ACTIVITIES TO PROMOTE MOTHER AND CHILD WELL-BEING IN CARE's PL480 TITLE II INTEGRATED PROGRAMS: A Closer Look at the Honduras & Mozambique Programs

photo: Mozambique/© CARE 2001/Mark Langworthy

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ACTIVITIES TO PROMOTE MOTHER AND CHILD WELL-BEING IN CARE TITLE II INTEGRATED PROGRAMS

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ACTIVITIES TO PROMOTE MOTHER AND CHILD WELL-BEING IN CARE TITLE II INTEGRATED PROGRAMS

A. Introduction

CARE adopted the Household Livelihood Security (HLS) framework in 1994. HLS is an integrated framework that promotes participatory problem analysis and program design, geographically focused programming strategies, coherent and often cross-sector monitoring and evaluation systems, and, importantly, reflective practice and continued learning. Household livelihood security is defined as "adequate and sustainable access to income and resources to meet basic needs".[1]

HLS uses an integrated or *systems* approach to programming, with recognition that poor people and poor households live and interact within broader socioeconomic and sociopolitical systems that influence resource production and allocation decisions. Food and livelihood insecure households may make trade-offs between basic needs -- such as food, health or education -- within the context of their situation. For example, poor households might reduce food purchases in order to pay for school fees or books to ensure that their children attend school.

Within this framework, HLS analysis has focused on identifying a limited number of key interventions that would, in combination, have the greatest positive impact on the basic needs of households. The USAID/BHR Food For Peace Title II Program has provided one avenue of opportunity for CARE to operationalize the HLS framework, evolving from school feeding and clinic-based food distribution to an integrated food and household livelihood security approach. For households to become food secure on a sustainable basis, they must rise from the level of poverty that restricts their ability to meet their basic needs. HLS poverty analysis of targeted geographic regions informs program design and long-range strategic planning for country offices.

Several of the CARE Title II programs include a component to improve household agriculture production, the key source of income for many rural households, along with a component to improve the health and nutrition status of mothers and young children, as the members of the household most vulnerable to the effects of poverty.

[1] *Operationalizing Household Livelihood Security: A Holistic Approach for Addressing Poverty and Vulnerability*, by T.R.Frankenberger, M.Drinkwater and D.Maxwell; CARE 2000.

This document takes a closer look at two CARE integrated Title II programs. These are:

- CARE Honduras Food Security Program (FSP), and
- CARE Mozambique Viable Initiatives for the Development of Agriculture Program (VIDA)

Both of these programs have completed one five-year cycle of development assistance (FY1996-2000 and FY1997-2001 respectively) in a specific targeted geographic area. Both have expanded coverage and increased activities within that area for a second cycle of assistance (FY2001/2-2005/6). Both programs have included interventions to address maternal and child health and nutrition (MCH/N) within integrated programs that also address other household basic needs. Yet, these two programs are very different and provide a view of the range of MCH/N interventions that can directly contribute to improvements in mother-child well-being.

The CARE USA PHLS Unit Institutional Strengthening Assistance Grant FY1999 calls for guidance to be developed on improving the quality of Title II Maternal Child Health and Nutrition interventions. This is the second in a series of documents that serve as one method for sharing information among for country offices. The first document provided technical assistance in identifying strategies and resources used in Child Survival programs.[2] This is the first attempt to provide an overview of a few case studies among the many recent experiences of CARE Title II programs with MCH/N interventions.

In addition, this document will take advantage of the opportunities provided by the CARE Honduras Food Security Program and the CARE Mozambique VIDA Program monitoring and evaluation (M&E) systems that have been established. With the introduction of HLS came the commitment to not only improve participatory diagnostic work for program design, but also to strengthen capacities to demonstrate measurable impact for program beneficiaries. Title II programs are an appropriate vehicle for advancing M&E techniques, in search of the balance that obtains sufficient and valid information on program impact while providing timely information for continuous improvement during the life of the program. Due to the efforts the CARE Honduras and Mozambique programs have invested in M&E, each of these programs can demonstrate positive impact for program beneficiaries to-date.

CARE promotes the use of monitoring and evaluation systems as an iterative process that can produce valuable insights on program performance, cross-sector synergies, specific vulnerable groups within regions, and more. CARE M&E systems are not developed only to report to donors but also to inform the on-going analysis and identification of how organizations can best contribute to the alleviation of poverty through sustainable development opportunities. Therefore, additional analysis was conducted of the FSP and VIDA evaluation databases, to take an introductory look at assessing the effect of potential

[2] *Strengthening Maternal Child Health and Nutrition Activities in Title II Programs: A Look at Child Survival,* by R. Charleston and J.Jennings; CARE USA PHLS Unit, October 2001.

synergies between program interventions in reducing the percentage of children under age five that are stunted in the region. Stunting is a cumulative process that is an indirect indicator of household poverty. Children under the age of five are completely dependent upon the production and care capacities of others in the family and thereby reflect the status of the household. These results are presented in this document.

