

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 (BLR) is a *key component of the impact evaluation for the World Food Programme's (WFP) Mozambique Gender Transformative and Nutrition Sensitive project (GTNS)*. GTNS is funded by the Austrian Development Agency (3 million Euros) over a two- and half-year period (2019-2021). It is being implemented in 49 villages in Chemba District, Sofala Province. It aims to improve women and adolescent girls' empowerment, while increasing nutritional diversity and reducing stunting among girls and boys under the age of five in the context of a changing climate. This evaluation is commissioned by the WFP Mozambique Country Office (CO).

Objectives and Scope of the Evaluation

The objective of the evaluation is to assess the project's contribution to reducing stunting among children under-five and the empowerment of women and girls. 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 out of GTNS's integrated intervention model to other contexts).

Subject of the Evaluation

GTNS programme primary target group is 1,500 households, comprising of 7,500 individuals, including at least 500 pregnant women, 500 adolescent girls, and 750 children under-two years of age. These are to be reached through Food Assistance for Assets (FFA) and Post-Harvest Loss (PHL) components. Its secondary target group is 5,000 households, comprising approximately 25,000 individuals, to be reached through Social and Behavioural Change Communication (SBCC) component. The programme expected and stated impact and outcomes are as follows:

Impact: Women and adolescent girls' empowerment enables improved nutritional diversity and reduced stunting among girls and boys under the age of five in the context of a changing climate.

Outcome 1: Improved availability, diversity, and consumption of nutritious food by women, adolescent girls, and children under-two through gender and nutrition sensitive household and community assets creation and post-harvest loss trainings in Chemba district that contribute to climate risk management.

Outcome 2. Increased women's and adolescent girl's empowerment related to early marriage, sexual and reproductive health, and health seeking behaviours for basic childhood illnesses through intensive SBCC targeted towards men, women, boys and girls.

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. The ICA is developed with the Government and makes use of historical trend data to identify geographical hotspots for intervention.

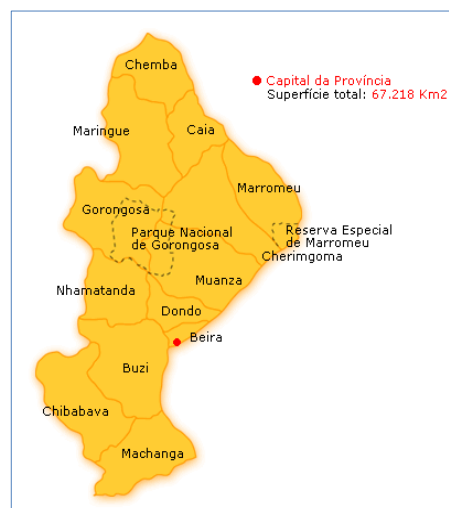


Figure 1 Map of Sofala Province

It assessed Chemba District as category 1, which means that it experiences persistent food insecurity and recurrent natural shocks. Moreover, as per the Integrated Phase Classification, Chemba is classified as category 3 —severely chronically food insecure.

Methodology

To evaluate the programme impact on nutrition, livelihoods, and women's empowerment a Non-equivalent Group Design (NEGD) is being used. This is because the communities where it is being implemented were purposively, rather than randomly, targeted. 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. And those that were targeted have the option of participating or not participating in the project's FFA and PHL components.

Reference:

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Baseline data was collected from 640 randomly sampled households, and anthropometric data was collected from a total of 997 children under five within these households.

Key Findings

This section presents the results of baseline survey. The results for 18 outcome indicators and 1 additional indicator for program exposure are each presented and reviewed individually.

Programme exposure Indicators

Proportion of households receiving food assistance

During the baseline survey households were asked specific questions pertaining to their exposure to programmes spearheaded by Government, community-based organizations (CBOs), and non-governmental organizations (NGOs). A very high percentage of households in the intervention villages reported having had benefited from external assistance (87%), against only 3% of households in the control villages. Moreover, out of those households that reported such exposure, 93% reported that they had received food assistance distributed by WFP.

