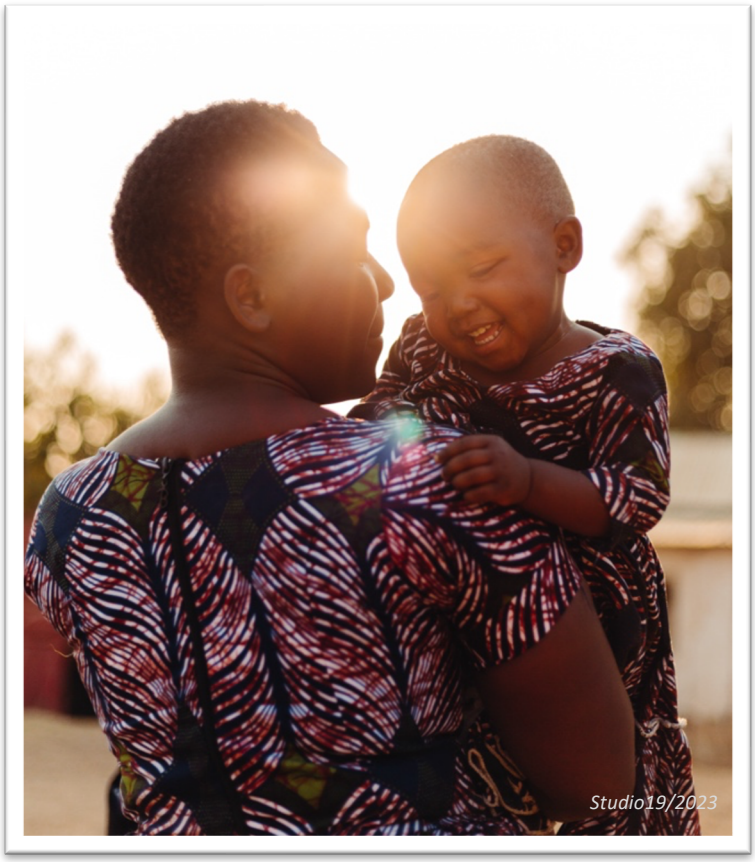
BASELINE
RESEARCH BRIEF
November 2024

STAWISHA MAISHA ("NOURISHING LIFE")

Impact Evaluation



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Introduction

Stunting and malnutrition remain significant problems in Tanzania. Despite progress, including decreases nationally from 42% in 2010 to 34% in 2016, in 2020 ***nearly 30% of children under five years in Tanzania were stunted***. Malnutrition in childhood has adverse consequences across the life course, including child mortality, disability, cognitive impairment, chronic disease, and reduced productivity in adulthood. Malnutrition perpetuates poor health and poverty throughout an individual's life and into the next generation. Key drivers of malnutrition include poverty; food insecurity; poor infant and young child feeding practices; and inadequate water, sanitation, and hygiene (WASH) conditions. The Government of the United Republic of Tanzania is taking action to reduce stunting and malnutrition in multiple ways through its flagship social protection program, the Productive Social Safety Net II (PSSN II). Implemented by the Tanzania Social Action Fund (TASAF), the PSSN II is an economic inclusion and anti-poverty program that aims to improve access to income-earning opportunities and socioeconomic services for targeted poor households while enhancing and protecting their children's human capital. Comprised of cash transfers, public works, and a livelihood program that includes business training and a business grant, the PSSN II currently reaches over one million households nationally, and the PSSN I was shown to reduce poverty and food insecurity and increase household consumption, school enrollment, and health insurance registration, among other outcomes. However, impacts on children's nutrition outcomes have not yet materialized. To further boost the potential for the PSSN II to reduce stunting and child malnutrition, TASAF is implementing a "cash plus" component, namely Stawisha Maisha ("Nourishing Life") among households already participating in the PSSN II program; technical assistance from UNICEF supported design of the plus component. Stawisha Maisha is being implemented in three regions nationally (Rukwa, Ruvuma, and Geita), starting in 2024. This plus component is being evaluated through a mixed method, longitudinal cluster randomized controlled trial (cRCT) design by Policy Research solutions (PRESTO), EDI Global, and Empathea, in collaboration with TASAF and UNICEF. This brief summarizing findings in the Baseline Report which can be accessed here.

