitation, schools, celebration of key life events and positive deviance (most likely without hearth sessions, at least initially). Interventions designed to improve interpersonal communication include Trials of Improved Practices, home visits and support groups (which include the use of GALIDRAA), peer education including education and support for husbands and mothers-in-law, and action cards. Communications strategies include radio and similar events to reinforce learning from radio.

The following tables complement the narrative in this report and provide current practices, barriers, target audiences and behavior change strategies. While the focus is on priority behaviors, Suaahara will emphasize a variety of messages related to family planning, maternal and child health, antenatal care, postnatal care, WASH, ENA, agriculture and health services promotion, not simply the messages for the five priority behaviors.

Early Initiation of Breastfeeding and Avoiding Prelacteals for Newborns

Optimal behaviors: 1) initiate breastfeeding immediately after birth or in the first hour of life and 2) avoid giving the newborn anything except breastmilk in the first few days of life

Primary focus[2] in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 3	No fixed time for initiating breastfeeding (often, initiation is delayed) Colostrum is sometimes discarded Prelacteals are common (ghee, honey, homemade beer, etc.)	New mothers are not aware of the importance of early initiation and avoiding prelacteals Families in the Terai give water/other fluids to babies because the baby is thirsty due to the warm weather	Mothers, husbands, mothers-in-law: information about benefits and support trying new practices	CM[3]: celebration of key life events (birth) to reinforce giving only breastmilk beginning in the first hour of life IPC[4]: use GALIDRAA and action cards in home visits and in groups to negotiate for behavior change peer education to raise awareness and support women as they try these behaviors Comm[5]: radio to share messages and change norms about early initiation of breastfeeding and prelacteals

[2]Based on 1) government of Nepal and global priorities 2) effectiveness in reducing stunting (determined from a review of the epidemiological literature) 3) need (existing practices are poor determined by examining the 2011 Demographic and Health Survey and *Suaahara's* baseline), and feasibility (based on a World Bank consultancy report).

[3]Community Mobilization

[4]Interpersonal communication

[5]Communications/media

Exclusive Breastfeeding

Optimal behavior: give only breastmilk to the infant and no other foods or liquids for the first six months of life

Primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 3	Mothers breastfeed less and introduce other foods and liquids before 6 months of age Mothers feed babies water to satisfy their thirst	Mothers feel they cannot produce enough milk Too much work without sufficient nutrition or liquid intake means less milk Mothers worry about infants not latching on Little or no counseling/lactation management Other mothers and mothers-in-law may perpetuate myths about breastfeeding After 3-4 months, families feel infants need other types of foods in addition to breast milk Mothers' work outside the home Little support from fathers and mothers-in-law to breastfeed exclusively given these circumstances	Mothers: support to overcome their sense that they do not have enough milk. Husbands, mothers-in-law: information that mothers are able to produce enough milk; ideas about how to encourage mothers to breastfeed on demand; ideas about actions they can take to 1) reduce mothers' workloads, and 2) ensure mothers get enough rest and eat nutritious foods FCHVs and other outreach workers: basic training in infant nutrition including lactation management and support Health workers, medical shop keepers and traditional healers: printed material to convince them of mothers' ability to breastfeed; printed material for health workers; greater training in lactation management and support including referral to lactation consultants	**IPC:** Trials of Improved Practices (TIPs) to identify small, do-able actions mothers, husbands and mothers-in-law can take to breastfeed on demand, reduce mothers' workloads and get them nutritious foods (including extra meals); GALIDRAA and action cards in home visits and in groups to negotiate for behavior change; peer education to raise awareness and support women as they try these behaviors; Health worker, pharmacist/medical shop keeper and traditional healer training in counseling regarding exclusive breastfeeding Support groups for husbands and mothers-in-law to learn about and practice behaviors that help mothers breastfeed exclusively for a full 6 months Positive deviant grandmothers who take infants to the field and other places of work so that mothers can breastfeed **Comm:** Radio to share messages and change norms about exclusive breastfeeding and to assure mothers that they are able to produce enough milk

Appropriate and Timely Complementary Feeding

Ideal behavior: varies by age but includes feeding frequently, feeding the right amount, giving foods that are of the right consistency, giving diverse foods and feeding responsively

Primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 2	Complementary foods not given frequently enough Premature introduction of complementary foods for girls Foods are thin and watery Cow's milk and buffalo milk Other foods and liquids when mothers felt breastmilk alone was not enough Purchase of foods from the market Few types of foods given; unhealthy foods given Few animal source foods Children left alone or in the hands of other caretakers	Lots of food (even if not nutritious) keeps baby well-nourished Rice feeding ceremonies reinforce premature introduction of complementary foods Families do not understand what foods are nutritious Foods with added vitamins mistaken as nutritious Taste more important than nutrition Animal source foods difficult for babies to swallow/digest Preference for market foods Fruits are scarce Meats are costly Same food eaten continuously until no longer available Rice-based diet considered progressive Mothers-in-law and fathers (but not mothers) purchase food	Mothers, husbands, mothers-in-law: information to counter prevailing beliefs; ideas for tasty recipes; evidence that young children are able to swallow and digest animal source foods; training in how to grow diverse, nutritious foods, preserve foods for later use, and feed responsively; access to animal source foods; greater control over food purchases FCHVs and other outreach workers: information about complementary feeding; skills in GALIDRAA to better negotiate for behavior change VMFs: training and support in how to raise chickens and other small animals and how to grow and preserve diverse fruits and vegetables Health workers, medical shop keepers, traditional healers: correct information about complementary feeding	**CM:** Rice feeding ceremonies at 6 months of age, not earlier VMFs to teach how to grow diverse foods then preserve them VMFs to help families raise chickens and other small livestock Positive Deviance/Hearth to identify healthy foods some community members give their children and to determine how some families are able to practice good complementary feeding Positive Deviance/Hearth to demonstrate that children are able to swallow and digest small bits of meat (and that it makes them healthy) **IPC:** Information to improve caregivers' understanding of appropriate and timely complementary foods Recipes that are tasty, easy and quick to prepare GALIDRAA to commit families to giving animal source foods, green leafy vegetables and orange fleshed foods Support groups for fathers and mothers-in-law to help them purchase then feed animal source foods to children **Comm:** Information to counter existing beliefs about complementary feeding and to establish optimal complementary feeding (including animal source foods at around 6 months of age) as the norm Ideas for recipes that are tasty, easy and quick to prepare Messages for fathers and mothers-in-law to help them purchase then feed animal source foods to children

Maternal Nutrition

Ideal behaviors: Feed mothers one extra meal during pregnancy. Give them two extra meals during breastfeeding.

Will be primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 2	Mothers normally eat last and receive less food than other family members Special or additional food is normally not prepared for pregnant mothers Providing new mothers with animal source food during the post-delivery period is a common tradition Foods choice informed by perception of "hot" or "cold" qualities ("hot" and "cold" do not refer to temperature but rather "imbalance"—too many "hot" or "cold" foods cause imbalance and sickness)	Feeding practices during pregnancy, often dependent on household income Pregnant women not viewed as a top priority Restrictions in food during pregnancy and after delivery were described in all regions Provision of special or additional food after delivery usually lasts a couple of days or weeks Caste-related food restrictions prevent women from including some animal source foods in their diet (Brahmin and Chhetri) Lack of local meat shops requires slaughtering a whole animal which is too expensive	Mothers: need information that supports consumption of a variety of foods during pregnancy and breastfeeding (most already understand the importance of extra food); ideas about what additional foods they should be eating; support from fathers and mothers-in-law Fathers/mothers-in-law: the above plus small, do-able actions they can take to support their wives; examples from positive deviant fathers and mothers-in-law	**CM:** Encourage families to raise diverse foods and animal source foods through Homestead Food Production and VMFs **IPC:** Counseling and action cards for mothers, fathers and mothers-in-law on the importance of eating more foods and diverse, healthy foods for the growth of the unborn child and to increase breastmilk production. Emphasize foods mothers already know are healthy (yellow fruits, milk, meat, ghee, eggs and beans). Then add green leafy vegetables. Use action cards to focus on barriers (notions about "hot" and 'cold' food) as well as positive deviants (mothers who consumed these foods regardless). Provide recipes from local women. Encourage existing practices to give eggs and meat to women who have recently delivered. Help families extend this practice beyond a couple of days and weeks **Comm:** Use radio to emphasize the above

Maternal Health

Optimal behaviors: Appropriate and timely care seeking for antenatal care (ANC; 4+ visits), delivery and post-natal care (PNC).

Primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 4	Regular visits to health posts for general health concerns Frequent visits for ANC Home delivery Little PNC	Inadequate facilities Feel shy/ashamed going to the health post Illiteracy, too busy with work Poor treatment from healthcare providers 'Simple' pregnancies meant no need to go to the health post Lack of knowledge about services provided at health facilities	Mothers: help from FCHVs, neighbors and others in arranging support for home-based delivery Husbands, mothers-in-law: reinforcement to encourage them to accompany women to health facilities for care	**CM:** Promotion of postnatal care during celebrations around birth **IPC:** TIPS to identify options for seeking ANC, PNC and health services for delivery GALIDRAA to negotiate greater sharing of workload between mothers, husbands and in-laws Support groups and peer education to discuss danger signs in pregnancy and what to do if they are present Strengthen IPC skills of health care providers Outreach to pharmacists, medical shop keepers and traditional healers **Comm:** Partnership Defined Quality (PDQ) training and implementation to improve relations between the community and health care providers Radio for messages about the need to seek ANC, PNC and care for deliveries. Reinforcement of the idea that modern, progressive women get care at health facilities Radio messages to help families recognize danger signs in pregnancy

Feeding During Illness

Optimal behavior: Feed the child as much or more during illness episodes and for two weeks thereafter.