This is both good and bad from an impact evaluation design perspective. It is good because the impact evaluation design depends on a high percentage of households with both under-two children and pregnant women/under-1-year children in the intervention villages participating in FFA and PHL components. It is bad, however, because it will likely ‘water down’ GTNS’s impact estimates, as explained in the full baseline report.

Household food security indicators

Food consumption is of interest in this evaluation because it serves as a pathway through which the asset building, post-harvest loss training, and direct nutrition support is expected to affect households and individual nutrition, and food security outcomes. The community and household asset creation intervention, for example, may increase household income and the production of nutritious food, allowing households to consume a more diverse and nutritious diet.

The FFA component of the programme emphasises on creating nutrition-sensitive community assets and gender and nutrition sensitive household assets to increase food availability and diversity in the long term. However, direct conditional food transfer is expected to increase households short term consumption of nutritious foods. Post-harvest loss technology and training is also expected to increase the availability, diversity, and consumption of nutritious foods. For the purpose of the evaluation, it is therefore useful to learn from the baseline data how diverse and adequate diets were across both intervention and control households.

Food consumption score

The 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. Higher (lower) weights are assigned to the best (worst) food groups in terms of their caloric density and macro and micro-nutrient content.

Figure 2 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. As is clear, a 76% of households in the control villages fall in the poor consumption category, while this is only 18% among households residing in the intervention villages.

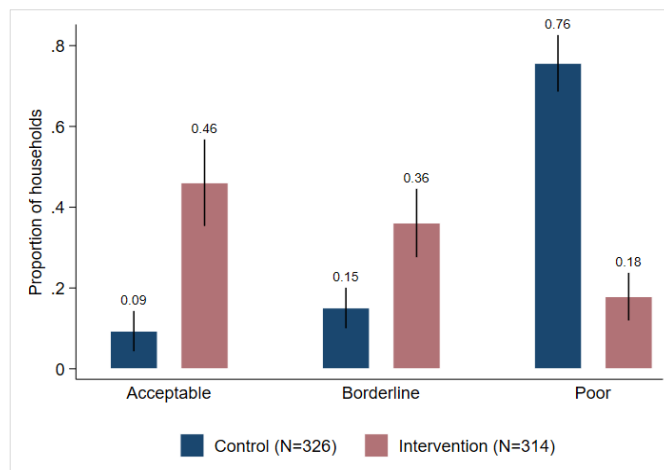


Figure 2 Food Consumption adequacy by category groupings Household Dietary Diversity Score (HDDS)

The Household Dietary Diversity Score (HDDS), is a proxy for the economic ability of a household to access a variety of foods. Its administration involved collecting data on the household’s consumption of 16 food items over the past 7 days prior to the survey, grouped into 13 categories. The average number of items from the 13 food categories is considerably higher for intervention households—nearly five items compared with just under 3.2 items for the control households. The vast majority of households (100% and 98% in the intervention and control villages, respectively) reported to have consumed cereals and tubers in the past seven days. This is not surprising, given that this group comprises food items form the primary staple food of the district—maize. A large majority of households in the intervention villages (90%) also reported to have consumed pulses, as compared with only 28% in the control group. There are also large and statistically significant differences in favour of intervention

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households in relation to meat, egg, and oil/fat consumption. This is surprising, given that the former two items were not part of the food ration distributions. It is possible that households used part of their food expenditure savings to purchase these more desired food items. However, because pure baseline data were not collected it is difficult to know for certain.

Food consumption score – Nutrition

The Food Consumption Score–Nutrition (FCS-N) is another indicator for household food security. It 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 one week 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, orange vegetables, and orange fruits. Protein rich foods include pulses, dairy, flesh meat, organ meat, and fish and eggs. Finally, 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 7 days (Never), 1 to 6 times in the last 7 days (sometimes), and every day (at least daily). Figure 3 shows the percentages of households within the three consumption frequency groups of nutrient rich foods. While households in the intervention villages are better off 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.

