

**Amalima Strategic Objective 3 Outcome Monitoring Report**

**September 2018**

**ZIMBABWE**

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# Acronyms

ANC-------------- ----Ante Natal Care

CA --------------------Catchment Area

CGV------------------ Care Group Volunteer

EBF--------------------Exclusive Breastfeeding

GMP------------ ------Growth Monitoring and Promotion

LM--------------------- Lead Mother

LQAS--------------- --Lot Quality Assurance Sampling

WASH-------------- Water, Sanitation and Hygiene

SA-------------------Supervision Area

SAM------------------ Severe Acute Malnutrition

# 1.0 INTRODUCTION

## 1.1 Project Description

Amalima is a Ndebele word for the social contract by which families come together to help each other engage in productive activities such as land cultivation, livestock tending, asset building and their own development initiatives. The goal of the project is to sustainably improve food and nutrition security by 2018 through strengthening the communities’ resilience to shocks, increase productivity, and improve drought mitigation and adaption and enhancing nutrition and hygiene practices.

Amalima is working with households to provide a combination of capacity building, training and mentoring, food rations, vouchers, tools, matching grants, and community-based messaging and mobilization.

Amalima has been operational in Matabeleland North’s Tsholotsho and Matabeleland South’s Mangwe, Bulilima and Gwanda districts since June 2013 and will continue up to 2020. The extension comes after approval by the donor as the project was set to end in June 2018.

The project has three strategic objectives:

1. SO1: Household access to and availability of food improved
2. SO2: Community resilience to shocks improved; and
3. SO3: Nutrition and health among pregnant and lactating women; and boys and girls under two improved; which has three Intermediate Results (IRs) as follows:
	* 1. IR 3.1 Consumption of diverse and sufficient foods for pregnant and lactating women; and boys and girls under 2 improved
		2. IR 3.2: Health and hygiene and caring practices of pregnant and lactating women, caregivers and boys and girls under 2 improved
		3. IR 3.3: Accessibility to and effectiveness of community health and hygiene services improved

# 2.0 Introduction to the Methodology

LQAS methodology was developed to help manufacturers determine (at a minimum cost) whether their products met a set of quality standards. This was achieved by utilizing small sample sizes. LQAS is a quality assurance analysis method that originated in the manufacturing industry and is now frequently applied in international health. In 1991, a World Health Organization (WHO) report on epidemiological and statistical methods for rapid health systems assessment concluded that LQAS was one of the more practical methods available and encouraged its further development to monitor health programs. LQAS analysis provides a method to classify whether a binary (yes/no) outcome is at or above a critical threshold level. LQAS analysis is also useful in emergency settings, where government and humanitarian agencies often need to know whether the prevalence of acute malnutrition has exceeded a certain threshold level or not. The threshold levels of 10%, 15%, and 20% acute malnutrition prevalence are often used to determine the severity of a situation, the scale of the response warranted, and the most appropriate type of nutrition intervention to implement (e.g., targeted supplementary feeding, blanket supplementary feeding). LQAS’s main applications in child survival are service adequacy, coverage, and quality. Reported applications present LQAS as a practical, relatively low-cost field method that is increasingly being applied in health programs. The method has been used to assess immunization coverage, women’s health issues such as family planning and antenatal care, use of ORT, disease incidence, and evaluation of health worker performance, in urban zones, rural areas, or on a national scale, in over 32 countries and the 5 continents. Lots have been defined as health center catchment areas, townships, villages, districts or zones in a city or within a province. Based on the above information presented about the methodology, it is crucial to posit that this methodology is useful in informing Amalima about the impact, effectiveness and relevance of its interventions in the operational areas. Results from this survey will also contribute to assess the sustainability of some of the promoted behaviors.

LQAS has emerged as a practical management tool for conducting baseline surveys and monitoring health services and health needs. Advantages of the methodology include the following:

* LQAS sampling procedures and analyses are relatively simple and the findings can be used immediately by local managers and health workers.
* The data from individual Supervision Areas (SA) can be aggregated into an estimate of coverage for the entire program Catchment Area (CA).
* Only a small sample is needed to classify whether a supervision area is under/over performing against a predetermined target.

