

# Summary Baseline Report

*Evaluation for evidence-based decision making*



## WFP Mozambique Gender Transformative and Nutrition Sensitive (GTNS) Programme (2019 to 2021) Summary Baseline Report

### Introduction

This Baseline Report is a key component of the impact evaluation for WFP Mozambique's *Gender Transformative and Nutrition Sensitive project* (GTNS). GTNS is funded by the Austrian Development Agency (EUR 3 million) over a two-and-a-half-year period (2019-2021). It is being implemented in 49 villages in Chemba District, Sofala Province. The project aims to improve women and adolescent girls' empowerment, while increasing dietary diversity and nutrient intake, and reducing stunting among children under 5 (CU5) in the context of a changing climate.

### Objectives and Scope of the Impact Evaluation (Baseline and Endline)

The objective of the evaluation (baseline and endline) is to assess the project's contribution to reducing stunting among children under-five and the empowerment of women and girls, through a baseline survey and an endline survey. The evaluation is intended to serve the twofold **purpose of accountability** (by assessing and reporting on project performance) and **learning** (by generating insights to support and enhance scaling up of GTNS's integrated intervention model to other contexts).

### Subject of the Evaluation

The programme's primary target group is 1,500 households, comprising 7,500 individuals of whom at least 500 are pregnant and/or lactating women (PLW), 500 are adolescent girls, and 750 children are under two years of age (CU2). These primary beneficiaries are being reached through Food Assistance for Assets (FFA) and Post-Harvest Loss (PHL) components. The programme's secondary target group is 5,000 households, comprising 25,000 individuals, who are reached through Social and Behavioural Change Communication (SBCC). The programme's impact and outcomes are:

**Impact:** Women and adolescent girls' empowerment enables improved dietary diversity and nutrient intake, and reduced stunting among girls and boys under 5 in the context of a changing climate.

**Outcome 1:** Improved availability, diversity and consumption of nutritious food by women, adolescent girls and CU2 through gender- and nutrition sensitive household and community asset creation, and PHL trainings that contribute to climate risk management.

**Outcome 2:** Increased empowerment of women and adolescent girls in relation to early marriage, sexual and reproductive health, and health seeking behaviours for basic childhood illnesses through intensive SBCC targeted at women, men, girls and boys.

**Geographic Targeting:** The programme is being implemented in Mulima Administrative Post in Chemba District, Sofala Province (Figure 1). This location was identified through WFP's Integrated Context Analysis (ICA) tool, which is developed with the government, and uses historical trend data to identify hotspots for intervention. The ICA assessed Chemba as category 1, which means that it experiences persistent food insecurity and recurrent natural shocks. According to the Integrated Phase Classification, Chemba is category 3 – severely chronically food insecure.

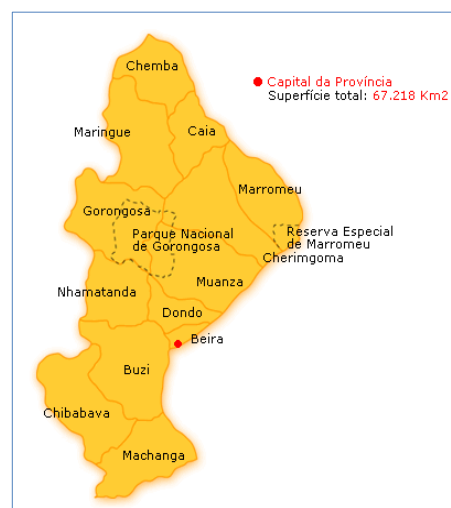


Figure 1. Map of Sofala Province

### Methodology

A Non-Equivalent Group Design was used to evaluate the programme's impact on nutrition, livelihoods and women's empowerment. This is because the communities where the programme is being implemented were purposively, rather than randomly, targeted.

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Moreover, households within these communities that meet the project's inclusion criteria and make up the primary beneficiary group, were targeted through a community-based participatory process. Those that were targeted have the option of participating or not participating in the project's FFA and PHL components.

For the Baseline Report, sample households containing PLW and CU2, were chosen at random in 49 intervention and 49 control villages. Baseline data were collected from 640 randomly sampled households, and anthropometric data were collected from a total of 997 CU5 within these households.

## Key Findings

This section presents the results of baseline survey. The results for 18 outcome indicators and one additional indicator for programme exposure are presented and reviewed.

## Women's Empowerment Indicators

### Women's Participation in Household Decision-Making

The ability to make choices is an important dimension of women's empowerment and socio-cultural status. Agency or empowerment is defined as the ability to define one's own goals and act upon them even in the face of opposition from others. The baseline status for indicators pertains to women's reported involvement in decisions, as well as control and agency.