As CARE moves forward in the new millennium, additional strategies are increasingly important. Initially the HLS focus was on improving the immediate *conditions* for household participants. As HLS has matured, CARE has recognized a need to broaden this perspective in order to achieve sustainable impact. In 1999, CARE began to seek ways to improve not only peoples' *condition* but also their *position* in society, integrating a Rights-Based Approach (RBA) into the household livelihood security framework.

The Rights-Based Approach seeks to deepen holistic analysis to address the root causes of poverty, which are often part of larger systemic sociopolitical structures. Current RBA efforts within CARE Title II programs include the promotion of good governance and institutional capacity-building of local government structures, as well as policy- and advocacy-related issues. No additional analysis in this area was conducted for this document; however, a good example of CARE efforts in this area can be found in descriptions of the Conflict and Rights Project in Sierra Leone.[3] In addition, the final evaluation results of local government capacity-building activities are available in the CARE Honduras FSP Final Evaluation report for FY1996-2000.

At present, this document confines itself to a description of two different sets of activities to improve mother-child well-being in integrated Title II programs and to an introductory analysis of the potential for synergistic impact on child malnutrition from integrated interventions.

B. Program Descriptions

The two programs discussed in this document, the CARE Honduras Food Security Program (FSP) and the CARE Mozambique Viable Initiatives for Development in Agriculture (VIDA), have been selected because they represent some of the variation possible between two integrated Title II programs.

The CARE Honduras Title II program has developed hand-in-hand with the Government of Honduras (GOH) strategies for improving the quality of life for its citizens. The GOH food and nutrition security policies of the early 1990's grew into the present targeted plans for poverty reduction. The CARE Honduras Title II program evolved from a program that was geographically dispersed, and in which food distribution was the primary focus as an

[3] Food Forum, Fourth Quarter 2001, Issue 58.

incentive for mothers to access available health services, into a geographically focused synergistic set of interventions based on food security analysis.

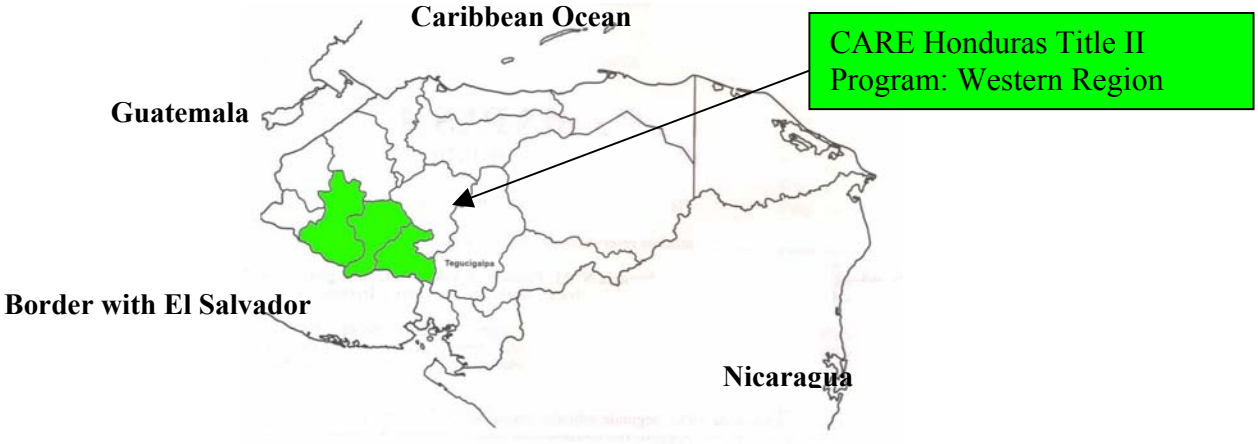


Figure No.1: Map of FSP area in Honduras

The CARE Honduras Food Security Program targets households in three geographic Departments in the region of Western Honduras -- one of the poorest regions of the country. It is an integrated program with direct food distribution and monetization of commodities. It includes three interventions:

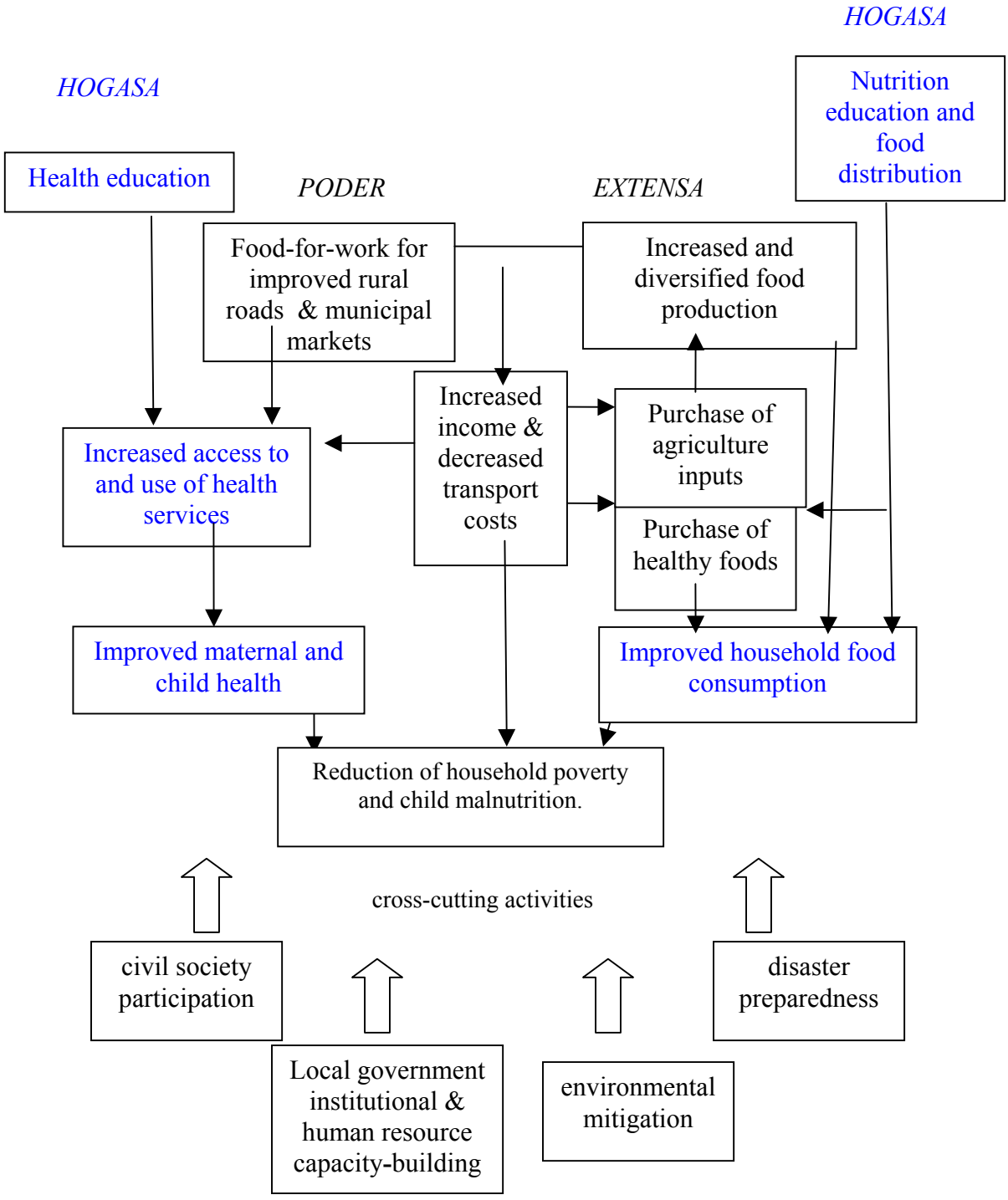
a) PODER: a food-for-work intervention for tertiary road construction and/or rehabilitation with a strong focus on activities for environmental mitigation; this intervention also serves as the entrance for local government capacity-building activities;

b) EXTENSA: an agriculture extension intervention to promote sustainable diversified production in a zone with limited land availability and poor soil quality, but with good potential for linkage with secondary economic corridors for marketing; and

c) HOGASA: a community-based maternal-child health intervention.

The PODER component reaches the greatest number of direct beneficiaries, followed by HOGASA. EXTENSA has limited coverage, due to financial limitations. Figure No.2 below describes the desired synergies between program interventions.

Figure No.2: Synergy between Food Security Program interventions



The HOGASA MCH/N intervention has a strong partnership with the Ministry of Health (MOH), which has been steadily increasing its institutional capacities for supporting mother-child well-being through the Integrated Management of Childhood Illness framework. Local

health centers achieve good coverage for the immunization of children and tetanus toxoid for women of reproductive age. They have sufficient supplies of oral rehydration solution, which is regularly provided to HOGASA community health volunteers. They collaborate with HOGASA in the development of a model for community-based treatment and referral of pneumonia cases.

The HOGASA MCH/N intervention directly supports all MOH maternal-child primary health care activities and further complements the strengths of the MOH by focusing on the following areas at the community level: 1) nutrition education for the use of appropriate complementary feeding practices; 2) growth monitoring of children that is community-based; and 3) the appropriate community-based case management for common childhood illnesses, such as diarrhea and/or acute respiratory infection.

These activities are carried out through training and support for community health volunteers. Direct food distribution of a monthly family ration to households with children age 6 to 24 months or pregnant or breastfeeding mothers provides a mechanism for nutrition education outreach.

