



2019 Report

Our program:

1. We evaluate children under 60 month of age every six months. We weigh and measure children. Using World Health Organization Standards we calculate nutritional status based on height for age (stunting), weight for age (underweight), and weight for height (wasting).
2. We provide nutritional supplements to all children under 5 who are moderately acute (MAM) or severely acute (SAM). We recommend that all MAM/SAM children be taken to the health centers immediately, while also aware that services are generally quite limited in most countries.
3. Emphasizing the first 1000 days, we provide nutritional supplements to children under 24 months who have every been undernourished, pregnant women, and nursing mothers with children under 6 months.
4. We also provide nutritional supplements to children between 24 and 36 months who are undernourished at the screening.
5. Supplements are distributed every month.
6. Health education classes are offered 6 times per year when supplements are distributed. We invite all caregivers to attend these lessons. Research shows that a combination of health education and nutritional supplementation are more effective than either approach separately.

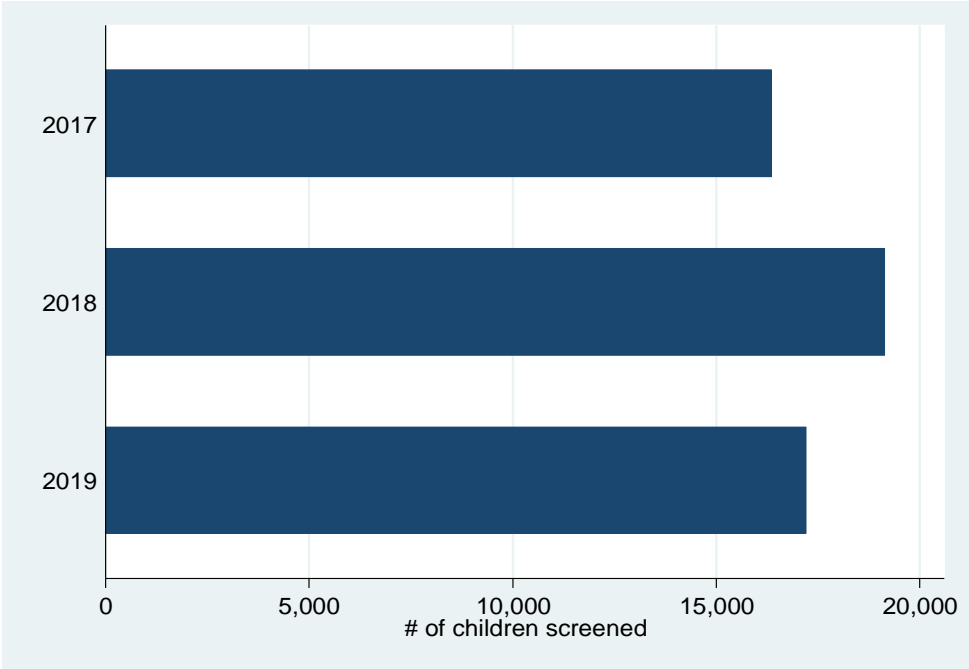
Note: Due to budgetary limitations we cannot provide optimal supplementation to all undernourished children.

Milestones in 2019:

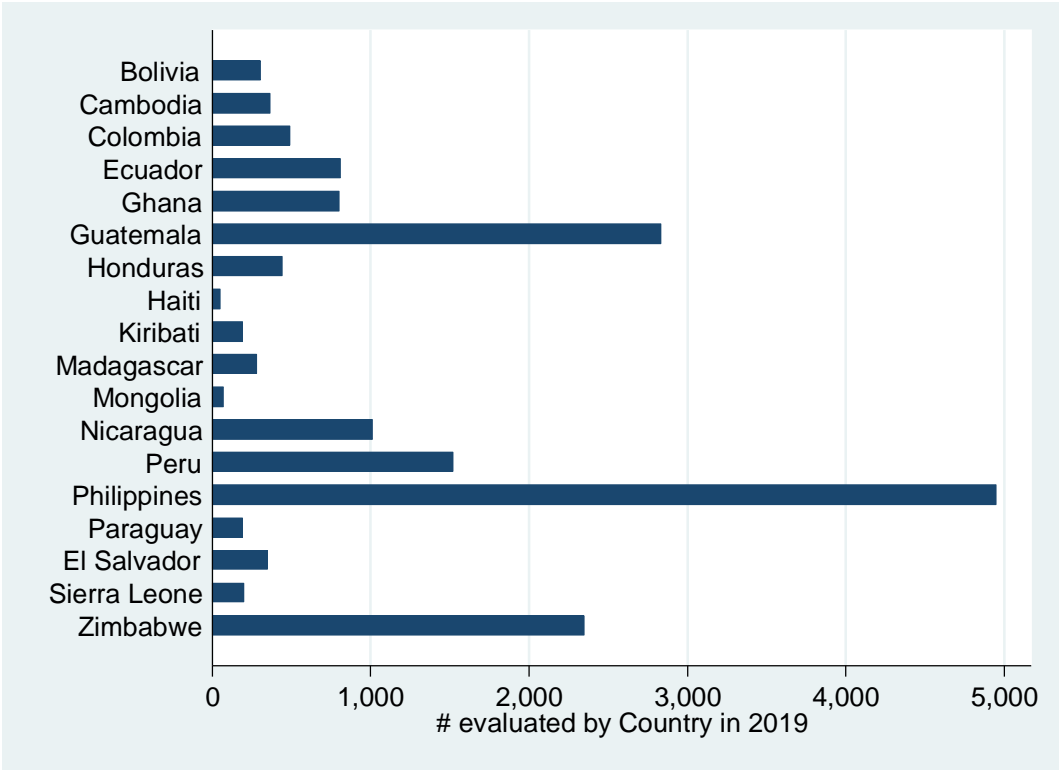
- We have started providing supplements for families in Venezuela
- Health professors have developed new lesson on cognitive development
- Carried out and passed our first audit

Statistics:

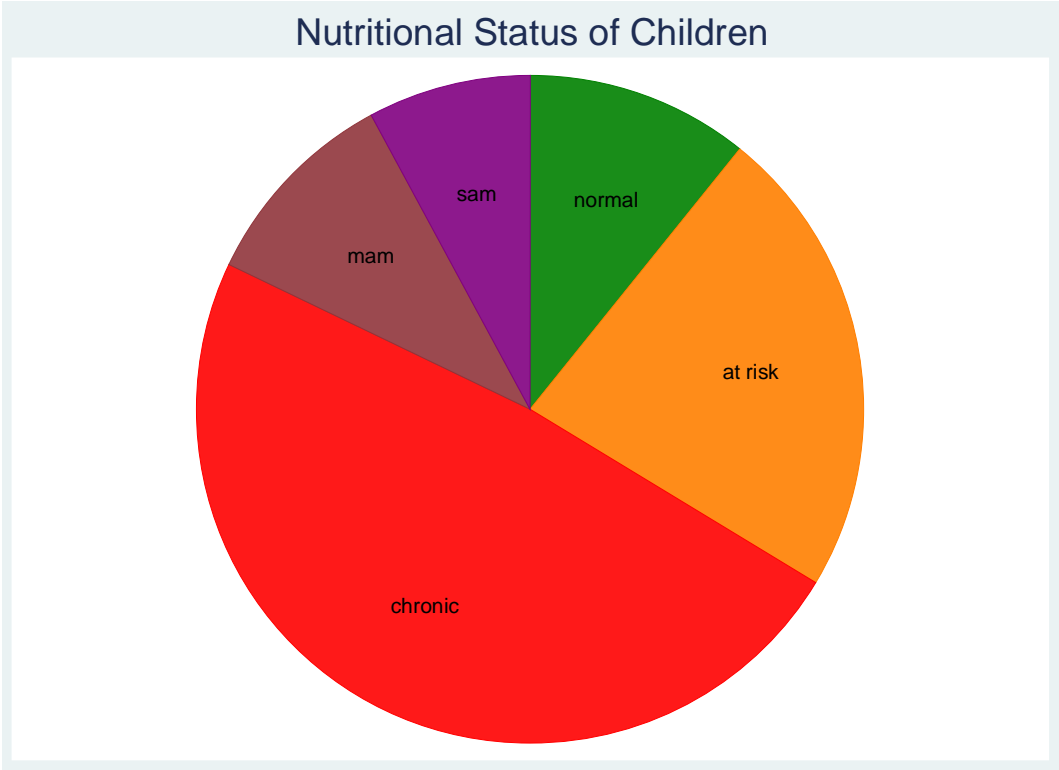
For each of the last 3 years we have evaluated between 16,000 and 19,000 children.