Women were first asked who usually decides whether they can go to hospital or seek health services. Almost all women (approximately 95%) in both intervention and control groups reported that it is they who decide. They were further asked who in their households decides whether they can visit family or other relatives. Only 28% expressed that such decisions were made in their respective households. However, among those for which this question was relevant, about 90% reported it is they, themselves, who decide. With respect to the use of agricultural produce and income from farm and off-farm sources, less than 20% of women in both the intervention and control groups reported that only men in their respective households make such decisions. According to these three indicators, most women in both the intervention and comparison villages appear to be significantly empowered.

### Women's Empowerment in Agriculture Index

Baseline data were collected on an abridged version of the Women's Empowerment in Agriculture Index (Pro-WEAI) which has ten indicators under three categories of agency: intrinsic agency (power within), instrumental agency (power to), and collective agency (power with). Each indicator was equally weighted. A woman is considered empowered if she scores positively on three or more of the ten indicators. Consequently, a score of 1 is given when this threshold is reached on this index which ranges from 0-1. Women who do not meet this cut-off but score positively on at least

one of the weighted indicators, are allocated a weighted index score.

Figure 2 shows average WEAI scores for women in the intervention and control groups. The graphs show relatively higher average scores on three indicators: input in productive decisions, ownership of land and other assets, and access to and decisions on credit. Women in the intervention group appear more empowered, as compared with their counterparts in the control group.

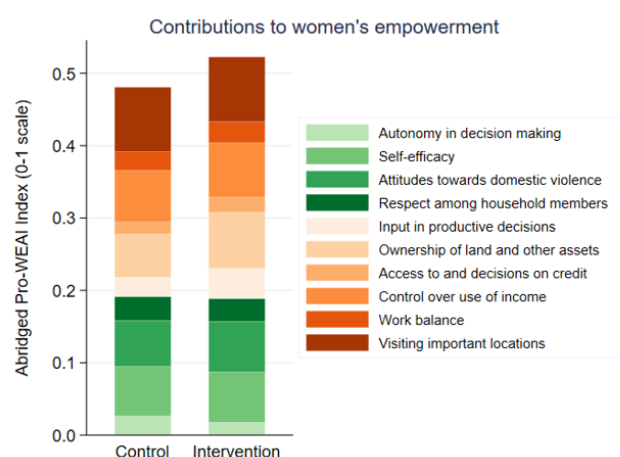


Figure 2. Pro-WEAI index and relative indicator index contribution

## Health Attitudes and Service Access

### Four or more (4+) Antenatal Care Visits

Antenatal care plays an important role in infant, child and women's health through screening for risk factors, and the provision of information on healthy pregnancies and health inputs for mothers and babies. During the baseline survey, women were asked to describe their experiences with antenatal care services, with reference to their child under 2 from whom anthropometric measurements were taken. Approximately 83% and 77% of women from the control and intervention groups respectively remembered the number of prenatal appointments made. The mean number of appointments attended was five, with no statistically significant difference between the two groups. The percentage of women who attended at least four antenatal sessions was 71% for the control and 73% for the intervention groups; this difference is statistically insignificant.

### Favourable Attitude Towards Recommended Practices

The SBCC component aims to increase women and adolescent girls' empowerment in relation to early marriage, sexual and reproductive health, and health seeking behaviours for basic childhood illnesses. The baseline survey asked respondents questions pertaining to their attitudes towards three recommended practices: 1. To seek advice when a child experiences breathing difficulties; 2. To use contraception to space pregnancies for the health of mother and child; 3. Before first pregnancy, young women

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should practise family planning. Most respondents in both groups agreed that it was important to seek medical advice when a child experiences breathing difficulties. However, only 11% and 6% of respondents, in the control and intervention groups respectively, agreed with all three recommended practices. There is therefore a clear opportunity for the GTNS programme to contribute to improved attitudes and perceptions towards health practices.

### Attitudes Towards Early Marriage

Respondents were also asked the extent to which they agree that marriage prior the age of 18 years has negative consequences for girls. Over one-third in both groups expressed that they did not know if this was the case, while only 33% and 26% of respondents in the control and intervention groups respectively agreed with the statement. There are therefore opportunities for the GTNS programme to contribute to improved attitudes and perceptions towards early marriage.