It should be noted, however, that the program has been careful to maintain as separate the actual food distribution activity from growth monitoring nutrition education activities. Research has shown that growth monitoring activities have a tendency to become focused on the first stage - measuring and recording growth - and fail to appropriately make use of the opportunity of this activity to provide nutrition education and counsel individual mothers.[4]

photo: Honduras/©CARE 2000

Figure No 3: Community Health Volunteers

[4] *A UNICEF Nutrition Information Strategy: Improving Decision-Making at Household, Community and National Levels,* by U.Jonsson, D. Pelletier and R. Shrimpton; UNICEF 1998.

In addition, the HOGASA intervention collaborates with other strong partners in the region, especially in the area of family planning and reproductive health, such as ASHONPLAFA (the IPPF affiliate) and the Population Council.

As described in Figure No.2, the conceptual model of expected synergy between interventions, the program also includes cross-cutting activities for local government capacity-building to increase civil society participation that are woven through the three distinct interventions of HOGASA, PODER and EXTENSA.

The CARE Mozambique Viable Initiatives for the Development of Agriculture (VIDA) program began as an agricultural extension program but has recently evolved into a program including interventions to directly promote mother-child well-being through a route very different to that of the CARE Honduras program.

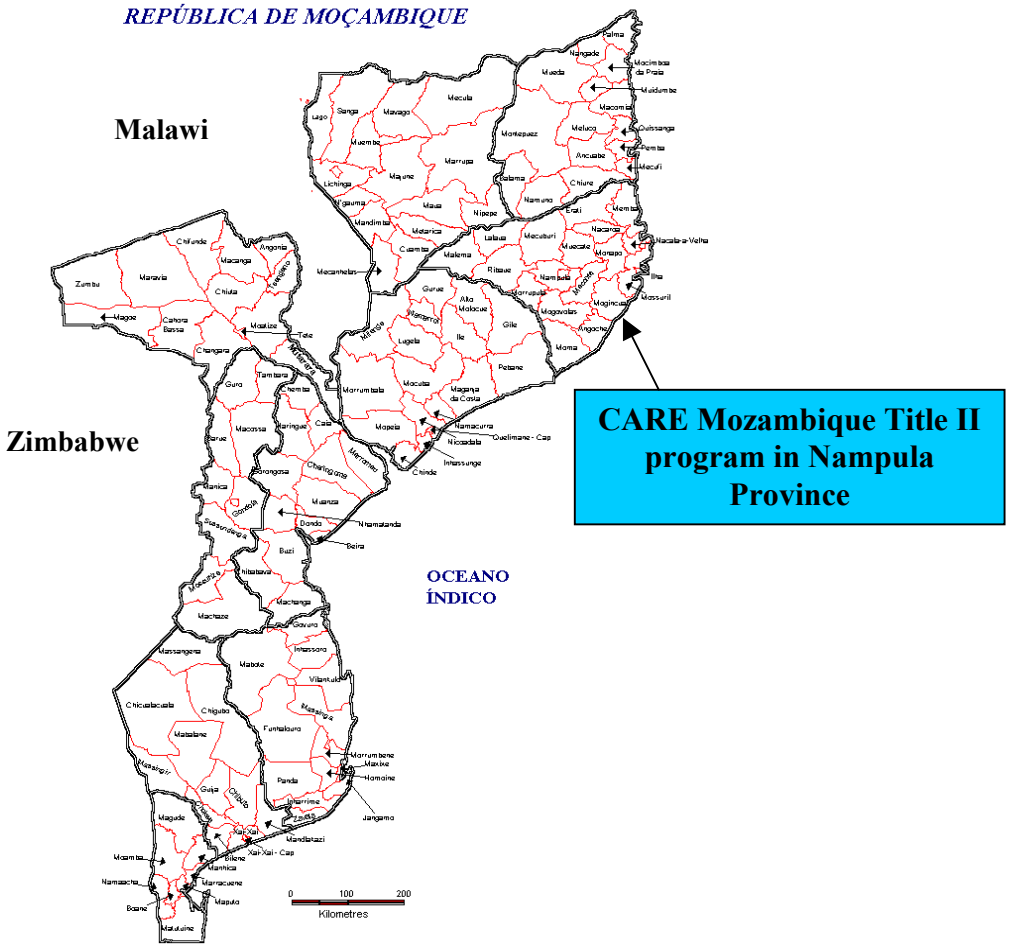


Figure No.4: Map of VIDA area in Mozambique

The VIDA program grew out of a successful CARE Mozambique program to promote an economically viable rural-based vegetable oil production capacity among poor households in the province of Nampula, in northern Mozambique (Figure 4). This area had historically been a strong area for commerce, with a railroad extending from the coastal port of Nacala to the border with Nacala. Today, one of the main highways of Mozambique parallels the railroad. The area is fertile and the low population density means there is little land pressure. In spite of all this potential, however, the province is among the poorest in Mozambique.