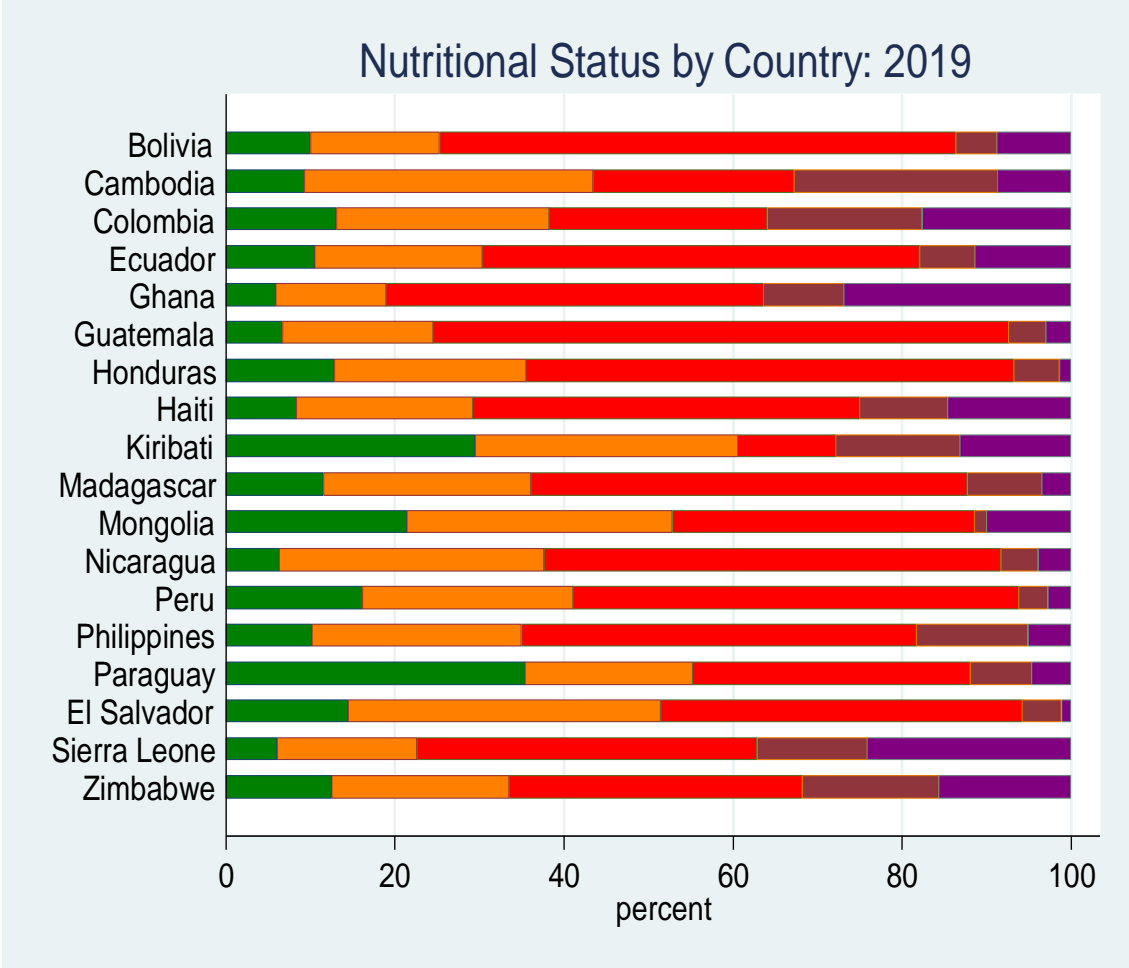
The Philippines has the largest number of children evaluated, followed by Guatemala and Zimbabwe.