### Assisted Delivery at a Health Facility

The baseline survey collected information about the location in which CU2 (from whom anthropometric measurements were taken) were born. In both intervention and control groups, 80% were reported as being born at a health facility. The small difference in favour of the control group is statistically insignificant.

## Child Health and Nutritional Status Indicators

### Prevalence of Child Illness

Caregivers of sample CU2 were asked whether these children had suffered from any illnesses two weeks prior to the survey and, if so, the type of illness. Fever and malaria were the most commonly reported (at 50% and 46% in the control and intervention villages, respectively) followed by diarrhoea and acute respiratory infection/cough. Less than one third of respondents in both groups reported that their children had been illness-free in the two weeks prior to the survey.

### Dietary Diversity (6-23-month-old children)

The age range for dietary diversity and nutritional adequacy analysis among sampled children 6-23 months, following WHO recommendations that children should be exclusively breastfed until 6 months of age.

Figure 3 presents the percentages of food items consumed by children aged 6-23 months during the day preceding the survey, disaggregated by age category. Food made from grain, roots, and tubers was the most common food item consumed (78%, 72% and 83% for children aged 6-11 months, 12-17 months and 18-23 months respectively). Food from the fruits and vegetables category is a distant second, followed by legumes.

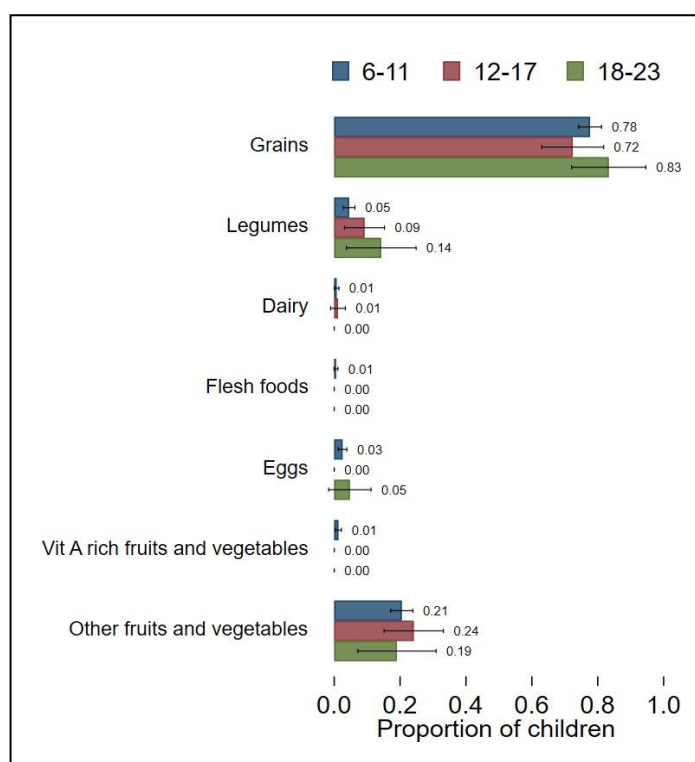


Figure 3. Food consumed during previous day by children aged 6-23 months by age category

### Minimum Acceptable Diet

**Minimum Dietary Diversity (MDD)** measures the proportion of children aged 6-23 months who consumed food from four or more food groups during the previous day. **Minimum Meal Frequency (MMF)** measures the proportion of breastfed and non-breastfed children aged 6-23 months who receive solid, semi-solid or soft foods (including milk for non-breastfed children) a minimum number of times or more during the previous day. The minimum frequency is conditional on the child's age and whether the child is breastfed or not. It is two times for breastfed infants aged 6-8 months, three times for breastfed children aged 9-23 months, and four times for non-breastfed aged 6-23 months. **Minimum Acceptable Diet (MAD)** is a composite indicator that measures proportion of children aged 6-23 months who can be considered as having a minimum acceptable diet. The baseline results indicate that almost no children aged 6-23 months met the cut-off for MDD ( $\geq 4$  food groups). This is largely driven by low levels of dietary diversity, as indicated Figure 3.

### Under 2 and Under 5 Anthropometric Results

The baseline survey collected anthropometric data from a total of 1,517 children based on physical body measurements of weight, height/length and how they relate to the age and sex of the child. Out of the 1,517 anthropometric measurements, only 997 were within acceptable ranges to be used for final analysis.

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National under 5 stunting prevalence in Mozambique, as measured by World Development Indicators (WDI) in 2008, 2011 and 2015, average 45-47% for boys and 38-41% for girls. Baseline estimates for under 5 stunting in both intervention and control groups is 42% for boys and 36% for girls. Although these estimates are lower than national averages, they are classified as high (girls) and very high (boys) according to WHO's severity index.