The VIDA program built upon the successful establishment of rural oil production capacity through a pilot project originally funded by other sources. As one of the objectives of the food security strategy of the USAID mission for Mozambique is to increase rural household income through increased sustainable agriculture output, CARE Mozambique sought funding from this source to expand coverage when the project's potential for success was apparent. The VIDA I program (FY1997-2001) was implemented in roughly two-thirds of the districts in Nampula Province. The agricultural intervention went beyond oil seed crops to a variety of crops for diversified production and sale, along with a focus on extending the harvest period for staple crops to promote food security throughout the year.

After 3 years of project implementation, there was evidence that there were increases in household income for participants. However, household livelihood security analysis raised the question as to whether increasing household income would immediately translate into improved household food consumption (an expected "natural" synergy), especially for vulnerable members of the household, such as women and children. At this point, the VIDA I program chose to incorporate a nutrition intervention that would be specifically targeted to mothers with children under age five in a limited number of program districts, or approximately one-third of the VIDA program target area.

The focus of the nutrition intervention has been to promote appropriate complementary feeding practices for the weaning period (extended breastfeeding is a traditional practice for the majority of women, while the introduction of solids occurs later than recommended). Due to the low educational levels of women in the area, the number of nutrition education messages were limited and careful efforts to assess the comprehension and retention of nutrition education materials were a part of the initial design of the activity.

The nutrition education strategy is based on improving the traditional weaning food, which is porridge made of corn or cassava. The recipes promoted for improved weaning foods rely upon available foods traditionally produced by households or food crops that are promoted through the agricultural extension intervention of VIDA. In addition, the nutrition intervention is linked with the agricultural intervention for the promotion of dark orange-fleshed sweet potatoes as a source of Vitamin A.

Mothers' Nutrition Groups have been formed and trained to further multiply the key messages regarding the appropriate frequency of feeding for children age 6 to 24 months, the importance of calorie-dense food and the importance of Vitamin A consumption for health

within their communities (Figure No.5). A diversified diet is also promoted, based on the linkage between nutritionally balanced diets and greater diversity in food consumption.[5]

Photo: Mozambique/©CARE 2001

Figure No.5: Women's Nutrition Groups preparing improved weaning foods

The program is entering a second funding period and has chosen to expand the coverage of the nutrition component to all program target districts and broaden the range of nutrition education messages disseminated. With high rates of anemia among women and children, nutrition education will begin to focus on the importance of the consumption of foods rich in iron by children during the weaning period. The intervention will also target pregnant women, providing nutrition education on appropriate diet during pregnancy and highlighting the importance of the sufficient consumption of calories, vitamins and micronutrients, such as iron. These actions will complement national micronutrient initiatives by the Helen Keller Institute, provincial initiatives for capacity-building activities for the Ministry of Health in Nampula and a CARE Child Survival program operating in two of the VIDA districts.

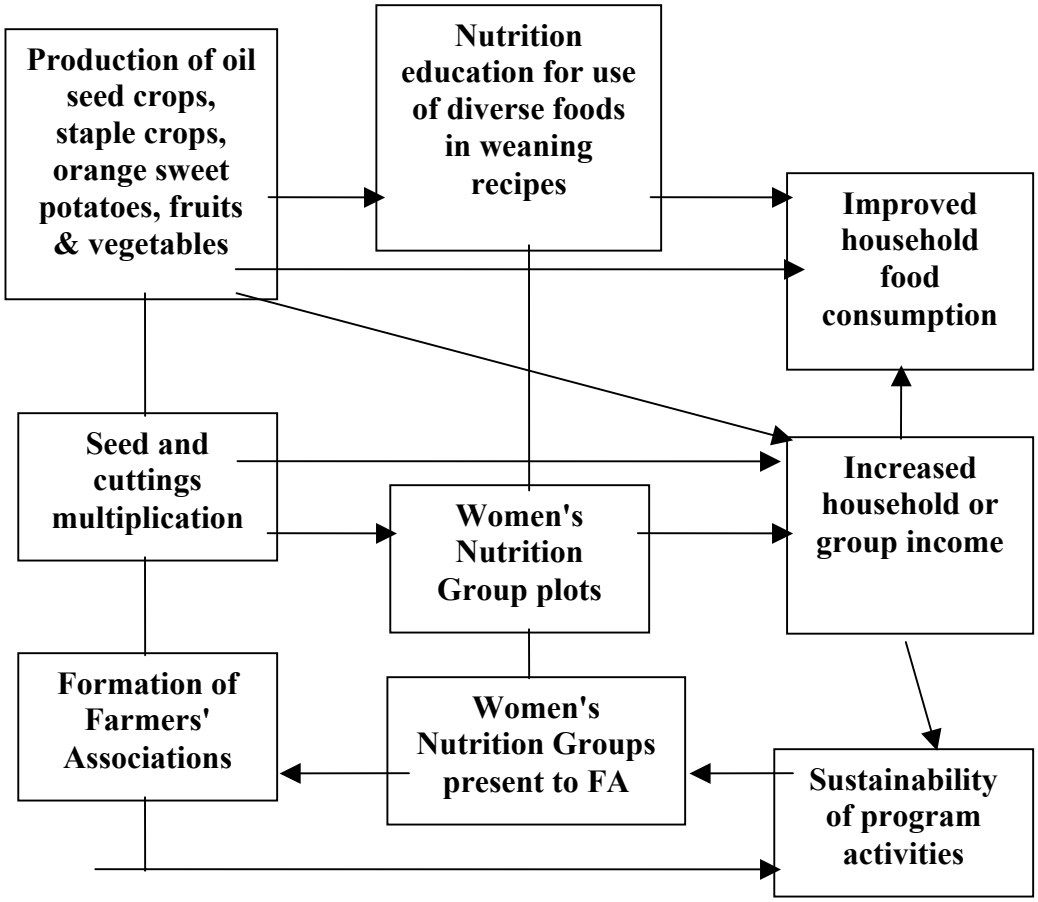
Staff will conduct formative investigation with focus groups to better understand the traditional and/or modified traditional dietary practices during pregnancy so that nutrition education messages can be tailored in response. It is likely the intervention will need to address issues related to gender equity as part of this process.