Intervention Objectives & Components

The intervention, Stawisha Maisha (Nourishing Life), is a Social Behaviour Change intervention aimed at improving maternal and child nutrition. It is comprised of a weekly edutainment radio listening session over 12 months, provision of free solar powered radios, and peer-led discussion groups (Figure 1), layered onto an existing social protection program (PSSN II). The PSSN II represents cash transfers (and additional components), while Stawisha Maisha represents a "plus component." The latter is targeted to primary caregivers of children aged less than five years in households participating in the PSSN II.

Figure 1. Design features of the intervention

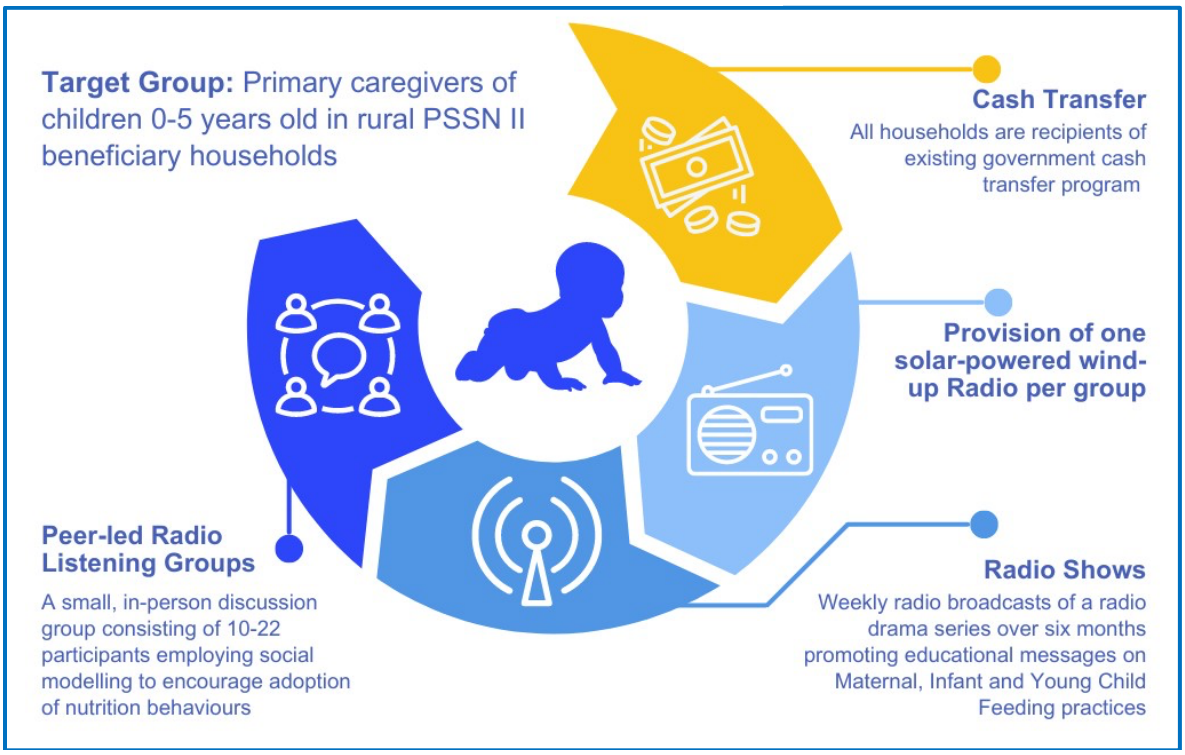
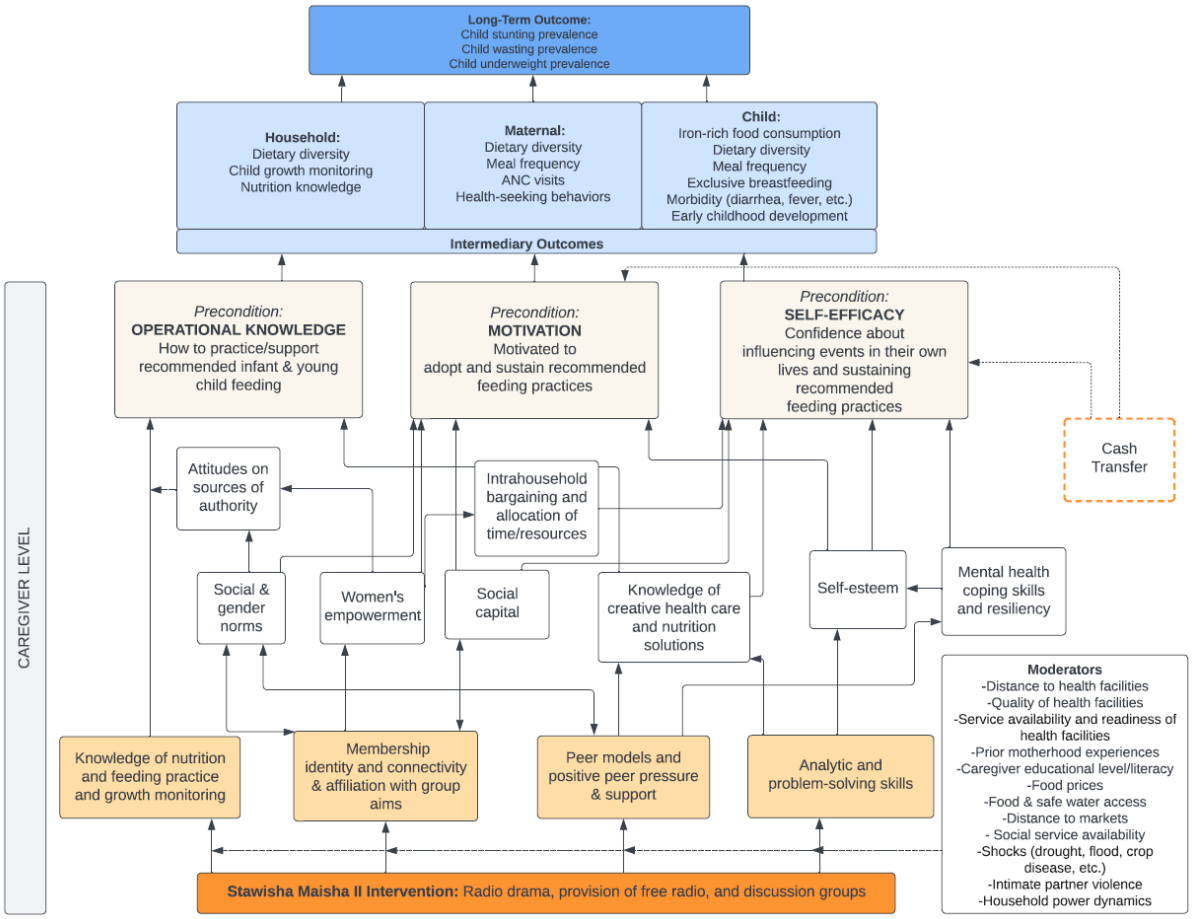