National under 5 wasting prevalence in Mozambique, as measured by WDI in 2008, 2011 and 2015, is 5.3% for boys and 5% for girls. The baseline found prevalences of 6% for boys and 5% for girls in the intervention group, and 7% for boys and 8% for girls in the control group. Both groups have higher rates than the national average and, apart from the girls in the intervention group, are classified as serious according to WHO's severity index.

## Post-Harvest Loss

PHL are crop losses that occur between harvest and consumption. Such losses can be due to on-farm factors, such as improper harvesting or storing; or off-farm factors, such as lack of access to roads or appropriate means of transportation.

The baseline survey captured information on household crop production, yield, and the respondents' assessment of PHL. Among those households that reported farming in the previous agricultural season, respondents were asked to provide their assessment of PHL due to on-farm factors and off-farm factors. The PHL indicator is calculated as a percentage PHL vis-à-vis total harvest in kilograms.

Variable	Control (1) Mean	Intervention (2) Mean	Dif. (2-1)
<b>Post-harvest loss factors</b>			
Any loss on crops grown due to on-farm factors	0.545 (0.499)	0.591 (0.493)	0.046 (0.057)
Any loss on crops grown due to off-farm factors	0.045 (0.208)	0.052 (0.222)	0.007 (0.028)
Post-harvest loss (average proportion lost)	0.262 (0.355)	0.313 (0.390)	0.051 (0.045)
<b>Observations</b>	<b>285</b>	<b>279</b>	<b>564</b>

*Figure 4. Proportion of households reporting on-farm and off farm loss factors and PHL*

The average harvest per household is 379 kgs and 275 kgs for the intervention and control households, respectively. Figure 4 displays the baseline PHL results for the intervention and control groups. The estimated PHL is 26% for the control households and 31% for the intervention households, and this difference is statistically insignificant. The estimated values are within the range of the national PHL, which are estimated to be over 30%. Approximately, 55% of households in the control group and 59% from the intervention group reported PHL due to on-farm factors, while about 5% of households in both the control and intervention groups reported losses due to off-farm factors.

## Programme exposure indicator

### Proportion of Households Receiving Food Assistance

During the baseline survey, households were asked specific questions about their exposure to programmes implemented by the government, community-based organisations and non-governmental organisations. A very high percentage of households in the intervention villages – 87% – reported benefitting from such programmes, against only 3% of households in the control villages. Of these beneficiary households, 93% reported that they had received food assistance from WFP. Put another way, 78% of households in the intervention group reported having already been exposed to the FFA voucher distribution of the GTNS, which was implemented prior to baseline data collection. As such, the data cannot be treated as pure, baseline data.

This presents both positive and negative ramifications from an impact evaluation perspective. It is positive because the impact evaluation design depends on a high percentage of households with PLW and CU2 in the intervention villages participating in FFA and PHL components. However, it will likely 'water down' GTNS's impact estimates. There are several indicators that are likely to have been affected by programme activities, for example food consumption score (FCS) and food expenditure share. Other indicators, such as some of the more fast-moving anthropometric measures, and even the WEAI, may have been influenced in a positive direction as well. The implication is that many of the project impact estimates that will be generated at endline will likely have been watered down considerably, thereby affecting the impact evaluation's ability to estimate the full impacts of GTNS.

## Household food security indicators

Food consumption serves as a pathway to assess how the programme's asset creation, PHL mitigation and direct nutrition support will affect nutrition and food security outcomes.

The asset creation of the FFA component is focused on building nutrition-sensitive community assets, and gender- and nutrition-sensitive household assets, to increase food availability and dietary diversity in the long term; the food transfer is expected to increase household consumption of nutritious foods in the short term. PHL technology and training are also expected to increase the availability and consumption of diverse, nutritious foods. For the purpose of final evaluation, baseline data were collected on the adequacy and diversity of diets in both intervention and control households.

### Household Dietary Diversity Score

The Household Dietary Diversity Score (HDDS), is a proxy for the economic ability of a household to access a variety of foods. It was calculated by collecting data on household consumption of 16 food items, grouped into 13 categories, in the seven days prior to the

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survey. The average number of items from the 13 food categories was considerably higher for intervention households, at almost five compared with under 3.2 items for the control households. Again, this is likely due to programme activities having started before the baseline was conducted.