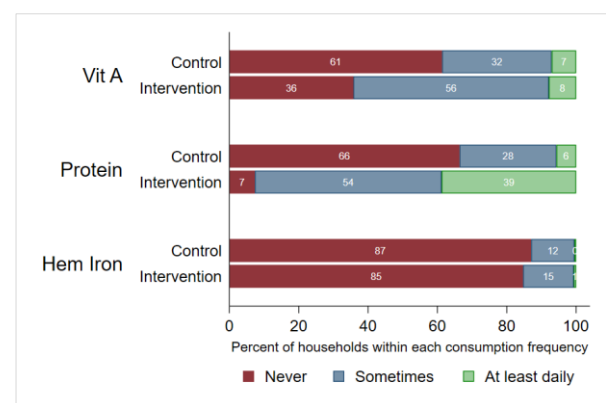


Figure 3 Percentage of households within the three consumption frequency groups of nutrition rich food

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 (e.g. toothpaste, transport, and haircare products) that are regularly purchased. They were also 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 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.

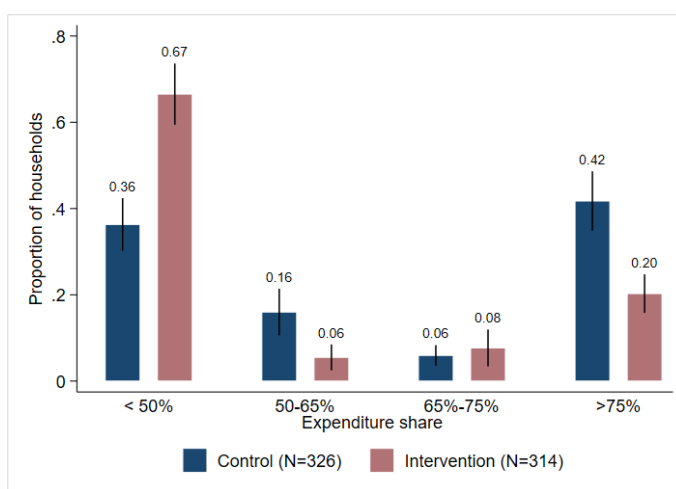


Figure 4 Households Food Expenditure

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 5 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.

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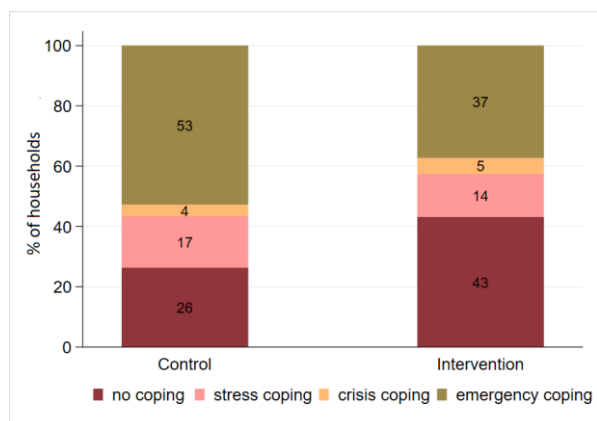


Figure 5 Households adopting livelihood coping strategies by category

Reduced Coping Strategies Index (rCSI)

The rCSI narrows in more specifically on food related coping strategies, and therefore complements the LCSi. 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 five strategies, as shown below

- 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, as compared to households in the intervention villages.

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 6, 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 villages. 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.