Figure 2. Conceptual Framework



The primary aim of Stawisha Maisha is to improve caregivers' knowledge and practices regarding the nutrition of mothers, infants, and young children, with the long-term goal of reducing stunting and malnutrition. Pathways to reach the desired changes include operationalized knowledge, increased self-efficacy, peer support, and openness to learning and change, increased aspiration for self and child(ren), improved skills for planning and goal setting, problem-solving, and increased resilience in the face of challenges and setbacks (*Figure 2*).

Study Design

Employing a cRCT design, this evaluation integrates both quantitative and qualitative data to assess the impact of the Stawisha Maisha intervention. The evaluation is being implemented in three regions (Geita, Rukwa and Ruvuma) across Tanzania. The study region of Geita is located in the Lake zone of Northern Tanzania, while Rukwa is in the south-west highlands and Ruvuma is situated in the southern highlands across the lake from Malawi and on the border with Mozambique. These regions were selected for the intervention and evaluation based on high stunting prevalence and burden and low rates of early antenatal care, exclusive breastfeeding, and dietary diversity among young children.

Baseline data were collected in July and August 2023, among 2,256 households. Within these households, anthropometric measurement of 3,605 children was conducted. Qualitative data were collected among mothers and primary caregivers via 17 in-depth interviews and eight focus groups. In addition, data were collected on village- and facility-level information in the 150 study villages and 87 health facilities. Randomization of 150 villages into treatment and study arms (75 villages in each) was conducted by TASAF in October 2023 during public randomization events. A follow-up round of data collection is planned for 2025, one year after the implementation of Stawisha Masha.