The vast majority of households (100% and 98% in the intervention and control villages, respectively) reported having consumed foods from the cereal and tuber category in the previous seven days. This is unsurprising as maize is primary staple food of the district. A large majority of households in the intervention villages (90%) also reported consuming pulses, compared with only 28% in the control group. There are also large and statistically significant differences in favour of intervention households in relation to meat, egg, and oil/fat consumption. The difference in consumption of meat and pulses is surprising given that these items are not part of the food ration. It is possible that households used the expenditure saving gained by the FFA voucher to buy these items – however, it is difficult to know for certain as pure baseline data were not collected.

### Food Consumption Score

FCS is a proxy indicator for household food access, and is used to classify households into different groups based on the adequacy of the foods consumed in the week prior to being surveyed. The FCS indicator focuses on three dimensions of food consumption: dietary diversity, food frequency, and relative nutritional importance. The score is calculated using the weighted frequency of consumption of nine food groups consumed by a household during the seven days before the survey. Values are assigned to food groups in terms of their caloric density and macro- and micronutrient content.

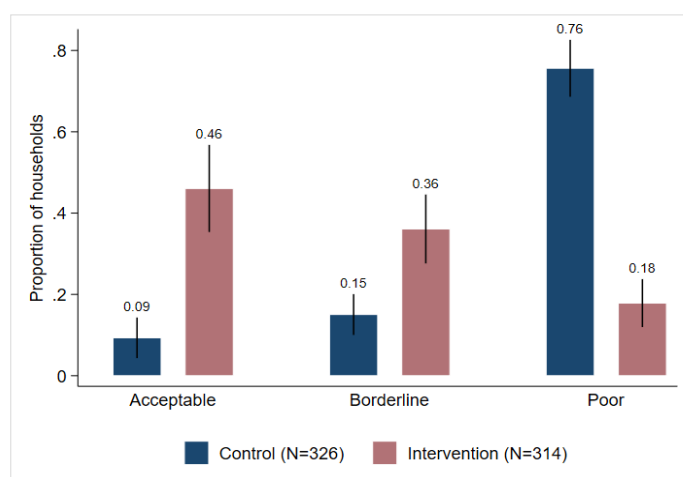


Figure 5. Food consumption adequacy by category groupings (acceptable, borderline and poor)

Figure 5 illustrates the estimated proportion of households within the three food consumption groups. Mean values are presented across the control and intervention households, with error bars indicating a 95% confidence interval for each group. Among the control group, 76% of households fall in the poor consumption

category, compared to 18% in intervention areas. Again, this is likely due to food distribution having occurred in intervention villages before the baseline was carried out, as mentioned above.

### Food Consumption Score – Nutrition

The Food Consumption Score–Nutrition (FCS-N) focuses on the nutritional adequacy of a household's diet. It uses the same data associated with the FCS, and provides an additional level of information on the nutritional value of the foods consumed by the household seven days prior to the baseline survey.

The frequency of consumption of food items was aggregated into three nutrient rich food groups. Vitamin A rich foods include dairy, eggs, and orange fruits and vegetables. Protein rich foods include pulses, dairy, flesh meat, organ meat, and fish and eggs. Hem iron rich foods include flesh meat, organ meat and fish. Following WFP's Consolidated Approach to Reporting Indicators of Food Security (CARI) module, households were categorized into three consumption frequency categories for each of the three nutrient rich food groups. These are: zero times in the last seven days (Never); 1-6 times in the last seven days (sometimes); and every day (at least daily). Figure 6 shows the percentages of households within the three consumption frequency groups of nutrient-rich foods. While households in the intervention villages score better in relation to both Vitamin A and protein consumption, there is considerable room for improvement, as is the case for households in both groups with respect to iron rich foods.

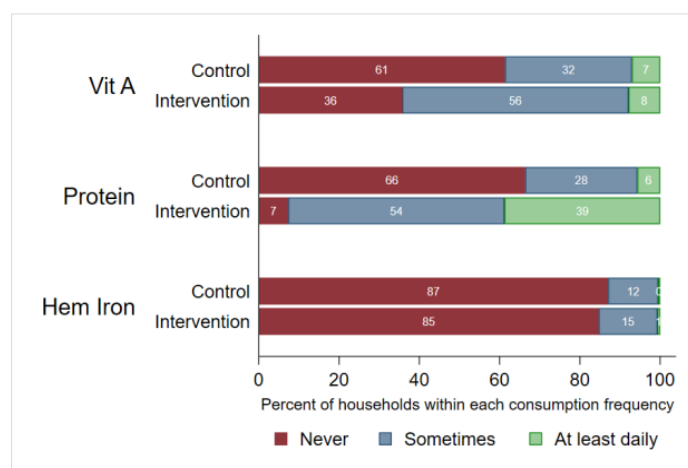


Figure 6. Percentage of households within the three (0 days, 1-6 days, 7 days) consumption frequency groups of vitamin A, hem iron and protein rich foods