# 2.1 LQAS Objectives for Amalima

In order to gather more detailed information in the project’s achievements toward Strategic Objective 3, which states, “Nutrition and health among pregnant and lactating women, and boys and girls under 2 years improved,” the consortium has conducted its third LQAS in two catchment areas, (Bulilima and Tsholotsho) with the following objectives:

* To determine coverage of promoted behaviors and practices in exclusive breastfeeding, maternal care, and water, hygiene and sanitation (WASH) in each program district.
* To understand which wards in a district are performing adequately or inadequately in comparison to established benchmarks
* To permit Amalima to carry out routine monitoring of promoted behaviors and practices, including learning from higher performing wards identified through LQAS
* To allow program management to better allocate resources and time to underperforming indicators and wards
* To determine coverage of key activities promoted, these are ration distributions and care group participation.

In 2014 Amalima conducted a Formative Research on Infant and Young Child Feeding (IYCF) and the results from this study led to the design of an IYCF strategy. The IYCF strategy endeavors to promote the below as key behaviors for mothers and caregivers according to age categories:

***Mothers of Infants less than 6 months:***

* Increase day time breast feeds to at least 8 during the day
* Increase number of night time feeds- 4 at night
* Empty one breast complete and offer the other at each feed
* Avoid giving water and complementary foods before 6 months

***Mothers of Infants 6-11 months***

* Increase number of meals up to three times a day
* Give one nutritious snack per day from locally available foods
* Feed animal source foods at least 2 times each week
* Enrich porridge with nuts legumes and vegetables
* Breastfeed before not after feeding solid foods

***Mothers of Infants and Young Children (0-24 months)***

* Wash Hands with soap/ash and running water before eating and feeding the baby
* Wash baby’s hands before eating
* Boil or treat water that is used for the baby
* Use Clean utensils to feed the baby
* Keep yard where baby plays and eats clean from feces
* Play and eat on a mat and Keep child away from animals at meal time

The outcomes from the study have been integrated into the project’s teaching aids and behavior change strategy to influence the nutrition and WASH outcomes under SO3. The LQAS under SO 3 is now used to rapidly allow the team to assess on annual basis the extent to which the promoted behaviors were being adopted in the communities.

# 3.0 INDICATORS

Amalima identified several outcomes to be monitored through LQAS out of the above-promoted behaviors. These outcomes, outcome indicators and year 5 targets are organized within established program intermediate results, and are available in annex 1: Indicators.

# 4.0 SURVEY METHODOLOGY

During the third round of this LQAS study, Amalima conducted two identical LQAS studies – one in Bulilima and another in Tsholotsho. In each district, wards were grouped based on physical access and staff management structures so that there were 5 supervision areas (SAs) per district. In each SA, the Census of 2012 was used to determine the sampling frame. The wards were listed with their total population, then the cumulative population was calculated as well as the sampling interval. The sampling interval was calculated for each SA by dividing the SA. A random number was chosen from a random number table, and this number was lying between 1 and the sampling interval. Using that initial random number and the sampling interval, the community locations for the interviews were identified. The assessment specifically targeted mothers with babies from 0-5 moths and mothers with children from 6-23 months in a parallel sample style. Two questionnaires was administered to 19 mothers in each SA; one for each sample. Therefore, in each district 190 interviews were conducted (5 SA \* 19\* individuals\*2 parallel samples = 190 interviews per District. This translated to 380 respondents for the program area (190Individuals/ District \* 2 Districts). This has been the same approach that has been used in the preceding two years. The questionnaires were pre-tested in Tsholotsho District. This gave enumerators an experience and a post pretest discussion was done to ensure that the data quality was of great value to inform decisions from this study.

## 4.1 Supervision Areas Covered

|  |  |  |
| --- | --- | --- |
| **SAs** | **Wards Covered (Tsholotsho)** | **Wards covered (Bulilima)** |
| SA 1 | Sipepa, Kapane, Dibutibu | Tjangwa, Gwambe, Natane |
| SA 2 | Dlamini, MpanedzibaJimila,Dombo | Nyele, Matjinge, Masendu, Ndiweni |
| SA 3 | Tshitatshwawa,Phumula,Sodaka | Dombodema, Dombolefu, Vulindlela, Malaswazi |
| SA 4 | Shaba, Nkunzi, Bubude, Chefunye | Bambadzi, Hingwe, Madlambuzi |
| SA 5 | Sikente, Nemane, Manqe, Jahe, Makaza, Mbamba | Makhulela, Ndolwane, Huwana, Gala, Khame |

## 4.2 Training of Enumerators

A two day training of enumerators for five (5) was held at the Amalima Head Office in Bulawayo. The training included a brief introduction to the LQAS methodology, data collection skills, survey etiquette, and an in-depth understanding of the indicators to be collected, and selection of respondents among other important aspects of enumeration. The team reviewed the questionnaires together and went on to conduct a pre-test in one ward in Tsholotsho before the data collection tools were printed.