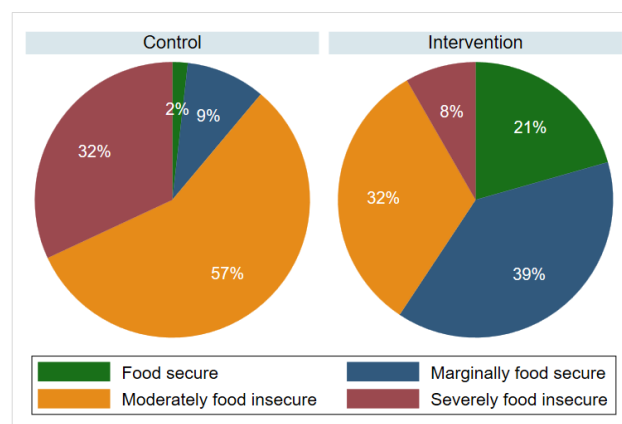


Figure 6 Overall household food security across the treatment and control group

Post Harvest Loss

According to FAO, post-harvest losses (PHL) are crop losses that occur from the site of immediate growth (harvest) to the moment it reaches the consumer. The loss could be due to either on-farm factors, such as improper harvesting, and/or off-farm factors, such as lack of access to road or appropriate means of transportation.

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

Variable	Control (1) Mean	Intervention (2) Mean	Dif. (2-1)
Post-harvest loss factors			
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)
Observations	285	279	564

Figure 7 Proportions of households reporting on-farm and off farm loss factors and PHL

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The average harvest per household is 379 kgs and 275 kgs for the intervention and control households, respectively. Figure 7 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 post-harvest losses, which are estimated to be over 30%. Approximately, 55% of households in the control group and 59% from the intervention group reported post-harvest losses due to on-farm factors, while about 5% of households in both the control and intervention groups reported losses due to off-farm factors.

Women’s Empowerment Indicators

Women’s participating 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 pertaining 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 comparison villages reported that it is they who decide. They were further asked who in their households decide 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.

While not as positive, the situation is similar with respect to decisions on the use of agricultural produce and income from farm and off-farm sources. Less than 20% of women in both the intervention and comparison villages reported that it is only men in their respective households that decide. According to these three indicators, most women in both the intervention and comparison villages appear to be significantly empowered.

Womens Empowerment in Agriculture Index (Pro-WEAI)

Baseline data were also collected on an abridged version of the Pro-WEAI which has 10 indicators under three domains of agency: intrinsic agency (power within), instrumental agency (power to), and collective agency (power with). A woman is considered empowered if she scores positively on three or more of the ten indicators. Consequently, she is given a score of 1 when this threshold is reached on this index that ranges from 0 to 1. Women who do not meet this cut-off and score positively on at least one of the weighted indicators, are allocated a weighted index score.

Figure 8 shows average WEAI scores for women in the intervention and comparison villages. 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 villages appear more empowered, as compared with their counterparts in the control villages.

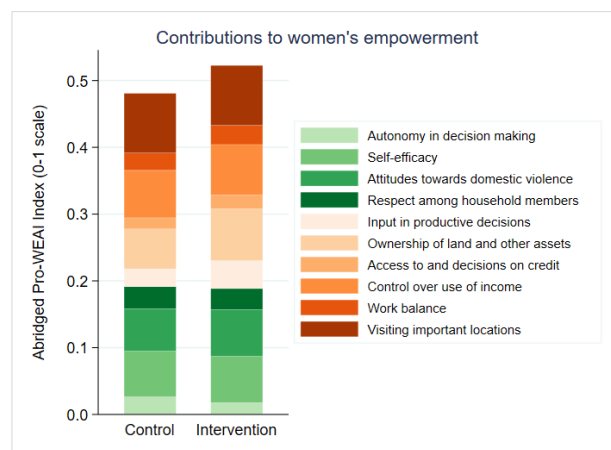


Figure 8 Pro-WEAI index and relative indicator index contribution

Health Attitudes and Service Access

4+ Antennal care visits

Antenatal care (ANC) can play an important role in infant, child, and women’s health through the provision of information on healthy pregnancy, screening for risk factors, and by providing health inputs for mothers and babies. During the baseline survey, women were asked to describe their experiences with antenatal care services with reference to the under-2 child for whom anthropometric measurements were taken. Approximately 83% and 77% of women from the control and intervention villages respectively reported remembering the number of prenatal appointments made. Conditional on attending, the mean number of sessions attended was five visits, with no statistically significant difference between the two groups of women. The percentage of women that attended at least four antenatal session is 71% for the control villages and 73% for the intervention villages, and this difference is statistically insignificant.