Nearly half of the children we evaluated in 2019 were chronically malnourished, ten percent are moderate- acute and eight percent are severe-acute. Only eleven percent were normal. Clearly, malnutrition is a major problem in the areas where we work.

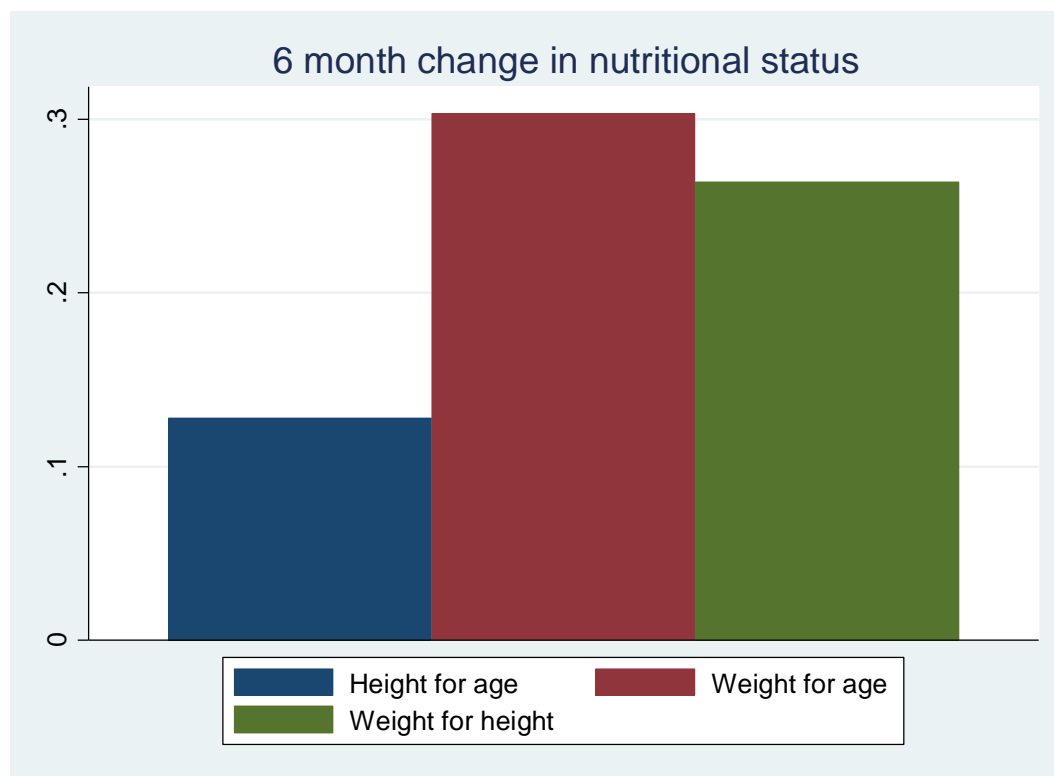


Although nutritional status varies by country, over half of the children are malnourished in every country where we work. Acute malnutrition is especially high in Cambodia, Colombia, Ghana, Kiribati, Sierra Leone and Zimbabwe. For countries where we have comparisons, the children we screen have higher malnutrition rates than the country averages.