## 4.3 Data Collection

Data collection was conducted over a period of 12 days by the team of 5 Enumerators (5 days in Tsholotsho and another 5 days in Bulilima) from the 27th August 2018 to the 12th of September 2018. A 3-day mop-up collection was then organized for both Bulilima and Tsholotsho as the data collection sample size was not met within the initially scheduled time.

## 4.4 Data Entry and Analysis

Data entry followed by hand tabulations in Microsoft Excel took place in Bulawayo for both districts.

# 5.0 Main Findings

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Outcome Indicator** | **Desired Direction of change** | **Target by End of Project** | **Amalima Baseline (*where available*)** | **FY15 Coverage Estimate** | **FY16 Coverage Estimate** | **FY17****Coverage Estimate** | **FY 18 Coverage Estimate** | **Indicator Needs** **Attention (Y/N)** |
|  |  | ***Breastfeeding Indicators*** |
| **Proportion of infants 0-5 months of age who are fed exclusively with breast milk** | 🡹 | 80% | 44.9% | 84.2% | 85.3% | 93.2% | 87.7% | No |
| **Proportion of children 0-5 months who were given something to drink other than breast milk within the first 3 days of birth** | 🡻 | 20% | - | 1.1% | 6.8% | 18.9% | 12.2% | No |
| **Proportion of children 0-5 months who were put to the breast within one hour of birth** | 🡹 | 80% | - | 66.1% | 79.5% | 87.9% | 87.7% | No |
| **Proportion of children born in the last 24 months who were ever breastfed** | 🡹 | 80% | - | - | 97.6% | 98.7% | 100% | No |
| Percent of mothers offering both breast during each breast feeding session | 🡹 | 80% | - | 91.3% | 90.5% | 88.9% | 95.8% | No |
| **Proportion of mothers with infants less than 6 months who completely empty the breast at each feed** | 🡹 | 80% | - | 54.2% | 75.8% | 71.6% | 92.6% | No |
| **Proportion of children 0-5 months of age who are fed on breast milk 8 times or more during the day** | 🡹 | 80% | - | - | 40% | 71% | 85.2% | No |
| **Proportion of children 0-5 months of age who are fed on breast milk 4 times or more during the night** | 🡹 | 80% | - | - | 76.8% | 73.7% | 84.7% | No |
|  |  | ***ANC*** |
| **Percent of pregnant women completing 4 antenatal visits** | 🡹 | 80% | - | 77.1% | 72.6% | 97.4% | 89% | No |
| **Proportion of pregnant women who registered the pregnancy at a health center within 3 months of pregnancy** | 🡹 | 50% | 23.2% | 23.7% | 25.8% | 41.1% | 52% | Yes |
| **Iron Folate intake during pregnancy** |  | 80% | - | - | 90.5% |  | 93.2 | No |
|  |  | ***Care Group, Growth Monitoring and Ration Coverage*** |
| **Proportion of caregivers with children 0-23M regularly attending care group activities** | 🡹 | 80% | - | 44.5% | 62.9% | 57.1% | 40.8% | Yes |
| ***0-5M*** | 50% | 40.5% | 38.4% | Yes |
| ***6-23M*** | 75.8% | 73.7% | 43.2% | Yes |
| **Proportion of caregivers participating in other Amalima activities (apart from rations and care groups)** | 🡹 | 80% | - | - | 31.8% | 23.2% | 25% | Yes |
| **Percent of children 0-23M months regularly attending growth monitoring and promotion** | 🡹 | 80% | - | 73.7% | 74.7% | 80.8% | 82.1% | No |
| ***0-5M*** | 90% | 90% | 92.1% |  |
| ***6-23M*** | 59.5% | 71.6% | 72.1% |  |
| **Rate of non-participation** | 🡻 | 20% | - | - | 8.7% | 3.95% | 9.5% | No |
|  | *Lactating women* | 12.63% | 6.3% | 11% | No |
|  | *Children 6-23M* | 4.7% | 1.6% | 7.9% | No |
|  |  |  |  ***Child Feeding Indicators*** |
| **Proportion of breastfed and non-breastfed children 6-23 months who received solid, semi-solid or soft foods the minimum number of times or more** | 🡹 | 80% | - | - | 71.1% | 67.2% | 74.7% | Yes |
| **Proportion of children 6-23 months who of age who received foods from 4 or more food groups** | 🡹 | 60% | - | - | 37.4% | 32.1% | 35.3% | Yes |
| **Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk)** | 🡹 | 30% | 3.4% | - | 23.2% | 24.7% | 31.2% | Yes |
| **Proportion of children 6-23 months of age who are fed breast milk (continued breastfeeding at 6 months)** | 🡹 | 80% | - | - | 73.7% | 82.1% | 73.2% | Yes |
| **Proportion of children 6-23 months who received a nutritious snack in the previous 24 hours** | 🡹 | 80% | - | - | 62.6% | 56.8% | 68.9% | Yes |
| **Proportion of children 6-23 months who received a "sugary/unhealthy" snack in the previous 24 hours** | 🡻 | 20% | - | - | 28.4% | 17.4% | 18.9% | Yes |
| **Proportion of children 6-23M who are fed on breastmilk before receiving solid foods** | 🡹 | 80% | - | - | 45.8% | 47.9% | 56.3% | Yes |
| **Proportion of children 6-23 months who received an animal source food twice during the previous seven days (based on 7 day recall)** | 🡹 | 80% | - | - | 55.8% | 50% | 42.6% | Yes |
| **Proportion of caregivers who wash baby’s hands with soap and water before offering solid foods** | 🡹 | 80% | - | - | 57.9% | 84.1% | 87.3% | Yes |
| **Proportion of children 6-23M who are fed from a separate bowl** | 🡹 | 80% |  | - | 93.7% | 93.2% | 86.8% | No |
| **Proportion of children 6-23 months of age receiving the recommended dose of vitamin A supplementation** | 🡹 | 80% | - | - | 57.9% | 94.7% | 86.8% | No |
|  |  | ***WASH Indicators*** |
| **Percent of household with soap/ash and water at a hand washing station commonly used by family members** | 🡹 | 50% | 1.6% | - | 23.4% | 37.1% | 26.1% | Yes |
| **Percent of households using an improved drinking water source** | 🡹 | 50% | 44.5% | - | 76.6% | 78.6% | 82.8% | No |
| **Percent of households using an improved sanitation facility** | 🡹 | 50% | 40.6% | - | 59.2% | 52.4% | 46.6% | Yes |