### Food Expenditure Share

Food expenditure share is an indicator of a household's vulnerability; poor households tend to spend a larger share of their income on food. During the survey, respondents were asked how much they spent on various food items during the previous month, as well as non-food items that are regularly purchased (e.g. toothpaste, transport, and haircare products). They were also

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asked about non-food items irregularly purchased (e.g. agricultural inputs, school and hospital fees and mechanical equipment) over the previous six months. The latter were converted into monthly values in order to compute the proportion of total household expenditure spent on food.

A significant reason why the food expenditure share is likely significantly greater among households in the control villages (in Figure 7) is because most households in the intervention villages benefited from WFP food assistance and, therefore, spent less on food, either on a cash or credit bases. Hence, concluding that households were less vulnerable in the intervention villages prior to the programme implementation is likely to be misleading.

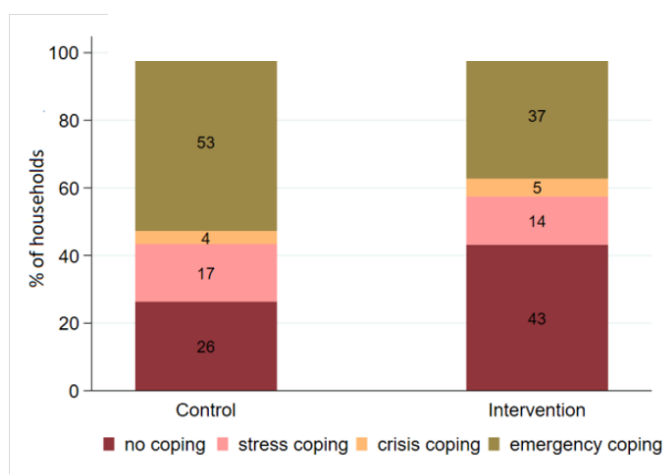


Figure 7. Households adopting livelihood coping strategies by category

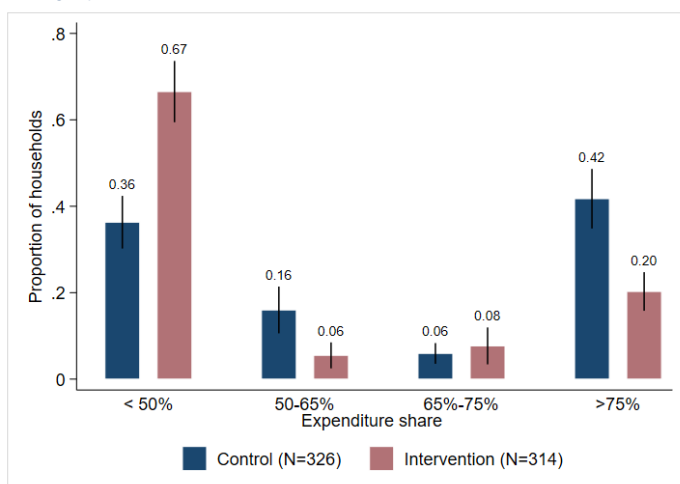


Figure 8. Proportion of households by food expenditure share category

### Livelihood Coping Strategies

The Livelihood Coping Strategies (LCS) indicator is constructed from a series of questions regarding the household's experience with livelihood stress and asset depletion during the previous 30 days prior to the survey. Following WFP's CARI module, the specific

livelihood coping strategies reported by the household were categorized into three groups: stress, crisis, and emergency strategies. Figure 9 shows the difference between control and intervention households.

Stress strategies indicate a reduced ability of the household to deal with future shocks due to asset depletion or increased indebtedness. The strategies adopted by the household can include borrowing money or spending savings. Crisis strategies are strategies that directly reduce future productivity, including human capital formation, such as the selling of productive assets. Emergency strategies can affect future productivity and can be more difficult to recover from, such as the selling one's land.