Results

Respondents of the household surveys were the primary caregiver of a child under 5 years living in the household (99.4% were female; 87.6% were the biological mother and 11.1% were the grandmother).

Nearly 70% of caregivers felt that they had a group of peers with whom they had a sense of belonging and membership; qualitative findings supported this sense of community among women and their neighbors, particularly in the days following childbirth. Most respondents trusted nutrition information from the radio, whether they currently owned a radio or not; however, only about a fifth of respondents reported listening to the radio weekly.

In the following section, we highlight some key findings based on evaluation indicators, compiled from both qualitative and quantitative baseline results.

Household characteristics and livelihoods

- The average household size was 6.6 members.
- Nearly 61% of households experienced food insecurity, 18% experienced moderate food insecurity and 43% experienced severe food insecurity.
- About one in four households experienced water insecurity.
- Only 11% of households treat their water, while 32.5% have access to improved toilets.

- Agriculture plays a significant role in the livelihoods of the households in our study, with around 93% of them engaging in crop cultivation in the past 12 months.
- Approximately 1 in 4 households (23.5%) operated non-farm enterprises in the past year.
- Over half (54.2%) of households own livestock.

Radio and communications

- Household ownership of mobile phones was widespread, with approximately 85.3% of households in our sample possessing them.
- Radio/radio cassette players were only owned by one in five households (19.8%), underscoring how the intervention's provision of free solar-powered radios to the discussion groups will be crucial to facilitate households' ability to take up the intervention.
- Only 21 per cent of respondents reported listening to the radio on a weekly basis.
- Very few women reported that they accessed the radio on their mobile phones, as many either did not have widespread access to a phone or did not have it activated if they did. Gender gaps in ownership and use of mobile phones have been highlighted in previous research in Tanzania.
- A large majority of respondents (80%) trust nutritional information from the radio, whether they currently own a radio or not, and qualitative findings supported this as well.
- A little more than 80% of caregivers stated they would trust information about nutrition from a radio program.

Caregiver Knowledge & Norms

- The rate of awareness about early initiation of breastfeeding was fairly high, with 82.2% of respondents stating breastfeeding should begin within one hour of a child's birth, but only 21% of caregivers had full knowledge of exclusive breastfeeding, i.e., they correctly defined both the phrase and age recommendation.
- Sixty-six percent of caregivers reported being stressed about the frequency and diversity of the food they were able to feed their children – they understood the importance of proper nutrition for themselves and their children, but lacked the means to provide healthy foods for their families because they did not have the resources to do so.
- In qualitative interviews, respondents reported that they did not know most of the maternal and child nutrition recommendations before they became parents, and that even while they were pregnant, they did not consume nutritious foods.
- Most caregivers could identify Vitamin A (60.7%) and iron rich foods (54.1 %).
- Close to 71% of caregivers knew that children with diarrhea should be given oral rehydration salts (ORS), but only 3.3% knew that they should be given more liquids than usual and the same or more food and breastmilk as usual.
- To evaluate if caregivers knew how to interpret their child's growth curve, we provided a sample card with a marked point and asked what this example says about the child. Only about half of caregivers (51.4%) correctly knew what the sample growth curve meant.
- Qualitative responses about child growth and development indicated that caregivers understood that children needed to go to the clinic regularly from the time they were about one month old, through the age of five years, to ensure that they received required vaccinations and that they were healthy and growing properly.

Nutrition Information

- Nearly two-thirds (63.7%) of respondents heard or saw something about nutrition in the last 12 months from a community health worker, on radio, on a flyer, or from another source.
- Among children 6–23-month-old, 31% met the minimum meal frequency and only 7% met minimum dietary diversity
- In qualitative interviews respondents overwhelmingly cited a lack of money, access to nutritious food, and access to water as the primary challenges preventing them from giving their families nutritious meals.

Young Child Feeding Practices

- Among children 6–23-month-old, 30.8% met the minimum meal frequency.
- Only 7.3% of children 6-23 months met minimum dietary diversity (that is, they were fed at least 5 out of 8 UNICEF and WHO specified food groups during the previous day).
- Only 15.3% of 6–23-month-olds consumed iron-rich or iron-fortified foods in the previous day and night at the time of the survey.
- In qualitative interviews, overwhelmingly, respondents cited a lack of money, access to nutritious food, and access to water as the primary challenges preventing them from giving their families nutritious meals.