Will be primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 2	Parents feed children less during sickness If extra food is given it is often stopped as soon as the child is better, rather than continuing for an extra two weeks Sick children are often given starchy foods, dal, milk and "light" foods	Other responsibilities of mother may prevent her from being able to provide care for the sick child Awareness among mothers, fathers, and grandmothers about the need to provide extra, nutritious foods during and after illness was low Mothers do not know how to address loss of appetite when children are sick Food choice informed by perceptions of "hot" or "cold" qualities (as noted previously).	Mothers, fathers, mothers-in-law: information about appropriate foods for children when sick and about the importance of continuing to feed the sick child, not just when the child is sick but for a full two weeks thereafter	**IPC:** In one-on-one and group counseling, emphasize the "stickiness" of healthy foods. Emphasize that thicker dal is "stickier;" focus on the two weeks after illness through action cards and by pointing out positive deviant families in the community who continue to give as much or more food for a full two weeks; give traditional healers and pharmacists as well as medical shop keepers correct information about dietary management of the sick child and help resolve any barriers they experience counseling mothers Reinforce families' understanding of the importance of liquids and oral rehydration therapy, in particular about feeding Jeevan Jal **Comm:** Use radio to emphasize the messages above and to showcase families who practice these behaviors

Hygiene and Sanitation

Optimal behaviors: Eliminate open defecation, wash hands at critical points, practice hygienic food preparation and storage

Primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 2 (eliminate open defecation; wash hands before feeding infant) Year 3 (wash hands at other critical points; point of use water treatment; hygienic food preparation and storage)	Handwashing was not practiced regularly Unhygienic conditions in many communities Close proximity to cattle and poultry Children play on unclean surfaces	Apathy toward cleanliness Lack of soap Perception that soap was an "extra, luxury" item Heavy workload Poor hygiene of other caregivers	Mothers: visible evidence that cleanliness is beneficial; information that laundry soap is good for handwashing; opportunity to practice handwashing at home and in groups; reduced workload to enable hand washing Husbands, mothers-in-law: the above plus norms that reinforce handwashing; opportunities to practice handwashing at home and in groups; commitment to try a few do-able actions to reduce mothers' workload Families: ideas for separating children from dirt and animals; chicken coops Health workers: in-service training and job aids to reinforce their own handwashing while providing care to families	**CM:** School programs to promote handwashing among children after defecation and before eating Child-to-parent and child-to-child handwashing to encourage handwashing at *all* critical times Construction of chicken coops and mats to keep children away from animal feces and out of the dirt CLTS/ODF to mobilize communities around sanitation **IPC:** Home-based and group-based GALIDRAA to negotiate reduced workloads for women Groups for mothers, husbands and mothers-in-law that demonstrate proper hygiene and provide individuals the opportunity to practice handwashing—after defecation, before preparing food, before feeding the child, and so on—over and over again A hand gel that demonstrates what parts of the hand are not being washed thoroughly In-service training and supporting materials for health workers, pharmacists, medical shop keepers and traditional healers Health worker and traditional healer demonstration of handwashing when families seek healthcare Comm: Information through radio about the importance of handwashing at all critical points Radio to let families know they can use laundry soap for handwashing Radio to give families ideas for separating children from unclean surfaces

Family Planning

Optimal behavior: Space births at least 3 years apart.

Will be primary focus in...	Current practice	Barriers to changing the practice	Who needs what	What Suaahara will do to help change the practice
Year 2	Injection methods were mentioned several times and oral contraceptives and condoms only occasionally	Shyness poses a significant barrier to women discussing family planning Men usually have little involvement in matters related to reproductive health Husbands and other family members may oppose a woman's use of birth control if she has not yet produced a son Women have little negotiating power Health care providers cited lack of knowledge and awareness about family planning methods, especially among marginalized communities (dalits)	Mothers: greater confidence when speaking with health care providers Fathers: information about the benefits of family planning, including delaying the first birth so that the child is healthy and so that greater resources can be devoted to a few children rather than many Grandmothers: praise for understanding that smaller families mean more resources to help a few children get ahead	**IPC:** Use action cards during home visits to describe the benefits of healthy timing and spacing of births, provide information about various family planning methods, encourage couples to seek professional advice about family planning and help families address barriers to using family planning Use support groups that: 1) build the confidence of mothers and husbands about speaking to health care providers regarding family planning 2) allow women to practice negotiation skills so that they are prepared to speak with health care providers and make informed choices about the most appropriate family planning method for them and 3) allay couples' concerns about the side effects of some family planning methods. **Comm:** Use radio and related activities to reinforce what is accomplished using the behavior change strategies noted above including increased knowledge regarding the importance of HTSP and greater intention and commitment to choose and use a family planning method that is appropriate to the couple

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