Besides the fact that the VIDA II agriculture and nutrition activities are targeted to the same areas, there are several distinct linkages between the interventions. To achieve the

[5] *Measuring Household Food Consumption: A Technical Guide,* by A.Swindale and P.Ohri-Vachaspati; Food and Nutrition Technical Assistance Project; November 1999.

sustainability of the Mothers' Nutrition Groups, the groups are provided with seeds through the agricultural intervention and encouraged to produce and sell these crops for the financial support of group nutrition education activities. Mothers' Nutrition Groups are also linked with legally inscribed Farmers' Associations and are expected to participate in periodic events in which the two groups participating in VIDA interventions share new information and discuss program successes and challenges (Figure No.6).

Figure No.6:
Synergy between VIDA agriculture and nutrition interventions



All of the VIDA program actions directly support the goals of the program counterpart, the Ministry of Agriculture and Fisheries, and the objectives of the Technical Secretariat for the Food and Nutritional Security Strategy (SETSAN) adjunct to that ministry and created as a focal point for coordination of the Action Plan for Food and Nutrition Security of the Republic of Mozambique.

C. Program Results To-Date

In line with CARE's commitment to demonstrate measurable positive impact for program beneficiaries and to monitor information in a timely fashion for the continuous improvement of program activities, both the CARE Honduras Food Security Program ((FSP) and the CARE Mozambique Viable Initiatives for the Development of Agriculture program (VIDA) include a strong focus on monitoring and evaluation.

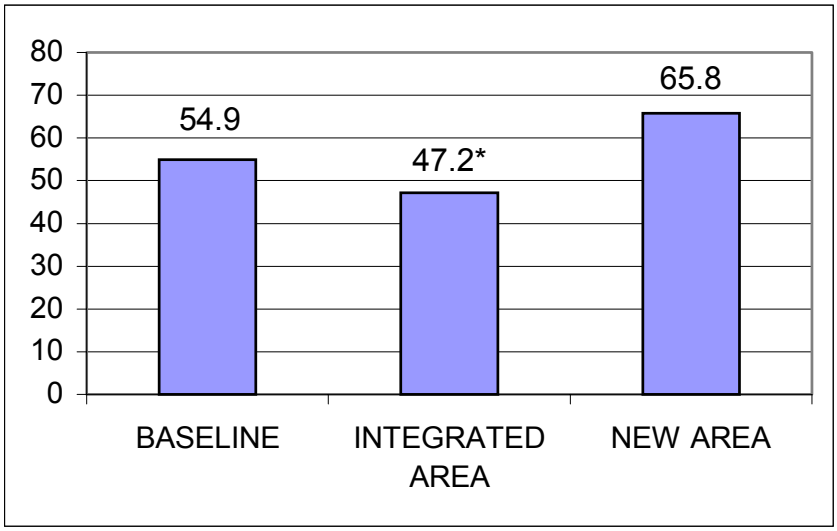
CARE Honduras has invested heavily in the monitoring and evaluation of its Title II Food Security Program. The FSP program has contracted the same external firm to conduct baseline survey in 1996, midterm evaluation in 1998 and final evaluation in 2000, which also served as a baseline for the FY2001-FY2005 period. This firm developed the survey instruments and has organized the training of external surveyors, with technical assistance from the Food and Nutrition Technical Assistance Project (FANTA) and from the CARE Honduras FSP Monitoring and Evaluation Specialist. The firm is also responsible for data entry and the production of frequency tables, cross-tabulations and analysis for statistical significance when comparing results over time. The CARE Honduras FSP staff internally conduct all quarterly monitoring activities and regularly participate in team workshops, along with program partners, to reflect upon both monitoring and evaluation results and adjust program strategies accordingly.