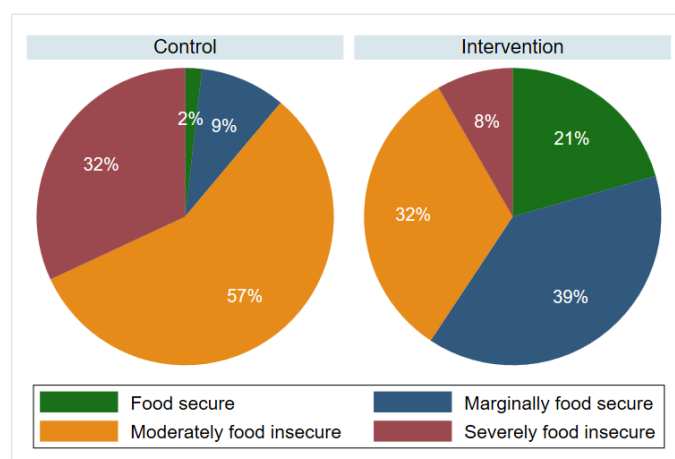


Figure 9. Households adopting livelihood coping strategies by category

### Reduced Coping Strategies Index

The Reduced Coping Strategies Index (rCSI) narrows in more specifically on food related coping strategies, and therefore complements the LCS Index. It is based on a universal list of five coping strategies and a common set of severity weights. During the survey, household respondents were asked how many times during the last seven days they relied on each of the following five strategies:

- Rely on less preferred and less expensive food
- Borrow food or rely on help from a relative or friend
- Limit portion size of meals at mealtimes
- Restrict consumption by adults for small children to eat
- Reduce number of meals eaten in a day

The data showed that that households in the control villages were more likely to resort to undertaking both more and more severe consumption-based coping strategies than the intervention households. The mean difference for the overall rCSI is statistically significant. However, households in the control villages are much more likely to be food insecure compared to households in the intervention villages.

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## Food Security Index

The Food Security Index (FSI) represents a household's overall food security status. It is constructed by combining food security indicators into a composite indicator based on WFP's CARI approach. It is a composite indicator of the food consumption score and coping capacity represented by maximum coping behaviour and food expenditure share. Specifically, the four-point FSI is calculated first by aggregating the averages of the above coping strategies and expenditure share categories. This value is then combined with household food consumption by averaging the two. The value is rounded off, which groups households into four discrete categories: 1) Food secure; 2) Marginally food secure; 3) Moderately insecure; and 4) Severely insecure

As shown in figure 9, large differences between intervention and control households are clearly visible. For instance, 32% of households in the control villages are classified as severely food insecure, while this is only 8% in the intervention. Conversely, 21% of households in the intervention villages are food secure, while this statistic is only 2% in the control villages. These differences are highly statistically significant.

## Lessons Learned for Future Data Collection

### 1. Ensure adequate lead time for data collection preparation and implementation:

As discussed, the implementation of the FFA component began prior to baseline data collection. This will seriously affect the impact evaluation's ability to measure the full potential impacts of the project. Due to the integrated nature of the project, it was difficult to identify an institution with the requisite skill-set to implement the baseline, and understandably, there was pressure to implement planned project activities on schedule. In the future, adequate time should be given to carry out baseline data collection prior to project activity implementation.

### 2. Invest heavily in both field-level and remote data collection quality oversight:

In hindsight, better efforts to check and oversee data quality should have taken place, both remotely through the server operated by ICRAF and in the field. For the former, this requires fulltime dedicated effort, so adequate time and budget should be set aside for this. For the latter, stricter procedures are needed to check, verify, and undertake corrective measures as necessary of inputted data in the field prior to uploading.

## Recommendations

There are four key recommendations:

### 1. Ensure the SBCC component adequately delivers nutrition educational messaging, and targets men and adolescent boys, as well as women and adolescent girls

Improving dietary diversity is a key issue that needs to be addressed in order to improve nutrition outcomes among both PLW and CU5. Evidence from other contexts shows that this does not necessarily happen automatically with increased access to food or improvements in income. The SBCC component is therefore both highly relevant and important. It is also widely acknowledged that changing gender relations necessitates engaging both women and men. Consequently, the SBCC component should design appropriate interventions that target both, building on insights obtained through the first knowledge, attitudes, and practices (KAP) survey, and addressing undesired attitudes evidenced in the baseline survey, e.g. those related to contraceptive use and early marriage.

### 2. Tailor the KAP and endline surveys to capture data and insights not covered by the baseline survey, including from men and adolescent boys and key contextual barriers that are likely to inhibit desired behaviour change

The baseline survey captured data on a predefined set of quantitative indicators and did not comprise a qualitative component. Yet, additional context-related insights, e.g. barriers against accessing healthcare services and diversifying diets, would be useful for informing the detailed design of interventions, as would understanding the knowledge and attitudes of men and adolescent boys and how these may change over the course of the project's lifespan. The planned KAP surveys should therefore be designed to address such prioritized gaps. Data on key indicators, such as MDD-Women, not captured during the baseline survey can also be collected during the endline survey, but administering the survey over several sessions is recommended to avoid respondent fatigue and corresponding data quality shortfalls.