Favourable attitude towards recommended practices

The SBCC component intends to increase women’s and adolescent girl’s empowerment related to early marriage, sexual and reproductive health, and health seeking behaviours for basic child illness. The baseline survey asked women respondents questions pertaining to their attitudes towards recommended practices. Only 11% and 6% of the respondents agreed categorically to all three recommended practices in the control and intervention villages, respectively. That said, there is variation in responses across the practices. Most respondents in both groups agreed that it was important to seek medical advice when a child experiences

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breathing difficulties. There are clearly opportunities for 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 brings negative consequences for girls. 33% and 26% of respondents in the control and intervention villages agreed categorically with this statement, while over one-third in both groups expressed that they did not know if this was the case. There are clearly opportunities for GTNS programme to contribute to improved attitudes and perceptions towards early marriage.

Assisted Delivery at a Health Facility

The baseline survey collected information on the location where the 6-23-month child from which anthropometric measurements were taken was born. 80% were reported as having had been born at a health facility in both the intervention and control villages. The small difference in favour of the control group is statistically insignificant.

Child Health and Nutritional Status Indicators

Prevalence of Child Illness

The caregivers 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. This is followed by diarrhoea and ARI/cough. Less than one third of respondents in both the intervention and control villages reported that the children had been illness free two weeks prior to the baseline survey.

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

The age range for dietary diversity and nutritional adequacy analysis among the children is restricted to six months or older, given that six months is the age at which a child's introduction to supplementary feeding is recommended. After 6 months of exclusive breastfeeding as recommended by WHO.

Figure 9 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, 12-17 and 18-23, respectively). Food from the fruits and vegetables category is a distance second followed by legumes.

Minimum Accepted Diet (MAD) – Children

The **Minimum Diet Diversity (MDD)** measures the proportion of children 6-23 months of age who consumed food from four or more food groups during the previous day. **Minimum Meal Frequency (MMF)**, on the other hand, 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 6-8months, three times for breastfed children aged 9-23 months, and four times for non-breastfed aged 6-23 months. 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 (≥ 4 food groups). This is largely driven by low levels of dietary diversity, as indicated Figure 9.

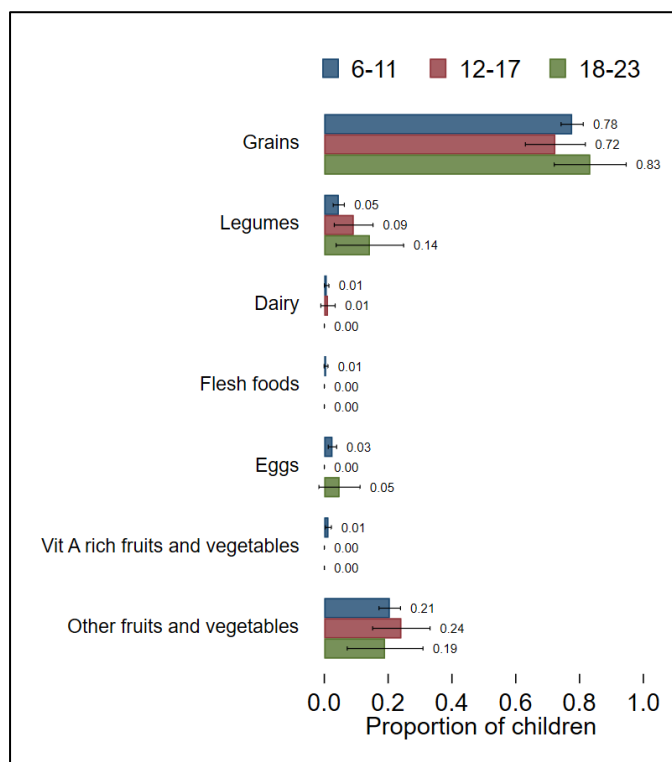


Figure 9 Food consumed during previous day for children aged 6-23 month by age category

Under 2 and Under 5 Anthropometric Results

This section assesses the nutritional status of children under 2 (i.e. 6-23 months) and those between 2 and 5 years of age (i.e. 23-59 months). 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.