Among the higher-level indicators that are evaluated by the CARE Honduras FSP are indicators of household income, household food consumption and child malnutrition. The tools and techniques for the measurement of household income from agricultural production and other sources of income were developed with significant assistance from FANTA and have not changed over the life of the program. However, the indicators reported upon from these tools have been adapted over time to better reflect the direct effects of the program.

At baseline in 1996, the survey also included a separate activity to measure household food consumption through repeated observational visits to a limited number of households, during which the food to be consumed was weighed and/or compared to containers calibrated for size and weight. This technique was exchanged for the 24 hour diet recall method for household consumption and is now included in the household survey instrument. The diversity of household food consumption, which has been found to correlate well with observational methods to calculate diet sufficiency, is now reported as the key indicator.

Anthropometric tools, or measurement of the weight and height of children from 0-59 months of age, have been a mainstay among the program's evaluation techniques. One of the most exciting results found during final evaluation FY2000 was a decrease in the percentage of children age 24-59 months classified as stunted (height-for-age <-2 standard deviations, Z-scores) when compared to baseline values. At baseline, 54.9% of children age 24-59 months were classified as chronically malnourished, or stunted. This had decreased to 47.2% by final evaluation (Figure No.7).

Figure No.7
Graph of the percent of stunting for children 24-59 months of age



*** Statistical significance at p<0.01.**

As a baseline survey for the FY2001-2005 period was conducted at the same time, it was also found that for another comparison group, the communities that would enter the program in FY2001 as coverage in the region is expanded, chronic malnutrition was even higher, at 65.8%.

Child malnutrition is a higher-level indicator that reflects multiple factors related to household livelihood security. One of these factors is child health care. When considering the activities addressed by the CARE Honduras FSP maternal-child health and nutrition intervention, improvement was found in multiple indicators of mothers' knowledge and practices for the care of child health and nutrition. As improvements were also found in household food consumption, along with other indicators of the agricultural extension intervention, EXTENSA, and the food-for-work and local government capacity-building activities of PODER, the next question was whether the synergies between interventions as conceived in the design of the program had also contributed to the achievement of reducing child malnutrition.

Regression analysis was conducted of household participation in the different program interventions. The idea was to see if there was a difference in the impact on child malnutrition between household participation in one, two or all three of the interventions, after controlling for a set of household and individual characteristics. The characteristics of household access to water and sanitation, gender of the head-of-household, and the child's age and sex were controlled, as well as the number of months of participation in the program. The regression model predicted the probability that a child within the household was chronically malnourished (Figure No.8).

Figure No.8
Effect of household participation in interventions of the CARE Food Security Program on child stunting, age 24-59 months

Variable	Coefficient	
Participation in any 1 intervention (reference)	1.0000	
Participation in 2 interventions	1.1115	
Participation in all 3 interventions	0.3441	*

*** Significant at 0.01**

The coefficient expresses the increase or reduction in the probability of finding a chronically malnourished child within the household as compared to the reference case (participation in any 1 intervention). A coefficient of 1.000 represents no difference in probability. Little difference was found for households participating in any two interventions. However, a clear relation between improvements in chronic malnutrition and participation by households in all three interventions was evident. When a household benefits from the expected synergies between all program components, the probability of finding a child with chronic malnutrition in that household is reduced by two-thirds (from 1.0000 to 0.3441).

Although this analysis is very preliminary, it may indicate that there is a "threshold" level where various changes and effects accumulate sufficiently to result in measurable positive impact on higher-level indicators. This analysis has encouraged the CARE Honduras Food Security Program to continue to seek to integrate project activities within communities as the results are clearly worth the effort. The database established will permit broader and more detailed regression analysis and comparison of evaluation results in FY2005.

For the CARE Mozambique VIDA program, it is still too early to expect to demonstrate a synergistic effect from combined program interventions as the nutrition component was integrated with the agricultural activity in only one-third of the target area and in only the final two years of the first program cycle. Comparison of the final evaluation results of 2002 to results from the baseline survey in 1997 revealed no statistically significant change in the overall percentage of chronic malnutrition found in children age 24-59 months, 60.0% to 59.2%.

However, a decrease in the *severity* of stunting was demonstrated, with 9.2% (more than 75 children) moving from the classification of severe stunting (height-for-age <-3 standard deviations) to the category of moderate stunting (<-2 sd but $\geq$-3 sd), as seen in Figure No.9.