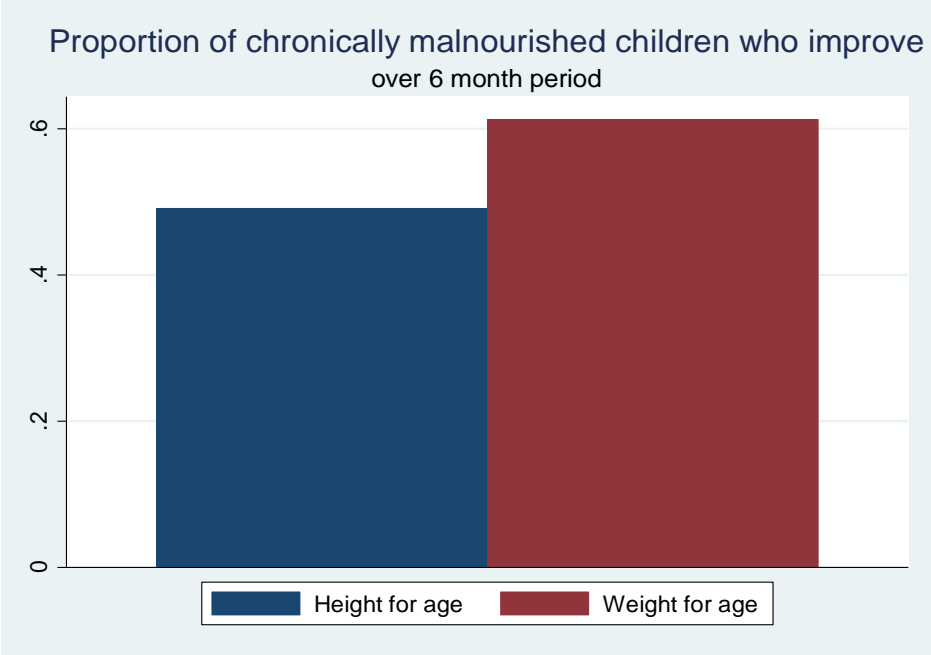
Impact on children:

Nutritional status is assessed by z-scores for height-for-age, weight for age, and weight-for-height. Change in height-for-age among malnourished children is relatively small because it is hard to make up for stunting. But improvements in weight-for age-and weight-for-height are substantial for children in our program.

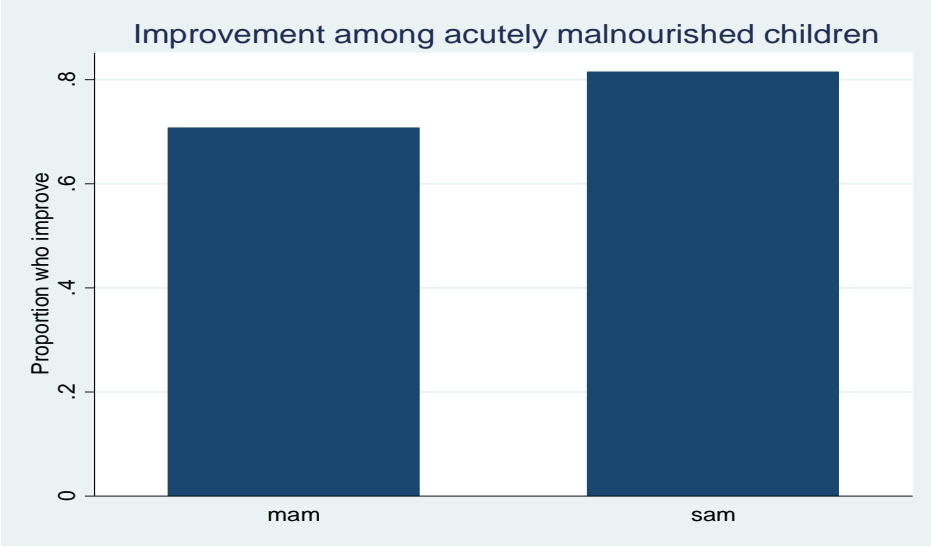


We also estimated multi-level models designed to adjust for individual differences in children and measurement error. With this adjustment we find that height-for-age z-scores improve by .087 for each 6 months in the program, while weight-for-age z-scores improve by .282 and weight-for-height z-scores improve by .328. In other words, more sophisticated statistical models yield about the same results as simple differences.