The stunting rates pooled for all children below 5 years of age in Mozambique, based on nationally representative estimates from the World Development Indicators (WDI) for three time periods 2008, 2011 and 2015 as well as the baseline estimates

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from the GTNS intervention and control villages conducted in 2020 showed that the national prevalence of under-five stunting for boys averaged between 45% and 47%, while that of girls averaged between 38% and 41% across the three time periods. The average stunting rates among the GTNS sampled villages in Chemba are 42% for boys and 36% for girls. Although the programme target area prevalence of stunting estimates are slightly lower than national averages (which modestly reduced over the three years), they are significantly greater than the WHO severity index for the developing countries average of (25%) and the global average of 22%. This is hardly surprising as it is well documented that Mozambique has one of the highest prevalence of stunting in the world among children under the age of five years, even though the severity and underlying drivers may vary depending on locality.

Some of the main underlying causes of stunted growth, also known as chronic malnutrition among children in Mozambique include inadequate nutritional intake and diet diversity such as low micronutrient-rich foods (other vegetables, fruit, and foods of animal origin), poor knowledge of healthy foods, inadequate food preparation, infrequent meals and high levels of disease. As already highlighted, Chemba District is classified as category 3—severely chronically food insecure, hence the high stunting prevalence.

Conclusions and Recommendations

Overall Assessment

The results of the baseline survey validate the relevance of GTNS programme in the context in which it is being implemented. The nutritional status of children is low, with 39% and 37% of under-fives being stunted in the intervention and control villages, respectively. When disaggregated by gender, the baseline found no significant differences in the prevalence of stunting and its severity between female and male children in the intervention and control samples. While programme's food assistance intervention was likely already having an effect at the time of data collection in terms of improving general household food consumption, household dietary diversity is a concern: very few under-five child in either the intervention or control villages reached the cut-off for the minimum acceptable diet for children (MAD) indicator and vitamin A and iron intake is low at the household level.

Protein intake is considerably higher in the intervention villages, but also with considerable room for improvement. While not as dire, the other outcomes targeted by programme—women's and girl's empowerment, post-harvest loss, and health seeking attitudes and behaviour—are worthy of intervention as well. This is both for their intrinsic importance and as a means of directly and indirectly improving nutritional outcomes.

Call to Action: Recommendations

The findings and conclusions of this baseline leads to the following 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 nutritional outcomes among both pregnant and lactating women and under-five children. 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, that SBCC component should design appropriate interventions that target both, building on insights obtained through the first knowledge, attitudes, and practices (KAP) survey and address undesired attitudes evidenced in the baseline survey, e.g. those related to contraceptive use and early girl 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 behavior 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 health care 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 be designed and implemented well.

Reference:

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4. Consider revising some of the indicator targets

The baseline recommendations some possible revisions to the original project indicators (See Annex 1). It should also be kept in mind that the many non-project related factors are likely to shape the trajectory of these indicators. Consequently, attention should be directed towards evaluating how these indicators change over project lifetime vis-à-vis the households, women, and children in the control villages.

Lessons Learned

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

As discussed above, the implementation of the FFA component commenced prior to baseline data collection. This will seriously affect the impact evaluation's ability to measure

[attribute] the full potential impacts of the project. Understandably, there was pressure to implement planned project activities on schedule. Consequently, in the future, ensure there is adequate time to carryout 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.

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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> For more information please contact the Office of Evaluation wfp.decentralizedevaluation@wfp.org