Child Nutritional Status

- Forty-four per cent of children in the sample were stunted, and 15.7% were severely stunted. This rate is higher than the national stunting average (30%).
- The rate of wasting in our sample was 5.5%, and 1.7% were severely wasted. The wasting rate in this sample was also higher than the national wasting average (3.3%) and that of two of the study regions (2.8% in Ruvuma and 3.3% in Geita).
- Nineteen per cent of children in the sample were underweight (compared to 12% nationally), and 4.4% were severely underweight.
- In terms of early childhood development, about one in five children were developmentally on track (as defined by the Early Childhood Development indicator, assessed through various questions covering health, learning, and psychosocial well-being sub-domains).

Antenatal Care

- Nearly all children 0-36 months had a mother who sought antenatal care (ANC) from a skilled provider (i.e., doctor, nurse, midwife, or auxiliary midwife) at some point during their pregnancy. However, early ANC (first trimester) occurred in fewer than half of pregnancies (45.2%).
- Approximately one in four (27.7%) women followed the recommended practice of eating four or more food groups per day during pregnancy.
- About two-thirds of children benefited from mothers who took iron folic acid (IFA) supplements for 90 or more days while pregnant.
- As with their knowledge of nutrition, respondents were not always able to reconcile what they knew to be best for themselves and their children with the reality of their resources. Poverty and lack of money were the major barriers to accessing antenatal care.

Breastfeeding Practices

- Fewer than half of children (42.2%) were, or are, exclusively breastfed.
- The rate of continued breastfeeding until up to two years or beyond was fairly low—just over one-fifth (21.9%) of children aged 24-59 months were breastfed up to two years or beyond.
- Qualitative interviews indicated that while women understood the importance of a mother's nutritional intake while breastfeeding, there was often a lack of access to nutritious food that limited their ability to eat healthy.

Conclusions

Overall, the baseline data provide a comprehensive snapshot of indicators relevant to the success of the intervention. Baseline findings from this evaluation demonstrate rates of children's malnutrition that were higher than the national average and caregivers' challenges accessing nutritious foods for their children. Nevertheless, many positive aspects were noted. Respondents had high levels of trust in information from health care workers and radio broadcasts. Generally, respondents felt they were knowledgeable about what they need to feed their children, despite often lacking resources to enact this knowledge. In addition, women felt a sense of support from the community among the women and their neighbors and said they help each other in times of need.

Based on baseline findings and statistical tests described in the full report, the evaluation team concludes that randomization was successful with a balanced distribution of outcomes between treatment and control groups. This lays the foundation for accurately estimating effects of the intervention in the forthcoming phases of the study. After one year of implementation of Stawisha Maisha, endline data will be collected in 2025. Intervention impacts will be estimated, and more in-depth analysis of the topics will be pursued after endline data are collected. Attrition will be carefully assessed after endline data are collected, especially in consideration of delays between baseline data collection (in 2023) and program rollout (in 2024). Endline data collection efforts will also include detailed modules on intervention take-up, including timing of listening sessions, issues with radios, and related information to inform future programming.

In terms of programmatic recommendations going forward, baseline findings suggest that, due to low rates of radio ownership and low rates of listening to radio on mobile phones, future TASAF programming involving radio messaging should consider provision of radios to communities. Moreover, the next iteration of edutainment programming should consider addressing gender norms in feeding practices (for example, the idea that boys expend more energy and need supplemental feeding before 6 months of age, which inadvertently may be contributing to higher stunting rates among boys, or practices that disadvantage adolescent girls from equitable shares of food).

This cash plus intervention is being implemented by government, through government structures, which strengthens generalizability of findings and potential for scale-up. It is hoped that findings from the evaluation can inform future programming and scale-up and contribute to regional and global debates on how social and behavioural change plus components implemented within national cash transfer programs can improve maternal and child nutrition.

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PRESTO, EDI Global, Empathea, TASAF, UNICEF. 2024. "Stawisha Maisha ('Nourishing Life') Impact Evaluation: Baseline Report". UNICEF Tanzania, Dar es Salaam. https://transfer.cpc.unc.edu/wp-content/uploads/2024/11/Baseline-Report_Stawisha-Maisha_public-FINAL.pdf