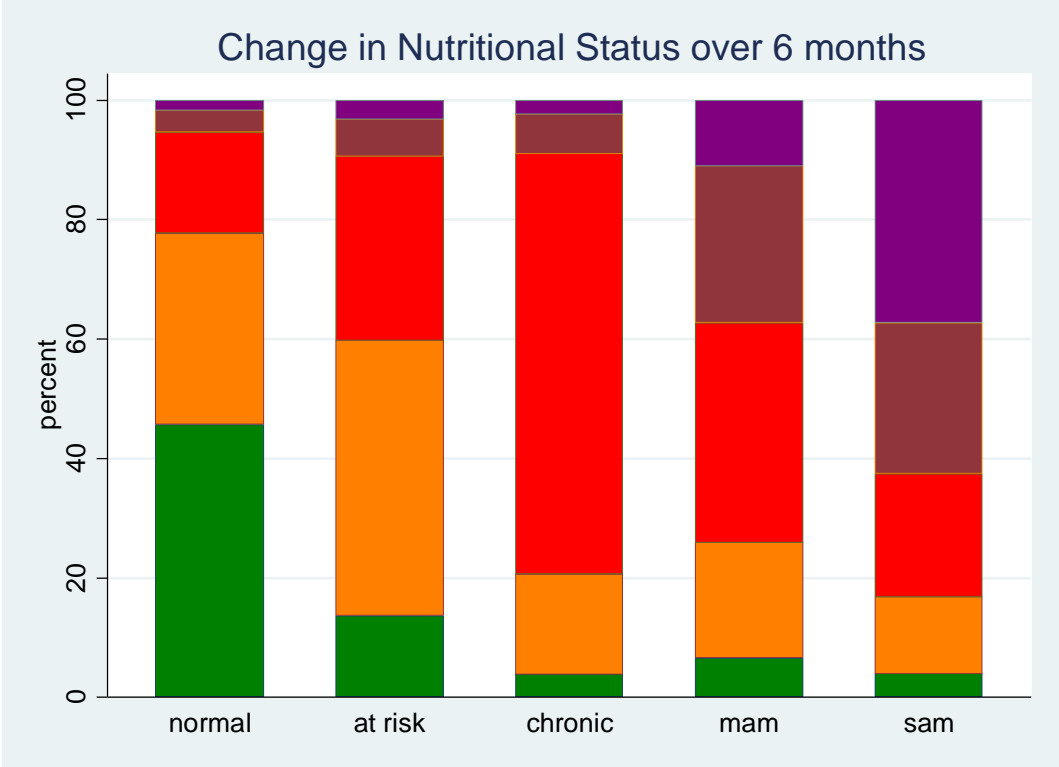
Since z-scores are difficult to interpret in common discourse, we also report the percent of undernourished children who improve. For children who are chronically undernourished, about 50 percent improve in height-for-age, and over 60 % improve in weight-for-age.



Seventy percent of moderately malnourished children improved and 82 percent of severely malnourished children improved.

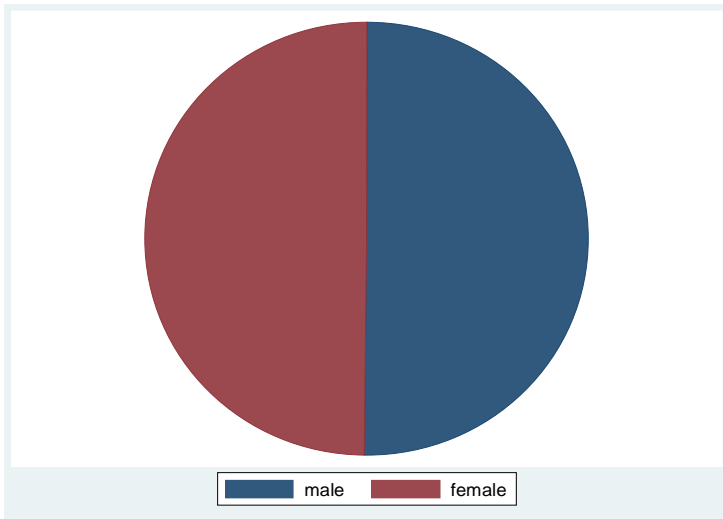


Another way to look at change is to compare a child’s status at the beginning and end of the six months between screenings. Sadly, almost 20 percent of the children who were normal at the beginning become malnourished. This is even higher for children classified as at-risk, where almost 40 percent shifted into the malnourished category. About 20 percent of the chronically malnourished children recovered. As noted previously, full recovery is difficult once children become stunted. Fortunately, most of the MAM and SAM children shifted to a less serious category, but not all of them did. We recommend that acutely malnourished children who do not recover in six months be taken to see a health professional.