### 3. Leverage the FFA and PHL components for sustainability

As highlighted above, there is evidence that the FFA component already made a difference, even following the one double distribution. There is an obvious concern that these benefits could discontinue once the distribution stops. The asset building component of FFA and the PHL component are designed to promote such sustainability. It is therefore critical that these two elements are designed and implemented well.

### 4. Consider revising some of the indicator targets

The baseline recommends some revisions to the original project indicators (See Annex 1). Many non-project related factors are likely to shape the trajectory of these indicators. Consequently, attention should be given to evaluating how these indicators change over project lifetime vis-à-vis the households, women and children in the control villages.

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## Conclusion

The results of the baseline survey validate the relevance of the GTNS programme in the context in which it is being implemented. The nutritional status of children is low, with 39% and 37% of CU5 being stunted in the intervention and control villages respectively, and very few children under 2 reaching the MAD threshold. While GTNS food assistance had likely had an effect at the time of baseline

data collection, household dietary diversity is a cause for concern, and there is considerable room for improving protein intakes. Women and girls' empowerment, PHL and health-seeking attitudes / behaviour are also worthy of intervention, both intrinsically as well as for their effects on the nutritional status of children. Finally, most female respondents reported less than desirable attitudes to early marriage and the use of contraception for family planning.

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*Evaluation for evidence-based decision making*



## ANNEX 1 :

#	GTNS Indicator	Intervention Villages	Control Villages	Initial Target	Recommendation for targets
1.	% of HH benefiting from food assistance	87%	3.4%	none	Set afresh
2.	Food consumption score (FCS) (% of HHs at Acceptable Level)	46%	9%	↑ by 5%	Increase significantly
3.	Food Consumption Score-Nutrition (FCS-N)			↑ by 5%	Increase for protein-rich foods
	a. Vit A rich foods (daily consumption)	8%	7%		
	b. Protein rich foods (daily consumption)	39%	6%		
	c. Hem Iron rich foods (daily consumption)	0.7%	0.5%		
4.	Household Dietary Diversity Score (HDDS) (Substitute for MDD-W)	4.95	3.17	None	Set afresh
5.	Food expenditure share (FES) (% HHs with 65% FES or greater)	28%	48%	None	Set afresh
6.	Livelihood Coping Strategies Index (LCSI) (Average weighted score out of 29 possible points)	3.7	4.7	↑ by 30%	Maintain but phrase as reduction
7.	Reduced Coping Strategies Index (rCSI) (Average weighted score out of 56 points)	17.9	9.4	None	Set afresh
8.	Post-harvest losses (PHL) (Average % of crop lost post-harvest)	31%	26%	↓ by 5%	Consider decreasing further
9.	Women's decision-making participation			↑ by 30%	Re-evaluate appropriateness of first two sub-indicators & reduce second by 10%
	a. Decisions on own health care access	93%	95%		
	b. Decisions on visiting family members/relatives*	90%	93%		
	c. Input into agriculture output and income use	76%	71%		
10.	Pro-WEAI (average index score)	0.52	0.48	None	Set afresh
11.	4+ antenatal care visits	73%	71%	↑ by 5%	Consider increasing to 10%
12.	Favorable attitude towards all 3 recommended practices (medical access & contraceptive use):	11%	6%	↑ by 25%	Maintain
13.	Favorable attitude against early marriage (Agree that it brings negative consequences)	26%	33%	None	Set afresh
14.	Assisted delivery at health facility (% of under-2s delivered at health facility)	82%	84%	↑ by 5%	Consider increasing to 10%
15.	Health seeking behavior (Healthcare visit or advice when child had cough/fever)	89%	89%	↑ by 3%	Consider increasing to 5%
16.	Prevalence of child illness (% with one or more reported illnesses previous 2 weeks)	68%	74%	None	Set afresh
17.	Minimum acceptable diet for children age 6-23 (MAD): (% reaching cut-off)	1.1%	0%	↑ by 10%	Maintain
18.	Prevalence of stunting			↓ by 2%	Maintain
	a. Under-2s	32%	34%		
	b. Under-5s	39%	37%		
19.	Prevalence of wasting			None	Set afresh
	a. Under-2s	8%	11%		
	b. Under-5s	6%	9%		

### Reference:

Full report of the evaluation is available at <http://www1.wfp.org/independent-evaluation>

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