Figure No.9
Severity of chronic malnutrition in children age 24-59 months

Z score Height-for-age	Baseline 1997		Survey 2002	
	n	%	n	%
Severe (<-3 sd)	304	34.5	210	25.3
Moderate (<-2 sd and ≥-3 sd)	224	25.5	282	33.9
Mild or none (≥-2 sd)	352	40.0	341	41.0
TOTAL	880	100.0	831	100.0

A reduction in stunting among children age 24-35 months was also found, from 65.2% to 57.7%, another positive effect that may accumulate to show measurable change in the stunting of children age 24-59 months by FY2006.

The sample selection for evaluation of Title II programs uses a population-based cross-sectional analysis over time and includes both participating and non-participating households. Although it is too soon to invest in additional analysis beyond that necessary to track and report on program indicators, simple cross-tabulation of program participation and nutritional status reveals a positive trend for program participants (Figure No.10).

Figure No.10
Percentage of children age 24-59 months with chronic malnutrition, by participation in VIDA I program activities

Household Participation in VIDA Project Activities	HEIGHT-FOR-AGE < -2 s.d.	
	n	%
Any project activity	181	56.9
No participation	225	64.1
Agriculture only	77	49.3
Nutrition only	86	62.7
Agriculture and nutrition	18	72.0
No participation	225	64.1

The results show a benefit from household participation in any project activity as compared to non-participation, although the benefit is greater for households participating in the agriculture intervention. However, even with only two years of intervention in one-third of the program's target area, a benefit is seen for those participating in the nutrition activity. The expected benefit from synergy between interventions is not seen, but the total number of households that participated in both interventions was very limited during the VIDA I period.

It is expected that the positive trends seen at the end of the first cycle of the CARE Mozambique VIDA program will continue and accentuate as the program implements a second cycle. Although program expansion brings additional challenges to reach new participants, the expansion of the nutrition component to all of the targeted districts is likely to result in a synergy between interventions that will potentiate positive impact for households, as seen in the CARE Honduras Food Security Program. The excellent database being established by the CARE Mozambique VIDA program will permit for a variety of analyses at final evaluation in FY2006 that can inform CARE's long-range strategic planning and program design for northern Mozambique.

D. Discussion

This document, which reflects upon the design and activities of maternal-child health interventions in two CARE Title II integrated programs, highlights several points worthy of further discussion.

Both programs have designed their interventions for maternal-child health and nutrition in response not only to the needs of the target population but also as complementary to the capacities of their government counterparts. The CARE Mozambique VIDA program has multiple direct linkages between the activities of its agricultural extension component and the nutrition education intervention. It directly supports the food security goals of its counterpart, the Ministry of Agriculture and Fisheries and the adjunct Technical Secretariat for the Food and Nutritional Security Strategy (SETSAN). The CARE Honduras MCH/N intervention complements and strengthens the efforts of local Ministry of Health partners. Program activities are integrated at the community level through a focus on local government capacity building that includes strengthening the abilities of community organizations to work effectively with local government.

Both programs show signs of a positive impact on household livelihood security, as measured by the nutritional status of one of the household's more vulnerable members, from the design of programs that include interventions to address mother and child well-being. The impact for the CARE Honduras Food Security Program is dramatic and statistically significant, with the program continuing to build upon its years of experience in maternal-child health and nutrition. For the CARE Mozambique VIDA program, the nutritional intervention is a new addition that is beginning to show positive results and can be expected in the future to synergistically multiply the positive effects already seen for households participating in the agriculture extension component and, to a lesser degree, participating in the nutrition component.

As the evaluation of Title II programs is population-based and cross-sectional over time, the need becomes apparent for Title II programs to not only focus on continuous improvement of the design of program activities for direct participants but also on the ways and means to reach non-participants. The opportunity provided by the programs' evaluation systems to look at new areas for program expansion as comparison groups, along with the opportunity to look at the indicators over time, addresses some of the issues which are naturally raised regarding participants vs. non-participants and external factors beyond the control of the programs.

The investment both country offices have made in conducting rigorous and large-scale evaluation is providing a wealth of information to assist program planning and design. Although only a few evaluation results were presented in this document, both programs

monitor and evaluate between 20 and 30 indicators, along with gathering information on demographic variables. Both programs have arranged for the training and materials necessary to conduct anthropometric measurement of children, which is an activity both technically and functionally different from household survey. (Additional information is available in either program's reports for final evaluation, which can be obtained through the CARE USA PHLS Unit.) In addition, although not discussed in this document, both programs regularly monitor a large number of indicators in the field, tracking a significant amount of information on program implementation, participant activities and seasonal effects or impact.

It is interesting to note that further analysis, beyond that needed to track and report upon the programs' performance indicators, was necessary to assess the effects of synergy between interventions and other variable levels of program participation and potential impact discussed in this document. CARE can continue to take advantage of the databases that have been developed and arrange for additional analyses to contribute to a better understanding of program design and integration, synergy between interventions, and other areas of interest, such as the effects of program activities on gender equity.