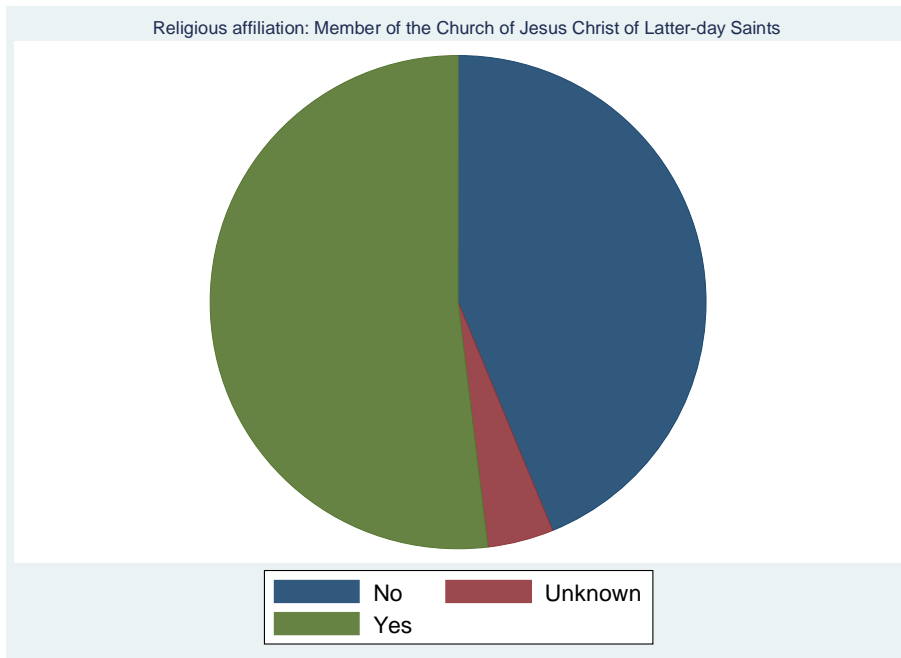


Demographics:

We evaluate equal numbers of males and females.