##

# 6.0 Discussion

The FY18 Lot Quality Assurance Sampling findings show a percentage of 87.7% of mothers in the program areas are practicing exclusive breastfeeding. For WASH behaviors, 82.8% of households are using an improved drinking water source, up from 78.6% in FY17. These improved behaviors are further reinforced by findings from the 2018 National Nutrition Survey, where the program districts have reduced stunting rates (see table below) as compared to Amalima’s baseline. While this reduction cannot be attributed solely to Amalima activities, it gives us insight on what expect from the endline survey.

**Comparison of current and past stunting rates in Amalima Districts**

|  |  |
| --- | --- |
|  | **Stunting Rates** |
| 2010 NNS  | 2014 Amalima Baseline  | 2018 NNS |
| National | 33.8% | N/A | 20.6% |
| Gwanda | 24.7% | 33.4% | 17.8% |
| Tsholotsho | 37.4% | 33.4% | 24.7% |
| Bulilima | 28.6% | 33.4% | 27.9% |
| Mangwe | 29.2% | 33.4% | 26.2% |

The Amalima program will continue to strengthen strategies aimed at addressing those behaviors which are not being easily adopted, this includes:

* Proportion of children 6-23 months of age who receive a minimum acceptable diet (31.2%).
* Proportion of children 6-23 months who of age who received foods from 4 or more food groups (35.3%)
* Percent of household with soap/ash and water at a hand washing station commonly used by family members (26.1%)
* Proportion of children 6-23 months who received a "sugary/unhealthy" snack in the previous 24 hours (18.9%)

Amalima will reinforce efforts to promote participation of SO3 beneficiaries in SO1 activities and continue to utilize social behavior change strategies at community platforms to highlight the benefits of adopting key optimal behaviors.