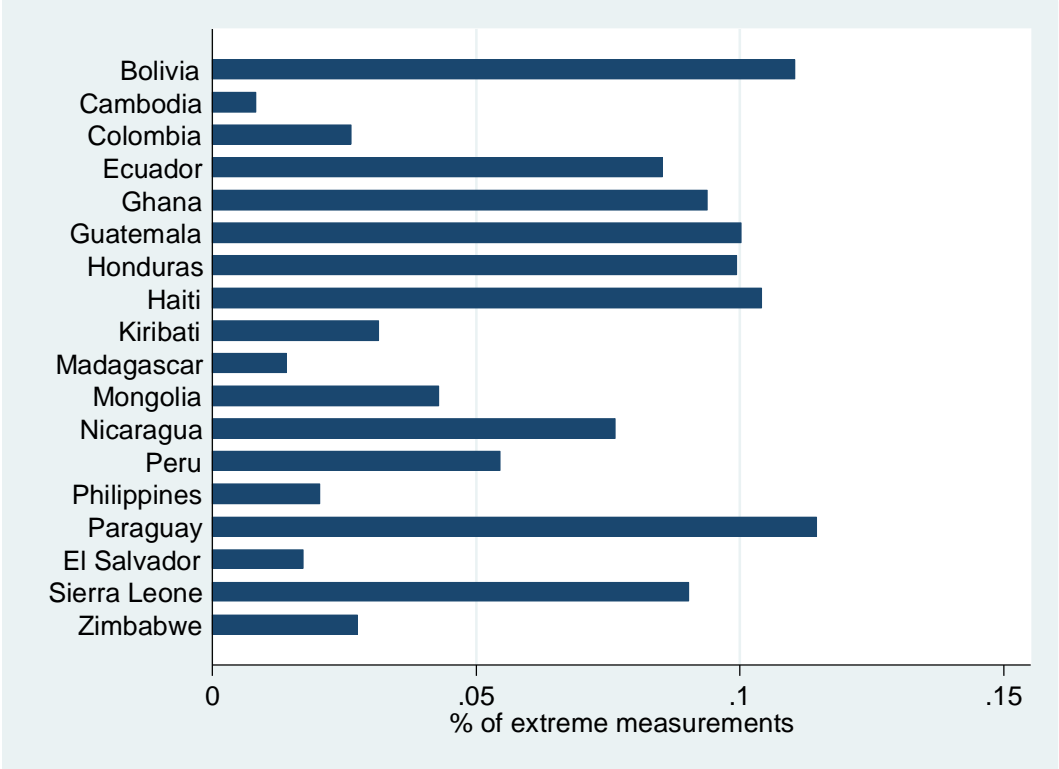


All children are welcome to participate in our programs, regardless of religious orientation. Our coordinators are members of the Church of Jesus Christ of Latter-day Saints and we often use facilities of this Church to evaluate children and teach lessons. Hence, slightly over half of our participants belong to this Church.

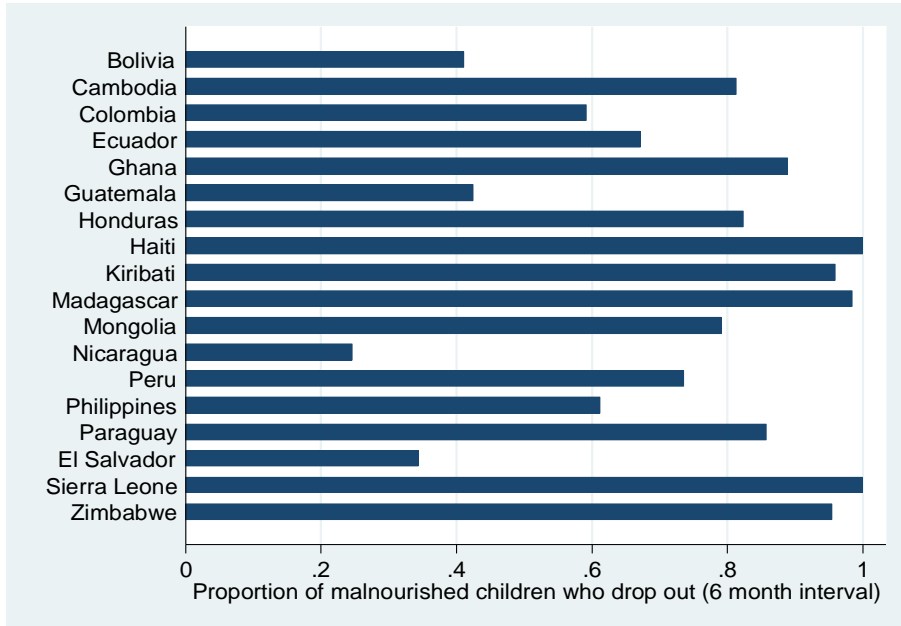


Challenges:

Poor measurement continues to be a serious problem in several countries including Bolivia, Ecuador, Ghana, Guatemala, Honduras, Haiti, Nicaragua, Paraguay and Sierra Leone. Other countries demonstrate that it is possible to achieve lower rates of measurement error. Our plan to improve this includes an increased focus on training in-country coordinators.



Loss to follow-up is another problem that continues to be a concern for us. The majority of children classified as malnourished do not come to be rescreened after 6 months. Thus, they do not get consistent treatment that is important for full recovery.



Loss to follow-up is somewhat higher among children who are not members of the Church.

